Part B Insider (Multispecialty) Coding Alert

GYNECOLOGY: Simplify Pap Smear Coding With V72.31

Important: You don't have to emphasize V76.2 anymore

This summer Medicare changed the way you can report Pap smear diagnosis codes. If you aren't up to speed on this change, you can expect claims denials. Here's the skinny on the V-code that will simplify reports for well-woman checks.

On July 1, 2005, Medicare approved use of V72.31 (Routine gynecological examination) with Q0091 (Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory).

New way: You will be able to use **v72.31** as another Medicare option provided the FP performs a full gynecological exam.

Advantage: Medicare will also accept the following codes for low-risk patients:

- V76.2 (Special screening for malignant neoplasm, cervix)
- V76.47 (Special screening for malignant neoplasms, vagina)
- V76.49 (Special screening for malignant neoplasms, other sites). Do this: Use this diagnosis code for women without a cervix.

Keep coders prepared: Staff training should now be deemphasizing reliance on V76.2 for well-women visits.

Good news: Most office staff are used to coding V72.31 on non-Medicare claims, so this shouldn't be too much of a difference, explains **Cathie Hays, RHIT**, a coding and billing specialist for **Community Hospital, Quality Healthcare Clinics** in Sparta, IL.

Remember: Medicare's change in the well-woman-check diagnosis code does not affect the procedure codes you use.