Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Boost Sigmoidoscopy Profits By Differentiating Payers and Purpose

Make your medical documentation clear to avoid confusion on services rendered.

You could be missing out on important reimbursement when your surgeon performs a flexible sigmoidoscopy. Know the different options and reap the revenue rewards.

Whether screening or diagnostic, or even when your surgeon converts a sigmoidoscopy procedure, we have the tips to take the guesswork out of coding these procedures. Read on to make sure your future sigmoidoscopy claims are clean and garner all the pay you deserve.

Classify Screening and Diagnostic Tests

When your surgeon examines the lower intestinal tract by introducing a flexible endoscope in the anus to view the distal portion of the colon up to the splenic flexure, the procedure is a flexible sigmoidoscopy. You have many codes available to describe the procedure, but the first feature you need to know to help you zero in on the correct code is whether the test is for screening or diagnostic purposes.

Diagnostic: If the surgeon performs the flexible sigmoidoscopy because the patient presents with symptoms, such as rectal bleeding, or to evaluate a condition, such as inflammatory bowel disease, you need to turn to CPT® codes that describe the procedure. If the surgeon looks only at the sigmoid colon and possibly takes a brushing or washing sample, you should report 45330 (Sigmoidoscopy, flexible; diagnostic, including collection of specimen[s] by brushing or washing, when performed [separate procedure]) for the procedure.

If your surgeon adds any other service during the sigmoidoscopy procedure, such as taking a biopsy or removing polyps, you should turn one of the more specific codes in the range 45331-45350 (Sigmoidoscopy, flexible;...)

Screening: On the other hand, if your surgeon does the procedure in the absence of signs or symptoms of disease as a preventive measure to check for any evidence of colorectal cancer, you should bill a screening test. That's when you need to turn specifically to HCPCS Level II code G0104 (Colorectal cancer screening; flexible sigmoidoscopy) for Medicare and some other payers. To bill for a screening flexible sigmoidoscopy, you'll need to meet some specific criteria, which we'll discuss in the next section.

Use History to Meet Screening Guidelines

If you're billing a screening test in the absence of signs or symptoms of disease, you need to meet certain coverage requirements if you want your surgeon to get paid for the work.

For instance: "There are rules about the interval between screening tests which apply to the coverage of procedures like Flexible Sigmoidoscopy," says **Michael Weinstein, MD**, former representative of the AMA's CPT® Advisory Panel. "According to CMS rules, the interval between screening sigmoidoscopy exams must be at least four years to be paid as a preventive health benefit."

Caveat: If the patient has a family history of Familial Adenomatous Polyposis (FAP) or has the genetic marker for the disease, many payers will cover screening flexible sigmoidoscopy procedures more frequently. According to the National Comprehensive Cancer Network (NCCN) Guidelines, annual screening should begin sometime between patient-age 10 to 15 and continue to age 24. Flexible sigmoidoscopy frequency should then decrease to once every two years until age 34, and once every three years until age 44, and subsequently continue every three to five years.

Medicare and most third-party payers cover these services without a co-pay or deductible, according to the U.S. Preventive Services Task Force (USPSTF). You must, however, submit payer-approved screening diagnosis codes to justify the claim. Because individual Medicare Administrative Contractors have different sets of allowable diagnosis codes, you should contact your individual MAC for exact information, which may include some of the following codes:

- Z80.0 (Family history of malignant neoplasm of digestive organs)
- Z12.12 (Encounter for screening for malignant neoplasm of rectum)
- Z12.11 (Encounter for screening for malignant neoplasm of colon)
- Z12.9 (Encounter for screening for malignant neoplasm, site unspecified)

Do This if Screening Procedure Turns Therapeutic

Sometimes your surgeon might begin a screening flexible sigmoidoscopy, but change to a therapeutic procedure during the same session based on a finding. In those cases, you should code the case using the appropriate therapeutic code (45331-45350) instead of screening code G0104. For instance, if the surgeon takes a biopsy of a suspicious lesion, you should report 45331 (Sigmoidoscopy, flexible; with biopsy, single or multiple), even if the procedure began as a screening service.

For example: A patient has no symptoms and presents for a screening flexible sigmoidoscopy. The surgeon performs the procedure, detects a growth in the distal colon, and performs a biopsy. You should report the service as 45331 (Sigmoidoscopy, flexible; with biopsy, single or multiple), even if the procedure began as a screening service.

Similarly, if the surgeon finds and removes polyp(s) during a screening flexible sigmoidoscopy, instead of G0104, you should report one of the following codes based on the surgeon's technique:

- For removal using hot biopsy forceps use 45333
- For removal by other method report 45338.

Diagnosis: Although you have to report the relevant ICD-10 codes for the identified polyp, such as K63.5 (Polyp of colon), you should always list the screening ICD-10 codes at the beginning of the claim to indicate that the procedure was initiated as screening procedure.

"Also remember to append modifier PT (Colorectal cancer screening test converted to diagnostic test or other procedure) to the procedure code," says Weinstein. "This is a HCPCS modifier used by CMS to indicate that a colorectal screening service, in this case a flexible sigmoidoscopy was converted to a diagnostic or therapeutic service. This modifier will allow the claim to be processed without a patient co-pay or deductible. For commercial payers, there is a corresponding CPT® modifier 33 (Preventive Services)."

Another lesson: "Be sure to read the medical documentation to accurately report the procedure," says **Catherine Brink, BS, CMM, CPC, CMSCS, CPOM**, president, Healthcare Resource Management, Inc. Spring Lake, NJ. If the surgical note documents that the procedure does not advance beyond the splenic flexure, you should ensure that you're billing only for a sigmoidoscopy and not a colonoscopy.