Breakout Session 3D
Preventive or Not Preventive? 
That is the Question!

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President
Reproductive Medicine Administrative Consulting, Inc.
West Orange, New Jersey
Monday, April 15, 2013

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Learning Outcomes

• At the end of this session, attendees will be able to:
  – Describe the history of billing and coverage for preventive medicine services.
  – Articulate the effects of the Affordable Care Act (ACA) on the billing of preventive medicine services, particularly in the field of women’s health.
  – Analyze various real-life circumstances to determine whether preventive medicine billing is appropriate for the service(s) provided.
Learning Outcomes

• At the end of this session, attendees will be able to:
  – Discuss the unique factors associated with billing for Medicare preventive care services in women’s health.
  – Explain various alternatives for ensuring proper billing and managing patient understanding concerning their liability for services.
The Pendulum Has Swung

THE HISTORY OF PREVENTIVE CARE COVERAGE
In the olden days...

• Health insurance existed for the purpose of treating “problems,” “illnesses,” and/or “injuries.”

• There was little or no coverage for preventive or “well-woman” services.

• Everybody had a “problem.”
As HMOs Came Into the Picture

• The benefits of preventive care were identified.
• It was seen as cost-effective, because it was better to address an issue before it became a problem.
• Coverage was still “hit or miss.”
As we arrive in 2013

- The Affordable Care Act (ACA) of 2010 mandated that certain preventive services be covered by all health plans, **with no out-of-pocket expense for the patient**.
- This would seem great, except...
Problems with “free” preventive care

• There are varying guidelines and rules about what is covered and when.
• Sometimes a “preventive” visit becomes a “problem” visit.
• Patients often aren’t clear (or don’t want to be clear) about the distinctions.
So, the pendulum has swung...

- No Preventive Care
- Preventive Care
- Preventive Care with no out-of-pocket cost
A Bottom-line Fundamental Principle

• Regardless of the circumstances or the patient’s desires, we cannot code for coverage.
• As ethical coders, we are required to “code it as we see it.”
• We can’t code things to make them “payable” or to help the patient avoid financial responsibility when it results in the inaccurate reporting of services (and often a negative financial outcome for the practice).
### New Patient Encounters

<table>
<thead>
<tr>
<th>E/M Services</th>
<th>RVUs</th>
<th>Preventive Medicine</th>
<th>RVUs</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>1.29</td>
<td>99383 (5-11 yo)</td>
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<td>99202</td>
<td>2.19</td>
<td>99384 (12-17 yo)</td>
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<td>99203</td>
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<td>99385 (18-39 yo)</td>
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<td>99204</td>
<td>4.84</td>
<td>99386 (40-64 yo)</td>
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<tr>
<td>99205</td>
<td>5.99</td>
<td>99387 (65 yo and over)</td>
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## Established Patient Encounters

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<td>99393 (5-11 yo)</td>
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<td>99212</td>
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<td>99214</td>
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<td>99396 (40-64 yo)</td>
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<tr>
<td>99215</td>
<td>4.20</td>
<td>99397 (65 yo and over)</td>
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So, What Services Are “Free?”

PREVENTIVE SERVICES UNDER THE AFFORDABLE CARE ACT
Payer’s Response

• Affordable Care Act requires private health plans to cover several evidence-based services (mammograms, colonoscopies, BP checks, immunizations)

• New plans must include recommended screenings for women without cost sharing by August 1, 2012

• Payers can define scope of services for women’s preventive care using “reasonable medical management”
## What is Covered Without Cost?

