Internal Medicine Coding Alert

Screen PSA Documentation to See When Claims Deserve a G Code

Plus, make sure you know when to support your coding with V76.44.

You could be incorrectly coding your often-performed prostate specific antigen (PSA) tests unless you can distinguish a screening PSA test from a diagnostic PSA test.

Follow these expert tips to ensure you're choosing the right codes every time.

Check Test's Reason to Determine Diagnostic or Screening

To identify which CPT code (G0103 or 84153) to report for a PSA test, look at the patient's diagnosis in the medical record -- but your physician shares the responsibility. Encourage your internist to include the specifics of the patient's diagnosis in the chart.

Diagnostic: Use the diagnostic code when the patient has an established disease or illness process that is outlined in the local coverage determinations (LCD) for that CPT code. The correct code for a diagnostic PSA test is 84153 (Prostate specific antigen [PSA]; total).

"I would bill 84153 when a diagnostic PSA is needed for another medically necessary reason; for example, observation of a rising PSA or a confirmed diagnosis of prostate cancer that requires the PSA be done after treatment has been initiated to assure its effectiveness," says **Elizabeth Hollingshead, CPC, CMC,** a corporate billing/coding manager in Marysville, Ohio.

Screening: Absent a sign or symptom, look to the screening code. Medicare requires that all yearly screening PSAs be billed with G0103 (Prostate cancer screening; prostate specific antigen test [PSA]), Hollingshead says. Some other payers follow these same guidelines.

Usually Associate V76.44 With G0103

When your physician orders a screening PSA test for a patient with no signs or symptoms of disease, you traditionally should use diagnosis code V76.44 (Special screening for malignant neoplasms; prostate) as the reason for the test. Otherwise, Medicare would not previously reimburse for G0103.

Official word: CMS's Guide to Medicare Preventive Services (www.cms.hhs.gov/mlnproducts/downloads/psguid.pdf) elaborates on this requirement. There are no specific diagnosis requirements for prostate screening tests. If, however, screening is the purpose of the test and/or procedure, choose the appropriate screening (V) diagnosis code when billing Medicare.

Hopeful news: According to some newer LCDs, you would get paid for G0103 with another diagnosis, so continue to use V76.44 if appropriate. The coverage determinations, however, allow you to code PSA screenings with diagnoses, such as benign prostatic hyperplasia (BPH, 600.00 or 600.01) and others.

Check Out These Diagnostic Diagnoses

The covered diagnoses for PSA tests vary from payer to payer. Each payer will have a list of acceptable, covered diagnoses. If you bill within these diagnoses, you should not have any denials. Regardless of the payer's coverage determinations, "you need to be sure that you have documentation to support your diagnosis choice," Hollingshead stresses.

When your internist orders a diagnostic PSA test and the documentation specifies that the test result shows an elevated PSA, you should report 790.93 (Elevated prostate specific antigen [PSA]) as the diagnosis.

If the test results are normal, you would report the BPH as the reason for the test. Because you must report the BPH code to the fifth digit, you'll have to know whether the patient has a urinary obstruction or is symptomatic so you can select the proper code as follows:

• 600.00 -- Hypertrophy (benign) of prostate without urinary obstruction and other lower urinary tract symptoms (LUTS)

• 600.01 -- Hypertrophy (benign) of prostate with urinary obstruction and other lower urinary tract symptoms (LUTS).

Alternative: If the ordering physician documents a more specific diagnosis, such as prostate cancer, you should report the appropriate code (185, Malignant neoplasm of prostate). Or if the physician noted only signs and symptoms, you should report that condition, such as 788.64 (Urinary hesitancy). According to recent LCDs, Medicare considers many ICD-9 codes indicating urological signs or symptoms -- such as 599.71 (Gross hematuria), 599.72 (Microscopic hematuria), 788.41 (Urinary frequency), or 788.43 (Nocturia) -- as payable diagnoses for PSA determinations.

Obey Once-a-Year Coding Limits

"In my opinion, the biggest pitfall for screening PSAs is the timing," Hollingshead says. "It is covered only once every 12 months for Medicare, with most commercial payers following suit. You need to make sure that you have at least 365 days (366 for leap years) between screening PSAs," she confirms.

"Medicare only pays for one screening PSA per year" for men over the age of 50, stresses **Gaye Pratt,** coder/biller for Dr. Vincent P. Miraglia in Stuart, Fla. But Medicare (and other payers) may reimburse you for as many diagnostic PSAs per year as the patient needs, "as long as you have a payable diagnosis," Pratt adds.

Watch out: Make sure you're not just checking your own practice's medical record. You should check to see if the patient has had a PSA screening at another office within the last year. On occasion you may have patients who have had a PSA done at another doctor's office, and when your practice draws a screening PSA, Medicare may deny it since Medicare will only pay for one screening PSA a year.

Self-pay option: If the patient wants or needs a screening PSA test before the one-year time limit is up, your best bet is to have the patient sign an advance beneficiary notice (ABN) agreeing to pay for the test.

Typically, you cannot use a "blanket" ABN; however, you may be able to have patients sign one stating that if they had the test done elsewhere within the allowed timeline, they will be responsible for payment.