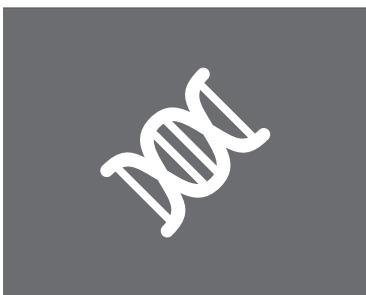
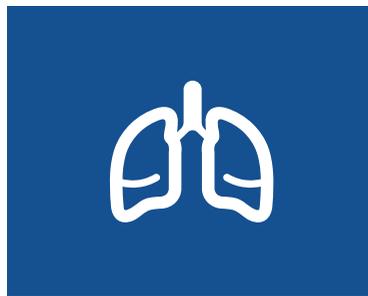




# Women's Preventive Services Initiative (WPSI) 2020 Coding Guide





**Women's Preventive Services Initiative (WPSI)**

**2020 Coding Guide**

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*Women’s Preventive Services Initiative (WPSI) Coding Guide 2020* was developed by WPSI’s Dissemination and Implementation Steering Committee and ACOG’s Coding Department.

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# Introduction



## Introduction to Coding for the Women's Preventive Services Initiative (WPSI) Recommendations

Correct medical coding for services rendered by physicians and other health care providers is an expectation of federal, state, and private payers and required by the False Claims Act. This document acts as guidance to assist practices with coding and billing preventive services for women and was developed in consultation with staff of the American College of Obstetricians and Gynecologists (ACOG).

### Coding Basics

There are several code sets used for different purposes. In this resource, two primary code sets will be discussed. For medical claims there are three primary sets: Current Procedural Terminology (CPT)<sup>®</sup>, Healthcare Common Procedure Coding System (HCPCS) Level II, and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM).

Each of the key code sets serves a different purpose.

- ✔ CPT/HCPCS codes describe *what service* was provided.
- ✔ ICD-10-CM codes describe *why a service* was provided.

Physicians must document and code both “what” and “why” for each service.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that electronic transmissions of health care claims and encounter information meet certain standards, including the adoption of uniform code sets. ICD, CPT, and HCPCS Level II codes are the only approved code sets when information is exchanged electronically. Another standard adopts certain requirements for the submission of electronic claim information.

CPT codes are 5-digit alphanumeric codes developed and copyrighted by the American Medical Association. They comprise the primary set of codes used to describe the cognitive and procedural services provided by a physician's practice. HCPCS Level II—National codes are 5-digit alphanumeric codes developed and maintained by the Centers for Medicare & Medicaid Services (CMS), America's Health Insurance Plans (AHIP), and the Blue Cross Blue Shield Association (BCBSA).

Some level II codes are considered permanent national codes. These codes are maintained by the HCPCS National Panel, which consists of representatives from CMS, AHIP, and BCBSA. Level II codes are used to report services not covered by CPT codes, such as durable medical equipment (DME) and supplies. The Centers for Medicare & Medicaid Services updates these codes annually. Level II codes must be used for services reported to Medicare and Medicaid. Other payers may or may not recognize Level II codes for reimbursement. It is advisable to check with specific payers regarding their billing and reimbursement policies.

An example is “J” coding. Healthcare Common Procedural Coding System codes that begin with a “J” describe drugs administered by a method other than oral administration. These codes are required under HIPAA regulations and identify drugs and dosages.

## INTRODUCTION

Other Level II codes are temporary national codes. These codes were developed to meet, within a short time frame, the operational needs of a particular insurer that are not addressed by an already existing national code. Any member of the HCPCS National Panel can establish a temporary national code that can be used by other insurers. Examples are the codes developed by CMS to report those portions of preventive medicine services covered by CMS.

Five-digit codes often are complemented by 2-digit modifiers. Modifiers provide the means to indicate that a service or procedure has been altered by some specific circumstance.

International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), is a clinical modification of the World Health Organization's (WHO) ICD, which is used worldwide to track morbidity and mortality statistics and is the standard for diagnosis coding in the United States. The word "clinical" emphasizes the intent to describe the clinical picture of the patient. This code set uses codes to identify the patient's diseases, signs and symptoms, abnormal findings and complaints, social circumstances, and external causes of injury or disease or other reasons for seeking medical care. The tenth edition of ICD-10-CM was adopted by WHO in 1994 and is currently used worldwide. In addition to data collection, it is used to convey the medical necessity of the service to third-party payers.

The tenth edition of ICD-10-CM codes support the medical necessity for performing a service. The physician must clearly indicate the reason(s) for all the services rendered to ensure the selection of the most specific code.

Correct coding implies that the code selection is:

- ✔ The most accurate description of "what" was performed and "why" it was performed
- ✔ Supported by documentation in the medical record
- ✔ Consistent with coding conventions and guidelines

When selecting ICD-10-CM diagnosis(es) for an encounter, the diagnosis code(s) must support the clinical need (medical necessity) for the service as described by the CPT code.

## Preventive Medicine Services

### OVERVIEW

Preventive medicine services are a type of evaluation and management (E/M) service that does not require a chief complaint. There are two types of preventive medicine services:

#### 1. Counseling Risk Factor Reduction and Behavioral Change Intervention (CPT Codes 99401–99412).

Preventive medicine counseling codes are used to report services that promote health and prevent illness/injury. That is, the patient has no current symptoms or diagnosed illness.

The counseling must be provided at a separate encounter from the preventive medicine service. These codes are selected according to the time spent counseling the patient. If a distinct problem-oriented E/M service also is provided, it may be reported separately.

These codes are not reported when the physician counsels an individual patient with symptoms or an established illness. In this case, a problem-oriented E/M service (CPT codes 99201–99215) is reported.

Behavioral change interventions are for persons who have a behavior that often is considered an illness itself, such as tobacco use or substance abuse. Any E/M service reported on the same day must be distinct, and time spent providing these services may not be used as a basis for the E/M code selection.

For counseling groups of patients with symptoms or established illness, see code 99078.

#### 2. Preventive Medicine Evaluation and Management Services (CPT Codes 99381–99387)

These services are provided to adults, children, and infants. These codes are used to report annual well-woman examinations. The code reported is determined by the age of the patient and whether they are considered a new or established patient to the physician and/or practice.

**NON-MEDICARE PAYERS**

The Patient Protection and Affordable Care Act (ACA) requires all new private health care plans to cover several evidence-based preventive services such as mammograms, colonoscopies, blood pressure checks, and childhood immunizations, without charging a copayment, deductible or coinsurance.

Most insurance policies with plan years beginning on or after August 1, 2012, must include these services without cost-sharing if they were obtained through an in-network provider. Some plans (“grandfathered plans”) that existed before the ACA are not yet required to provide this coverage. Certain types of employers are exempted from having an insurance plan that provides no-cost coverage of contraceptive services and supplies. The rules governing coverage of preventive services allow plans to use reasonable medical management to help define the nature of the covered services for women’s preventive care.

Note: Although the reforms mandated by the ACA remain largely in effect in the individual and group markets, the current administration has introduced regulations that allow noncompliant plans (such as short-term plans) to be offered in the individual market. These plans do not have to cover essential health benefits, such as maternity care, preventive services, or prescriptions, and can underwrite and exclude those with preexisting conditions. Be sure to check with your specific payers for their coverage policies.

**Modifier 33**

The modifier 33 is used to indicate preventive services that are not subject to cost sharing. The modifier is not necessary for services that are clearly identifiable as preventive care, such as the codes used for well-woman exams (CPT codes **99381–99397**). The descriptor for modifier 33 reads:

Preventive services: When the primary purpose of the service is the delivery of an evidence-based service in accordance with a U.S. Preventive Services Task Force A or B recommendation in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as a preventive, the modifier should not be used.

**MEDICAID**

States participating in the Patient Protection and Affordable Care Act’s Medicaid Expansion program are required to provide the same level of preventive services for the expansion populations as private plans. For those who qualify for Medicaid through other pathways, states may choose to but are not required to, cover the WPSI guidelines supported by the Health Resources and Services Administration (HRSA) (WPSI recommendations). For more information on state Medicaid programs, please see Appendix B.

