New Medicare Preventive Services and Screening Tests You Can Perform in the Office

Charles B. Root, PhD

Medicare is finally getting serious about preventive services. Until now, the limited preventive testing available to Medicare patients has not been widely used. With the addition of new coverage and an aggressive promotion of the new screening benefits contained in the Medicare Modernization Act (MMA), for the first time, beneficiaries have access to a comprehensive set of services designed to identify and treat chronic illness.

New Medicare coverage for screening tests can provide increased service volume and profits for physician practices. As with any government program, however, getting paid for these new services depends on knowing the codes and coverage rules that apply and using that knowledge to produce "clean claims" and minimal denials.

The Medicare Initial Preventive Physical Examination (IPPE)

Medicare's new "Welcome to Medicare Physical Examination" is designed to ensure that new beneficiaries receive all appropriate preventive services, especially those critical for the early detection and treatment of serious illnesses. Until recently, Medicare has excluded from coverage any routine physical examinations or other preventive services not considered reasonable and necessary for the diagnosis or treatment of illness or injury. Even though Congress has added Medicare coverage for a number of screening tests and services, utilization of these tests by Medicare beneficiaries has been relatively low. Utilization of the "Welcome to Medicare Physical Examination" should significantly increase both the number of screening tests and, more importantly, the number of additional diagnostic tests performed for beneficiaries as a result of the initial exam's findings.

The IPPE includes:

- A review of the patient' s medical and social history, with attention to modifiable risk factors, potential for depression, and functional ability;
- An examination including measurement of height, weight, and blood pressure, a visual acuity screen, and a screening electrocardiogram;
- Disease prevention education, counseling on diet if overweight, and referral to a cardiologist for an abnormal electrocardiogram; and
- Education, counseling, and referral for all other preventive services separately covered by Medicare Part B, including:
  - Pneumococcal, influenza, and hepatitis B vaccination, including administration;
  - Screening mammography;
  - Screening pap smear and pelvic exam;
  - Prostate cancer screening, including prostate-specific antigen (PSA) testing and digital rectal examination (DRE);
  - Colorectal cancer screening tests, including fecal occult blood and colonoscopy;
  - Diabetes self-management training;
  - Bone mass measurements;
  - Glaucoma screening;
  - Nutrition therapy services for individuals with diabetes or renal disease; and
  - Cardiovascular and diabetes screening blood tests.

Table 1.

Billing Medicare for the IPPE

- The following special HCPCS codes are used to bill the IPPE:
  - G0344: IPPE;
  - G0366: electrocardiogram, with interpretation and report, performed as a component of the IPPE;
  - G0367: electrocardiogram tracing only, performed as a component of the IPEE; and
  - G0368: electrocardiogram interpretation and report only, performed as a component of the IPPE.
- When a physician performs the complete IPPE, codes G0344 and G0366 would be reported. Codes G0367 and G0368 are used when another provider performs one or both components of the electrocardiogram. In such a case, the electrocardiogram must be completed before code G0344 can be billed.
- ICD-9 code V70.0 (routine general medical examination) may be used as the diagnostic code; however, no specific ICD-9 codes are required for the IPPE and corresponding screening electrocardiogram.
- The above codes are included in the Medicare Physician Fee Schedule. Reimbursement for a complete IPPE is approximately $125.00.
- For complete billing instructions, refer to *The Guide to Medicare Preventive Services for Physicians, Suppliers, and Other Health Care Professionals*. Available at: http://www.cms.hhs.gov/MedlearnProducts/downloads/PSGUID.pdf.

All of these currently covered preventive services are paid separately using existing CPT codes and coverage rules (Table 1). However, the IPPE must be performed during the first 6 months of a patient's Medicare Part B coverage. Follow-up preventive services are available to existing, as well as new Medicare beneficiaries.

When appropriate, physicians are allowed to bill for an additional level I or II evaluation and management service on the same date of service as the IPPE for patients presenting with an illness or injury. The IPPE should generate a significant number of additional laboratory and radiology procedures as new Medicare beneficiaries are diagnosed and treated for chronic conditions, such as prediabetes, abnormal lipid levels, and problems that would otherwise go undetected until more serious symptoms appear.

