Surveillance Colonoscopy Interval in Patients with a History of Adenomatous Polyps

Coding Specifications

Codes required to document patient has a history of colonic polyp(s) and a surveillance colonoscopy occurred:

A line item ICD-9-CM diagnosis code for a history of colonic polyp(s) and a CPT procedure code or G-code for surveillance colonoscopy are required to identify patients to be included in this measure.

All measure-specific coding should be reported ON THE SAME CLAIM.

History of colonic polyp(s) line item ICD-9-CM diagnosis code

- V12.72

AND

CPT procedure codes or G-code for surveillance colonoscopy

- 44388, 44389, 44392, 44393, 44394, 45355, 45378, 45380, 45381, 45383, 45384, 45385, G0105

  WITHOUT

  - CPT Category I Modifiers: 52, 53, 73, 74

Quality codes for this measure:

CPT II Code descriptors

(Data collection sheet should be used to determine appropriate code.)

- ***CPT II 0529F:*** Interval of three or more years since patient's last colonoscopy, documented
- ***CPT II 0529F–1P:*** Documentation of medical reason(s) for an interval of less than three years since the last colonoscopy (eg, patients with high risk for colon cancer, last colonoscopy incomplete, last colonoscopy had inadequate prep, piecemeal removal of adenomas, or last colonoscopy found greater than 10 adenomas)
- ***CPT II 0529F–3P:*** Documentation of system reason(s) for an interval of less than three years since the last colonoscopy (eg, unable to locate previous colonoscopy report)
- ***CPT II 0529F–8P:*** Interval of less than three years since patient's last colonoscopy, reason not otherwise specified

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