Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Q0091 Won't Do the Trick When Reporting Post-Hysterectomy Pap

Remember: The rules change when malignancy is involved.

Warning: The rules for coding standard Paps aren't the same for Medicare patients who underwent a hysterectomy due to malignancy.

Avoid botching up your post-hysterectomy claims by following our experts' coding advice for handling these tricky situations.

How to Handle Post-Hysterectomy Pap Claims

Problem: When a Medicare patient returns after a hysterectomy (for a malignant condition) for follow-up vaginal Pap smears in your office, should you report 99212 or 99213, or should you just report Q0091?

Watch out: First of all, you should not report Q0091 (Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory), because this code refers to collection of a screening Pap smear.

After a hysterectomy that the ob-gyn performed to treat cancer, all of the Paps will be diagnostic, not screening. Therefore, you should report the Paps with an E/M code (for example, 99213, Office or outpatient visit for the evaluation and management of an established patient ...), but payers now include the collection in the E/M service.

Confront the Years-Afterward-Pap-Smear Question

Problem: But what if the ob-gyn conducts the Pap smear six years after the hysterectomy? Could you submit Q0091?

The Pap code (Q0091) remains the same. If the purpose of the E/M visit is to follow up for the patient's cancer, then the Pap smear is diagnostic, coding experts say.

If the ob-gyn wishes to put the patient back into the screening group, then she reverts to one Pap smear every two years instead of one each year, under Medicare rules, because the Medicare criteria list for screening each year does not include a history of cancer (for example, V10.42, Personal history of malignant neoplasm; other parts of uterus).

ICD-10: When your diagnosis coding system changes from ICD-9 to ICD-10 in 2013, code V10.42 will become Z85.42 (Personal history of malignant neoplasm of other parts of uterus).

If your physician thinks the patient requires a yearly Pap smear, considering her history, it will have to be a diagnostic service with the collection of the specimen included in the E/M code.

G Code Refers Only to Screening

Similarly, G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination) involves a screening exam, not a diagnostic exam. Therefore, as long as the ob-gyn doesn't use the cervical or vaginal exam to check for recurrent cancer for the post-hysterectomy Medicare patient, you can report G0101.

Keep in mind: For Medicare patients, you have to have 7 of the 11 exam elements for a pelvic exam (G0101). If your ob-gyn is dealing with a posthysterectomy patient, then he can state, "the uterus, cervix and ovaries are surgically absent," and that counts, says **Jenny Baker, CPC**, **COBGC, CPC-I,** professional services coder of Women's Health at Oregon Health and Sciences University in Portland. On the other hand, if he does perform a cancer check, insurers will include

the pelvic exam in the E/M service.

No diagnosis: Keep in mind, however, that if your physician does place a patient back into the screeningpool after she had a hysterectomy because of malignancy, there are no diagnosis codes that Medicare will accept with G0101 and Q0091 that capture this fact. The only correct code to report in this situation would be V45.77(Other postprocedural states; acquired absence of genital organs). This is correct coding but will not help you collect reimbursement with the G and Q codes.

ICD-10: Code V45.77 will become Z90.79 (Acquired absence of other genital organ[s]).

Keep in mind: Because Medicare does not accept V45.77 when you bill either the G or Q code, you have two options: 1) bill G0101 and Q0091 with V45.77 and receive a denial, or 2) bill a diagnostic Pap and exam annually with the correct code. Some coders have had luck persuading their Medicare carriers to put into writing that they can use one of the approved codes (such as V76.2 if she has a cervix, or V76.47 if she does not), even though the patient had cancer. If your carrier agrees, you can bill the G and Q codes every two years.

ICD-10: Code V76.2 will become Z12.4 (Encounter for screening for malignant neoplasm of cervix), and V76.47 will become Z12.72 (Encounter for screening formalignant neoplasm of vagina).

Remember: You should use the code that is correct, not the code that gets the service paid.