

Same-Day E/M Services: What to Do When a Health Plan Won't Pay

These ideas will help you deal with the difficult consequences of this common policy.

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When Aetna recently agreed to stop bundling problem-oriented services with preventive services provided on the same date, the AAFP contacted 40 other health plans and asked that they follow Aetna's lead. To date, none have agreed to change their policies, although a few did respond that they already allow payment for both services on the same date (see "Aetna's decision" at right for more information). While Aetna's policy change will make a positive difference for many family physicians, most continue to face the same old dilemma: Should you provide both services at one visit knowing you'll get paid for just one, or should you ask the patient to return for a second visit knowing the inconvenience this will cause? Most family physicians choose the first approach, but some have reluctantly decided the second approach is necessary. This article describes processes that make it easier to implement.

Before the visit

The key to dealing with this problem is managing patient expectations, an effort that should begin before the patient arrives for his or her appointment. First, you have to know your payers and their policies. Your billing staff should contact each payer and ask about its policy. This is an important step that shouldn't be skipped; you and

AETNA'S DECISION

Aetna recently announced that it would begin reimbursing physicians for both a problem-oriented evaluation and management (E/M) service (e.g., 99201-99205 or 99211-99215, billed with modifier -25) and a preventive E/M service (e.g., 99381-99387 or 99391-99397) provided on the same date. Aetna will also reimburse physicians for an E/M service (billed with modifier -57) performed in conjunction with a major (global, 90-day) procedure.

Physicians may resubmit affected claims for services that were delivered no more than 180 days prior to Feb. 11, the effective date of the new policy, provided the original claims were submitted within the timely filing period defined by their contract with the health plan. No interest or penalties for late payments will apply to these claims.

A handful of other insurers, all of them regional Blue Cross Blue Shield (BCBS) plans, have indicated in response to an AAFP inquiry that their current policy is to reimburse for both services: BCBS of Illinois, BCBS of Kansas City, BCBS of Massachusetts, Highmark BCBS, Independence Blue Cross and Premera Blue Cross. The AAFP is following up with health plans that have not responded to its letter.

your billing staff might be pleasantly surprised by the answer. Next, create a spreadsheet that lists each payer, whether the payer allows separate reimbursement of a problem-oriented evaluation and management (E/M) service on the same date as a preventive service, and whether the payer requires documentation with the claim. Some members of your billing staff may already know this information, but writing it down in a format that's easy to reference will help to spread the knowledge.

Your scheduling staff should be among the first to receive a copy of the spreadsheet. Any patient requesting to schedule a preventive service should be asked if he or she wishes to discuss any other health problems with the doctor. If the patient does want to discuss other problems and the spreadsheet indicates that the patient's health plan bundles the E/M service with the preventive service, the scheduler should ask the patient to come in for a problem-oriented visit first and the physical at a later date, and then schedule both appointments. If the patient indicates that he or she has no health problems to discuss with the doctor, the scheduler should let the patient know that if a health problem arises that requires significant time to address, another visit may be necessary.

A notice like the one on page 60 can also be used to explain the policy and the reasons for it. It should be sent to patients along with confirmation of their physical appointment or presented to them when they check in. The policy should also be explained in the information about the practice that you send to new patients prior to their first appointment. ►



■ Most health plans refuse to pay for more than one E/M service per patient encounter.

■ Aetna recently announced that it would stop bundling these codes.

■ In most cases, family physicians must either absorb the cost of the second service or require the patient to schedule separate visits.

If the patient is unhappy with the policy, your scheduler should be prepared to address the patient's concerns. The scheduler should let the patient know that you understand his or her concerns and that you find the situation frustrating too – and then encourage the patient to inform the insurance company and his or her employer that the consequences of the insurer's payment policy are inconvenience and lost work time.

Finally, develop a method for noting in patients' charts whether their health plan will pay for preventive and problem-oriented services on the same date. If you have a staff member do insurance verification prior to the visit, this may be as simple as having that person make a note on the chart.

