

# How to effectively code for Endoscopic procedures in Gastroenterology

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## Objectives

- Diagnosis and Terminology used in endoscopic procedure in gastroenterology
- Basic and advanced endoscopy procedures and techniques in gastroenterology (videos) will be shown for each procedure)
- Current CPT & ICD-10 coding instruction
- “Multiple Endoscopy Reimbursement”

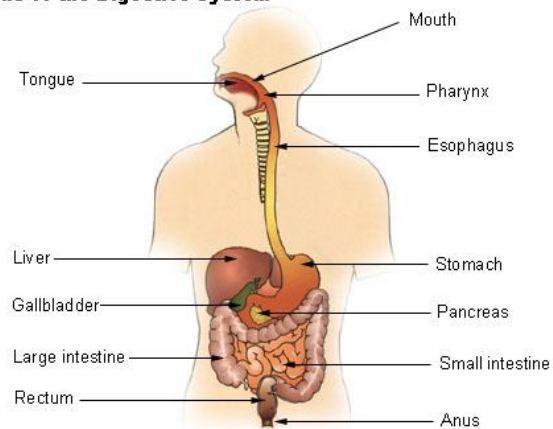
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➡ **Location** ⬅

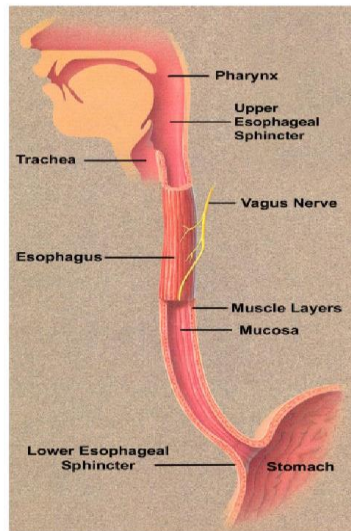
**“If it isn’t documented, it doesn’t exist”**

## Anatomy

**Organs of the Digestive System**



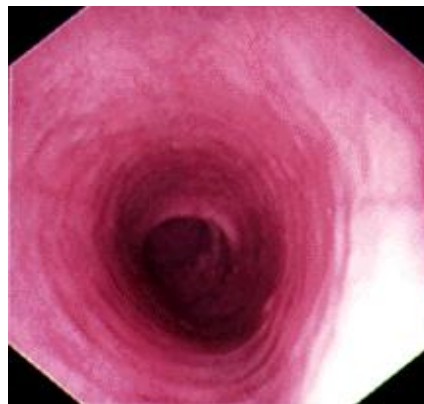
# Esophagus



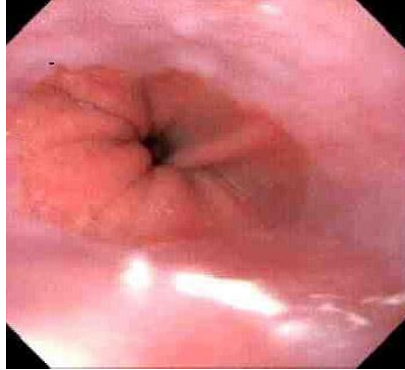
- Pharynx
- Upper esophageal sphincter (UES)
- Upper esophagus
- Middle esophagus
- Lower esophagus
- Lower esophageal sphincter (LES)

\*Most common endoscopic report using Location by distance from incisors (CM)\*

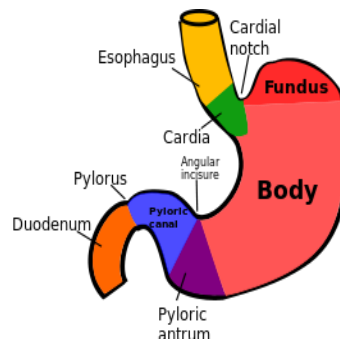
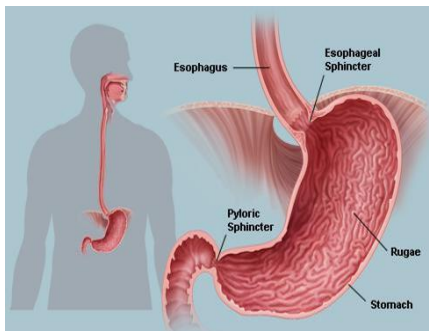
## Normal esophagus – endoscopic view



## Lower esophageal sphincter (LES) endoscopic view



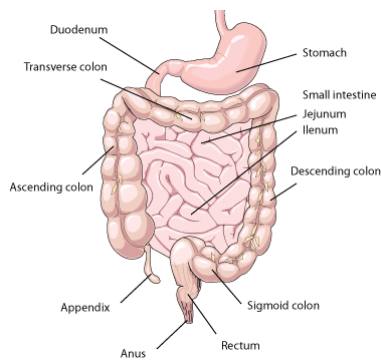
## Stomach - Gastric



# Stomach Endoscopy

- Video file

## Small Bowel : Small Intestine



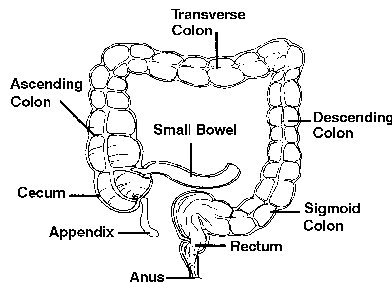
- Duodenum
  - Duodenal Bulb
  - 2<sup>nd</sup> part of duodenum

(Upper endoscopy ends here)