**MEDICARE PAYERS**

Medicare covers certain screening services, such as a pelvic exam, clinical breast check, and collection of a Pap smear specimen, that are often performed in conjunction with a preventive visit. **However, Medicare does not cover the comprehensive Preventive Medicine Services (CPT codes 99381-99397).**

Medicare also covers other screening and preventive services such as:

- Initial preventive physical examination (IPPE)
- Annual wellness visit (AWV)
- Diabetes and cardiovascular screening
- Flu shots
- Annual depression screening
- Alcohol and tobacco use screening and behavioral counseling
- Screening hemocult
- Screening mammography
- Bone mass measurement

The Centers for Medicare & Medicaid Services publish several documents related to Medicare-covered screening and preventive services. Additional information and coding guidance for preventive services under Medicare can be found on the Medicare website at: <https://www.cms.gov/Medicare/Prevention/PreventionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html>. Additional information about Medicare can be found in Appendix A of this document.

## Women's Preventive Services Initiative (WPSI) Breast Cancer Screening for Average-Risk Women

**Clinical Recommendations:** The Women's Preventive Services Initiative recommends that average-risk women initiate mammography screening no earlier than age 40 and no later than age 50. Screening mammography should occur at least biennially and as frequently as annually. Screening should continue through at least age 74 and age alone should not be the basis to discontinue screening.

These screening recommendations are for women at average risk of breast cancer. Women at increased risk should also undergo periodic mammography screening, however, recommendations for additional services are beyond the scope of this recommendation.

**Implementation Considerations:** The Women's Preventive Services Initiative recommends, as a preventive service, that women initiate mammography screening no earlier than age 40 and no later than age 50 and continue through at least age 74. Screening mammography should occur at least biennially and as frequently as annually.

Decisions regarding when to initiate screening, how often to screen, and when to stop screening should be based on a periodic shared decision-making process involving the woman and her health care provider. The shared decision-making process assists women in making an informed decision and includes, but is not limited to, a discussion about the benefits and harms of screening, an assessment of the woman's values and preferences, and consideration of factors such as life expectancy, comorbidities, and health status.

### NON-MEDICARE PAYERS

#### PROCEDURE CODES

- 77067** Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed
- +77063** Screening digital breast tomosynthesis, bilateral (list separately in addition to code for primary procedure). (Use this as an add-on code when tomosynthesis is performed and is medically necessary in addition to 2-dimensional mammography.)

#### DIAGNOSIS CODES

ICD-10-CM diagnosis code(s) (**Z12.31, Encounter for screening mammogram for malignant neoplasm of breast**) should be linked to the appropriate CPT mammography code reported. The Medicare deductible and co-pay/coinsurance are waived for this service.

Effective October 1, 2019, new codes for overlapping quadrants (**N63.15, Unspecified lump in the right breast, overlapping quadrants, and N63.25, Unspecified lump in the left breast, overlapping quadrants**) were added by CMS as possible diagnosis codes, and codes **N63.10, Unspecified lump in the right breast, unspecified quadrant** and **N63.20, Unspecified lump in the left breast, unspecified quadrant** were deleted by CMS as possible diagnosis codes effective December 31, 2019.

A diagnostic mammogram (when the patient has an illness, disease, or symptoms that indicate the need for a mammogram) is covered whenever it is medically necessary.

When it is appropriate to report a screening and a diagnostic mammogram on the same day, use modifier **-GG** to indicate a screening mammography turned into a diagnostic mammography.



## Women's Preventive Services Initiative (WPSI) Breastfeeding Services and Supplies

**Clinical Recommendations:** The Women's Preventive Services Initiative recommends comprehensive lactation support services (including counseling, education, and breastfeeding equipment and supplies) during the antenatal, perinatal, and postpartum periods to ensure the successful initiation and maintenance of breastfeeding.

**Implementation Considerations:** Lactation support services include counseling, education, and breastfeeding equipment and supplies. A lactation care provider should deliver lactation support and provide services across the antenatal, perinatal, and postpartum periods to ensure successful preparation, initiation, and continuation of breastfeeding. Lactation care providers include, but are not limited to, lactation consultants, breastfeeding counselors, certified midwives, certified nurse-midwives, certified professional midwives, nurses, advanced practice providers (eg, physician assistants and nurse practitioners), and physicians. Breastfeeding equipment and supplies, as agreed upon by the woman and her lactation care provider, include, but are not limited to, double electric breast pumps (including pump parts and maintenance) and breast milk storage supplies. Access to double electric pumps should be based on optimization of breastfeeding and not predicated on prior failure of a manual pump.

### NON-MEDICARE PAYERS

Routine lactation counseling is considered part of the global obstetrics package for postpartum services and is, therefore, not reported separately. Only codes for complications, illness, or disease can be excluded from the routine postpartum care and billed in addition to global services.

However, different payers have varying policies on whether they will reimburse for this service during the postpartum period. It is advisable to check with individual payers for their specific policies and to obtain those instructions in writing.

If approved by the payer, the following procedure codes could be used in combination with ICD-10-CM diagnosis code **Z39.1, Encounter for care and examination of lactating mother:**

<b>99401</b>	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
<b>99402</b>	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
<b>99403</b>	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
<b>99404</b>	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
<b>99411</b>	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes
<b>99412</b>	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes

Antepartum counseling, depending on specific payer global obstetrics reimbursement policies, on the other hand, may be reported. If the counseling is reportable outside the global obstetrics package, you may consider billing the visits as follows:

#### The patient sees the physician and the lactation counselor.

Report a single Evaluation and Management (E/M) code. The code level selected would be based on the combined level of service by the two providers and supported by adequate documentation.

#### The patient sees the lactation counselor only.

For a visit in which the patient sees only the lactation counselor who is a licensed nonphysician practitioner (NPP) such as a physician assistant (PA), nurse practitioner (NP), etc., it may be appropriate to report E/M code **99211 (Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional)**.

CPT code **98960** (Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient [could include caregiver/family] each 30 minutes; individual patient) could be reported for education and training of patients for self-management, if all components of the code were performed and documented by the NPP.

For the group visits, the following codes would be appropriate:

<b>98961</b>	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients
<b>98962</b>	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients

### Existing Breastfeeding Problem

If a patient presents with a breastfeeding problem that the physician must evaluate and manage, the following E/M codes are appropriate to report: **99201-99205 (Office or other outpatient visit for the evaluation and management of a new patient)** or **99212-99215 (Office or other outpatient visit for the evaluation and management of an established patient)**. This would include taking the woman's history, examining her breasts and nipples, observing a breastfeeding, and making a diagnosis and treatment plan for the woman.

### Follow-up Services Provided by a Nonclinical Provider

To report follow-up services provided by a nonclinical provider to treat a lactation problem diagnosed by a physician, you may consider reporting from code series **96156, 96158, 96159, 16164, 96165, 96167, 96168, 96170, 96171 (new codes for 2020) (Health and behavior assessment/intervention)**.

<b>96156</b>	Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)
<b>96158</b>	Health behavior intervention, individual, face-to-face; initial 30 minutes
<b>96159</b>	Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
<b>96164</b>	Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes
<b>96165</b>	Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
<b>96167</b>	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes
<b>96168</b>	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
<b>96170</b>	Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes
<b>96171</b>	Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (list separately in addition to code for primary service)

### HCPCS Codes

If your payer accepts HCPCS codes, you may report code **S9443 (Lactation classes, nonphysician provider, per session)**.

For breast pumps, report the following supply codes:

<b>E0602</b>	Breast pump, manual, any type
<b>E0603</b>	Breast pump, electric (AC and/or DC), any type
<b>E0604</b>	Breast pump, hospital grade, electric (AC and/or DC), any type

Women can contact their insurance company to find out who their insurance contractor for medical supplies is.

