Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Prevent 'Welcome to Medicare' Problems With 4 Simple Steps

Go with new G codes for proper reimbursement

The **Centers for Medicare and Medicaid Services** has jumped on the preventive services bandwagon, allowing physicians to better assess and screen future patients - and get paid for it.

Medicare is taking a more proactive approach to preventive care in 2005 by offering every new Medicare beneficiary a "Welcome to Medicare" (WTM) exam. The exam will allow physicians to evaluate the overall health of a patient and recommend covered screenings for heart disease, diabetes and glaucoma.

Details: The WTM exam includes an EKG, which you need to report separately. For CMS to cover the WTM exam, your physician must perform the service within six months of the patient's enrollment in Medicare.

1. Get to Know 4 New G Codes

CMS has created four new G codes for you to use when reporting a WTM exam - one code for the actual exam and three codes for the accompanying EKG.

When your physician performs a WTM exam on a new Medicare beneficiary, you should report G0344 (Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first six months of Medicare enrollment). The exam includes such basic points as the patient's height, weight, blood pressure, a visual acuity screening, a review of the patient's medical and social history, the patient's functional ability and level of safety, and an assessment of the patient's potential for depression.

Note: Be sure to link diagnosis code **V70.0** (Routine general medical examination at a healthcare facility) to justify the service to Medicare

2. Choose the Right CPT for the EKG

The WTM exam includes an EKG - and you'll need to select the appropriate G code for that service, depending on what portion of the EKG your provider performs. Choose from the following three new codes:

1. G0366 (Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report, performed as a component of the initial preventive physical examination) for the global EKG.

2. G0367 (...tracing only, without interpretation and report, performed as a component of the initial preventive physical examination) for the tracing only.

3. G0368 (...interpretation and report only, performed as a component of the initial preventive physical examin- ation) for the interpretation and report only, says **Mary I. Falbo, MBA, CPC**, president of **Millennium Healthcare Consulting Inc.** in Lansdale, PA.

   No EKG code when: If an outside physician performs the global EKG, then that physician needs to charge Medicare using global code G0366 and append the proper V code, V70.0, says **Charlene Burgette, BS, CMA, CMM, CPC, CCP**, an administrator for **North Scottsdale Family Medicine** in Arizona. Your physician, who only performs the WTM exam,

should document that he outsourced the EKG and include the EKG results in the patient's chart, she adds.

Scenario: Suppose your physician performs a WTM exam on a patient and then sends the patient to an outside facility for the EKG. When the EKG results are ready, your physician reads the tracing. You would code the exam with G0344 and also report the EKG's interpretation and report component with G0368, explains Falbo.

3. Bill an E/M and G0344 With Modifier -25

If a patient presents with a medical or mental problem requiring treatment during the same session as a WTM exam, you can report an office visit along with G0344, says Falbo. An initial CMS ruling stated providers could only report up to a level-two E/M service during the same session as the WTM exam. But so many physicians complained this was unfair that in the final ruling, no limits were placed on the E/M level allowed, Falbo explains.

Watch out: You should select the E/M code based on the patient's history with the physician, not with Medicare.

If your physician has seen the patient in the last three years, bill an established patient visit with 99211-99215 (Office or other outpatient visit for the evaluation and management of an established patient...) even though the patient is a new Medicare beneficiary. If your physician provides the service for a new patient, use 99201-99205 (Office or other outpatient visit for the evaluation and management of an new patient...).

Must-have modifier: Remember to append modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to the selected E/M code. And don't forget to link the proper diagnosis codes (hypertension, depression, etc.) to the E/M code as well.

Scenario: An established patient who your physician has seen in the last six months comes in three months after enrolling in Medicare for his WTM exam. The patient also asks the physician to look at a badly swollen finger he caught in a door two days ago. The physician examines the finger and determines it is only bruised and doesn't require X-rays. She then performs the WTM exam, has the office staff perform the EKG, and reads the report. You would code the exam as follows: G0344 and G0366 linked to V70.0, and 99212-25 for the E/M linked to 923.3 (Contusion of upper limb; finger) and 729.5 (Pain in limb).

4. Watch for These Reimbursable Medicare Screenings

During the WTM exam, your physician may recommend a number of screenings for the patient - many of which Medicare now covers. These screenings are not part of the WTM exam, and Medicare covers them separately if the physician orders them, says Falbo. Some of the covered screenings are:

4. Bone mass measurement: 76075 - Dual energy x-ray absorption (DXA), bone density study, one or more sites; axial skeleton (e.g hips, pelvis, spine)
5. Pelvic and breast exam: G0101 - Cervical or vaginal cancer screening; pelvic and clinical breast examination
6. Several types of colorectal cancer screenings, such as: G0107 - Colorectal cancer screening; fecal occult blood test, 1-3 simultaneous determinations
7. Pap tests: Q0091 - Screening Papanicolaou smear; obtaining, preparing, and conveyance of cervical or vaginal smear to laboratory

More preventive coverage: For 2005, CMS added coverage for two more preventive screening services: cardiovascular screening blood tests and diabetes screenings.

For cardiovascular screening blood tests, you should report 82465 (Cholesterol, serum or whole blood total), 83718 (Lipoprotein, direct measurement; high density cholesterol [HDL cholesterol]), 80061 (Lipid panel) and 84478 (Triglycerides) linked to V81.0-V81.2 (Special screening for cardiovascular, respiratory, and genitourinary diseases...).

For a diabetes screening test, you should submit 82947 (Glucose; quantitative blood [except reagent strip]), 82950 (...post glucose dose [including glucose]), and 82952 (...tolerance test, each additional beyond three specimens) linked to V77.1 (Special screening for endocrine, nutritional, metabolic, and immunity disorders; diabetes mellitus).

Warning: Make sure you check the frequency limits of the screening tests first. Bone mass measurement may only be done every 24 months for qualified individuals (but more often if medically necessary), while cardiovascular screening blood tests may be performed once every five
years.

No Raise in Reimbursement

Despite complaints from providers, Medicare has not increased the reimbursement for the WTM exam, reports Falbo. The reimbursement for G0344 is approximately $97, while global EKG code G0366 pays about $26. G0367 and G0368 are reimbursed at $17 and $9, respectively.