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Part B Insider (Multispecialty) Coding Alert

Transmittals: CMS Improves Pap Smear Coding Options

But normal Pap smear after abnormal pap still not covered

You can look forward to easier claim preparation for Pap smears now that The **Centers for Medicare and Medicaid Services** has fixed some problems with coding for routine Paps.

Problem: Some claims for preparation and conveyance of Pap smears were "paying incorrectly" when providers performed them outside of the frequency edits that Medicare laid down, CMS says in Transmittal 440, issued Jan. 21.

Solution: CMS is adding a new edit to the Common Working File, which carriers use to process claims, that will allow providers to bill screening Pap smear code **Q0091** every two years for low-risk beneficiaries and every year for high-risk beneficiaries. The new edit will prevent you from obtaining payment for Q0091 if you accidentally perform a Pap smear more often than every two years for a normal patient. In cases where you obtain an unsatisfactory Pap smear specimen that a lab can't interpret, use modifier -76 (Repeat procedure by same physician) to bypass the frequency edits, CMS advises.

New V code: Another change announced in Transmittal 440 has providers cheering. CMS says it's adding a new diagnosis code, V72.31 (Routine gynecological examination), to the list of diagnosis codes covered for screening Pap smears. You should append this code only when the provider performs a full gynecological examination, CMS instructs.

The addition of V72.31 "actually makes it possible to code more accurately," says **Jo Anne Steigerwald,** senior consultant with the **Wellington Group** in Cleveland.

The change allows coders to clarify that the Pap smear was part of an overall gynecological examination, says coder **Becky Swank** with the **Wichita Clinic** in Wichita, KS. Medicare already covered other screening V-codes, such as V76.2, V76.47 or V76.49 with screening Pap smears, and V15.89 for high-risk screenings.
Coding before the addition of V72.31 "was kind of confusing for us" because a provider would perform a breast and pelvic exam along with a Pap smear, but coders were unable to clarify that the Pap was part of a comprehensive gynecological exam, Swank says. "This makes much more sense."

But Medicare still won't cover diagnostic Pap smears with diagnosis code V72.32 (Encounter for Papanicolaou cervical smear to confirm findings of recent normal smear following initial abnormal smear), Swank says. This code would allow providers to bill accurately for Pap smears when a patient has had an abnormal Pap smear followed by a normal Pap smear, and the provider wants to double-check the normal finding.

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