Internal Medicine Coding Alert

Bill E/M in Addition to FOBT to Optimize Medicare Payment

Only nine percent of eligible fee-for-service Medicare beneficiaries get their annual fecal occult blood testing (FOBT), according to a recent study by the U.S. General Accounting Office (GAO). While the recent colorectal cancer awareness campaign by Today show host Katie Couric may increase public demand for the services, the GAO study found that many physicians do not encourage their patients to get an annual FOBT because they believe the reimbursement rates are inadequate to cover their costs. In many instances, however, internists should be able to boost their reimbursement income by billing Medicare for both the FOBT and an office visit.

Medicares coverage of various colorectal-cancer screenings was enacted with the passage of the Balanced Budget Act of 1997. Internists will be concerned primarily with Medicares provisions for screening FOBTs, which are covered at a frequency of once every 12 months for beneficiaries who have attained age 50.

Use the Proper HCPCS and ICD-9 Codes

The proper HCPCS codes need to be submitted to Medicare to report the FOBTs. Code G0107 (colorectal cancer screening; fecal-occult blood test, 1-3 simultaneous determinations) should be used to report to Medicare fecal occult blood tests done on asymptomatic patients, says **Jim Stephenson, CPC,** billing manager for Premium Medical Management Inc, a multispecialty physician group practice in Elyria, Ohio. Code 82270 (blood, occult; feces, 1-3 simultaneous determinations) is reserved for reporting the diagnostic evaluation of symptomatic patients to Medicare. Reimbursement for both codes is the same.

Although screening FOBTs are for asymptomatic patients, those services also must be reported with the proper ICD-9 diagnosis code, which may differ from state to state. In Ohio, for example, the local medical review policy lists the following approved ICD-9 codes for asymptomatic individuals: V10.05 (personal history of malignant neoplasm; large intestine), V10.06 (personal history of malignant neoplasm; rectum, rectosigmoid junction, and anus), V12.72 (diseases of digestive system; colonic polyps) and V76.41 (special screening for malignant neoplasms; rectum).

Connecticut, on the other hand, has stated that it will accept only two ICD-9 codes: V76.41 (special screening for malignant neoplasms; rectum) and V76.49 (special screening for malignant neoplasms; other).

Unfortunately, HCFA didnt really publish a list of covered diagnosis codes, says **Glenn Littenberg, MD, FACP,** a gastroenterologist in Pasadena, Calif., and a member of the American Medical Associations (AMA) CPT editorial panel. It will vary from carrier to carrier.

Other Coverage Issues

The fecal occult blood test screenings are covered at a frequency of once every 12 months, which means that at least 11 months have passed following the month in which the last covered screening FOBT was done, explains Littenberg. If a patient received a test in January 2000, the count starts with February 2000. The patient will be eligible to receive another covered screening in January 2001the month after 11 full months have passed.

Littenberg, however, does not closely track the screening frequencies of his patients. If I happen to notice that a patient was last tested 10 months ago, I may wait another month to have them re-tested, he notes. But I also dont want to lose an opportunity to test a patient, especially when Im not sure when I will see them again. So sometimes I will test the patient anyway and not get reimbursed by Medicare.

It is permissible to charge the patient for the test as a non-covered service, and that doesnt require a signed waiver,

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Littenberg adds. But patients should understand why it wont be covered at this frequency and offered the chance to wait a bit longer to do the test.

FOBTs are a CLIA (Clinical Laboratory Improvement Amendments of 1988)-waived test, notes Stephenson, which means that internists must have a CLIA number to get reimbursed for these services.

Reimbursement for Office Visit Also Available

Internists may be able to bill for an office visit in addition to the FOBT if the primary purpose of the visit is to discuss other ailments or conditions.

If the focus of a patients office visit is to discuss his/her hypertension, for example, and the internist asks the patient in the course of the conversation if he/she has had a colorectal cancer screening, then the office visit can be billed, explains Littenberg, who suggests that modifier -25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) be attached to the office visit code.

Initially, the Correct Coding Initiative (CCI) guidelines denied payment for same-day services, Littenberg explains. But after widespread physician protest, the policy was changed to allow use of modifier
-25 with same-day E/M services as long as the visits arent preventive in nature.

Using a different diagnosis code for the office visit that is representative of the primary focus of the visit, instead of using the colorectal screening code for both services, will help establish the office visit as a significant, separately identifiable service, he adds.

While Stephenson agrees that an office visit can be billed in addition to the FOBT when the screening test is not the primary purpose of the visit, he says that not all carriers require the modifier -25. Some may stipulate that another modifier, such as -59 (distinct procedural service), be used. Others may not require any modifier.

Because the ICD-9 diagnosis codes for an FOBT and the modifiers required to report a separate office visit will vary from carrier to carrier, internists should contact their local Medicare carrier to obtain a copy of its local medical review policy and specific coding instructions.

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