Codify by AAPC

Internal Medicine Coding Alert

Mind Your Gs and Qs, or Face Medicare Denials on Well-Woman Exams

When your internist provides a Medicare patient with a well-woman examination, you'll need to use a combination of CPT and HCPCS codes to receive the fullest possible reimbursement.

Filing these claims also involves carving out covered portions of the preventive medicine code to ensure claim compliance. Check out this plan for filing well-woman exams for your Medicare beneficiaries.

Carve Out Non-Covered Portions of CPT Code

For the preventive examination you'll choose one of the following codes, confirms **Jan Allen**, claims and accounts receivable manager for a three-physician practice in Santa Paula, Calif.

New patient:

• 99387 -- 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; 65 years and over.

Established patient:

• 99397 -- Periodic comprehensive preventive medicine re-evaluation and management of an individual including an age- and gender-appropriate history, examination... established patient; 65 years and over.

However, Medicare does not cover these routine exams. For that reason, your practice will have to carve out the covered services and not charge the patient the entire preventive care fee. To arrive at the amount the practice can collect from the patient:

• take the billing price for the preventive care exam,

• subtract the billing prices for a well-woman exam (G0101 [Cervical or vaginal cancer screening; pelvic and clinical breast examination] and a Pap smear (Q0091 [Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory]) and

Result: Charge the patient that amount.

For example, if the practice charges $150 for a preventive care exam, $50 for G0101 and $25 for Q0091, the practice can collect $75 from the patient.

Also, remember to append modifier GY (Item or service statutorily excluded or does not meet the definition of any Medicare benefit) to the CPT code. This modifier will allow Medicare to formulate the amount the patient owes on the evaluation of benefits (EOB).

So let's say your internist provides a routine exam to a 68-year-old established Medicare patient. On the claim, report 99397-GY for the service.

Add Appropriate HCPCS Codes

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For patients with Medicare coverage, you'll be able to report pelvic/breast exams and Pap smears separately, in addition to the CPT code for the preventive medicine visit. Report breast/pelvic exams with G0101, confirms Allen. If the internist also obtains a Pap smear during the encounter, report that service with Q0091, Allen relays.

So let's say the internist provides a complete well-woman exam, with breast/pelvic exam, and Pap smear for a 68-year-old new Medicare patient. On the claim, you'd report the following:

• 99387-GY for the general exam

• G0101 for the breast/pelvic exam

• Q0091 for the Pap smear.

Define Pap Risk Category

You'll need to observe strict qualification guidelines for your patients who receive well-woman exams and Pap smears in the same session. Medicare has set risk categories for patients receiving Pap smears; average-risk patients are eligible for the test every two years, while those at high risk can have one annually.

For many average-risk patients, you'll attach V76.2 (Special screening for malignant neoplasms; cervix: routine cervical Papanicolaou smear) to Q0091 to explain the reason for the test, explains **Sean Weiss, CPC, CPC-P, CMPE, CCA-P, CCP-P,** senior partner at The CMC Group LLC in Atlanta. (Note: Medicare covers breast/pelvic exams once every two years for its patients).

According to chapter 18 of the Medicare Claims Processing Manual (MCM), Medicare will also accept these diagnoses for average-risk Pap patients:

• V72.31 -- Routine gynecological examination

• V76.47 -- Special screening for malignant neoplasms; vagina

• V76.49 -- ... other sites.

In order for a patient to be in the high-risk category, she must have at least one of the following characteristics, according to the MCM:

• The beneficiary has not had a screening Pap smear test during the preceding three years (meaning, 35 months have passed following the month that the woman had the last covered Pap smear);

• There is evidence (on the basis of her medical history or other findings) that she is of childbearing age and has had an examination that indicated the presence of cervical or vaginal cancer or other abnormalities during any of the preceding 3 years; **and** at least 11 months have passed following the month that the last covered Pap smear was performed; or

• She is at high risk of developing cervical or vaginal cancer **and** at least 11 months have passed following the month that the patient received her last covered screening Pap smear.

Here's Medicare's high-risk factors for cervical and vaginal cancer:

• Early onset of sexual activity (under 16 years of age; V69.2, [High-risk sexual behavior])

• Multiple sexual partners (5 or more in a life-time, V69.2)

• History of a sexually transmitted disease (including HIV infection, V08, [Asymptomatic human immunodeficiency virus

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(HIV) infection status]; or 042, [Human immunodeficiency virus (HIV) disease])

• Fewer than three negative or any Pap smears within the previous 7 years (795.0x, [Abnormal Papanicolaou smear of cervix and cervical HPV]; V15.89, [Other specified personal history presenting hazards to health; other])

• DES (diethylstilbestrol)-exposed daughters of women who took DES during pregnancy (760.76, Noxious influences affecting fetus or newborn via placenta or breast milk; diethylstilbestrol [DES]).

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