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Internal Medicine Coding Alert

How to Bill for Separately Payable Preventative Services

Although the Medicare Carriers Manual (MCM) does not include a national policy on separately payable preventative services, internists should carve out a fee for a Pap smear and pelvic/breast exam from the fee charged for an annual physical examination so they can bill Medicare for these services separately. Other preventive services covered by Medicare such as fecal-occult blood tests (FOBTs), influenza vaccinations and digital rectal exams (DREs) do not have to be carved out from the fee for the physical and can be reported separately.

The preventive medicine codes, 99381-99387 for new patients and 99391-99397 for established patients, are used to report the evaluation and management (E/M) of an individual and can include a comprehensive history, comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate laboratory/diagnostic procedures.

The codes are broken down by the patients age. Internists most frequently will report 99386 (initial preventive medicine evaluation and management, 40-64 years) and 99387 (initial preventive medicine evaluation and management, 65 years and over) for new patient visits or 99396 (periodic preventive medicine reevaluation and management, 40-64 years) and 99397 (periodic preventive medicine reevaluation and management, 65 years and over) for established patient visits.

A preventive medicine visit or annual exam will include services such as counseling for risk factors for diseases such as diabetes or hypertension, FOBT to screen for colorectal cancer, an influenza and pneumococcal immunization and a tetanus shot, says **Andrea Lamb, CPC,** billing clerk at St. Josephs Medical Plaza, a 14-physician multispecialty practice in Buckannon, W.Va. In addition, women may have a Pap smear and pelvic/breast examination, while men may have a digital rectal exam to check for prostate cancer.

Getting Paid for a Preventive Visit

Although these are typical services performed during a preventive visit, Medicare does not cover all of them including the E/M portion of the visit. The patient is responsible for paying the portion not covered by Medicare.

To correctly split the billing between Medicare and the patient, the internist and/or internal medicine coder should calculate Medicares portion and the patients portion of the preventive visit. Section 15501.1(E) of the MCM instructs internists to deduct the cost of the covered services from the cost of the internists fee for the exam to arrive at the patients portion of the visit. The manual states, The physician may charge the beneficiary, as a charge for the noncovered remainder of the service, the amount by which the physicians current established charge for the preventive medicine service exceeds his/her current established charge for the covered visit.

Although this section of the manual traditionally has been applied to situations when a patient has a preventive medicine visit and a sick visit on the same day, carriers now consider the Pap smear and pelvic/breast exam as covered services that should be deducted from the fee for the preventive visit.

Because the Pap smear and pelvic/breast exam are traditionally considered part of a well-woman visit, those are the only covered preventive procedures that are deducted from the internists fee for the preventive medicine service, explains **Vicki Balistreri, CPC,** senior consultant at Baird, Kurtz, and Dobson, a healthcare consulting firm in Kansas City, Mo., and a member of the national advisory board for the American Academy of Professional Coders.

Deducting From Fee for Preventive Visit

For example, if a 66-year-old female established patient has a preventive medicine visit, and the Pap smear (Q0091) and

pelvic/breast exam (G0101) are the only covered services she receives, then the internist would report those codes on the claim, Lamb explains.

To calculate the patients payment for the noncovered portion of the exam, assume the internist has the following standard fees:

Code; Service; Internist Fee;
99397; Preventive medicine visit; $125
Q0091; Collection of Pap smear; $30
G0101; Pelvic/breast exam; $35

The noncovered portion of the exam to be paid by the patient is $60 (or $125-$30-$35). She is also responsible for a portion of the covered services.

Medicare fees are only estimates and will vary according to geographic region. Reimbursement from Medicare is 80 percent of the allowable fee, with the patient responsible for the remaining 20 percent (also known as the patient coinsurance). Medicares reimbursement for the covered services will be as follows:

Code; Medicare Fee; Actual Reimbursement; Patient Coinsur.;

Q0091; $28.00; $22.40; $5.60
G0101; $30.42; $24.34; $6.08
Total; $58.42; $46.74; $11.68

Lamb calculates that the internist should receive payment of $46.74 from Medicare, $11.68 from the patient for the coinsurance and $60 from the patient for the preventive medicine part of the visit for a total of $118.42. The difference between the internists standard fee for the visit ($125) and the total reimbursement ($118.42) is $6.58, which represents the difference between the internists fees for the covered services and Medicares allowable fee.

