Codify
BY AAPC

Internal Medicine Coding Alert

Reader Questions: Look to Patient's Diagnosis for High-Risk Clues

Question: A 70-year-old established Medicare patient with regional enteritis of the duodenum and a family history of gastrointestinal cancer reports to the internist for a screening colonoscopy. Should I report G0121 or G0105?

North Carolina Subscriber

Answer: Given the patient's family history and current condition, he is at high risk for colorectal cancer, meaning you should report the colonoscopy with G0105 (Colorectal cancer screening; colonoscopy on individual at high risk).

Don't forget to attach these ICD-9 codes to G0105 to prove medical necessity for the service:

• 555.0 -- Regional enteritis; small intestine

• V16.0 -- Family history of malignant neoplasm; gastrointestinal tract.

Why it matters: Since your patient is at high risk for colorectal cancer, he is entitled to a screening colonoscopy every 48 months. If your patient was at average risk, you would report the service with G0121 (Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk). Average-risk patients are entitled to a screening once every 10 years.

High-risk criteria: When your internist performs a colonoscopy screening on a Medicare patient at high risk for colorectal cancer, the patient 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.