

UCDHS COMPLIANCE OFFICE
CODING AND BILLING NOTICE

Topic: Separate evaluation and management (E/M) service with a screening colonoscopy

This notice outlines the criteria for billing for a separate E/M service for patients referred for a screening colonoscopy.

A separate E/M service for patients referred for a screening colonoscopy may be billed when one of the following conditions is met:

1. When the GI physician performs the components of an E/M and based on the patient's risk factors (i.e., COPD, high-risk medication, etc.) decides not to proceed with the procedure; or
2. When the GI physician performs the components of an E/M and finds that the patient has significant signs and symptoms that support a diagnostic colonoscopy rather than a screening colonoscopy.

It is important to understand the difference between a screening and a diagnostic colonoscopy.

A **screening** colonoscopy is performed on patients who do not have signs or symptoms and there are no significant findings found during the examination.

A **diagnostic** colonoscopy is defined as one performed to evaluate signs or symptoms of disease.

If a lesion or growth that results in a biopsy or lesion/growth removal is detected during a **screening** colonoscopy, the appropriate CPT code for **diagnostic** colonoscopy with biopsy or lesion/growth removal (instead of screening) should be billed.

It is also important to understand that a referral for a screening colonoscopy does not constitute a consultation. A consultation is distinguished from an office visit because it is provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. If the primary physician is referring their patient for a screening colonoscopy, the need for a screening colonoscopy was already established and there is no opinion being sought.

When a patient is referred for a screening colonoscopy, the term "screening" indicates that the patient does not have signs or symptoms that support a diagnostic colonoscopy. Although the GI physician may wish to see and evaluate the patient prior to a screening colonoscopy, the evaluation and management visit is generally not separately billable.

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The patient may be at high-risk for the screening procedure due to other conditions (i.e., COPD, medications, etc.) that affect the pre-operative instructions given to the patient or how the procedure is performed, however, the consideration given to these risk factors is inclusive in the usual “pre-operative” work associated with the procedure. Reporting an E/M service with a diagnosis code associated with one of the patient’s risk factors implies that the GI physician saw the patient in order to diagnose or manage the illness identified and that is not the case. The GI physician is seeing the patient in order to determine the suitability of the patient for the screening procedure and CMS has stated that these visits are not billable.¹ The following FAQ was posted on the CMS website:

Evaluation and Management Visit prior to Screening Colonoscopy

Q. Can a provider bill an E&M visit if a beneficiary is referred for a screening colonoscopy?

A. A provider preparing to perform a screening colonoscopy cannot also bill for a pre-procedure visit to determine the suitability of the patient for the colonoscopy. There E/M services, to include consultations, are not separately payable. While the law specifically provides for a screening colonoscopy, it does not also specifically provide a separate screening visit prior to the procedure. Although no separate payment can be made for these visits currently, the fee schedule payment for all procedures, including colonoscopy, contains payment for the usual pre-procedure work associated with it. This reflects the principle that each procedure has an evaluative component.

If the GI physician performs the components of an E/M service and determines that the patient’s risk factors are significant enough that the screening procedure cannot be performed, then the GI physician can bill for his/her E/M service. This allows the physician to receive reimbursement for the E/M service provided, a service which otherwise would have been included in the reimbursement for the procedure.

If the GI physician performs the components of an E/M service and determines that the patient has significant indications that a colonoscopy should be performed, then the visit can be billed and the colonoscopy procedure becomes a diagnostic, not a screening procedure.

¹ In a May 2, 2002 letter to Randy Fenninger, MARC Associates, Thomas A. Gustafson, director, Purchasing Policy Group, CMS, wrote in response to an inquiry by William Larson of the CMS Coverage and Analysis Group, Office of Clinical Standards and Quality, requesting payment for a pre-procedure visit to determine the suitability of the patient for a screening colonoscopy:....While the law specifically provides for a screening colonoscopy, it does not also specifically provide for a separate screening visit prior to the procedure....Thus, a pre-procedure visit performed on an asymptomatic patient prior to a screening colonoscopy is not covered under current law. We would note that, while we do not currently make a separate payment for these visits, fee schedule payment amounts for all procedures, including colonoscopy, contain payment for the usual pre-procedure work associated with the procedure.

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Resources

1. Centers for Medicare and Medicaid Services (CMS) “Frequently Asked Questions” (FAQs)
2. “Ask the Coding Expert”- The American Gastroenterological Association, November 2003
3. National Heritage Insurance Company (NHIC), LMRP for Diagnostic Colonoscopy (L9662, L9988)