During the exam

You should be prepared for patients to ask you questions about the policy. They may need help understanding the difference between a problem that requires little work and time and one that requires significant work and time. Some patients will ask you to make an exception. Unless the clinical circumstances and your medical judgment tell you otherwise,

you should explain that while you regret the inconvenience to the patient, you cannot inconvenience the other patients who are waiting to see you and that you will address the problem at this visit and reschedule the preventive visit at the patient's convenience. It may help to remind the patient that you implemented your policy in response to the patient's health plan's decision not to reimburse for both services on the same date.

If you decide the preventive service requires a separate visit, be aware that patients may delay scheduling the physical for a variety of reasons. You should note on the charge slip that the patient needs to be seen for a physical so that he or she will be encouraged at check-out to schedule the appointment.

Documentation and billing

If you elect to provide both services on the same date even though your health plan bundles payment for them, you should go ahead and submit a claim for both services, with modifier -25 attached to the problem-oriented service. Simply billing for the service you know the health plan will pay for and omitting the additional service obscures the problem. Instead, you should submit a claim that represents your full services and force the health plan to bundle the services instead of doing it yourself. With this approach you will also be following the CPT rules, which is what you want the health plan to do. (Medicare recognizes this coding convention but does not cover comprehensive preventive examinations. See "What about Medicare?" on the opposite page for more information.)

Most health plan contracts prohibit billing the patient for the additional service in this situation, as it is considered balance billing,

SAMPLE NOTICE REGARDING SAME-DAY WELLNESS CARE AND ILLNESS CARE

You can download this notice from the online version of the article at <http://www.aafp.org/fpm/20060400/58same.html> and modify it for use in your practice.

Dear Patient,

Thank you for choosing our practice for your medical needs. We value our relationship with you and want to serve as your "personal medical home."

Unfortunately, because of your insurer's payment policy, in some cases we may have to complete your wellness care and your illness care in two separate visits. If you have a health problem you want to discuss with your doctor during your well visit, the doctor may decide to treat that problem and ask you to schedule another appointment for your well visit.

We realize the inconvenience this may cause and regret that your insurer's payment policy has led us to make this business decision. Your understanding of this situation is appreciated.

ABC Family Practice

About the Author

Cindy Hughes is the coding and compliance specialist for the AAFP and is a contributing editor to *Family Practice Management*. Thanks to Trevor Stone, the AAFP's private sector advocacy manager, for his assistance with the article. Author disclosure: nothing to disclose.



It may help to remind the patient that you implemented your policy in response to the patient’s health plan’s decision.

although it would be worthwhile to confirm with each health plan that this is the case.

When billing payers who do pay for both services, be sure that your documentation of the problem-oriented visit is separately identifiable in the patient record. The CPT definition of modifier -25 was revised for 2006 to emphasize the need for documentation. It now reads, “A significant, separately identifiable E/M service is defined or substan-

tiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported... .” Payers may request that you submit documentation to substantiate that the service was significant and separate and that the level of service was correctly chosen. Keep in mind that no element of the documentation can be counted as both part of the preventive service and part of the problem-oriented service. ➤

It’s important to confirm your payers’ policies and make the information available to your staff.

Patients who call for a well-visit appointment should be informed that two separate visits may be necessary.

A written notice can also be used to inform patients of your policy and the reasons behind it, and you should be prepared to answer related questions that arise during exams.

WHAT ABOUT MEDICARE?

Medicare does not provide reimbursement for the comprehensive preventive medicine services codes described in CPT, but it does provide reimbursement for a one-time “Welcome to Medicare” physical and certain screening services, such as a screening pelvic and clinical breast exam.

