Internal Medicine Coding Alert

READER QUESTIONS: Try Q0091-76 With Private Payers

Question: When a Medicare patient requires a repeat Pap smear, I use Q0091 with 795.08. Should I report the same codes to a commercial payer?

Indiana Subscriber

Answer: Unfortunately, the old adage "Check with the insurer" rings true in this scenario. CPT does not contain a code that describes a Pap smear, so commercial insurers may create their own coding policies.

Some third-party payers accept Medicare's Pap smear code Q0091 (Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory). If the insurer denies the HCPCS level-II code Q0091, try the CPT miscellaneous supply code 99000 (Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory).

Important: You should attach modifier 76 to Q0091 when submitting a repeat Pap smear, regardless of insurer. Modifier 76 (Repeat procedure by same physician) tells the carrier that the physician had to repeat the procedure.

Because insurers may have frequency edits to limit payments for annual screens, you will need modifier 76 to receive payment for the repeated procedure during the noncovered period. Medicare made this coding mandatory on July 1, 2005.

The diagnosis will further explain the repeat Pap. You should report the resubmission Pap smear (such as Q0091) with V76.2 (Special screening for malignant neoplasms, cervix), V76.47 (Special screening for malignant neoplasms, vagina) or V76.49 (Special screening for malignant neoplasms, other sites).

Link 795.08 (Unsatisfactory smear) to the E/M encounter (such as 99212, Office or other outpatient visit for an established patient ...).