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<thead>
<tr>
<th>Code(s)</th>
<th>Description</th>
<th>USPSTF Grade</th>
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<tbody>
<tr>
<td>Q0091, P3001, G0101</td>
<td>Screening pap test and for cervical cancer screening (for women who have been sexually active)</td>
<td>A</td>
</tr>
<tr>
<td>86592, 86593</td>
<td>Syphilis screening for those who are at risk</td>
<td>A</td>
</tr>
<tr>
<td>86631, 86632</td>
<td>Chlamydial infection screening, sexually active &lt; 24 years old</td>
<td>A</td>
</tr>
<tr>
<td>86689, G0432</td>
<td>Screening for HIV</td>
<td>A</td>
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<tr>
<td>Various, 90471, 90472</td>
<td>Hepatitis B Vaccine (various dose protocols)</td>
<td>A</td>
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<tr>
<td>99406, 99407, G0436, G0437</td>
<td>Counseling for tobacco usage</td>
<td>A/I</td>
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<td>G0104-G0106, G0120-G0121, 82270</td>
<td>Screening for Colorectal Cancer</td>
<td>A</td>
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<tr>
<td>80061, 82465, 83718, 84478</td>
<td>Screening for Cholesterol Abnormalities</td>
<td>A/B</td>
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<tr>
<td>77052, 77057, G0202</td>
<td>Screening for Breast Cancer (mammography)</td>
<td>B</td>
</tr>
<tr>
<td>G0130, 77078-77083, 76977</td>
<td>Screening for Osteoporosis</td>
<td>B</td>
</tr>
<tr>
<td>G0108, G0109</td>
<td>Screening for Diabetes</td>
<td>B</td>
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<tr>
<td>97802-97804, G0270, G0271</td>
<td>Screening for a Healthy Diet/Obesity</td>
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<td>90660, 90460, 90471, 90472, G0008</td>
<td>Flu Vaccine</td>
<td>B</td>
</tr>
<tr>
<td>90670, G0009</td>
<td>Pneumonia Vaccine</td>
<td>B</td>
</tr>
<tr>
<td>G0108, G0109</td>
<td>Screening for Diabetes</td>
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What do the Grades Mean?

• A-The USPSTF recommends the service. There is high certainty that the net benefit is substantial.
• B-The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.
• C-Clinicians may provide the service, depending on individual circumstances. Without signs or symptoms, there is likely minimal benefit.
• D-The USPSTF recommends against this service.
Modifier 33
Preventive Services

• Created to address coverage issues related to the Affordable Care Act

• Identifies service as preventive based on USPSTF A or B rating

• Not required if service specifically identified as preventive (ie, not required on Preventive Medicine Codes 99381-99397)
  – Note some payers are requiring the modifier on wellness visits
Collection and Handling of Pap Smears

• Collection considered part of pelvic exam
• It is not appropriate to code the collection separately
• Some payers reimburse for handling of specimen when reported with CPT 99000 (conveyance/handling)
Collection and Handling of Pap Smears

• CPT 99000 intended to reflect work involved in preparation of specimen
• CPT considers this an “adjunctive” service, therefore modifier 25 is not required on the E/M code
Collection and Handling of Pap Smears

- **Q0091** (Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory) was developed for Medicare program
- A limited number of payers reimburse for this code in addition to Preventive visit
- **Verify before billing** - refunds have been requested from practices!
Interpretation of Pap Smears

• Laboratory codes (88150, etc.) should never be reported for collection or handling of specimen

• If interpretation billed by physician for lab
  – Report lab code (88000 series)
  – Append 90 modifier (outside lab services)

• Practices should determine appropriate code from lab
Non-Medicare Payers and Pap Smears

• Coverage depends on payer and contract
• Coverage impacted by screening vs. diagnostic Pap smear
• Patient responsible for non-covered services
Non-Medicare Payers and Pap Smears

• **Screening Pap Smear**- *Absence* of illness, disease, symptoms

• ICD-9 CM options:
  - V72.31  Routine gyn exam
  - V76.2   CA screening, cervix
  - V76.47  CA screening, vagina
  - V67.01  F/up vaginal Pap smear (post-hysterectomy for malignant condition)
Non-Medicare Payers and Pap Smears

- **Diagnostic Pap Smear**- *Presence* of illness, disease, symptoms

- ICD-9 CM Options:
  - 795.00 Abnormal glandular Pap of cervix
  - 795.01 ASC-US
  - 795.02 ASC-H
  - 795.03 LGSIL
The Giant Challenge

• Medicare is pretty clear about paying for these services—many of the services have HCPCS codes specifically designed for them.

