Part B Insider (Multispecialty) Coding Alert

Screening Vs. Diagnostic: Base Your Colonoscopy Exam Coding on Diagnosis

G-codes are handy if the screening doesn't turn diagnostic.

You know the deal: If your physician performs colonoscopy screening on a patient, you must always link a "screening" diagnosis to the procedure, even if the physician discovers any abnormality in the process.

In short, your physician's findings will dictate how you will tackle your colonoscopy coding. Here are some essential ideas on what to expect.

1. Put G Codes into Good Use for Screenings

You have 2 G codes as an option when reporting colonoscopy screenings for Medicare-eligible patients: G0105 (Colorectal cancer screening;colonoscopy on individual at high risk) or G0121 (Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk).

You should support G0105 for high-risk patients with selected diagnoses, including:

- V10.05 -- Personal history of malignant neoplasm; gastrointestinal tract; large intestine
- V10.06 -- Personal history of malignant neoplasm, rectum, rectosigmoid junction, and anus
- V12.72 -- Personal history of certain other diseases; diseases of digestive system; colonic polyps
- V16.0 -- Family history of malignant neoplasm; gastrointestinal tract
- V18.51 -- Family history, colonic polyp Family history of certain other specific conditions; digestive disorders (colon polyps)

Medicare also allows inflammatory bowel diseases, Crohn's disease (555.x, Regional enteritis) or ulcerative colitis (556, Ulcerative eterocolitis), as primary diagnosis for G0105.

If your gastroenterologist clears the patient of any high risk for colorectal cancer, you would use a primary diagnosis of V76.51 (Special screening for malignant neoplasms; colon) to support G0121.

Example: A 66-year-old male with a personal history of malignant neoplasm of the large intestine undergoes covered colonoscopy screening. To report the procedure, you should pick the "high-risk" CPT G0105, and link it to V10.05.

Tidbit: Medicare will pay for screening colonoscopy as often as once every 24 months for those patients defined as "high risk" for colorectal cancer depending on the clinical circumstances, or once every ten years -- but not within 48 months of a screening sigmoidoscopy -- for those patients who do not qualify as "high risk."

2. Turn Code-Specific for Abnormal Findings

It should be a different story if your physician finds a lesion during a screening exam, and performs a biopsy or removal. In this case, you should forget about G codes, and rely on a diagnostic colonoscopy code that specifically describes the resulting procedure.

Example: A 70-year-old asymptomatic patient receives his first colonoscopy screening. The doctor finds and removes by snare technique two colonic tumors during the exam. You should use 45385 (Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique) instead of G0121.

3. Don't Touch Your V Codes

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Even if the physician biopsies or removes a lesion during what began as a screening colonoscopy, you should still retain the appropriate V code as your primary diagnosis. "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" (Medicare Learning Network Matters article SE0746, "Coding for Polypectomy Performed During Screening Colonoscopy or Flexible Sigmoidoscopy"), according to CMS instructions.

ICD-9 coding guidelines support the same principle. "A screening code may be a first-listed code if the reason for the visit is specifically the screening exam," it states.

Catch: You should link the biopsy/removal procedure to the "line 2" diagnosis in your report. This should be a polypdiagnosis, and not V-code.

In the example above, if a patient undergoes a screening that evolves into diagnostic colonoscopy with polyp removal by snare technique, you would report 45385. You should keep V76.51 as the primary diagnosis, and report a neoplasm diagnosis (for instance, 211.3, Colon polyp) as the secondary diagnosis.

Resolve a Screening Request for No Reason

If an asymptomatic patient request a colonoscopy that does not meet Medicare screening requirements, you could turn to advance beneficiary notice (ABN) to bill the patient directly for the service.

What it is: An ABN tells the patient it's likely that Medicare won't cover the service, and therefore it will be the patient's responsibility to pay. The patient can then determine whether he wants to have the procedure done.

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