Coding Preventive Care Services

by Dianne Wilkinson, RHIT

According to the Partnership for Prevention—a program-based organization of businesses, nonprofits, and government agencies—"the U.S. health care system suffers a quality deficit in part because too many patients do not get the effective preventive care they need when they need it."[1] The organization cites the potential to save more than 100,000 lives annually by simply increasing the use of just five preventive services, including providing smoker counseling and assistance to quit and breast screening for women.

Submitting claims for preventive medicine services can be a challenge, and not all third-party payers reimburse them. This article reviews Current Procedural Terminology (CPT) coding and reimbursement practices for preventive medicine services provided in the physician office setting.

Coding Guidelines for CPT Preventive Medicine Services

In CPT, preventive medicine services are represented in evaluation and management (E/M) codes 99381–99429. These E/M codes may be reported by any qualified physician or other qualified healthcare professional.

CPT codes 99381–99397 for comprehensive preventive evaluations are age-specific, beginning with infancy and ranging through patients age 65 and over for both new and established office patients.

Documentation requirements for a preventive visit such as an "annual physical" include an age- and gender-appropriate history and physical examination, counseling or anticipatory guidance, and risk factor reduction interventions. CPT codes for immunizations and ancillary studies such as laboratory and radiology are reported separately. The preventive medicine comprehensive examination documentation requirements represent significant work for the physician or other provider, and payer fee schedules appropriately reflect that work.

CPT codes 99401–99409 report counseling risk factor reduction and behavioral change intervention services provided at an encounter separate from the preventive medicine examination. Individual preventive medicine counseling codes 99401–99404 are used to report counseling services in areas such as family problems, diet, and exercise.

New 2008 CPT codes 99406–99409 for individual behavioral change are available to report intervention services for patients with a behavior typically regarded as an illness, such as smoking or obesity. Group counseling and other preventive medicine services are reported with codes 99411–99429.

Reimbursement Practices

Physician practice office staff can encounter administrative challenges for accurate claims submission for preventive medicine services. Unfortunately not all third-party payers reimburse for these services. Among those who do, coverage guidelines and policies can vary greatly from payer to payer.

If the physician practice has a large Medicare patient population, it is a challenge for all clinicians to stay current with the Medicare preventive medicine coverage policies. This is crucial, because physicians are most often the ones discussing coverage issues and presenting patients with advance beneficiary notices (ABNs) required by Medicare when the patient is likely to be held financially responsible for a service that may be denied due to coverage policy.[2]

For example, Medicare covers many preventive services and screenings such as cancer screenings, immunizations, and cardiovascular disease screening. The Medicare preventive services coverage policies include specific HCPCS/CPT and

ICD-9-CM codes for reporting types of beneficiaries who are covered, various screening coverage frequency, and beneficiary payment responsibility.

Also, with the exception of the one-time Medicare initial preventive physical exam, Medicare does not cover annual or "routine" physicals.[3] Therefore, Medicare does not provide reimbursement for the CPT comprehensive preventive medicine services codes.

Coding and Reimbursement for Medicare Same-Day Preventive Service and E/M Visit

In this example, described in the text, an established 67-year-old female Medicare patient presents for a comprehensive annual exam.

Same-Day Services	Physician Service Fee	Medicare pays	Carved out Reduced Fee	Patient pays
E/M preventive service 99397-GY	$200	$0 Noncovered service	$30	$30
Screening pelvic and breast exam G0101-GA	$50	$ Allowed amount		$ Copayment/co-insurance No deductible
Pap test collection Q0091-GA	$50	$ Allowed amount		$ Copayment/co-insurance No deductible
E/M problem-focused service 99213-25	$70	$ Allowed amount		$ Copayment/co-insurance Deductible

Tips for Coding Combined Preventive E/M and Problem-Oriented Service Visit

It seems logical for physicians to treat a patient's chronic or new illness during a preventive medicine office visit. However, this may present challenges related to coding and reimbursement under some third-party preventive medicine payer policies.

Physician practices that approach patient visit opportunities to deliver same-day preventive medicine care and problem-oriented chronic or new illness care should consider the following suggestions:

- Request third-party payer payment policies for providing a same-day office outpatient problem-oriented service during the course of a comprehensive preventive examination by the same physician. Perform internal claim audits to be sure you are receiving appropriate payment from each payer.
- At the beginning of a patient visit physicians should note the patient's specific payer preventive medicine coverage and reimbursement policy.
- Per CPT preventive medicine coding guidelines, "modifier 25 should be added to the Office Outpatient code to indicate that a significant, separately identifiable Evaluation and Management service was provided by the same physician on the same day as the preventive medicine service. The appropriate preventive medicine service is additionally reported."[4]

- As specified in CPT coding guidelines, physician documentation of the office outpatient problem-oriented E/M service should be significant and separately identifiable from the preventive medicine service.
- Be prepared to respond to payer requests for health record documentation to support the same-day preventive medicine E/M visit with an office outpatient E/M problem-oriented service.
- If needed, in writing, remind third-party payers of the importance of adhering to official CPT coding guidelines.
- In order to stay informed and take action on inappropriate payer payment practices, review the AMA advocacy and health plan settlements resource at www.ama-assn.org/go/settlements.

