Preventive care coding isn't hard, but the differences from E/M coding can be confusing.

DOCUMENTING AND CODING PREVENTIVE VISITS: A Physician's Perspective

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In our experience, family physicians vary widely in their understanding of preventive care coding. Questions we've heard range from "What ICD-9 codes are appropriate with preventive care visits?" all the way down to "Preventive codes? What are preventive codes? I only use evaluation and management [E/M] codes." No matter what your level of comfort (or discomfort) with coding preventive visits, we hope to offer information you'll find useful. We will define the documentation components necessary to code preventive visits for patients 18 to 64 years old, review the appropriate ICD-9 and CPT codes and how to properly pair them, and discuss the proper use of modifier 25. We won't cover the Medicare guidelines for preventive visits or how to code pediatric preventive visits. Coding resources for these visits are listed on page 16.

Components of a preventive visit

Preventive visits, like many procedural services, are bundled services. Unlike documenting problem-oriented E/M office visits (99201-99215), which involves complicated coding guidelines, documenting preventive visits is more straightforward. The following components are needed:

- A comprehensive history and physical exam findings;
- A description of the status of chronic, stable problems that are not "significant enough to require additional work," according to CPT;
- Notes concerning the management of minor problems that do not require additional work;
- Notes concerning age-appropriate counseling, screening labs, and tests;
- Orders for vaccines appropriate for age and risk factors.

According to CPT, the comprehensive history that must be obtained as part of a preventive visit has *no* chief complaint or present illness as its focus. Rather, it requires a "comprehensive system review and comprehensive or interval past, family, and social history as well as a comprehensive assessment/history of pertinent risk factors." The preventive comprehensive exam differs from a problem-oriented comprehensive exam because its components are based on age and risk factors rather than a presenting problem.

Some have attempted to use modifier 52 to denote

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ACCEPTABLE CODES FOR PREVENTIVE CARE VISITS

Description of service	ICD-9	HCPCS*	CPT
Well male exam	V70.0		New patient • 99385 (18-39 years old) • 99386 (40-64 years old) Established patient • 99395 (18-39 years old) • 99396 (40-64 years old)
Well woman exam (no GYN)	V70.0		
Well woman exam (with GYN)	V72.31	S0610, S0612, S0613	
Defined subpopulations such as military, pre-employment screening, prisoners, refugees	V70.5		
Administrative physicals such as for school admission, sports preparticipation, camp, driver's license	V70.3		
Preoperative physical exam	V72.83, V72.84		99241-99245

*HCPCS "S codes" are used by some commercial payers.

reduced services when less than a comprehensive history and exam are performed during a preventive visit. This is inappropriate because modifier 52 applies to procedural services only. Preventive visits that do not satisfy the minimum requirements may be billed with the appropriate E/M office visit code.

When submitting a preventive visit CPT code, it is not appropriate to submit problem-oriented ICD-9 codes. Linking problem-oriented ICD-9 codes with preventive CPT codes may delay payment or result in a denied claim. See "Acceptable codes for preventive care visits," above, for the appropriate ICD-9 codes and the HCPCS and CPT codes with which to pair them.

Coverage of preventive visits varies by insurer, so it is important to be aware of the patient's health plan. Most plans limit the frequency of the preventive visit to once a year, and not all tests are covered. Fecal occult blood tests, audiometry, Pap smear collection, and vaccines and their administration should be billed separately. Visual acuity testing is not separately reimbursed. Without a new or chronic-disease diagnosis, all labs and other tests ordered during a preventive visit are for screening purposes, and an ICD-9 code for screening should be assigned on the order form and claim.

Another service that has a preventive purpose is the preoperative clearance. Review of the details of this encounter is beyond the scope of this discussion, but it is worth mentioning that many private payers cover the preoperative clearance when billed by primary care physicians using consultation E/M codes (99241-99255).

Preventive visits and the role of counseling

Preventive visit codes 99381-99397 include "counseling/anticipatory guidance/risk factor reduction interventions," according to CPT. However, when such counseling is provided as part of a separate problem-oriented encounter, it may be billed using preventive medicine codes 99401-99409. For example, if you provide significant counseling on smoking cessation during a visit for an ankle sprain, you could bill for the counseling in addition to submitting an E/M office visit code for the problem-oriented service. A synopsis of the counseling should be included in your documentation, and ICD-9 codes for preventive counseling should be paired with your CPT codes (see "Acceptable codes for preventive counseling services," page 14). Such a visit requires the use of modifier 25.

Modifier 25

When providing a preventive visit with a problem-oriented E/M service or procedural service on the same day, including modifier 25 in your coding may enable you to be paid for both services. CPT says modifier 25 is appropriate when there is a "significant, separately identifiable evaluation and management service by the same physician on the same day." Stated another way, if the second service requires enough additional work that it could stand on its own as an office visit, use modifier 25. Modifier 25 should usually be attached to the problem-oriented E/M code. However, if the second service is a procedure, such as removal of a skin lesion performed in conjunction with a preventive visit, the modifier should be attached to the preventive visit code because it is the E/M service. ➤

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Coding preventive care visits is just enough different from most E/M care to be confusing.