• Other payers may not recognize these codes... so how do you report these services (e.g. E/M services)?
  – Specific instructions from payers?
  – ICD-9/ICD-10 codes?
We Need to Clarify the Definition First

LET’S TACKLE SOME REAL WORLD PROBLEMS...
Preventive Medicine Services

- **E/M Services for adults, children, infants (99381-99387; 99391-99397)**
  - Codes based on age of patient and whether new/established
  - Not gender specific
  - Well-woman exams (9938X and 9939X)
Content of the E/M Preventive Service

• Service *includes*:
  – Comprehensive History and PE
  – Risk factor reduction/counseling
  – Anticipatory Guidance
  – Ordering of lab/diagnostic procedures
  – Treatment of insignificant abnormalities
Comprehensive History

• Not problem-oriented and does not require CC or HPI
• *Does include* comprehensive ROS, comprehensive or interval PFSH, and assessment of risk factors *appropriate for the patient’s age, gender, and identified risks*
• E/M Documentation Guidelines *do not apply*
Comprehensive Exam

- Multi-system exam based on age, gender, and identified risk factors
- *E/M Documentation Guidelines do not apply*
Counseling

• Age appropriate counseling included
  – Contraception in women of child-bearing age
  – Menopausal concerns with older women

• Other examples:
  – Safety issues
  – Need for screening tests
  – Status of previously diagnosed stable conditions
Content of the Service

- Services *not included*:
  - Performance of ancillary studies or immunizations
  - *Significant additional* work associated with abnormalities or pre-existing problem
Here’s the Problem...

• It is clearly and obviously 100% a preventive medicine service.
• There are elements of the service that are clearly preventive and other elements that are clearly problem-based.
• The visit was intended to be 100% preventive, but the physician found an issue that requires immediate attention.
• It is clearly and obviously 100% a problem-based visit.
It is clearly and obviously 100% a preventive medicine service.

• Megan is a 23 year old single female who is sexually active. She presents today as a new patient for an “annual” preventive medicine exam. Dr. Elliott, an OB/GYN, takes a comprehensive history and performs a comprehensive examination. During the history portion of the exam, Dr. Elliott learns that Megan is using the pill for birth control, but she is not completely certain about the sexual history of her current partner.
It is clearly and obviously 100% a preventive medicine service.

• Dr. Elliott discusses with Megan the risks associated with sexually transmitted infections (STIs) and recommends that she consider a barrier form of birth control, such as condoms. Megan is not receptive to this idea. After a 10 minute conversation concerning STIs and birth control options, Megan does agree to a screening for STIs, such as HPV, HIV, chlamydia, and gonorrhea.
It is clearly and obviously 100% a preventive medicine service.

• Dr. Elliott completes the exam, collecting a Pap smear of the cervix, as well as vaginal cultures and drawing blood for further laboratory testing. He will follow up with Megan with results and another appointment will be scheduled, as appropriate.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by line)

1. V72.31 Routine gynecological examination
2. V73.81 Screening exam for HPV
3. V74.5 Special screening for venereal disease
4. V73.89 Special screening for other specified viral diseases

22. MEDICAID RESUBMISSION

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE
   | From | To |
   | MM   | DD | YY | MM | DD | YY |

B. PROCEDURES, SERVICES/SUPPLIES

<table>
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<tr>
<th>CPT/HCPCS</th>
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<th>DX POINTER</th>
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C. POS
| 11 |

D. PROCEDURES, SERVICES/SUPPLIES (Explain Unusual Circumstances)

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E. DX POINTER
| 1234 |

F. CHARGES
| 1 |

G. DAYS OR UNITS
| 1 |

H. QUAL
| NPI |

I. RENDERING PROVIDER ID. #

J. RENDERING PROVIDER ID. #
| NPI |

CPT Codes | CPT Description
---|------------------
36415 | Venipuncture
It is clearly and obviously 100% a preventive medicine service.

- Why not bill for the discussion concerning birth control and STIs?
  - It falls within the standard of service for a preventive medicine exam.
  - What significant, separately identifiable service was documented?
    - If a comprehensive history and exam was performed as part of the preventive service, what history and exam was done related to the birth control/STI issue?
    - What about time?
Defining “typical”
Defining “typical”

Percentage

68%

27%

5%
There are elements of the service that are clearly preventive and other elements that are clearly problem-based.