When providing a noncovered preventive service to a Medicare patient on the same date as a covered problem-oriented service, Medicare requires you to carve out the cost of any covered service from your charge for the preventive service. For example, let’s say you provide an annual physical and a digital rectal exam to a Medicare-covered patient. You also document a level-III service related to the patient’s diabetes. Medicare allows you to bill the patient the difference between your charge for the preventive service and the allowed amount for the problem-oriented service. Medicare does not reimburse for a digital rectal exam when done on the same date as an E/M service.

As you can see, the Medicare carve-out is another way of bundling the E/M service into the preventive service. In this example, payments from Medicare and the patient would equal \$150. If you were to provide the services on separate days, you could bill the patient your full charge of \$150 for the preventive medicine service. This plus the total of \$50 you’d be paid by Medicare and the patient for the level-III service would raise your total reimbursement for the services to \$200.

Services provided on the same day	Charge	Medicare pays	Patient pays
Preventive service 99397	\$150	\$0 (noncovered service)	\$100
Digital rectal exam G0102	\$35	\$0 (bundled)	\$0
Problem-oriented service 99213	\$75	\$40 (80 percent of Medicare allowable)	\$10 (20 percent of Medicare allowable)
Totals	\$260	\$40	\$110

Getting to the root of the problem

In addition to implementing policies that help your practice deal with the fact that same-day preventive and problem-oriented services are usually bundled, it would also be worth your time to make sure the health plans know how you feel about this practice. The sample letter below, which is adapted from a letter the AAFP sent to health plans earlier this year, may

help you to accomplish this without too much trouble. A modifiable version of the letter may be downloaded from the online version of this article. The few minutes spent customizing the letter and sending it to the health plans you contract with may help in changing the policy that costs time, money and patient satisfaction. **FPM**

Send comments to fpmedit@aafp.org.

■ You should bill for both E/M services, attaching modifier -25 to the problem-oriented code; billing the patient for the balance is prohibited by most health plan contracts.

■ Document both services thoroughly and distinctly because the health plan may ask you to submit documentation to support your claim.

■ Send your health plans a letter letting them know about the consequences of their policy.

SAMPLE LETTER TO HEALTH PLANS

You can download this letter from the online version of the article at <http://www.aafp.org/fpm/20060400/58same.html> and modify it for use in your practice.

Re: Preventive and problem-oriented evaluation and management (E/M) visits

Dear [Health Plan Executive],

I am writing to ask that [Health Plan Name] follow the use of CPT as published by the American Medical Association. In particular, the intent of this letter is to focus on the inappropriate bundling of a preventive medicine service and a problem-oriented E/M service on the same date of service.

CPT is very clear on this point. In the guidelines preceding the Preventive Medicine Services codes, CPT states:

“If an abnormality/ies is encountered or a pre-existing problem is addressed in the process of performing this preventive medicine evaluation and management service, and if the problem/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.** Modifier -25 should be added to the office/outpatient code to indicate that a significant, separately identifiable evaluation and management service was provided by the same physician on the same day as the preventive medicine service. **The appropriate preventive medicine service is additionally reported.**”

Some payers argue that if they were to follow these CPT guidelines physicians would game the system and would more often than not find a medical problem that would enable them to bill for both services.

In fact, the primary motivation of many physicians in this situation is to avoid inconveniencing patients who present with acute problems at a preventive care visit. Rather than asking them to return on another date to divide the services, most perform both, submit a claim for both, and, when payment for the second service is denied, write it off, since physicians are usually prohibited under contract from balance billing the patient. From my perspective, this is an unfair business practice amounting to your members receiving free care.

To get paid for both services, physicians must ask patients to return for a second appointment. This inconveniences the patient and leads to fragmentation of care. To the extent that this forces a patient to need more time away from work, it also leads to lower productivity for the employer with whom you contract. In addition, it produces another claim that your company must process, which adds to your administrative expenses.

Aetna changed its payment policy effective February 2006 to allow for payment of two E/M codes on the same date of service. I ask you to do the same. This issue has existed unnecessarily for far too long, to the disadvantage of both physicians and patients.

Sincerely,
Physician name