Codify
BY AAPC

Internal Medicine Coding Alert

You Be the Coder: Billing Preventive Examinations

Test your coding knowledge. Determine how you would code this situation before looking at the box below for the answer.

Question: Our internal medicine physicians are billing preventive examinations with sick examinations for Medicare patients. I know this is acceptable, but I am not sure about how to handle the discounted component when billing patients. Our doctors are not discounting the difference between what the sick exam costs and the preventive exam costs.

Anonymous Kentucky Subscriber

Answer: When a patient presents for a preventive visitan annual physical for examplethat service is not covered by Medicare. If the physician also treats a medical problem at that same visit, however, he or she is entitled to carve out the problem-oriented service and procedures and bill a separate evaluation and management (E/M) code to Medicare (99211-99215, established patient, or 99201-99205, new patient).

Note: For more information, see the article Maximize Your Reimbursement for Annual Physicals on Medicare Patients on page 33 of the May 1999 Internal Medicine Coding Alert.

The preventive medicine portion of the visit should be reported with a code for preventive services (i.e, 99391-99397). These services are not covered by Medicare and should be paid for by the patient. Because Medicare never covers these services, a waiver is not necessary. It may be a good practice for the physician group to have patients sign a waiver anyway, to ensure that the patient knows that he or she is responsible for this portion of the visit.

Medicare has special payment rules for these combined preventive service/problem-focused visits. The sick portion of the visit should be reported with the appropriate E/M code. The practice can bill this code to Medicare. The amount of reimbursement from Medicare for the sick portion of the visit should be subtracted from the physicians normal charge for the preventive medicine service (e.g., annual physical) with the difference billed to the patient. Basically, the practice cannot charge the patient for the full amount of the annual physical and then bill Medicare for the separate E/M. The patient should still only be responsible for the amount of the physical or other non-covered preventive service.

Caution: Medicare now covers certain preventive services on a limited basis. The services are reported with specific HCPCS codes. For example, pelvic examinations are now covered for Medicare beneficiaries once every three years (more often if the patient meets the Medicare criteria for high risk). The exam should be reported with HCPCS code G0101. You should check to ensure that the preventive service is not eligible for coverage before billing with a CPT code for a preventive-medicine exam.

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