• Nora, a 52-y-o G₁ P₁₀₀₀₁, is an established patient of Dr. Ibsen, here for her wellness exam. She is experiencing some vaginal itch and irritation especially on the right side of her vulva. Her LMP was 3 years ago. She is not on HT.

• She states that for the last 6 months she has had occasional bleeding requiring the use of 1-2 pads per day. The bleeding usually lasts 1-2 days. She has no pain or other associated symptoms.
There are elements of the service that are clearly preventive and other elements that are clearly problem-based.

• Medication: None
• ROS: Positive for tired and sluggish, frequent headaches. Remainder of ROS neg. See Gyn intake form.
• PMH: Last mammogram 1 year ago. No changes in medical/surgical history since last visit.
There are elements of the service that are clearly preventive and other elements that are clearly problem-based.

- SH: No change. Denies sexual problems
- FH: Breast CA and heart disease maternal grandmother. HTN mother and grandmother.
There are elements of the service that are clearly preventive and other elements that are clearly problem-based.

• Physical Exam
  – Constitutional: Ht. 5’8”; Wt. 138; B/P 120/82. Pt. is well nourished and well developed.
  – Psychiatric: She is oriented X 3.
  – Skin: Moist without lesions
  – Neck: Thyroid neg. Neck supple without adenopathy
  – Chest: Clear to auscultation
There are elements of the service that are clearly preventive and other elements that are clearly problem-based.

- **Heart**: RRR w/o M, G, R
- **Breasts**: Checked in all positions. No masses, lesions, or galactorrhea.
- **Abdomen**: Soft, non-tender.
  
  No hepatosplenomegaly. No hernia.
- **Pelvic**: External genitalia: Skene’s, Bartholin’s and urethra negative. There was mild irritation of vulva.
There are elements of the service that are clearly preventive and other elements that are clearly problem-based.

– **Vagina:** Normal appearance. No sign of infection or bleeding
– **CX:** Well epithelialized.
– **Uterus:** Anterior, normal size and shape
– **Adnexa:** Both left and right were negative.
– **Rectal:** Good tone. No hemorrhoids. Occult-neg.
There are elements of the service that are clearly preventive and other elements that are clearly problem-based.

- Procedure note:
  EMB was performed without difficulty. The patient tolerated the procedure well.
There are elements of the service that are clearly preventive and other elements that are clearly problem-based.

- Impression/Plan
There are elements of the service that are clearly preventive and other elements that are clearly problem-based.

- Impression/Plan (Cont’d)
  3. Postmenopausal bleeding - EMB performed. F/up visit scheduled for 10 days to discuss biopsy results and management options.
Dr. Ibsen

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by line)

1. V72.31  Routine gynecological examination
2. 627.1  Postmenopausal bleeding
3. V82.81  Special screening for osteoporosis

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      POS

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      CPT/HCPCS           MODIFIER
      DX POINTER

   E. $ CHARGES

   F. DAYS OR UNITS

   G. QUAL

   H. RENDERING PROVIDER ID. #

   I. NPI

   J. NPI

   K. NPI

   L. NPI

   M. NPI

CPT Codes          CPT Description

77080              Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)

58100              Endometrial sampling (biopsy)

Occult blood test not reported since requirement for code 82270 not met
The visit was intended to be 100% preventive, but the physician found an issue that requires immediate attention.

- Ashley, a 35 year old female, an established patient, presents to Dr. Webster for an annual well-woman exam. Dr. Webster enters the room and says hello to Ashley. Immediately, Ashley begins sobbing and tells Dr. Webster that her husband is abusing her and that she fears for her life. She feels desperate and hopeless.
The visit was intended to be 100% preventive, but the physician found an issue that requires immediate attention.

• Dr. Webster works to calm Ashley, and then takes a brief history. She determines that Ashley is in danger and that she is having suicidal ideations as a result of her situation. Dr. Webster and members of her staff spend 50 minutes talking with Ashley and coordinating appropriate social services on her behalf.
1. V61.11 Counseling for victim of spousal and partner abuse
2. V62.84 Suicidal ideation

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The visit was intended to be 100% preventive, but the physician found an issue that requires immediate attention.

