Codify
BY AAPC

Internal Medicine Coding Alert

READER QUESTIONS: Check LCD When Considering High-Risk Dx

Question: A 65-year-old established Medicare patient with regional enteritis and a family history of gastrointestinal cancer reports to the internist for a scheduled Medicare colonoscopy screening for colorectal cancer.

The patient's medical record indicates that he has never received a covered screening from our internist; however, a gastroenterologist at a different practice performed a screening colonoscopy on the patient in March 2006. Is this patient eligible for another covered screening?

Indiana Subscriber

Answer: The patient's enteritis and family history of cancer almost certainly put him at high risk for colorectal cancer, meaning he is eligible for a covered screen once every 24 months. On the claim, you'll likely report G0105 (Colorectal cancer screening; colonoscopy on individual at high risk) for the screening.

According to the local coverage determination (LCD) for First Coast Service Options Inc., a Florida Medicare payer: "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 (V16.0).

• A family history of familial adenomatous polyposis (V18.51-V18.59).

• A family history of hereditary nonpolyposis colorectal cancer (V16.0).

• A personal history of adenomatous polyps (V12.72).

• A personal history of colorectal cancer (V10.05, V10.06).

• A personal history of inflammatory bowel disease, including Crohn's Disease, and ulcerative colitis (555.0-555.9, 556.0-556.9, or 558.1-558.9)." (LCD L29100). (Check your individual Medicare payer for more information on its high-risk qualifications.)