Internal Medicine Coding Alert

Pay Attention to 5-Year Rule for Cardiovascular Screens, or Risk Denials

ABN protects you if patient forgets last screening date

Medicare patients who report to your internist for cardiovascular screenings are probably expecting the carrier to pay for the test. But the beneficiary or your office will be left footing the bill unless you correctly choose from four screening codes, use an approved V81.x code, and observe strict frequency guidelines.

In 2005, Medicare started covering cardiovascular screening blood tests (at proscribed intervals). Check out this information on cardiovascular screening test types and how to code for each of them.

Choose Lipid Panel Code When Doctor Performs 3 Screens

Patients who are at risk for certain types of heart disease -- such as coronary artery disease or peripheral arterial disease -- often require cardiovascular screenings, says **Mary Franklin,** coding/billing specialist at Virginia Medical Alliance in Springfield.

There are four types of screenings available to internists, says **Sean M. Weiss, CPC, CPC-P, CMPE, CCA-P, CCP-P,** senior partner at The CMC Group LLC in Atlanta. The test the internist performs (or orders) will depend on the patient:

- **Total cholesterol.** This test measures the patient's total cholesterol. Code these screenings with 82465 (Cholesterol, serum or whole blood, total).
- **Cholesterol test for high-density lipoproteins.** This test checks the patient's level of "good" cholesterol. Code these screenings with 83718 (Lipoprotein, direct measurement; high-density cholesterol [HDL cholesterol]).
- **Triglycerides.** This test checks the patient's triglyceride levels. Code these screenings with 84478 (Triglycerides).
- **Lipid panel.** Although your internist might perform one of the above screens individually, he could also perform all three of the tests as a panel in the same session, Weiss says. When the internist performs total cholesterol, cholesterol test for high-density lipoproteins and triglycerides in the same encounter, report 80061 (Lipid panel) for the service.

Verify CLIA Cert Before Testing

Internal medicine practices without a waived status Clinical Laboratory Improvement Amendments (CLIA) certification can forget about reporting the above cardiovascular screening codes. "If a provider's office does not have a CLIA certification or other lab certification, they are not able to provide the [cardiovascular screening] service or bill for it," Weiss says.

Only internal medicine practices with CLIA-waived status should perform cardiovascular screening tests. If you code for a CLIA-waived practice, remember to attach modifier QW (CLIA-waived test) to cardiovascular test codes to indicate you are billing for a waived test.

Suppose a patient reports to a CLIA-waived internal medicine practice. The physician conducts a total cholesterol test. You should report 82465-QW for the service. (For more information on CLIA-waived status, see "Discover How Waived

Status Can Impact the Bottom Line" on page 71.)

Including V Code a Necessity

No matter what test the internist runs on the patient, Medicare requires you to include one of these diagnosis codes on the claim. You are likely to receive a payer denial without one of these codes:

- V81.0 -- Special screening for ischemic heart disease
- V81.1 -- Special screening for hypertension
- V81.2 -- Special screening for other and unspecified cardiovascular conditions.

Example: A Medicare patient reports to the internist for a cardiovascular screening to check for hypertension. The physician performs a lipid panel. On the claim, report 80061 with V81.1 appended to prove medical necessity for the test.

Observe Frequency Guidelines or Face Denials

Internal medicine practices that conduct cardiovascular screenings for Medicare patients also need to be aware of frequency guidelines for the tests, Franklin says.

The basics: Medicare will pay for **one** cardiovascular screening every five years for its patients, Weiss says. Carriers will deny your screening claims if "there is already evidence of a paid claim within the prior 60 months with a diagnosis code of V81.0, V81.1 or V81.2, along with a procedure code of 80061, 82465, 83718, or 84478," he says.

So if a Medicare patient had a total cholesterol screen (82465) today, he would not be able to have **any** covered cardiovascular screens (82465, 83718, 84478, 80061) for five years. And you have to make sure it has been at least five years since the last screen, Weiss says.

If the physician performs the screening even one day prior to the expiration of the five-year "between test" period, Medicare will deny the service on the basis of frequency guidelines. Medicare payers "are sticklers for dates," Weiss says.

For more information on determining a beneficiary's eligibility for Medicare preventive services, see www.cms.hhs.gov/MLNProducts/downloads/Preventive_Services_Eligibility.pdf.

Cover Your Bases With a Signed ABN

Experts recommend that you formulate an advance beneficiary notice (ABN) for patients who get cardiovascular screenings. That way, if the payer denies payment of the screening, you can make sure the patient will be responsible for the bill.

Otherwise, the office will have to pay whatever part of the bill Medicare won't cover. This is sound practice for internists who perform screenings with frequency guidelines -- just in case the patient has had a screening in the past five years that he forgot to tell you about.

For example, the internist sees an established patient and performs a lipid panel to check for cardiovascular disease. The patient reports that he has never had a lipid panel before. However, the patient's file indicates that another physician

performed a Medicare-covered total cholesterol screen for him three years ago, making him ineligible for a covered lipid panel.

If you do not have a signed ABN from the patient, you will not be able to bill him for the lipid panel if Medicare decides not to pay.