Part B Insider (Multispecialty) Coding Alert

Part B Mythbuster: Calculate Fees Using Medicare's 'Carve Out' Rule

Applying this modifier alerts Medicare that you know the service.

Myth: You can't collect for both a preventive and sick visit during the same encounter.

Reality: To estimate what your practice should charge a Medicare patient when your doctor performs a preventive service as well as an E/M service at the same visit means applying the "carve out" rule. Depending on whether the patient's preventive exam is covered, your outcome will be very different.

For Medicare beneficiaries, you should take your normal charge amount of the preventive service **minus** the charge amount for the sick visit. This will give you the total amount you can bill the patient for the preventive part of the visit.

Example: A 66-year-old established patient comes in for her yearly pelvic exam. Last year when she presented for her annual exam, you billed Medicare for the breast, pelvic, and Pap, and it was reimbursed. Remember: "Medicare will pay for these services once every two years," says **Arlene J. Smith, CPC, insurance specialist at Tacoma Women's Specialists** in Wash.

Don't Double-Dip

When the physician enters the examination room, the patient complains of pain in her left-lower quadrant and blood in her stool. The physician documents an expanded problem-focused history regarding the problem, then completes the annual exam and collects a Pap smear specimen. He orders an abdominal ultrasound and performs an immunoassay test for fecal blood.

First, you would report a well-woman exam (99397, Periodic comprehensive preventive medicine re-evaluation and management of an individual including an age- and gender- appropriate history...) with modifier GY (Item or service statutorily excluded or does not meet the definition of any Medicare benefit) appended. Modifier GY tells Medi-care you know this is not covered, but you need a denial so the patient's secondary insurance will pay the non-covered portion, Smith says. Link this code to V72.31 (Gyne-cological examination).

Secondly, according to your physician's documentation, you might add 99213 (Office or other outpatient visit ...) with modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service). Link that with 789.04 (Abdominal pain; left lower quad-rant) and 578.1 (Blood in stool).

You must be vigilant about checking your documentation, as "you cannot use any part of the documentation for the preventive exam to determine the level of service for the E/M code," Smith says.

Tip: Ask yourself, "can I find enough carved-out history, exam, and medical decision-making to support an E/M service that is not part of the preventive care?" says **Barbara J. Cobuzzi, MBA, CPC-OTO, CPC-H, CPC-P, CPC-I, CHCC**, president of **CRN Healthcare Solutions**, a coding and reimbursement consulting firm in Tinton Falls, N.J.

Bottom line: In the above example, the patient's additional problems and the physician's additional work present sufficient reason to report the problem-oriented portion of the visit separately.

Do The Math

Calculate your fee: Suppose the office fee for 99397 is $150.

Your office also normally charges $75 for 99213.

If you're billing both a preventive visit and the office visit to Medicare, then you should subtract these amounts. In other words, the amount you can charge the patient for the non-covered portion is $150 - $75 = $75.

Translation: The $75 is what the patient owes for the non-covered service (or the amount you will be submitting to her secondary insurance). Don't forget: The patient will also be responsible for paying her share of the Medicare allowable and any applied deductible for the problem service.

Watch out: You **should not** charge $150 for the preventive visit and then also collect reimbursement for the office visit (99213).