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When a Preventive Visit Uncovers a New Patient Complaint

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Occasionally, a provider will learn of a new or worsened patient condition during a scheduled preventive (or well-patient) visit. If the patient is asymptomatic at the time of the encounter, discussion of chronic problems and medication refills are an expected part of the preventive exam. But if the patient complaint requires additional workup, beyond that usually associated with the preventive service, you may choose to report a problem-focused E/M service in addition to the preventive service. The CPT codebook confirms:

If an abnormality is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service, and if the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate Office/Outpatient code 99201-99215 should also be reported.

Documentation must support both services. A preventive visit requires a comprehensive history and patient exam; therefore, effort to support the additional E/M service must be beyond that documented to support the preventive medicine visit already performed. Any work performed for the preventive service *does not count* toward the E/M service. A separate HPI (history of present illness) describing the patient's complaint supports additional work in the history. If a portion of the exam performed is not routine for a preventive service, identify that portion.

When reporting the preventive visit and a problem-focused visit on the same day, you must append modifier 25 — *significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service* — to the problem-focused visit code. For example, CMS specifically allows a separate E/M service with its annual wellness visit, but requires:

... a significant, separately identifiable medically necessary E/M service (Current Procedural Terminology codes 99201-99215) billed at the same visit as the Annual Wellness Visit, (AWV) [must be] billed with modifier -25. That portion of the visit must be medically necessary to treat the beneficiary's illness or injury, or to improve the functioning of a malformed body member.

Note the explicit requirement of documented medical necessity in the guidelines, above. To demonstrate, consider the following vignette, quoted from the AMA's August 1997 *CPT Assistant*:

"A 33-year-old established female patient presents to the physician's office for her yearly gynecological examination. During the examination, the physician identifies a palpable, solitary lump in the right breast. The physician considers this finding significant enough to require additional work and the performance of the key components of a problem oriented E/M service. Therefore, CPT code 99395 [Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years] would be reported for the preventive medicine services visit, and an additional code (99212-99215) would be reported for the problem oriented E/M service related to the breast lump."

The appropriate problem oriented level of E/M service should be selected based on the key components associated with providing the problem oriented E/M service. For established patient office visits or other outpatient visits, two of the three key components (history, examination, and medical decision making) must meet or exceed the stated requirements to qualify for a particular level of E/M service. Modifier -25 would then be appended to the office visit level of service

reported, to indicate that a significant, separately identifiable E/M service was provided. The ICD-9-CM diagnosis codes reported should also reflect the services provided.

Remember: When selecting the additional E/M level of service, only the work "above and beyond" that performed as part of the preventive service may be counted toward the problem-focused visit. To differentiate the two services, best practice is for the provider to write separate encounter notes (one for the preventive service and one for the "sick" visit).

Alert Patients to Costs

When billing Medicare (which specifies its own codes for many preventive services), any additional E/M service must be "carved out" from the preventive service. This portion of the service may be submitted to Medicare for coverage. The Medicare beneficiary may be billed for the difference between the standard fee for the preventive service and the amount that Medicare will cover. Patients may be confused to see two bills for one office visit. Educating patients prior to billing can help to avoid potential confusion and complaints.

Commercial payers' policies vary. Some will not pay for two evaluation and management service on one date of service, or may reduce payment for one of the services. Check with the payer to verify both the coding policy, and the patient's benefits.