Making *Sense* of Preventive Medicine Coding

Find out how to properly code and bill for the preventive services you provide.

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CME
Covered in *FPM* Quiz

Preventive care is a cornerstone of family medicine. Routine visits for patients of all ages are scheduled to promote wellness and disease prevention. These visits can also include additional services, such as vaccinations, screening laboratory services, counseling and even management of medical problems. Understanding how to code and be reimbursed for all of these services can be challenging, especially since third-party payers' reimbursement policies on preventive services vary.

This article explains how to properly code and bill for the standard preventive evaluation and management (E/M) visit, the preventive E/M visit with a problem-oriented service, the preventive visit for a Medicare patient and the preventive counseling visit.

ILLUSTRATION BY ELIZABETH LADA

The standard preventive E/M visit

Specific preventive medicine services for a 25-year-old healthy female will be very different from those for a 55-year-old male and even a 55-year-old female, but the general components of a preventive medicine visit

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Preventive visits can include additional services, such as vaccinations, screening laboratory services, counseling and management of medical problems.

Understanding how to code and be reimbursed for these services despite third-party payers' varying reimbursement policies can be challenging.

CPT's preventive medicine services codes include a comprehensive history and exam, anticipatory guidance and counseling, the ordering of immunizations and procedures and management of insignificant problems.

The documentation guidelines don't apply to preventive medicine services.

according to CPT's preventive medicine services codes (99381-99397) remain the same:

- A comprehensive history and physical examination,
- Anticipatory guidance, risk factor reduction interventions or counseling,
- The ordering of appropriate immunizations or laboratory/diagnostic procedures,
- Management of insignificant problems.

The comprehensive history and examination performed during a preventive medicine encounter are not the same as the comprehensive history and exam that are required for certain problem-oriented E/M codes (99201-99350) and defined in Medicare's *Documentation Guidelines for Evaluation & Management Services.* In fact, the documentation guidelines don't apply to preventive medicine services. The history associated with preventive medicine services is not problem-oriented and does not involve a chief complaint or history of present illness. It does include a comprehensive review of systems, a comprehensive or interval past, family and social history, and a comprehensive assessment/history of pertinent risk factors. The preventive-visit examination is multisystem, but the precise content and extent of the exam is based on the patient's age, gender and identified risk factors.

Age-appropriate counseling and discussion of issues common to the age group are also included in the preventive medicine services. For example, issues related to contraception are discussed with women of child-bearing age, and anticipatory guidance is given to parents of pediatric patients. Review of safety issues, the need for screening tests and discussions about the status of previously diagnosed stable conditions are also considered part of the comprehensive preventive medicine service.

Although the decision to order immunizations or laboratory/diagnostic procedures is part of the preventive medicine service, the actual performance of those services should be billed separately. Therefore, if you provide an immunization or perform the laboratory study in your office, you should bill the services in addition to the preventive E/M visit.

Insignificant problems may be addressed as part of a preventive visit. For example, a patient seen in the spring or fall might request a prescription renewal for allergy medications. Unless significant work is required to assess this complaint, writing the prescription is included in the preventive medicine services code submitted for the visit. (See the example of a standard preventive E/M visit below.)

KEY POINTS

- Preventive medicine coding varies based on the type of visit – a standard preventive E/M visit, a preventive E/M visit with a problem-oriented service, a preventive visit for a Medicare patient and a preventive counseling visit.
- Some, but not all, payers will reimburse both preventive and problem-oriented services on the same date.
- Medicare does not provide reimbursement for CPT's preventive medicine services codes, but it does cover some screening services.

THE STANDARD PREVENTIVE E/M SERVICE: AN EXAMPLE

A 28-year-old established patient comes to your office for her well-woman examination. You take the patient's interval medical, family and social history and perform a complete review of systems. You also perform a physical examination that includes a blood-pressure check and thyroid, breast, abdominal and pelvic examinations, and you obtain a Pap smear. The patient is on oral contraceptives and has concerns about intermittent break-through bleeding. You counsel the patient regarding alternatives and give her a prescription for a new medication. You also counsel the patient about diet, exercise, substance abuse and sexual activity. Then you send the Pap smear to an outside laboratory that will bill the test directly to the payer. Although the patient has concerns about her current method of birth control, the associated counseling and change in medication is considered part of the preventive medicine service for her age group, so you should submit 99395, "Periodic comprehensive preventive medicine ..., established patient; 18-39 years," and ICD-9 code V72.3, "Gynecological examination."

