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Internal Medicine Coding Alert

Master Frequency Rules, Risk Categories for Medicare Colonoscopy Screenings

Medicare has specific frequency requirements for average- and high-risk patients

Medicare patients who present to your internist for a colorectal cancer screening colonoscopy can present coding confusion if you don't know all the basics of the screening policy. The patients must meet age and frequency requirements to have an average-risk Medicare-approved screening--and the guidelines only get more stringent when you're coding for a high-risk screening.

Danger: Coders who don't know these requirements risk miscoding one of their screening claims. And if your internist provides a colorectal cancer screening to a Medicare patient who does not meet screening parameters, the practice will have to cover the screening itself.

50 Is the Magic Number for Average-Risk Patients

Medicare allows patients who are at average risk of colorectal cancer to receive covered screening colonoscopies once every 10 years, says **Carol Pohlig, BSN, RN, CPC**, senior coding and education specialist at the University of Pennsylvania department of medicine in Philadelphia. These patients must also be at least 50 years old, she says.

Example: A 60-year-old average-risk patient reports for a colonoscopy screening to check for colorectal cancer on March 2, 2007. The internist provides the screening and sends the patient home. On the claim, you should report G0121 (Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk) for the screening.

Unless this patient's risk category changes, he is not entitled to another covered screening until March 2, 2017.

Caveat: If your patient has had a Medicare-covered cancer screening via flexible sigmoidoscopy within the last 48 months (G0104, Colorectal cancer screening; flexible sigmoidoscopy), he is not eligible for a colonoscopy screening, says **Cynthia Swanson, RN, CPC**, senior managing consultant for **Seim, Johnson, Sestak & Quist LLP**, in Omaha, Neb.

According to Medicare, average-risk patients who have had covered flexible sigmoidoscopy screenings must wait four years before having a covered colonoscopy screening, she says. So if a 54-year-old average-risk Medicare patient had a flexible sigmoidoscopy screening on May 5, 2004, he would not be eligible for a covered screening colonoscopy until at least May 5, 2008.

LCDs Show You Medical-Necessity Requirements for G0121

Many Medicare carriers only require that the patient be over 50 to receive G0121 service, Pohlig says. However, some payers may have certain medical-necessity requirements specific to their region.

Best bet: If you don't know the payer's policy on G0121, check its local coverage determination for more information, Swanson says. "LCDs will contain diagnosis information specific to medical necessity for G0121," she says.

High-Risk Screenings Require ICD-9 Proof

When your internist performs a colonoscopy screening on a Medicare patient at high risk for colorectal cancer, you'll code the encounter with G0105 (Colorectal cancer screening; colonoscopy on individual at high risk). Patients at high risk are entitled to a covered screening once every two years, Pohlig says.

Some payers might set a minimum age of 50 for covered high-risk screenings, even though Medicare has no age requirement for G0105 screenings. "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.

Tip: Despite this edict from Medicare, you might still have trouble getting G0105 claims paid for patients under 50. If you get a denial on a G0105 claim because the patient is under 50, contact the carrier and reference the aforementioned MedLearn Matters article.

The most important aspect of a successful G0105 claim is proving medical necessity for the service. You can prove necessity through the patient's personal and family history and exact ICD-9 coding, experts say.

Swanson says that an individual at high risk for colorectal cancer could have one or more of the following characteristics:

• 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 colorectal cancer
• A personal history of adenomatous polyps
• Inflammatory bowel disease, including Crohn's disease, and ulcerative colitis.

Watch for These Diagnosis Codes

As for diagnosis codes that meet the high-risk criteria, Pohlig offers these choices:

• 555.0, 555.1, 555.2, 555.9--Regional enteritis ...
• 556.0, 556.1, 556.2, 556.3--Ulcerative colitis ...
• 556.8--Other ulcerative colitis
• 558.2--Toxic gastroenteritis and colitis
• 558.9--Other and unspecified noninfectious gastroenteritis and colitis
• V10.05--Personal history of malignant neoplasm; large intestine
• V10.06--Personal history of malignant neoplasm; rectum, rectosigmoid junction, and anus
• V12.72--Personal history of diseases of digestive system; colonic polyps
• V16.0--Family history of malignant neoplasm; gastrointestinal tract
• V18.51--Family history of colonic polyps
• V18.59--Family history of other digestive disorders.

(Note: This is not an all-inclusive list of acceptable diagnosis codes for G0105.)

Suppose a 56-year-old Medicare patient reports for a colorectal cancer screening. The patient has a family history of digestive disorders. On the claim, you should:

• report G0105 for the screening.
• attach V76.51 (Special screening for malignant neoplasms; colon) and V18.59 to G0105 to prove medical necessity for the screening.

Adjust When Screening Becomes Diagnostic

When your internist starts out performing a screening colonoscopy for colorectal cancer but ends up addressing another problem during the colonoscopy, you should report the appropriate procedure code and leave G0105 off the claim, Swanson says.

Example: A 61-year-old Medicare patient reports for a high-risk colorectal cancer screening. During the procedure, the internist finds a pair of polyps, which he biopsies (results come back negative). On the claim, report 45380 (Colonoscopy,

flexible, proximal to splenic flexure; with biopsy, single or multiple) for the colonoscopy. Remember to attach 211.3 (Benign neoplasm of other parts of digestive system; colon) to 45380 to represent the patient's polyps.