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Internal Medicine Coding Alert

Ride This FAQ to Medicare Cancer Screen Pay Dirt

Remember frequency rules differ for average, high risk.

Getting Medicare to pony up for colorectal cancer screenings is not difficult provided you follow its frequency guidelines and eligibility requirements to the letter. A coding slip up on one of these items will knock you out of the saddle, and Medicare won't accept the claim at all.

Rope in all the coding info you'll need via this Medicare colorectal cancer screening FAQ.

Who's Eligible for Average-Risk Test?

If the Medicare patient is 50-plus years old, he is eligible for a covered Medicare screening, confirms **Dena Rumisek, CPC,** biller at Michigan's Grand River Gastroenterology PC.

However: These patients are considered average risk, and can have a colorectal cancer screening only once every 10 years, says **Cheryl Ray, CCS, CPMA,** of Atlantic Gastroenterology in Greenville, N.C. Ignore Medicare's frequency guidelines at your peril, experts warn.

"Medicare is very stringent on the date ... it has to be 10 years or longer -- it can't be 9 years and 360 days," between covered screening colonoscopies, assures Rumisek.

Example: A 68-year-old established Medicare patient reports for a screening colonoscopy on Dec. 5, 2009. The patient's records indicate that he last had a covered screening on Sept. 15, 1998. On the claim, you should report G0121 (Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk).

What ICD-9 Codes Are In Play for G0121?

Just one, provided there is no need for any therapeutic intervention during the colonoscopy. Medicare requires V76.51 (Special screening for malignant neoplasms; colon) on all G0121 claims. You might list other identified conditions secondarily, including diverticulosis (562.10) or hemorrhoids (455.0).

Always list the V code first for an average-risk screening, however.

What if the Patient Had a Recent Flexible Sig?

The frequency rules differ depending on whether other related colorectal cancer tests were performed previously;

if a patient has had a routine flexible sigmoidoscopy screening (G0104, Colorectal cancer screening; flexible sigmoidoscopy), he is not entitled to a screening colonoscopy for at least 48 months, advises **Cynthia Swanson RN, CPC,** senior managing consultant for Seim, Johnson, Sestak & Quist LLP in Omaha, Neb.

Example: An average-risk established Medicare patient reports to the internist for a screening colonoscopy on Dec. 7, 2009. The patient's medical record indicates that he had a flexible sigmoidoscopy screening on Nov, 17, 2007. This patient is not now eligible under Medicare guidelines for a screening colonoscopy because it has been only three years since his sigmoidoscopy.

What About Coverage for High-Risk Patients?

A patient who is considered at high risk for colorectal cancer is entitled to a screening colonoscopy once every 24

months, Ray says. You'll list a V code (such as V10.05 [History of Colon Cancer] or V12.72 [Diseases of digestive system; colonic polyps]) as the primary diagnosis for these tests -- most of the time.

If the patient already suffers from a condition that automatically put him at high risk for colorectal cancer, list that condition as the primary diagnosis. (Want to know who Medicare considers at high risk for colorectal cancer? See "Mine Medicare LCD for High-Risk Diagnoses" on page 108.)

Example: A 69-year-old established Medicare patient with a personal history of colonic polyps reports to the internist for a colonoscopy screening on Dec. 1, 2009. The patient record indicates that the patient's last colonoscopy screening was May 4, 2006. On the claim, report G0105 (Colorectal cancer screening; colonoscopy on individual at high risk) with V12.72 appended.

Can I Bill Private Payers for Screenings?

The answer will vary. Some private carriers pay fully for colonoscopy screenings -- their coding practices for these services can differ from Medicare, however. Many U.S. states have passed legislation similar to the Medicare regulations requiring all health insurance carriers to cover routine colorectal cancer screening starting at age 50. Most non-Medicare payers accept 45378 (Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen[s] by brushing or washing; with or without colon decompression [separate procedure]) for a screening colonoscopy, Ray relays.

Caveat: Though 45378 is likely the code you'll choose for private payer screens, Ray recommends that you still check with the carrier before coding these services; specifically, look for the private payer's frequency and diagnosis guidelines, which might differ from Medicare's. "Each carrier pays [for screenings] according to the patient's policy," she says.

G codes possible: Other private payers might want you to code the same way as Medicare. For instance, BCBS of Michigan accepts the G codes and follows most of the same diagnosis guidelines as Medicare, according to Rumisek.

What Happens When Screening Turns Diagnostic?

You should report the proper CPT code based on the encounter notes, Swanson confirms. Remember, the Medicare G codes are for screenings only. "Note: 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 should be billed and paid rather than G0105," according to the Medicare Benefit Policy Manual (280.2.2.C).

Example: A 67-year-old Medicare patient at average risk for colorectal cancer reports to the internist for a scheduled screening colonoscopy. During a complete screening colonoscopy to the cecum; a pair of polyps are found and removed from the ascending colon using hot biopsy forceps. The pathology demonstrates that these were both benign.

In this example, you'll 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) with 211.3 (Benign neoplasm of other parts of digestive system; Colon). You would not bill G0105.