### Replacement Codes

<b>A4281</b>	Tubing for breast pump, replacement
<b>A4282</b>	Adapter for breast pump, replacement
<b>A4283</b>	Cap for breast pump bottle, replacement
<b>A4284</b>	Breast shield and splash protector for use with breast pump, replacement
<b>A4285</b>	Polycarbonate bottle for use with breast pump, replacement
<b>A4286</b>	Locking ring for breast pump, replacement

### ICD-10-CM codes

Breast and Nipple Issues:

<b>O91.02</b>	Infection of nipple associated with puerperium
<b>O91.03</b>	Infection of nipple associated with the lactation
<b>O91.12</b>	Abscess of breast
<b>O91.13</b>	Abscess of breast associated with lactation
<b>O91.22</b>	Nonpurulent mastitis associated with the puerperium
<b>O91.23</b>	Nonpurulent mastitis associated with lactation
<b>O92.03</b>	Retracted nipple associated with lactation
<b>O92.13</b>	Cracked nipple associated with lactation
<b>O92.29</b>	Other disorders of breast associated with pregnancy and the puerperium
<b>O92.3</b>	Agalactia
<b>O92.4</b>	Hypogalactia
<b>O92.5</b>	Suppressed lactation
<b>O92.6</b>	Galactorrhea
<b>O92.70</b>	Unspecified disorders of lactation
<b>O92.79</b>	Other disorders of lactation
<b>Q83.8</b>	Other congenital malformations of breast
<b>R20.3</b>	Hyperesthesia (burning)
<b>B37.2</b>	Candidiasis of skin and nail
<b>L01.00</b>	Impetigo, unspecified
<b>Z39.1</b>	Encounter for care and examination of lactating mother

## Women's Preventive Services Initiative (WPSI) Screening for Cervical Cancer

**Clinical Recommendations:** The Women's Preventive Services Initiative recommends cervical cancer screening for average-risk women aged 21 to 65 years. For women aged 21 to 29 years, the Women's Preventive Services Initiative recommends cervical cancer screening using cervical cytology (Pap test) every 3 years. Cotesting with cytology and human papillomavirus testing is not recommended for women younger than 30 years. Women aged 30 to 65 years should be screened with cytology and human papillomavirus testing every 5 years or cytology alone every 3 years. Women who are at average risk should not be screened more than once every 3 years.

**Implementation Considerations:** The Women's Preventive Services Initiative recommends as a preventive service, cervical cancer screening for average-risk women aged 21 to 65 years. For average-risk women aged 30 to 65 years, informed shared decision making between the patient and her clinician regarding the preferred screening strategy is recommended.

Women who have received the human papillomavirus vaccine should be screened according to the same guidelines as women who have not received the vaccine.

These recommendations are for routine screening in average-risk women and do not apply to women infected with human immunodeficiency virus, women who are immunocompromised because of another etiology (such as those who have received solid organ transplantation), women exposed to diethylstilbestrol in utero, or women treated for cervical intraepithelial neoplasia grade 2 or higher within the past 20 years. Screening strategies for high-risk women are outside the scope of these recommendations.

Cervical cancer screening is not recommended for women younger than 21 years or those older than 65 years who have had adequate prior screening and are not otherwise at high risk of cervical cancer. Adequate prior negative screening is defined as documentation (or a reliable patient report) of three consecutive negative cytology results or two consecutive negative cotest results within the previous 10 years with the most recent test within the past 5 years. Cervical cancer screening is also not recommended for women who have had a hysterectomy with removal of the cervix and who do not have a history of a high-grade precancerous lesions (eg, cervical intraepithelial neoplasia grade 2 or grade 3 or cervical cancer within the past 20 years).

### NON-MEDICARE PAYERS: COLLECTION AND HANDLING OF PAP SMEAR SPECIMEN

The American College of Obstetricians and Gynecologists' Committee on Health Economics and Coding considers the collection of the Pap smear specimen, when performed, to be part of a pelvic examination. Therefore, it is not appropriate to code the collection of the specimen separately in addition to the E/M service code.

Some payers reimburse for the handling of the Pap smear specimen when CPT code **99000 (Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory)** is reported. Ask your insurer to verify coverage for this code in writing.

Code **99000** is intended to reflect the work involved in the preparation of a Pap smear specimen before sending it to the laboratory. In addition to the preparation of the Pap smear specimen, it may be used for other specimens. Typical work involved in this preparation may include centrifuging a specimen, separating serum, labeling tubes, packing the specimens for transport, filling out laboratory forms and supplying necessary insurance information and other documentation.

CPT considers this code to be an adjunctive service that further describes the basic service rendered. Therefore modifier **25** should not be appended to the E/M code reported.

HCPCS code **Q0091** was developed for a specific benefit within the Medicare program. A limited number of payers reimburse for this code. You should verify coverage for this code including its specific application with the insurer. Be sure to obtain a payer reimbursement policy regarding this code in writing. Payers have requested takebacks from physician practices when this code was paid in error.

Under no circumstances should a laboratory procedure code (eg, **88141-88177**) be used to report the collection or handling of the Pap smear specimen. Doing so may result in the denial of the laboratory claim as a duplicate service. The patient then may be held responsible for the payment of the interpretation.

### NON-MEDICARE PAYERS: INTERPRETATION OF PAP SMEAR

If the physician is billing for the interpretation of the Pap smear on behalf of the laboratory, he or she can report the appropriate laboratory code on the claim. A modifier 90 must be added to the interpretation code (eg, **88150-90**).

**The modifier 90** (Outside Laboratory Services) indicates that the interpretation was performed by an outside laboratory and not in the physician's office. Modifier 90 is necessary because laboratory interpretation of a Pap smear is not a waived office-based test under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations. The modifier also informs the payer that a fee should not be paid to the laboratory in addition to the one paid to the physician's office.

If a physician is reporting interpretation of Pap smears on behalf of the laboratory, he or she should find out which code (eg, thin prep, manual screening, computer-assisted rescreening, etc.) is appropriate. The physician also should be aware of state regulations that may prohibit physicians from billing on behalf of the laboratory.

Additional information about CLIA regulations is available at the CMS website: [www.cms.hhs.gov/clia/](http://www.cms.hhs.gov/clia/). The website includes a categorization of tests and information about how to apply for a CLIA certificate.

### Coverage for Interpretation of Pap Smears

Health insurers vary, from contract to contract, in their coverage of preventive services and interpretation of Pap smear. Coverage may depend upon whether the Pap smear is a screening or diagnostic test. Noncovered services are the responsibility of the patient.

**Screening Pap smears** are performed in the absence of illness, disease, or symptoms. Most health plans around the country provide coverage for an annual screening Pap smear.

ICD-10-CM CODING OPTIONS INCLUDE:

<b>Z01.411</b>	Encounter for gynecological exam with abnormal findings
<b>Z01.419</b>	Encounter for gynecological exam without abnormal findings
<b>Z12.4</b>	Encounter for screening for malignant neoplasms of cervix
<b>Z12.72</b>	Encounter for screening for malignant neoplasm of vagina
<b>Z08</b>	Encounter for follow-up examination after completed treatment for malignant neoplasm (Used for follow-up vaginal Pap smear [status post hysterectomy for malignant condition])

### Human Papillomavirus Screening

CMS will cover screening for cervical cancer with human papillomavirus (HPV) cotesting under the following conditions:

Human papillomavirus testing once every 5 years for asymptomatic beneficiaries aged 30 to 65 years in conjunction with the Pap smear test with the appropriate U.S. Food and Drug Administration (FDA)-approved/cleared laboratory tests, used consistent with FDA-approved labeling, and in compliance with CLIA regulations.

This service is reported with the following HCPCS code:

<b>G0476</b>	Infectious agent detection by nucleic acid (DNA or RNA); human papillomavirus (HPV), high-risk types (eg, 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68) for cervical cancer screening, must be performed in addition to Pap smear
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The following diagnosis codes are reported for this service:

<b>Z11.51</b>	Encounter for screening for human papillomavirus (HPV), <b>AND</b>
<b>Z01.411</b>	Encounter for gynecological exam (general)(routine) with abnormal findings, <b>OR</b>
<b>Z01.419</b>	Encounter for gynecological exam (general)(routine) without abnormal findings.