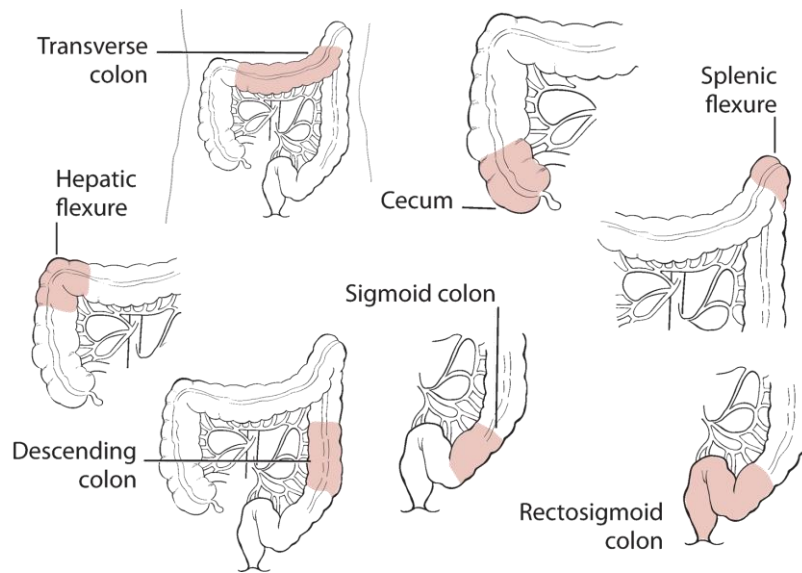
  - 3<sup>rd</sup> part of duodenum
  - 4<sup>th</sup> part of duodenum
- Jejunum
- Ileum
  - Terminal Ileum

(Enter from colonoscopy)

# Colon : Large Intestine



- Endoscopy report using **location** by **landmark** or distance from anus (cm)
- ICD 10 is very specific to the location, especially for polyps.
- This is an **important key** for coding for multiple procedures for polypectomy.



## ICD 10 code for polyps

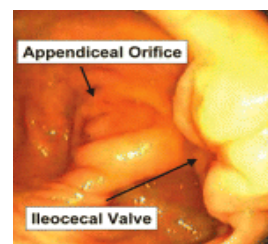
### 211.3 Benign neoplasm of colon

- 10 D12.0 Benign neoplasm of cecum
- 10 D12.1 Benign neoplasm of appendix
- 10 D12.2 Benign neoplasm of ascending colon
- 10 D12.3 Benign neoplasm of transverse colon
- 10 D12.4 Benign neoplasm of descending colon
- 10 D12.5 Benign neoplasm of sigmoid colon
- 10 D12.6 Benign neoplasm of colon, unspecified
- 10 K63.5 Polyp of colon

### 211.40 Benign neoplasm of rectum and anal canal

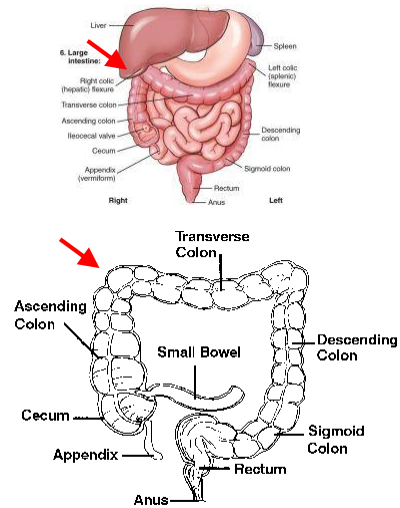
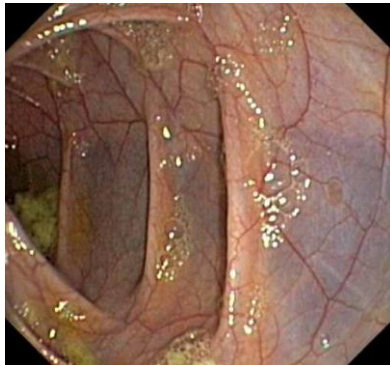
- 10 D12.7 Benign neoplasm of rectosigmoid junction
- 10 D12.8 Benign neoplasm of rectum
- 10 D12.9 Benign neoplasm of anus and anal canal

## Anatomical Landmark in colon



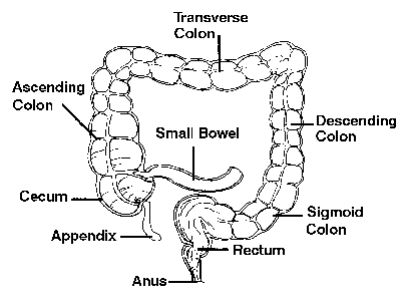
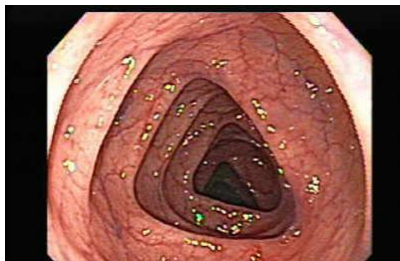
# Anatomical Landmark in colon

## Hepatic flexure



# Anatomical Landmark in colon

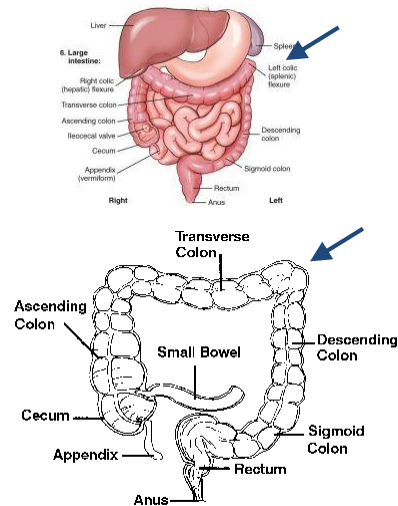
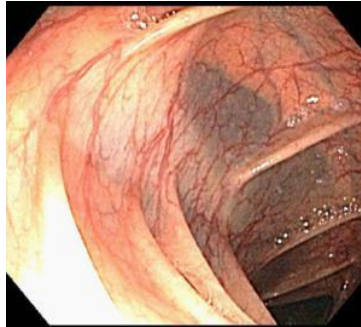
## Transverse colon





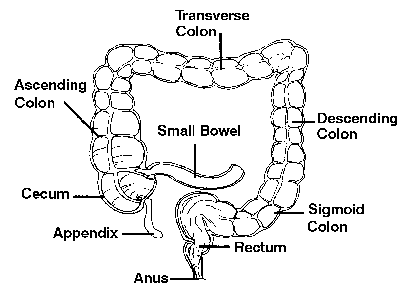
## Anatomical Landmark in colon

Splenic flexure



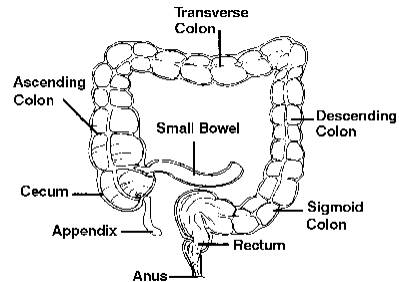
## Anatomical Landmark in colon

Sigmoid colon



# Anatomical Landmark in colon

Rectum



## ICD 10 code for polyps

### 211.3 Benign neoplasm of colon

10	D12.0 Benign neoplasm of cecum
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10	D12.3 Benign neoplasm of transverse colon
10	D12.4 Benign neoplasm of descending colon
10	D12.5 Benign neoplasm of sigmoid colon
10	D12.6 Benign neoplasm of colon, unspecified
10	K63.5 Polyp of colon

