Case Studies in Coding: Coding for Medicare screening services

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The Balanced Budget Act of 1997 provided coverage for certain screening services for Medicare beneficiaries. This did not include a comprehensive preventive medicine visit, but did incorporate some aspects of a well-woman examination. In the February issue, we looked at coding case studies involving preventive medicine services. This time, let's look at similar scenarios and how these services should be reported to Medicare.

Helena's encounter

Helena, an 83-year-old patient, is followed regularly for hypertension, Type 2 diabetes, and preventive care by her internist, Dr. Rousillon. He does not, however, perform well-woman exams but sends Helena to Dr. Bertram, a gynecologist, for her pelvic and breast exam and collection of a Pap smear. Dr. Bertram agrees to provide only these services because Helena is receiving ongoing care from Dr. Rousillon.

Magdalen's encounter

Dr. Bertram's next patient is Magdalen, a 65-year-old who is scheduled for an annual exam. Dr. Bertram reviews the new patient history form that Magdalen has completed. The patient has no complaints and no gynecological issues and is seen by her family physician, Dr. Parolles, for management of mild, well-controlled hypertension. Dr. Bertram performs a complete physical examination, which is normal, and gives Magdalen Hemoccult cards to return to the office and a referral for a screening mammogram. He also discusses recommendations for gynecological screening services with her.

Diana's encounter

Dr. Bertram's third patient is Diana, a 70-year-old established patient scheduled for her well-woman exam. Diana indicates (complains) she has had periodic episodes of dizziness for the last few months. The episodes have occurred more frequently over the last couple of weeks. Dr. Bertram takes additional history relating to her symptoms and medication usage. Diana denies any upper respiratory or cardiac symptoms. Dr. Bertram reviews the remainder of her personal and family history, which consists of a strong family history of cardiovascular disease. He performs a detailed cardiovascular and ear, nose, and throat exam; all findings are negative. Dr. Bertram then completes the well-woman examination, including obtaining a Pap smear and giving Diana the necessary referrals for routine screening studies. Because of Diana's family history and increasing symptoms, he arranges for an appointment with an internist.

Table 1- Medicare's high-risk factors for cervical or vaginal cancer

The woman is of childbearing age and **ANY** of the following apply: Cervical or vaginal cancer is present (or was present) OR Abnormalities were found in the preceding 3 years OR The woman is in a **high-risk category**, as reported by ICD-9-CM code V15.89
Medicare's high-risk factor for **cervical cancer** include one or more of the following: Onset of sexual activity under 16 years of age Five or more sexual partners in a lifetime History of sexually transmitted diseases (including HIV) Fewer than **three negative Pap smears** within previous 7 years, OR **No Pap smears at all** within the previous 7 years
Medicare's high-risk factor for **vaginal cancer** is: DES (diethylstilbestrol)-exposed daughters of women who took DES during pregnancy

Table 2- Requirements for Healthcare Common Procedure Coding System (HCPCS) code G0101

Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge Performance and documentation of **any 6** of the following 10 elements: 1- Digital rectal examination including sphincter tone, presence of hemorrhoids, and rectal masses. Pelvic examination (with or without specimen collection for smears and cultures) including: 2- External genitalia (e.g., general appearance, hair distribution, or lesions) 3- Urethral meatus (e.g., size, location, lesions, or prolapse) 4- Urethra (e.g., masses, tenderness, or scarring) 5- Bladder (e.g., fullness, masses, or tenderness) 6- Vagina (e.g., general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, or rectocele) 7- Cervix (e.g., general appearance, lesions, or discharge) 8- Uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent, or support) 9- Adnexa/parametria (e.g., masses, tenderness, organomegaly, or nodularity) 10- Anus and perineum

Coding the encounters

Although Medicare does not cover comprehensive well-woman services, it does cover a pelvic/clinical breast exam and a screening Pap test every 2 years. These services are covered annually for women considered to be at high risk for the development of cervical or vaginal cancer (Table 1). They are reported using Healthcare Common Procedural Coding System (HCPCS) codes rather than CPT-4 codes. In addition, certain ICD-9 codes must be reported in conjunction with these services.

