Internal Medicine Coding Alert

Remember G0101 and Q0091 to Get Paid for Gynecologic Screeings for Medicare Patients

With the passage of the Balanced Budget Amendment in 1997, Medicare began covering more preventive services for its beneficiaries.

In particular, Medicare now covers screening Pap smears and breast and pelvic exams for women once every three years routinely and more often if the patient is deemed at high risk for cancer or is of childbearing age.

However, many internal medicine practices and clinics are not getting the reimbursement they deserve for these services because they are failing to report the new codes or are reporting them improperly, reports **Jan Rasmussen, CPC,** a coding consultant and instructor for Med Learn, a medical practice management training and consulting firm based in Minneapolis/St. Paul, MN.

These codes are particularly applicable to ob/gyns, family practitioners and internists, Rasmussen notes. However, when I go in to perform chart reviews, I often see that they are not billing for these services for their Medicare patients. Or, if they are, they are not including the proper documentation.

Using G0101

For clinical breast and pelvic examinations, internal medicine coders should use G0101 (cervical or vaginal cancer screening; pelvic and clinical breast examination).
According to the 1999 edition of Medicare National Level II Codes, HCPCS (Health Care Financing Administration Common Procedure Coding System), these services are covered by Medicare Part B when ordered by a physician under the following conditions:

the patient has not had a test during the preceding three years or is a woman of childbearing age.

there is evidence (on the basis of medical history or other findings) that she is at high risk of developing cervical cancer and her physician (or authorized practitioner) recommends that she have the test performed more frequently than every three years.

High-risk factors for cervical and vaginal cancer are defined as: early onset of sexual activity (under age 16), multiple sexual partners (five or more in a lifetime), history of sexually transmitted disease (including HIV infection), fewer than three negative or no Pap smears within the previous seven years, and DES (diethylstilbestrol)-exposed daughters of women who took DES during pregnancy.

Proper Documentation of Pelvic Examination

In order for the screening breast/pelvic examination services to be covered by Medicare, the physicians exam must include at least seven of the following 11 elements:

inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge;

digital rectal examination including sphincter tone, presence of hemorrhoids, and rectal masses. Pelvic examination (with or without specimen collection for smears and cultures) including

external genitalia (e.g., general appearance, hair distribution, or lesions)

urethral meatus (e.g., size, location, lesions, or prolapse)

urethra (e.g., masses, tenderness, or scarring

bladder (e.g., fullness, masses, or tenderness)

vagina (e.g., general appearance, estrogen
deficit, discharge lesions, pelvic support, cystocele, or retocele

cervix (e.g., general appearance, lesions, or discharge)

uterus (e.g., size, contour, position, mobility,
tenderness, consistency, descent or support)

adnexa/parametria (e.g., masses, tenderness, organomegaly, or nodularity)

anus or perineum

Note: This description was published in HCPCS 1999 and taken from the Documentation Guidelines for Evaluation and Management Services, published in May 1997 by HCFA and the AMA.

In practices that use G0101, Rasmussen has seen many charts that dont have the documentation to support reporting this code. Sometimes, they have five or six of the necessary 11 elements, but not seven.

Use Q0091 to Report Collection of Specimen for Pap

Jean Stoner, CPC, manager of coder training for the University of Pittsburgh Medical Center (UPMC) Health System in Pittsburgh, PA, reports that the systems offices have been getting reimbursed by Medicare for both the breast/pelvic examination and the collection of a specimen for a Pap smear.

Most of our practices are using the G0101 for the Medicare gynecological visits and Q0091 for the Medicare Pap collection and we are getting payment as expected, she reports.

Q0091 is listed in HCPCS as screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to the laboratory.

The note in the definition indicates that Medicare covers the Pap test once every three years unless the physician suspects abnormalities and shortens the interval.
Most of the UPMC offices have the patients sign an advance beneficiary notice (ABN) each time they come in for the exam and then bill the patients for the off years when Medicare doesnt pay, Stoner reports.

Note: HCPCS Q codes are assigned to procedures, services and supplies on a temporary basis. When a permanent code is assigned, the Q code is deleted and cross-referenced. HCPCS 1999 also notes that Q codes fall under the jurisdiction of the local carrier unless the code represents an incidental service or it is otherwise specified.

Correct Diagnosis Coding

The report of a Pap smear code with a pelvic examination claim must be accompanied by one of two ICD-9 codes that indicate the beneficiarys low- or high-risk status:

V76.2- special screening for malignant neoplasms of the cervix, indicates low risk, or

V15.89- other specified personal history presenting hazards to health, indicate high risk.

If the code for the Pap smear is not linked to one of the ICD-9 codes on line one of item 24E on the HCFA-1500 form, the claim will be rejected.