Preventive care histories have no chief complaint or history of the present illness.

Having a separate note for the second service can greatly decrease the likelihood of having it inappropriately bundled or denied. Note that no one item of documentation can count toward both services. A problem-oriented E/M service that requires a considerable amount of work and pertinent documentation may absorb so many of the elements that would otherwise count toward the preventive service that you don't have a comprehensive history and exam for the preventive service. This is one reason some doctors provide two visits in these situations.

Bundling is more likely if the separate service can be considered age-appropriate, such as initiating treatment for acne. However, if a separate E/M note can be written for the problem, the CPT description of modifier 25 and the exclusions listed for the preventive visit CPT codes indicate that the separate service should *not* be bundled. See "Appropriate use of modifier 25 during a preventive visit," page 16, for examples of complaints that under some circumstances would be handled as part of a preventive visit, but under different circumstances may require additional work that should be billed separately using modifier 25.

Unfortunately, not all carriers pay for services billed with modifier 25. For example, Aetna did not reimburse at all for modifier 25 until 2006, when it changed its policy as part of a class action settlement with multiple state medical societies. The circumstances in which its use is permitted and the amount of payment for the separate service vary. The lack of consensus on the use of modifier 25 for preventive services places the onus on providers to learn the requirements of each of their payers.

ACCEPTABLE CODES FOR PREVENTIVE COUNSELING SERVICES

Description of service	ICD-9	CPT
Dietary counseling	V65.3	99401 (15 min) 99402 (30 min) 99403 (45 min) 99404 (60 min)
Exercise counseling	V65.41	
Injury prevention counseling	V65.43	
HIV counseling	V65.44	
STD counseling	V65.45	
Contraception counseling	V25.0-V25.09	
Counseling concerning problems relating to lifestyle	V69.0-V69.9	
Advice or treatment for a non-attending third party	V65.19	
Pediatric pre-birth visit for expectant parents	V65.11	
Counseling related to parental concerns about a child	V61.20	
Marital and partner-problem counseling	V61.10	
Smoking and tobacco use counseling	305.1 or V15.82	99406 (3-10 min) 99407 (> 10 min)
Substance use and abuse counseling (structured screening and brief intervention)	V65.42	99408 (15-30 min) 99409 (> 30 min)

Preventive care and productivity

Discussing the cost-effectiveness of preventive visits for the practice is tricky because of the number of variables to consider. Time spent per preventive visit is a key confounding variable. Others include fee schedule variations between payers, payer mix, productivity variations between physicians, which preventive service is being considered (for patients in the 18-39 age group vs. those in the 40-64 age group or new vs. established), and accuracy of coding, to mention a few.

While the numerous variables make broad generalizations about the immediate cost-effectiveness of preventive visits extremely difficult, careful analysis may lead some practices to conclude that preventive care is beneficial not only for the patient but for the practice as well. As an example, we averaged payment for two visit types from nine actual payers. The visits we considered were a 40-year-old established-patient preventive visit (CPT 99396), minus immunizations and other separate charges, and a level-4, established-patient, problem-oriented visit (CPT 99214). We found the average payment for the preventive visit to be 25 percent higher than for the problem-oriented visit. That is, the preventive visit produces more revenue per unit of time unless the preventive visit takes at least 25 percent longer. Of course, if a preventive visit requires considerably more time than a comparable level-3 or level-4 E/M visit, replacing preventive visits with a larger number of problem-oriented visits could result in more reimbursement overall, at least in theory. ➤

PREVENTIVE VISIT ALGORITHM: PATIENTS AGES 18-64*

Patient check-in

- Verify that 1 year has passed since patient's last visit.
- Verify that visit is covered by insurance and that patient is willing to pay if visit is not covered.