Medicare Same-Day Preventive Service and E/M Visit

An established 67-year-old female Medicare patient presents for a comprehensive annual exam including screening pelvic exam, breast exam, and screening Pap test. (For the purpose of this example, this patient is considered low risk under the Medicare preventive service coverage policy, and the screening pelvic and breast exams and collection of the Pap test are covered for this visit.[5]) During the visit a level III problem-oriented service is also performed for follow-up of hypertension and type II diabetes.

In this particular patient encounter there are services that are always covered by Medicare (level III E/M problem-oriented service), services that are not covered (comprehensive annual exam), and services that are covered under certain coverage conditions (screening pelvic and breast exams and screening Pap test).

When providing a noncovered preventive service to a Medicare patient on the same date as a covered preventive screening service and a covered E/M problem-oriented service, Medicare requires the physician to "carve out" the cost of any covered service from the charge for the preventive service.

As shown in the table above, modifier GY is appended to code 99397 to indicate a statutorily Medicare noncovered service. Modifier GA is appended to codes G0101 and Q0091 to indicate a valid ABN is obtained and on file. Modifier 25 is appended to code 99213 to identify a significant and separately E/M service was performed by the same physician on the same date of service as preventive screening services. All covered service fees (G0101, Q0091, and 99213) are deducted from the preventive medicine service.

Ensuring Coding and Claims Accuracy

Following are some additional important coding and claim processing points to ensure accurate preventive medicine service reimbursement:

- Include major third-party coverage policy, coding, and documentation training for all new staff who interact with patients and provide patient preventive medicine services. Stay current with major payer preventive medicine coding and billing regulations. Just a small change will affect the claims submission process and reimbursement.
- Incorporate preventive medicine services in ongoing compliance monitoring and education activities. Audits may also assist in identifying missed opportunities for reporting same-day preventive care in chronic or new illness visits as well as promote appropriate coding and billing practices.
- Design a dedicated ABN form, a form with the high risk criteria, a preprinted encounter form to contain all documentation required for coding and billing (whether on electronic records or not), and any other information sheets that will help explain coverage issues for preventive medicine visits to patients (especially to Medicare patients).
- During the process of obtaining the ABN, staff should clearly communicate information about services that will not be covered before the services are rendered. For example, some Medicare patients may refuse the full comprehensive preventive service when they learn routine physicals are not covered.
- If a patient requests that staff manipulate diagnostic codes (which were submitted correctly to the carrier the first time) in order to prevent paying for noncovered preventive services, emphasize that staff adhere to standards of ethical coding. Inform patients that this type of practice would constitute a false claim and explain the ramifications.
- When scheduling patient visits, clearly identify the reason for the visit. For example, determine whether the patient expects to receive a preventive medicine visit only or a same-day preventive medicine and a problem-oriented visit.
- Care must be taken to link screening diagnosis codes to screening procedure codes; otherwise Medicare will deny payment even if the particular screening service is a covered one. Likewise, a CPT diagnostic procedure code must be

linked to an ICD-9-CM diagnosis code for a problem or symptom in order to meet medical necessity requirements and receive payment.

As in the physician-patient relationship, HIM coding professionals are important advocates in the US preventive medicine initiative through sharing their coding, reimbursement, and compliance knowledge with clinicians, patients, and third-party payers. HIM coding professionals are in a position to promote the need for clinicians to participate in available physician quality improvement reporting initiatives that will contribute to vital quality national preventive care healthcare statistics.

Notes

1. Partnership for Prevention. "Preventive Care: A National Profile on Use, Disparities, and Health Benefits." 2007. Available online at www.prevent.org/images/stories/2007/ncpp/ncpp%20preventive%20care%20report.pdf.
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3. CMS. "Medicare and You." Available online at www.medicare.gov/Publications/Pubs/pdf/10050.pdf.
4. American Medical Association. *2008 AMA CPT Professional Edition*, Chicago, IL: AMA, 2007.
5. For applicable coverage policy, see CMS. "Quick Reference Information: Medicare Preventive Services. Available online at www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf.

Resources

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Dianne Wilkinson *(dianne@aeneas.net) is director of quality management at Med South Healthcare in Dyersburg, TN.*

Article citation:
Wilkinson, Dianne. "Coding Preventive Care Services" *Journal of AHIMA* 79, no.3 (March 2008): 80-82.