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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: You're Losing Big On G0344 Claims If You Don't Report Diabetes & Cardio Screenings Separately

Plus: Easy ways to reduce your "Welcome to Medicare" denials

Things aren't always as simple as they seem when coding for the "Welcome to Medicare" (WTM) exam--and that's why easy-to-make mistakes are still forcing many coders to forfeit due revenue and grapple with unnecessary denials.

You can stop costly oversights now by making sure to remove the following four errors from your coding as soon as possible.

Mistake #1: Forgetting To Report Separate Preventative Screenings

Don't give up the reimbursement your practice deserves. Remember that you can report all preventive screening tests separately in addition to G0344 (Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first six months of Medicare enrollment).

Fact: The **Centers for Medicare & Medicaid Services** recently released a Medlearn Matters article (MMA) which stresses that "the diabetes screening tests and cardiovascular screening blood tests are each stand alone billable services separate from the Initial Preventive Physical Examination (IPPE) or 'Welcome to Medicare' Physical Exam."

Know 3 Diabetes Codes

If your provider renders both G0344 and a diabetes screening test, you may be able to report:

• 82947 (Glucose; quantitative blood [except reagent strip]),

• 82950 (...post glucose dose [includes glucose]), and

• 82951 (...tolerance test, three specimens [includes glucose]).

First: Make sure that the patient qualifies for coverage of this screening: "Two screening tests per calendar year are allowed for patients with pre-diabetes, and one screening test per year for patients previously tested who were not diagnosed with pre-diabetes, or who have never been tested," says **Barbara J. Cobuzzi, MBA, CPC, CPC-H, CHBME** of **CRN Healthcare Solutions** in Tinton Falls, NJ. In case you're unsure, CMS defines "pre-diabetes" for coverage purposes in the same MMA (#SE0556), which you can find at www.cms.hhs.gov/medlearn/matters/.

Don't forget the Dx: You must link **V77.1** (Special screening for endocrine, nutritional, metabolic, and immunity disorders; diabetes mellitus) to the diabetes screening test codes in order to receive reimbursement.

Cardio Screening Gets Just 1 Code

If your provider renders a WTM exam and a cardiovascular blood screening test, you may be able to report 80061 (Lipid panel) in addition to G0344. Medicare beneficiaries are eligible for coverage of this screening test once every five years, Cobuzzi says.

Don't forget the Dx: To secure reimbursement for 80061, you must report a diagnosis of V81.0 (Special screening for ischemic heart disease), V81.1 (Special screening for hypertension) and/or V81.2 (Special screening for other and

unspecified cardiovascular conditions), Cobuzzi adds.

Reimbursement Opportunities: Learn This List

Reporting separate preventive screenings doesn't stop with diabetes and cardiovascular blood tests. There is a considerable list of other screening services that Medicare will cover separately in addition to G0344, Cobuzzi notes, and that list includes the following:

1. Pneumococcal, Influenza, and Hepatitis B vaccine and their administration;

2. Screening mammography;

3. Screening pap smear and screening pelvic exam;

4. Prostate cancer screening services;

5. Colorectal cancer screening tests;

6. Diabetes outpatient self-management training services;

7. Bone mass measurements;

8. Screening for glaucoma; and

9. Medical nutrition therapy services for individuals with diabetes or renal disease.

Note: There is one exception to the "report all screenings separately" rule. The WTM exam does include a visual acuity screening which is covered under G0344, so remember that no additional code is necessary for this requisite component of the exam.

Further information: MMA #SE0556 also provides details on whether a patient qualifies for a preventive screening test related to the WTM exam.

Mistake #2: Billing A WTM Exam For Pre-2005 Beneficiaries

Despite repeated reminders from CMS, some practices are still reporting G0344 and related services for beneficiaries whose Medicare coverage became effective before Jan. 1, 2005--and this only spells denials.

Key to success: Remember that the WTM exam "is a once-in-a-lifetime benefit that must be performed within six months after the effective date of the beneficiary's first Part B coverage, but only if such Part B coverage begins on or after January 1, 2005," states CMS in MMA #SE0556. For example, if your provider rendered a WTM exam on Jan. 20, 2005 to a beneficiary whose Medicare Part B coverage was first effective on December 1, 2004, then a claim for G0344 would not be valid.

Solution: Ask, ask and ask again. You can't ask your patients enough times when their Medicare benefits began--and whether they've had the WTM exam yet. This is especially important when you're dealing with snowbirds who receive their care from different physicians during the winter months, says **Catherine Brink, CMM, CPC,** president of **HealthCare Resource Management** in Spring Lake, NJ.

Patients who receive their care in multiple locations tend to get confused or forget which services they've had and where. And because you don't have a consistent record of their care and coverage, it's easy for a Part B beneficiary start date to get lost in the shuffle and cause you a denial.

Tricky: Many of the separately-billable screening tests that go along with the WTM exam may be covered even if the

beneficiary's coverage began prior to January 1, 2005. For example, your physician may perform a routine preventive service on an established Medicare patient who has had coverage for two years. If the physician orders a diabetes screening test or other screening that often accompanies the WTM, don't be fooled into thinking the service isn't covered just because you can't report G0344. For such a visit, you might report 82947 (Glucose; quantitative blood [except reagent strip]) for the screening, in addition to 99397 (Periodic comprehensive preventive medicine reevaluation and management...65 years and over) for the exam, assuming that the patient is eligible for coverage of the screening and hasn't exceeded her frequency limit.

Mistake #3: Failing To Use The Correct EKG Code

You may be among the many coders who accidentally choose the wrong EKG code to go along with G0344.

By statute, every WTM exam rendered must include a separately-billable screening electrocardiogram (EKG). But if you hastily report G0366 (Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report, performed as a component of the initial preventive physical examination) for a global EKG when your practice really only performed the interpretation and report--or nothing at all--you're headed for a denial. Even worse, you may secure undue reimbursement that could land you in hot water down the road.

Quick fix: Steer clear of this mistake by making sure your superbill and physician documentation clearly indicate which portion of the EKG your provider performed. Use G0367 if your facility performed only the tracing without the interpretation and report, and use G0368 if your physician performed only the interpretation and report.

Note: Even if your provider has recently rendered a diagnostic EKG (93000) on the patient, you still have to perform and bill for a screening EKG as a requisite part of the WTM exam.

Mistake #4: Reporting 99387 Or 99397 Instead Of G0344

This may sound like a beginner's mistake, but it's still costing coders denials. If you don't have the WTM exam clearly identified on your superbill and in your physician's notes, chances are you won't be able to tell which type of preventive exam to report.

Codes 99387 or 99397 (for new or established patient preventive medicine services on patients 65 years and over) are the logical choices if there's no special mention in your documentation of G0344 (Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first six months of Medicare enrollment).

Quick fix: If you haven't already, take the time to add G0344 to your superbill and make sure all your providers know to clearly label the WTM as such in their documentation.