Internal Medicine Coding Alert

Optimize Reimbursement by Billing Separately For Pap Smears, Pelvic Exams and E/M Service

Internists should document and bill separately for Pap smears and pelvic exams for Medicare beneficiaries. In addition, if the patient is seeing the internist for a separate medical problem on the day of either screening procedure, a separate evaluation and management (E/M) service may be reported. This will ensure that the practice receives optimum reimbursement.

Although screening Pap smears for the early detection of cervical or vaginal cancer have been a Medicare benefit since 1990, separate coverage for pelvic examinations, which includes a clinical breast examination, was added in January 1998. According to Section 50-20.1 of the Medicare Coverage Issues Manual, a woman is eligible for a screening Pap smear or pelvic examination if she has not had one during the proceeding three years. Code V76.2 (special screening for malignant neoplasm; cervix) should be used on the claim form to indicate low risk.

The examinations can be performed once a year if the patients medical history indicates she is at risk of developing cervical or vaginal cancer. Code V15.89 (other specified personal history presenting hazards to health) should be used on the claim form to indicate high risk.

High-risk factors for cervical or vaginal cancer include:

Early onset of sexual activity (under 16 years of age);
Multiple sexual partners (five or more in a lifetime);
History of sexually transmitted disease (including HIV infection);
Fewer than three negative pap smears within the previous seven years; and
DES (diethylstilbestrol)-exposed daughters of women who took DES during pregnancy.

The examinations also can be performed once a year if the woman is of childbearing age (premenopausal) and has had a Pap smear during any of the preceding three years that indicated the presence of cervical or vaginal cancer or other abnormality. Code V15.89 should be used on the claim form to indicate high risk.

Report Pap Smear and Pelvic Exam Separately

Code Q0091 (screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory) is used to report the Pap smear and G0101 (cervical or vaginal cancer screening; pelvic and clinical breast examination) is used for the pelvic exam, according to **Andrea Lamb, CPC**, billing clerk at St. Josephs Medical Plaza, a 14-physician multispecialty group in Buckhannon, W.Va. The exams are reported separately and can be performed on the same day or on different days, she says.

Pelvic Exam Requires Documentation

The pelvic examination, like the examination component in an E/M service, also requires the internist to document the results in the patients medical record. According to the Medicare Coverage Issues Manual screening pelvic examinations should include at least seven elements taken from the female genitourinary examination outlined in the Health Care Financing Administrations (HCFA) 1997 Documentation Guidelines for Evaluation and Management Services.

The elements include the inspection and palpation of breasts for masses or lumps, tenderness, symmetry or nipple discharge; digital rectal examination including sphincter tone, presence of hemorrhoids and rectal masses; and pelvic

examination (with or without specimen collection for smears and cultures) including:

External genitalia (for example, general appearance, hair distribution or lesions);
Urethral meatus (for example, size, location, lesions or prolapse);
Urethra (for example, masses, tenderness or scarring);
Vagina (for example, general appearance, estrogen effect, discharge lesions, pelvic support, cystocele or rectocele);
Cervix (for example, general appearance, lesions or discharge);
Uterus (for example, size, contour, position, mobility, tenderness, consistency, descent or support);
Adnexa/parametria (for example, masses, tenderness, organomegaly or nodularity); and
Anus and perineum

Although most internists probably are doing the appropriate examination, Lamb believes that many dont write down everything that was covered during the exam, which could be problematic if there is a Medicare audit. Our Medicare representative said that if the chart is not complete, dont bother filing a claim, she says. We do a chart review of all our physicians and monitor their documentation. If their notes are not complete, we wont bill Medicare.

Report Separate E/M Service for Separate Problem

Because of revisions made by Medicare in 1999, a separate E/M service can be reported with the Pap smear or pelvic examination codes if the reason for the E/M service is unrelated to the examinations. If a patient discusses changing her hypertension medication with the internist on the same day that she has the Pap smear and/or pelvic examination, for example, that hypertension discussion can be reported as a separate E/M service with modifier -25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) attached to the code, Lamb states.

In our practice, the physicians would document each service separately by writing up the hypertension discussion first, then skipping a few lines and writing up the Pap smear and/or pelvic exam portion of the visit next, she explains. The level of service for the E/M visit will be determined by the level of history, examination and medical decision-making that occurred only during the hypertension discussion.

Diagnostic examinations that are done on patients with symptoms such as vaginal bleeding, are not reported separately, according to Lamb. Any diagnostic Pap smear is bundled into the E/M service, she says.

Use HCPCS Codes for Private Payers Also

Reimbursement from private insurance companies for Pap smears will vary depending on the type of coverage the patient has. With most managed care plans, Lambs practice will not submit a charge. Most indemnity plans, on the other hand, will reimburse for the examinations, and Lamb will submit the same HCPCS codes to a private payer that she does to Medicare because there is no corresponding Pap smear collection or pelvic examination code listed in CPT.

Another problem with reimbursement from private payers is that they usually will not pay for the thin layer preparation test that Medicare reimburses and is used by most internists. The swab in a thin-prep test goes into a jar and is taken directly to the lab, reducing the chance of contamination to the sample, Lamb explains. Lots of insurance companies wont pay for the thin-prep test. Instead, they cover the standard slide test where the swab is rubbed on a slide that is later sprayed with a fixative.

Because Medicare generally will reimburse for only one examination every three years, internists might want to explain to their patients that they might have to pay for the examination themselves, Lamb adds. Lots of patients cant remember when they had their last Pap smear and pelvic exam. Or they may not want to tell you that they went to another doctor and had one, she explains. At our practice, we have the patients sign a waiver that says they will pay for the service if Medicare does not.