Part B Insider (Multispecialty) Coding Alert

READER QUESTION :Document Pelvic Exam and Pap Elements Properly to Improve Pay -- And Keep Patients Happy

If you don't document appropriately, the patient could end up being responsible for applicable non-covered services.

Question: If my ob-gyn sees a Medicare patient for a breast and pelvic exam, but the documentation does not qualify for the seven of 11 elements to bill the G0101 code, should I bill the wellness code instead?

Also, if my ob-gyn did a Pap smear, should I still bill Q0091 with 99397, instead of billing it the usual way of G0101 and Q0091?

Answer: Ask your ob-gyn why she isn't documenting seven of the 11 required elements to get paid? This suggests poor documentation. If your ob-gyn routinely does not document the required elements, then you cannot bill G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination). The patient will be responsible for the entire non-covered service. If this is a covered year, then the patient will be very unhappy.

You can bill Q0091 (Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory) for the collection of the screening Pap.

That way, at least the patient would not have to pay for a small portion.

Keep in mind: Medicare patients classified as high risk can have a screening pelvic exam once annually; but for low-risk patients, you can only code a covered G0101 service every two years. The same rules apply for Pap smear patients: Those at high risk can get a covered screening every year, while all others are eligible every two years.

Best advice: Show your ob-gyn how documenting the seven elements is easy, even when the patient does not have her uterus.

The 11 elements to choose from are breast, external genitalia, urethra, urethral meatus, bladder, vagina, cervix, uterus, adnexa, anus and perineum, and rectal exam.

If the patient has had a hysterectomy, the physician need only document that these three elements (uterus, cervix, adnexa) are surgically absent in addition to any other four elements to meet Medicare requirements.