### 211.40 Benign neoplasm of rectum and anal canal

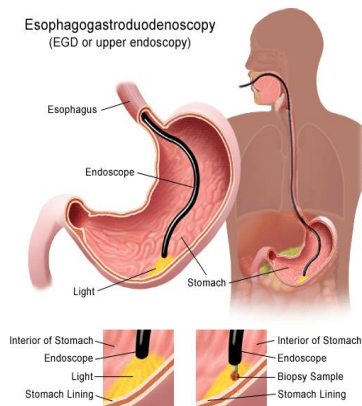
10	D12.7 Benign neoplasm of rectosigmoid junction
10	D12.8 Benign neoplasm of rectum
10	D12.9 Benign neoplasm of anus and anal canal

# Endoscopic procedure



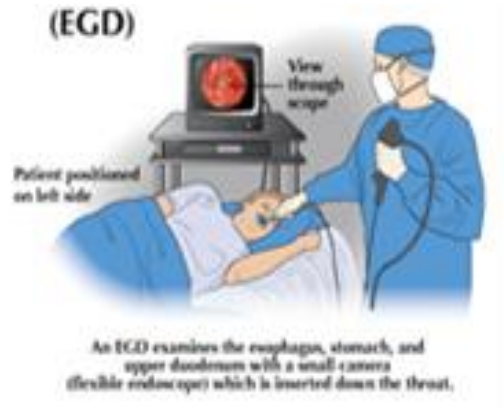
## Upper Endoscopy

EGD = Esophagogastroduodenoscopy

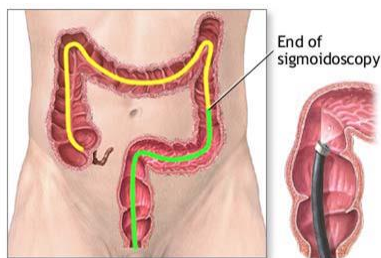


- Esophagoscopy  
Only view esophagus to LES
- Esophagogastroduodenoscopy  
- Standard procedure  
- Esophagus – stomach – duodenal bulb – 2<sup>nd</sup> part duodenum
- Push enteroscopy  
- Using pediatric colonoscopy  
- Advance to Jejunum

# Upper Endoscopy

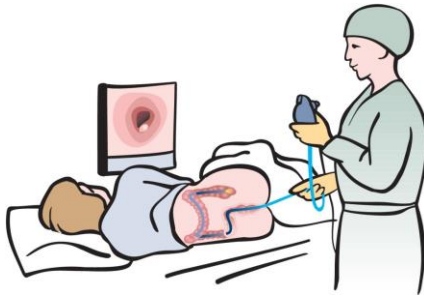


# Flexible Sigmoidoscopy



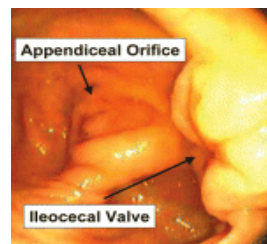
- Using Flexible sigmoidoscope or Upper endoscope
- Advance to **distal** to spenic flexure

# Colonoscopy



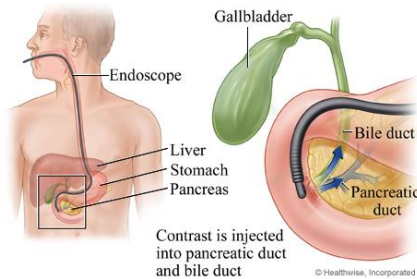
- Using pediatric colonoscope or adult colonoscope
- Advance to **proximal** to splenic flexure
- Goal :
  1. Cecum, identified by appedical orifice and/or IC valve (direct visualization, transillumination, palpation)
  2. Terminal Ileum

## Goal



## Endoscopic retrograde cholangiopancreatography (ERCP)

- Examination of bile duct and pancreatic duct using a side view endoscope.
- Use Fluoroscopy with radiograph interpretation



## ERCP

- Diagnostic ERCP
  - Biopsy / Brushing cytology
  - Manometry
- Therapeutic ERCP
  - Endoscopic sphincterotomy
  - Removal / Destruction of stones
  - Insertion of stent – Metal vs Plastic
  - Dilation of strictures

# Cholangioscopy

- Mother-Daughter scope
- Spyglass by Boston Scientific



Polyp = **Benign** neoplasm  
???

- A polyp is an abnormal growth of tissue projecting from a mucous membrane

**Pathologic diagnosis = don't know at the time of procedure**

- Malignant : cancer, dysplasia
- Adenomatous :serrated, tubular, villous.
  - Hamartomatous/Juvenile
  - Hyperplastic
  - Inflammatory
  - Skin tag, lymphoid aggregate, normal colonic tissue

## ICD 10 code for polyps

### 211.3 Benign neoplasm of colon

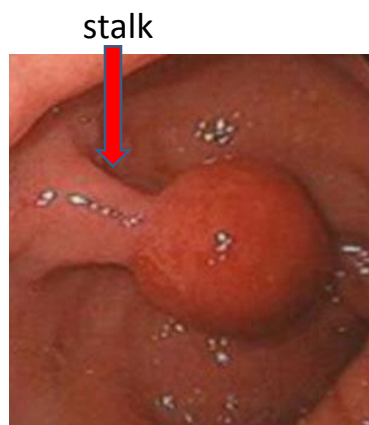
- 10 D12.0 Benign neoplasm of cecum
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Ref : [www.pulseinc.com](http://www.pulseinc.com)

