Colonoscopy Procedure Note

The indication decides the coding, and the times and landmarks decide the quality measures. Both get recorded here, before the findings.

Patient / MRN / DOB	
Date of service	*Date _____ · endoscopist _____ · assistant _____ · facility _____*
Indication	***Screening*** *(average risk / high risk) ·* ***surveillance*** *(prior adenoma or CRC, IBD) ·* ***diagnostic*** *(symptom _____) · positive stool-based test Y / N*
Risk factors	*First-degree relative with CRC or adenoma · FAP · Lynch · personal history of adenoma or CRC · IBD · none*
Consent and sedation	*Consent obtained Y / N · ASA class ___ · sedation: moderate / MAC / general · agents and doses _____*

A Bowel Preparation

Adequacy is a priority quality indicator

Preparation regimen	*Agent _____ · split dose Y / N · last dose to procedure interval ___ h*
Preparation quality	*Boston Bowel Prep Score: right ___ transverse ___ left ___ · total ___ / 9 · adequate Y / N*
If inadequate	*Repeat interval recommended _____ · reason documented*

B Extent of Examination

Photodocumentation supports the cecal intubation rate

Cecum reached	*Y / N · landmarks identified: appendiceal orifice / ileocecal valve ·* ***photodocumented Y / N***
If not reached	*Furthest extent _____ · reason _____*
Terminal ileum	*Intubated Y / N · findings _____*
Scope and technique	*Instrument _____ · CO2 insufflation Y / N · position changes, abdominal pressure, cap assist*

C Timing

Record clock times, not a duration estimate

Times	*Scope in _____ : _____ · cecum reached _____ : _____ · scope out _____ : _____*
Withdrawal time	*___ min ___ sec ·* ***excluding time spent on biopsy and polypectomy***

Why the indication field is first. Screening, surveillance and diagnostic are three different claims, and the patient's cost share depends on which one you documented. For Medicare, **G0121** is average-risk screening at a 10-year interval and **G0105** is high-risk screening at 24 months, where high risk means a sibling, parent or child with colorectal cancer or an adenomatous polyp, familial adenomatous polyposis, Lynch syndrome, a personal history of adenomatous polyps or colorectal cancer, or inflammatory bowel disease. If the indication is not documented clearly, the coder has to guess, and the patient finds out on the bill.

Colonoscopy Findings and Plan

One row per lesion, with size, shape, location and resection method. That combination is itself a quality indicator, with a target of 98 percent.

D Findings

Size · morphology · location · resection method · retrieved

#	SIZE (MM)	MORPHOLOGY	LOCATION	RESECTION METHOD	RETRIEVED	PATH SENT
1						
2						
3						
4						
5						
6						
7						

E Other Findings and Complications

Other findings	*Diverticulosis · hemorrhoids · angiodysplasia · colitis · stricture · normal mucosa*
Immediate complications	*None / bleeding / perforation / cardiopulmonary · intervention _____*
Estimated blood loss and tolerance	*EBL _____ · patient tolerated the procedure well Y / N*

F Assessment and Recommendations

Assessment	
Surveillance interval recommended	*_____ · based on findings and current guideline · communicated to patient and referring clinician Y / N*
Post-procedure instructions	*Diet · activity · anticoagulation resumption · warning signs given Y / N*

G Coding

Codes	*Screening: G0121 / G0105 · diagnostic 45378 · biopsy 45380 · hot forceps 45384 · snare 45385 · ablation 45388 · dx _____*
If a screening became therapeutic	*Modifier **PT** for Medicare / modifier **33** for commercial and Medicaid · appended to each CPT Y / N*

H Attestation

Attestation	*Endoscopist signature _____ · name and credentials _____ · date and time signed _____*

1. The patient's bill. When a screening colonoscopy becomes therapeutic, the claim needs the therapeutic CPT plus a modifier preserving the screening origin: **PT for Medicare, 33 for commercial and Medicaid**. Wrong modifier for the payer and the screening benefit is lost. Under the Consolidated Appropriations Act the Medicare beneficiary owes **15% from 2023 to 2026**, 10% from 2027 to 2029, nothing from 2030. **2. Your quality numbers,** all computed from this page. 2024 ASGE and ACG targets: adenoma detection **≥35%** (≥50% after a positive stool test), sessile serrated lesion detection **≥6%**, cecal intubation **≥95%**, withdrawal time **≥8 min**, adequate prep **≥90%**, and size, shape, location and resection method recorded for **≥98%** of resected lesions.