Internal Medicine Coding Alert

Get Paid for Same-Day Pelvic/Breast Exam and Problem-Oriented Office Visit

Effective July 1, 2001, Medicare's Program Memorandum 1823 released on Feb. 1, 2001, changed the allowed frequency of pelvic/breast exams and Pap smears from once every three to once every two years. These exams can be billed separately from a patient's unrelated, problem-focused office visit.

Medicare allows providers to bill G0101 (cervical or vaginal cancer screening; pelvic and clinical breast examination) and Q0091 (screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory) with an office visit (99201-99205, new patient; or 99211-99215, established patient) on the same date of service provided by the same physician only if the gynecological services are distinctly separate from the office visit. When both services are provided during the same encounter for distinctly different reasons, you should append 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.

Note: As of January 1998, CMS (formerly HCFA) decided reimbursement of a pelvic/breast exam (G0101) was comparable to an E/M level two (99202, office or other outpatient visit for the evaluation and management of a new patient, which requires an expanded history and examination, and straightforward medical decision-making). The physician work relative value unit (RVU) for G0101 is .66, and for 99202 is .64.

Effective Billing for More Frequent Gyn Exams

Carol Schobert, MD, says her 15-physician internal medicine practice almost always codes G0101 and Q0091 with a problem-focused office visit. "It is rare that I use only G0101 and Q0091 -- although it does happen.

"I usually treat my patients for medical problems such as hypertension and diabetes. When their pelvic is due, I schedule extra time for an appointment just as I do for any other preventive services, mammograms for example. Because my patients usually are older, I like to perform a pelvic exam once a year as a preventive measure. The patient is responsible for paying for the exam when it is not covered. The fact that Medicare now covers the service once every two years means my patients pay less out-of-pocket."

Medicare, however, will cover gynecological exams more than once every two years if there is evidence on the basis of medical history or other findings that the patient is at high risk of developing cervical cancer and her physician recommends frequent testing.

According to the 1999 edition of Medicare National Level II Codes, Medicare, Part B, covers HCPCS G0101 under two conditions:

1. The patient has not had a test during the preceding two years or is a woman of childbearing age.

2. There is evidence (on the basis of medical history or other findings) that she is at high risk of developing cervical cancer and her physician (or authorized practitioner) recommends that she have the test performed more frequently than once every two years.

High-risk factors for cervical and vaginal cancer are defined as early onset of sexual activity (under age 16), multiple sexual partners (five or more in a lifetime), history of sexually transmitted disease (including HIV infection), fewer than three negative or no Pap smears within the previous seven years, and DES (diethylstilbestrol)-exposed daughters of

women who took DES during pregnancy.

Medicare Part B pays for a screening pelvic examination if it is performed by an MD, DO, certified nurse midwife, physician assistant, nurse practitioner, or clinical nurse specialist who is authorized under state law to perform the examination. This exam does not have to be ordered by a physician or other authorized practitioner, making it more accessible to women.

Including Essential Elements

To apply G0101 correctly, the exam should include at least seven of the following 11 elements, according to Medicare Title XVIII, Section 1861:

1. Inspection and palpation of breasts for masses or lumps, tenderness, symmetry or nipple discharge.

2. Digital rectal examination including sphincter tone, presence of hemorrhoids and rectal masses.

3. Pelvic examination (with or without specimen collection for smears and cultures) including external genitalia (for example, general appearance, hair distribution or lesions).

4. Urethral meatus (for example, size, location, lesions or prolapse).

5. Urethra (for example, masses, tenderness or scarring).

6. Bladder (for example, fullness, masses or tenderness).

7. Vagina (for example, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele or rectocele).

8. Cervix (for example, general appearance, lesions or discharge).

9. Uterus (for example, size, contour, position, mobility, tenderness, consistency, descent or support).

10. Adnexa/parametria (for example, masses, tenderness, organomegaly or nodularity).

11. Anus and perineum.

Modifier -25 Unlocks Reimbursement

Mary Mulholland, BSN, RN, BPC, reimbursement analyst for the department of medicine of the University of Pennsylvania, emphasizes the need to append modifier -25 to a problem-oriented office visit to get reimbursed for both the services provided in the visit as well as the gynecological exam.

