Outpatient Facility Coding Alert

You Be the Coder: Cancelled, Postponed, or Discontinued? How to Code an Incomplete Colonoscopy

Question: Our gastroenterologist performed a diagnostic colonoscopy under anesthesia but was unable to get past the rectum due to a tight surgical colorectal anastomosis. He discontinued the procedure. The physician suggested that the patient would need surgery to correct the anastomosis. He also mentioned inadequate preparation for the procedure. He then sent the patient to radiology for a barium enema examination. Can I bill the colonoscopy procedure that our gastroenterologist attempted? If so, should I use the modifier 52 or 53?

Oklahoma Subscriber

Answer: Since your gastroenterologist started out the procedure with the intention of performing a complete colon exam, you can bill the colonoscopy with 45378 (Colonoscopy, flexible; diagnostic, including a collection of specimen[s] by brushing or washing, when performed [separate procedure]). You don't mention a place of service, but the location where the procedure is performed will affect which modifier you choose.

If the colonoscopy was performed in an outpatient setting, you'd refer to modifiers 73 (Discontinued out-patient hospital/ambulatory surgical center [ASC] procedure prior to the administration of anesthesia) or 74 (Discontinued out-patient hospital/ambulatory surgical center [ASC] procedure after the administration of anesthesia). In your case, the correct choice would be 74.

Watch Out: Modifiers 73 and 74 should only be used to indicate that a procedure was discontinued due to medical complications. Cancelled or postponed procedures due to reasons besides medical complications (i.e. elective cancellations) are not billable; however, you may bill for services provided to the patient up until the point of elective cancellations.

Good to Know: Modifier 73 is reimbursed at 50 percent of the allowable rate for Medicare patients. However, the patient must be in the operating room or procedure room not the pre-op area. Modifier 74 is reimbursed at 100 percent.

Modifiers 52 (Reduced services) and 53 (Discontinued procedure) are used for physician reporting, not facility reporting. Since your gastroenterologist stopped the procedure due to an unexpected situation where it was unsafe to continue (colorectal anastomosis), you'd append modifier 53 to the colonoscopy code. Modifier 52 would only be used if the patient or provider electively chose to stop the procedure.

Rule of Thumb: Here's a simple way to remind yourself of the difference between modifiers 52 and 53, says **Rhonda Buckholtz, CPC, CPCI, CPMA, CEDO, CRC, CHPSE, COPC, CENTC, CPEDC, CGSC,** vice president of strategic development for Eye Care Leaders. "Think of 52 when you can't complete the procedure, and 53 when it is unsafe to continue, she advises.