- Ashley, a 35 year old female, an established patient, presents to Dr. Webster for an annual well-woman exam. Dr. Webster performs a comprehensive history and examination, with a Pap smear collection.

- Toward the end of the exam, as Dr. Webster is about to leave the room, Ashley breaks down in tears. tells Dr. Webster that her husband is abusing her and that she fears for her life. She feels desperate and hopeless.
The visit was intended to be 100% preventive, but the physician found an issue that requires immediate attention.

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2. V62.84  Suicidal ideation  
3. V72.31  Routine gynecological exam

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Preventive Visits and Other Services: Principles

• You can only bill *ONCE* for the same service for the same patient on the same day

• Services must be medically necessary and clinically relevant

• Documentation should reflect the *additional* work performed
It’s a Whole Different Story Than Commercial Payers

MEDICARE PREVENTIVE SERVICES
Medicare’s Approach to Preventive Care

- Comprehensive Preventive Medicine Services (99387, 99397) are not covered under traditional Medicare.
- Medicare Advantage programs may have different guidelines and billing instructions.
- Traditional Medicare covers screening services based on specific coverage policies.
Medicare Preventive Coverage

• Comprehensive preventive exams never covered
• Covered screening services:
  – Pelvic/clinical breast exam
  – Screening Pap test
  – Screening hemoccult
  – Screening mammography
  – Bone mass measurement
Medicare Preventive Coverage

• Covered screening services (Cont’d):
  – Initial Preventive Physical Examination
  – Annual Wellness Visit
  – Diabetes screening
  – Cardiovascular screening
  – Flu shots
  – Annual depression screening
  – Alcohol screening and counseling
Medicare Preventive Coverage

• Medicare publishes numerous documents outlining preventive care

• Neither the Initial Preventive Physical Exam (IPPE) nor the Annual Wellness Visit (AWV) include all the services provided during a typical preventive medicine visit

• The typical preventive medicine visit does not include all the required components of the IPPE and the AWV
Screening Pelvic/
Clinical Breast Exam

• Once every 2 years for all women
• Annually for high risk women
• Both deductible and co-pays are waived under the Affordable Care Act (ACA)
Women at High Risk

• *Childbearing age* and any of the following apply:
  – Cervical or vaginal cancer is/was present
  – Abnormalities found in preceding 3 years
  – Meets other Medicare high risk criteria
Women at High Risk

• *Other women* at high risk for *cervical cancer* with *one* of the following 5 criteria:
  – Onset of sexual activity under age 16
  – Five or more sexual partners in a lifetime
  – History of STI (including HPV and/or HIV)
Women at High Risk

– Fewer than 3 negative Pap smears within previous 7 years
– Absence of any Pap smear within previous 7 years

• Women at high risk for vaginal cancer:
  – Prenatal exposure to DES
Screening Pelvic/
Clinical Breast Exam (G0101)

• 7 of the following 11 elements:
  • Inspection/palpation of breasts
  • Digital rectal
  • External genitalia
  • Urethral meatus
  • Urethra
  • Bladder
  • Vagina
  • Cervix
  • Uterus
  • Adnexa/parametria
  • Anus and perineum
Content of G0101

• *Includes only* defined exam elements
• Does *not include* other elements common to a well-woman exam
• Does *not include* a ROS or PFSH
Collection of Screening Pap Smear

- **Screening- Absence** of illness, disease, symptoms
- Reported with HCPCS code Q0091
- Criteria for coverage same as G0101
- No deductible/no copayment
- Interpretation paid separately to lab/pathologist
  - Patient has no deductible/co-pay per ACA
Collection of Diagnostic Pap Smear

- **Diagnostic- Presence** of illness, disease, symptoms
- Separate payment *not* made for collection
- Collection part of exam
- Interpretation of Pap smear and E/M service will be paid when medically necessary
Procedural Coding for Screening Services

• HCPCS codes:
  – Screening pelvic/clinical breast exam:
    • G0101
  – Collection of screening pap smear:
    • Q0091
• Q0091, G0101, and/or problem-oriented E/M all may be reported as appropriate
Diagnosis Coding for Screening Services

