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Internal Medicine Coding Alert

Well Visits: Understand Payer Differences Before Coding Pap Smears With Annual Physicals

Heads up: Medicare follows its own guidelines, not CPT® rules.

If your physicians sometimes conduct Pap services when patients come for their yearly physicals, you should be paid for both services. Keep these tips in mind when documenting the encounter and selecting the appropriate diagnosis.

Understand the Visit Codes

An annual physical is typically reported with a preventive medicine evaluation and management code, such as 99396 (Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 40-64 years) or 99397 (…65 years and older). The correct code will depend on the patient's age and whether the patient is new (99381-99387) or established (99391-99397) with your practice.

Inclusions: Notice that these codes include the physical exam as well as the ordering of laboratory/diagnostic procedures, such as a Pap smear. Also note that, from a CPT® perspective, the services to obtain the Pap smear are inherent in the procedure being performed and are not reported separately.

You can report code 99000 (Handling and/or conveyance of specimen for transfer from the office to a laboratory) for the handling and conveyance of the specimen to an outside laboratory. Be aware, however, that many payers, including Medicare, consider this a bundled service and will not pay separately for it.

"Remember that 99000 is not a stand-alone code," notes **Kent Moore,** senior strategist for physician payment at the American Academy of Family Physicians in Leawood, Ks. "You should always report it in addition to the basic services rendered. In this case, that would be a preventive medicine visit."

Watch for Medicare Differences

Medicare benefits include a screening Pap smear and cervical or vaginal cancer screening, including pelvic and clinical breast examination. Because these are Medicare benefits and because Medicare does not otherwise cover the preventive medicine service codes (described above) that would normally include the services, Medicare created separate codes for both benefits. You should report Q0091 (Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory) and G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination) when your physician provides these services to a Medicare beneficiary.

Commercial pay: Because CPT® considers Pap smear collection to be part of the visit being performed and because a breast and pelvic exam may be considered part of "an age and gender appropriate . . . examination," many private payers do not pay separately for Q0091 and G0101 when done in conjunction with a preventive medicine visit. Some private payers might not reimburse for either code under any circumstances, even if the Pap collection and preventive visit take place on separate dates. Your best bet is not to submit these codes to a private payer with a preventive service code unless you know that the payer recognizes and pays for them like Medicare does.

Choose the Diagnosis Carefully

The diagnosis for a routine gynecological examination, such as an annual well-woman visit, is V72.31 (Routine gynecological examination). Per ICD-9-CM, this diagnosis includes a general gynecological examination with or without a cervical Pap smear, as well as an annual or periodic pelvic examination.

If your physician completes a routine vaginal Pap smear in conjunction with the visit, ICD-9-CM directs you to also report V76.47 (Special screening for malignant neoplasms; other sites; vagina). If, for whatever reason, your physician does not consider the yearly physical a routine gynecological examination, the alternative is to report a diagnosis of V70.0 (Routine general medical examination at a health care facility).

Option: Some physician offices ask patients to schedule one visit for the physical exam and another for the well woman check. They explain that the physician won't be reimbursed for both services when performed during the same encounter, so the office policy is to separate the visits. If a cervical Pap smear is done without a general gynecological examination, then you will report diagnosis code V76.2 (Special screening for malignant neoplasms; cervix).