Do Not Deduct Other Covered Services

The Pap smear and pelvic/breast exam are the only covered services that are carved out of the fee for the preventive medicine visit, explains Lamb. Any other covered services are reported separately but do not reduce the amount that the patient is expected to pay for the preventive medicine visit. If the same patient in the previous example also has an FOBT (G0107) during her annual exam, then the services provided would be billed:

Code; Service; Internist Fee
99397; Preventive medicine visit; $125
Q0091; Collection of Pap smear; $30
G0101; Pelvic/breast exam; $35
G0107; Fecal-occult blood test; $15

Medicare reimburses 100 percent of its allowed fee for FOBTs. There is no patient coinsurance for the service. The FOBT should not be billed until the patient returns the cards to the internist, which may not be the same day that the preventive visit took place.

The internists reimbursement for services covered by Medicare now would be:

Code; Medicare Actual Patient Allowed Fee; Reimbursement; Coinsurance
Q0091; $28.00; $22.40; $5.60
G0101; $30.42; $24.34; $6.08
G0107; $3.50; $3.50; $ 0
Total; $61.92; $50.24; $11.68

The internists total reimbursement for the visit and all the services provided would be $121.92, which includes the patients portion of the preventive visit.

Get Patients to Sign a Waiver

A noncovered service such as a screening electrocardiogram (EKG) administered to a patient who has no signs or symptoms of heart disease also may be performed during the annual physical. Payment for the EKG is the responsibility of the patient or his or her secondary insurer. Lamb recommends having the patient sign a waiver acknowledging his or her financial responsibility for noncovered services. The waiver also covers a Pap smear that will not be reimbursed because she had one within the past three years and is not considered to be a high-risk individual, says Lamb.

Lamb also recommends attaching modifier -GA (waiver of liability statement on file) to all the services reported to Medicare to indicate that the waiver is on file. If the patient is at average risk for developing cervical or vaginal cancer and has not had a Pap or pelvic/breast exam within the past three years, Medicare records will show that the patient is due and will reimburse even if the -GA modifier is attached. Lamb estimates that 90 percent of the claims at her practice move electronically from Medicare to secondary payers, some of which will pay for the preventive part of the exam or for noncovered services such as a screening EKG.

Sick Visit Also Gets Deducted

Many times during the course of an annual exam, the internist will discuss with the patient a chronic condition that the patient has such as diabetes or hypertension or possible signs and symptoms of an undiagnosed condition. In this situation, there may be a sick visit portion to this service that should be carved out of the preventive visit and billed to Medicare, says Balistreri.

For example, the physician conducts an annual physical and also a level-three established patient office visit (99213). Modifier -25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) should be attached to 99213, Balistreri recommends. The patients portion of the visit would be:

Code; Service; Internist Fee
99397; Preventive medicine visit; $125
Q0091; Collection of Pap smear; $30
G0101; Pelvic/breast exam; $35
G0107; Fecal-occult blood test; $15
99213; Established patient office visit; $50

In this case, the patients portion of the exam is $10 (or $125-30-35-50, remember Medicare pays for 100 percent of the FOBT). The reimbursement from Medicare would be as follows:

Code; Medicare Actual Patient
Allowed Fee; Reimbursement; Coinsurance;
Q0091; $28.00; $22.40; $5.60
G0101; $30.42; $24.34; $6.08
99213; $43.00; $34.40; $8.60
G0107; $3.50; $3.50; $0
Total; $104.92; $84.64; $20.28

Total payment to the internist, including the patients portion of the preventive visit, will be $114.92.

This method for calculating the patients portion and Medicares portion of the preventive visit is not specifically outlined in the MCM and is a result of individual carrier interpretation of the regulations. Internists should check with their local carrier for specific instructions on split visit billing for preventive services.