Internal Medicine Coding Alert

Optimize Reimbursement From Medicare and Third-Party Payers for Flexible Sigmoidoscopies

Internists are performing an increasing number of screening flexible sigmoidoscopies because of growing publicity concerning Medicares screening benefits for the detection of colorectal cancer. Although most commercial insurers do not cover a screening flexible sigmoidoscopy, there are additional services often performed during the diagnostic procedure that these private payers will cover but Medicare does not. The differing policies can be confusing to coders, especially when the diagnostic flexible sigmoidoscopy is added to the equation. This diagnostic procedure is generally performed if the patient has signs or symptoms of gastrointestinal disease, and should be reported with an appropriate diagnosis code to support the medical necessity of the procedure.

Section 4180 of the Medicare Carriers Manual stipulates that screening flexible sigmoidoscopies are covered once every 48 months for asymptomatic beneficiaries who are 50 years of age or older.

HCPCS code G0104 (colorectal cancer screening; flexible sigmoidoscopy) should be used to report to Medicare all screening flexible sigmoidoscopies performed on patients without signs or symptoms of gastrointestinal disease. Code 45330 (sigmoidoscopy, flexible; diagnostic, with or without collection of specimen[s] by brushing or washing [separate procedure]) should be used to report a diagnostic flexible sigmoidoscopy performed on patients with signs and symptoms of gastrointestinal disease.

Use Different Diagnosis Code for Screening and Diagnostic Procedures

To report the screening flexible sigmoidoscopies, the internist will have to use an approved diagnosis code for the screening procedure, which will differ from the covered diagnosis codes for the diagnostic procedure. There is no list of covered ICD-9 codes outlined in the national policy, but local Medicare carriers in the following states have designated their own list of covered ICD-9 codes for the procedure:

Alaska, Arizona, Colorado, Hawaii, Nevada, North Dakota, Oregon, South Dakota, Washington, and Wyoming accept any valid ICD-9 code.

Connecticut accepts only V76.41 (special screening for malignant neoplasm; rectum) and V76.49 (special screening for malignant neoplasm; other).

New York (Upstate Medical) accepts V76.9 (special screening for malignant neoplasm; unspecified).

Ohio and West Virginia accept V71.1 (observation for suspected malignant neoplasm), V76.41 and 790.5 (other nonspecific abnormal serum enzyme levels).

Because these codes are frequently updated, internists should check with their local Medicare carriers to obtain their latest lists of covered ICD-9 codes for screening flexible sigmoidoscopies. For a list of covered diagnosis codes for the diagnostic flexible sigmoidoscopies, internists should consult their carriers local medical review policy for the procedure.

Screening Becomes Diagnostic

Medicare states that if, during the course of a screening flexible sigmoidoscopy, a lesion or growth is detected that results in a biopsy or removal of the growth, the appropriate diagnostic procedure code may be billed instead of the screening code. Code 45331 (sigmoidoscopy, flexible; with biopsy, single or multiple) should be used to report a

diagnostic flexible sigmoidoscopy with biopsy, says **Pat Stout, CMT, CPC,** an independent coding consultant in Knoxville, Tenn., who specializes in gastroenterology. Depending on the technique used, 45333 (sigmoidoscopy, flexible; with removal of tumor[s], polyp[s], or other lesion[s] by hot biopsy forceps or bipolar cautery), 45338 (sigmoidoscopy, flexible; with removal of tumor[s], polyp[s], or other lesion[s] by snare technique) or 45339 (sigmoidoscopy, flexible; with ablation of tumor[s], polyp[s], or other lesion[s] not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique) can all be used to report the removal of a growth.

If the internist detects a growth during a screening flexible sigmoidoscopy but does not perform a biopsy or removal, either a screening or diagnostic procedure can be reported to Medicare, as long as the appropriate diagnostic code is used, according to **Glenn Littenberg, MD, FACP,** a gastroenterologist in Pasadena, Calif., and a member of the American Medical Associations CPT Editorial Panel. If the internist uses 211.3 (benign neoplasm of the colon) as the diagnostic code, then he or she would have to report 45330 for the procedure because 211.3 is not a diagnosis used for screenings, Littenberg explains.

Bill Private Payers for Surgical Tray

Most commercial insurance companies do not cover screening flexible sigmoidoscopies and do not recognize G0104. When reporting a diagnostic flexible sigmoidoscopy, however, there may be additional services that will be reimbursed by private payers, but not by Medicare.

Many private insurers will reimburse for supplies used when the flexible sigmoidoscopy is performed in an office setting. As a general rule, Medicare considers supplies to be an integral part of the service provided and does not reimburse separately for them. Internists may be able to bill a private insurer for a surgical tray when the flexible sigmoidoscopy is done in an office, Littenberg explains. In addition to the procedure, 99070 (supplies and materials [except spectacles], provided by the physician over and above those usually included with the office visit or other services rendered [list drugs, trays, supplies, or materials provided]) should be used to report a surgical tray to private insurers.

Some Payers Cover India Ink Tattooing

Another service that may be reimbursed by a private insurer is India ink tattooing, which is used to mark lesions found during the flexible sigmoidoscopy for easy identification during a subsequent procedure. Despite its value to the patient, Medicare does not consider India ink tattooing to be a reimbursable service. There is no specific CPT code for the procedure, and according to the national Correct Coding Initiative, the identification of anatomical landmarks is one of many generic services for which it would be inappropriate to separately code based on standard medical and surgical principles.

Although Medicare providers generally will not reimburse for the procedure, Stout says that many private payers will cover the service if the internist uses the codes for unlisted procedures. When billing for India ink tattooing, Stout recommends listing the CPT code for the flexible sigmoidoscopy procedure performed, followed by the unlisted code for the site of the body being tattooed. For example, 45330 should be listed first, followed by 44799 (unlisted procedure, intestine). A description of the tattooing procedure must accompany the claim, emphasizes Stout. Unless a description of the procedure and the purpose for doing the tattooing is attached, the claim is no good, she says. The documentation has to support the service.