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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Hone Your Pap Coding Skills With This Screening-Turned-Diagnostic Case

See if you can code the case.

With 15 CPT® codes and 10 HPCS Level II codes for Pap tests, is it any wonder that coders often feel confused? Let us help you cut through the clutter with this multi-step Pap case.

Step 1: Medicare Patient Gets Timely Pap Screening

A 65-year-old female Medicare beneficiary with a history of syphilis reports for a screening Pap test one year and one month after her last Pap. The lab performs an automated thin layer preparation (liquid based) test with automated screening.

Several pieces of information are crucial for you to correctly code this case and get paid for the services, as follows:

- Screening Both the diagnosis and procedure codes can vary for Pap tests depending on whether the physician orders the test for screening or diagnosis
- Payer Because the payer is Medicare and this is a screening test, you should turn to the HCPCS Level II codes
- Risk level The history of sexually transmitted disease means that the patient is in the high risk category
- Frequency The lab performs the test more than one year after the patient's last screening, which matches Medicare's frequency requirements for high risk patients. Low risk patients get a covered Pap screening only once every two years
- Lab method The procedure code selection depends on the lab method, reporting method, and details about screening/rescreening and manual/automated processes.

"Billing for Pap tests is difficult precisely because there are so many details you have to consider to choose the proper code," says Melanie Witt, RN, COBGC, MA, an independent coding consultant in Guadalupita, N.M.

Code it: Report the diagnosis as V76.2 (Special screening for malignant neoplasm, cervix) because it is a screening test. You'll need to add an additional diagnosis code due to the patient's history of syphilis: V13.89 (Personal history of other specified diseases).

This is a liquid-based cervical cytopathology screening test with automated screening, so you should bill the procedure as G0144 (Screening cytopathology, cervical or vaginal [any reporting system], collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision).

Tip for other cases: You have six other HCPCS Level II codes to choose from for the screening test (P3000, G0123, G0143, G0145, G0147, and G0148), but G0144 is the only code that captures the details of this example. Additionally, most payers won't accept these codes for screening Pap tests, but expect you to use CPT® codes instead.

Step 2: Abnormal Results Requires Interpretation

The Pap screening returns an "abnormal" result, so the pathologist is called on to examine the slides and provide a diagnosis. The final diagnosis is atypical squamous cells of undetermined significance (ASC-US).

You'll need to report the ASC-US findings in this case in addition to the "V" codes you listed to show that this was a screening test. Select 795.01 (Papanicolaou smear of cervix with atypical squamous cells of undetermined significance [ASC-US]) to report the pathologist's findings.

Capture pathologist's service: "Report the pathologist's interpretation of the abnormal Pap test using a separate code in addition to the code for the original screening Pap test," Witt says. In this case, you should list G0124 (Screening cytopathology, cervical or vaginal [any reporting system], collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician).

Tip for other cases: Code G0124 isn't the only HCPCS Level II code for interpretation of an abnormal screening Pap there are two others (P3001 and G0141) that you might use if you reported a different code for the initial screening. You have to match the interpretation code to the code for the original screening test, and that's G0124 in this case. Also, for non-Medicare payers that require CPT® codes, you would report the pathologist interpretation in addition to the screening code using 88141 (Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician).

Step 3: Look for Additional Tests

Based on the ASC-US findings, the ordering physician requests a follow-up Pap and an HPV test in six months. "ASC-US indicates minor cellular changes that might be due to something as simple as mild inflammation, or may be due to changes caused by HPV infection, which would require further monitoring," explains R.M. Stainton Jr., MD, president of Doctors' Anatomic Pathology Services in Jonesboro, Ark.

The lab performs the same Pap test again, plus an HPV test by amplified probe technique.

Surprise! Although the lab performs the same Pap test, you won't use the G0144 code again, even though the payer is Medicare. That's because the repeat Pap is a diagnostic test ordered based on signs and symptoms of disease, not a screening test. That also means the frequency limits don't apply. Instead, you should report the CPT® code for this same test: 88174 (Cytopathology, cervical or vaginal [any reporting system], collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision).

Capture HPV: You should also report 87621 (Infectious agent detection by nucleic acid [DNA or RNA]; papillomavirus, human, amplified probe technique) for the HPV test.

Beware diagnosis: Although the ASC-US diagnosis (795.01) indicates medical necessity for the HPV test, some payers have an HPV screening benefit that requires no patient co-payment and is only payable with diagnosis code V73.81 (Special screening examination for human papillomavirus [HPV]). Check with payers for how you should handle this scenario, possibly reporting both 795.01 and V73.81 as the ordering diagnosis.