### 211.40 Benign neoplasm of rectum and anal canal

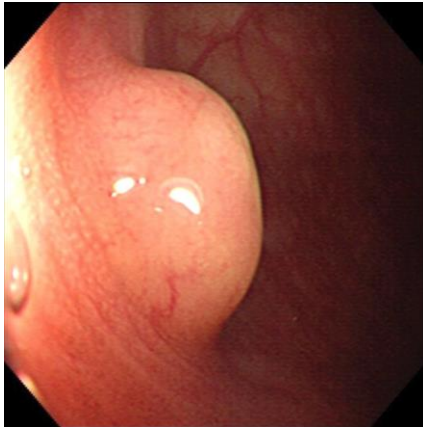
- 10 D12.7 Benign neoplasm of rectosigmoid junction
- 10 D12.8 Benign neoplasm of rectum
- 10 D12.9 Benign neoplasm of anus and anal canal

## Pedunculated polyp



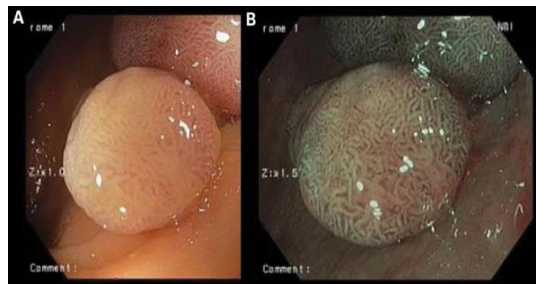


## Sessile polyp

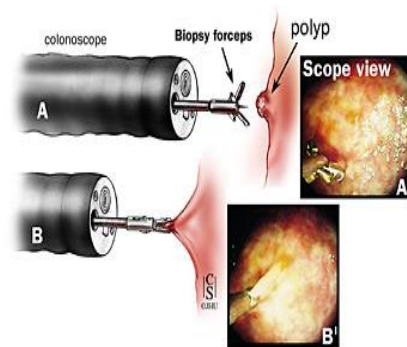


- No stalk

## Narrow band imaging



## Forcep Biopsy



## Snare polypectomy



## Cauterization

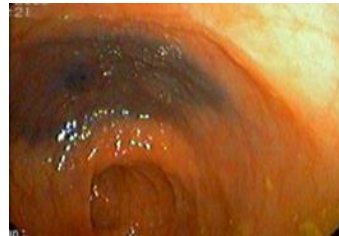
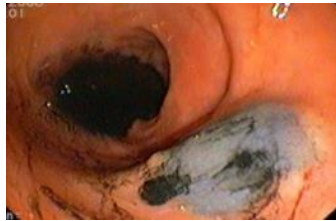


- Burning of part of a body to remove or close off a part of it in a process called cautery
- Hot Forceps
- Hot snare

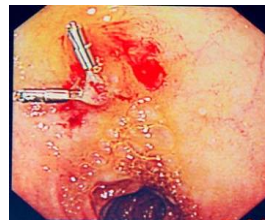
## Endoscopic Injection



- Sclerosing agent, such as ethanolamine, absolute alcohol, Histoacryl glue (cyanoacrylate)
- Steroid
- Botulinum Toxin
- India Ink for tattoo
- Saline for Lift polypectomy
- epinephrine



## Endoscopic hemostasis



## Argon plasma coagulation (APC)



- Use to provide tissue coagulation and hemostasis
- Angiodysplasia, GAVE – gastric antral vascular ectasia, bleeding malignant tumors and bleeding peptic ulcer

## Dilation



- **Mercury weighted bougies** - Maloney
- **Bougie over guidewire dilators** - Savary-Gilliard\*
- **Pneumatic dilatation\***
- **Balloon dilatation**

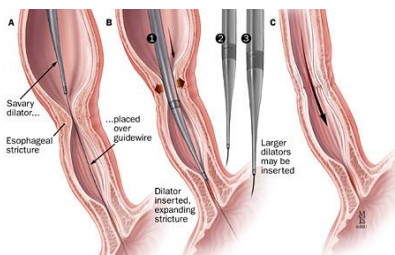
**\*Fluoroscopy**

## Maloney



- blindly inserted bougies placed into the esophagus by the treating physician or patient.
- They are passed in sequentially increasing sizes to dilate the obstructed area.

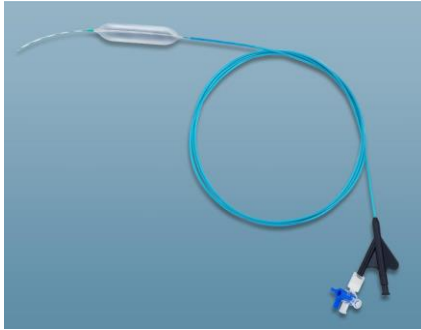
## Savary-Gilliard



- Use Guidewire during endoscopy
- Billable for radiographic interpretation



## Balloon Dilatation




## Endoscopy report and billing

- Dictation system
- Electronic medical record
  - Provation
  - gMed
  - EndoSoft
  - Endoeasy
  - Mediscope

## Report : Key subject areas

Patient demographics and history

Assessment of patient risk and comorbidity

Procedure indication(s) 

Procedure: technical description

Colonoscopic findings

Assessment

Interventions/unplanned events

Follow-up plan

Pathology

## Provation MD Gastroenterology

- Develop in 2002
- Widely used in hospital and ambulatory surgical center (ASC)
- Automatic coding system



Upper GI endoscopy

MRN: 000000  
Patient Name: [Redacted]  
Birth Date: 1/1/1998

Exam: Upper GI endoscopy  
Provider: Hamid Raza  
Referring MD: [Redacted]  
Requesting Physician: [Redacted]  
Indications: [Redacted]  
Comorbidities: [Redacted]  
Patient Profile: [Redacted]  
Medication: [Redacted]  
Findings: [Redacted]  
Complication: [Redacted]  
Estimated Blood Loss: [Redacted]  
Impression: [Redacted]  
Recommendation: [Redacted]  
Post Op Orders: [Redacted]  
Patient Instructions: [Redacted]  
Pathology: [Redacted]  
Coding: [Redacted]  
Images: [Redacted]

