Codify
BY AAPC

Internal Medicine Coding Alert

Diagnostic Tests: Colonoscopy Screening: Always Check Frequency Rules and Risk Categories

Watch out: Medicare has specific requirements other payers might not follow.

The days have passed when patients always saw a gastroenterologist for colonoscopy screenings. According to the AAFP's position paper on colonoscopy, physicians in many specialties now perform the procedure.

Note: Even if your internist physician doesn't perform colonoscopy screenings, you should know the coding regulations.

"Our family physicians do not perform the actual screening colonoscopies, but they are the ones who order them," says **Linda Vargas, CPC, CEMC,** coding and reimbursement specialist for Cass Regional Medical Center in Harrisonville, Mo. "I think it's important that primary care providers know the coverage guidelines, as they play a vital role in making sure their patients receive their scheduled preventive screenings."

Ask yourself these questions and follow our experts' advice to be sure you're up to date on frequency and eligibility requirements.

Is the Timing Right?

Medicare allows patients (ages 50 and over) who are at average risk for colorectal cancer to receive covered screening colonoscopies once every 10 years. And Medicare is very stringent on the date, experts say -- the gap between screenings must be at least 10 years or longer.

"The information I've read states that 'at least 119 months have passed following the month in which the last covered screening colonoscopy (HCPCS code G0121) was performed,'" says Vargas. "So if the screening was performed on June 15, 2000, you would start counting 119 months in July 2000. The next screening could be scheduled for any day in June 2010 or after."

Example: A 65-year-old established Medicare patient comes to your office for a screening colonoscopy on June 14, 2011. The patient's records indicate that she last had a covered screening colonoscopy on March 5, 2001. On the claim, you'll report G0121 (Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk). Many payer policies state that only diagnosis V76.51 (Special screening for malignant neoplasms; colon) justifies reporting G0121. Some payers, such as Palmetto GBA, however, also accept V76.41 (Screening for malignant neoplasms; rectum), says **Dawn Silva, CPC, CCP,** compliance officer and certified coder for Marin Medical Practice Concepts in Novato, Cal.

Unless the patient's status changes, she won't be eligible for another covered screening until June 2021, or later.

Exception: If the patient had a Medicare-covered cancer screening via flexible sigmoidoscopy (G0104, Colorectal cancer screening; flexible sigmoidoscopy) within the last 47 months, she is not eligible for a colonoscopy screening.

Can You Prove High Risk?

If your Medicare patient is at high risk for colorectal cancer, the screening guidelines -- and your coding -- change. Patients at high risk are entitled to a covered screening once every two years, says **Carol Pohlig, RN, CPC, ACS,** a senior coding and education specialist at the University of Pennsylvania department of medicine in Philadelphia. "High risk" includes factors such as a personal history of colon cancer, inflammatory bowel disease (including Crohn's Disease and ulcerative colitis), or adenomatous polyps. A family history of adenomatous polyposis or hereditary nonpolyposis colorectal cancer also increases a patient's risk, as does having a close relative (sibling, parent, or child) who has had

colorectal cancer or an adenomatous polyp.

Code it: Report screenings for high risk patients with G0105 (Colorectal cancer screening; colonoscopy on individual at high risk). List a V code such as V10.05(Personal history of malignant neoplasm; Gastrointestinal tract; Large intestine) or V12.72 (Personal history of certain other diseases; Diseases of digestive system; colonic polyps) as the primary diagnosis supporting the test and the patient's high risk status. If the patient already suffers from a condition that automatically puts him at high risk for colorectal cancer, list that condition as the primary diagnosis instead. Possible conditions could include regional enteritis of an unspecified site (555.9), ulcerative (chronic) enterocolitis (556.0), or ulcerative (chronic) ileocolitis (556.1), Silva says.

Many diagnosis codes could be considered acceptable for G0105. Check your payers' policies, but always code based on the encounter documentation your physician provides.

How Do You Handle Diagnostics?

Sometimes the physician begins performing a screening colonoscopy for colorectal cancer but ends up addressing another problem during the procedure. When that happens, report the appropriate procedure code and leave G0105 or G0121 off the claim.

Example: During a screening (asymptomatic) colonoscopy, the physician encounters a polyp that he decides to remove via a snare technique. You would report 45385 (Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor[s], polyp[s], or other lesion[s] by snare technique), Vargas says, instead of G0121.

Remember modifier PT: For Medicare contractors, providers should include modifier PT (Colorectal cancer screening test; converted to diagnostic test or other procedure). Append modifier PT to the diagnostic procedure code that you'll report instead of the screening test (such as 45385 in the example above), according to the Medicare Physician Fee Schedule Final Rule published in the Nov. 29, 2010 Federal Register.

Can You Bill Private Payers?

Some private payers reimburse for colonoscopy screenings, but others don't.

Most non-Medicare payers accept 45378 (Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen[s] by brushing or washing, with or without colon decompression [separate procedure]) for the test. Policies can differ, however, so check your local regulations before submitting the claim.