Internal Medicine Coding Alert

READER QUESTIONS: Get Elemental to Ensure Well-Woman Success

Question: The internist performs a well-woman examination with Pap smear for a low-risk 67-year-old Medicare patient. Notes indicate the internist addressed eight elements during the exam; however, I see no evidence of a breast exam. Can I still report the wellwoman exam?

Illinois Subscriber

Answer: Provided the patient is eligible for both services, you can report G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination) for the well-woman exam, along with Q0091 (Screening Papanicolaou smear; obtaining, preparing, and conveyance of cervical or vaginal smear to laboratory) for the Pap smear.

Explanation: Despite the descriptor, a breast exam is not required in order to report G0101. In order to report this code, the exam must include seven of the following 11 elements:

1. Inspection and palpation of breasts for masses or lumps, tenderness, symmetry , nipple discharge, etc.

2. Digital rectal examination (DRE) including sphincter tone, presence of hemorrhoids, rectal masses, etc.

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

3. External genitalia (appearance, hair distribution, lesions, etc.).

4. Urethral meatus (size, location, lesions, prolapse, etc.).

5. Urethra (masses, tenderness, scarring, etc.).

6. Bladder (fullness, masses, tenderness, etc.).

7. Vagina (appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele, etc.).

8. Cervix (appearance, lesions, discharge, etc.).

9. Uterus (size, contour, position, mobility, tenderness, consistency, descent, support, etc.).

10. Adnexa/parametria (masses, tenderness, organomegaly, nodularity, etc.).

11. Anus and perineum.

Mind frequency limits: The coding advice for this scenario is correct provided the services don't violate Medicare's frequency guidelines. The rules for G0101 and Q0091 exams are the same: Medicare patients classified as high risk can receive these services annually; but for low-risk patients, these services are covered once every two years.

If you're unsure about a patient's status, get a signed advance beneficiary notice (ABN) on file before performing G0101 or Q0091.