Part B Insider (Multispecialty) Coding Alert

Medicare Modifiers: Modifier PT: Use This When Colorectal Screening Becomes Diagnostic

New modifier became effective Jan. 1--here's how you'll report it.

The question of how to code a screening colonoscopy that becomes diagnostic during the course of the procedure -- and whether the patient's deductible applies -- has long puzzled gastroenterological practices, but a new Medicare modifier solves that problem.

Effective Jan. 1, Medicare carriers accept new modifier PT (CRC screening test converted to diagnostic test or other procedure) to represent this scenario. "This tells the MAC contractor that the service started as a screening procedure (e.g. G0105, G0121) but an abnormality was found and the procedure became diagnostic or therapeutic," **Joel V. Brill, MD, AGAF, CHCQM** tells Part B Insider.

When appended to your procedure code, "the modifier will indicate to Medicare to waive the deductible for a diagnostic procedure," says **Christine Ross, CPC** with Digestive Healthcare Center in Hillsborough, N.J.

Why the change? Practices needed a way to tell MACs that their procedures started out as screening services but changed to diagnostic but didn't want patients subjected to deductibles for these services. "The Affordable Care Act waives the Part B deductible for colorectal cancer screening tests that become diagnostic," CMS noted in MLN Matters article MM7012, which announced the new modifier PT (http://www.cms.gov/MLNMattersArticles/downloads/MM7012.pdf).

Avoid Reporting G Code With Modifier PT

Once the physician indicates that the screening procedure has turned diagnostic, you'll report only the diagnostic colonoscopy code, and not the screening code (G0104-G0106, G0120-G0121). Not only is this correct coding, but it's also the only way you can use modifier PT.

The MLN Matters article notes that modifier PT should only be appended to a CPT code in the surgical range of 10000 to 69999. Therefore, you should not append modifier PT to a G code, says Brill, who represents the American Gastroenterological Association on the CPT Editorial Panel.

For example: During a screening colonoscopy for an average-risk Medicare patient, the physician discovers several polyps. He removes the polyps (which are later determined to be benign) during the same procedure using a snare technique. In this case, you should report the colonoscopy with polyp removal via snare technique (such as 45385, Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor[s], polyp[s], or other lesion[s], by snare technique) with modifier PT appended to 45385.

Don't Ditch 'V' Codes

Because your colonoscopy started out as a screening procedure, your diagnosis code should reflect both the screening nature of the visit and the actual condition that the physician treated.

CMS tackled this topic in MLN Matters article SE0706, with the instruction, "CMS advises that, whether or not an abnormality is found, if a service to a Medicare beneficiary starts out as a screening examination (colonoscopy or sigmoidoscopy), then the primary diagnosis should be indicated on the form CMS-1500 (or its electronic equivalent) using the ICD-9 code for the screening examination... Indicate the secondary diagnosis using the ICD-9-CM code for the abnormal finding (polyp, etc.)." This article can be accessed at

http://www.cms.gov/MLNMattersArticles/downloads/SE0746.pdf.

Therefore, in the example described above, the claim would appear with V76.51 (Special screening for malignant neoplasms, colon) as the primary diagnosis.

You should then append the appropriate diagnostic modifier to your claim. For example, if the surgeon removes a benign polyp from the colon, you'll report 211.3 (Benign neoplasm of colon), says **Cheryl H. Ray, CCS, CPMA, CGCS,** with Atlantic Gastroenterology, PA in Greenville, N.C.