PROFESSIONAL NETWORK REIMBURSEMENT POLICY

POLICY TITLE	**Failed Colonoscopy**
POLICY NUMBER	**NR-04.002**

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DESCRIPTION/BACKGROUND DEFINITIONS POLICY
EXCLUSIONS VARIATIONS - No REFERENCES

I. DESCRIPTION/BACKGROUND TOP

This policy describes the reimbursement methodology for failed colonoscopies.

II. DEFINITIONS TOP

American Medical Association (AMA) **–** An organization whose missions is to promote the science and are of medicine and the betterment of public health. The AMA speaks out on issues important to patient and the nation's health and exercises a strong advocacy agenda on behalf of patients and provider. The AMA is also committed to providing timely information on matters important to the health of America and includes the development and promotion of standards in medical practice, research and education.

Current Procedural Terminology (CPT) – A set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care professionals. Each procedure or service is identified with a five-digit code. The use of CPT codes simplifies the reporting of procedures and services.

Colon – Large intestine of bowel; The colon consists of several portions including, but not limited to: anal canal, rectum, sigmoid colon, descending colon, transverse colon, ascending colon, cecum, splenic fixture, hepatic flexure.

Colonoscopy – A visual examination of the lining of the large intestine with a flexible fiber optic endoscope. The endoscope is inserted into the anal canal and advanced as far as the cecum. The endoscope is withdrawn at the end of the procedure.

Failed Colonoscopy – The inability of the provider to examine the patient's intestine as far as the splenic flexure.

Healthcare Common Procedure Coding System (HCPCS) - A national standard, alphanumeric coding system established by the Centers for Medicare and Medicaid Services. It standardizes billing and payment for certain covered services (for example, medical supplies, prosthetics and durable medical equipment). HCPCS Level I codes are copyrighted by the American Medical Association (CPT). Level II codes are five-position alphanumeric codes maintained jointly by the Alpha-Numeric Panel (consisting of the Centers for Medicare and Medicaid Services (CMS), the Health Insurance Association of America, and the BlueCross and BlueShield Association). The American Dental Association copyrights the D-code series in Level II HCPCS.

Modifier – A two-digit numeric, alphanumeric or alphabetic code appended to a CPT or HCPCS code, which indicates that a service or procedure has been altered by some specific circumstances but not changed in its definition or code. This information is important because it provides payors with additional information to process a claim. There are three levels of modifiers: Level I (CPT) modifiers are developed by the American Medical Association; Level II (HCPCS) modifiers are developed by the Centers for Medicare and Medicaid Services; Level III modifiers are unique to each Medicare Part B carrier and begin with an alpha prefix of S, W, X, Y or Z.

Sigmoidoscopy - Use of a sigmoidoscope (tubular speculum) for examination of the sigmoid colon and the rectum.

III. POLICY

TOP

A colonoscopy may be performed as a screening procedure or a diagnostic procedure. In some instances, a provider may begin a colonoscopy (screening or diagnostic), but decide to terminate the procedure. Termination of the procedure usually occurs due to extenuating circumstances or circumstance that may threaten the well-being of the patient. When a colonoscopy is terminated, it is referred to as a failed colonoscopy.

A failed colonoscopy should be reported using the appropriate procedure code for either a diagnostic test (45378, 44388) or screening test (G0105, G0121). In addition, professional providers should append Modifier –53 (Discontinued Procedure) to the appropriate procedure code to indicate that the procedure was discontinued. Reimbursement for the failed colonoscopy will equal the Plan allowance for a flexible sigmoidoscopy.

44388 – Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)

45378 – Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without colon depression – separate procedure)

G0105 – Colorectal cancer screening; colonoscopy on individual at high risk

G0121 – Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk

In addition to the criteria and conditions contained in this policy, the service, procedure or item must be deemed medically necessary, must be a covered member benefit and is subject to member cost sharing provisions.

IV. EXCLUSIONS TOP

N/A

V. VARIATIONS TOP

This policy is applicable to all programs and products administered by Capital BlueCross unless otherwise indicated below.

VI. REFERENCES TOP

EncoderPro for Payers
Optum™ 2020

CPT 2020 Professional Edition
American Medical Association

HCPCS Level II Expert
Optum™ 2020

The American Gastroenterological Association, Coding FAQs

Chapter 12 of the Medicare Claims Processing Manual can be viewed by accessing the Centers for Medicare & Medicaid Services website