Internal Medicine Coding Alert

Reader Question: Diagnosis and E/M Codes Should Go Hand In Hand

Question: A PCP performed evaluation and management for a patient and referred him to our internal medicine specialist for colorectal cancer screening. He claimed 99214 for the procedure and listed diagnosis 401.1, V45.89 and V76.51. My question is whether or not he can use the diagnosis code V76.51 as he is not performing the colorectal cancer screening. Also, can I use the code G0105 along with the diagnosis code V76.51 for the screening colonoscopy that our physician provided? If the internal medicine specialist also performed evaluation and management prior to the screening, can I claim the E/M services separately?

Alabama Subscriber

Answer: Since the PCP performed evaluation and management services, he can claim the appropriate E/M code such as 99214 (Office or other outpatient visit for the evaluation and management of an established patient...) for the visit. Since the need for screening is determined by the level of risk and the internist would have established the need for screening in the E/M service provided, it is appropriate for him to claim the diagnosis codes that you have listed:

- 401.1 (Benign essential hypertension)
- V45.89 (Other postsurgical status, presence of neuropacemaker or other electronic device)
- V76.51 (Special screening for malignant neoplasms colon)

On the other hand, even though it is common that your gastroenterologist might want to perform an evaluation prior to performing the screening colonoscopy, you cannot claim a separate E/M code for the services your internal medicine specialist provided. You can only claim reimbursements for the screening colonoscopy that your internist performed.

For the screening colonoscopy, you can list the diagnosis code with V76.51 that supports the medical necessity for performing the procedure. You can use the codes G0105 (Colorectal cancer screening; colonoscopy on individual at high risk) when your internal medicine specialist provides a screening for a Medicare patient in the high risk category. You can use G0121 (Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk) for other Medicare patients. For other commercial carriers, you can report the procedure with the CPT® code (Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen[s] by brushing or washing, with or without colon decompression [separate procedure]) along with the diagnosis code.