

# compliance

## Coding for Lung Cancer Screening

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There's an old saying that an ounce of prevention is worth a pound of cure, and when treating a malignancy, finding it early may help improve the patient outcome. At present, many insurers reimburse for screening Papanicolaou (PAP) smears to detect cervical cancer, screening prostate specific antigen (PSA) tests to detect prostate malignancy, and screening colonoscopies to detect colon cancer. In addition to these standardized screening services, some cancer programs have initiated or are considering a lung cancer screening program.

### Making the Grade

On December 30, 2013, the U.S. Preventive Services Task Force (USPSTF) finalized its grade "B" draft recommendation that current or past heavy smokers between 55 and 80 receive annual CT scans to detect lung cancer. Preventive services given an "A" or "B" rating by the USPSTF must be reimbursed by insurers at no cost to patients under the Affordable Care Act (ACA).<sup>1</sup> However, this recommendation remains controversial; the panel's draft report in July 2013 noted that 96 percent of CT lung cancer tests that initially tested positive were actually false positive results. This means that the vast majority of positive results would require confirmation through other tests, exposing the patients to more radiation or more invasive and costly procedures that carry a higher risk of complications.

The USPSTF also advised some caution in the use of CT scans for screening. According to Task Force chair Virginia Moyer, "The

benefits of screening may be significantly less in people with serious medical problems and there is no benefit in screening someone for whom treatment is not an option. In these people, screening may lead to unintended harm, such as unnecessary tests and invasive procedures." co-vice chair Michael LeFevre added, "When clinicians are determining who would most benefit from screening, they need to look at a person's age, overall health, how much the person has smoked, and whether the person is still smoking or how many years it has been since the person quit."

Information from *JAMA Internal Medicine* indicates that nearly one in five patients with a history of cigarette smoking who are diagnosed with lung cancer as a result of CT screening do not have clinically significant disease and are overdiagnosed.<sup>2</sup> According to Edward Patz, Jr., MD, lead author of the study and a professor of pathology and radiology at Duke Medical Center, "What we're saying is that in the absence of screening, some of these individuals would never have known they had lung cancer, and never would have been treated for lung cancer, and never would have been labeled for lung cancer, and would have died from other causes rather than from this disease."

Patz says that the research findings in no way suggest that patients at high risk should not undergo lung cancer screening. "But what we do say is that, for full disclosure, you need to let people know that there is this downside of screening." That's because for many of the people who are treated who didn't have clinically significant disease, "some will have inherent complica-

tions from their treatment," resulting in morbidity and mortality from treatments and surgery, rather than the disease itself. In addition to the potential for physical harm, there may be concerns related to psychological harm, financial harm, absence from work or job loss, and missed opportunities to be with family and friends.

### Lung Cancer Screening

For the purposes of this article, lung cancer screening refers to strategies used to identify early lung cancers before they cause symptoms and at a point where they are more likely to be considered curable. Screening is defined as the use of medical tests to detect disease in asymptomatic individuals. Prevention of disease with screening involves detection of disease at an early stage, such that intervention at that point improves survival.

Blue Cross Blue Shield of Kansas (BCBSKS) has a policy for "Screening for Lung Cancer Using CT Scanning,"<sup>3</sup> which includes the following background information:

*Given the poor prognosis of lung cancer, there has been longstanding research interest in developing screening techniques for those at high risk. Previous studies of serial sputum samples or chest x-rays failed to demonstrate that screening improved health outcomes. More recently, there has been interest in low-dose computed tomography (CT) scanning as a screening technique, using either spiral (also referred to as helical) or electron beam (also referred to as ultrafast) CT scanning. Compared to conventional CT scans, these scans allow for the continuous acquisition of images, thus shortening the scan time and*

radiation exposure. A complete CT scan can be obtained within 10-20 seconds, or during 1 breath hold in the majority of patients. The radiation exposure for this examination is greater than for that of a chest x-ray but less than for a conventional CT scan.

There are also growing applications of computer-aided detection or diagnosis (CAD) technologies that may have an impact on the use of CT scanning or chest radiographs for lung cancer screening. Computer-aided detection points out possible findings to the radiologist who then decides if the finding is abnormal. Computer-aided detection uses a computer algorithm to analyze features of a lesion to determine the level of suspicion and is intended to enhance the reader's diagnostic performance.

