Internal Medicine Coding Alert

Reader Question: Screening Exams

Question: How do we bill for screening exams, such as a pelvic examination or colonoscopy on the same day that the patient comes in for a routine evaluation and management (E/M) service, such as a high blood pressure check?

ICA Subscriber

Answer: Encounters like these are becoming much more problematic since the 1999 Correct Coding Initiative Policy Manual, Versions 5.0 and 5.1 were published, says Fitzgerald. In the past, internists were able to bill the E/M established patient visit codes along with other services. Now, in many cases, Medicareand commercial insurance companies, as wellare saying you may only bill for the screening exam and not the E/M service, or vice-versa. Hypertension monitoring is usually bundled with an established patient visit, and most insurances will not cover it separately because it is an integral component of a physical examination.

However, not all situations are the same.

Screening colonoscopy: In spite of all predictions, Medicare still wont pay for screening colonoscopy on a routine basis. However, this service is available to patients age 50 or over at high-risk for colon cancer, at two-year intervals. High risk is defined as a patient with a family history of colon cancer; prior cancer, or precursor neoplastic polyps; history of chronic digestive disease, such as inflammatory bowel disease, Crohns disease, or ulcerative colitis; or presence of recognized genetic markers for colorectal cancer.

Note that if you do schedule the patient for a screening colonoscopy for any of these reasons and report it, you cannot report a concomitant office visit. Screening colonoscopies are reported with HCPCS Code G0105, effective Jan. 1, 1999.

However, lets say the patient comes in for another reason, such as a routine visit for a blood pressure check. You find after taking the history and physical that you need to do a colonoscopy and collect a specimen. Now you can report the CPT code for colonoscopy with collection of specimens (45378) along with the visit code for the blood pressure check CPTa 99213, for example.

Tip: You must add modifier -25 to the visit code because it was an E/M service performed on the same patient by the same physician on the same day as a procedure. ICD-9 codes should match the services: a diagnosis code for hypertension should be linked to 99213, and a diagnosis code for signs and symptoms indicating a colonoscopy should be linked to 45378.

Pelvic screening: Effective Jan. 1, 1998, Medicare-covered women of childbearing age or those at high risk of cervical or vaginal cancer can receive annual breast and pelvic screening exams. (See article on reporting screening gynecological exams for Medicare patients in the March issue of ICA, page 21.) A new HCPCS code to cover these services was put into use in 1998: G0101 (cervical or vaginal cancer screening; pelvic and clinical examination). Routine pelvic screens, clinical breast exams, and Pap smears are covered every three years for women who are not at high risk.

Note: G0101 is bundled with new and established patient office and hospital visits and consultations (CPT 99201-99255), which means you will be paid either for the screen or the E/M service, but not both. If at the same encounter you were to provide a service beyond screening, you could bill the CPT code for that service, plus the E/M code with modifier -25.