Instrument Search

File Select Edit  
Close Select Add Delete Edit

Instrument Name: [Redacted] View: Restricted

Instrument Name	Site	Activated	Specialty
EC 3400 F	UMC Endoscopy Center	Yes	GI
EC-2700 327	UMC Endoscopy Center	Yes	GI
EC-2901 732	UMC Endoscopy Center	Yes	GI
EC-2901 752	UMC Endoscopy Center	Yes	GI
EC-3930T 019	UMC Endoscopy Center	Yes	GI
GF-UM20 014	UMC Endoscopy Center	Yes	GI
GIF-130 004	UMC Endoscopy Center	Yes	GI
GIF-130 988	UMC Endoscopy Center	Yes	GI
GIF-180	UMC Endoscopy Center	Yes	GI
GIF-1T20 202	UMC Endoscopy Center	Yes	GI
GIF-2T10 609	UMC Endoscopy Center	Yes	GI
ICD9 Code(s):	UMC Endoscopy Center	Yes	GI
GIFH180-5781	UMC Endoscopy Center	Yes	GI
GIF-H180-9654	UMC Endoscopy Center	Yes	GI
GIF-H180-9701	UMC Endoscopy Center	Yes	GI
GIF-H180-9704	UMC Endoscopy Center	Yes	GI
GIF-H180-9707	UMC Endoscopy Center	Yes	GI
GIF-H180-9710	UMC Endoscopy Center	Yes	GI
GIF-H180-9745	UMC Endoscopy Center	Yes	GI
GIFIT140 0765	UMC Endoscopy Center	Yes	GI
GIFITQ160-0557	UMC Endoscopy Center	Yes	GI
GIFQ160	UMC Endoscopy Center	Yes	GI
GIFQ160-7859	UMC Endoscopy Center	Yes	GI

6 Image

Upper GI endoscopy

MRN: 000000  
Patient Name: Test, 2  
Birth Date: 1/1/1998  
Proc. Date: 1/3/2013 11:15:48 AM  
Age: 15

Exam: Upper GI endoscopy  
Provider: Arwan Rakit, MD (Doctor)

Advanced To: [Redacted]  
Esophagus  
Stomach  
Duodenum  
Jejunum

Area of papilla  
Operative stoma

Small Bowel Enteroscopy:  
-Medical necessity must be documented-  
-in order to support SBE choices-  
-These choices are designed to-  
-generate SBE CPT codes-

Post Op Orders:  
Patient Instructions:  
CC Letter to:  
Attending Dr. Participation:

6 Image

Upper GI endoscopy	
Select a Preference: <input type="text"/> Clear	
Exam	MRN: 000000
Staff	Patient Name: Test, 2
Attending Dr. Participation	Birth Date: 1/1/1998
Endoscopes	Exam: Upper GI endoscopy
EC 3400 F	Provider: Arwan Rakvi, MD (Doctor)
Office - Mouth	Referring MD: Arwan Rakvi, MD (Referring MD)
Advanced To - Second part of duodenum	Requesting Provider:
Pre Anesthesia Assessment	Normal
Difficulty/Tolerance	No gross lesions
Patient Profile	Z line
Indication	Esophagogastric Landmarks
Comorbidities	Barrett's Esophagus (Suspect/Confirm)
Medication	Barrett's Esophagus, Simple
Findings	Dysphagia - Normal Exam
Esophagitis	
Complication	Hiatus Hernia, Simple
Estimated Blood Loss	Hiatus Hernia, Detailed
Impression	Stenosis / Stricture
Recommendation	Ulcer
Post Op Orders	Varices, Simple
Patient Instructions	Varices, Detailed
Pathology	Tortuosis
Coding	
Images	
	Lumen
	Contents
	Motility
	Mucosa
	Flat lesions
	Protruding lesions
	Excavated lesions
	Esophagus Otherwise Normal
	Esophagus Otherwise Norm / Careful Exam
	Pertinent Negatives
	Pertinent Negatives w / Maneuvers
	Add Custom
	Customs by Site
	Attending Dr. Participation:
	6 Images

## Other details

Bowel preparation quality: percent adequate to detect polyps > 5 mm

Cecal intubation rate

Rate of photodocumentation of cecal landmarks

Mean colonoscopic withdrawal time in patients without polypectomy or biopsy

Adenoma detection rate in first-time screening examination based on patient's sex

Adverse or unplanned events occurring within 24 h of colonoscopy

Rates of

Hospitalization

Bleeding, requiring transfusion

Bleeding, requiring unplanned endoscopic intervention

Perforation

Surgery

Rate of documentation of recommendations for follow-up

## GI endoscopy coding guide

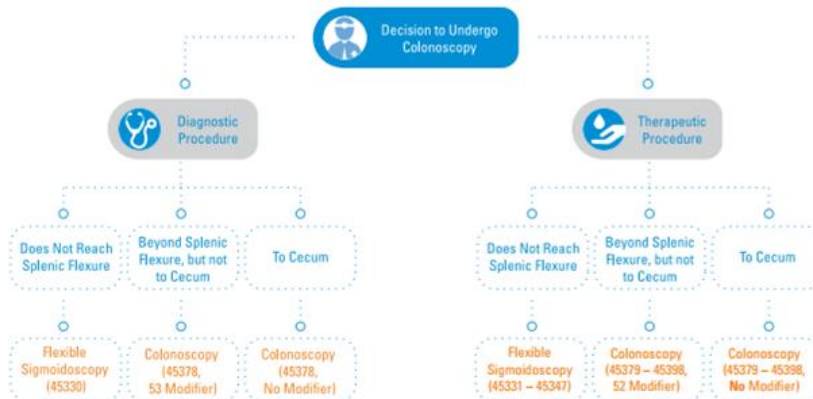
- Current Procedural Terminology (CPT) code set is maintained by the American Medical Association through the CPT Editorial Panel.
- International Classification of Diseases :  
ICD-10

## CPT code

- Current Procedural Terminology code is a registered trademark of the American Medical Association.
- The AMA holds the copyright for the CPT coding system.
- Despite the copyrighted nature of the CPT code sets, the use of the code is mandated by almost all health insurance payment and information systems, including the Centers for Medicare and Medicaid Services (CMS) and HIPAA
- As a result, it is necessary for most users of the CPT code to pay license fees for access to the code

## CPT 2014 → CPT 2015

- Main change is for colonoscopy



- **Average risk** screening, by definition, is a service performed on a patient in the **absence** of signs and symptoms.
- A patient is eligible for screening colonoscopy on or after age 50.
- Some payors allow for screening to begin at age 45 for patients of certain gender and/or ethnic origin.

