Preventive coding can be a snap

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Coding and billing for the care provided at a well-woman visit can be uncomplicated if you know the right codes for the right program. Here, I present information for straightforward preventive care. (I am assuming the patient has not also presented with a significant problem at the same visit.)

First, a patient who is not Medicare-eligible should have the annual well-woman exam billed using the CPT preventive medicine codes. There are some private insurers, however, that will only accept HCPCS codes for an annual gyn exam. These special codes are:

S0610 *Annual gynecological examination, new patient*

S0612 *Annual gynecological examination, established patient*

S0613 *Annual gynecological examination; clinical breast examination without pelvic evaluation*

Notably, Aetna Cigna, and United Healthcare require these codes for a gyn exam, but many BC/BS programs, for whom these codes were originally created, are now reverting to the CPT preventive medicine codes for all preventive care.

The CPT preventive codes are grouped by age and require an age- and gender-appropriate history, examination, and counseling/anticipatory guidance. The Medicare E/M documentation guidelines do not apply to preventive services, and a head-to-toe examination is also not required. CPT recognizes ACOG as an authoritative body to make recommendations for the expected preventive service for women, and if such a service is provided and documented, the preventive codes are to be reported.

The chart below summarizes the CPT preventive codes by patient status and age in comparison to ACOG age groupings.

New Patient Preventive Medicine Code

New patient codes include an *initial comprehensive* preventive medicine evaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures

ACOG: **13–18 years**	ACOG: **19–39 years**	ACOG: **40–64 years**	ACOG: **65 years and older**
99384 (12–17 years)	99385 (18–39 years)	99386 (40–64 years)	99387 (65 years and older)
99385 (18–39 years)			

Established Patient Preventive Medicine Codes

Established patient codes include *periodic comprehensive* preventive medicine reevaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures

ACOG: **13–18 years**	ACOG: **19–39 years**	ACOG: **40–64 years**	ACOG: **65 years and older**
99394 (12–17 years)	99395 (18–39 years)	99396 (40–64 years)	99397 (65 years and older)
99395 (18–39 years)			

The main code

The appropriate diagnostic link for the CPT preventive gyn annual well-woman exam is **V72.31**, whether or not a Pap specimen is collected. The collection of the Pap specimen is included in the preventive service, as is counseling regarding birth control, or general questions about preventing problems, including hormone replacement therapy.

If a pelvic examination is not performed, say because the patient is young and not sexually active, but an examination of other areas is carried out, the same preventive codes are reported, but the diagnosis code changes to **V70.0**, *general health exam*.

What about Medicare?

Coding. Medicare requirements are somewhat different. First, Medicare covers only a small portion of the preventive service; that is, they cover a physical examination of the genital organs and breasts and the collection and conveyance of a Pap specimen to the lab in the covered year only. Think of the complete preventive service as described in CPT as a pie—Medicare pays for 2 slices of that pie in a covered year. The two codes for these services are:

G0101 (*Cervical or vaginal cancer screening; pelvic and clinical breast examination*)

Q0091 (*Screening Papanicolaou smear; obtaining, preparing, and conveyance of cervical or vaginal smear to laboratory*)

If the patient is at **low risk** for developing cervical or vaginal cancer, the screening pelvic exam and Pap collection are paid every 2 years. If the woman is at **high risk**, Medicare will cover this portion of the encounter every year. The high-risk criteria must be re-documented every year and must include one of the following:

1. Early onset of sexual activity (under age 16)
2. Multiple sexual partners (five or more in a lifetime)
3. History of a sexually transmitted disease (including HIV infection)
4. Fewer than three negative Pap smears within the previous 7 years
5. Diethylstilbestrol (DES)-exposed daughters of women who took DES during pregnancy.

If the Medicare-eligible patient is still of childbearing age, she is also considered high-risk if she has had an examination that indicated the presence of cervical or vaginal cancer or other genital abnormalities during any of the preceding 3 years. Note that these criteria do not include a history of breast cancer or a past history of cancer more than 3 years ago.

Billing. Because Medicare is paying only for a portion of the preventive service, you will need to subtract the Medicare allowable for codes G0101 and Q0091 from your normal fee for the preventive service.

Example: If your usual fee for 99397 is $200, and the Medicare allowable for both the G and Q service is $82, you will charge the patient for the noncovered parts of the service at the rate of $118, and you will bill Medicare for their share of $82. You will collect from all sources the $200 for the preventive service. Remember, however, to get the patient to sign an ABN with regard to the Medicare part of the service. This will ensure that, if denied by Medicare, the patient will be held fully responsible for the denied amount.

The Medicare modifier is **–GA** (add it to codes G0101 and Q0091). Diagnostic coding is **V72.31** (because a pelvic exam is performed). This code may also be linked to the collection code. For a high-risk patient, use code **V15.89** (rather than V72.31). This code must be linked to the G and Q codes.

Go to obgmanagement.com for a detailed Medicare checklist. This special handout, offered by the author, includes all billing scenarios for a Medicare patient. Ms. Witt can be contacted directly at nielynco@aol.com should you have additional questions regarding coding and billing for preventive services.

Ms. Witt is an independent coding and documentation consultant and former program manager, department of coding and nomenclature, American Congress of Obstetricians and Gynecologists.

ON THE **WEB**

A special downloadable handout including all Medicare billing scenarios, at obgmanagement.com

FAST TRACK

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—Robert L