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Part B Insider (Multispecialty) Coding Alert

Frequency Rules and Risk Categories Call the Shots in Colonoscopy Screenings

Watch out: Medicare has specific requirements other payers might not follow.

The U.S. Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer beginning at age 50 years and continuing until age 75 years. The following tips can help you collect for these services.

Get Your Timing for Screening Right

Medicare allows patients (ages 50 and over) who are at average risk for colorectal cancer to receive covered screening colonoscopies once every 10 years. And Medicare is very stringent on the date, experts say -- the gap between screenings must be at least 10 years or longer.

Rules state that at least 119 months should have passed following the month in which the last covered screening colonoscopy (HCPCS code G0121, Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk) was performed. So, if the screening was performed on June 3, 2015, you would start counting 119 months in July 2015. The patient can then schedule the next screening for any day in June 2025 or after.

Exception: "If the patient had a Medicare-covered cancer screening via flexible sigmoidoscopy (G0104, Colorectal cancer screening; flexible sigmoidoscopy) within the last 47 months, then she is next eligible for a colonoscopy screening in the 48th month after the sigmoidoscopy," informs **Michael Weinstein, MD,** Vice President of Capital Digestive Care.

Prove High Risk Eligibility for Screening

If your Medicare patient is at high risk for colorectal cancer such as patients with a history of polyps on prior colonoscopy the screening guidelines, and your coding, change.

Patients at high risk are covered for a follow-up screening as often as once every two years depending on the clinical circumstance, Weinstein says. "High risk" includes factors such as a personal history of colon cancer, inflammatory bowel disease (including Crohn's Disease and ulcerative colitis), or adenomatous polyps. A family history of adenomatous polyposis or hereditary nonpolyposis colorectal cancer also increases a patient's risk, as does having a close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp.

Code it: Report screenings for high risk patients with G0105 (Colorectal cancer screening; colonoscopy on individual at high risk). List a V code such as V10.05 (Personal history of malignant neoplasm; of large intestine) or V12.72 (Personal history of colonic polyps) as the primary diagnosis supporting the test and the patient's high-risk status. If the patient already suffers from a condition that automatically puts him at high risk for colorectal cancer, list that condition as the primary diagnosis instead. Possible conditions could include regional enteritis of an unspecified site (555.9), ulcerative (chronic) enterocolitis (556.0), or ulcerative (chronic) ileocolitis (556.1). The V codes will convert to Z85.--- (Personal history of malignant neoplasm...) after ICD-10 kicks in. Similarly, 555.9 crosswalks to K50.90 (Crohn's disease, unspecified, without complications), and 556.0 556.1 will both convert to K51.80 (Other ulcerative colitis without complications).

Many diagnosis codes could be considered acceptable for G0105. Check your payers' policies, but always code based on the encounter documentation your physician provides.

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Take Care When Diagnostic Becomes Therapeutic

Sometimes the physician begins performing a screening colonoscopy for colorectal cancer but ends up addressing another problem during the procedure with a therapeutic technique. When that happens, report the appropriate procedure code, and leave G0105 or G0121 off the claim.

Example: During a screening (asymptomatic) colonoscopy, the physician encounters a polyp that he decides to remove via a snare technique. You would report 45385 (Colonoscopy, flexible, with removal of tumor[s], polyp[s], or other lesion[s] by snare technique), instead of G0121.

Remember modifier PT: For Medicare contractors, providers should include modifier PT (Colorectal cancer screening test; converted to diagnostic test or other procedure). Append modifier PT to the diagnostic procedure code that you'll report instead of the screening test (such as 45385 in the example above).

Query Private Payers Before Billing for Screening

"Most private payers reimburse for colonoscopy screenings, others don't, but only if the plan predated the Accountable Care Act which mandates that any coverage plan initiated after the Act was passed must cover all preventable services with a rating of A or B by the United States Preventive Services Task Force (USPSTF)," Weinstein says. Most non-Medicare payers accept 45378 (Colonoscopy, flexible, diagnostic, including collection of specimen[s] by brushing or washing, when performed [separate procedure]) for the test. Policies can differ, however, so check your local regulations before submitting the claim.

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