- Medicare's definition of average risk is
  - no personal history of adenomatous polyps, colorectal cancer or inflammatory bowel disease, including Crohn's disease and ulcerative colitis
  - no family history of colorectal cancers or an adenomatous polyp, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer
- 
- Easiest way is for the physician to mark "average risk for colon cancer screening"
  - Do not mention any symptoms : Hematochezia, constipation, abdominal pain, diarrhea, etc.

### Abnormal occult blood test (ICD 10 = R19.5)

- If a patient has abnormal fecal occult blood test (FOBT), fecal immunochemical test (FIT), or other brand, then colonoscopy is no longer a screening procedure.
- For Medicare is **no longer** a preventive service = patient is now responsible for the co-pay/deductible for the diagnostic colonoscopy
- For commercial payors, check payor policy.

### Billing for Screening colonoscopy in an **average risk** patients

- Medicare: G0121
- Commercial, Medicaid: 45378 with the appropriate ICD-10
  - ICD-10 codes for colorectal cancer screening:  
Z00.00, Z00.01, Z12.10, Z12.11, Z12.12, Z80.0,  
Z83.71, Z83.79

## High risk screening/surveillance

- Patients who have
  - a personal history of adenomatous polyps, colorectal cancer or inflammatory bowel disease **OR**
  - a family history of adenomatous polyps, colorectal cancer, familial adenomatous polyposis or hereditary nonpolyposis colorectal cancer
  - Family history as including only first degree relatives (siblings, parents or children).
- 
- Billing for screening/surveillance colonoscopy in a high risk patient:
  - Medicare: G0105
  - Commercial, Medicaid, Tricare: 45378

Colonoscopy

Select a Preference ---Select Preference--- Clear

<b>Exam</b> MRN - 0000000 Exam Type - Colonoscopy Proc. Date - 3/20/2015 11:24:46 AM Status Room # Consent On File - Unknown	<b>Patient Name:</b> Test, 2 <b>MRN:</b> 0000000 <b>Birth Date:</b> 1/1/1998 <b>Ethnicity:</b> <b>Exam:</b> Colonoscopy <b>Provider:</b> Test, test, MD (Doctor) <b>Referring MD:</b> <b>Requesting Provider:</b> <b>Indications:</b> <b>Comorbidities:</b>	<b>Proc. Date:</b> 3/20/2015 11:24:46 AM <b>Age:</b> 17 <b>Race:</b> Unknown
<b>Staff</b> Attending Pre-Anesth Difficulty/T Patient Pr Medication Findings Complicat Impressio Recommen Post Op O Patient Ins Pathology Coding Images	<b>Endoscope</b> DONE Search Content Screening No Previous Colonoscopy Surveillance IMPORT Date of Last Colonoscopy Select Date of Last Colonoscopy Therapeutic procedure Therapeutic procedure Diagnostic Abdominal pain Diarrhea Gastrointestinal bleeding Anemias Polyps Inflammatory bowel disease Family history Personal history Genetic cancer syndrome Abnormal imaging Assessment Diseases Symptoms and Signs Incidental Indications QI Indications OTHER Add Custom Customs by Site	<b>Patient Profile:</b> <b>Medications:</b> Procedure: After obtaining informed consent, the endoscope was passed under direct vision. Throughout the procedure, the patient's blood pressure, pulse, and oxygen sa --Average Risk-- Screen for Colorectal CA, Average Risk Screen for Colorectal CA Timeframe FH Colon Cancer - Distant Relative --Increased Risk-- Family History Polyps Family History Advanced Adenoma Family History Serrated Polyp FH Colon CA - 1st deg relative (unspec) FH Colon CA - 1st deg relative (details) FH Colon CA - multi 2nd deg relatives Family History Familial Polyposis Family History HNPCC --For Personal History Polyps or Cancer --Choose Surveillance (not Screening)-- --For incidental indications noted during a screening exam, see Incidental Indications on the base menu below Symptoms & Signs

## ICD

- The International Classification of Diseases (ICD) is published by the World Health Organization (WHO)
- It is known as a health care classification system that provides codes to classify diseases.
- It is used in several aspect of health care, including reimbursement.



# ICD-10

- More details = specific location
- AAPC provides ICD code-9 to ICD code 10 conversion

<b>9</b>	<b>530.85</b> Barrett's esophagus
<b>10</b>	<b>K22.70</b> Barrett's esophagus without dysplasia
<b>10</b>	<b>K22.710</b> Barrett's esophagus with low grade dysplasia
<b>10</b>	<b>K22.711</b> Barrett's esophagus with high grade dysplasia
<b>10</b>	<b>K22.719</b> Barrett's esophagus with dysplasia, unspecified

Ref : [www.pulseinc.com](http://www.pulseinc.com)

**9** **455.0** Internal hemorrhoids without complication

- 10** **K64.0** 1st degree hemorrhoids
- 10** **K64.1** 2nd degree hemorrhoids
- 10** **K64.2** 3rd degree hemorrhoids
- 10** **K64.3** 4th degree hemorrhoids
- 10** **K64.8** Other hemorrhoids (without mention of degree)
- 10** **K64.9** Unspecified hemorrhoids

**9** **556.9** Ulcerative colitis, unspecified

- 10** **K51.90** Ulcerative colitis, unspecified
- 10** **K51.911** Ulcerative colitis, unspecified with rectal bleeding
- 10** **K51.912** Ulcerative colitis, unspecified with intestinal bleeding
- 10** **K51.913** Ulcerative colitis, unspecified with fistula
- 10** **K51.914** Ulcerative colitis, unspecified with abscess
- 10** **K51.918** Ulcerative colitis, unspecified with other complications
- 10** **K51.919** Ulcerative colitis, unspecified with unspecified complications

Re

# Anesthesia

- A -33 modifier should be added to the 00810 anesthesia code to include anesthesia for screening colonoscopy.
- For Medicare, add modifier PT to anesthesia code if lesion is found during colonoscopy.

