Codify
BY AAPC

Internal Medicine Coding Alert

Preventive Services: Avoid These Common Errors in Preventive Care Coding

Report your well-patient services properly to collect accurate reimbursement.

As a internal medicine coder, you will come across preventive care coding scenarios commonly. Don't fall into the trap of losing out on precious reimbursement by committing frequently made mistakes in preventive care coding. Check out these three common errors that involve some preventive care services.

1. Don't Report G0438 Per Physician: Many providers believe that they can report G0438 (Annual wellness visit; includes a personalized prevention plan of service [PPS], initial visit) annually as long as a different physician performs each one, but that isn't the case.

If Physician A performs the initial annual wellness visit (AWV) in 2013 and Physician B performs another in 2014, then Physician A should report G0438, but Physician B should not.

The correct code for Physician B is G0439 (...subsequentvisit). "The determination of whether the AWV is an initial or subsequent is based on the patient and not the person providing the service," according to a Q&A on this topic on the NGS Medicare website. G0438 is actually a "once in a lifetime" code, so Medicare will only reimburse this one time, which is during the patient's first AWV.

2. Don't Avoid G0436 When Patient Is Asymptomatic. As many practices are aware, smoking and any other tobacco-use cessation counseling are covered under Medicare. In the past, only those patients who were diagnosed with a tobacco-related condition or showed symptoms of a tobacco-related condition were covered. However, from 2010 onward, even those beneficiaries not currently showing any signs or symptoms of a tobacco-related condition are eligible for counseling.

Depending on the time spent for the counseling sessions with an asymptomatic Medicare patient, you can report it as G0436 (Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes) or G0437 (...intensive, greater than 10 minutes) for patients that are covered under Medicare.

For all other payers not following Medicare guidelines and for symptomatic Medicare patients whom you are counseling therapeutically (rather than preventively, as with G0436 and G0437), you can report 99406 (Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes) or 99407 (...intensive, greater than 10 minutes).

Under Medicare, two attempts at cessation of use are covered for counseling, and only four counseling sessions are covered per attempt. Consequently, you can only get coverage for a maximum of eight sessions in a calendar year. After the usage of eight sessions within the year, another round of counseling is allowed only after the passage of 11 months since the first Medicare-covered cessation counseling session.

For example, if the patient started the first of his eight covered sessions in January 2014, then the waiting period is applicable from February 2014, and the beneficiary can receive a second series of eight sessions beginning in January 2015, independent of when he finished his first series.

3. Note Increased Pap Frequency for High-Risk Patients. For Medicare patients, you can code for obtaining the Pap specimen for screening purposes by reporting HCPCS code Q0091 (Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory). Typically, this is done in conjunction with a

screening pelvic and breast examination, which may be separately reported to Medicare with the HCPCS code G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination).

Explanation: CPT®'s Pap smear codes, such as 88175 (Cytopathology, cervical or vaginal [any reporting system], collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening or review, under physician supervision), represent the pathologist's work of supervising the actual screening of the specimen and interpreting the results. CPT® does not have separate codes for reporting the obtaining of a Pap smear specimen, because CPT® considers it inherent in the procedure or other service (e.g., office visit) being performed.

For non-Medicare patients, obtaining a Pap smear specimen is not separately reportable. Instead, you will need to report a code for the encounter at which the Pap smear specimen is collected. This will likely be a preventive service code or a standard office visit code (9920x or 9921x), depending on the nature of the encounter. "This is also true for Pap smear specimen collection done for diagnostic, rather than screening purposes," points out Kent Moore, senior strategist for physician payment at the American Academy of Family Physicians.

Screening Pap smears are a separate benefit under the Medicare program, which is why Medicare has HCPCS code Q0091 for this purpose.

Know the "High Risk" Definition: Medicare covers Pap smears and screening pelvic exams once every 12 months for women who are of childbearing age and have had aPap test in any of the previous three years that indicated the presence of cervical or vaginal cancer or other abnormalities; or who are considered high risk for developing cervical or vaginal cancer on the basis of their medical history or other findings. Women are considered to be at high risk for cervical or vaginal cancer if they:

- Engaged in sexual activity before the age of 16;
- Had multiple sexual partners (5 or more in a lifetime);
- Have a history of a sexually transmitted infection (including HIV infection);
- Had fewer than 3 negative Pap tests or no Pap tests within the previous 7 years
- DES(diethylstilbestrol)-exposed daughters of women who took DES during pregnancy

Pap smears and pelvic exams for all other women (low risk) are covered every two years under Medicare.