

How Do You Code Colonoscopies Correctly?

Donald B. Colvin, M.D. • Kelly M. Tyler, M.D.

On behalf of the American Society of Colon and Rectal Surgeons Healthcare Economics Committee

COMMON COLONOSCOPY CODES IN THE ENDOSCOPY CODE FAMILY¹

45378: Colonoscopy, proximal to splenic flexure; diagnostic, with or without collection of specimens(s) by brushing or washing, with or without colon decompression (separate procedure)

45380: biopsy, either single or multiple.

45384: removal of tumor(s), polyp(s), lesions(s) by a hot biopsy

45384: removal of tumor(s), polyp(s), lesions(s) by a snare

45381: directed submucosal injection(s), any substance

45382: with control of bleeding, any method

44389: through a stoma with a single or multiple biopsy

COLONOSCOPIES THROUGH A STOMA

44388: including specimen washing or brushing

44392: with tumor, polyp, or other lesion removal by hot biopsy forceps

44394: with tumor, polyp, or other lesion removal by a snare technique

44401: with tumor, polyp, or other lesion ablation, including pre- and postdilation and guidewire passage

GENERAL GUIDELINES COMMERCIAL AND MEDICAID

- Patients without high-risk factors are eligible for screening colonoscopy every 10 years.
- Beneficiaries at high risk for developing colorectal cancer are eligible once every 24 months.
- Add “modifier 33” (preventive) to each Current Procedural Technology (CPT).

CENTERS FOR MEDICARE AND MEDICAID COLONOSCOPY G CODES

G0105: colorectal cancer screening; colonoscopy on individual at high risk (history of colon cancer, polyps, or family history of polyps or colon cancer)

G0121: colorectal cancer screening; colonoscopy on individual not at high risk

Biopsy codes are the same as for Commercial and Medicaid coverage

WHAT IS A G CODE?²

- G codes identify professional health care services and medical services that could otherwise be coded in CPT[®]-4.
- Centers for Medicare and Medicaid (CMS) determines that a Healthcare Common Procedural Coding System level II code should be issued (level I codes are part of CPT[®]).
- G codes are established by CMS typically through notice and comment rulemaking specifically to support Medicare policy and claims processing needs.
- There is no path to apply for a G code.
- G codes may also be used by non-Medicare insurers.

RECOMMENDATIONS FOR BILLING MEDICARE COLONOSCOPIES

- Medicare covers screening colonoscopies once every 24 months for patients at high risk for colorectal cancer.
- For high-risk patients, Medicare covers the test once every 120 months or 48 months after a previous flexible sigmoidoscopy.
- Positive noninvasive stool-based screening test colonoscopy is covered as screening.

PT MODIFIER

- Add the PT modifier when a screening procedure becomes a therapeutic procedure (biopsy or polyp removal). A reduced coinsurance applies. For covered years 2023–2026, coinsurance is 15%; for 2027–2029, coinsurance is 10%; and starting in 2030, there is no coinsurance.

INCOMPLETE COLONOSCOPY

An incomplete colonoscopy is when the colonoscope cannot be advanced to the cecum or colon-small intestine anastomosis due to unforeseen circumstances. A description of the condition and treatment and supportive clinical

Submit coding and billing questions to: dcr4codingcorner@gmail.com

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documentation are needed. The procedure code must be appended with the modifier “-53” to indicate a discontinued procedure.

DOCUMENTATION

- The maximum depth of penetration.
- A description of any abnormal findings.
- Any procedures performed as the result of such findings (eg, biopsy).

DISCLAIMER

Your question will be answered to the best of our ability using currently available legitimate resources. These include but are not limited to Current Procedural Technology (CPT®) Codes, International Classification

of Diseases – Tenth Edition (ICD-10), Centers for Medicare and Medicaid (CMS) Healthcare Common Procedure Coding System (HCPCS), and Diagnosis Related Groups (DRG), as well as common hospital billing practices. Please understand that in some instances, there may be varying opinions of the best answer to your question.

REFERENCES

1. American Medical Association. Current Procedural Terminology. CPT® Professional Edition. Chicago: American Medical Association, 2023:366–370.
2. CMS.gov. Centers for Medicare & Medicaid Services. Overview of Coding and Classification Systems: Last referenced June 23, 2024. <https://www.cms.gov/cms-guide-medical-technology-companies-and-other-interested-parties/coding/overview-coding-classification-systems#:~:text=G%20codes%20and%20M%20codes,II%20code%20should%20be%20issued>.