Screening Medicare Patients for Cardiovascular Disease

From 1979 to 2001, cardiovascular disease was the leading diagnosis among Americans discharged from short-stay hospital visits. In 2001 alone, more than 6 million Americans were admitted to the hospital with a diagnosis of cardiovascular disease, of which 64.5% were 65 years of age or older. Heart disease remains the number 1 killer of American women, with 1 in 3 women dying of heart disease each year.[1] Medicare patients, especially women, often fail to make the connection between risk factors, such as high blood pressure, high cholesterol, and their own chance of developing heart disease.

In response to these statistics, Medicare now provides coverage of blood tests for the early detection of cardiovascular disease and abnormalities associated with an elevated risk of heart disease and stroke. Medicare wants all eligible beneficiaries to take advantage of this coverage, which can determine whether beneficiaries are at high risk for cardiovascular disease.

The cardiovascular screening blood tests covered by Medicare are:

- Total cholesterol,
- HDL cholesterol, and
- Triglycerides.

These tests may be ordered individually or together as a lipid panel (CPT code 80061) (Table 2). Frequency is limited to either each individual test or 1 lipid panel every 5 years. However, it is important to remember that once an abnormal value is obtained, any subsequent tests are considered diagnostic rather than screening, and are subject to more liberal coverage rules. The above tests, as well as all other established preventive services, are available both to existing and new Medicare beneficiaries.

Screening Medicare Patients for Diabetes

Diabetes is the 6th leading cause of death in the United States. Seventeen million Americans have diabetes, and over 200,000 individuals die each year of related complications.[2] However, millions of people have diabetes and do not know it. With early detection and treatment, the more likely it is that the serious health consequences of

diabetes can be prevented or delayed. The MMA has expanded diabetic services covered by Medicare to include diabetes screening for beneficiaries at risk for diabetes and those diagnosed with pre-diabetes. This benefit is intended to improve the quality of life for Medicare beneficiaries by preventing more severe conditions that may occur without proper treatment from undiagnosed or untreated diabetes.

Medicare patients already diagnosed with diabetes are not eligible for diabetes screening tests. Tests for such individuals are already covered as medically necessary diagnostic tests when reported with covered diagnostic codes included in the glucose testing National Coverage Determination (NCD).

Medicare defines diabetes as:

- A condition of abnormal glucose metabolism, diagnosed from a fasting blood sugar >126 mg/dL on 2 different occasions;
- A 2-hour post-glucose challenge >200 mg/dL on 2 different occasions; or
- A random glucose test >200 mg/dL for an individual with symptoms of uncontrolled diabetes.

Diabetes screening tests are covered for Medicare beneficiaries who present with 1 of the following risk factors:

- Hypertension,
- Dyslipidemia,
- Obesity (body mass index ≥30 kg/m^2),
- Previous elevated impaired fasting glucose or glucose intolerance, and
- Individuals with at least 2 of the following characteristics:
  - Overweight (body mass index >25 but <30 kg/m^2),
  - Family history of diabetes,
  - Age 65 years or older, and
  - History of gestational diabetes or delivering a baby weighing over 9 lbs.

The term "pre-diabetes" includes impaired fasting glucose and impaired glucose tolerance. Pre-diabetic individuals are allowed 2 screening tests per year. All other qualified individuals are entitled to just 1 screening test per year. Pre-diabetes is defined as:

- Abnormal glucose metabolism diagnosed from a previous fasting glucose level of 100 to 125 mg/dL, or
- A 2-hour post-glucose challenge of 140 to 199 mg/dL.

How to bill Medicare for diabetes screening tests is outlined in Table 3. Table 4 provides an example of billing for screening glucose tolerance tests for pre-diabetic patients.