Bill	Diagnosis code(s)		Procedure code(s)	
Patient	V72.3	Gynecological examination	99395	Preventive service

THE PREVENTIVE E/M VISIT WITH A PROBLEM-ORIENTED SERVICE: AN EXAMPLE

A 52-year-old established patient presents for an annual exam. When you ask about his current complaints, he mentions that he has had mild chest pain and a productive cough over the past week and that the pain is worse on deep inspiration. You take additional history related to his symptoms, perform a detailed respiratory and CV exam, and order an electrocardiogram and chest X-ray. You make a diagnosis of acute bronchitis with chest pain and prescribe medication and bed rest along with instructions to stop smoking. You document both the problem-oriented and the preventive components of the encounter in detail. You should submit 99396, "Periodic comprehensive preventive medicine ..., established patient; 40-64 years" and ICD-9 code V70.0, "Routine general medical examination at a health care facility"; and the problem-oriented code that describes the additional work associated with the evaluation of the respiratory complaints with modifier -25 attached, ICD-9 codes 466.0, "Acute bronchitis" and 786.50, "Chest pain" and the appropriate codes for the electrocardiogram and chest X-ray.

Bill	Diagnosis code(s)		Procedure code(s)	
Patient	V70.0	Routine exam	99396	Preventive service
	466.0	Acute bronchitis	99213-25*	Office outpatient E/M service for established patient
	786.50	Chest pain	93000	Electrocardiogram
			71020	Chest X-ray, PA and lateral

*The level of service represents only an example. The level reported should be determined by the documented history, exam and/or medical decision making.

The preventive E/M visit with a problem-oriented service

When a patient comes into the office for a routine preventive examination and also has significant new complaints (e.g., chest pain or irregular bleeding) and, in some instances, a new or established chronic condition (e.g., hypertension or type-II diabetes), the visit becomes a combination of preventive and problem-oriented care. As long as the problem-oriented service is clearly documented and distinct from the documentation of the preventive service, CPT suggests submitting a preventive medicine services code (99381-99397) for the routine exam and the appropriate office visit code (99201-99215) with modifier -25, "Significant, separately identifiable [E/M] service by the same physician on the same day of the procedure or other service," attached to the problem-oriented service. It's also especially important to link the appropriate ICD-9 code to the applicable CPT code in these cases to help distinguish between preventive and problem-oriented services. (See the example of a preventive E/M visit with a problem-oriented service above, and for more on ICD-9 codes, see "Using diagnostic codes effectively" on page 54.)

Note that the work associated with performing the history, examination and medical decision making for the problem-oriented E/M service will likely overlap those performed as part of the comprehensive preventive service to a certain extent. Therefore, the E/M code reported for the problem-oriented service should be based on the *additional* work performed by the physician to evaluate that problem. An insignificant or trivial problem or abnormality that does not require performance of these key components should not be reported separately from the preventive medicine service.

Reporting both preventive and problem-oriented services on the same date can often lead to inconsistent results.

Reporting both preventive and problem-oriented services on the same date can often lead to inconsistent results. While some payers will reimburse the full allowable amount for both the problem-oriented E/M code and the preventive medicine services code, some will assess a co-pay for each service, some will carve out the reimbursement for the problem-oriented E/M service from the payment for the preventive exam (which

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The precise content and extent of a preventive exam should be based on the patient's age, gender and identified risk factors.

When a preventive visit includes a problem-oriented service, CPT suggests submitting a preventive services code, an office visit code and modifier -25.

It's also important to link the appropriate ICD-9 code to the applicable CPT code to help distinguish preventive services from problem-oriented ones.

The work associated with the problem-oriented service will likely overlap that of the preventive service and should be coded accordingly.

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Depending on the payer, you may not be fully reimbursed for a preventive and a problem-oriented service performed on the same date.

To ensure at least some reimbursement, you can try reporting either the preventive medicine or the problem-oriented service.

Medicare does not provide reimbursement for CPT's comprehensive preventive medicine services codes.