Helena. Because Dr. Bertram did not perform all the components of a well-woman examination, he cannot report the CPT code for a preventive medicine service. G0101 is the HCPCS code used to report a screening pelvic/clinical breast exam. Table 2 lists the exam elements required to report code G0101.

HCPCS code Q0091 is reported for collection of the Pap smear. This is not the code that the lab uses for the interpretation of the Pap test. Rather, it represents the work done in the physician's office to collect the specimen. Q0091 applies only to collection of a screening Pap smear. Collection of a diagnostic Pap smear is included in the E/M service (Figure 1).

Notice that the ICD-9 code V72.31 (gynecological exam) is not used to report Medicare screening services. Instead, one of the following ICD-9 codes is used:

- **V76.2** Special screening for malignant neoplasms, cervix (patient who has an intact cervix or uterus)
- **V76.47** Special screening for malignant neoplasms, vagina
- **V76.49** Special screening for malignant neoplasms, other sites OR
- **V15.89** Other specified personal history presenting hazards to health (patient who is considered high risk according to Medicare's criteria).

Modifier -GA is appended to the HCPCS codes to indicate that the patient has signed an advanced beneficiary notice (ABN). Medicare screening services can be reported annually if the physician does not know when the last covered screening service was provided. If it is not a covered year, Medicare will deny the service and the patient can be held responsible for payment. The patient can be charged only if an ABN has been signed.

Figure 1: Helena's claim

21. DIAGNOSES OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. V76.2 Special screening for malignant neoplasm, cervix 2. 3. 4.												22. MEDICAID RESUBMISSION CODE 23. PRIOR AUTHORIZATION NUMBER	
24. A						B	C	D		E	F	G	
DATE(S) OF SERVICE						Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS CODE	RVUs	DAYS OR UNITS	
From MM	DD	YY	To MM	DD	YY			CPT-4/HCPCS	MODIFIER				
						11		G0101	-GA	1		1	
						11		Q0091	-GA	1		1	

Magdalen. Because Dr. Bertram provided comprehensive services to Magdalen, CPT code 99387 (preventive medicine service for new patient 65 years and over) is reported to describe this care. Code G0101 incorporates only the exam associated with performing a clinical breast and pelvic exam. It does not include other components of a comprehensive well-woman exam, nor does it include obtaining or reviewing the patient's history.

Remember that Medicare never covers comprehensive preventive medicine services. It does, however, pay for services described by codes G0101 and Q0091. Therefore, a portion of the well-woman exam will be paid by Medicare every 2 years for all Medicare beneficiaries and annually if the patient meets the high-risk criteria.

Based on these coverage policies, Dr. Bertram reports code 99387 and HCPCS codes G0101 and Q0091 for the services provided to Magdalen (Figure 2). ICD-9 code V72.31 is associated with the CPT code for the comprehensive preventive medicine service and code V76.2, V76.47, V76.49, or V15.89 is linked to Medicare's HCPCS codes.

Modifier -GY indicates a service does not meet the requirements for a covered Medicare benefit. It is linked to the comprehensive preventive medicine code, since this service is never covered by Medicare. When this modifier is used, the patient's Explanation of Benefits (EOB) indicates that she may be charged for the service.

When Magdalen returns the Hemoccult cards, the practice can report HCPCS code G0107 (colorectal screening/fecal occult blood test) for their interpretation. Medicare policy states that samples must be obtained from two different sites of three consecutive stools in order to receive reimbursement for this service. Diagnosis code V76.41 (special screening for malignant neoplasm of the rectum) or V76.51 (special screening for malignant neoplasm of the colon) is reported with this code.

