Internal Medicine Coding Alert

Get Paid for Annual Physical and Problem-Focused Exam on Same Day by Using -25 Modifier

Its a situation commonly encountered in internal medicine: A patient comes in for his or her annual physical, but, just as the physician is finishing up, the patient adds, By the way, . . . and brings up a new health complaint.

In many cases, physicians just bill for a level five office visit, considering the evaluation of the additional problem to be part of a comprehensive exam. However, they should actually be billing two codes for this visit: a preventive medicine code for the annual exam (99381-99387, new patient; 99391-99397, established patient) and an office/outpatient E/M (99201-99205, new patient; 99211-99215, established patient) for the problem-focused exam.

Recently, we were advised on billing for history and physicals and annual Pap smears, writes **Brinn Coffey,** bookeeper in the billing department of Jack R. Smardo, MD, Raymond F. Rossi, MD, and James R. Metzger, MD, Internal Medicine Offices. We were told that if a patient is seen for the routine physical as well as evaluated for additional problems that we should be billing a preventive medicine code along with an E/M code. Is this accurate?

Bill E/M Code with Modifier -25

It is accurate, says **Emily Hill, PA-C,** managing partner of Strategic Healthcare Services in Southport, NC. The practice should be billing a preventive medicine code for the routine physical, then bill an office/outpatient E/M code with a -25 modifier (significant, separately identifiable procedure or service performed on the same day) for the problem-focused exam.

CPT guidelines allow this, but reimbursement varies from payer to payer, she notes.

Medicare, for example, only pays for a select few preventive medicine services and often doesnt cover routine physicals.

What Medicare does do is pay you for that regular, problem-focused service and allow you to charge the patient the difference between your fee for the E/M service and your fee for the preventive medicine service, Hill explains.

Practices are not required to get a waiver signed in order to bill the patient because the preventive exam is a non-covered service, Hill notes. It would not be denied on a claim because of the lack of medical necessity. It is simply not covered. You are allowed to bill the patient for this. But, I would explain to them up front that Medicare does not pay for this and they will be charged for it.

Private payers may reimburse you for both services, but many do not. It is different from one payer to the next, she says. Some will pay you for one and not the other. But, this is correct coding according to CPT.

Documentation Issues

Of course, if you expect to get paid for both codes, then the documentation and ICD-9 coding should support two separate services.

Although use of modifier -25 does not require a separate diagnosis code, you would expect that the preventive medicine annual visit would be linked with a V70 series general medical examination code, while the problem-focused visit would be linked with a separate ICD-9 code indicating the patients specific problem.

Also, Hill recommends that the physician finish the documentation for the preventive medicine visit, skip a line on the chart, and then, under a separate heading, list the documentation for the problem-focused exam.

I usually advise them to write a separate note, it can even be on the same page, and label it encounter for diabetes, or something like that, so that you are showing the additional work in treating the diabetes.