Efficacy of screening is primarily assessed by how significantly a screening test decreases mortality. In general, national organizations with recommendations on lung cancer screening all include a recommendation that the low-dose CT screening

of eligible patients occurs in settings that use a multidisciplinary approach and involve participation of a sub-specialty qualified medical team (see "Rescue Lung, Rescue Life, pages 20–29).

Of the 21 leading academic centers identified by *US News and World Report*, 19 responded to a survey regarding screening programs and 15 institutions said they already had CT-based lung cancer screening programs up and running.<sup>4</sup> Eleven of those 15 programs offer optional smoking cessation courses, and three more make the smoking cessation course mandatory for individuals undergoing lung cancer screening. In addition, there may be a number of local and community hospitals that are providing lung cancer screening that were not included in this analysis.

### American Lung Association

On April 23, 2012, the American Lung Association (ALA) published a report titled "Providing Guidance on Lung Cancer

Screening to Patients and Physicians" that includes, in part:<sup>5</sup>

1. Low-dose CT screening should be recommended for those people who meet the National Lung Screening Trial (NLST) criteria:
  - Current or former smokers, age 55 to 74 years
  - A smoking history of at least 30 pack-years
  - No history of lung cancer.
2. Individuals should not receive a chest X-ray for lung cancer screening.
3. Low-dose CT screening should NOT be recommended for everyone.
4. ALA should develop public health materials describing the lung cancer screening process in order to assist patients in talking with their doctors. This educational portfolio should include information that explains and clarifies for the public:
  - The difference between a screening process and a diagnostic test

**Table 1. Procedure Codes, Modifiers & Definitions**

CODE/MODIFIER	DEFINITION
71250	Computed tomography thorax; without contrast material.
71260	Computed tomography thorax; with contrast material(s).
71270	Computed tomography thorax; without contrast material, followed by contrast material(s) and further sections.
+0174T	Computer-aided detection (CAD) (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation and report, with or without digitization of film radiographic images, chest radiograph(s), performed concurrent with primary interpretation. (List separately in addition to code for primary procedure.)
0175T	Computer-aided detection (CAD) (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation and report, with or without digitization of film radiographic images, chest radiograph(s), performed remote from primary interpretation.
S8092	Electron beam computed tomography (also known as ultrafast CT, cine CT).
<b>Modifier 52</b>	Reduced services: under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified healthcare professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.

**Table 2. ICD-9-CM Diagnosis Codes**

CODE	DEFINITION
V76.0	Special screening for malignant neoplasms, respiratory organs
V15.82	Personal history of tobacco use
305.1	Tobacco use disorder (tobacco dependence)

- The benefits, risks, and costs (emotional, physical, and economic)
  - That not all lung cancers will be detected through use of low-dose CT scanning.
5. A call to action should be issued to hospitals and screening centers to:
- Establish ethical policies for advertising and promoting lung cancer screening services
  - Develop educational materials to assist patients in having careful and thoughtful discussions between patients and their physicians regarding lung cancer screening
  - Provide lung cancer screening services with access to multidisciplinary teams that can deliver the needed follow-up for evaluation of nodules.

### Insurance Reimbursement

Some insurers already reimburse for the lung cancer screening CT scan. BCBSKS provides the following payment guidelines for screening CT scans. Of note, the patient selection criteria are based on the National Lung Screening Trial:

- A. Low-dose computer tomography (CT) scanning, no more frequently than annually, may be considered medically necessary as a screening technique for lung cancer in individuals who meet ALL of the following criteria:
- Between 55 and 74 years of age, and
  - History of cigarette smoking of at least 30 pack-years, and
  - If former smoker, quit within the previous 15 years.

Number of pack-years = (number of cigarettes smoked per day × number of

- years smoked) ÷ 20 (1 pack has 20 cigarettes). A pack year is defined as 20 cigarettes smoked every day for one year.
- B. Low-dose CT scanning is considered experimental and/or investigational as a screening technique for lung cancer in all other situations.
- C. This policy does not apply to individuals with signs and/or symptoms of lung disease. In symptomatic individuals, a diagnostic work-up appropriate to the clinical presentation should be undertaken, rather than screening.