However, it does provide reimbursement for certain screening services provided in the absence of an illness, disease, sign or symptom.

THE PREVENTIVE VISIT FOR A MEDICARE PATIENT: EXAMPLES

A 65-year-old established Medicare patient presents for her annual well-woman exam. Medicare covers the collection of a screening Pap smear and her pelvic exam and clinical breast check for that year. You should submit the following codes (and related charges) to Medicare: G0101 for the pelvic exam and clinical breast check, Q0091 for the collection of the Pap smear specimen and V76.2, "Special screening for malignant neoplasms; cervix"; and the following codes (and related charges) to the patient: 99397, "Periodic comprehensive preventive medicine ... established patient, 65 years and over," and V72.3, "Special investigations and examinations; gynecological examination." The total amount billed and received for this visit should equal your usual charge for an annual exam of $100.

Bill	Diagnosis code(s)		Procedure code(s)		Charge
Medicare	V76.2	Special screening for malignant neoplasms; cervix	G0101	Pelvic exam and clinical breast check	$36.60
			Q0091	Collection of Pap smear specimen	$37.70
Patient	V72.3	Gynecological examination	99397	Preventive service	$25.70
				Total amount billed and received	$100.00

An established Medicare patient presents for management of hypertension and preventive services. Medicare covers the full allowable amount for all reported services. You should submit the following codes and related charges to Medicare: G0101 for the pelvic exam and clinical breast check, Q0091 for the collection of the Pap smear specimen and V76.2; and 99213 for the established-patient office visit (with modifier -25 attached) and 401.1, "Essential hypertension, benign." The total amount billed for this visit should be $127.30.

Bill	Diagnosis code(s)		Procedure code(s)		Charge
Medicare	V76.2	Special screening for malignant neoplasms; cervix	G0101	Pelvic exam and clinical breast check	$36.60
			Q0091	Collection of Pap smear specimen	$37.70
	401.1	Hypertension, benign	99213-25*	Office visit	$53.00
				Total amount billed and received	$127.30

*The level of service represents only an example. The level reported should be determined by the documented history, exam and/or medical decision making.

results in a total charge that does not exceed that of a comprehensive preventive examination alone), and some will simply deny the claim on the basis that they do not accept coding for both a preventive and problem-oriented service on the same date regardless of the amount of the charge because, they say, you're billing twice for the portions of the preventive and problem-oriented services that overlap.

To ensure that you'll receive at least some reimbursement, you can try reporting either the preventive medicine or the problem-oriented service, depending on which of the two services was the primary focus of the visit and required the most significant amount of physician time and work. Or you could have the patient return for another visit to address the management of the problem or the preventive care. Deciding which of these options to choose depends on the clinical circumstances and your medical judgment. In either case, any diagnostic tests or additional services provided should be reported separately.

The preventive visit for a Medicare patient

Medicare does not provide reimbursement for CPT's comprehensive preventive medicine services codes described above, but because of the Balanced Budget Act of 1997, it does provide reimbursement for certain screening services provided in the absence of an illness, disease, sign or symptom, such as a screening pelvic and clinical breast exam.

So when you provide a comprehensive

THE PREVENTIVE COUNSELING VISIT: AN EXAMPLE

A 46-year-old established patient, who was seen six months ago for a health maintenance visit, is in overall good health and is within 10 percent of his ideal body weight, comes to your office to discuss a diet and exercise program. The patient is now interested in a regular exercise program and diet to reduce his risk of cardiovascular disease since his 52-year-old brother recently had a heart attack. You spend 15 minutes discussing these issues with him. You should submit the appropriate preventive medicine counseling code for this visit and ICD-9 codes V65.3 and V65.41.

Bill	Diagnosis code(s)		Procedure code(s)	
Patient	V65.3 V65.41	Dietary surveillance and counseling Exercise counseling	99401	Preventive medicine counseling

history and examination as described by the preventive medicine services codes to a Medicare patient, you should submit the appropriate HCPCS and ICD-9 codes to Medicare for the covered screening services and assign the appropriate CPT preventive medicine services code to the rest of the visit, charging the patient for that portion. These codes can be reported for the same visit because the Medicare-covered screening services don't include all the work normally included in a preventive medicine visit. For example, HCPCS code G0101 only includes a breast and pelvic examination; it does not include other elements normally included in a preventive exam, such as taking vital signs, examining the skin, heart, lungs, etc., and performing a review of systems or past family and social history. Since the screening services do overlap with some of the preventive services though, the amount allowed by Medicare for the screening should be deducted from the amount billed to the patient for the other preventive services. (See the examples of preventive services for Medicare patients on page 52 and "Medicare's covered preventive services" below for a list of covered services.)

