Colonoscopy and related anesthesia services billing

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The Affordable Care Act (ACA) requires many health plans to cover recommended preventive care services without member cost sharing when the services are rendered by an in-network provider and/or facility. Screening colonoscopies (even when polyps are removed) are included as a covered preventive care service. Since colonoscopies are rendered for both screening and diagnostic purposes, it is very important for providers to use appropriate coding guidelines when reporting colonoscopies. When inappropriate CPT and ICD-10 codes are submitted on claims, it can result in incorrect provider payment and/or incorrect member cost sharing.

The following services are covered with no member cost share:

- Colonoscopy screening procedure
- Anesthesia charges when anesthesia is billed with the appropriate screening CPT code (even when polyps are removed)
- Other associated facility charges when the colonoscopy is billed with an appropriate screening diagnosis code
- Removal, examination and analysis of polyps when the polyps are removed during a screening colonoscopy

In the instance where a screening colonoscopy starts out as screening but turns into a diagnostic procedure due to polyps being removed, we follow CPT guidelines for our Commercial members, not Medicare guidelines. The CPT® 2018 Professional Edition manual shares the following information regarding the billing of anesthesia for any screening colonoscopy, “Report 00812 to describe anesthesia for any screening colonoscopy regardless of ultimate findings.”

URL: https://providernews.anthem.com/maine/article/new-pre-service-clinical-review-requirement-for-egd-services-begins-november-1-2018-4

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