## Women's Preventive Services Initiative (WPSI) Contraception

**Clinical Recommendations:** The Women's Preventive Services Initiative (WPSI) recommends that adolescent and adult women have access to the full range of female-controlled contraceptives to prevent unintended pregnancy and improve birth outcomes. Contraceptive care should include contraceptive counseling, initiation of contraceptive use, and follow-up care (eg, management and evaluation as well as changes to and removal or discontinuation of the contraceptive method). The WPSI recommends that the full range of female-controlled U.S. Food and Drug Administration-approved contraceptive methods, effective family planning practices, and sterilization procedures be available as part of contraceptive care.

The full range of contraceptive methods for women currently identified by the U.S. Food and Drug Administration include: (1) sterilization surgery for women, (2) surgical sterilization via implant for women, (3) implantable rods, (4) copper intrauterine devices, (5) intrauterine devices with progestin (all durations and doses), (6) the shot or injection, (7) oral contraceptives (combined pill), (8) oral contraceptives (progestin only, and), (9) oral contraceptives (extended or continuous use), (10) the contraceptive patch, (11) vaginal contraceptive rings, (12) diaphragms, (13) contraceptive sponges, (14) cervical caps, (15) female condoms, (16) spermicides, and (17) emergency contraception (levonorgestrel), and (18) emergency contraception (ulipristal acetate), and additional methods as identified by the FDA. Additionally, instruction in fertility awareness-based methods, including the lactation amenorrhea method, although less effective, should be provided for women desiring an alternative method.

**Implementation Considerations:** The Women's Preventive Services Initiative recommends, as a preventive service, access to and provision of the full range of female-controlled U.S. Food and Drug Administration-identified contraceptive methods. This includes access to contraceptive counseling, initiation of contraceptive use, and follow-up care (eg, management, evaluation, as well as changes to and removal or discontinuation of the contraceptive method) by a health care provider or appropriately trained individual. Additionally, effective family planning practices, and patient-specific services or U.S. Food and Drug Administration-approved methods that may be required based on individual women's needs are recommended as part of contraceptive preventive services.

The Women's Preventive Services Initiative recommends accommodation of an alternative form of contraception when a particular drug or device (generic or brand name) is medically inappropriate for a patient as determined by the individual's health care provider. Research indicates that delayed initiation or disruption of contraceptive use increases the risk of unintended pregnancy; therefore, the Women's Preventive Services Initiative recommends timely authorization of contraceptives.

The Women's Preventive Services Initiative also recommends, as a preventive service, counseling that emphasizes patient-centered decision making and allows for discussion of the full range of contraceptive options.

For some women, more than one visit may be needed to achieve effective contraception. More than one visit may also be necessary to identify the appropriate contraceptive methods to optimize compliance and effectiveness as determined by a woman and her health care provider, based on shared decision making.

**CONTRACEPTION BASICS**

Correct coding can result in more appropriate compensation for services and reduce claim denials.

**Evaluation and Management (E/M) Services Code Only**

If a patient comes to your office to discuss contraception options but no procedure is performed at that visit:

- ✔ If the discussion takes place during an annual preventive visit (99381-99387 or 99391-99297), it is included in the preventive medicine code. The discussion is not reported separately.
- ✔ If the discussion takes place during an E/M office or outpatient visit (99201-99215), an E/M services code may be reported if an E/M service (including history, physical examination, or medical decision making or time spent counseling) is documented. The diagnosis ICD-10-CM code should support medical necessity of services performed.

**E/M Services Code and Procedure Code**

If discussion of contraceptive options takes place during the same encounter as a procedure, such as insertion of a contraceptive implant or intrauterine device (IUD), it may or may not be appropriate to report both an E/M services code and the procedure code:

- ✔ If the clinician and patient discuss several contraceptive options, decide on a method, and then the service is performed during the visit, an E/M service may be reported, depending on the documentation.
- ✔ If the patient comes into the office and states, “I want an IUD,” followed by a brief discussion of the benefits and risks and the insertion, an E/M service is not reported because the E/M services are minimal.
- ✔ If the patient comes in for another reason and, during the same visit, a procedure is performed, then both the E/M services code and procedure may be reported.

If reporting an E/M service and a procedure, the documentation must indicate a significant, separately identifiable E/M service. The documentation must indicate the key components (history, physical examination, and medical decision making) or time spent face-to-face with the patient. Note the “typical times” listed in outpatient E/M services codes 99201-99215. If the physician spends more than 50% of the visit face-to-face with the patient counseling or coordinating a patient’s care, the visit can be coded basing on time. The level of history, physical examination, and medical decision making do not matter in selecting this code.

A modifier 25 (significant, separately identifiable E/M service on the same day as a procedure) is added to the E/M code to indicate that this service was significant and separately identifiable. This indicates that two distinct services were provided: an E/M service and a procedure.

STERILIZATION SURGERY FOR WOMEN

There are three ways that sterilization for women can be performed: 1) minilaparotomy, 2) laparoscopy, or 3) hysterectomy. The following codes can be used:

**1) Minilaparotomy**

The following codes can be used

Type	CPT/HCPCS	Modifier	ICD-10-CM Diagnosis
<b>Minilaparotomy</b>	<b>58600</b> Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral		<b>Z30.2</b> Encounter for sterilization
	<b>58605</b> Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure)		<b>Z30.2</b> Encounter for sterilization
	<b>58611</b> Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)		<b>Z30.2</b> Encounter for sterilization
	<b>58615</b> Occlusion of fallopian tube(s) by device (eg, band, clip, Falope ring), vaginal or suprapubic approach		<b>Z30.2</b> Encounter for sterilization

**2) Laparoscopy**

**PROCEDURE CODES**

- ✔ When performing an elective sterilization, report code **58670 (Laparoscopy, surgical, with fulguration of oviducts [with or without transection])**.
- ✔ When performing a salpingectomy in addition to a primary procedure, or at a time of a laparoscopy for a gynecological procedure that does not include the adnexal structures, code **58661 (Laparoscopy, surgical; with removal of adnexal structures [partial or total oophorectomy] and/or salpingectomy)** is appropriate.

**DIAGNOSIS CODES**

**Z30.2** Encounter for sterilization

Type	CPT/HCPCS	Modifier	ICD-10-CM Diagnosis
<b>Laparoscopy</b> Elective Sterilization	<b>58670</b> Laparoscopy, surgical, with fulguration of oviducts (with or without transection)		<b>Z30.2</b> Encounter for sterilization
<b>Laparoscopy</b>	<b>58661</b> Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)		<b>Z30.2</b> Encounter for sterilization

2) **Hysteroscopy**

**Coding for Surgical Sterilization With Implant for Women**

Type	CPT/HCPCS	Modifier	ICD-10-CM Diagnosis
<b>Minilaparotomy</b>	<b>58565</b> Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants	<b>52</b> , if appropriate  Note: <b>58565</b> is a bilateral procedure. If performed on one side only, modifier 52 (Reduced Services) should be added to <b>58565</b> .	<b>Z30.2</b> Encounter for sterilization
	<b>992XX</b> E/M based either on the key components or time—Report only if separate and distinct from the procedure with modifier 25	<b>25</b>	As appropriate
<b>Supply</b>	<b>A4264</b> Permanent implantable contraceptive occlusion device(s) and delivery system		

IMPLANTABLE RODS

A single-rod progestin-only female contraceptive implanted under the skin of the upper arm and preventing pregnancy for a period up to 3 years.

