Codify
BY AAPC

Internal Medicine Coding Alert

Reader Questions: Forget Pap Risk Category, and Denial Could Come

Question: An established 67-year-old Medicare patient reports for a Pap smear. How should I report this encounter? Are there frequency parameters to observe?

Colorado Subscriber

Answer: When the internist provides a Medicare patient with a Pap smear, coders should be aware of the qualification guidelines before coding. Otherwise, your practice could be stuck paying for an uncovered Pap smear screening.

Medicare policy allows average-risk patients a covered Pap smear once every two years; patients at high risk can have the covered screening once a year. We'll show you how to code for each risk category in the next two examples:

Example 1: The patient is at average risk for cervical cancer, and she has never had a Pap smear before. On the claim, you would report the following:

• Q0091 (Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory) for the Pap smear

• V76.2 (Special screening for malignant neoplasms; cervix: routine cervical Papanicolaou smear) appended to Q0091 to explain the reason for the test.

Example 2: The patient is at high risk for cervical cancer due to early onset of sexual activity. She last had a covered Pap smear in June 2006. On the claim, you would report the following:

• Q0091 for the Pap smear

• V15.89 (Other specified personal history presenting hazards to health; other) appended to Q0091 to define the patient's risk category

• V69.2 (High-risk sexual behavior) appended to Q0091 to describe the patient's risk factor[s].

Diagnosis options: You'll use V15.89 on nearly all your high-risk Pap screens. According to Chapter 18 of the Medicare Claims Processing Manual, you should use one of the following V codes on your low-risk Pap smear screenings:

• V76.2 -- Special screening for malignant neoplasms; cervix

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

• V76.49 -- Special screening for malignant neoplasms; other sites

• V72.31 -- Routine gynecological examination.

Remember to use V76.49 for women without cervixes who receive Pap smears; also, only use V72.31 if the provider performs a complete gynecological exam during the encounter.

Private payers differ: Most private payers want you to append V72.31 (Routine gynecological examination) to either Q0091 or 99000 (Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory) for a screening Pap smear that the provider performs with a preventive medicine service.

The V72.31 code is for use on annual exams, with or without Pap smear. For private payers, you should only use V76.2

when the only purpose of the visit is to collect a Pap smear.