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Internal Medicine Coding Alert

Preventive Services: Sidestep 5 Traps When Offering Yearly PSA, DRE

Warning: Code 84153 does not belong on these claims.

Pay attention to prostate screenings' hidden coding traps to ensure accurate reporting or your patients can get stuck paying for these services.

Prostate cancer is the second deadliest cancer for men. Encourage patients to take advantage of covered prostate screenings so that both you and your patients can benefit from preventive services. Compliantly report these encounters for Medicare beneficiaries and other payers that follow Medicare guidelines by following these rules.

Ensure 11 Full Months Have Passed Since Last Screening

Make sure the individual meets the frequency criteria. Any male Medicare beneficiary whois at least a day past his fiftieth birthday is eligible to receive prostate cancer screening services, if at least eleven full months have passed since the last Medicare-covered screening Digital Rectal Exam (DRE) or Prostate Specific Antigen (PSA) blood test.

Calculate frequency: If a beneficiary received a screening PSA blood test in January 2010, you would count forward eleven months starting from February 2010, which would result in renewed eligibility for the test in the same month the following year: January 2011.

Beneficiaries are not responsible for any coinsurance or Part B deductible for the PSA test;however, they generally must pay 20 percent of the Medicare-approved amount for the DRE after meeting the yearly Part B deductible.

Stick With G and V Codes

There are two options for screening for prostate cancer, and each has its own HCPCSlevel II code:

G0102 -- Prostate cancer screening; digital rectal examination

G0103 -- ... prostate specific antigen test (PSA).

Medicare covers both exams for eligible beneficiaries (within the above stated frequency guidelines), so you don't need to choose just one. Even without documentation of increased risk, an eligible beneficiary may receive the two prostate screenings because "there does not need to be assessed risk for preventive services," says **Penny Osmon, CHC, CPC, CPC-I, PCS,** coding and reimbursement educator at Wisconsin MedicalSociety in Madison.

ICD-9: There is only one diagnosis code to report with one or both of these screening services: V76.44 (Special screening for malignant neoplasms, prostate).

Documentation: Ensure that the chart reflects that a qualified provider ordered the PSA, or performed the DRE. The screening PSA must be ordered (and the DRE must be performed) by the beneficiary's physician (doctor of medicine or osteopathy) or by the beneficiary's physician assistant, nurse practitioner, or clinical nurse specialist, states the Guide to Medicare Preventive Services (www.cms.gov/MLNProducts/downloads/PSGUID.pdf).In addition, the provider must be:

fully knowledgeable about the beneficiary's medical condition,

and responsible for explaining the results of the test to the beneficiary.

Skip Over Diagnostic PSA Code

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Another trap to avoid is sticking a CPT code where a HCPCS code belongs. Whensubmitting claims for the annual preventive prostate cancer screening PSA blood test, you must report the code for a screening test (HCPCS code G0103) and not for a diagnostic PSA test (CPT code 84153, Prostate specific antigen [PSA]; total).

Important: Even if the PSA screening for an asymptomatic patient results in a positive finding, still report the screening HCPCS and ICD-9 code (V76.44), instructs **Jennifer Swindle, RHIT, CCS-P, CPC, CPMA,** director of coding and compliance at Pivot Health LLC in Nashville, Tenn.

With lab tests such as the PSA, the results include no immediate, definitive diagnosis, Swindle says. After the internist provides subsequent care and captures a definitive diagnosis, you would report that diagnosis code (such as 185, Malignant neoplasm of prostate) for follow-up services.

Drop DRE Code from E/M Encounters

One simple mistake can cause you to submit a faulty claim. Don't report a DRE if the provider is also performing an E/M service on the same date. Reimbursement for the screening DRE (G0102) is bundled into payment for a covered E/M service (99201-99456 and 99499), when the provider furnishes the two services on the same day, states the Guide to Medicare Preventive Services.

Why: Medicare is differentiating between the "screening" patient and a problemoriented patient, says **Terry Fletcher, BS, CPC, CCS-P, CCS, CMSCS, CCC, CEMC, CMC,** healthcare coding consultant and CEO/President of Terry Fletcher Consulting Inc. in Laguna Beach, Calif. Since a screening patient comes in for a DRE with no symptoms, the argument is that there should not be a problem-oriented E/M on the same date, she says.

Forget 25: Don't think that appending modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service ...) can release you from that bundle, even if the E/M service is unrelated to the DRE. Modifier 25 on the E/M service is not allowed when attempting to add the DRE to the claim, says Osmon.

Good news: The screening PSA blood test (G0103) is not bundled with an E/M code.

Offer Multiple Screenings Without Unbundling

Your internist may provide combination screenings at one time,if a beneficiary meets the criteria for receiving more than one.

Additional preventive services may be separately reported, provided that the beneficiary meets the qualification and frequency criteria for other screening services.

Example: If the beneficiary has not received a lipid panel in the previous five years, the internist may order a lipid panel (80061; Lipid panel; This panel must include the following: Cholesterol, serum, total [82465], Lipoprotein, direct measurement, high density cholesterol [HDL cholesterol] [83718], Triglycerides [84478]) to screen for cardiovascular disease at the same visit as the DRE and/or PSA. For more information on cardiovascular disease screenings, refer to "4 Q&As Help You Fall In Line With Heart Disease Screening Criteria" in Internal Medicine Coding Alert, February 2009, Vol. 13, No. 2.

Exception: Medicare does not make separate payment, however, for DRE (G0102) when the internist performs it on the same day as the one-time Initial Preventive Physical Exam (G0402, Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment), reports Swindle

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