

Coding, Billing and
Reimbursement Issues for
the Coding Professional

Outpatient Colonoscopy Coding

There are many idiosyncrasies in the ICD9 and CPT coding assignments for colonoscopy coding, some of which are the result of Medicare-specific guidelines.

Medicare Coding for Screening Colonoscopies

In 1998, Medicare created the "G" codes for screening colonoscopies, specifically, G0105 for patients at high risk for colorectal cancer, and G0121 for those patients not meeting Medicare criteria for high risk for colorectal cancer. These codes are utilized for screening colonoscopies on Medicare recipients in lieu of 45378. If a colonoscopy is performed that results in a surgical intervention (removal of tumor, polyps, lesions, biopsy), these codes are not reported.

According to Medicare guidelines, the only conditions qualifying for high risk of colorectal cancer or an adenomatous polyp are as follows:

- close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp
 - (NOTE: Since an adenomatous polyp and a colon polyp both code to 211.3,
 - MARSJ feels it would be appropriate to allow this distinction in either instance)
- family history of familial adenomatous polyposis
- family history of hereditary nonpolyposis colorectal cancer
- personal history of adenomatous polyps
- personal history of colorectal cancer
- inflammatory bowel disease, including Crohn's disease, ulcerative colitis

ICD-9-CM diagnosis code V76.51 would be utilized as the primary diagnosis when the patient presents

with no signs or symptoms of GI disease at the time of the screening. Any findings during the course of the screening colonoscopy should also be reported as subsequent ICD-9-CM code assignments.

When screening colonoscopy is being performed for surveillance purposes (i.e. patient already has history of colon cancer/polyposis), and the colonoscopy is for follow-up purposes, V67.09 (following surgery) or V67.59 (following other treatment) should be utilized, followed by the appropriate V codes for history, if the cancer has not recurred followed by other finding(s). If polyps/cancer has recurred, V67.XX and V12.72 are not assigned but the condition that has recurred.

Non-Medicare patients who present for screening colonoscopies would follow the above diagnosis guidelines, however, refrain from utilizing the Medicare G codes, and assign 45378. Make certain the carrier does not follow Medicare guidelines before utilizing the 45378 code assignment.

Non-Screening Colonoscopies

Non-screening colonoscopies do not meet the criteria as outlined above, or are performed for a specific condition or complaint. Diagnosis should be assigned appropriately; again, code 45378 would not be appropriate for a Medicare patient with the diagnosis code V76.51.

The assignment of CPT code(s) for non-screening colonoscopies should be based on the definitive technique employed to resect/remove the tissue sample. Each of the non-diagnostic colonoscopy CPT codes describe specific techniques, and can only be used once for a single colonoscopy procedure regardless of whether that technique is utilized on multiple polyps, or multiple times on a single polyp.

When two (2) techniques are employed for the same problem (same polyp/lesion), only the most significant technique is assigned.

Code 45380 – Colonoscopy with Biopsy

Should be assigned for cold biopsy, cold forceps polypectomy or when biopsy is unspecified as to the technique employed. The term piecemeal simply implies that the biopsy or polypectomy was utilized multiple times on a single polyp.

Code 45381 – Submucosal Injections, Any Substance

Should be assigned in addition to any additional therapeutic service during the same encounter. Substances include saline, methylene blue, Botox, steroids and India ink to “tattoo” the area for later identification in a subsequent service.

Code 45382 – Control of Bleeding

Should be assigned when technique such as injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator are employed to control bleeding that may have resulted

from diverticulosis, angiodysplasia or conditions from prior procedures. Bleeding that is the result of current interventions is not assigned an additional code and is considered inherent in the procedure performed.

Code 45383 – With Ablation not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique

Should include polyps that are destroyed only, and cauterization of a single polyp without documentation of removal.

Code 45384 – Hot Biopsy Forceps or Bipolar Cautery

Should be assigned when either technique is employed, without regard to whether the polyp is completely excised, partially or biopsied as long as either of the techniques are utilized.

Code 45385 – Snare Technique

Should be assigned when snare technique is utilized to remove or biopsy a lesion, tumor or polyp. The terms “Hot, cold, piecemeal” accompanying the snare technique do not change the code assignment.

Discharge Status Code on Inpatient Accounts

Accurate patient status code reporting affects reimbursement now more than ever. As

previously noted, CMS has expanded the postacute care transfer policy to include even more DRGs (190 DRGs for FY 2007). The FY 2008 Proposed Rule intends to further expand the postacute care transfer DRGs to **263 DRGs** in FY 2008. Certain hospital discharges, called qualified discharges, to postacute care settings are treated as transfers for payment purposes. The DRGs qualifying are recognized as high volume and with a high usage of postacute care. A qualified discharge is a discharge from a PPS hospital, falling into one of the 190 DRGs, and the patient is:

- Admitted to a non-PPS hospital or hospital unit,
- Admitted to a skilled nursing facility (does not include swing beds),
- Or discharged home under a written plan of home health care to begin within three days after discharge.

