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Part B Insider (Multispecialty) Coding Alert

Preventive Service Coding: CMS Sheds Light on Several Preventive Service Coding and Billing Mysteries

The agency won't provide a standard AWV diagnosis code.

It has never been simple to navigate the rules and regulations of CMS's preventive service payment structure, but the agency has attempted to simplify the process with a new publication that outlines the ins and outs of collecting for these visits.

Although you'll now have access to all of the preventive service specs in one place, it won't be a quick read. The new document, entitled, "The Guide to Medicare Preventive Services," is 298 pages long. To read the complete book, visit www.cms.gov/MLNProducts/downloads/MPS_guide_web-061305.pdf. But in the meantime, we've distilled the guidebook down to share the most essential issues that you'll need to code these services.

For 'Welcome to Medicare' Exam, You Must Document 7 Components

Call it what you will--the "Welcome to Medicare," the "WTM," the "Initial Preventive Physical Exam," the "IPPE," or any other moniker, but the service is the same. When a new patient enrolls in the Medicare Part B program, he is entitled to a one-time preventive physical. Practices should report this service using G0402 (Initial preventive physical examination). If you report an ECG with the WTM physical, you'll also report a code from the G0403-G0405 range.

Although most practices have the coding aspect of the WTM down pat by now, the documentation requirements still tend to trip up some physicians. Your documentation for this service "must show that the physician and/or qualified non-physician practitioner performed, or performed and referred, all seven required components of the IPPE," the Medicare guide says. Those seven requirements are as follows:

1. Review the beneficiary's medical and social history with attention to modifiable risk factors for disease detection (e.g., drug use, diet, family history, past medical and surgical history, etc.)

2. Review the patient's potential risk factors for depression and other mood disorders (to detect current or past experiences with mood disorders)

3. Review the beneficiary's functional ability and level of safety (checking for hearing impairment, falls risk, etc.)

4. An examination (including visual screening, vitals, and other factors)

5. End-of-life planning (such as advance directives)

6. Education, counseling, and referral based on the previous five components (e.g., weight counseling, smoking cessation)

7. Education, counseling, and referral for other preventive services (e.g., bone mass measurements, colorectal cancer screening)

Tip: You might consider turning these seven requirements into a checklist so your physician can be sure that she goes over each of them during the WTM visit.

CMS Does Not Require Particular AWV Diagnoses

Now that most Part B practices are getting comfortable with reporting annual wellness visits (AWVs), which went into

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effect on Jan. 1, many coders are curious about which ICD-9 code CMS would like to see on the claims. But the agency has not specified any particular diagnosis that it wants you to report with the AWV (G0438-G0439).

"Medicare providers should choose an appropriate ICD-9- CM diagnosis code," the Medicare book notes. "Contact the local Medicare Contractor for further guidance."

Not a physical: Also, it's important to remind your patients that "the AWV is a preventive wellness visit and is **not** a routine physical checkup," the CMS guide stresses. "Medicare Part B does not provide coverage for routine physical examinations."

Therefore, it's important to use the language "wellness visit" when discussing the appointment with your patients so they don't continue to erroneously think they're getting a free physical. Instead, the AWV allows the physician to create a personalized prevention plan for patients.

Wait 11 Months Between Screening Mammograms

Most Part B practices know that Medicare will cover screening mammograms (G0202, 77052, 77057) annually, but some are confused about the specific amount of time that must lapse between visits. CMS lays out the specs about screening mammograms in its new publication, noting that it will pay for these services under the following circumstances:

- No screening mammography payment for patients 35 years of age or younger
- Baseline screening for women ages 35 through 39
- Annual screening for female patients age 40 and older -- 11 months must pass between screening mammograms

You won't need a physician's prescription or referral for a screening mammogram to be covered by Medicare. Instead, MACs base coverage determinations on the woman's age and the frequency parameters. (You do, however, need physician orders for diagnostic mammograms, which are not considered a "preventive" benefit).

Avoid These Common PSA Denial Reasons

Physicians who provide prostate cancer screenings via PSA blood tests (G0103) or digital rectal exams (G0102) can collect their reimbursement for these procedures by avoiding these most common denial reasons:

- The beneficiary is not at least 50 years of age or older (coverage begins the day after the patient's 50th birthday)
- The patient has received a covered PSA/DRE during the past year. Make sure at least 11 months have passed following the month in which the last Medicare-covered screening PSA or DRE was performed before billing another.
- The patient had a covered E/M service on the same day as the DRE from the physician. Payment for screening DRE is already bundled into E/M payment when performed on the same date.

Take Two (Years) Between Bone Density Screenings

When determining whether a patient qualifies for a Medicare-covered bone density screening, you should confirm that two years have passed since the patient's last bone density test.

Although many practices think of osteoporosis risks of existing mainly in female patients, Medicare does cover both genders under this benefit. The following six coverage requirements must be met to collect for bone density screening tests:

1. The test is performed on a "qualified individual." This refers to one of the following types of patients:

- An estrogen-deficient women at clinical risk forosteoporosis
- A patient with vertebral abnormalities on x-ray indicative of osteoporosis, osteopenia, or vertebral fracture
- Someone with known primary hyperparathyroidism
- A patient being monitored to assess response to or efficacy of an FDA-approved osteoporosis drug therapy

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2. The treating physician must provide an order for the bone mass test

3. The service is performed with a bone densitometer or a bone sonometer, for the purpose of identifying bone mass, detecting bone loss, or determining bone quality. A physician has interpreted the procedure's results

4. A qualified supplier or provider has furnished the service under the appropriate supervision level

5. The service is reasonable and medically necessary to diagnose, treat, or monitor the patient

6. The service meets frequency requirements.

If you're confident that you've met the criteria, you'll report the screening with either G0130 (SEXA bone density study) or the appropriate code from the 77078- 77082 range (bone density study).

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