Internal Medicine Coding Alert

Use These 4-Steps to Solve Pelvic-Pap Coding Questions

Medicare covers routine exam and Pap at same office visit.

Code cervical cancer screenings correctly and you'll boost office revenue while improving patients' health. Save time and money by observing these easy steps to reporting women's health services to Medicare and private payers:

1: Link to Medicare's Covered Screening Codes

In some cases, you'll use different codes to report the same services, depending on whether the patient is covered by Medicare or a private insurer.

Medicare expects G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination) for a routine gynecological examination and Q0091 (Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory) for the Pap smear collection, if performed, notes **Kris Cuddy, CPC, CIMC,** an independent consultant based in DeWitt, Mich.

Medicare covers both G0101 and Q0091 at the same intervals, says Goodwin:

• every two years for average-risk patients and

• every year for high-risk patients, says Goodwin.

Medicare will even cover both G0101 and Q0091 during the same office visit, notes **Brenda Dombkowski, CPC,** of the Yale University Department of Internal Medicine in New Haven, Conn.

Tip: Make sure your patient signs an Advance Beneficiary Notice (ABN) for theannual services, in case she had them done in another office, advises Goodwin. Since Medicare pays every two years for low-risk patients, patients may forget the last time they received the service. "If you don't have the ABN, you will be stuck with the cost," Goodwin warns.

2: Differentiate Pap From Pelvic for Private Payers

Gyn services consist of several V screening codes, but which one applies to your patient is not always clear-cut. Two of the most common screening codes are:

• V72.31 (Routine gynecological examination, general gynecological examination with or without Papanicolaou cervical smear, pelvic examination [annual] [periodic]), and

• V76.2 (Special screening for malignant neoplasms, cervix, routine cervical Papanicolaou smear).

Key: The difference between the two codes is whether a gyn exam was performed. Use V72.31 as part of the annual gyn visit for a healthy patient and V76.2 if the doctor is doing only a Pap and not the complete exam, adds **Kathleen Goodwin, CPC,** coding coordinator with La Porte Regional Health Systems in Indiana.

Don't double up: You may not report V72.31 and V76.2 on the same claim for the same encounter. Code V76.2 is included (when performed) in V72.31, Witt adds.

Example: A patient came in only for a Pap smear collection because at the last visit she was menstruating. Since the visit's purpose was to perform only a screening Pap smear, report V76.2, and link it to a low-level problem E/M service (99211, Office or other outpatient visit for the evaluation and management of an established patient, that may not

require the presence of a physician), says **Melanie Witt, RN, CPC, COBGC, MA,** an ob-gyn coding expert based in Guadalupita, N.M.

Remember, some private payers follow Medicare guidelines and thus expect you to use Q0091 to report a Pap-only visit rather than V76.2, points out **Bruce Rappoport, MD, CPC, CHCC,** a board-certified internist and medical director of Broward Health's Best Choice Plus and Total Claims Administration in Fort Lauderdale, Fla. Check individual private payers' reporting requirements.

3: Select a Procedure Code

Don't forget to include the appropriate procedure code along with the V code to confirm that the internist performed the screening.

With V codes, many private insurers expect to see a routine health maintenance examination code, such as 9938x (Preventive Medicine Services, New Patient) or 9939x (Preventive Medicine Services, Established Patient), explains Cuddy. Select the appropriate code in the range based on the patient's status (new or established patient) and age.

Often, you won't need to search for a CPT code to report the Pap smear specimen collection. Most private payers include the collection as incidental, and the American College of Gynecology and CPT both advise that you should not code the specimen collection separately, says Witt.

Again, verify your payer-specific guidelines and make sure that you're meeting documentation requirements whenever you report a preventive medicine service code, stresses Rappoport.

4: Prepare for Screenings That Turn Positive

Even when a screening comes back abnormal, still report the screening code for the visit, advises Witt. For the initial visit, the lab will list the screening diagnosis first, followed by a secondary diagnosis indicating the abnormal finding. This secondary diagnosis comes into play for the follow-up visit.

Example: The internist orders a routine Pap for the patient and the lab interpretation indicates the result is ASCUS (atypical squamous cells of undetermined significance).

The lab will bill V76.2, 795.01 (Papanicolaou smear of cervix with atypical squamous cells of undetermined significance [ASC-US]) to the payer, explains Witt. When the internist sees the patient for a follow-up visit, list the reason for the follow-up visit as 795.01.

Rule: The patient needs to have three consecutive normal Paps before returning to the routine screening code, relates Witt. If the second and third visits are normal, report V72.32 (Encounter for Papanicolaou cervical smear to confirm findings of recent normal smear following initial abnormal smear) as the diagnosis code on the third screen, she concludes.