

Internal Medicine Coding Alert

Reader Question: Screen Asymptomatic Pap Smear Codes

Question: What are Medicare's coverage requirements for Pap smears for asymptomatic patients, and are E/M services separately billable?

Nebraska Subscriber

Answer: According to CMS, screening Pap smears are covered every two years for low-risk Medicare patients and annually for high-risk patients the trick is differentiating the low- from the high-risk patients.

To qualify as "high risk," a Medicare patient must meet one of the following criteria:

1. History of HIV V08 or 042
2. History of STDs V13.8
3. Five or more sexual partners in her lifetime V69.2
4. Onset of sexual activity before age 16 V69.2
5. Diethylstilbestrol (DES) exposure 760.76
6. History of no Pap smears in the last seven years V15.89
7. Absence of three consecutive negative Pap results 795.0x
8. Any gynecological problem (such as cervical or vaginal cancer or genitourinary system problem) in the last three years if the patient is of childbearing age.

Anytime a Medicare patient meets the risk and frequency requirements for a screening mammogram, Medicare will reimburse for the collection of a specimen, reported with code Q0091 (Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory). If the Medicare patient is considered "low risk" and receives her Pap smear biennially, link Q0091 to V76.2 (Special screening for malignant neoplasms; cervix); for Medicare patients considered "high risk" and receiving a Pap smear annually, link Q0091 to primary diagnosis code V15.89 and any secondary diagnosis codes that classify the patients as "high risk."

And if a separate E/M service is provided for a separate, significant problem, you can bill the E/M service separately if you 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 indicate that it is separate from the Pap.