Internal Medicine Coding Alert

Use Correct Coding to Maximize Reimbursement for Pap-Smear Collection

Many practices erroneously bill laboratory codes instead of correct E/M codes

Coding for Pap smears can get complicated in an internal medicine practice. Correct CPT coding can vary depending on the circumstances: Was the test performed as part of a well-woman gynecological visit, or as a diagnostic test during a problem-focused examination? Is the patient covered by Medicare or private insurance?

Complicating matters is the fact that many payers, Medicare included, have traditionally accepted a number of different methods of coding for Pap-smear collection. In this era of heightened scrutiny, however, it is vital to the financial stability of internal medicine practices that they bill for this service properly, both to avoid an audit and to ensure they are getting the reimbursement they deserve.

Here are some guidelines from internal medicine consultants and coders on the correctand cost-effectivemethods for billing Pap-smear collection.

1. Lab codes alone should only be billed if the specimen is read in the office. Many inexperienced internal medicine coders are miscoding in-office Pap smears using the laboratory CPT Codes 88150-88152 for specimen collection, say coding experts.

Internal medicine practices should only be billing the 88000 codes if they are putting the specimens under the microscope and reading them on-site, says **Shon Pirollo**, a practice management consultant with Winer & Bevilacqua in Akron, OH.

What has been happening is that Medicare has been paying the charges, but then, they will come back later and say, You miscoded this, says Pirollo. They then demand that you repay them. It can trigger audits. We go in and clean up after audits, so I know.

The mistake often happens when a coder goes to the CPT index and looks up Pap Smear, says Pirollo. The only codes listed at that point in the index are the codes 88141-88158.

But, when you turn to that section, it should become clear that these are laboratory and pathology codes, she says.

It says, use codes 88150-88155 to report Pap smears that are examined using non-Bethesda reporting, Pirollo explains. The terms Bethesda and non-Bethesda clearly mean that these are lab codes.

In addition, the CPT section heading is Pathology and Laboratory, she adds.

These codes are not to be used by internal medicine or family practices, unless they are the ones actually looking at the culture. If they are, then its fine, she says. But in reality its rarely the situation.

Collecting a Pap smear is really included in the evaluation and management service, concurs **Gail Pfeiffer**, director of procedural coding for the Cleveland Clinic Foundation in Cleveland, OH. If I do a Pap smear as part of my exam then that is an element of a comprehensive examination. If all I do is the Pap smear then that is a single, problem-focused exam.

A lot of people doing coding need to learn that you have to look beyond just what is written in one section, notes Pfeiffer.

The service the internist is really performing is an exam, not the reading of the cell types, she says.

2. If Pap is part of well-woman visit, use preventive medicine E/M codes. If the test is done during a patients routine annual gynecological exam, the preventive-medicine codes (99384-99387, new patient or 99394-99397, established patient) should be billed, says **Jean Stoner**, CPC, manager of the coding and compliance department at the University of Pittsburgh Medical Center Health System.

I would think the preventive medicine codes 99387 or 99385 [are correct], she says. These series of codes for preventive-medicine visits should be used for gyn visits. You are not going to bill anything separate for the collection of a Pap smear. There is no code for it except for Medicare.

3. For Medicare patients, bill annual gyn visits with G0101, plus Q0091 for Pap collection. Medicare recently instituted a new HCPCS code (G0101- cervical or vaginal cancer screening; pelvic and clinical breast examination) to be used for Medicare patients well-woman exam, says Stoner.

Medicare also has a code, Q0091, for Pap smear collection, she adds.

Thats still allowable and they pay you $25 on that, plus the $21 for the G0101 screening. But, that G0101 visit is allowed only once every three years, she explains.

4. If Pap is performed during problem-focused exam, use 99213-99215. If the patient presents with a complaint and the Pap is performed during the course of an office visit, the E/M office visit codes, 99213-99215, would be used, Stoner advises.

For Medicare, you would think that you could bill the 99213 (for the office visit) and the G0101 and then the Q0091, she notes. Unfortunately, Medicare is saying that both the gyn visit and the Pap smear collection are an integral part of an E/M code, and they are not going to pay for all of them.

In this case, Stoner recommends increasing the level of the office visit.

The genito-urinary section (of the E/M documentation guidelines) has all of the elements that are part of the gyn exam, she says. So, it does make sense that your exam is going to be more comprehensive. So, instead of 99213 for abnormal bleeding, if you also do the gyn E/M service, you would probably code it as a 99214.

The coder should also be sure to use the diagnosis code to match the presenting complaint instead of a standard V code to go with the Pap, notes Stoner. You shouldnt use a V code with a regular E/M.