Getting Paid for Prevention

Getting paid for preventive services depends on correct coding. Here's how to code four common types of preventive visits.

**A standard preventive E/M visit.** Use a CPT preventive medicine service code (99381-99397) plus the appropriate ICD-9 code.

**A preventive E/M visit with a problem-oriented service.** Use a CPT preventive medicine service code (99381-99397) plus the appropriate E/M code (99201-99215) with modifier 25 attached to show that the services were significant and separate. Link the appropriate ICD-9 code(s) to each CPT code to help distinguish the services. Note that not all payers will reimburse for both preventive and problem-oriented services on the same date.

**A preventive visit for a Medicare patient.** Medicare does not reimburse for CPT's preventive medicine services codes, but it does cover certain screening services. (See "What's New in Medicare Preventive Benefits," *FPM*, February 2007.) 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 any other preventive service provided, charging the patient for that portion of the visit.

**A preventive counseling visit.** Counseling that occurs during a preventive medicine encounter is considered to be part of the preventive medicine services codes. When preventive counseling is the focus of a separate visit, it should be reported with the preventive counseling codes (99401-99412).

Making Sense of Preventive Medicine Coding

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

**Emily Hill, PA-C**

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.

The standard preventive E/M visit
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.

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 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 multi-system, but the precise content and the 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 childbearing 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.)
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)
V72.3
Gynecological examination
Procedure code(s)
99395
Preventive service

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

When a patient comes into the office for a routine preventive examination, and 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, and for more on ICD-9 codes, see "Using diagnostic codes effectively.")

THE PREVENTIVE SERVICE 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)**

V70.0

Routine exam

**Procedure code(s)**

99396

Preventive service

466.0

786.50

Acute bronchitis

Chest pain

99213-25*

Office outpatient E/M service for established patient

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.

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.

**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)**
Charge
Medicare
V76.2
Special screening for malignant neoplasms; cervix

**Procedure code(s)**
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)**
Charge
Medicare
V76.2
Special screening for malignant neoplasms; cervix

**Procedure code(s)**
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.

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 copay for each service. Others may carve out the reimbursement for the problem-oriented E/M service from the payment for the preventive exam (which 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. They say you are 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. Another option is, 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 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)
Patient
V65.3
V65.41
Dietary surveillance and counseling
Exercise counseling
Procedure code(s)
99401
Preventive medicine counseling

**The preventive visit for a Medicare patient**

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

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 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 and "Medicare's covered preventive services" for a list of covered services.)

**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.)

<table>
<thead>
<tr>
<th>Screening service</th>
<th>Frequency</th>
<th>HCPCS code</th>
<th>ICD-9 code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening pelvic and clinical breast exam</td>
<td>Once every 2 years; once every year for high-risk patients*</td>
<td>G0101</td>
<td>V76.2, V76.47, V76.49 or V15.89</td>
</tr>
<tr>
<td>Screening Pap smear</td>
<td>Once every 2 years; once every year for high-risk patients*</td>
<td>Q0091</td>
<td>V76.2, V76.47, V76.49 or V15.89</td>
</tr>
<tr>
<td>Digital rectal exam</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.

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 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.)

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).
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.

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Women’s Health Screens will often use the following:

99395: "Periodic comprehensive preventive medicine re-evaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of the appropriate immunization(s), laboratory/diagnostic procedures, established patient; 18-39 years," This would be in addition to the health problem for which the patient scheduled the appointment.

For more information see "Making Sense of Preventive Medicine Coding," FPM, April 2004.

**Billing for Preventive Behavioral Services (Postpartum Depression Assessment and other Mental Health-Related Services)**

Multiple sets of billing codes are provided—some for visits completely devoted to preventive services, and some for primary care physician use for mental health diagnosis and patient management. For most visits, the screening will take less than 3 minutes. Follow-up on screening results can then be billed as diagnosis and patient management.

Benefit packages will differ among and between insurance carriers and different policies offered by a single carrier. Practitioners will have to check with the insurance carrier or managed care plan to decide which codes to use to provide specific services to specific patients.

