Outpatient Facility Coding Alert

E/M Coding: Watch Out for E/M Pitfalls with Pre-Colonoscopy Screenings

Know when, when not to include an E/M code.

Physicians performing colonoscopies in an outpatient facility will often see patients for pre-colonoscopy screenings, but it can be confusing to know how to report these services accurately - and when you can report them at all.

That's because not every pre-colonoscopy screening warrants a separate evaluation and management (E/M) code.

Read on for an in-depth guide on when you should, and should not, code separately for your pre-colonoscopy E/M visits.

First, Read Your Encounter Notes

As with any other service, you can only code what the provider has documented in the chart, and in many cases, a pre-colonoscopy visit will not include the elements necessary for reporting E/M codes 99201-99215.

For example, suppose your physician billed 99213 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity...) with his last six screening colonoscopies (e.g., G0121 [Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk]).

Ask this: When reviewing the documentation, ask yourself what the chief complaint is for the E/M visit. A patient presenting solely for the purpose of a screening colonoscopy would likely not have a chief complaint to report. In addition, ask yourself to find the location, timing, quality, context, duration, severity, associated signs and symptoms, and modifying factors of the patient's complaint. You are not likely to find any. Therefore, it's clear that the documentation does not meet the medical necessity for an E/M service.

Here's What Medicare Says

If your gastroenterologist is convinced that he or she should be able to bill E/M codes with screening colonoscopies, provide the language from CMS or your local Medicare Administrative Contractor (MAC).

For example, Part B MAC Palmetto GBA updated its article on this topic on in 2018. In its directive, Palmetto notes, "The physician performing the colonoscopy may wish to see and evaluate the patient prior to the screening colonoscopy. In this case, the evaluation and management (E/M) visit is generally not separately billable."

Even in patients deemed high-risk, the reimbursement for the appropriate high-risk screening code (such as G0105 [Colorectal cancer screening; colonoscopy on individual at high risk] already includes the pre-service work associated with a screening colonoscopy in a high-risk patient, Palmetto advises.

Here's When You CAN Report the E/M

Although you are typically out of luck when reporting an E/M for patients who present for colonoscopy pre-screens, there are a few exceptions, according to the Medicare rules. You can report a separate E/M code when patients present for a screening colonoscopy and either of the following scenarios takes place, Palmetto says:

- You've documented all the required E/M components, and based on the evaluation, the physician decides not to perform the procedure; or
- You've documented all the required E/M components, and the gastroenterologist determines that the

patient's signs and symptoms warrant a diagnostic colonoscopy instead of the screening colonoscopy.

In these situations, you will report the appropriate E/M code based on the elements documented. If your documentation meets the requirement in the second option above, you'll report the appropriate diagnostic colonoscopy code (such as 45378 [Colonoscopy, flexible; diagnostic, including collection of specimen[s] by brushing or washing, when performed (separate procedure)]), as well as the E/M code on the applicable date(s) of service.

In the event the E/M service is performed on the same day as the procedure, append modifier 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service) to the E/M code since the National Correct Coding Initiative (NCCI, or CCI) bundles the E/M codes into the diagnostic colonoscopy codes or any same-day endoscopic procedure. Since gastrointestinal (GI) endoscopic services are "zero-day global" services, E/M services qualifying for reporting performed on a different date does not require a modifier.

Resource: To read Palmetto's complete document on this topic, visit https://www.palmettogba.com/palmetto/providers.nsf/DocsR/JJ-Part-B~8EELDY5430.

What About Conditions Requiring Special Consideration Before Colonoscopy?

Physicians commonly do screening or surveillance colonoscopies for patients with serious comorbid conditions, and perform medically necessary visits to provide for assessment (to determine whether the patient is stable enough to proceed) and for special instructions (such as how to manage anticoagulants, complex diabetic regimen, severe asthma, severe sleep apnea, etc.). In these situations, most Medicare contractors don't question E/M visits before a colonoscopy.

In such cases, the ICD-10 coding should first list the medical condition that the gastroenterologist assesses and counsels. Payer policy differs regionally whether to use the screening or surveillance codes for the exam (such as Z86.010 for polyp history, etc.); or the code for a pre-op evaluation, such as Z01.810 (Encounter for preprocedural cardiovascular examination-e.g. history anticoagulation needing management) or Z01.818 (Encounter for other preprocedural examination). If the reason relates to morbid obesity, code any comorbidities such as sleep apnea, or at least the ICD-10 code for the patient's body mass index (BMI).

If there are no apparent requirements for use of such specific codes, chart documentation should make clear the medical necessity for the pre-procedure evaluation, even if the patient has no GI symptoms or disease.

What About Non-Medicare Payers?

Private payers may have different rules than Medicare when it comes to pre-colonoscopy screening visits, so check with the insurers you bill most often to find out their policies on whether you can report these services. "Non-Medicare plans governed by Affordable Care Act regulations are required to cover pre-colonoscopy visits, but payers vary whether they want usual visit codes reported or preventive service codes reported for this service," says **Glenn D. Littenberg, MD, MACP, FASGE, AGAF**, a gastroenterologist and former CPT® Editorial Panel member in Pasadena, California. In any event, be sure your documentation clearly supports a separate E/M.