**PROCEDURE CODES**

The following CPT codes are reported for insertion and/or removal:

- 11981** Insertion, non-biodegradable drug delivery implant
- 11982** Removal, non-biodegradable drug delivery implant
- 11983** Removal with reinsertion, non-biodegradable drug delivery implant

**DIAGNOSIS CODES**

For initial prescription, counseling, advice, and insertion of the implant, even when insertion is performed at a separate encounter, report the following ICD-10-CM code:

- Z30.017** Encounter for initial prescription of implantable subdermal contraceptive

For checking, reinsertion, or removal of the implant, report ICD-10-CM code:

- Z30.46** Encounter for surveillance of implantable subdermal contraceptive



**SUPPLY CODES**

To bill for the cost of the supply, use HCPCS Level II code:

**J7307** Etonogestrel (contraceptive) implant system, including implant and supplies

Type	CPT/HCPCS	Modifier	ICD-10-CM Diagnosis
<b>Implantable Rods</b>	<b>11981</b> Insertion, non-biodegradable drug delivery implant		<b>Z30.017</b> Encounter for initial prescription of implantable subdermal contraceptive
	<b>11982</b> Removal, non-biodegradable drug delivery implant		<b>Z30.46</b> Encounter for surveillance of implantable subdermal contraceptive
	<b>11983</b> Removal with reinsertion, non-biodegradable drug delivery implant		<b>Z30.46</b> Encounter for surveillance of implantable subdermal contraceptive
<b>Supply</b>	<b>J7307</b> Etonogestrel (contraceptive) implant system, including implant and supplies		

COPPER/HORMONAL IUDS

**PROCEDURE CODES**

The following CPT codes are reported for insertion and/or removal:

**58300** Insertion of IUD

**58301** Removal of IUD

**DIAGNOSIS CODES**

The following ICD-10-CM codes could be reported for insertion, routine checking, and removal of IUDs:

**Z30.014** Encounter for initial prescription of intrauterine contraceptive device  
(Note: This code includes the IUD prescription, counseling, but not the IUD insertion)

**Z30.430** Encounter for insertion of intrauterine contraceptive device

**Z30.431** Encounter for routine checking of intrauterine contraceptive device

**Z30.432** Encounter for removal of intrauterine contraceptive device

**Z30.433** Encounter for removal and reinsertion of intrauterine contraceptive device  
(Note: Could be also reported for the replacement of an intrauterine contraceptive device)

**SUPPLY CODES**

CPT codes do not include the cost of the supply and should be reported separately using HCPCS Level II codes:

**J7296** Levonorgestrel-releasing intrauterine contraceptive system, 19.5 mg, 5-year duration

☑ Kyleena

**J7297** Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 4-year duration

☑ Liletta

**J7298** Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 5-year duration

☑ Mirena

**J7300** Intrauterine copper contraceptive

☑ Paragard

**J7301** Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg, 3-year duration

☑ Skyla

CONTRACEPTIVE SHOT OR INJECTION

**PROCEDURE CODES**

**96372** Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular

Please note that code **96372** should not be reported if service was provided without direct physician or other qualified health care professional supervision. In this case, report code **99211** (Office or other outpatient visit for the evaluation and management of an established patient) instead of **96372**.

**DIAGNOSIS CODES**

**Z30.013** Encounter for initial prescription of injectable contraceptive

**Z30.42** Encounter for surveillance of injectable contraceptive

**SUPPLY CODES**

**J1050** Injection; medroxyprogesterone acetate, 1 mg

This code should be used for Depo-Provera injections. Due to the change in dosage in comparison to the old discontinued codes for Depo-Provera, the appropriate dosage in units should be reported based on the needs of the patient.

ORAL CONTRACEPTIVES: COMBINED PILL, ORAL CONTRACEPTIVES (EXTENDED OR CONTINUOUS USE)

Type	CPT/HCPCS	Modifier	ICD-10-CM Diagnosis
<b>Initial</b>	E/M code		<b>Z30.011</b> Encounter for initial prescription of contraceptive pills
<b>Surveillance</b>	E/M code		<b>Z30.041</b> Encounter for surveillance of contraceptive pills
<b>Supply</b>	<b>S4993</b> Contraceptive pills for birth control		Note: Check with payer for appropriate codes and whether separately reimbursed

CODING FOR CONTRACEPTIVE PATCHES AND VAGINAL RINGS

Type	CPT/HCPCS	Modifier	ICD-10-CM Diagnosis
<b>Initial</b>	E/M code		<b>Z30.015</b> Encounter for initial prescription of vaginal ring hormonal contraceptive  <b>Z30.016</b> Encountere for initial prescription of transdermal patch hormonal contraceptive device
<b>Surveillance</b>	E/M code		<b>Z30.44</b> Encounter for surveillance of vaginal ring hormonal contraceptive device  <b>Z30.45</b> Encounter for surveillance of transdermal patch hormonal contraceptive device
<b>Supply</b>	<b>J7303</b> Contraceptive supply, hormone containing vaginal ring, each  <b>J7304</b> Contraceptive supply, hormone containing patch, each		Note: Check with payer for appropriate codes and whether separately reimbursed



BARRIER METHODS CODING

Coding for Diaphragms, Cervical Caps

Type	CPT/HCPCS	Modifier	ICD-10-CM Diagnosis
Initial	57170 Diaphragm or cervical cap fitting with instructions		<b>Z30.018</b> Encounter for initial prescription of other contraceptives
	992XX E/M based either on the key components or time – Report only if separate and distinct from the procedure with modifier 25	25	As appropriate
Surveillance	992XX E/M based either on the key components or time		<b>Z30.049</b> Encounter for surveillance of other contraceptives
Supply	<b>A4261</b> Cervical cap for contraceptive use <b>A4266</b> Diaphragm for contraceptive use		Note: Check with payer for appropriate codes and whether separately reimbursed

Coding for Contraceptive Sponges, Female Condoms, Spermicides

Type	CPT/HCPCS	Modifier	ICD-10-CM Diagnosis
Initial	E/M code		<b>Z30.018</b> Encounter for initial prescription of other contraceptives
Surveillance	E/M code		<b>Z30.049</b> Encounter for surveillance of other contraceptives
Supply	<b>A4268</b> Contraceptive supply, condom, female, each <b>A4269</b> Contraceptive supply, spermicide (eg, foam, gel), each		Note: Check with payer for appropriate codes and whether separately reimbursed

EMERGENCY CONTRACEPTION CODING

Coding for Levonorgestrel and Ulipristal Contraceptive Pills

Type	CPT/HCPCS	Modifier	ICD-10-CM Diagnosis
Emergency Contraception	E/M code		<b>Z30.012</b> Encounter for prescription of emergency contraception
Supply	<b>J3490</b> Unclassified drugs <b>S4993</b> Contraceptive pills for birth control	As appropriate	Note: Check with payers on accepted J or S code and modifiers, if appropriate

Coding for Natural Family Planning

Type	CPT/HCPCS	Modifier	ICD-10-CM Diagnosis
Initial	E/M code		<b>Z30.02</b> Counseling and instruction in natural family planning to avoid pregnancy
Surveillance	E/M code		<b>Z30.02</b> Counseling and instruction in natural family planning to avoid pregnancy

## Women's Preventive Services Initiative (WPSI)

### Screening for Anxiety

**Clinical Recommendations:** The Women's Preventive Services Initiative recommends screening for anxiety in adolescent and adult women, including those who are pregnant or postpartum. Optimal screening intervals are unknown and clinical judgement should be used to determine screening frequency. Given the high prevalence of anxiety disorders, lack of recognition in clinical practice, and multiple problems associated with untreated anxiety, clinicians should consider screening women who have not been recently screened.

**Implementation Considerations:** Clinicians may consider screening for anxiety in conjunction with screening for depression, which is recommended by the USPSTF, because of the frequent co-occurrence of anxiety and depressive disorders. Validated instruments that screen simultaneously for both disorders may be clinically efficient in practice settings, such instruments include the EPDS (specifically for pregnant and postpartum women), PHQ-4, and the HADS in adult women and the Bright Futures Y-PSC in adolescents and young women. Several additional screening instruments demonstrate moderate to high accuracy in identifying anxiety disorders in women (eg, GAD, HADS, BAI) and adolescents and young adult women (eg, 5-item SCARED). Although not evaluated in research studies of adolescents, the GAD-7 and Bright Futures youth self-report PSC (Y-PSC) are commonly used in clinical practice.

While no studies have evaluated the benefits and harms of population screening for anxiety, trials among patients with clinically diagnosed anxiety support the effectiveness of treatment with cognitive behavioral therapy, medications, or both. When screening suggests the presence of anxiety, further evaluation is necessary to establish the diagnosis and determine appropriate treatment. Screening should ideally be implemented in conjunction with collaborative and team-based approaches to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

## PROCEDURE CODES

### NON-MEDICARE PAYERS

Anxiety and depression screening may be performed during the annual well-woman visit. For commercial payers, you may be able to report a preventive medicine Evaluation and Management (E/M) service code (**99381-99387, 99391-99397**) for the annual exam in addition to code **96127, Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument**. No bundling relationship exists between these two services per the federal National Correct Coding Initiative (NCCI) and as such, both can be reported separately if the commercial payers choose to do so.

