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Internal Medicine Coding Alert

Protect Reimbursement for Lab Tests and Preventive Services

Although Medicare does not cover most preventive services, it does cover a pelvic examination and pap smear once every three years for most patientsmore frequently if the patient is deemed at high-risk for these types of cancer. A specific HCPCS code, G0101 (cervical or vaginal cancer screening; pelvic and clinical breast examination), is used to report the examination to Medicare.

A female Medicare patient is seen in your internists office for the first time for evaluation of hip pain after a fall. While reviewing the medical history, the physician discovers that the patient cannot remember the date of her last Pap smear or screening for vaginal or ovarian cancer. The patient believes it may have been two years ago, but it could have been three or four years. So the physician performs a pelvic examination and Pap smear to screen for these possible diseases.

In this case, if the patient, who does not meet Medicare criteria for being high-risk, has not had a cervical or vaginal cancer screening in the past three years, the service will be paid by Medicare. If it has only been two years, the service is not covered.

According to Medicare guidelines, the practice can inform the patient that the service may not be covered and ask them to sign a form stipulating that she will be responsible for payment if that service is denied. This form is known as an advance beneficiary notice (ABN) or waiver of liability.

You only have to use it when it is a service that you may have to bill the patient on, explains **Susie Taylor, CCS-P,** senior consultant with Hill and Associates, a practice management consulting firm based in Roanoke, Va. Medicare doesnt want to see a waiver used when there is no concern that the service would not be covered, and when the service is a noncovered service that Medicare would not cover at all.

A signed waiver is the only way a practice can bill a Medicare patient for a service that Medicare does cover, but is denied because the carrier deems it not to be medically necessary for that patient at that time, she adds. If you dont have a waiver signed, you cannot bill the patient.

For internal medicine practices, this issue comes up most often when a patient receives covered lab tests or diagnostic procedures, but for a noncovered diagnosis. The tests are covered by Medicare, but only for specific diagnoses on a list compiled by the carriers.

When the practice does have a waiver signed, the code for the service or procedure in question should be reported with the HCPCS -GA modifier (waiver of liability statement on file) attached.

In the above example, the following codes would be reported: An office/outpatient E/M code for the appropriate level of service (99201-99205, new patient); and G0101-GA.

Other Uses of Waivers

Although the waiver of liability is required in certain circumstances, many practices use a similar form for their patients who are covered by private insurance.

Many offices go ahead and work up a similar waiver form to use with their commercial carriers as well, just as something to use in the office so that the patient understands that they are responsible for paying if their insurance doesnt cover something, says Taylor.

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And many practices have patients sign waivers when the patient receives a service or procedure that is never covered by Medicare. For example, Medicare does not cover annual preventive medicine health examinations. But many groups have patients sign a waiver prior to these visits to be certain that the patient understands that they will be responsible for the cost.

It is difficult for the patient to understand the difference between a preventive medicine office visit and a visit that would be covered, notes **Garnet Dunston, CPC, MPC,** president and CEO of Dunston Enterprises Inc., a medical practice management, coding and reimbursement consulting firm in Phoenix. Especially if the patient is a new Medicare patient, their private insurance may have covered this service the previous year, and they do not realize Medicare does not. I would also add that the nurse or receptionist who makes the appointment should inform them that they will be responsible for the bill.

Waivers that are signed just for the patients convenience and for the offices peace of mind should not be reported on the claim form, says Taylor. You would not want to indicate to Medicare that you have a waiver on file for a never-covered service because it is not necessary, she says. But you wont get in trouble for it. The only thing that will get you in trouble is not having the patient sign a waiver and then trying to bill the patient.

Dunston does recommend reporting the waiver when it is used with standard preventive medicine visits, however, because in many cases a valid E/M code is billed along with the preventive medicine service. For many Medicare patients who come in for their annual physical, they may also report a complaint, she notes.

Medicare allows the physician to bill an office/outpatient code (99211-99215, established patient, 99201-99205, new patient) in addition to a preventive medicine service (99381-99387, new patient, 99391-99397, established patient). Medicare will pay for the regular office/outpatient service, with the patient responsible for the portion of the visit that is preventive medicine.

Note: For more information, see the article, How to Bill an Annual Physical and E/M on the Same Day, on page 19 of the March 2000 Internal Medicine Coding Alert, and the article, Maximize Your Reimbursement for Annual Physicals on Medicare Patients on page 33 of the May 1999 issue.

Because both services, represented by two codes, occur at the same physician visit, the waiver is a good way to make sure the patient understands what service will be covered by Medicare and what they will be responsible for, Dunston says. In some cases, part of the visit will be covered by Medicare and part will not.

Taylor advises practices not to have a waiver signed for every service just in case it is not covered at that visit. Medicare wouldnt want to see the waiver used when there is no question that the service is covered for that visit, she says. That will draw their attention, and they will have questions, like What? Why was this done when it was not necessary? You should not have a Medicare patient sign a waiver every single time they come in.

Blanket Waivers Are a Definite No-No

To be a valid waiver of liability, the notice to the beneficiary must have three things:

1. It must specify the service that the physician believes may not be covered by Medicare;

2. It must state the reason the physician believes the service will not be covered for this visit; and

3. The waiver must be signed by the patient on the date the service is performed.

Although practices may have waivers signed even when they are not required, Medicare does not recognize blanket waivers, or waivers that are designed to cover the patient for a variety of procedures and services that may or may not be paid, says Taylor.

For example, if a patient comes in to get a repeated service, you cannot have a waiver that states services from this

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date to this date may not be covered and the patient will be responsible, she says. You have to have a waiver signed for each time a service is performed.

Some clinics she has worked with use one form for a repeated, specific service and then have the patient re-sign and re-date the same form each time they come in for that service. What they did was fill out the waiver and, at the bottom of the waiver, there are blanks for a new date and a place for the patient to sign again, she says.

When a Patient Refuses to Sign

Sometimes a patient will refuse to sign the waiver, even after being informed that Medicare may not pay, says Taylor. You can run into a person who just says, No, Im not signing it, because they do not want to be responsible for the charge, she says. You should still fill out the form and have the nurse sign it with their name and title and have another person witness it, basically affirming that the patient was fully informed and just refused to sign.

When you report the code for that service, you should still attach the -GA modifier (waiver of liability statement on file) as if the waiver were signed, says Taylor. It does not automatically mean that Medicare will allow you to bill that patient, but at least you have the back-up.

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