# Challenges

- Get familiar with Gastroenterology report / dictation system.
- Good communication with your gastroenterologist.
- Lesion is found during a screening colonoscopy
- Incomplete procedure.
- Multiple endoscopy procedures.

## Lesion is found during a screening colonoscopy

- During a screening colonoscopy, polyps or other lesions can be found which are biopsied or removed.
  - The procedure is now considered a “surgical colonoscopy”, even though the initial indication was screening.
  - ?? patient’s financial responsibility
- 
- For commercial payors, add modifier 33 to the claim
  - It informs the payor that the intent of the colonoscopy was a preventive service.
  - Then billed with screening as the principal diagnosis and the finding as the secondary diagnosis
  - Many commercial payors will continue to pay preventive benefits

- For Medicare, add modifier PT to the claim.
- It informs Medicare that the intent of the colonoscopy was a preventive service.
- Modifier PT waives the patient's deductible
- But the patient is now responsible for the 20% co-pay.

### Incomplete procedure : modifiers 52 and 53

- Upper endoscopy vs colonoscopy :
- EGD Not examined because significant situations preclude such exam (e.g., significant gastric retention precludes safe exam of duodenum, or blood in stomach)
- If repeat examination is not planned = append modifier 52
- If repeat examination is planned = modifier 53

## Example 1

- EGD is performed and a tube is placed into the stomach.
- The duodenum is not examined and there is no plan to perform repeat EGD to examine the duodenum.
- Report procedure with modifier 52

## Example 2

- EGD is performed for evaluation of GI bleeding
- the stomach is full of blood and the duodenum is not examined.
- Plan to control bleeding, lavage stomach and repeat upper endoscopy.
- Report procedure with modifier 53.

## Colonoscopy : modifiers 52 and 53

- If it is **diagnostic** or **screening** endoscopic procedure and 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.** (ie : inadequate bowel preparation quality, mass)
- 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.**

## Example 1

- 55-year-old male, asymptomatic, undergoing screening colonoscopy.
- The scope was advanced to the cecum, but prep is incomplete with poor visibility.
- He returned for repeat colonoscopy after repeat prep. no lesions are biopsied or removed

- The incomplete first attempt report is 45378 with Modifier 53
- The second attempt report is G0121



## Example 2

- 57-year-old male undergoing high risk screening due to personal history of transverse colon cancer.
  - The scope was advanced to the ascending colon, but prep is incomplete with poor visibility
  - He returned for repeat colonoscopy after repeat prep. no lesions are biopsied or removed
- 
- The incomplete first attempt report is 45378 with Modifier 53
  - The second attempt report is G0105 (high risk)

## Example 3

- 72-year-old female undergoing screening colonoscopy.
- Obstructing mass found in the transverse colon, which prevented examination of the right colon. Biopsies were taken.

- Report 45380 with Modifier 52 (for incomplete)

+

- either modifier PT (if a Medicare beneficiary) or 33 (if a commercial, Medicaid, Tricare patient) → indicates the procedure was intended to be screening; but once a biopsy was performed it became therapeutic

## Multiple endoscopy procedures

- Be specific as to how the biopsy/polypectomy was performed.

The phrase, "multiple polypectomies" does not give enough information to submit a claim.

- LOCATION, LOCATION, LOCATION.

In order to get paid for the different techniques in different sites within the intestine, the location of the lesion is important.

- So, go back to the beginning of the presentation : anatomy

- D12.0 Benign neoplasm of cecum
- D12.1 Benign neoplasm of appendix
- D12.2 Benign neoplasm of ascending colon
- D12.3 Benign neoplasm of transverse colon
- D12.4 Benign neoplasm of descending colon
- D12.5 Benign neoplasm of sigmoid colon
- D12.6 Benign neoplasm of colon, (polyposis)
- D12.7 Benign neoplasm of rectosigmoid junction
- D12.8 Benign neoplasm of rectum
- D12.9 Benign neoplasm of anus and anal canal

## Anemia

- Anemia unspecified (D64.9) is not covered by most Medicare payers for colonoscopy and/or upper GI endoscopy.
- Be specific : payable code
- D50.9 Iron deficiency anemia, unspecified
- D50.0 Chronic blood loss anemia

# Sample report

Proton MD Q

File Edit Tools Preferences

Close Exit Print Past Notes Patient Chart Capture Search Navigate Recalls Highlight View

Colonoscopy

Select a Preference —Select Preference— Clear

Exam  
Staff  
Endoscopes  
Endoscopy  
Office - Anus  
Advanced To - the cecum, identified by appendix  
Attending Dr. Participation  
Pre-Anesthesia Assessment  
Difficulty/Tolerance  
Patient Profile  
Age / Gender  
H & P on Chart  
Indication  
Contraindications  
Medication  
Findings  
Complication  
Estimated Blood Loss  
Impression  
Recommendation  
Post Op Orders  
Patient Instructions  
Pathology  
CPT/ICD  
Images

Patient Name: Test, 2  
MRN: 000000  
Birth Date: 1/1/1999  
Ethnicity:  
Proc. Date: 3/20/2015 11:24:46 AM  
Age: 17  
Race: Unknown

Exam: Colonoscopy  
Provider: Test, MD (Doctor)  
Referring MD:  
Requesting Provider:  
Indications: Screening for colorectal malignant neoplasm  
Contraindications:

Patient Profile: This is a 17 year old patient. Refer to note in patient chart for documentation of history and physical.  
Medications: Propofol per Anesthesia  
Procedure: Pre-Anesthesia Assessment:  
- Anway Examination: Mallampati Class II (the uvula but not tonsillar pillars visualized).  
- ASA Grade Assessment: II - A patient with severe systemic disease.  
After obtaining informed consent, the endoscope was passed under direct vision. Throughout the procedure, the patient's blood pressure, pulse, and oxygen saturations were monitored continuously. The Colonoscope was introduced through the anus and advanced to the cecum, identified by appendiceal orifice and ileocecal valve. The colonoscopy was performed without difficulty. The patient tolerated the procedure well. The quality of the bowel preparation was good.