Some commercial payers consider depression/anxiety testing as a part of preventive service. Physicians should check with their individual payers regarding their specific policies.

For anxiety and depression screening of a patient without symptoms and not performed as part of the annual exam, report a preventive medicine code. These codes are selected according to the time spent in face-to-face counseling with the patient. Again, physicians should check with their individual payers regarding reimbursement policies for preventive medicine codes.

Possible procedure codes are:

<b>99401-99404</b>	Preventive medicine, individual counseling
<b>99411-99412</b>	Preventive medicine, group counseling

If the encounter was for treatment for a patient with a diagnosis of depression or documented symptoms of depression, report an outpatient E/M code. These codes list a "typical time" in the code descriptions. For visits in 2020, time spent face to face counseling the patient must be documented in the medical record, and the record must document that either all of the encounter or more than 50% of the total time was spent counseling the patient.

Possible procedure codes are:

<b>99201-99205</b>	New patient, office or other outpatient visit
<b>99211-99215</b>	Established patient, office or other outpatient visit

Please note that for Patient Health Questionnaire (PHQ-9) screening, some payers accept E/M code with modifier **25** billed with **96161/96160**, while others may request using CPT code **96127, Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument**.

**OBSTETRIC PATIENTS**

If the physician is providing the global obstetrical service (and reporting a global code), the payer may consider screening for depression/anxiety as a part of the global service and not reimburse additionally for the service. This is particularly true if the physician screens every patient for depression as routine. However, some payers may reimburse for this service. Physicians should check with their specific payers. However, if the physician diagnoses depression/anxiety, you may report it separately since the global package was valued for uncomplicated antepartum, delivery and postpartum care. You should be aware, though, that some payers will only reimburse psychologists and psychiatrists for treating mental disorders. You need to know your specific payer policies.

When using Edinburgh Postnatal Depression Screening (EPDS) to screen for depression in pregnant/postpartum patients, it is more appropriate to report CPT code **96160, Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument.**

When using Edinburgh Postnatal Depression Screening (EPDS) or PHQ-9 to screen mother during a baby’s visit, CPT code **96161, Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument.**

**ICD-10-CM Codes**

The possible ICD-10-CM codes are as follows:

- G47.9** Sleep disorder, unspecified
- R53.81** Other malaise
- R53.83** Other fatigue
- R45.-** Symptoms and signs involving emotional state
- Z13.39** Encounter for screening examination for other mental health and behavioral disorders
- Z13.30** Encounter for screening examination for mental health and behavioral disorders, unspecified
- Z13.31** Encounter for screening for depression
- Z13.32** Encounter for screening for maternal depression
- F40.0-** Agoraphobia
- F40.1-** Social phobias
- F40.2-** Specific (isolated) phobias
- F40.8** Other phobic anxiety disorders
- F40.9** Phobic anxiety disorder, unspecified
- F41.0** Panic disorder [episodic paroxysmal anxiety]
- F41.1** Generalized anxiety disorder
- F41.3** Other mixed anxiety disorders
- F41.8** Other specified anxiety disorders
- F41.9** Anxiety disorder, unspecified

**Women’s Preventive Services Initiative (WPSI)  
Screening for Diabetes Mellitus After Pregnancy**

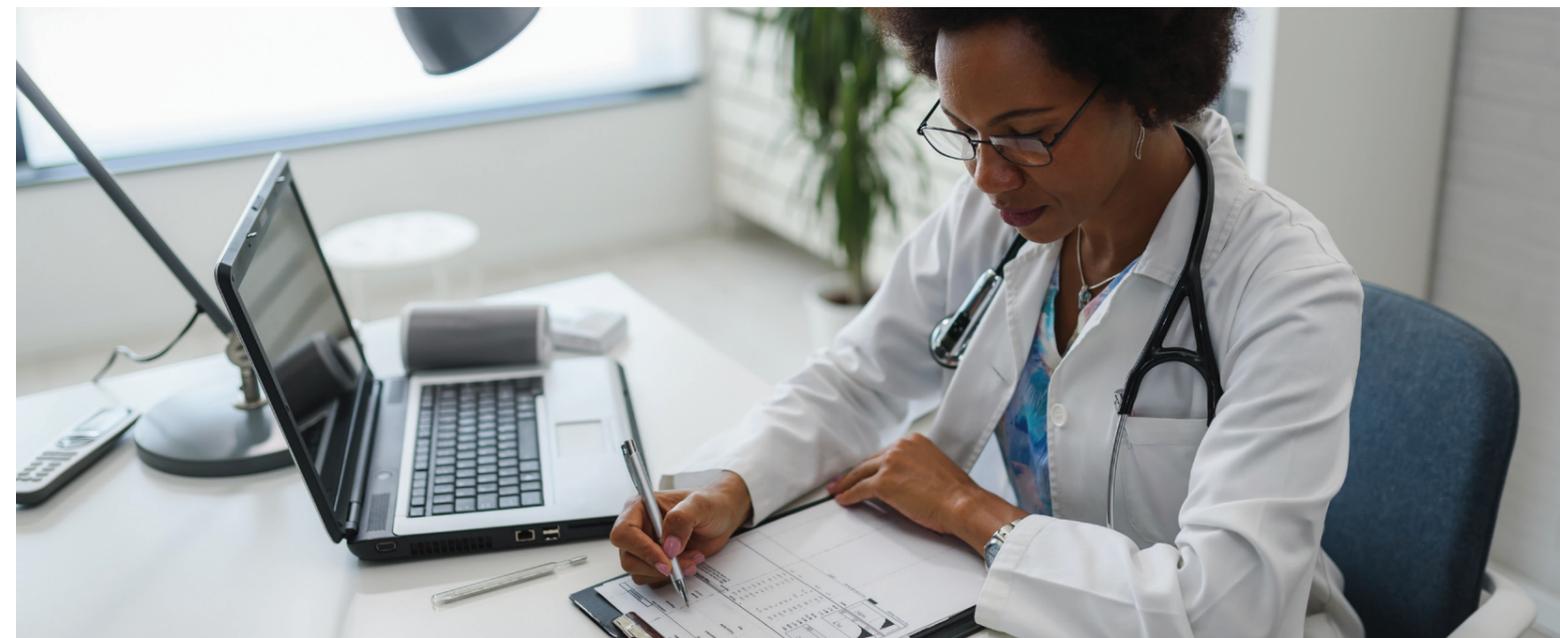
**Clinical Recommendations:** The Women’s Preventive Services Initiative recommends women with a history of gestational diabetes mellitus (GDM) who are not currently pregnant and who have not previously been diagnosed with type 2 diabetes mellitus should be screened for diabetes mellitus. Initial testing should ideally occur within the first year postpartum and can be conducted as early as 4–6 weeks postpartum (see Table 1).

Women with a negative initial postpartum screening test result should be rescreened at least every 3 years for a minimum of 10 years after pregnancy. For women with a positive postpartum screening test result, testing to confirm the diagnosis of diabetes is indicated regardless of the initial test (eg, oral glucose tolerance test, fasting plasma glucose, or hemoglobin A<sub>1c</sub>).

Repeat testing is indicated in women who were screened with hemoglobin A<sub>1c</sub> in the first 6 months postpartum regardless of the result (see Implementation Considerations below).

Table 1. Preferred Testing Strategy Based on Postpartum Timeframe

Postpartum Timeframe	Testing Strategy		
	Oral Glucose Tolerance Test	Fasting Plasma Glucose	Hemoglobin A <sub>1c</sub>
<b>4 weeks – 6 months</b>	Preferred	Acceptable	Consider only when recommended alternatives are not feasible
<b>After 6 months</b>	Acceptable	Acceptable	Acceptable



**Implementation Considerations:** In addition to the follow-up screening for women with a history of GDM recommended above, the Women’s Preventive Services Initiative recommends all women should adhere to diabetes mellitus screening guidelines for the general population. Guidelines for general population screening are available from the U.S. Preventive Services Task Force and American Diabetes Association.

