

SPECIAL REPORT

Billing a Well Woman Exam to Medicare

G0101 & Q0091

**MEDICAL BILLING
EXPERT SERIES**



From the desk of Manny Oliveres...

Dear Physician, Practice Manager and Medical Biller,

First, I'd like to thank you for taking the time out of your busy day to download (and READ) this *Billing a Well Woman Exam to Medicare* report. I recognize that time is money and as a business owner, I feel the demands and pressure of this economy just as you do.

Please let me briefly introduce myself. My name is Manny Oliveres and I've been helping physician practices with their medical billing for over 16 years. My fascination with medical billing began when I noticed that insurance companies didn't always pay doctors as they should. They would under pay, deny claims inappropriately and just plain lose the claim in hopes that the doctors would not notice and their staff would not follow-up.

I tried to learn everything I could about medical billing and how insurance companies played their games. I would ask every question that came to mind to try to learn how to get our physicians properly reimbursed for the work they provided to their patients.

In 1999 I came to help a solo practitioner, John Farrell Jr. MD, who had essentially inherited a medical practice from his physician father. With the practice came his two part-time nurses his dad had hired in the 70's. We applied sound business principles and focused on the medical billing to do it right to get paid for our work. From those humble beginnings we grew the practice to 13 physicians in two locations.

Our success did not go unnoticed. In 2004 a medical practice that was struggling to pay their bills, meet payroll and whose physician owners had not been paid in months came to us for help. We started to do their medical billing. Within 6 months there was a noticeable difference and in only a year later they were able to pay their bills on time and the doctors were able to receive bonuses.

Seeing how we were able to help that one practice we decided to make it our mission to help other medical practices by taking on the burden of their medical billing. With my partner, Dr. Farrell, Capture Billing was born. Now we handle medical billing for many practices in a variety of specialties allowing the providers to do what they love, provide quality healthcare to their patients.

As a medical billing service provider, I understand that the financial health of your practice depends on getting highly experienced outside help and making sure that your medical billing isn't delegated to your administrative staff or a biller with lesser experience.

continued...

Our medical billers have years of experience and receive ongoing training to stay abreast of all the changing rules and regulations. Our coders are certified by the American Academy of Professional Coders (AAPC) and American Health Information Management Association (AHIMA). We even teach medical billing and coding at a local community college.

But in cases where you still want to try to do it in-house, I've created this Billing a Well Woman Exam to Medicare report for at least this one area where there is a lot of confusion to help you.

Also to help you, in the next 48 hours, I'm setting appointments for a FREE 25-Minute Consultation. All you need to do is complete the form on the next page and Fax or Email it back to us to request your spot.

Once we've got you set up we'll talk about medical billing, maybe give you some tips on how to improve your billing or get you pointed in the right direction. Maybe outsourcing your medical billing may be the better option for the success of your practice.

When you succeed, we succeed!



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Additionally, laws and regulations and insurance and payer policies (as well as coding itself) are subject to change. The information that has been accurate previously can be particularly dependent on changes in time or circumstances.

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If you have a question about a specific matter, you should contact a professional advisor directly.

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As we are all aware, Medicare still does not allow an Annual Well Exam (as most routine, preventive services are still not covered) but now allows for the Annual Wellness Visit (AWV) G0438 or subsequent AWV G0439. How does either the Annual Exam or AWV relate to an Annual Well Woman Exam? **THEY DON'T.**

An annual Well Woman Exam is a completely separate evaluation and management service from an AWV and just a component of the routine Annual Exam. So how does a provider bill out for an annual Well Woman Exam for a patient covered by Medicare? Let's discuss the components of the routine annual exam first.

What does an Annual Exam include?

Preventive Medicine Service codes 99381-99387 and 99391-99397 are defined by CPT as an evaluation or 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.



The purpose of the annual exam includes screening for disease, assessment risk of future medical problems, promoting a healthy lifestyle, and to update vaccinations. Aspects of the annual exam may include all or some of the following:

1. Review of History
2. Checking Vital Signs
3. General Appearance
4. Heart Exam
5. Lung Exam
6. Head and Neck Exam
7. Abdominal Exam
8. Neurological Exam
9. Dermatological Exam
10. Extremities Exam
11. Males: Testicular and Prostate Exams
12. Females: Breast and Pelvic Exams
13. Counseling
14. Routine Laboratory Tests
15. Immunizations

Does an Annual Exam Also Include A Well Woman Exam?