Findings:  
- A 5 mm polyp was found in the sigmoid colon. The polyp was sessile. The polyp was removed with a cold biopsy forceps. Resection and retrieval were complete.  
- A 10 mm polyp was found in the descending colon. The polyp was sessile. The polyp was removed with a hot snare. Resection and retrieval were complete.  
Complications: No immediate complications. Estimated blood loss: Minimal.  
Estimated Blood Loss: Estimated blood loss was minimal.  
Impression: - One 5 mm polyp in the sigmoid colon. Resected and retrieved.  
- One 10 mm polyp in the descending colon. Resected and retrieved.  
Recommendation: - Await pathology results.  
- Return to GI clinic in 1 week.  
- Discharge patient to home (via wheelchair).  
Additional Images:  
Procedure Code(s): — Professional —  
43385, Colonoscopy, flexible, with removal of tumor(s), polyp(s), or other lesion(s) by snare technique  
43380, 59, Colonoscopy, flexible, with biopsy, single or multiple  
Diagnosis Code(s):  
Post Op Orders:  
Repeat colonoscopy date to be determined after pending pathology results are received for surveillance.  
Patient Instructions:  
CC Letter to:  
Attending Dr. Participation:  
I personally performed the entire procedure.

Proton Coding Module

File View Codes Tools

Return to Note View Case Fax Email Re-Run Codes Cancel Codes Send Charges ICD Shortcuts CPT Shortcuts View Codes Professional Edit ProTech

CPT/ICDPCS | ICD-10-PCS

43385 Colonoscopy, flexible, with removal of tumor(s), polyp(s), or other lesion(s) by snare technique

43380: 59 Colonoscopy, flexible, with biopsy, single or multiple

22 52 59 26 50 RT PT  
51 53 74 TC GC LT 33

ICD-10-CM

Screening for colorectal malignant neoplasm

☐ Z12.11 Encounter for screening for malignant neoplasm of colon

Single colonic polyp seen

☐ D12.5 Benign neoplasm of sigmoid colon

☐ D12.4 Benign neoplasm of descending colon

CPT/ICD codes generated here are intended as suggestions and were generated based on input data. The physician is responsible for the final selection and proper appending of CPT/ICD code(s) and modifiers.

**Provision MD-05** | Preferences | Print | Past Notes | Patient Chart | Capture | Search | Navigate | Results | Highlight | View

**Colonoscopy** | Select a Preference | Select Preference | Clear

**Exam**  
☒ Doctor - Test test  
☒ Endoscopes  
☒ Office - Anus  
 Advanced To - the cecum, identified by appendix  
**Attending Dr. Participation**  
☒ Pre Anesthesia Assessment  
☒ Difficulty/Tolerance  
**Patient Profile**  
☒ Age - Gender  
☒ N & P on Chart  
**Comorbidities**  
**Medication**  
**Findings**  
☒ Complication  
☒ Estimated Blood Loss  
☒ Impression  
☒ Recommendation  
☒ Post Op Orders  
☒ Patient Instructions  
☒ Pathology  
☒ Images

**Patient Name:** Test 2  
**DOB:** 000000  
**Birth Date:** 11/1/1988  
**Ethnicity:**  
**Exam:** Colonoscopy  
**Provider:** Test test, MD (Doctor)  
**Referring MD:**  
**Requesting Provider:**  
**Indications:** Screening for colorectal malignant neoplasm  
**Contraindications:**  
**Patient Profile:** This is a 37 year old patient. Refer to note in patient chart for documentation of history and physical.  
**Medications:** Propofol per Anesthesia  
**Procedure:** Pre-Anesthesia Assessment:  
 - Anxolytic Examination: Mallampati Class I (the oropharynx and not tonsillar pillars visualized).  
 - ASA Grade Assessment: II - A patient with severe systemic disease.  
 After obtaining informed consent, the endoscope was passed under direct vision. Throughout the procedure, the patient's blood pressure, pulse, and oxygen saturations were monitored continuously. The Colonoscope was introduced through the anus and advanced to the ileocecal junction, identified by appendiceal orifice and ileocecal valve. The colonoscopy was performed without difficulty. The patient tolerated the procedure well. The quality of the bowel preparation was good.  
**Findings:**  
 - A 5 mm polyp was found in the sigmoid colon. The polyp was sessile. The polyp was removed with a cold biopsy forceps. Reaction and retrieval were complete.  
 - A 10 mm polyp was found in the descending colon. The polyp was sessile. The polyp was removed with a hot snare. Reaction and retrieval were complete.  
**Complications:** No immediate complications. Estimated blood loss: Minimal.  
**Estimated Blood Loss:** Estimated blood loss was minimal.  
**Impression:** One 5 mm polyp in the sigmoid colon. Resected and retrieved.  
 One 10 mm polyp in the descending colon. Resected and retrieved.  
**Recommendation:** Await pathology results.  
 Return to GI clinic in 1 week.  
 Discharge patient to home (via wheelchair).  
**Additional Images:**  
 - Professional --  
 42300. Colonoscopy, flexible, with removal of tumor(s), polyp(s), or other lesion(s) by snare technique  
 42300. 59. Colonoscopy, flexible, with biopsy, single or multiple  
 - Professional --  
 D12.4. Benign neoplasm of descending colon  
 D22.5. Benign neoplasm of sigmoid colon  
 Z12.11. Encounter for screening for malignant neoplasm of colon  
**Post Op Orders:**  
 Repeat colonoscopy data to be determined after pending pathology results are received for surveillance.  
**Patient Instructions:**  
 CC Letter to:  
**Attending Dr. Participation:**  
 I personally performed the entire procedure.

## Summary

- Understand the report system at your practice.
- Good communication and feedback with your physician. \*\*If you have questions, don't make a decision by yourself\*\*
- Double check "automatic coding system" by the electronic medical record.
- Location, Indication and Detail of each procedures

- Questions

- CEU code

## Office visit for screening colonoscopy

- For Medicare, unless the patient has symptoms or a chronic condition/disease that has to be managed by the GI provider, an E/M visit prior to the colonoscopy is **not covered** and will be denied with no patient responsibility.
- For private payors, it will depend whether preventive visits are covered.
- Remember that when billing new patient (99201–99205) or existing patient (99212–99215) E/M codes, there should be a chief complaint.
- Each payor may have individual policies; for instance, Anthem BC/BS policy is to bill this as a preventive visit 99381– 99397.