Compared with other tests, hemoglobin A<sub>1c</sub> is less accurate in the first months after pregnancy. In addition, hemoglobin A<sub>1c</sub> levels may be inaccurate in women with conditions such as anemia, renal failure, certain hemoglobinopathies (eg, thalassemia and sickle cell disease or trait) or women who have had a recent transfusion. However, given the low rates of postpartum testing with fasting plasma glucose and 2-hour 75-gram oral glucose tolerance tests, hemoglobin A<sub>1c</sub> may be considered as an alternative for appropriately counseled patients when other tests are not feasible. By 6 months postpartum, the physiologic changes related to pregnancy have usually resolved; therefore, all standard screening tests are acceptable after 6 months.

## DIAGNOSIS CODES

Per ICD-10-CM, “Screening is the testing for disease or disease precursors in seemingly well individuals so that early detection and treatment can be provided for those who test positive for the disease.” If the reason for the visit is the screening exam, then a screening code may be a first listed code. If the screening is done during an office visit, then a screening code may be used as an additional code.”

**Z13.1** Encounter for screening for diabetes mellitus

For patient with a history of GDM, a history code **Z86.32, Personal history of gestational diabetes**, should be assigned along with the screening code **Z13.1**.

## PROCEDURE CODES

The following CPT codes are recommended to report services for diabetes mellitus screening:

### Fasting plasma glucose test (FPG)

**82947** Glucose; quantitative, blood (except reagent strip)

### Oral Glucose Tolerance Test (OGTT)

**82951** Glucose; tolerance test (GTT), 3 specimens (includes glucose)

### Hemoglobin A<sub>1c</sub>

**83037** Hemoglobin; glycosylated (A<sub>1c</sub>) by device cleared by FDA for home use

Note: These codes are for reporting by the laboratory, not the physician.

## Women’s Preventive Services Initiative (WPSI) Screening for Gestational Diabetes Mellitus

**Clinical Recommendations:** The Women’s Preventive Services Initiative recommends screening pregnant women for gestational diabetes mellitus after 24 weeks of gestation (preferably between 24 and 28 weeks of gestation) in order to prevent adverse birth outcomes. Screening with a 50-g oral glucose challenge test (followed by a 3-hour 100-g oral glucose tolerance test if results on the initial oral glucose challenge test are abnormal) is preferred because of its high sensitivity and specificity.

The Women’s Preventive Services Initiative suggests that women with risk factors for diabetes mellitus be screened for preexisting diabetes before 24 weeks of gestation—ideally at the first prenatal visit, based on current clinical best practices.

**Implementation Considerations:** The Women’s Preventive Services Initiative recommends screening pregnant women for gestational diabetes mellitus after 24 weeks of gestation to prevent adverse birth outcomes. Risk factors for diabetes mellitus that may help identify women for early screening include, but are not limited to, those identified by the Institutes of Medicine (now National Academies of Science, Engineering, and Medicine). The optimal test for screening prior to 24 weeks of gestation is not known. However, acceptable modalities may include a 50-g oral glucose challenge test, a 2-hour 75-g oral glucose tolerance test, a hemoglobin A<sub>1c</sub> test, a random plasma glucose test, or a fasting plasma glucose test. If early screening is normal, screening with a 50-g oral glucose challenge test should be conducted at 24 to 28 weeks of gestation as described above.

## PROCEDURE CODES

The following CPT codes are used for GDM screening:

**82947** Glucose; quantitative, blood (except reagent strip)  
This test is often called a fasting blood sugar (FBS).

**82951** Glucose; tolerance test (GTT), three specimens (includes glucose)

**82952** Glucose; tolerance test, each additional beyond three specimens (List separately in addition to code for primary procedure)

**82962** Glucose; blood by glucose monitoring device(s) cleared by the FDA specifically for home use

Glucose monitoring devices may also be used in physician offices or in clinics.

**83037** Hemoglobin; glycosylated (A<sub>1c</sub>) by device cleared by FDA for home use

This code (**83037**) may be billed when provided at the physician’s office and not for use to report a test result when obtained in a patient’s home by the patient or family members.

In 2018, a new Category III code **0488T** was added to CPT to report services provided for diabetes mellitus prevention.

New CPT code **0488T, Preventive behavior change, online/electronic structured intensive program for prevention of diabetes using a standardized diabetes prevention program curriculum, provided to an individual, per 30 days**, was developed in addition to already existing Diabetes Prevention Program (DPP) Code **0403T, Preventive behavior change, intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to individuals in a group setting, minimum 60 minutes, per day**.

The CPT Assistant (August 2018) lists the following eligibility requirements for referral to a Centers for Disease Control and Prevention (CDC)-recognized lifestyle change program:

- ✔ Be at least 18 years old, **AND**
- ✔ Be overweight (body mass index  $\geq 25$  kg/m<sup>2</sup>;  $\geq 23$  kg/m<sup>2</sup>, if Asian American), **AND**
- ✔ Have no previous diagnosis of type 1 or type 2 diabetes mellitus, **AND**
- ✔ Have a blood-test result in the prediabetes range within the past year:
  - Hemoglobin A<sub>1c</sub>: 5.7%–6.4%, or
  - Fasting plasma glucose: 100–125 mg/dL, or
  - Two-hour plasma glucose (after a 75-gm glucose load): 140–199 mg/dL, or
  - Be previously diagnosed with gestational diabetes

After training, the enrolled patient receives educational lessons each week through online or electronic technology based on a standardized curriculum for education on lifestyle change in combination with lifestyle health coaching.

### DIAGNOSIS CODES

Per ICD-10-CM, “Screening is the testing for disease or disease precursors in seemingly well individuals so that early detection and treatment can be provided for those who test positive for the disease.” If the reason for the visit is the screening exam, then a screening code may be a first listed code. If the screening is done during an office visit, then a screening code may be reported as an additional code.

<b>Z13.1</b>	Encounter for screening for diabetes mellitus
<b>Z36.89</b>	Encounter for other specified antenatal screening

For diagnosed gestational diabetes mellitus, codes from subcategory **O24.4, Gestational diabetes mellitus**, should be assigned. No other code from category **O24, Diabetes mellitus in pregnancy, childbirth, and the puerperium**, should be used with a code from **O24**.

## Women’s Preventive Services Initiative (WPSI) Screening for Human Immunodeficiency Virus Infection

**Clinical Recommendations:** The Women’s Preventive Services Initiative recommends prevention education and risk assessment for human immunodeficiency virus (HIV) infection in adolescents and women at least annually throughout the lifespan. All women should be tested for HIV at least once during their lifetime. Additional screening should be based on risk, and screening annually or more often may be appropriate for adolescents and women with an increased risk of HIV infection.

Screening for HIV is recommended for all pregnant women upon initiation of prenatal care with retesting during pregnancy based on risk factors. Rapid HIV testing is recommended for pregnant women who present in active labor with an undocumented HIV status. Screening during pregnancy enables prevention of vertical transmission.

**Implementation Considerations:** The Women’s Preventive Services Initiative recommends, as a preventive service for women, prevention education and risk assessment for HIV infection in adolescents and women at least annually throughout the lifespan. More frequent screening for high-risk women, as determined by clinical judgment, is also recommended as a preventive service. Annual or more frequent HIV testing may be needed and is recommended as a preventive service for women who are identified or self-identify as high risk.

This recommendation refers to routine HIV screening, which is different from incident-based or exposure-based HIV testing. Risk factors for HIV infection in women include, but are not limited to, being an active injection drug user; having unprotected vaginal or anal intercourse; having multiple sexual partners; initiating a new sexual relationship; having sexual partners who are HIV-infected, bisexual, or injection drug users; exchanging sex for drugs or money; being a victim of sex trafficking; being incarcerated (currently or previously); and having other sexually transmitted infections.

Approximately 20–26% of infected patients are not identified by risk-based screening. Early detection and treatment improves outcomes for patients and reduces transmission; therefore, based on clinical best practice, screening annually or more frequently may be reasonable.

### PROCEDURE CODES

#### **NON-MEDICARE PAYERS**

Per CPT, codes **99384–99397** include age-appropriate counseling, anticipatory guidance, and risk factor reduction interventions provided at the time of the initial or periodic comprehensive preventive medicine examinations.