Comprehensive history**

Comprehensive exam**

Age 18-34	Age 35-44	Age 45-49	Age 50-54	Age 55-64
Screening† Blood pressure Obesity DM 2 screen if sustained BP > 135/80 Depression Alcohol misuse Syphilis, HIV (high risk) Gonorrhea (F sexually active, high risk)				
Cholesterol (M & F ≥ 20 y high risk) Pap (F ≥ 21 y every 3 years) Chlamydia (F ≤ 24 y sexually active; F ≥ 25 y high risk)	Cholesterol (M) Cholesterol (F high risk) Pap (F every 3 years) Breast cancer (F ≥ 40 y) Chlamydia (F high risk)	Cholesterol (M) Cholesterol (F high risk) Pap (F every 3 years) Breast cancer (F) Chlamydia (F high risk)	Cholesterol (M) Cholesterol (F high risk) Pap (F every 3 years) Colorectal cancer Breast cancer (F) Chlamydia (F high risk)	
Immunizations†† Td or Tdap with booster every 10 years Varicella if not immune Yearly influenza Pneumococcal (high risk)				
HPV (F ≤ 26 y; M ≤ 21 y; M 22-26 y high risk)				Zoster (≥ 60 y)
Counseling† Healthy diet (high risk) Folic acid supplementation (F capable of pregnancy) Obesity (BMI ≥ 30) Sexually transmitted infections (high risk) Tobacco use Alcohol misuse				Daily aspirin (F ≥ 55 y, when benefit exceeds risk)
		Daily aspirin (M, when benefit exceeds risk)	Daily aspirin (M, when benefit exceeds risk)	

*Pregnancy-related recommendations are not included.

The CPT manual characterizes a comprehensive history and exam in the context of a preventive visit as "age and gender appropriate" and "not** synonymous with the 'comprehensive' examination required in Evaluation and Management codes 99201-99350."

†Consistent with U.S. Preventive Services Task Force grade A/B preventive recommendations.

††Consistent with Centers for Disease Control and Prevention 2012 immunization schedule.

APPROPRIATE USE OF MODIFIER 25 DURING A PREVENTIVE VISIT

Complaint	Inappropriate to use modifier 25	Appropriate to use modifier 25
Shortness of breath	Occurs with exercise in otherwise healthy but deconditioned, overweight 50-year-old.	Worsened shortness of breath in a 50-year-old with congestive heart failure who has been gaining weight.
Chest pain	Started after minor chest trauma in healthy 25-year-old. Improving now.	Occurs with coughing in 25-year-old smoker with fever.
Vaginal bleeding	35-year-old with periodic irregular menses. Has been irregular her entire life. No change from baseline.	35-year-old with history of multiple spontaneous abortions now with menorrhagia and dysmenorrhea.
Skin lesion	Benign nevus in 21-year-old. Patient reassured.	Dysplastic nevus in 21-year-old. Lesion excised and sent for pathology.
Knee pain	64-year-old with stable chronic osteoarthritis. No change.	64-year-old with exacerbation of chronic osteoarthritis. Knee injection given.
Desires contraception	Start oral contraceptives.	Place intrauterine device.

Age-appropriate preventive counseling provided during problem-oriented visits may be separately billable.

Preventive care may be more remunerative than acute care for some practices.

Role of preventive services in our health care system

Some researchers estimate that 75 percent of all health care costs are due directly to preventable chronic conditions, yet as recently as 2004, only 1 percent of money spent on health care in the United States was devoted to prevention.[1,2] We don't wish to spark a debate on whether preventive services directly reduce health care costs, but we speculate that preventive care has the potential to play a more valuable role in our health care system than it does currently. The Centers for Medicare & Medicaid Services did not cover preventive care visits until the institution of the "Welcome to Medicare" visit in 2005. In contrast, many private payers have covered preventive visits for some time. Perhaps this is because they have long recognized that healthy lifestyle choices and routine health surveillance mitigate the risk of chronic disease.

Regardless of insurance coverage, patients should at least be offered preventive services even if they must pay out of pocket for them. The "Preventive visit algorithm" on page 15 illustrates how one might approach a preventive visit for a patient in the 18 to 64 age range (except for recommended pregnancy-related services). This schematic is not intended to reflect all the anticipatory guidance or all of the screening that you might recommend for a given patient, but rather includes suggestions based on the strongest evidence-based recommendations from the Centers for Disease Control and Prevention and the U.S. Preventive Services Task Force. FPM

Send comments to **fpmedit@aafp.org.**

ADDITIONAL RESOURCES FOR CODING PREVENTIVE CARE

Coding for Pediatric Preventive Care 2012. American Academy of Pediatrics. http://brightfutures.aap.org/pdfs/Coding%20PR%20F0809.pdf.

What You Need to Know About the Medicare Preventive Services Expansion. *FPM.* Jan/Feb 2011. http://www.aafp.org/fpm/2011/0100/p22.html.

Making Sense of Preventive Medicine Coding. *FPM.* Apr 2004. http://www.aafp.org/fpm/2004/0400/p49.html.

Medicare Preventive Services: Quick Reference. Centers for Medicare & Medicaid Services. http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/downloads/MPS_QuickReferenceChart_1.pdf.

1. Center for Medicare & Medicaid Services. National Health Expenditures and Selected Economic Indicators, Levels and Average Annual Percent Change: Selected Calendar Years 1990-2013. Washington, DC: Center for Medicare & Medicaid Services, Office of the Actuary; 2004.

2. Institute of Medicine. The Future of the Public's Health in the 21st Century. Washington, DC: National Academy Press; 2002.