Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

Reader Question: Assess Risk to Arrive at Diagnosis Code Rather Than Payer Type

Question: We have patients from time to time whose benefit plans don't recognize high risk screening codes, i.e.: V10.05,V12.72 and will apply their diagnostic benefits instead of screening/preventative benefits. I've been taught that you can't bill V76.51 as primary dx on a high risk patient. You have to list the high risk code as primary.

Example:Patient is having colonoscopy for personal history of colon cancer, V10.05. Nothing was found during procedure and we billed 45378 w/ V10.05 but the patient's plan doesn't recognize V10.05 under screening benefits. They only recognize V76.51, so the patient's diagnostic benefits were applied. (**also this carrier doesn't accept Medicare code G0105).

Answer: Regardless of findings, it is essential to stick to V10.05 (Personal history of malignant neoplasm of large intestine) as the patient has had a history of colon cancer.

If you're billing Medicare, you should report the procedure as a high risk screening with code G0105 (Colorectal cancer screening; colonoscopy on individual at high risk). Then, report V code V10.05 as the primary diagnosis.

Code V10.05 fits the bill for primary diagnosis because the patient presents to the office for a screening exam and not specifically for follow-up evaluation of the cancer. If the encounter's purpose is for cancer surveillance and follow-up at an interval close to the surgical treatment, you could instead code V67.09 (Follow-up examination following other surgery) as your primary diagnosis although this ICD-9 code is not frequently used.

On the other hand, some commercial carriers would require the code 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]) with modifier 33 (Preventive services) appended to denote that the service was preventive, and the V code V10.05 as diagnosis.

"CPT® modifier 33 has been created to allow providers to identify to insurance payers and providers that the service was preventive under the applicable laws, and that patient cost-sharing does not apply," according to AMA. This means that a patient's co-insurance, co-payment, and deductible are waived for the applicable services (in this case, 45378). All commercial carriers and Medicare payers should be in compliance with these rules as established in the Accountable Care Act (Obamacare).

List V10.05 as your primary diagnosis for both circumstances (Medicare and commercial payers), whether the results were clear or not. Don't report a cancer code (153.3, Malignant neoplasm of sigmoid colon) or the family history code (V16.0, Family history of malignant neoplasm of gastrointestinal tract) as the primary diagnosis.

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