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# Internal Medicine Coding Alert

## Charge the Right Amount for Well Woman Checks Every Time

**4 payer-specific steps unlock reimbursement for these common services**

Coding all female complete exams the same will result in underpayments for some claims and overcharged insurers for others. Here's a simple plan to make sure you charge the appropriate amount every time.

**Tip:** Although practices use one fee for a well woman check, the visit typically encompasses three portions:

• a general preventive examination (GPE) that includes an age- and gender-appropriate examination.

• gynecological issues (including a breast and pelvic exam)

• a Pap smear.

**Step 1: Use 99381-99397 Across the Board**

For the general health check, you should assign a preventive medicine service code. The correct preventive medicine code depends on two factors:

• the patient's status--new or established

• 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.

**Catch:** Medicare does not cover routine annual exams. When an internist performs this service "for a Medicare patient, you should carve out the services and not charge the patient the entire preventive care fee," says **Bruce Rappoport, MD, CPC**, a board-certified internist who works with physicians on compliance, documentation, coding and quality issues for **Rachlin, Cohen & Holtz LLP**, a Fort Lauderdale, Fla.-based accounting firm with healthcare expertise.

**Be careful:** On the claim form, you still need to send the Medicare carrier the preventive care code with modifier GY

(Item or service statutorily excluded or does not meet the definition of any Medicare benefit), Rappoport says. The modifier indicates that the service is not covered and allows Medicare to correctly state the amount the patient owes on the evaluation of benefits (EOB) form.

**Don't forget:** Check with commercial payers for their policies and procedures regarding the coding of a "well-woman" exam.

Do not use alternative E/M codes to attempt to obtain payment. For instance, don't code a well exam with 99201-99215 for a Medicare patient's preventive medicine service in order to get the service covered. Coding based on insurer can be construed as coding for reimbursement instead of based on correct coding guidelines, says **Vicky V. O'Neil, CPC, CCS-P**, coding and compliance educator in St. Louis, Mo. You should instead select the E/M code based on the visit's purpose (preventive medicine service or sick visit.)

For tips on coding E/M services when an internist encounters problems in the course of a well check, see "Combat Dual E/M Service Denials With 2 Tried-and-True Strategies".

**Step 2: Break Out Breast, Pelvic Exam With G0101**

There are two reasons you may overlook separately reporting a routine breast and pelvic exam. First, physicians usually perform these services during a preventive medicine service, so many private payers include the breast and pelvic exam portions in 99381-99397. Also, CPT contains no codes for specifically reporting these services.

But Medicare does offer a HCPCS code for breast and pelvic exams. Why: Because preventive medicine services are not a covered Medicare benefit, but breast and pelvic exams are (every two years), CMS had to create a unique reporting system to capture these services. When an internist performs breast and pelvic exams for patients on Medicare or Medicare replacement plans, you should assign G0101, says **Linda Tiedt, CPC**, with **Affinity Health System** in Northeast Wisconsin. At least one third-party payer uses the NCCI edits and allows you to report G0101, she says.

**Step 3: Try 2 Codes to Collect Pap Fee**

Don't overlook coding one additional code for the Pap smear associated with the well woman check. "We use Q0091 on our Paps for the handling and collection," Tiedt says.

**Problem:** Not all private payers recognize the Pap smear collection HCPCS code (Q0091, Screening Papanicolaou smear; obtaining, **preparing and conveyance of cervical or vaginal smear to laboratory**). Check with the payer to identify its policies and procedures for coverage and billing guidelines, Rappoport says.

**Step 4: Carve Out Payable Portions**

If you use a single fee for well woman checks and the fee includes the breast and pelvic exams, you have to subtract this portion to bill properly for either the preventive medicine service (99381-99397) or the breast and pelvic portion (G0101). "We carve out the G0101 from the preventive for Medicare patients, whereas with commercial carriers we bill out only the preventive," Tiedt says.

"The charge for G0101 [about $29] and Q0091 [for instance $27] must be deducted from the usual charge for the preventive service" (such as $150) according to the article "Medicare Coding for Preventative Care Services" by **Robert Clutter, MD**, and **Joy Newby, LPN, CPC,** published by the Indiana Academy of Family Physicians available at http://www.in-afp.org/x2845.html.

**Kathy Pride, CPC, CCS-P**, director of consulting and training for the Reston, Va.-based QuadraMed, offers the following example: A 65-year-old established female patient not considered high-risk receives a preventive service that includes a clinical breast and screening pelvic exam with obtaining of a Pap smear, Pride says. The correct way to bill this to Medicare is:

- G0101--$29
- Q0091--$27
- 99397-GY--$150.

"The amount the patient owes is $94 (99397-- [G0101 + Q0091] = Amount owed by patient)," Pride says.

When billing a third-party payer that does not recognize G0101 and Q0091, you would instead report:

- 99397 with V70.0 (Routine general medical examination at a healthcare facility)--$150.