Internal Medicine Coding Alert

6 Tips for Preventive and Problem

Internists often see patients for preventive measures and during the course of the exam discover something that must be treated during the visit but for practices to get paid for both services in the single visit is much less common without going through hoops.

Here are six ways to increase your chances for reimbursement.

1. The Right Preventive Medicine Code + Modifier -25 = Payment for Both Services. Choose a preventive medicine services level (99381-99397) depending on the patient's age and whether he is new or established. Also code the appropriate-level E/M office or other outpatient service code (99201-99215) depending on the complexity of the problem, says **Lynn Handy, LPN, CPC**, director of professional development, consulting and auditing services at Revcare, a healthcare revenue management company in Cypress, Calif., and a professional medical coding curriculum (PMCC) instructor through AAPC. Append modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to the office visit code to show that it is separate from the preventive service.

When you choose the E/M level for the problem visit, try to stay away from higher levels unless circumstances require it, Handy says. If the patient is sick enough to warrant a high-level E/M, Medicare will wonder why he required the preventive service in the first place and may invite closer scrutiny or deny the claim.

Don't sell your reimbursement short, though. If a situation arises during the preventive activity that requires the physician to perform a higher-level E/M service (for example, acute reaction to an allergy shot), the service deserves payment at the appropriate level. Not coding it correctly costs your office dollars and also means you have undercoded, which is a no-no.

2. Match Up ICD-9s. "One of the keys to getting paid for the preventive/problem combo visit is linking the diagnosis codes properly to show the medical necessity of both services," says Marta Kramer, CCS-P, a health information technician at Fairview Lakes Regional Medical Center in Chicago City, Minn. Link a V code (such as V70.0, Routine general medical examination at a healthcare facility) to the preventive service code, and the diagnosis(es) of the problem(s) encountered to the office visit code.

3. Carve Out the Cost. Medicare does not reimburse for preventive exams, so the patient will be responsible for that portion of the visit. But you still have to report both services, Handy emphasizes. Medicare will deny the preventive service and pay the E/M, assuming it is otherwise covered under Medicare. The physician may charge the patient the amount that the doctor's current established charge for the preventive medicine service exceeds his current established charge for the covered visit.

Medicare reimburses the problem visit based on its usual fee schedule for that service. For example, the physician's usual charge for the preventive service is $100, his usual charge for the problem visit is $50, and the Medicare-allowed amount for the problem visit is $40. If the patient has met her deductible for the year, Medicare will pay $32 (80 percent of $40), and the patient will be responsible for $58 (that is, the $8 coinsurance on the problem visit plus the $50 difference between the physician's usual charges for the two services).

Some commercial carriers do cover preventive services, however, and you should appeal if they deny the bill due to the combination of the services. Notify patients before the visit that their insurance may exclude preventive services. If they are Medicare patients, you should also give them an advanced beneficiary notice if you're unsure that the commercial

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insurer will cover this service. If patients have to pay out-of-pocket, they will appreciate the warning and may even help you if you have to appeal.

4. Document Separately. "The doctors need to pay extra attention to documentation for preventive/problem visits," Handy says. "Auditors like to see separate notes for each service." For the preventive visit, internists will document a comprehensive history, a comprehensive exam and some type of counseling, but not medical decision-making. On a separate piece of paper, if possible, the doctor will document the problem visit, which includes a separate history, exam and medical decision-making. Physicians cannot include the history and exam from the preventive visit as components in the problem visit. "The physician cannot get reimbursed for the same service twice," Handy says.

Physicians must also resist the temptation to help their patients avoid out-of-pocket costs by turning preventive services into problem-oriented ones. You could document the visit so it appears that the patient initially came in for a problem visit, but that is fraudulent if he actually came in for a preventive service.

Some practices that have many preventive/problem combo visits have a special form for these particular visits. One side of the form aids in documenting the office visit, and the other aids in the physical examination.

5. Appeal. If these visits are clearly separate and you have attached modifier -25, you deserve to be properly paid. The most common reasons insurers list on explanation of benefits (EOB) forms for the denials are "redundant," "not normally performed on the same day or in the same session" or "unbundled." None of these are acceptable reasons to deny the special circumstances of the preventive/problem visit.

In your appeal letter, you should reference the CMS policy on billing a medically necessary visit on the same occasion as a preventive medicine service as detailed in the Medicare Carriers Manual, section 15501.E. Also, explain to the carrier that the visit and services are properly coded according to CPT guidelines, which are accepted by CMS.

"I won most of my appeals on this subject by simply photocopying the preventive medicine section of CPT that states that an E/M can be billed in addition to a preventive and sending payers that along with the documentation," Handy says. Include the documentation with your appeal letter and inform the carrier that you have sent a copy of the letter to the patient. Sending the patient a copy of the appeal not only keeps him apprised of the situation but may spur the patient to help the practice get paid (the patient knows that if the insurance company doesn't pay, it will come out of his own pocket). Sometimes, just showing the insurer that its customer is aware of an appeal can help get the claim paid.

6. Check Your Payer Contracts. Know which preventive services are covered under your contracts. "You really need to know what your payers will reimburse for," Kramer says. Medicare covers some preventive services, but patients are responsible for charges on the noncovered services. Other insurers also specify which preventive benefits they will reimburse. If a practice knows which preventive services are covered under its payer contracts, it can properly bill the insurer initially and sometimes avoid the denial and appeal, Kramer says. And knowing which preventive services are covered can help you educate patients on the parts of the bill that may be their responsibility.

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