

## Internal Medicine Coding Alert

### Maximize Your Reimbursement for Annual Physicals on Medicare Patients

Annual preventive-medicine visits for patients with several chronic medical problems should not be coded as high-level sick visits.

Because internal medicine practices see a large percentage of elderly Medicare patients, accurately reporting annual preventive-medicine visits can be a challenge.

Many of the Medicare patients who go to see an internist have multi-system disease in addition to needing an annual physical, explains **Bonnie Lewis, RN, CPC**, a coding specialist and consultant to the Idaho State Medical Association in Twin Falls, ID.

Internists often misreport annual exams for these patients in one of two ways:

Many miscode the visit as a high-level office/outpatient E/M service (99214-99215, established patient; 99204-99205, new patient) because they evaluated several different body systems to monitor the patients chronic medical problems.

Or, some misreport the visit by using only the age-based preventive medicine codes (99391-99397) to report the entire visit, which might have included a problem-focused exam as well.

#### Correct Coding and Compliance Issues

In the first example, the practice can draw a Medicare audit and may actually be committing Medicare fraud if the visit was primarily an annual visit to check on the patients progress and not warranted by significant problems or changes to the patients existing conditions, warns **Susan Stradley, CPC**, a senior consultant with the accounting firm of Elliot, Davis and Co., in Augusta, GA.

I argue with physicians all of the time about this, she says. A lot of internal medicine doctors argue that because a Medicare patient has multiple problems the visit does not fall into the category of preventive care. But, if the patient is there telling you, I dont have any major problems or any changes to existing conditions, then you cant charge for treating conditions that the patient is not complaining about.

In the past, Medicare has not been strict about enforcing the distinction between a preventive service and a sick visit. And, because Medicare does not pay for preventive physicals, patients often pressured the physician to find a way to report the exam as a problem-oriented visit. However, in this era of heightened attention to fraud issues and enforcement, internists cant be too careful.

At some point, if you are billing 99215 a lot for Medicare patients, then the carrier will get a clue about what you are doing, she continues.

If an audit of patient charts reveals preventive-medicine services reported as high-level office/outpatient E/M visits, then your practice could face a demand of repayment and fines and, in extreme cases, a criminal fraud charge, Stradley adds.

At the other end of the spectrum, the error in the second example occurs mostly when a physician simply writes annual exam on the patient chart in addition to his documentation, resulting in a visit that is reported with just a preventive-medicine code, as a true annual physical should be, Lewis says.

We use slang terms such as annual physical and we write it in the appointment book and the doctor says, Bessie Jones is here today for her annual physical. But then the whole body of the report is laced with indications the patient is also treated for new illnesses or problems, too, she explains. If you are fortunate, you have an astute coder who reads the documentation and recognizes that what was actually performed was an annual preventive-medicine service and an evaluation for multi-system disease.

The internist can be losing out on an opportunity to bill Medicare for the problem-focused exam, which would be covered, and relying solely on the patient to pay for the preventive-medicine exam, which is often unlikely.

### **Carve Out Problem-Focused Exam from Preventive Medicine Services**

If a Medicare patient presents for an annual preventive medicine exam, but then turns out to have new problems or significant complications to existing ones, the visit should be carved out into two services and reported with two CPT codes, advise Stradley and Lewis.

Medicare says, We recognize that what you are doing as an overall service is a head-to-toe evaluation, but we are willing to pay you for the part of the exam that concerns a significant problem, Stradley explains.

The key here is that the patient must actually come into the office with a significant medical problem, she adds. CPT even says that minor adjustments to existing conditions are outside; they don't count extra, Stradley notes. You have to have significant changes to current conditions or have completely new problems in order to consider billing a problem-oriented service.

For example, says Lewis, a patient comes to the office for his annual physical, but also has complications with his hypertension and diabetes, which the internist evaluates and recommends changes in treatment.

The correct way to report the total service would be to code the preventive-exam portion using the preventive-medicine code for the patient's age (99381-99387, new patient, and 99391-99397, established patient), then carve out the diagnosis, history, examination and medical decision-making elements that are related to hypertension and diabetes complications to assign an office/outpatient E/M code, she says.

This would probably be a 99213 or maybe a 99214, adds Stradley. You would probably end up with a lower-level E/M code to report in addition to the preventive-medicine code.

The practice should also report two different ICD-9 codes for the visit, continues Lewis. You would have a V code linked to the preventive CPT code, indicating a preventive-medicine exam, and a separate diagnosis code for the problem(s) evaluated that would be linked to the office/outpatient E/M code.

Correct linkage of ICD-9 codes is also important when diagnostic or screening procedures are performed.

If you performed an EKG as part of the patient's routine annual screening, then the procedure code for the EKG (93000) would be linked to the V code, says Lewis. But, if it were performed to evaluate a specific problem, then it should be linked to the problem diagnosis.

Note: This can also make a difference in whether the procedure is covered. Medicare may not pay for screening tests and procedures, but will pay for them if they are diagnostic and linked to a diagnosis code that is on the carrier's list of covered diagnoses for that procedure.

### **How to Bill**

Because Medicare does not cover preventive-medicine exams, the charge for these physicals is the responsibility of the patient. But, the portion of the service that is problem-focused, and reported with the office/outpatient code, can be billed to Medicare, note Stradley and Lewis.

However, because both of these services took place during the same office visit, Medicare has specific regulations about how the visit can be billed.

The bill for the two E/M codes cannot total more than what the internist would normally charge for a preventive-medicine physical, says Lewis.

For example, say the offices normal charge for a preventive-medicine exam is \$125, and the part that is carved out as a problem-focused exam is worth \$50. The practice should bill the E/M office/outpatient to Medicare and expect the carrier to pay the \$50, minus the patients \$10 co-pay. The patient would then be billed \$75 for the preventive-medicine visit, which is the difference between what Medicare would cover and the total charge for the preventive-medicine visit. The patient would pay \$85 (including the \$10 co-pay) and Medicare would pay \$40.

The practice should still receive the total amount it would normally receive for a preventive-medicine physical, but not what it would receive for these two codes separately, says Lewis.

You are not getting more money for these services, but at least you aren't losing money on the visit, she says.

### **Use of the -25 Modifier and Waivers**

Of course, in order to get paid for the two CPT codes, the first E/M code should have the -25 modifier (significant, separately identifiable service or procedure by the same physician on the same day) attached, indicates Lewis.

And, the practice should decide whether or not to have the patient sign an advance beneficiary notice (ABN), she adds. Because this (an annual preventive exam) is a non-covered service, you are not required to get a waiver signed in order to bill the patient because this service is never covered, she explains.

ABNs are only required by Medicare when the service is a covered service but may be denied due to medical necessity, she says. For example, many diagnostic tests are only covered when they are performed in association with particular diagnoses.

You might want to consider getting a waiver signed anyway because this is a confusing area for both the practice and the patient, she says. Many patients are used to having Medicare pay for everything. Particularly, with preventive visits, we need a lot more patient education in this area. I would be in favor of getting a waiver, just to be sure the patient was aware that they would be responsible for some portion of the visit bill.

Note: In the event that you need a waiver, or want to have a patient sign one just to be sure, check your Medicare carriers policy manual. Carriers often indicate the language they want used in an ABN, and may require different language in waivers for different exams or tests. If your carrier later deems your ABNs to contain improper language, they will be invalid and you will have to reimburse patients what they were charged.