Billing Medicare Patients for Denied Screening Services

Medicare patients cannot be billed for services denied by Medicare unless they have signed an Advance Beneficiary Notice (ABN), stating that they understand that if the service is denied, they are responsible for payment. Because it may be impossible to know if a Medicare beneficiary

Table 2.
Billing Medicare for Cardiovascular Screening Tests

- The following CPT codes are used to bill for Medicare-covered cardiovascular screening tests:
  - 80061: lipid panel (includes codes 82465, 83718, and 84478);
  - 82465: total cholesterol, serum or whole blood;
  - 83718: HDL cholesterol; and
  - 84478: triglycerides.
- When all 3 tests are ordered together, they should be reported using code 80061. However, when individual tests are ordered, the following ICD-9 diagnostic codes must be used:
  - V81.0: special screening for cardiovascular disease, ischemic heart disease;
  - V81.1: special screening for cardiovascular disease, hypertension; and
  - V81.2: special screening for cardiovascular disease; other and unspecified cardiovascular conditions.
- All of the above test codes are included in the Medicare Laboratory Fee Schedule. Medicare reimbursement for a lipid panel is $18.72 in most states. An HDL screen alone pays $11.44. No patient copayment applies to tests on the Medicare Laboratory Fee Schedule. Thus, the patient pays nothing, and the entire scheduled fee amount is paid to the provider.
- For complete billing instructions, refer to *The Guide to Medicare Preventive Services for Physicians, Suppliers, and Other Health Care Professionals*. Available at: http://www.cms.hhs.gov/MedlearnProducts/downloads/PSGUID.pdf.

has already exhausted his/her screening benefits, it is always appropriate to obtain an ABN for all screening tests that are subject to frequency limits. The ABN must state the existence of a frequency limit as the reason that the ABN is requested.

When an ABN has been obtained, a GA modifier should be added to the HCPCS or CPT code to indicate the fact. This alerts the Medicare carrier that the test may be denied and suppresses the clause on the patient' s explanation of benefits that states that they are not responsible for payment if the service is denied. If Medicare denies payment and a signed ABN is on file, the patient can be billed for the denied test or service at the usual or customary rate, the Medicare fee schedule amount, or any other reasonable price.

Performing Screening Tests in a Physician's Office

Don' t give away valuable revenue to other health care providers who will be sure to get into the Medicare screening business. All laboratory screening tests covered for cardiovascular disease and diabetes are available in Clinical Laboratory Approved Assessment (CLIA)-waived versions, which easily can be performed in a physician's office or clinic. Results can be obtained while the patient is present and abnormal results can be acted upon immediately. Providers should add the services that are financially advantageous to their practice and make sure to identify all Medicare patients entitled to screening benefits.

Although a number of cholesterol monitoring tools are available for use in the physician's office, look for systems that have been certified by the United States Cholesterol Reference Method Laboratory Network (CRMLN). The CRMLN ensures that the system meets the gold standard for accuracy and reproducibility developed by the Centers for Disease Control and Prevention (CDC) for the measurement of total and HDL cholesterol, consistent with National Cholesterol Education Program (NCEP) analytical goals.

Table 3.

Billing Medicare for Diabetes Screening Tests

- The following CPT codes are used to bill for Medicare diabetes screening tests:
  - 82947: glucose, quantitative, blood (except reagent strip);
  - 82950: glucose, post glucose does (includes glucose); and
  - 82951: glucose, tolerance test (GTT), 3 specimens, (includes glucose).
- Screening tests performed for pre-diabetic patients must be identified by use of the TS modifier (follow-up service).
- Diagnosis code V77.1 (special screening for endocrine, nutritional, metabolic and immunity disorders, diabetes mellitus) must be used as the diagnosis for Medicare screening diabetes tests.
- All of the above test codes are included in the Medicare Laboratory Fee Schedule. Medicare reimbursement for a glucose test is $5.48. No patient copay applies to tests on the Medicare Laboratory Fee Schedule.
- For complete billing instructions, refer to *The Guide to Medicare Preventive Services for Physicians, Suppliers, and Other Health Care Professionals*. Available at: http://www.cms.hhs.gov/MedlearnProducts/downloads/PSGUID.pdf.

Table 4.

Billing Example: Screening Glucose Tolerance Test for Pre-diabetic Patients

- Prior to January 2005, when the diabetes screening benefit became effective, the glucose tolerance test would not have been covered because the patient's condition did not fall under Medicare's definition of "diabetes." However, glucose tolerance testing is now covered under the diabetes screening benefit because the previously measured glucose levels define the patient as pre-diabetic and entitle the patient to 2 screening tests per year. The glucose tolerance test is reported using CPT code 82951-TS and diagnostic code V77.1.
- Failure to use ICD-9 code V77.1 will result in denial of the claim.
- Failure to use the TS modifier will limit the patient to only 1 screening test per year.

