By Jennifer Swindle

Coding for Colonoscopies Based on Patient Risk

I received a denial for billing a Medicare patient for a colonoscopy screening with a diagnosis code of V76.51 for colon cancer screening and procedure code G0105 for a colonoscopy screening. What is wrong with the claim?

Answer: The G0105 code is for a high-risk-screening colonoscopy. If the patient is not high-risk, the correct procedure for the service would be G0121. While the V76.51 is the correct primary diagnosis to indicate a screening service for the G0121, when reporting the G0105, there must be a diagnosis of the condition that places a patient into the high-risk category. There are several factors that would support a patient being high-risk:

- Sibling, parent, or child with a history of colorectal cancer or adenomatous polyps
- Family history of adenomatous polyps
- Family history of hereditary nonpolyposis colorectal cancer
- Personal history of adenomatous polyps
- Personal history of colorectal cancer
- Personal history of inflammatory bowel disease, such as Crohn's disease or ulcerative colitis

A high-risk colonoscopy is covered every 24 months and a low-risk colonoscopy is covered once every 10 years, so frequency limitations may also impact payment. Without a diagnosis to support high-risk patients, the service will not be paid. If, for example, a patient has a history of polyps, the primary diagnosis code V12.72 would be reported with G0105.

Remember that if a patient is scheduled for a screening colonoscopy, but a more definitive procedure needs to be performed, such as polyp removal, the procedure code no longer is captured with the G series of codes. It becomes a therapeutic procedure, and a PT modifier should be added to show the procedure changed from a screening to a diagnostic/therapeutic colonoscopy.

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