Top Errors to Avoid and Specialty Coding Updates for 2013: OBGYN	
Questions	**Answers**
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Where can I ask questions after the webinar?	The online member forums, where over 100,000 AAPC members have access to help each other with all types of questions. *Forum Posting Instructions* 1.Login to your online account 2.In the middle of the page you will see "discussion forums" 3.Click on "view all" – top right hand side 4.Select "general discussion" under "medical coding" unless you see a topic that suits you more – 5.On the top left side of the forum box, you will see a blue button, "new thread" – click on that 6.Type your question and submit 7.Check back in that location for answers as you please

he said 30yrs, should it be 3 yrs	You are correct. Just want to see if you are listening. Glade
The G0008 code and associated Q codes are for Medicare only correct?	Correct
It was stated that G0008 was the administration code for the flu vaccine. This is for Medicare only.	This is for medicare only.
Would this be billed with an office place of service?	Yes.
I Q0091 a professional fee only? Can it be billed in OPPS?	It is a professional fee only. (used/reported only for Medicare pts) You would not report on theUB -04 for the facility but on a 1500 form for the physician only. It may have been performed in the OPPS setting (like an outpt clinic) but would not be submitted for reimbursement for the facility/cliinic on the UB 04.
Would you be able to charge an EM after the 99444 within 7 days if the online assessment and plan was not providing adequate treatment for the patient?	This will depend on the individual payer. For now, I would treat it similar to a phone call. If the patient is seen less than 24 hours after the online care, and an E/M is generated, I would include it in the E/M. As you say, it is 2 days later and then the patient is seen, I would bill for both the 99444 and the E/M for the visit. I have tried to find some guidelines to back this up, I don't think we have them, yet. I'm sure we will see more on this in the future.
What about other payers?	For other payers, regular CPT codes. I am not sure specifically what you are asking about. Can you be more specific?
Just so I understand if I have a 19 year old..with no vaccine- and is sexually active...no pap till 21	That is the recommendation now, regardless of sexual activity

What was the age range for women to be screened every 5 years?	For women aged 30-65 years, co-testing with cytology and HPV testing every 5 years is preferred. Or, screening with cytology alone every 3 years is acceptable.
So we should not report 88142 with any of the 99384-99397 codes?	Medicare does not reimburse for the comprehensive preventive services that are reported with CPT 99384-99397.
How do we report just a pap/pelvic exam for carriers other than medicare? Provider is not really doing a comprehensive exam such as 99385 for example	It will depend on a lot of factors including whether it is a new or established patient. It will be an E/M code and depend on the level of care. Some payers will reimburse for code 99000 if the office incurs costs for supplies, preparation of a specimen to the laboratory. Collection of the Pap smear specimen itself is usually included in the E/M service. It isn't appropriate to report a code in the 88150-88175 range for collection of the Pap smear. These codes are reported by the laboratory for the interpretation of the test.
Why would we need to provide an ABN for a statutorily excluded service?	You are right. The only reason is to make sure the patient is aware it is an excluded service.
so can OBGYNs can bill for the AWV for a gyn annual exam or an IPPE visit for the first year?	The information Medicare patients got regarding this can be found at www.medicare.gov web site for beneficiaries. The AWV is not the same as the IPPE. The IPPE can be performed only once per beneficiary. The AWV isn't covered until 12 months after the IPPE or not until 12 months after the date of enrollment if no IPPE is performed.

My understanding is that the preventive visit is statutorily non covered by Medicare so an ABN is not required, only recommended?	I agree, recommended, not required.
Could you tell me where I could find the documentation that CMS will not allow 99384-99397 to be billed w/an AWV?	I received this information from ACOG. If you have access to ACOG, it was in their regular coding updates. Otherwise, look on the CMS website, I believe it is there as well.
It is my understanding that this service CAN be billed if documenation supports the service by providing the age appropriate comprehensive exam.	Are you referring to 99384-99397? I am not sure what service you are referring to. What I said about CMS not allowing this code range when AWV is billed came from ACOG.
I'm confused about welcome to mcare vs. IPPE.	IPPE may be performed only within the 12 month period immediately following a beneficiary's enrollment in Medicare Part B, it is billed using HCPCS G0402. Welcome to Medicare can be done once, within the first 6 months of Medicare coverage.
Do either include a PAP?	By either, I think you mean IPPE or AWV and they do not inculde a Pap. You can get specific information at http://www.coms.gov/MLNProducts
So after 12 months enrollement with medicare- they will pay G0438 or G0439- what dx code is payable if they have no issues or problems...just want a yearly check up	Yes, that is my understanding. I would start with V70.0, other possibilities include V76.2, V76.47, V76.49 or V72.31.