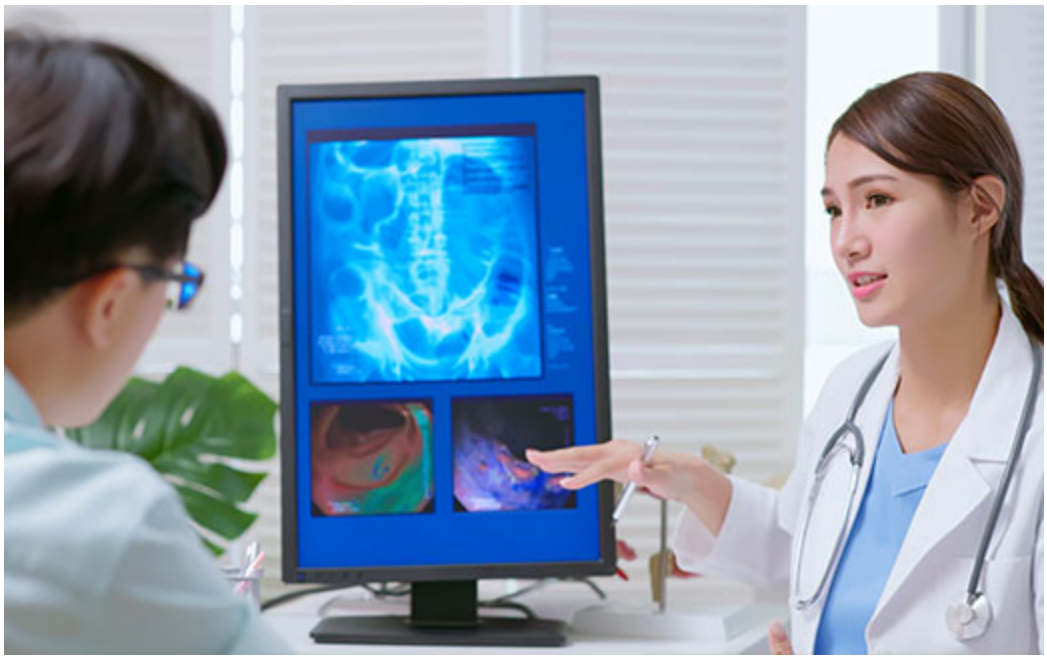
Billing for preventive care: Protecting the member cost-share arrangement



Regular preventive care can help detect and avoid serious health issues. To encourage members to take advantage of preventive care, many Blue Cross® Blue Shield® of Arizona (BCBSAZ) benefit plans offer preventive care coverage with little or no cost share. Preventive care benefits may include wellness visits, preventive lab tests, and cancer screenings. Be sure to check the member's eligibility and benefits for specific information about preventive coverage.

When preventive care includes diagnostic services: Billing tips

What starts out as preventive care can end up including diagnostic services. In these instances, you may be able to bill in a way that protects the member cost-share arrangement. Here are some high-level tips.

WELLNESS VISITS

Preventive wellness visits are typically performed on an annual basis to check a person's overall health. To bill for preventive services rendered as part of a routine physical exam, use an appropriate preventive diagnosis code as the ***primary diagnosis,*** along with a corresponding preventive CPT®/HCPCS procedure code. This helps ensure that the member's preventive cost-share arrangement will be applied.

If additional, medically necessary services are performed that fall outside of the wellness visit and are separately identifiable, a second line item can be reported with a separate, unique diagnosis. This may incur a non-preventive cost-share responsibility for the member. Please be sure to inform the member when this is the situation.

PREVENTIVE LAB SERVICES
According to the member's benefit plan, certain lab tests qualify for preventive services and should be billed with a ***well-care diagnosis code*** so the member's preventive cost-share arrangement will be applied. If non-preventive diagnostic tests have been ordered for the same lab session, the member may have a non-preventive cost-share responsibility. Ordering providers should inform the member of non-preventive tests.

PREVENTIVE HEALTH SCREENINGS
For Medicare Advantage plans, BCBSAZ processes most health screening codes (both preventive and diagnostic) to allow the preventive cost-share arrangement. For all other plans, routine preventive screenings such as mammograms and colonoscopies can often be billed to ensure that the member's preventive cost-share arrangement is applied, even when the screening becomes diagnostic. Your professional coding resources will guide you on the specifics of the following rules for commercial plans:

- Certain procedure codes are always processed as preventive, regardless of the diagnosis.
- Certain diagnostic procedure codes will be processed as "scheduled for preventive" only when billed with a well-care diagnosis code.
- Certain diagnostic procedure codes will be processed as "scheduled for preventive" only when billed with modifier PT or 33. These modifiers may not be used with every code. Be sure to check your coding resource to apply them accurately.
- Some codes will be processed as "scheduled for preventive" if they are billed with either or both of these: a well-care diagnosis code and/or a modifier. **Example:** For a colonoscopy billed with CPT code 45384 (includes tumor/polyp ablation or removal), you can protect the member's preventive cost-share arrangement by doing one or both of the following:
    - Use a well-care diagnosis as primary.
    - Add modifier PT or 33.
- Some diagnostic/therapeutic codes are always processed as diagnostic, regardless of the diagnoses code or an added modifier.

If an additional, medically necessary service is performed that falls outside of the routine preventive screening and is separately identifiable (e.g., ultrasound is done to further investigate), a second line item can be reported with a separate, unique diagnosis code. In this case, the member should be informed of the diagnostic procedure(s) and alerted to expect a non-preventive cost-share responsibility.

PATHOLOGY/ANESTHESIA BILLING
Bill the claim with a **well-care diagnosis as the primary diagnosis.** Use of a modifier is not relevant for pathology and anesthesia services.

- For pathology, the claim-processing system looks for lab claims related to preventive services. A matching claim will trigger the member's preventive cost-share arrangement.
- For anesthesia, we apply the preventive cost-share arrangement for certain codes when billed with a well-care diagnosis.

Summary

Billing for preventive care should always include a preventive diagnosis as primary. Certain types of preventive care have multiple procedure codes and associated modifiers to indicate that the service started as routine preventive care and ended up being diagnostic. Accurate use of these coding options may preserve the member's preventive cost-share arrangement. Your patients will appreciate the savings, especially if they need additional care as a result of the screening. For Medicare Advantage plans, CMS billing and coding guidelines should be followed to ensure correct benefit application.

As indicated in the above scenarios, there are times when it's medically appropriate to report a second line item that will likely incur a non-preventive cost-share responsibility for the member. To avoid an unpleasant surprise, always let the member know of the unexpected out-of-pocket cost.

If you have questions, please reach out to your provider liaison, or call us at 602-864-4231 or 1-800-232-2345, ext. 4231.

BCBSAZ member ID cards are available for download via eligibility and benefits search results.