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Internal Medicine Coding Alert

Making Preventive Medicine Services Work: Understand The Intricacies Of Coding and Educate Patients on Payment

A popular coding myth is that internists steer away from preventive medicine services because they believe carriers dont want to pay for them.

However, preventive services are being performed more widely than ever, and internists who are up to speed on the coding technicalities have the best opportunity to maximize their reimbursement.

Besides learning how and what to bill, internists and their staff must begin to educate patients because often its the patients responsibility to pay for at least part of any preventive service. Asking a patient to pay often creates an awkward situation, but the sooner internal medicine practices make their billing policies clear to patients, the faster reimbursement will be obtained.

Coding the Annual Physical

By definition, preventive medicine services are performed in the absence of complaints or symptoms for the purpose of detecting any new diseases. Probably the best-known example of a preventive service is the annual physical.

Knowing that Medicare doesnt pay for physicals, many internists have for years accommodated patients by charging a higher-level office sick visit (99201-99205, office or other outpatient services, new patient; or 99211-99215, established patient) instead of a well visit (99381-99387, preventive medicine services, new patient; or 99391-99397, preventive medicine services, established patient) so insurance carriers would pay for the visit. This practice is fraudulent because it has been accomplished by breaking out a billable service, which, in turn, allows physicians to reduce, or even eliminate the patients financial burden by subtracting the fee for a broken-out service from any fee the patient is liable for.

But breaking out a billable service can be a legitimate process if a problem or abnormality is detected that, according to CPT guidelines, is significant enough to require additional work to perform the key components of a problem-oriented E/M service. To code it, modifier -25 (significant, separately identifiable E/M service) should be attached to the appropriate office/outpatient code (99201-99215) and reported along with the applicable preventive service code (99381-99397).

Preventive Service Claims Are Being Watched

This has been common practice, but its changing because carriers are now watching preventive service claims very carefully, says **Susan Callaway, CPC, CCS-P,** an independent coding consultant and educator based in North Augusta, S.C., who recently made a teleconference presentation on this topic for the Coding Institute.

Callaway points out that although Medicare maintains its policy of not reimbursing for physicals, it is continually expanding the range and increasing the frequency of the preventive screen tests it will reimburse.

Medicare pays for pap smears, pelvic exams, breast exams (annually for women 40 and over), prostate exams (annually for men 50 and over) as well as screening tests for osteoporosis and colorectal cancer at differing intervals and ages. On July 1, the frequency for pelvic and breast exams will increase from once every three years to once every two years for non-high-risk patients. Also on July 1, Medicare will add coverage for a screening colonoscopy once every 10 years.

Medicare Focuses on Medical Necessity

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Apart from those screening tests, Medicare doesnt cover preventive services, particularly the annual physical because it doesnt meet Medicares definition of medically necessary.

Callaway believes that because Medicare is paying for more preventive screenings, its more reluctant now than ever to pay for comparable screening services that are broken out with a problem-oriented E/M service.

By contrast, many commercial carriers reimburse for physical exams but frequently deny payment for screening services because they feel these exams should be bundled into the preventive care code used to bill for the physical.

Carriers usually reimburse for a physical exam or for preventive screen tests, but not usually for both, Callaway says. As a result, internists and coders often must try to adapt their reimbursement claims to suit what they believe are each carriers requirements. Its not a bad thing to know what the insurance companies policies are, Callaway says. But its a bad idea trying to tailor a patients visit so as to limit their personal financial liability.

Determine the Reason for the Visit

What are the key criteria for determining whether a service is preventive or problem-oriented? Callaway says: First, consider the reason for the visit. Was it to have an annual exam? If yes, then next consider how the visit addressed the patients chronic problems. If the patient is stable in all areas, then again it is considered preventive. To be considered problem-oriented, even for part of the visit, you must document significant information related to the problem.

But what if a patient comes in for an annual exam as follow-up for the management of a chronic medical condition (e.g., diabetes or hypertension), yet is asymptomatic? Would Medicare consider it a covered service?

Regional interpretation may differ. In Florida, for example, Medicare says that if a physician is actively treating a chronic condition, E/M services associated with the monitoring and updating of an ongoing treatment plan are covered services. However, services rendered to asymptomatic patients not being actively treated are considered screening and are not covered.

For example, a patient who is taking medication for hypertension comes in for an annual physical. The internist determines the hypertension is stable and advises the patient to continue taking the current medication. The portion of the exam that is related to the hypertension can be carved out of the preventive care visit and billed to Medicare as a covered service (i.e., 99212).

If the patient has multiple chronic conditions, all stable but under active treatment, the level of sick E/M will increase. The level of E/M would be based on the elements of the history, exam and medical decision- making that are related to the chronic conditions.

As a safeguard, ask your local Medicare carrier for guidelines, and try to get their response in writing.

