

# Gastroenterology Coding: Screening Versus Diagnostic Colonoscopy

To define the procedure, a colonoscopy is the examination of the entire colon from the rectum to the cecum, and it may include examination of the terminal ileum (small intestine). With that being said, there are two types of colonoscopies: screening and diagnostic. Medicare has specific guidelines for screening and diagnostic colonoscopies. Other payers may have very specific criteria for both types of colonoscopies as well.

Medicare defines these two types as:

1. Screening – used for patients who have:

- No family history of colon cancer or colon polyps
- No personal history of colon cancer or polyps
- No symptoms before the procedure (abdominal cramping, blood in the stool, weight loss, anemia, vomiting)

2. Diagnostic – used for patients who have:

- Family history of colon cancer or polyps
- Personal history of colon cancer or polyps
- Symptoms before the procedure (abdominal cramping, blood in the stool, weight loss, anemia, vomiting)
- Previous colonoscopy(ies) with findings of polyps, colon cancer, diverticulitis, etc.

Medicare also defines what they consider to be high risk for colorectal cancer as an individual with:

- A close relative (sibling, parent or child) who has had colorectal cancer or an adenomatous polyp
- A family history of familial adenomatous polyposis
- A family history of hereditary nonpolyposis colorectal cancer
- A personal history of adenomatous polyps;
- A personal history of colorectal cancer; or
- Inflammatory bowel disease, including Crohn's Disease and ulcerative colitis

Medicare uses HCPCS codes to bill for screening colonoscopies. For a patient of typical risk, the screening procedure is reported with HCPCS code G0121; for a patient at high risk, it is reported with HCPCS code G0105. Providers should

review the policies of their insurance payers to be certain which coding system is used, especially for Medicare Advantage plans offered by commercial insurers.

Per the 2019 AMA CPT Professional Edition guidelines:

*When performing a diagnostic or screening endoscopic procedure on a patient who is scheduled and prepared for a total colonoscopy, if the physician is unable to advance the colonoscope to the cecum or colon-small intestine anastomosis due to unforeseen circumstances, report 45378 (colonoscopy) or 44388 (colonoscopy through stoma) with modifier 53 and provide appropriate documentation.*

*If a therapeutic colonoscopy (44389-44407, 45379, 45380, 45381, 45382, 45384, 45388, 45398) is performed and does not reach the cecum or colon-small intestine anastomosis, report the appropriate therapeutic colonoscopy code with modifier 52 and provide appropriate documentation.*

*For colonoscopy through stoma, see 44388-44408.*

So, the first step to coding a colonoscopy is to determine if it is a screening or diagnostic colonoscopy. If the patient has had any signs or symptoms such as abdominal pain, weight loss or rectal bleeding, then it is not a screening but rather a diagnostic (symptomatic) colonoscopy. Also, if the patient has had previous findings such as polyps or diverticulitis, then it is not a screening colonoscopy.

Aside from the CPT coding guidelines, if you're wondering what the current Medicare reimbursement rates are for selected GI services, GI.org has a helpful chart.

Keeping track of gastroenterology code changes should not fall solely on you or your staff. You should have tools in place like a gastroenterology EHR system that can help in the process.

### **Sources:**

Centers for Medicare and Medicaid Services. Medicare Fee for Service Payment and Clinical Lab Fee Schedule (42 CFR 410.37 ).

[https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/410\\_37.pdf](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/410_37.pdf).

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