Yes. The annual exam also includes the components of a Well Woman Exam. If a patient is seen by her primary care physician (PCP) for an annual, the provider will also include the pelvic and breast exam and a pap smear collection. If the patient elects to have the Well Woman Exam performed by her Gynecologist, the PCP must document that the Pelvic and Breast exams and pap smear collection were deferred and will be performed by a Gynecologist.



Incorrect Billing Procedures

- 1. What if you run out of time?** If the patient is seen for an annual and the well woman exam portions are not done during the same visit, the provider may need to see the patient again in order to complete the comprehensive exam. *This second visit is merely a continuation and is not billable. Do not bill an additional E & M code, such as a 99213 as that would be billing for the same service twice.*
- 2. Can you bill an annual with a V72.31 Annual Gynecological Exam diagnosis and get paid separately?** No. If you have already billed out an annual in a given year (Routine Annual Exam V70.0) then you cannot charge another annual with a different diagnosis.
- 3. What if the patient did not want the Well Woman Exam portions done during the regular annual?** *If the patient did not want the pelvic/breast exam and pap smear collection during the routine physical but later decided to not see the Gynecologist and comes back for these screenings you still cannot bill for these separately. They are already included in the annual. The patient may be seen but it cannot be billed.*

Requirements of Coding and Billing an Annual Well Woman Exam to Medicare

Medicare does not cover preventive services such as an annual exam but certain Well Woman Exam screenings are reimbursed either every two years or annually.

Covered Services

Medicare covers the following screening exams in conjunction with a Well Woman Exam:



1. G0101 Cervical or Vaginal Cancer Screening; Pelvic and Clinic Breast Examination

- a. G0101 is reimbursed by Medicare every two years unless the patient is considered high risk and then it is allowed on an annual basis.
- b. According the CMS website, the ICD-9-CM Codes billable with the G0101 are V76.2, V76.47, V76.49, V15.89, and V72.31. Select the appropriate codes.
 - i. V76.2 Special screening for malignant neoplasms, cervix
 - ii. V76.47 Special screening for malignant neoplasms, vagina
 - iii. V76.49 Special screening for malignant neoplasms, other sites
 - iv. V15.89 Other specified personal history presenting hazards to health
 - v. V72.31 Routine gynecological exam

2. Q0091 Screening Papanicolaou Smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory

- a. Q0091 is reimbursed by Medicare every two years unless the patient is considered high risk and then it is allowed on an annual basis.
- b. Per the CMS website, the ICD-9-CM Codes billable with the Q0091 are V76.2, V76.47, V76.49, V15.89, and V72.31. Select the appropriate codes.

3. 82270 Fecal Occult Blood Test

- a. 82270 can be billed on an annual basis.
- b. Per the CMS website, the appropriate code varies by carrier. An applicable code is V76.51 Special Screening for Malignant Neoplasms; Colon.

High Risk Factors and Frequency

High Risk Factors determine whether or not a patient may have the G0101 and Q0091 on an annual basis. If a patient is considered high risk then these screening tests may be done annually.

According to the CMS Website the following factors are listed as high risk factors for screening pap smears and pelvic exams:

1. Cervical High Risk Factors

- a. Early onset of sexual activity (under 16 years of age)
- b. Multiple sexual partners (five or more in a lifetime)
- c. History of a sexually transmitted disease (including HIV infection)
- d. Fewer than three negative pap smears within the previous 7 years

2. Vaginal Cancer High Risk Factors: DES (diethylstilbestrol) exposed daughters of women who took DES during pregnancy

3. Personal History of Health Hazards: If a patient has a specified personal history presenting hazards to health then apply the V15.89 diagnosis and the appropriate health history hazard (example: V10.3 History of Breast Malignancy). Any V15.89 diagnosis is considered high risk and also eligible for the yearly G0101 and Q0091.

Advanced Beneficiary Notices (ABNs)

An ABN is a Medicare Waiver of Liability that providers are required to give a Medicare patient for services provided that may not be covered or considered medically necessary. ABNs do not apply to services that are specifically excluded from Medicare coverage, such as an annual exam.

