General Surgery Coding Alert

You Be the Coder: Code to Capture Screening Intent

Question: While performing a screening flexible sigmoidoscopy, the surgeon detected and removed a distal-colon polyp by snare technique. How should I code this case?

Louisiana Subscriber

Answer: The answer depends partly on the payer.

For Medicare, the correct code for a screening colonoscopy is G0104 (Colorectal cancer screening; flexible sigmoidoscopy), but most non-Medicare payers accept the CPT® code 45330 (Sigmoidoscopy, flexible; diagnostic, including collection of specimen[s] by brushing or washing, when performed [separate procedure]).

Once the surgeon removes a polyp, the situation changes to a diagnostic procedure, which in this case, codes to 45338 (…with removal of tumor[s], polyp[s], or other lesion[s] by snare technique). That's the code you should use to report this case.

NCCI edit: Whether the initial code is G0104 or 45330, you cannot bill the screening procedure with the diagnostic procedure 45338. National Correct Coding Initiative (NCCI) edits bundles the screening codes with the diagnostic code with a modifier-indicator of "0," meaning that you can never override the edit pair.

Diagnosis: Because this procedure begins as a colon-cancer screening, which most payers cover with no deductible or copay, you'll need to account for the switch to diagnostic. That way, the patient gets the screening benefit even though you're not reporting a screening procedure code. The diagnosis code and a modifier can help you achieve that goal.

Although you must to report the relevant ICD-10 codes for the identified polyp, such as K63.5 (Polyp of colon), you should always remember to add the screening ICD-10 code at the beginning of the claim to indicate that the procedure was initiated as screening procedure. In this case, you should list Z12.11 (Encounter for screening for malignant neoplasm of colon).

If the payer in this case is Medicare, you should also append modifier PT (Colorectal cancer screening test converted to diagnostic test or other procedure) to the procedure code. This is a HCPCS modifier that CMS uses to indicate that the surgeon converted a colorectal screening service, in this case a screening flexible sigmoidoscopy to a diagnostic or therapeutic service. This modifier allows the Medicare payer to process the claim without a patient copay or deductible.

For most commercial payers, you should append modifier 33 (Preventive services) to the procedure code instead of PT.