Take-Away Message

- The Medicare Modernization Act (MMA) made available to beneficiaries access to a comprehensive set of services to identify and treat chronic illnesses.
- Previously, Medicare had not provided coverage for routine physical examinations. These are now available under the Medicare Initial Preventive Physical Examination (IPPE).
- Additional services include those available to screen Medicare patients for cardiovascular disease and diabetes.

ROI

- Under the MMA, additional Medicare services are available that can be performed in the office setting and billed to Medicare. These include the IPPE and screening tests.
- By having a patient sign an Advance Beneficiary Notice (ABN), patients can be billed for services denied by Medicare.
- Screening tests can be performed in the office through Clinical Laboratory Improvement Amendments (CLIA)-waived test kits.

A good example of CRMLN-certified, state-of-the-art technology for testing in the physician office is illustrated by the Cholestech LDX system. Using a simple finger-stick, the Cholestech LDX point-of-care system provides for the measurement of cholesterol and other lipid tests, glucose, alanine aminotransferase (ALT) and aspartate aminotransferase (AST) liver enzymes, and high-sensitivity C-reactive protein (hs-CRP). This enhances the ability to quickly identify patients with the most prevalent risk factors for heart disease and offer treatment or counseling in the same office visit. Generating comprehensive, lab-accurate results in minutes, the Cholestech LDX system enables physicians to focus on getting patients on the right treatment sooner and making sure they stay on the right therapeutic mix, rather than chasing down lab results.

A Clinical Laboratory Improvement Amendments (CLIA) certificate of Waiver is easy to obtain and costs just $150.00 every 2 years. CLIA-waived tests can be performed by anyone in the office with a high school education who has been trained to understand and follow the simple manufacturer's instructions. No inspections or proficiency tests are required for holders of a CLIA Certificate of Waiver; the only requirement is to follow manufacturer's instructions.

In addition to the coverage and billing requirements already mentioned, physicians performing tests under a Certificate of Waiver must append a QW modifier to each laboratory test CPT code to indicate they are using a CLIA-waived test kit. Reimbursement for CLIA-waived tests is the same as for nonwaived counterparts that are performed in hospitals or reference laboratories.

Conclusion

In summary, providers should use the Medicare IPPE as a means of identifying new Medicare patients who are eligible for covered preventive care services. Virtually all of the laboratory tests covered (lipids, glucose, and fecal occult blood tests) can be performed in the office with simple to use CLIA-waived products. Even PSA tests will most likely become available in CLIA-waived format in the near future. Medicare and private payer reimbursements for screening tests are sufficient to cover the cost of performing the tests plus providing a reasonable profit. In addition, patients appreciate getting their test results at the same time as their examination or while they wait, and follow-up treatment can often be determined without an additional office visit. Expect increased emphasis from Medicare on using clinical laboratory tests to monitor and control chronic disease (eg, frequent hemoglobin A1c testing for diabetic patients). Again, the most efficient way to administer such tests is by the use of simple CLIA-waived test kits. The fast turn-around time possible by using such kits allows both better patient outcomes and increased compliance. *MPM*

Charles B. Root, PhD, is the President of CodeMap® LLC, located in Barrington, IL. CodeMap® offers a line of publications, data files, services, and training that enable health care professionals to manage the complex rules and regulations governing the federal Medicare program.

References

1. National Heart, Lung, and Blood Institute. *What is the Heart Truth?* Bethesda, MD: National Heart, Lung, and Blood Institute, National Institutes of Health, US Department of Health and Human Services. Available at: http://www.nhlbi.nih.gov/health/hearttruth/whatis/index.htm. Accessed February 15, 2006.

2. The Centers for Medicare & Medicaid Services. *Diabetes Brochure.* 2004. Baltimore, MD: Centers for Medicare & Medicaid Services, US Department of Health and Human Services, 2004, Available at: www.cms.hhs.gov/medlearn/diabetes_brochure.pdf. Accessed February 15, 2006.