Internal Medicine Coding Alert

Relax Your Medicare Well-Woman Requirements With New CMS Info

Your internist might not need to provide breast exam to report G0101

A new transmittal from Medicare appears to make counting exam elements for your well-woman patients less restrictive. Read on for specifics about G0101 clarifications, and a quick primer for coding your Medicare well-woman exams.

Apply This New CMS Clarification for G0101

On your well-woman exam claims, you'll still report G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination) for the cervical/pelvic portion of the well-woman test, says **Sheldrian LeFlore, CPC,** director of revenue management with The Coding Group in Carlsbad, Calif.

What's new: CMS Transmittal 1541, however, indicates that the breast exam does not necessarily need to be one element of the service. Previously, CMS organized the bulleted elements in a way that suggested that the physician is required to give a breast exam. Also, G0101's definition includes a clinical breast exam. Therefore, most coders believed that a breast exam must be one of the elements. Thanks to this clarification, you can see this is not the case.

Heads up: According to CMS Transmittal 1541, when your physician performs a screening pelvic examination, the exam needs to include at least seven of the 11 elements listed on page 82 in order to report G0101.

"The intent was to indicate that [a breast exam] is one of the 11 elements, and you can choose any seven,"**Melanie Witt, RN, CPC-OBGYN, MA,** a coding consultant in Guadalupita, N.M. But among coders and even some payers, "there is still confusion" even after the clarification.

Advice: Be on the lookout for more CMS news on coding G0101. In the meantime, before filing a G0101 claim without a clinical breast exam, contact your local Medicare carrier for more information to see how it will interpret the rule, Witt recommends.

Observe Frequency Limits or Receive Denials

For Medicare patients who receive complete periodic comprehensive preventive medicine evaluations, report G0101 and Q0091 (Screening Papanicolaou smear; obtaining, preparing, and conveyance of cervical or vaginal smear to laboratory), instructed **Jacqueline Stack, CPC, CPC-I, CPC-E/M, CCP-P,** during her recent audioconference "6 Strategies to Improve Your Preventive Billing Now" (www.audioeducator.com).

Medicare patients classified as high risk can have a screening pelvic exam once annually; but for low-risk patients, you can only code a covered G0101 service every two years, Stack explained. The same rules apply for Pap smear patients: those at high risk can get a covered screening every year, while all others are eligible every two years.

Protect Your Bottom Line With ABN

Experts say that just to be on the safe side, you should get an advance beneficiary notice (ABN) on file before performing G0101 or Q0091.

Why? It may not always be clear when a patient's last Pap smear or pelvic exam was, explains Witt. If it turns out that a patient's screening violates frequency rules, and you don't have that ABN on file, your office will be on the hook for any portion of the bill Medicare won't cover.

"Not all patients can remember if they had a pelvic and Pap from another physician," or how long ago it occurred, Witt

explains.

Example: A 69-year-old low-risk Medicare patient reports to the internist for well-woman services. She says it has been three years since her last exam; the internist performs a complete well-woman exam. Further examination of the patient's medical record reveals that it has been three years since her last pelvic exam (G0101), but that she had a covered Pap test last year (Q0091).

If you have an ABN on file, you'll be able to bill the patient (or the patient's secondary insurer) for the Q0091 service the internist provided.

Be sure to obtain the ABN before performing any services tied to it, and remember to include modifier GA (Waiver of liability statement on file) to show Medicare that you are billing for a service that it may or may not cover, says LeFlore.

"I reference getting the ABN first because I've audited some practices that had patients signing an ABN after the [well-woman] claim was filed," LeFlore says.

Do not ever obtain an ABN post-exam, as it is important that the patient understand the potential cost of the service before agreeing to it; additionally, you could open your practice up to fraud allegations if you obtain an ABN after the service.

File Preventive CPT Code to Obtain Denial

For Medicare patients who receive complete periodic comprehensive preventive medicine evaluation, you'll also need to report a preventive medicine code (99387 for new patients or 99397 for established patients) with modifier GY (Item or service statutorily excluded, does not meet the definition of any Medicare benefit or, for non-Medicare payers, is not a contract benefit) appended, Stack said.

The modifier is necessary because Medicare will not pay for all of 99387 or 99397, only the service's cervical (G0101) and Pap (Q0091) portions.

Medicare will automatically reject any codes with GY appended. But it protects you from any coding impropriety, as the modifier indicates that you know Medicare won't pay for the service and you are just coding to obtain a denial.

Example: A 72-year-old, low-risk, new Medicare patient reports to the internist for a periodic comprehensive preventive medicine evaluation. The patient says she "cannot remember" the last time she had a well-woman exam, but she's "pretty sure" it was at least three years ago. Prior to the service, a nurse explains that it is practice policy to obtain an ABN before well-woman exams and gets the patient to sign an ABN. The internist performs a complete preventive history and exam, including a Pap smear, and sends the patient home.

On the claim, report the following:

• Q0091-GA for the cervical portion of the exam

• G0101-GA for the Pap portion

• 99387 (Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization[s], laboratory/diagnostic procedures, new patient; 65 years and older)-GY for the preventive portion.