Documentation Dissection

Introduction: A male patient presents for an elective outpatient Colonoscopy [1].

Indications: Screening [2].

Consent: The benefits, risks, and alternatives to the procedure were discussed and informed consent was obtained from the patient.

Preparation: Pulse, pulse oximetry and blood pressure were monitored throughout the procedure.

Medications:

Demerol 50 mg IV throughout the procedure.

Versed 3 mg IV.

Rectal Exam: Normal rectal exam.

Procedure: The colonoscope was passed with ease through the anus under direct visualization; it was extended to the cecum, confirmed by appendiceal orifice and ileocecal valve. The scope was withdrawn and the mucosa was carefully examined [3]. The quality of the preparation was good. The views were good. The patient's toleration of the procedure was good. Retroflexion was performed in the rectum.

Findings: The colonoscopy examination was completely normal. Complications: There were no complications associated with the procedure. Impressions: Normal colonoscopy [4].

Recommendations:

Colonoscopy recommended in 5 years.

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[1] Indication of what procedure is to be performed.

[2] Further indication patient is having a screening colonoscopy.

[3] Complete diagnostic colonoscopy is performed going all the way to the cecum. No therapeutic procedure is performed.

[4] Diagnosis.

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What are the CPT® and ICD-10-CM codes reported?

CPT® Code: 45378

ICD-10-CM Code: Z12.11

Rationales:

CPT®: A diagnostic colonoscopy is performed. In CPT Index look for Endoscopy/Colon/Exploration referring you to codes 44388 and 45378. The colonoscopy was not performed through a stoma, not reporting code 44388. CPT code 45378 is selected.

ICD-10-CM: The main reason for the encounter is a screening colonoscopy. In the Alphabetical Index look for Screening/ colonoscopy referring you to code Z12.11. Confirmation in the Tabular List confirms Z12.11 is coded to the highest specificity and is the correct code for *Encounter for screening colonoscopy NOS*.