Internal Medicine Coding Alert

Get the Lowdown on Medicare's New Diabetes Coverage

Rely on lab and E/M codes to report the screening tests

Your internist could be losing deserved payment for diabetes screenings if you don't know how to code the two glucose tests and if the documentation fails to specify the Medicare-approved risk factors.

Important: As the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) requires, Medicare began paying for most diabetes screenings (82947, 82950, 82951) as of Jan. 1, 2005. In the past, Medicare did not reimburse physicians for diabetes screenings.

CMS will reimburse "diabetes screening tests at the same amounts paid for these tests when performed to diagnose an individual with signs and symptoms of diabetes," according to the Nov. 15, 2004, Federal Register. **Translation:** Expect your Medicare insurer to pay $6 to $17 for the tests, according to the Clinical Laboratory Fee Schedule.

Educate Your Physicians

One problem IM offices - and their patients - face when Medicare issues new coverage decisions is that the physicians either forget or ignore the decisions.

"Our difficulty [with the diabetes screening tests] is getting the doctors to remember they can do them," says **Cathy Satkus,** a professional coder for Harvard Family Physicians, an internal medicine and family practice in Tulsa, Okla. "With so many new rules and tests/screenings added, it is difficult to get the doctors to remember what tests they can now do."

What to do: If your internists are too busy to read this article, give them our tool on page 28 that highlights the screening codes and other important features.

Another problem: Many IM offices aren't sure when to bill for lab tests. Remember that if you sent the blood specimen to an outside lab, you should report only a venipuncture (36415, Collection of venous blood by venipuncture). But if your office has an appropriately licensed lab, you can bill for the glucose test and the venipuncture, says **Kathy Pride, CPC, CCS-P,** a coding consultant for QuadraMed in Port St. Lucie, Fla.

Why the Screening Codes Require Modifiers

If your internist wants to screen a Medicare patient for diabetes, he should use either the fasting blood glucose test, the post-glucose challenge test, or the glucose tolerance test.

To code the fasting blood test, you should assign 82947 (Glucose; quantitative, blood [except reagent strip]). The post-glucose test requires 82950 (... post glucose dose [includes glucose]), and the glucose tolerance requires 82951 (... tolerance test [GTT], three specimens [includes glucose]). Medicare pays for only one test, so you should submit only one of the above codes.

ICD-9 coding: When you use 82947, 82950 or 82951, you should list V77.1 (Special screening for diabetes mellitus) as your primary diagnosis code, according to CMS.

Modifier tip #1: The three Medicare-approved diabetes-screening tests carry a "waived status." That means if your IM office has obtained the Clinical Laboratory Improvement Amendments (CLIA) certification, your internist can perform the

tests in the office. Be sure you attach modifier -QW (CLIA waived test) to the codes (for example, 82950-QW).

If your office doesn't have CLIA certification, your physician won't perform the tests but a lab will, and you cannot bill for lab work performed outside of your office, says **Bruce Rappoport, MD, CPC,** a board-certified internist who works with physicians on compliance, documentation, coding and quality issues for Rachlin, Cohen & Holtz LLP, a Fort Lauderdale, Fla.-based accounting firm with healthcare expertise.
Modifier tip #2: If the internist performs a screening test on a patient with "prediabetes," Medicare requires that you attach modifier -TS (Follow-up service) to the CPT code. Therefore, if your internist performed the glucose tolerance test on a prediabetes patient, you would report 82951-QW-TS.

Private-payer watch: Don't assume commercial insurers will follow Medicare's lead on the screening coverage. In fact, most private carriers won't accept diabetes screening or any other screening codes, Satkus warns. For example, one of her carriers requires her office to report venipuncture code 36415 (Collection of venous blood by venipuncture), even though her office performs the tests with an in-house lab.

Learn Medicare's Coverage Guidelines

You may bill one test every six months for patients with "prediabetes." But you should report only one test every 12 months for patients whom the internist has not diagnosed with prediabetes, or whom a physician has never tested, according to Medicare guidelines.

Also, before you report the screening codes, be sure the patient has at least one of the following risk factors for diabetes:

1. hypertension
2. dyslipidemia
3. obesity (with a body mass index greater than or equal to 30 kg/m2)
4. previous identification of elevated impaired fasting glucose or glucose intolerance.

If the patient has none of these, you should check whether the patient has at least two of these risk factors:

5. overweight (a body mass index >25, but <30 kg/m2)
6. family history of diabetes
7. age 65 years or older
8. history of gestational diabetes mellitus or giving birth to a baby weighing > 9 lb.

Denial pitfalls: Don't report screening codes to Medicare for a patient whom a physician has already diagnosed with diabetes (250.xx). You should also avoid these codes if the patient shows symptoms of uncontrolled diabetes, such as excessive thirst (783.5, Polydipsia) or frequent urination (788.41, Urinary frequency). Medicare already covers those conditions for diagnostic diabetes testing.