- ICD-9 CM codes:
  - V15.89  High risk
  - V72.31  Routine gyn exam (only if comprehensive preventive service performed)
  - V76.2   Cervix
  - V76.47  Vagina
  - V76.49  Other sites
Medicare: ABN Forms

• Medicare screening services may be reported annually (eg, G0101, Q0091)
• Medicare will deny any non-covered services
• An Advanced Beneficiary Notice (ABN) should be signed
• Claim should be submitted with appropriate modifier
Medicare: Advanced Beneficiary Notice

• ABN *is required* when a *covered* service might be denied because of coverage criteria
  – Frequency of coverage
  – Diagnosis restrictions, etc

• ABN *is not required* for *non-covered* services such as cosmetic surgery or routine comprehensive preventive exams
  – Practice can issue an ABN voluntarily
Medicare Modifiers

• **GA: ABN on file**
  – Covered service might be denied due to coverage criteria-required ABN

• **GX: Voluntary ABN on file**
  – Reported if ABN signed for a non-covered service (submit only with non-covered services)
Medicare Modifiers

• **GY: ABN not required/not issued**
  – Service is always “non-covered” and ABN not signed

• **GZ: Item or service not reasonable and necessary-ABN not signed**
  – Covered service might be denied due to coverage criteria but ABN not signed
Diana

• Diana, an 80-year-old female, is followed regularly by her internist, Dr. Hunter, for hypertension, coronary artery disease, and preventive care.

• Dr. Hunter, however, does not perform well-woman exams and sends her to Dr. Archer, a gynecologist, for her pap and pelvic.
**21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by line)**

1. **V76.2 Special screening for malignant neoplasm, cervix**

2. 

3. 

**22. MEDICAID RESUBMISSION**

<table>
<thead>
<tr>
<th>CODE</th>
<th>ORIGINAL REF. NO.</th>
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**23. PRIOR AUTHORIZATION NUMBER**

**24. A. DATE(S) OF SERVICE**

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
</tr>
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</table>

**B. PROCEDURES, SERVICES/SUPPLIES (Explain Unusual Circumstances)**

<table>
<thead>
<tr>
<th>CPT/HCPCS</th>
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**D. PROCEDURES, SERVICES/SUPPLIES**

<table>
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<tr>
<th>POS</th>
<th>PROCEDURES, SERVICES/SUPPLIES</th>
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**E. DX POINTER**

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**F. CHARGES**

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<th>$</th>
<th>CHARGES</th>
<th>DAYS</th>
<th>UNITS</th>
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**G. DAYS OR UNITS**

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<th>UNITS</th>
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</table>

**H. QUAL**

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</table>

**I. ID.**

<table>
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<tr>
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**J. RENDERING PROVIDER ID.**

<table>
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<tr>
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**Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>G0101</td>
<td>Screening pelvic and clinical breast exam</td>
</tr>
<tr>
<td>Q0091</td>
<td>Collection of screening pap smear</td>
</tr>
</tbody>
</table>

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Medicare: Preventive Service With Other Services

• Comprehensive Preventive Medicine Service is never covered by Medicare

• Preventive Service with covered service
  – Non-covered “carved out” (preventive)
  – Medicare pays only for covered service

• May occur with:
  – G0101, Q0091
  – 99201-99215
Allowable Charges and Patient Billing

• Physician charges patient the *difference* between:
  – Established charge for non-covered preventive service, **AND**
  – Medicare’s allowable for the covered E/M service
Medicare Regulations

• Must code accurately for preventive and problem-oriented services
• Cannot accept payment for non-covered services from Medicare
• Cannot charge the patient for any covered services
Covered Screening Service with Non-Covered Preventive Service

- Non-covered services “carved out”
- Patient responsible for *non-covered* Preventive Service
- Medicare responsible for *covered* screening services
Preventive Medicine Services

- Comprehensive History
- Exam of Other Systems
- Breast & Pelvic Exam
- Pap Smear
- Anticipatory Guidance
- Counseling
- Ordering Labs
Preventive Medicine Services for Medicare Patients

