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Internal Medicine Coding Alert

Correct Coding is Crucial for Pap Smear and Evaluation for Hypertension and Diabetes

One of the most difficult coding and billing problems for internal medicine practices is reporting combined preventive medicine and sick-visit services that occur on the same day. The key is to use the correct preventative services code and the E/M code with the appropriate modifier.

How do you bill a routine Pap smear and an office visit for diabetes and hypertension at the same time? asks a reader from the office of **Gregory Weiner, MD,** in Chula Vista, CA.

This situation often comes up in internal medicine offices: A patient may come in for a problem-focused visit (the diabetes and hypertension), and the internist may notice that she has not had a routine screening test (Pap smear) at a scheduled interval. To get the needed screening and save the patient time, the physician offers to perform the preventive screening at the same time as the sick-visit.

In that case, you would really be performing two
services, a preventive medicine visit and a sick-visit. So, you should report two codes, advises **Marilyn Johnson, CPC,** a certified professional coder and medical coding and billing consultant with Mercy Health System in Rogers, AK. For commercial payers, you should report a CPT preventive service code for the patients age, usually either 99395, 99396 or 99397. And, you would report a separate, office/outpatient E/M code (99211-99214) for the evaluation of the diabetes and hypertension.

The first code should be reported with a -25 modifier (separately identifiably service on the same day), in order to receive reimbursement for both services.

Private payers have different policies regarding payment for preventive medicine services, so payment for the first code may vary, she continues. However, payment for the separate, problem-oriented visit is justifiably separate from the preventive service. Coders and physicians must be sure, however, not to count the services provided during the screening portion as elements when determining the level of office/outpatient E/M to report for the sick portion of the visit.

Note: For more information on reporting well- and sick-visits on the same day, see the article Maximize Your Reimbursement for Annual Physicals on Medicare Patients on page 33 in the May 1999 issue of Internal Medicine Coding Alert.

Medicare has Specific Code
for Screening Pap and Pelvic

Coding could be different in the above scenario if the patient is a Medicare patient, notes Johnson.
The Balanced Budget Amendment (BBA) of 1997 mandated coverage of several screening tests, including
Pap smears, for Medicare patients. Screening Pap and pelvic examinations are covered by Medicare once every three yearsmore often if the patient is of childbearing age or is deemed at high risk for cervical or vaginal cancer. To report a Medicare-covered screening, carriers require the specific HCPCS code for the screening service, which in this case is Pap smear and/or pelvic examination (G0101, cervical or vaginal cancer screening; pelvic and clinical breast examination).

Medicare Payment Regulations
on Same-Day Preventive/Sick Services

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Medicare does not cover annual physicals or many preventive screenings (except for the new services mandated in the BBA). So, physicians are instructed to carve out the sick portion and bill it separately with a
-25 modifier.

However, notes Johnson, even though the two codes are reported separately, Medicare does not allow physicians to bill the patient the full amount for each separate code. Medicare participation rules state that the physician, if performing a preventive service and sick service on the same day, can bill Medicare for the portion of the visit that was problem-oriented (i.e., the office/outpatient E/M service). The physician can then bill the patient only the difference between the normal charge for the preventive visit and the reimbursement for the sick portion that will be paid by Medicare.

For example, if your normal charge for the preventive visit would be $100, and the reimbursement for the sick portion of the visit is $70, then you could bill the patient only the $30 difference, says Johnson.

However, in the above situation, provided the patient has not had a screening Pap in the previous three years or meets the high-risk criteria, both services would be paid by Medicare. The practice should report the E/M code
with the -25 modifier and the G code for the screening
Pap smear.

If the practice is in doubt about the patients eligibility for the screeningfor example, the patient may not remember whether she has had a Pap in the previous three yearsthey should get the patient to sign a waiver agreeing to pay for the screening if Medicare does not, and apply the -GA modifier (waiver of liability statement on file) to the G0101 code.

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