Figure 2: Magdalen's encounter

21. DIAGNOSES OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. V72.31 Gynecological exam 2. V76.2 Special screening for malignant neoplasm, cervix 3. 4.											22. MEDICAID RESUBMISSION CODE 23. PRIOR AUTHORIZATION NUMBER	
24. A						B	C	D		E	F	G
DATE(S) OF SERVICE						Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS CODE	RVUs	DAYS OR UNITS
From MM	DD	YY	To MM	DD	YY			CPT-4/HCPCS	MODIFIER			
						11		99387	-GY	1		1
						11		G0101	-GA	2		1
						11		Q0091	-GA	2		1

Diana. This encounter poses a different issue than either of the other patients. The evaluation of Diana's symptoms is not a routine part of a well-woman encounter. Since CPT guidelines permit reporting a problem-focused encounter in addition to the preventive medicine service, a problem-oriented code (99201-99215) is reported to describe the work associated with evaluating Diana's dizziness (Figure 3). Modifier -25 is appended to the problem-oriented encounter to identify it as an E/M service that is "significant and separately identifiable" from the wellness encounter. In this case, code 99213 was selected. The level of service could have been higher or lower depending on the extent of the additional service.

It has been 3 years since Diana's last gynecological examination. Since Medicare will cover portions of the comprehensive service, Dr. Bertram must report G0101 and Q0091, as was done in Magdalen's case. Medicare will also cover the problem-oriented service.

The ICD-9 code(s) reported for the problem-oriented portion of the encounter should be linked only to the problem-oriented CPT code (99201-99215) on the claim. Likewise, the preventive medicine code should be associated only with ICD-9 code V72.31, and G0101 and Q0091 with the appropriate ICD-9 code required by Medicare.

Figure 3: Diana's encounter

21. DIAGNOSES OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. V72.31 Gynecological exam 2. 780.4 Dizziness and giddiness 3. V76.2 Special screening for malignant neoplasm, cervix 4.											22. MEDICAID RESUBMISSION CODE 23. PRIOR AUTHORIZATION NUMBER	
24. A						B	C	D		E	F	G
DATE(S) OF SERVICE						Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS CODE	RVUs	DAYS OR UNITS
From MM DD YY			To MM DD YY					CPT-4/HCPCS	MODIFIER			
						11		99397	-GY	1		1
						11		99213	-25	2		1
						11		G0101	-GA	3		1
						11		Q0091	-GA	3		1

Getting paid

Medicare guidelines indicate that if non-covered preventive services are provided at the same time as an E/M service covered by Medicare (for example, G0101 and Q0091), then the covered components are "carved out" of the preventive care. Medicare reimburses for the covered services. The physician charges the patient the difference between the practice's established charge for the non-covered preventive care and what Medicare allows for the covered service(s).

Figures 4 and 5 illustrate how the responsibility for the payment is divided between the patient and Medicare in the latter two scenarios. A hypothetical charge for the preventive service and an average for Medicare's allowable amounts for the covered services are used.
Practices need to ensure that systems are in place to appropriately deal with Medicare's coverage policies. The result is good for the practice and for patients.

Figure 4: Magdalen's encounter

Bill to:	S Code	Code(s)	Established Hypothetical Charge	Charge to Pt/ Medicare Allowable
Patient	99387-GY	V72.31	$150.00	$75.70
Medicare	G0101-GA	V76.2	N/A	36.60
Medicare	Q0091-GA	V76.2	N/A	37.70
Total Allowable Charges:				$150.00

Figure 5: Diana's encounter

Bill to:	S Code	Code(s)	Established Hypothetical Charge	Charge to Pt/ Medicare Allowable
Patient	99397-GY	V72.31	$150.00	$23.05
Medicare	99213-25	780.4	N/A	52.65
Medicare	G0101-GA	V76.2	N/A	36.60
Medicare	Q0091-GA	V76.2	N/A	37.70
Total Allowable Charges:				$150.00

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