Find Out Patients Intentions Beforehand

Callaways perspective is shared by **Carol Schobert, MD,** a practicing internist in a 15-physician outpatient office in LaPorte, Ind. Its important for our practice to find out as much as we can about why the patient has come to our office before the face-to-face visit with the doctor starts, Schobert says. If its strictly a physical, we want to determine that beforehand. If theres a problem, and it seems that almost every patient has some chronic complaint, then we have to look at carving that out as a separately identifiable service. I want to know as much as possible about what direction Im heading, medically speaking, before I get started.

In Schoberts office, this is accomplished at just about every previsit point of contact with the patient. When a patient phones to schedule an office visit, the receptionist tries to draw out as much relevant information as possible about the reason for the visit. Then when the patient comes to the office, this process is repeated at the reception desk to confirm whats already known and to probe diplomatically for further information. If theres any doubt, the patient is asked to sign a waiver accepting financial responsibility in case insurance claims are denied. Finally, a nurse reviews all the

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information about the reason for the visit again, and further questions are asked after the patient is taken to an exam room.

It really helps to keep us all on track, Schobert says. I like to know where I stand, and I want the patient to know where he or she stands. Preventive visits tend to get more complicated if there are problems. If we can anticipate those problems, everybodys better off.

Put the Split-bill Process to Work

Its important for internists to know what should or should not be broken out of a preventive service. For example, a 48-year-old woman makes an appointment for a preventive visit. During the checkup she complains of recent lethargy and increased thirst. Concerned that the patient may be developing diabetes, the internist focuses part of his examination on these symptoms and orders the appropriate lab work. This encounter should be coded as a split bill: Preventive code 99396 (established patient, periodic preventive medicine, 40-64 years) and diagnosis code 250.0 (diabetes mellitus without mention of complication) should be reported along with the appropriate level of E/M visit for an established patient (i.e., 99212 or 99213). Modifier -25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) would be attached to the E/M code.

Note: Modifier -25 is never attached to a procedure or other preventive service.

Callaway emphasizes the importance of internists to document clearly occasions when a preventive visit includes E/M services so coders can report complete charges for reimbursement. Its very important to keep the note for the sick visit completely separate from the well visit documentation, she says.

Time Becomes a Key Component

According to the AMA, since no examination or decision-making took place, the key component becomes time. CPT 2001 specifies: When counseling and/or coordination of care dominates more than 50 percent of the physician/patient encounter (face-to-face time in the office or other outpatient setting), time may be considered the key controlling factor to qualify for a particular level of E/M service. The extent of the counseling and/or coordination of care must be documented in the medical record. For example, codes 99212-99215 typically require 10, 15, 25 and 40 minutes respectively.

The AMA says to bill a brief preventive visit (not including comprehensive history or exam) with office visit codes rather than adding modifier -52 (reduced services) to a preventive visit.

Callaway says thats good advice, but she also suggests asking local carriers how they want limited preventive visits billed. The AMA doesnt pay the claims, she says. So, check with your carrier.

Determining Fees

Medicare encourages internists to charge the patient the difference between their E/M fee and preventive service fee. This way, when Medicare and the patient pay, the physician has received payment for the preventive service.

Callaway says that with Medicare, Diagnosis is the absolute key and all preventive service codes must be linked to a V code. Check with your local carrier about accepted V codes because they vary.

For example, when using modifier -25 to break out an office/outpatient visit, list the preventive service code first without any modifier, followed by an approved diagnosis code (e.g., V70.0, routine general medical examination at a health care facility) for the routine physical. Dont use a sick diagnosis code here. Next, list the office visit with modifier -25 attached to designate that the service is separate from the preventive service. Finally, list the diagnosis codes for the problems treated during the sick visit and list any additional procedures performed or lab tests ordered.

Educate Patients on Payment

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The biggest adjustment internal medicine practices must make with preventive services is educating their patients. Circumstances will vary according to each patients coverage, but for preventive services and associated screening tests, some financial responsibility must be borne by the patient, otherwise some claims just wont get paid.

Callaway suggests two strategies in raising patient awareness:

Create a brochure that plainly outlines policies for problem-oriented and preventive services. State the practices commitment to correct coding and reporting these services and make sure every patient gets a copy of the brochure and understands whats in it before services are rendered. When theyre being shown to the exam room, the nurse should ask if the patient has any questions about the updated payment policies.

Have the patient sign a waiver (usually an advanced beneficiary notice [ABN]) in advance of service that commits him or her to accepting personal responsibility for payment if a claim is denied.

Audiotapes of Susan Callaways teleconference presentation, Develop Correct Coding Policies for Preventive Care Services, can be ordered from the Coding Institute at **www.codinginstitute.com/teleconference** or by calling customer service at 800-508-2582.

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