A completed and signed ABN is key for reimbursement. It also notifies Medicare that the patient acknowledges that certain procedures were provided and that the patient will be personally responsible for full payment if Medicare denies payment for a specific procedure or treatment. If there is no signed ABN then you cannot bill the patient and it must be written off if denied by Medicare (translation: Free Services, Lost Revenue).

ABN Criteria

1. The ABN must be given to the patient prior to any provided service or procedure
2. Patient's name, specific service and estimated charge amount must be listed on the ABN
3. ABN cannot be given to a patient who is under duress or requires emergency treatment
4. Check for specific criteria and download the form at http://www.cms.gov/BNI/02_ABN.asp

Appropriate Medicare Modifiers

Certain modifiers are required when billing with an ABN.

1. **GA Modifier:** Waiver of Liability Statement Issued as Required by Payer Policy. This modifier indicates that an ABN is on file and allows the provider to bill the patient if not covered by Medicare.
2. **GX Modifier:** Notice of Liability Issued, Voluntary Under Payer Policy. Report this modifier only to indicate that a voluntary ABN was issued for services that are not covered.
3. **GY Modifier:** Notice of Liability Not Issued, Not Required Under Payer Policy. This modifier is used to obtain a denial on a non-covered service. Use this modifier to notify Medicare that you know this service is excluded.
4. **GZ Modifier:** Item or Service Expected to Be Denied as Not Reasonable and Necessary. When an ABN may be required but was not obtained this modifier should be applied.

Carve out Billing for a Well Woman Exam

Since specific well woman screening components of the annual are covered by Medicare, these are billed out separately. These screenings are carved out from the provider's usual fee for preventive service since they are allowable and reimbursable by Medicare. The remainder balance for the preventive service is the patient's financial responsibility and is not covered by Medicare. The total fee does not change, only how it is billed and who pays.

The G0101 and the Q0091 are the services that are reimbursed and carved out of the regular annual fee. The Medicare reimbursement for the G & Q and patient portion equal the same annual fee that a non-Medicare patient would be charged.

For example, if the fee for an annual for a non-Medicare patient is \$235.00 this is the breakdown for a Medicare patient:

Annual	99397 Annual Exam – established pt 65 and older	\$142.35
G0101 Pelvic/Breast Exam		\$ 41.96
Q0091 Papsmear Collection		\$ 50.69
TOTAL		\$235.00

It is the same total fee of \$235 but billed out differently. In this scenario the patient will be billed for \$142.35 and Medicare billed \$41.96 and 50.69 for the two procedures they cover. Check with your local Medicare carrier to obtain current fees.

Here is an example of a claim:

C. MG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSD Famih Plan	
	99397			142 35	1		
	G0101	GA		41 96	1		
	Q0091	GA		50 69	1		
26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For govt. claims, see back)		28. TOTAL CHARGE	29. AMC
				<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		\$ 235 00	\$
32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH #			

For additional clarification please refer to:

<http://www.acog.org/departments/coding/MedicareScreeningServices.pdf>

Reference

The CMS website has a quick reference guide for Medicare Preventive Services which lists applicable tests, diagnoses and frequencies:

http://www.cms.gov/MLNProducts/Downloads/MPS_QuickReferenceChart_1.pdf

Contact your local Medicare carrier for up to date information.

The information contained in this document is of a general nature and cannot substitute for professional advice. Always seek the advice of a medical coding professional, lawyer, accountant or healthcare consultant.

How is your Medical Billing?

OK? Are you sure?

One of our clients told us a story of how their previous office manager was in charge of their medical billing. The Accounts Receivables were out of control and they had major cash flow problems. The manager ended up leaving the practice. When the physicians were cleaning up they found a file cabinet filled with insurance EOBs that were not posted or followed up on which resulted in claims not being appealed, patients not being billed and lost revenue. The bigger surprise to the doctors was there were also checks attached to some of the EOBs. When added up the loss amounted to about \$100,000.

While this is an extreme example, it illustrates the fact that you need to be asking the right questions about your medical billing. Are you losing money? If so, how much money are you losing? Are your billers qualified and know all the rules and laws? Medical billing is very complex and doing it right requires experienced, well trained people who are accountable to the physicians and go after insurance companies to make sure the practice gets paid.

Call Us Today see how Outsourcing your Medical Billing with Capture can increase your revenue and give you peace of mind.

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