Coding Scenario 1: During her regular pelvic exam, a 65-year-old Medicare patient mentions she has heart palpitations. The physician takes her vitals, listens to her chest, and determines her heartbeat is irregular and orders an electrocardiograph (EKG). The EKG shows an abnormality, so the internist refers the patient to a cardiologist for further treatment. In this case, make sure the medical decision-making (MDM) is linked to the problem (i.e., 785.3, symptoms involving cardiovascular system; other abnormal heart sounds), then use G0101 for the pelvic/breast exam and Q0091 for obtaining the Pap smear specimen.

Depending on the level of MDM, also code the gyn exam with the appropriate E/M code, which would most likely be 99213 (office or other outpatient visit for the evaluation and management of an established patient, which requires an expanded problem focused history and examination, and medical decision making of low complexity) or 99214 (... a detailed history and examination, and medical decision making of moderate complexity) and attach modifier -25. You can also bill 93010 (electrocardiogram ... interpretation and report only) for the EKG interpretation.

Coding Scenario 2: During her first visit with the internist for a pelvic/breast exam, a 35-year-old Medicare patient complains of head pain, pressure and congestion. After the exam the physician diagnoses the unrelated medical complaint as acute maxillary sinusitis, 461.0. Because this is a Medicare patient, use G0101 and Q0091 for the pelvic/breast exam and Pap smear and report the problem-oriented portion of the exam with the appropriate E/M code (i.e., 99202) appended with modifier -25. The sinusitis diagnosis code should only be linked to the E/M code.

Coding for Non-Medicare Patients

Sherry Straub, RHIT, CCCS, manager of coding and compliance of Esse Health in St. Louis, says some payers recognize the preventive-medicine services codes 99381-99387 (new patient) and 99391-99397 (established patient) for billing pelvic/breast exams, although carriers usually establish their own reimbursement policies for these services. When using these codes for a pelvic/breast exam that also includes a separate E/M service, attach modifier -25 to the office-visit code.

Preventive-medicine codes for new patients comprise initial preventive-medicine E/M of an individual including a comprehensive history, a comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions, and ordering appropriate laboratory/diagnostic procedures. The code you use depends on the patient's age. Codes for established patients (99391-99397) provide periodic preventive medicine re-evaluation and management.

Coding Scenario 3: If the same 65-year-old woman from Scenario 1 had private insurance rather than Medicare coverage, use the preventive-services code 99397 for the pelvic/breast exam (... 65 years and over) and append modifier -25 to the office-visit E/M code 99213 or 99214. Again, make sure the documentation links the diagnosis code -- 785.3 -- to the problem-oriented office visit code and any other tests or procedures performed in relation to the medical problem. Submit Q0091 for handling the Pap specimen.

Alternative Pelvic Exam Codes

Straub suggests checking with local carriers because some use special "S" codes to identify pelvic/breast exams. For instance, a private carrier in Missouri uses S0612 to indicate an annual gynecological exam for an established patient, and S0610 for a new patient. Both codes include obtaining the Pap specimen.

In Florida, Cigna uses its own non-CPT procedure code 90769 for pelvic/breast exams. The procedure code comes from Cigna's provider manual. Mulholland says you must depend on each carrier's published guidelines to determine the payment. "Most carriers, however, follow Medicare guidelines," she says.

Pap-smear reimbursement from private payers depends on the patient's coverage. You should probably submit the same HCPCS codes (Q0091) to a private payer because CPT lists no corresponding Pap-smear collection or pelvic-exam codes. Some carriers will recognize the Q0091 code for handling the Pap specimen.

Using V Codes Correctly

"For the pelvic/breast exam, it is important to link the diagnosis to the Q0091 and either the G0101 or preventive services code," Straub says. Medicare requires one of two ICD-9 codes to indicate low- or high-risk status:

1. V76.2 special screening for malignant neoplasms of the cervix, indicates low risk, or
2. V15.89 other specified personal history presenting hazards to health, indicates high risk.

If the code for the Pap smear is not linked to one of the ICD-9 codes above on line one of item 24E on the HCFA-1500 form, the claim will be rejected.