Aetna has similar criteria for reimbursement in its Clinical Policy Bulletin on Lung Cancer Screening (Policy 0380):<sup>6</sup>

1. Aetna considers annual low-dose computed tomography (LDCT) scanning, also known as spiral CT or helical CT scanning, medically necessary for current or former smokers ages 55 to 79 years with a 30 pack-year or more smoking history and, if a former smoker, has quit within the past 15 years. Aetna considers LDCT experimental and investigational as a screening test for all other indications.
2. Aetna considers computer-aided detection for chest radiographs experimental and investigational for screening or diagnosis of lung cancer and for all other indications. There is presently inadequate evidence in the medical literature that population-based mass lung cancer screening with computer-aided detection for chest radiographs will contribute substantially to the detection of smaller cancers, or decreases mortality.

### Code Assignment

It's important to keep in mind that the requirement to pay for lung cancer screening under the ACA is limited to reimbursement for the low-dose CT scan. There may be minimal or no reimbursement for any patient visits before or after the scanning service. For example, a visit to discuss the risks, benefits, and/or potential complications of a screening CT scan would not meet the definition of the existing Preventive Medicine codes or Counseling and/or Risk Factor Reduction codes. These codes are reported for "comprehensive" preventive medicine services, instead of discussion of a single body system or single screening focus. If there is no patient visit code that exactly describes the service, the physician or qualified nonphysician healthcare practitioner can report an unlisted code:

- **99499.** Unlisted evaluation and management service.

Remember that when an unlisted patient visit code is reported, there may be a need to submit supporting documentation to obtain reimbursement.

With respect to coding the screening CT service, the following authoritative coding guidance is included in *CPT® Assistant*, July 2007, page 13:

*Question: What is the appropriate code to report for screening computed tomography (CT) of the thorax?*


*Answer: Reporting of CT is based on the anatomic site studied. If a complete study is performed of the thorax, one of the following CPT codes should be reported, based on the use or nonuse of contrast: 71250, 71260, or 71270.*

Please note that if a limited study is performed, it is appropriate to report either the limited code **76380**, computed tomography, limited or localized follow-up study, or the anatomic site code with **modifier 52**, reduced services.

Additionally, the ICD-9-CM codes reported will inform the payer when a diagnostic or screening study has been performed.

Table 1, page 13, shows a list of potential procedure codes for the screening CT to detect lung cancer. Table 2, left, and Table 3, below, offer a list of diagnosis codes that identify the asymptomatic screening patient.

Nearly 90 million Americans are smokers, and about 7 million of these individuals are in the target group. Estimates are that if these 7 million people each received a CT scan annually for lung cancer screening, the result would be increased healthcare costs of \$2.1 to \$3.5 billion.<sup>7</sup> Cancer programs that are considering the addition of a lung cancer screening program should analyze current

demographics, review existing payer policies, and ensure that the cost of providing the program will be offset with a sufficient number of patients and adequate reimbursement. 

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**Table 3. ICD-10-CM Diagnosis Codes**

CODE	DEFINITION
Z12.2	Encounter for screening for malignant neoplasm of respiratory organs
Z87.891	Personal history of nicotine dependence
F17.210	Nicotine dependence, cigarettes, uncomplicated
F17.211	Nicotine dependence, cigarettes, in remission
F17.213	Nicotine dependence, cigarettes, with withdrawal
F17.218	Nicotine dependence, cigarettes, with other nicotine-induced disorders
F17.219	Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders
F17.290	Nicotine dependence, other tobacco product, uncomplicated
F17.291	Nicotine dependence, other tobacco product, in remission
F17.293	Nicotine dependence, other tobacco product, with withdrawal
F17.298	Nicotine dependence, other tobacco product, with other nicotine-induced disorders
F17.299	Nicotine dependence, other tobacco product, with unspecified nicotine-induced disorders

\*ICD-10-CM includes diagnosis codes to describe nicotine dependence, chewing tobacco, and a series of codes for inhalant dependence in addition to the codes listed above. (ICD-10 is scheduled to go into effect Oct. 1, 2014.)