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Internal Medicine Coding Alert

4 Q&As; Help You Fall In Line With Heart Disease Screening Criteria

Don't forget the appropriate E/M code if the patient presents with a separate complaint.

Keeping America heart-healthy takes a lot of work, particularly with our country's apparent addiction to fast food and large portions. To help counteract the rising heartdisease trend, CMS recommends that all eligible beneficiaries take advantage of cardiovascular disease screenings.

Here's what you need to know to catch heart disease early -- and get reimbursed for your efforts in the process.

Who Is Eligible?

Offer the cardiovascular screening test to all Medicare beneficiaries -- as long as they have not had the test in the last five years, which is as often as Medicare will cover the screening.

59 months: To be exact, you must make sure that at least 59 months have passed since the last covered cardiovascular screening blood test.

No symptoms: The beneficiary must by **asymptomatic** in order to report the lipid panel as a screening test. This means that the beneficiary must have "no apparent signs or symptoms of cardiovascular disease," according to The Guide to Medicare Preventive Services at www.cms.hhs.gov/mlnproducts/downloads/psguid.pdf, starting on page 43.

Also, make sure that the medical record documentation reflects that a physician or qualified non-physician practitioner (NPP) ordered the test and used it in the management of the patient.

Revenue tip: Inform patients about the availability of screening tests based on age and family history. "Education is the key to making sure you are not leaving money on the table," asserts **Terry Fletcher, BS, CPC, CCS-P, CCS, CMSCS, CCC, CEMC, CMC,** healthcare coding consultant and CEO/President of Terry Fletcher Consulting, Inc. in Laguna Beach, Calif. Also, use advance beneficiary notices (ABNs) to make patients aware of what they could be paying out of pocket should their insurer not allow for the services.

Which Tests Are Covered?

Three clinical laboratory tests comprise the cardiovascular blood screening:

• 82465 -- Cholesterol, serum or whole blood, total

• 83718 -- Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)

• 84478 -- Triglycerides test.

Combo: Although the physician may order the tests individually, it is recommended to order the full lipid panel(80061), notes **Ashleigh A. Raubenolt, CPC, CPC-H,CPC-P, CPMA, CEMC, CHCA,** director of Chart Watch Auditing and Review, and Credentialing and Physician Contracting, at S.A. Medical of Virginia, Inc. in Fredericksburg .Although Medicare reimburses for the tests separately for screenings, "from a clinical aspect I'm not sure why," she adds. "The total cholesterol test is useless as a stand alone test;" it does not aid in the prevention nor treatment of cardiovascular disease.

Reason: If a cholesterol test came back abnormal, the physician would need to know whether the HDL and, potentially, the low density lipoprotein (LDL) measurements, were high or low in order to treat the patient, Raubenolt continues.

The five-year frequency limit for each test applies regardless of whether the physician ordered the tests individually or in a panel.

Example: If one doctor ordered only one test, then another may order the remainder within the five-year time period. The second physician, however, will not be reimbursed for the same test if it was already provided within the last five years, Raubenolt points out.

Careful: You must order the lipid panel from a laboratory that offers the panel without the direct LDL measurement. If the screening lipid panel results, however, indicate an abnormality that calls for a direct LDL measurement, the physician may order this test to continue with a diagnosis and treatment plan.

Which ICD-9 Codes Do I Report?

To correctly report the lipid panel screening, you must include a diagnosis code. The codes most commonly associated with the lipid panel screen are V81.0-V81.2 (Special screening for cardiovascular, respiratory, and genitourinary diseases):

• V81.0 -- Special screening for ischemic heart disease

• V81.1 -- Special screening for hypertension

• V81.2 -- Special screening for other and unspecified cardiovascular conditions.

You may select more than one V code, says Raubenolt,but always indicate the primary reason the patient is receiving this service. For instance: "The patient has a family history of ischemic heart disease but is currently asymptomatic. No other family history is noted." In this case, you would report only V81.0, the special screening for ischemic heart disease. If the patient has multiple family history conditions, such as heart disease and hypertension, then you may select both ICD-9 codes (V81.0 and V81.1).

Attention: If you find no reason for the screening indicated in the chart, ask the physician why she orderedthe screening, recommends Raubenolt. "Even though a patient may be asymptomatic, there has to be a reason to prompt the physician to order the screening -- [knowing that reason] will direct coders to the appropriate code selection," she says.

Alternate diagnoses: Codes V81.0-V81.2 are the diagnoses that come up as "payable" without questions. But many payers will also reimburse for morbid obesity (278.01), defined as a body mass index of greater than 30, diabetes (250.x), hypertension (997.91), and even history of tobacco use (V15.82) if the patient is more than 50 years old, shares Fletcher. Always check with the individual payer for guidance on covered diagnoses.

Can I Report an E/M for the Screening?

If your internist performs a significant and separately identifiable service at the time of the cardiovascular screening service, you may report both the E/M and the screening study.

Example: An established patient comes in complaining of suspected esophageal reflux (530.81), at which time the physician orders a lipid panel for a cardiovascular screening due to a family history of hypertension.

For this encounter you may report:

• V81.1, for the family history of hypertension;

• 80061, for the lipid panel;

• 530.81, for the esophageal reflux complaint; and

• an E/M code, such as 99212 (Office or other outpatient visit for the evaluation and management of an established

patient, which requires at least 2 of these 3 key components: a problem focused history...), depending on the extent of the history, exam, and medical decision making.

Don't miss: Medicare's coverage of the cardiovascular screening benefit is a stand-alone billable service separate from the Initial Preventive Physical Examination (IPPE). The patient does not have to receive it within a certain time frame following his Part B enrollment.