Codify
BY AAPC

Modifier Coding Alert

Reader Question: Choose PT or 33 Depending on the Screening Findings

Question: A 67-year-old Medicare patient at average risk for colorectal cancer reports to the surgeon for a scheduled screening colonoscopy. During a complete screening colonoscopy to the cecum, the physician identifies and removes a pair of polyps from the ascending colon using hot biopsy forceps. The pathology indicates that these polyps were benign. How do I report this?

Washington Subscriber

Answer: In this case, you would report 45384 (Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor[s], polyp[s], or other lesion[s] by hot biopsy forceps or bipolar cautery) for the procedure. Attach modifier PT (Colorectal cancer screening test converted to diagnostic test or other procedure) to indicate that the encounter went from a screening to a diagnostic procedure. Use 211.3 (Benign neoplasm of colon) as the diagnosis code.

For Medicare contactors, providers should append modifier PT "to the diagnostic procedure code that is reported instead of the screening (test) when the screening test becomes a diagnostic service," according to the Medicare Physician Fee Schedule Final Rule published in the Nov. 29, 2010 Federal Register.

Tip: You would not bill G0105 (Colorectal cancer screening; colonoscopy on individual at high risk) because the Medicare G codes are for screenings only. Since the surgeon also performed the polyp removal, you can't use the G codes in this case.

On the other hand, modifier 33 (Preventive services) identifies screening/preventive services. Usually, the lack of signs or symptoms would tell you that the service is a screening colonoscopy. If the physician found no polyps, you would append modifier 33 to the screening colonoscopy code (G0105-33).