It is important to note that billing codes are expressed in terms of “encounters,” and that an outpatient visit may include multiple “encounters.” Here again, a provider must inquire with his or her managed care plan or insurance carrier to determine which encounters, within a single
outpatient visit, are to be “bundled,” and which are to be billed separately.

Preventive Medicine, Individual Counseling, and/or Risk Factor Reduction Intervention Provided to an Individual as a Separate Procedure

CPT Code and Approximate Duration of Procedure
99401 - 15 minutes
99402 - 30 minutes
99403 - 45 minutes
99404 - 60 minutes

CPT Code for Initial Evaluation of New Patient (Bold)
CPT Code for Periodic Reevaluation

Age Range
99381 – 99391 - Under 1 year
99382 – 99392 - 1-4
99383 – 99393 - 5-11
99384 – 99394 - 12-17
99385 – 99395 - 18-39
99386 – 99396 - 40-64
99387 – 99397 - 65 and over

Code 99420 is specific to administration and interpretation of health risk assessment instruments. Payers may or may not allow use of this code for behavior-related questionnaires such as the Pediatric Symptom Checklist or one of the longer alcohol- or depression-related questionnaires.

Finally, the last of the preventive medicine codes is 99429, Unlisted Preventive Medicine Service. Practitioners are urged to check with the managed care plan or insurance carrier before using this code.

There are a number of promising psychiatric codes that may be accessible to primary care physicians for follow-up on brief screening tests, especially for depression and any form of substance use. In these cases, the 1- or 2-minute screening interview would not be reimbursed separately. The diagnostic interview, counseling, and development of a treatment plan may be billable in the same manner as billing for diagnosis and management of a purely physical chronic disease.

The major codes of interest here are —

• 90801: Psychiatric interview examination
• 90804: Individual psychotherapy, insight-oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with patient
• 90805–90804: With medical evaluation and management services
• 90847: Family psychotherapy (conjoint psychotherapy) (with patient present)
• 90862: Pharmacologic management, including prescription use and review of medication with no more than minimal medical psychotherapy
• 90887: Interpretation or explanation of results of psychiatric, other medical examinations and
procedures, or other accumulated data to family or other responsible persons, or advising them how to assist the patient.

In addition, in the context of psychoeducational interventions, including simple biofeedback training for presurgical patients—

- 90875: Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight-oriented, behavior modifying, or supportive psychotherapy); approximately 20–30 minutes
- 90901: Biofeedback training by any modality

**New CPT Codes for Chemical Dependency Screens (AUDIT and DAST)**

The AMA CPT codes for substance abuse screening and brief intervention (SBI) fall under the category of Preventive Medicine Services, Behavior Change Interventions-Individual.

"These codes are to be billed in addition to the code for the service that the physician has provided and can be used by all physicians," Becky Yowell, deputy director of APA’s Healthcare Systems Financing, explained to *Psychiatric News.*

Here are descriptions of CPT codes 99408 and 99409. They are used only for the initial SBI (see Federal Workers Get Coverage for Substance Abuse Screening).

- 99408: Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services of 15 to 30 minutes.
- 99409: Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services greater than 30 minutes.

Note: When billing Medicare use G0396: Alcohol and/or substance (other than tobacco) abuse structured assessment (for example, AUDIT, DAST), and brief intervention of 15 to 30 minutes. Use G0397 for greater than 30 minutes.

Do not bill for anything less than 15 minutes

Major health insurers that pay for SBI under certain coverage plans include Aetna (nationwide), CIGNA (nationwide), Anthem Blue Cross and Blue Shield (Colorado, Connecticut, Indiana, Kentucky, Ohio, Maine, Missouri, Nevada, New Hampshire, Virginia, and Wisconsin), Blue Cross of California, Blue Cross-Blue Shield in Georgia, Blue Cross-Blue Shield of Minnesota, Empire Blue Cross-Blue Shield in New York, and Independence Blue Cross HealthPlus (Michigan).

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