Part B Insider (Multispecialty) Coding Alert

Physician Note: Medicare Offers Handy Tool to Ease Preventive Service Billing Burden

Plus: Part B therapy cap will be held off a bit longer, thanks to Congressional vote.

Between the IPPE, AWV, AAA, and beyond, you're probably confused at the alphabet soup of options when billing preventive services to Medicare. CMS feels your pain, and has released a quick reference chart that can ease your billing woes when you provide preventive care to Medicare patients.

The "Medicare Preventive Services Quick Reference Information: Preventive Services" chart can guide you through which services are billable, show you who is covered, and which CPT® and diagnosis codes to report.

For instance: If your practice performs an ultrasound screening for an abdominal aortic aneurysm (AAA), you'll report G0389 for this once-in-a-lifetime (per beneficiary) service, the chart explains. For services performed on or after Jan. 1, 2011, the coinsurance and deductible are waived for this visit.

Likewise, if your patient presents for a quantitative blood glucose test to screen for diabetes, the chart indicates that you'll report 82947 with diagnosis code V77.1, and you should not charge the patient coinsurance or deductible. Medicare covers this visit twice a year for pre-diabetic patients and once a year for patients with certain diabetes risk factors.

To access the chart, visit the CMS Web site at www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf.