Dermatology Coding Alert

Reader Questions: Examine Reason for Repeat Pap Before Billing

Question: How should I bill for a patient's repeat pap smear when there's an abnormality? Can I bill for the test as the physician's biller, or do I have to let the lab bill for it?

South Dakota Subscriber

Answer: You're correct that the billing issue in this situation is whether the physician can bill for the repeat pap, not the lab. Because the patient's last pap smear was abnormal, you should bill for the next pap smear using the diagnosis for the abnormality (795.0x).

Since the second pap smear is a diagnostic rather than screening pap, you must consider the collection as part of the E/M service you're billing.

If your physician only collected the pap smear, you should report 99212 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem-focused history; a problem-focused examination; straightforward medical decision-making).

If the physician performed other services during the office visit, bill 99213 (Office or other outpatient visit for the evaluation and management of an established patient,which requires at least two of these three key components: an expanded problem-focused history; an expanded problem-focused examination; medical decision-making of low complexity ...). This applies to both commercial and Medicare payers.

Caution: If the physician repeated the pap smear because of an insufficient sample rather than an abnormal result, you should bill the service to commercial insurance carriers using 795.08 (Unsatisfactory smear). Report this scenario to Medicare carriers using Q0091 (Screening diagnosis for the abnormality (795.0x).

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Caution: If the physician repeated the pap smear because of an insufficient sample rather than an abnormal result, you should bill the service to commercial insurance carriers using 795.08 (Unsatisfactory smear). Report this scenario to Medicare carriers using Q0091 (Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory). Indicate a repeat Pap smear by attaching modifier 76 (Repeat procedure by same physician) to Q0091.

Why: Per CPT, billers cannot report 99000 (Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory) for the collection of the pap specimen and you can only report 99000 if the office incurs an actual cost in transferring/preparing the specimen to go to the lab (such as pickup of the specimen or special preparation that is a cost to the practice).

The answers to the Reader Questions were provided and/or reviewed by **Barbara J. Cobuzzi, MBA, CPC, CPC-H, CPC-P, CHCC**, president of CRN Healthcare Solutions, a coding and reimbursement consulting firm in Tinton Falls, N.J.