- Comprehensive History
- Exam of Other Systems
- Ordering Labs
- Counseling
- Anticipatory Guidance
- Pap Smear Q0091
- Breast & Pelvic Exam G0101
- All rights reserved
## Non-Covered Preventive Service with G0101

<table>
<thead>
<tr>
<th>Bill To</th>
<th>CPT/HCPCS Code(s)</th>
<th>ICD-9 Code(s)</th>
<th>Established Hypothetical Charge</th>
<th>Charge to Pt/Medicare Allowable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>99397-GX</td>
<td>V72.31</td>
<td>$200.00</td>
<td>$161.88</td>
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<tr>
<td>Medicare</td>
<td>G0101-GA</td>
<td>V76.2, V76.47, V76.49, V15.89, V72.31</td>
<td>$38.12</td>
<td>$38.12</td>
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</table>

**Total allowable Charges**

$200.00
## Non-Covered Preventive Service with G0101 and Q0091

<table>
<thead>
<tr>
<th>Bill To</th>
<th>CPT/HCPCS Code(s)</th>
<th>ICD-9 Code(s)</th>
<th>Established Hypothetical Charge</th>
<th>Charge to Pt/Medicare Allowable</th>
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<td>Patient</td>
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<td>Medicare</td>
<td>G0101-GA</td>
<td>V76.2, V76.47, V76.49, V72.31 or V15.89</td>
<td>N/A</td>
<td>$38.12</td>
</tr>
<tr>
<td>Medicare</td>
<td>Q0091-GA</td>
<td>V76.2, V76.47, V76.49, V72.31 or V15.89</td>
<td>N/A</td>
<td>$45.95</td>
</tr>
<tr>
<td><strong>Total Allowable Charges</strong></td>
<td></td>
<td></td>
<td><strong>$200.00</strong></td>
<td></td>
</tr>
</tbody>
</table>
Reporting Covered E/M with Non-Covered Preventive Service

• Care of abnormalities or pre-existing problems reported using E/M code
• Must require significant, separately identifiable E/M service
• Level of service consistent with *evaluation of problem*
• 25 modifier appended to covered E/M
Mrs. Simpson

• A 72-year-old established patient, Mrs. Simpson, is seen for her annual, well-woman examination.

• During the visit, the patient notes that she has not been sleeping well and has been “on edge”. She also states that her skin has been excessively dry.
Mrs. Simpson

• She has been stable on thyroid meds for over 20 years and admits it has been some time since a panel was done.

• Dr. Edwards performs a careful exam of her thyroid and checks reflexes and muscle tone. He obtains additional history relating to her symptoms and thyroid disease, and reviews her medication usage. A thyroid panel is ordered.
Mrs. Simpson

- Dr. Edwards documents the problem-oriented encounter and then proceeds with documentation of the WWE. Copies of both are sent to Mrs. Simpson’s internist.
<table>
<thead>
<tr>
<th>Bill To</th>
<th>CPT/HCPC Code(s)</th>
<th>ICD-9 Code(s)</th>
<th>Established Hypothetical Charge</th>
<th>Charge to Pt/Medicare Allowable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>99397-GX</td>
<td>V72.31</td>
<td>$200.00</td>
<td>$127.49</td>
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<tr>
<td>Medicare</td>
<td>99213-25</td>
<td>799.2, 782.8, 244.8</td>
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<td>$72.51</td>
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<tr>
<td>Total Allowable Charges</td>
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<td></td>
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<td>$200.00</td>
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</table>
## Covered Screening with Covered E/M

<table>
<thead>
<tr>
<th>Bill To</th>
<th>CPT/HCPCS Code(s)</th>
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<tr>
<td>Medicare</td>
<td>99213-25</td>
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<tr>
<td>Medicare</td>
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<td>V76.2 or V15.89</td>
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<tr>
<td>Medicare</td>
<td>Q0091-GA</td>
<td>V76.2 or V15.89</td>
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<td>$45.95</td>
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<td><strong>$156.58</strong></td>
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</table>
Other Covered Screening Services

• Screening Hemoccult- Guaiac Based
  Annually over age 50
  – Must have written order for test
  – Must have consecutive collection

