Part B Insider (Multispecialty) Coding Alert

Screening Tests: 5 Mistakes You May Be Making With Billing for Pap Smears/Pelvic Exams

Learn where the pitfalls are before you fall in

Most coders know that Medicare covers **G0101** (Pelvic exam) and **Q0091** (Pap smear) every two years, or every year for high-risk patients. You may also be aware that you can bill for other services, such as an evaluation and management visit, with these services. But are you billing correctly?

Coding experts offer this list of common mistakes coders often make when billing for E/M services along with screening exams for women:

1. Not having enough documentation. "The biggest issue I see is failing to adequately document the separateness of the problems from the rest of the exam," says consultant **Joan Gilhooly**, president of Medical Business Resources in Evanston, Ill. "The documentation isn't clear, and the progress notes might look like any other preventive medicine service." The only clue that the physician addressed something else is the fact that she ordered lab tests or prescribed meds that she wouldn't routinely give as part of a well-woman exam.

2. Forgetting to add modifier -25 (Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service) to the E/M claim to show that it's a separate and distinct service.

3. Not linking the diagnoses correctly to each service. **Marvel Hammer**, principal of MJH Consulting in Denver, says coders often list diagnoses in the same pattern out of habit, which results in "a linkage of the diagnosis to the procedure that's not accurate." If the patient needs an E/M service for an upper respiratory infection, the diagnosis code should reflect this. Most of all, you don't want the upper respiratory diagnosis linked to the Pap smear.

4. Not putting the E/M service on a separate form from the physical exam. "Personally, as an auditor I want to see that they have done some separate, identifiable service for that patient to warrant billing that office visit along with the PE," says **Pat Larabee** with Intermed in South Portland, Maine.

5. Forgetting to chase down the copay. If the patient comes in for a regular screening exam, Medicare covers those services at 100 percent. But you need to collect a copay for the E/M service if you perform one and Medigap or secondary payers don't pick up the tab.