The preventive counseling visit

As described above, age-appropriate counseling that occurs during a preventive medicine encounter is part of the preventive medicine services codes, but preventive counseling and/or risk factor reduction interventions that are provided at a *separate*

MEDICARE'S COVERED PREVENTIVE SERVICES

This table lists some of the preventive screening services that are covered by Medicare. It shows the covered frequency and the associated HCPCS and ICD-9 codes that should be submitted for each service. (For information about other Medicare-covered screening services, go to http://www.medicare.gov/health/overview.asp.)

Screening service	Frequency	HCPCS code	ICD-9 code
Screening pelvic and clinical breast exam	Once every 2 years; once every year for high-risk patients*	G0101	V76.2, V76.47, V76.49 or V15.89
Screening Pap smear	Once every 2 years; once every year for high-risk patients*	Q0091	V76.2, V76.47, V76.49 or V15.89
Digital rectal exam	Once every 12 months for patients 50 years or older	G0102	V76.44
PSA	Once every 12 months	G0103	V76.44
Fecal occult blood test	Once every 12 months	G0107 G0328	V76.41 V76.51

*Medicare's definition of "high risk" includes patients of childbearing age in which cervical or vaginal cancer is or was present or other abnormalities have been found in the preceding three years and patients with one or more of the following high-risk factors for either cervical or vaginal cancer: onset of sexual activity under 16 years of age, five or more sexual partners in a lifetime, history of sexually transmitted diseases (including HIV), fewer than three negative Pap smears within the previous seven years, no Pap smears at all within the previous seven years or prenatal exposure to DES.

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Some of the screening services covered by Medicare include a screening pelvic and clinical breast exam, a screening Pap smear and a digital rectal exam.

Preventive counseling and/or risk factor reduction interventions provided at an encounter separate from the standard preventive medicine visit should be reported with preventive counseling codes.

Preventive counseling generally includes such issues as diet, exercise, smoking cessation and sexual practices.

Counseling provided to patients with diagnosed conditions or signs and symptoms should be reported with the problem-oriented E/M service codes instead.

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The ICD-9 codes associated with preventive services are found in the V codes, which describe the reasons for health care encounters other than disease or injury.

Understanding how preventive medicine coding works can help you to distinguish preventive services from problem-oriented ones, track the preventive services you provide and improve your reimbursement.

encounter should be reported with the preventive counseling codes. This type of counseling varies according to the age of the patient, but it generally includes such issues as diet, exercise, smoking cessation and sexual practices. Note that counseling provided to patients with diagnosed conditions or signs and symptoms should be reported with the problem-oriented E/M service codes instead. (See the example of a preventive counseling visit on page 53.)

USING DIAGNOSIS CODES EFFECTIVELY

Appropriate ICD-9 codes should be reported on every claim to provide an accurate reflection of the reason a service was provided. It's also important to link each ICD-9 code to the applicable CPT code on the claim form, especially when preventive and problem-oriented services are provided at the same visit. The ICD-9 codes associated with preventive services are found in the V codes, which describe the reasons for health care encounters other than disease or injury. For example, V70.0 should be used for a routine general medical examination performed at a health care facility, and V70.3 should be used to identify examinations for administrative purposes, such as marriage and school admission. Other V codes commonly used for preventive services include V72.3 for reporting a gynecological examination performed in conjunction with a preventive service, V20.2 for a routine infant or child health check and V73.0-V82.9 for any special screening examinations (e.g., for colorectal cancer or lipid disorders).

Making sense

Understanding how preventive medicine coding works can help you to accurately distinguish wellness and disease-prevention services from problem-oriented ones in your coding. This will not only improve your reimbursement but also will allow you to track the preventive services provided by your practice so that you are always aware of the health maintenance services due for each patient. FPM

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