Internal Medicine Coding Alert

Are You Forfeiting Payment Are You Forfeiting Payment

Say goodbye to your confusion over screening guidelines

The next time your internist performs a well-woman exam, you'll have trouble coding the visit if you don't know how Medicare and private payers' guidelines differ, and when you should separately code breast/pelvic exams and Pap smears.

Best bet: Use these two quick tips for accurate well-woman coding.

1. Break Out Services for Medicare

If the internist provides a complete well-woman exam for a Medicare patient, you should report G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination) for the breast and pelvic exams. When the physician also obtains a Pap smear, use Q0091 (Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory), says **Carol Pohlig, BSN, RN, CPC**, senior coding and education specialist at the University of Pennsylvania department of medicine in Philadelphia.

Remember that you can also report a new or established patient E/M code (99201-99215) in addition to G0101 and Q0091, Pohlig says. But the physician must have documented a separate and distinct E/M service, and you must attach modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to the E/M code. For example, the physician performs the well-woman exam but also evaluates and manages the patient's diabetes.

Important: For Medicare patients at normal risk, you can report a Pap smear only once every two years. The diagnoses your physician will use in these cases include V76.2 (Special screening for malignant neoplasms; cervix) and V76.47 (... Other sites; vagina), says **Pat Larabee CPC, CCP**, a coding specialist at InterMed, a multispecialty healthcare network in South Portland, Maine.

Avoid High-Risk Coding

If the patient is high risk, you can bill the Pap smears annually. To classify a patient as high risk, you will likely use V15.89 (Other specified personal history presenting hazards to health; other) for medical justification of a screening Pap smear, Larabee says.

Your physician should supply secondary diagnoses to explain why the patient is high-risk. These diagnoses are:

History of HIV (V08 or 042)

History of sexually transmitted diseases

Five or more sexual partners (V69.2)

Began sexual activity before 16 years of age (V69.2)

Diethylstilbestrol (DES) exposure (760.76)

Seven years without a Pap smear (V15.89)

Absence of three consecutive negative Pap results (795.0x).

2. Rely on CPT's Codes for Private Insurers

Although most commercial payers follow Medicare's lead when setting coding policies, many accept neither G0101 nor Q0091 for well-woman visits. In those cases, you may report one of CPT's preventive medicine codes (99381-99397), depending on your payer's policies, Pohlig says.

Coding tip: The correct preventive-medicine code depends on whether the patient is new or established, and the patient's age. For instance, if your internist sees a new patient, you'll likely report one of three codes:

99385 - Initial comprehensive preventive medicine evaluation and management of an individual including an age- and gender-appropriate history, examination,
counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; 18-39 years

99386 - ... 40-64 years

99387 - ... 65 years and over.

If the patient is established, you should report one of these codes:

99395 - Periodic comprehensive preventive medicine re-evaluation and management of an individual including an age- and gender-appropriate
history, examination...established patient; 18-39 years

99396 - ... 40-64 years

99397 - ... 65 years and over.

In some cases, private payers will reimburse for handling the Pap specimen. If so, you can also report 99000 (Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory). Typically, you'll link ICD-9 code V72.3x (Gynecological examination) to 99000.

Note: You should only use this code if the physician incurs a cost for handling the specimen.