Internal Medicine Coding Alert

Figure Frequency Into Your Colonoscopy Screening Coding -- or End Up With Denials

2-year rule applies to high-risk patients

If you fail to observe frequency guidelines for Medicare screening colonoscopies, or if you miscalculate the beneficiary's risk category, your practice probably won't receive payment.

Read on for more advice on filing top-notch screening colonoscopy claims.

Dx Not Necessarily a Must on Average-Risk Screening

Medicare patients age 50 and over are entitled to a screening colonoscopy once every 10 years, says **Cynthia Swanson, RN, CPC,** senior managing consultant for Seim, Johnson, Sestak & Quist LLP in Omaha, Neb. You'll code these encounters with G0121 (Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk).

Example: A 64-year-old Medicare patient reports to the internist for a screening colonoscopy. The patient's record indicates that he last had a screening in 1996, when he was 52. This patient qualifies for a covered screening. On the claim, report G0121.

Diagnosis coding: Some Medicare carriers require only that the patient be at least 50 to qualify for G0121 service. But Swanson recommends that you check your local coverage determination (LCD) to see if G0121 has any diagnosis requirements.

Here's what Riverbend GBA of Tennessee/New Jersey reports in its LCD for colorectal cancer screenings: "No ICD-9 codes are required to support this service."

However, other LCDs might require certain diagnosis codes for G0121, so it's safest to check your LCD before filing G0121.

Observe 4-Year Rule for Sigmoidoscopy Patients

There is one more important rule regarding patients receiving G0121 service. If that patient has had a covered flexible sigmoidoscopy screening (G0104, Colorectal cancer screening; flexible sigmoidoscopy), he is not entitled to a screening colonoscopy for at least 48 months, Swanson says.

Suppose an average-risk established Medicare patient reports to the internist for a screening colonoscopy on March 8, 2008. The patient's medical record indicates that he had a flexible sigmoidoscopy screening on April 7, 2005. This patient is not now eligible under Medicare guidelines for a screening colonoscopy because it has been only three years since his sigmoidoscopy, says **Bruce Rappoport, MD, CPC, CHCC,** a board-certified internist and medical director of Broward Health's Best Choice Plus and Total Claims Administration in Fort Lauderdale, Fla.

High Risk Has Different Frequency Rules

If a patient is at high risk for colorectal cancer, Medicare allows a covered screening once every two years, Swanson says. You'll code these encounters with G0105 (Colorectal cancer screening; colonoscopy on individual at high risk).

Example: A 59-year-old established Medicare patient with a personal history of colonic polyps reports to the internist for a colonoscopy screening on March 8, 2008. The patient's record indicates that he last had a screening on Jan. 21, 2005.

This patient qualifies for a high-risk screening. On the claim, report G0105 for the service. Don't forget to append V12.72 (Personal history of diseases of digestive-system; colonic polyps) to G0105 to prove medical necessity for the visit.

Age shouldn't matter: Some Medicare payers might have a minimum age requirement for high-risk screenings, even though Medicare itself forbids the restriction. "For beneficiaries considered to be at high risk for developing colorectal cancer, Medicare covers one screening colonoscopy every two years, regardless of age," according to MedLearn Matters article SE0613.

While it is not common practice, your internist may provide a high-risk screening to a Medicare patient under 50. If she does, be sure to code it just as you would any other G0105 claim -- and remind the payers of the MedLearn Matters guidance on high-risk screenings.

You should always check your individual LCDs for specific information on proving medical necessity for G0105, Rappoport says. Here's a sample from Florida's First Coast Service Options colorectal cancer screening LCD:

"Screening colonoscopies (code G0105) are covered at a frequency of once every 24 months for beneficiaries at high risk for colorectal cancer. High risk for colorectal cancer means an individual with one or more of the following:

• a close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp

• a family history of familial adenomatous polyposis

• a family history of hereditary nonpolyposis colorectal cancer

• a personal history of adenomatous polyps

• a personal history of colorectal cancer

• a personal history of inflammatory bowel disease, including Crohn's disease, and ulcerative colitis."

Note: For more information on diagnosis coding for high-risk screenings, see "Look to Screening LCDs for High-Risk Clues" on page 27.

Use CPT Code When Screening Turns Diagnostic

If the internist starts a colonoscopy screening and then encounters an unforeseen problem that he must address, Medicare wants you to report a CPT procedure code for the encounter, Swanson says.

Check out this guidance from First Coast: "If during the course of the screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a colonoscopy with biopsy or removal (procedure codes 45378-45386) should be billed rather than code G0105."

Example: A 58-year-old established Medicare patient reports to the internist for a screening colonoscopy. During the screening, the internist finds a pair of 0.8-cm colonic polyps, which he removes using biopsy forceps. Pathology demonstrated that both were tubular adenomas.

On the claim, report 45384 (Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor[s], polyp[s], or other lesion[s] by hot biopsy forceps or bipolar cautery) for the service.

Don't forget to link 211.3 (Benign neoplasm of other parts of digestive system; colon) to 45384 to represent the patient's polyps.