Part B Insider (Multispecialty) Coding Alert

PART B CODING COACH: Cure Your Colonoscopy Denials by Following CMS' Advice

Guidance concerning what diagnosis codes you should report may surprise you

If you-re confused about what constitutes a screening versus a therapeutic colonoscopy and how to order your ICD-9 codes, you-re not alone. Four scenarios break down CMS- stance on this tricky subject and help lead to picture-perfect colonoscopy claims.

Secure What a Screening Procedure Entails

Scenario 1: A Medicare patient with no gastrointestinal symptoms reports for a screening colonoscopy (or flexible sigmoidoscopy). The gastroenterologist performs the procedure and sees nothing out of the ordinary.

Solution: This is a screening procedure. CMS waives the annual Part B deductible for colorectal cancer screening tests.

For the procedure code, you should report G0121 (Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk) for an average-risk patient receiving a screening colonoscopy or G0105 (Colorectal cancer screening; colonoscopy on individual at high risk) for a high-risk patient. Use G0104 (Colorectal cancer screening; flexible sigmoidoscopy) if the physician performs a screening flexible sigmoidoscopy.

As for the diagnosis, your primary ICD-9 code should be a screening V code. The only code for individuals not meeting criteria for high risk is V76.51 (Special screening for malignant neoplasms; colon). In other words, you-ll use V76.51 for low-risk patients. For high-risk patients, you might use V10.05 (Personal history of malignant neoplasm; large intestine), V10.06 (... rectum, rectosigmoid junction, and anus) or V16.0 (Family history of malignant neoplasm; gastrointestinal tract).

Know How to Code Contrast Screening

Scenario 2: A Medicare patient with no gastrointestinal symptoms reports for a screening colonoscopy (or flexible sigmoidoscopy). The gastroenterologist performs the procedure and sees an abnormality (such as a polyp or lesion), which he biopsies or removes.

Solution: This is a screening procedure that turned into a therapeutic procedure. You cannot report this procedure as a screening, nor can you waive the deductible.

In this case, you should use the code for the actual procedure and not the G screening code. For instance, if the physician discovers a polyp during the colonoscopy, you should report 45380 (Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple). If the physician performs a flexible sigmoidoscopy, you-ll report 45330-45345.

As for the diagnoses, the primary diagnosis should be the screening code: V76.51. Your secondary diagnosis code should reflect the abnormal finding--for instance, 211.3 (Benign neoplasm of other parts of digestive system; colon). -This way tells the payer that this was a screening colonoscopy and that the physician found a polyp(s) during the exam,- says **Debora K. Schulte, CPC**, a medical coder at UCSD Medical Group Business Services in San Diego.

Helpful hint: Enter a -2- in Box 24E of the CMS 1500 to link the biopsy or polypectomy with the polyp, CMS says.

Solve This Incidental Diagnosis Challenge

Suppose your gastroenterologist finds more than a polyp. How would you choose your ICD-9 codes?

Scenario 3: A Medicare patient with no gastrointestinal symptoms comes in for a screening colon-oscopy (or flexible sigmoidoscopy). The gastroenterologist performs the procedure and sees an abnormality (such as a polyp or lesion), which he biopsies or removes. He also determines the patient has diverticulosis and internal hemorrhoids.

Solution: Again, this procedure is a screening that turned into a therapeutic procedure. Therefore, you would report 45380 and not the G screening code.
As for the diagnoses, you would report the following sequence:

- V76.51 to show the intention was a screening test
- 211.3 for the polyp
- 562.10 (Diverticulosis of colon [without mention of hemorrhage]) for the diverticulosis
- 455.0 (Internal hemorrhoids without mention of complication).

Good idea: -In our practice, we post the first charge as a dummy charge (we call it ADX) with no dollar amount, just a diagnosis,- says **Gaelin Simson**, a billing specialist in Lansing, Mich. Example:

CPT	**DX**
ADX	V76.51
45380	211.3

Watch Out for Screening, Surveillance Differences

Scenario 4: A patient came into our practice last year, and the gastroenterologist removed a huge polyp. The physician requested that the patient come back after one year. He returned, and the colon was negative. Should you bill 45378 with V12.72 or G0105 with V12.72?

Answer: First, you can only report G0105 (Colorectal cancer screening; colonoscopy on individual at high risk) every two years. If you try to report it again, you-ll receive a denial.

If your gastroenterologist de-cides he wants to look at the colon during the in-between year, you should consider this a -surveillance- service. You should therefore report 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]) and attach V12.72 (Personal history of certain other-diseases; diseases of digestive system; colonic polyps).

Hint: Don't confuse -screening,- which in this case occurs every two years, with -surveillance.- Surveillance relates to a particular problem the doctor wants to review.