

Gastroenterology Coding & Compliance Quick Reference

A one-page teaser covering screening vs. diagnostic colonoscopy distinctions and endoscopic bundling — practical starting points for coders, billers, and providers. This is general education, not a substitute for payer-specific policy or a full audit.

Documentation Musts

- Indication for the procedure (screening vs. diagnostic vs. surveillance) documented clearly before the scope begins — this single distinction drives patient cost-sharing under most payer policies.
- Findings and any intervention (polypectomy, biopsy) documented per site/lesion, not as a single summary statement.
- Conversion from a planned screening to a diagnostic/therapeutic procedure documented with the specific finding that triggered it.
- Bowel prep quality and any incomplete-procedure reason documented for repeat-procedure justification.

Common Denial Triggers

- Screening colonoscopy billed as diagnostic (or vice versa) inconsistent with the documented indication, driving unexpected patient cost-sharing complaints and appeals.
- Multiple polypectomy techniques billed in the same session without distinct per-lesion documentation.
- Repeat procedures billed sooner than payer screening intervals without a documented qualifying reason.

Modifier Watch-Outs

Modifier 33 (preventive service) and PT (screening converted to diagnostic) are the two GI-specific modifiers most often missing or misapplied — getting these right directly affects what the patient is billed.

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