Internal Medicine Coding Alert

Reader Question: Home Colorectal Screening

Question: Our doctor likes to send home a colorectal screening kit with patients. The patient drops the guaiac paper into the toilet then documents the results on a card that is later mailed in to the office for review. Sometimes as an advance measure he even gives a wife one for her husband who isn't being seen that day. How can we code for this? Can we use 82270? I'm unsure because we aren't performing the screening ourselves; the patient is doing the test.

Illinois subscriber

Answer: No, you cannot use CPT code 82270 (Blood, occult, by peroxidase activity [e.g., guaiac] qualitative; feces, 1-3 simultaneous determinations) or the HCPCS equivalent G0107 (Colorectal cancer screening; fecal-occult blood test, 1-3 simultaneous determinations) for this type of test. These codes are for another type of guaiac card, on which the patient places a small stool sample collected at home. The patient then returns that card to the office, where a developing agent is added and the results are interpreted by the staff or a physician.

With the colorectal screening kits you describe, the patient performs the test and interprets the results (with the possibility of error) and sends this information to the physician. This type of test is typically a piece of paper that has a test area, a small control area that changes color (for example, blue or green) to show the test is working, and another small control area that stays white if the test is working correctly. The patient tosses the paper in the toilet after giving a "sample" and watches the test area (and control boxes) to see if any parts of the paper change color. After observing, the patient flushes that paper away and then records the date of the test and any locations that changed color on a small card that is sent back to the office.

Most offices do not bill for this type of screening because the patient not the physician or staff performs the test and interprets the results. The only possible code you can use is 99070 (Supplies and materials [except spectacles], provided by the physician over and above those usually included with the office visit or other services rendered [list drugs, trays, supplies, or materials provided]) to cover the cost of the cards. Use this code **only** if the physician incurs a cost for the cards. For example, if the physician buys the cards for $1 each, then the physician should be allowed to pass that cost along to the patient. But if a drug company or lab supplies the cards at no charge to the physician, you should not bill for the cards.

Answers to You Be The Coder and Reader Questions were provided by **Kathy Pride, CPC, CCS-P, HIM,** applications specialist with QuadraMed, a national healthcare information technology and consulting firm based in San Rafael, Calif.; **Susan Callaway, CPC, CCSP,** an independent coding and reimbursement consultant in North Augusta, S.C.; and **Linda Parks, MA, CPC,** lead coder at Atlanta Gastroenterology Associates, a 23-physician practice.