The reimbursement received for the qualifying DRGs can be affected based on the length of stay and the discharge status code reported, and the discharges are treated as transfers for payment purposes. Therefore, it is vital to determine the correct discharge status and verify that the correct discharge status code is reported.

The final rule for 2006 expanded the transfer policy from 30 to 182 DRGs, and increased to 190 DRGs in FY 2007, which has cost hospitals dearly. The CMS has determined that it is imperative that facilities correctly identify the discharge status on every claim submitted. Incorrect status codes may lead to charges of fraud or abuse, as it may be viewed as an attempt to receive a higher payment than is due.

The Discharge Status code “03” would be used for patients “discharged or transferred to a skilled nursing facility with Medicare certification **in anticipation of covered skilled care.**” Documentation of “discharged to the nursing home” may not be adequate documentation to accurately identify the discharge status, and may need verification for accurate discharge status code assignment and accurate reimbursement.

The discharge status code has been under CMS scrutiny as it relates to patient transfers versus being discharged home. It is important that those who enter the code know where the patient went when discharged. It is accepted that the nursing unit is the logical choice for this task, however often coders must verify the accuracy of the code.

It is expected that accurate reporting of discharge dispositions will become an OIG emphasis. Of

RACs

The Recovery Audit Contract Program (RAC) was put into effect in 2005 by the Centers for Medicare and Medicaid Services (CMS).

According to the CMS website, "the RAC Program's mission is to reduce Medicare improper payments through the efficient detection and collection of overpayments, the identification of underpayments and the implementation of actions that will prevent future improper payments."

The demonstration program began operating in California, Florida, and New York. It was designed to determine whether the use of RACs will be a cost-effective means of adding resources to ensure that correct payments are being made to providers and suppliers and, therefore, protect the Medicare Trust Fund. The pilot states of Florida, New York, and California were chosen because these states have the highest volume of Medicare expenditures. It was anticipated that the demonstration project would last three years.

RACs are private companies that contract with the CMS to conduct analyses and audits of claims beyond those conducted by the Medicare Administrative Contractors (MACs) (formerly Fiscal Intermediaries). RAC audits are intended to supplement the traditional MAC audits, and claims reviewed by RACs must have been submitted to the MAC at least a year before the audit to ensure that the regular review process has been completed. A RAC should not review a claim that has previously been reviewed by another entity.

RACs are paid based on a percentage of overpayments recovered. RAC determinations can be appealed to the MAC. The first level of appeal on an inpatient claim currently goes to the QIO, however RAC appeals will go to the MAC that

particular concern is the three-day window for referrals to postacute settings. If a hospital learns that a patient was assumed to have been discharged home but was admitted to another acute care facility the same day or to skilled care or home health services within three days of discharge, an adjusted claim must be submitted with the correct discharge disposition. This can only be accomplished if communication channels stay open after a patient is discharged. Depending on the FI to catch these errors is not considered to be reliable.

processed the claim. Identified underpayments will be processed by the MAC for payment to the providers. The CMS claims that this is not a punitive program, however concern has been expressed that there is nothing to preclude the CMS from altering the program to a punitive program. Of course, designing the program to reimburse on a contingency basis causes scrutiny regarding accusations of "federally sanctioned bounty hunting." It is not clear that the present system will ensure the same amount of effort will be used in identification of underpayments as overpayments. In addition, recovery through a RAC audit does not preclude further investigations by OIG or other enforcement authorities of potential fraud and false claims.

According to the CMS RAC Status Document for FY 2006, **\$303.5 million** in total improper payments were identified in FY 2006 in the three pilot states.

The expansion of the program was decided before the completion of the pilot project. Section 302 of the Tax Relief and Health Care Act of 2006 makes the RAC program permanent and requires the Secretary to expand the program to all 50 states by no later than 2010. The first step involves adding one or two states to each of the current 3 RAC jurisdictions. By 2010, the CMS plans to have 4 RACs in place. Each RAC will be responsible for identifying overpayments and underpayments in approximately 1/4 of the country.

If your state is not included in the current RAC program, it still is not too soon to prepare. Suggestions include creating a RAC team so that trends and patterns can be followed and appeals can be tracked. Also, since the majority of RAC audits are ultimately based upon physician documentation in the medical record, physician documentation improvement programs that assist physicians in complying with CMS guidelines are the most important final solution