• Screening Hemoccult- Immunoassay
  Annually over age 50
  – Must have written order for test
  – Number of specimens depends on manufacturer’s instructions
Reporting Screening Hemoccult

- 82270  Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided three cards or single triple card for consecutive collection)
Occult Blood Test

- **82272** Blood occult, by peroxidase activity (e.g., guaiac), qualitative, feces, 1-3 simultaneous determinations, performed for other than colorectal neoplasm screening
Reporting Screening Hemoccult

• CPT codes:
  – G0328 Immunoassay
  – 82270 Guaiac based

• ICD-9 codes:
  – V76.41  Ca screening, rectum
  – V76.51  Ca screening, colon
Other Covered Screening Services

• Screening Mammography
  Annually age 40 and over
  – Deductible/co-pay waived under ACA

• Report with codes:
  – 77057 Bilateral screening mammogram
  – +77052 CAD
  – V76.12 Other screening mammogram
Other Covered Screening Services

• Screening Bone Mass Measurement
  – Every 24 months
  – Deductible and co-pay waived under ACA
  – Must be ordered by qualified provider using results in treatment of patient (MD, PA, NP, CNS, CNM)
  – Provider may choose appropriate test
Screening Bone Density Measurement Criteria

• Subject to **one** of the following criteria:
  – Estrogen-deficient, at clinical risk for osteoporosis based on history or other findings, **OR**
  – Documented vertebral abnormalities (osteoporosis, osteopenia, vertebral fx), **OR**
Screening Bone Density Measurement Criteria

– Glucocorticoid therapy ≥5.0 mg Prednisone qd for >3 months (or expectation of Rx), OR
– Primary hyperparathyroidism, OR
– Monitored to assess FDA approved osteoporosis drug therapy
Diagnosis Codes

• Local carriers publish list of ICD-9/ICD-10 codes that reflect coverage criteria
• Check Medicare bulletins, provider manuals, etc.
• Make certain criteria and diagnosis are clearly documented in medical record
Patients Don’t Always Get It

RESOLVING CHALLENGING ISSUES
When the Patient Doesn’t Understand

- Patient comes in for a routine GYN exam
- Claim is filed to insurer as 99395 with a diagnosis of V72.31. Claim is denied because the patient had their “annual physical” with their internist (who doesn’t do pelvic exams).
- Payer only covers one “annual exam” per year
- Patient calls; states that she came in for dysmennorhea (625.3). Wants it to be refiled as 99213 with 625.3 diagnosis.
When the Patient Doesn’t Understand

• Patient tells provider that the insurance company told her that if the office had “coded it right”, the claim would be paid.

• Coder goes to the EHR. The “annual exam” chart note form was used. In “complaints” section, dysmenorrhea was noted as “2” on a 10 point scale. No indication of any treatment or significant counseling was noted, related to that condition.
When the Patient Doesn’t Understand

• Patient is a long-time, loyal patient whose insurance had paid for annual pelvic exams in the past. She recently began seeing an internist for monitoring of a chronic health condition
  – She is not going to pay the bill
  – She is going to speak to the doctor and “have you fired”
  – “You are incompetent!”

• Now What???
When the Patient Doesn’t Understand

• What are the ethical issues here?
  – Money vs. truthfulness
  – A lack of understanding of how insurance coverage works
  – Long-term relationships vs. small amount of money
  – Principles of coding vs. protection of your professional image
When the Patient Doesn’t Understand

• What if you comply with the patient’s request?
  – You are downcoding (payment for 99395 is generally greater than that of 99213)
    • You will receive lesser revenue for this service
  – Your chart is inconsistent with your billing
  – You may keep the patient happy (for now)
  – The staff has been thrown “under the bus”
The Real Solution

• Communicate, Communicate, Communicate
  – And Then Communicate It Again
• Educate as best you can
• Eliminate the element of surprise
  – Notify patients of possible scenarios
• Enhance customer service skills
Thank you for attending.

If I can be of help, please contact me.

Brad Hart, President
Reproductive Medicine Administrative Consulting
bhart@rmaci.com
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LinkedIn: www.linkedin.com/in/bchart