Internal Medicine Coding Alert

Reader Question: PAP/Pelvic Codes Depend on Payer

Question: I noticed that there are multiple codes for pap smears and for routine gynecological exams. Can you explain when I use the different codes and if I can report them together?

Idaho Subscriber

Answer: You must choose the code that the individual payer recognizes. For instance, Medicare expects G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination) for a routine gynecological examination and Q0091 (Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory) for a Pap smear collection.

Medicare covers both G0101 and Q0091 during the same office visit, as long as it has been at least two years since the last service for average-risk patients and one year for high-risk patients.

On the other hand, many private payers only recognize V72.31 (Routine gynecological examination, general gynecological examination with or without Papanicolaou cervical smear, pelvic examination [annual] [periodic]), and V76.2 (Special screening for malignant neoplasms, cervix, routine cervical Papanicolaou smear) for these services.

For an exam with a Pap collection report only V72.31, since the code's descriptor includes the collection. Report V76.2 only if the internist collected a Pap sample without performing a routine pelvic exam.

Answers to You Be the Coder and Reader Questions were reviewed by **Bruce Rappoport, MD, CPC, CHCC,** a board-certified internist and medical director of Broward Health's Best Choice Plus and Total Claims Administration in Fort Lauderdale, Fla.