Pocket Coding Adviser

Coding Medicare Well-woman Exams

When it comes to well-woman exams, Medicare's rules differ from those of private third-party payers. In order to code a well-woman exam for a Medicare beneficiary, it's important to understand those differences. Proper coding of these services can reduce claim denials and ensure that you are paid for services provided.

Routine annual exams are not covered under the Medicare program, but Medicare does cover a clinical breast and pelvic exam and Pap smear once every two years for normal-risk patients, and annually for patients who meet Medicare's high-risk criteria.* Secondary/HMO insurance may provide more comprehensive coverage, but many Medigap policies do not.

The first step is to determine if the patient wants a full check-up, or just a breast and pelvic exam and a Pap smear. Some patients may only want services that are covered by Medicare, others are willing to pay out-of-pocket for services that are not covered. Staff should obtain an Advance Beneficiary Notice (ABN) for any services that Medicare will probably deny.

Use the following codes to report a well-woman exam to Medicare:

G0101	Cervical or vaginal cancer screening; pelvic & clinical breast exam. (ICD9 code: V72.31; use V15.89 for high-risk)
Q0091	Screening Pap smear; obtaining, preparation, and conveyance. (ICD9 code:V76.2 for cervical, V76.47 for vaginal; use V15.89 for high-risk)

If these services are provided as part of a routine annual exam, report the appropriate CPT preventive medicine code with diagnosis code V72.31 in addition to G0101 and Q0091. To report these services correctly, you must "carve out" the portion of the exam covered by Medicare from your normal fee for a preventive exam.

Coding example for an established patient over age 65

G0101-GA	Screening breast & pelvic exam	$37.04
Q0091-GA	Collection of screening Pap smear	41.69
99397-52-GY	Periodic preventive medicine exam	46.27
	Total fee for 99397	$125.00

Fees for G0101 and Q0091 should be the Medicare allowed amount for your locality. These amounts are "carved-out" (subtracted) from your normal fee for the full preventive exam. Add the modifier 52 (Reduced Services) to the basic code (99397) to identify the carve-out.

Using modifiers appropriately causes the charges to become the patient's responsibility if Medicare denies the claim. Modifier "GA" tells Medicare that an ABN has been signed. Modifier "GY" is used for services that are statutorily excluded by Medicare.

**For a list of Medicare's high-risk criteria, consult Section 210.2 of the "Medicare National Coverage Determination Manual," available online at http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part4.pdf.*

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