Preventive Medicine counseling codes are used to report services for promoting health and preventing illness and injury. That is, the patient has no current symptoms or diagnosed illness.

The counseling must be provided at a separate encounter from the preventive medicine service. These codes are selected according to the time spent counseling the patient. Use codes **99401, 99402, 99403, 99404** for individual counseling, and codes **99411**, and **99412** for group counseling as appropriate:

- 99401** Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
- 99402** Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
- 99403** Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
- 99404** Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
- 99411** Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes
- 99412** Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes

These codes are not reported when the physician counsels a patient with symptoms or an established illness. In this case, an appropriate problem-oriented E/M service (**99201-99215**) is reported. Codes **99201-99215** list “typical times” in their descriptions.

If the physician spends more than 50% of the total time with the patient providing counseling or if he or she spends the entire visit providing counseling for a patient and/or patient’s family, then the level of service may be determined using time alone. CPT states:

When counseling and/or coordination of care dominates (more than 50%) the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then time may be considered the key or controlling factor to qualify for a particular level of E/M service. This includes time spent with parties who have assumed responsibility for the care of the patient or decision making whether or not they are family members (eg, foster parents). The extent of counseling and/or coordination of care must be documented in the medical record.

**DIAGNOSIS CODES**

**GENERAL**

For human immunodeficiency screening (HIV), use diagnosis code **Z11.4 (Encounter for screening for human immunodeficiency virus [HIV])** as primary and **Z72.89, Z72.51, Z72.52, Z72.53**, or other codes listed below as secondary. Pregnant patients would also have a pregnancy status code reported (such as **Z34.- or O09.9-**), in addition to the appropriate **Z11.4** as primary and **Z34.0-, Z34.8,- or O09.9-** as appropriate).

For the purposes of incident-based or exposure-based HIV testing, ICD-10-CM code **Z20.2, Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission, or Z20.6, Contact with and (suspected) exposure to human immunodeficiency virus [HIV]**, can be reported.

*Additional codes for HIV screening:*

High-Risk Sexual Behavior	
Code Description	Code
High-risk heterosexual behavior	Z72.51
High-risk homosexual behavior	Z72.52
High-risk bisexual behavior	Z72.53
Other problems related to lifestyle	Z72.89
Drug Use	
Drug use complicating pregnancy, childbirth, and puerperium	O99.32-
Opioid use, uncomplicated	F11.9-
Opioid abuse, uncomplicated	F11.1-
Opioid dependence, uncomplicated	F11.2-
Sex Trafficking	
Beginning October 1st, 2018, the National Center for Health Statistics at the CDC added new codes for patients experiencing sexual trafficking.	
Adult forced sexual exploitation, confirmed	T74.51-
Child sexual exploitation, confirmed	T74.52-
Adult forced sexual exploitation, suspected	T76.51-
Child sexual exploitation, suspected	T76.52-
Personal history of forced labor or sexual exploitation in childhood	Z62.813
Personal history of forced labor or sexual exploitation	Z91.42
Imprisonment	
Imprisonment and other incarceration	Z65.1

**Sexually Transmitted Infections**

Codes for infections with a sexual way of transmission could be found in categories **A50-A64**.

**Personal History of Drug Use or Other Specified Conditions**

To document history of drug use, **ICD-10-CM code Z86.59, Personal history of other mental and behavioral disorders**, should be assigned.

For a history of drug use, non-dependent, in remission, use code **Z87.898, Personal history of other specified conditions**.

Additional HIV-Related Codes	
Code Description	Code
Asymptomatic human immunodeficiency virus [HIV] infection status	Z21
Human immunodeficiency virus [HIV] disease	B20
Inconclusive laboratory evidence of human immunodeficiency virus [HIV]	R75
Human immunodeficiency virus [HIV] disease complicating pregnancy	O98.71-
Human immunodeficiency virus [HIV] disease complicating childbirth	O98.72
Human immunodeficiency virus [HIV] disease complicating the puerperium	O98.73
Inconclusive laboratory evidence of human immunodeficiency virus [HIV]	R75

**Women’s Preventive Services Initiative (WPSI)  
Screening for Interpersonal and Domestic Violence**

**Clinical Recommendations:** The Women’s Preventive Services Initiative recommends screening adolescents and women for interpersonal and domestic violence, at least annually, and, when needed, providing or referring for initial intervention services. Interpersonal and domestic violence includes physical violence, sexual violence, stalking and psychological aggression (including coercion), reproductive coercion, neglect, and the threat of violence, abuse, or both. Intervention services include, but are not limited to, counseling, education, harm reduction strategies, and referral to appropriate supportive services.

**Implementation Considerations:** The Women’s Preventive Services Initiative recommends as a preventive service, screening adolescents and women for interpersonal and domestic violence. Factors associated with increased risk include, but are not limited to, pregnancy; younger and older age; increased stress; lesbian, gay, bisexual, transgender, and queer (or questioning) status; dependency; drug and alcohol misuse; former or current military service; and living in an institutional setting. There are multiple screening tools that have shown adequate sensitivity and specificity for identifying intimate partner violence and domestic violence in specific populations of women. Minimum screening intervals are unknown; however, based on the prevalence of interpersonal and domestic violence as well as evidence demonstrating that many cases are not reported, it is reasonable to conduct screening at least annually although the frequency and intensity of screening may vary depending on a particular patient’s situation.

**Counseling**

**PROCEDURE CODES**

Per CPT, codes **99384-9397** include age-appropriate counseling, anticipatory guidance, and risk factor reduction interventions provided at the time of the initial or periodic comprehensive preventive medicine examinations.

If the encounter was for screening for a patient without symptoms, report a preventive medicine code. These codes are selected according to the time spent in face-to-face counseling with the patient. Use codes **99401, 99402, 99403, and 99404** for individual counseling, and codes **99411, and 99412** for group counseling as appropriate:

- 99401** Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
- 99402** Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
- 99403** Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes

<b>99404</b>	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
<b>99411</b>	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes
<b>99412</b>	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes

These codes are not reported when the physician counsels a patient with symptoms or an established illness. In this case, an appropriate problem-oriented E/M service (**99201–99215**) is reported. Codes **99201–99215** list “typical times” in their descriptions.

If the physician spends more than 50% of the total time with the patient providing counseling or if he or she spends the entire visit providing counseling for a patient and/or patient’s family, then the level of service may be determined using time alone. CPT states:

When counseling and/or coordination of care dominates (more than 50%) the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then time may be considered the key or controlling factor to qualify for a particular level of E/M service. This includes time spent with parties who have assumed responsibility for the care of the patient or decision making whether or not they are family members (eg, foster parents). The extent of counseling and/or coordination of care must be documented in the medical record.

## DIAGNOSIS CODES

### ABUSE AND NEGLECT

Codes from category **T74** (confirmed cases) or **T76** (suspected cases) should be reported, as follows:

#### Confirmed

<b>T74.0</b>	Neglect or abandonment, confirmed
<b>T74.1</b>	Physical abuse, confirmed
<b>T74.2</b>	Sexual abuse, confirmed [Rape, confirmed; Sexual assault, confirmed]
<b>T74.3</b>	Psychological abuse, confirmed [Bullying and intimidation, confirmed; Intimidation through social media, confirmed – revised text for 2019]
<b>T74.5</b>	Forced sexual exploitation, confirmed (New code for 2019)
<b>T74.6</b>	Forced labor exploitation, confirmed (New code for 2019)
<b>T74.9</b>	Unspecified maltreatment, confirmed

#### Suspected

<b>T76.0</b>	Neglect or abandonment, suspected
<b>T76.1</b>	Physical abuse, suspected
<b>T76.2</b>	Sexual abuse, suspected
<b>T76.3</b>	Psychological abuse, suspected [Bullying and intimidation, confirmed; Intimidation through social media, confirmed] – revised text for 2019]
<b>T76.5</b>	Forced sexual exploitation, suspected (New code for 2019)
<b>T76.6</b>	Forced labor exploitation, suspected (New code for 2019)
<b>T76.9</b>	Unspecified maltreatment, suspected

### ABUSE AND NEGLECT COMPLICATING PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM

Codes from Chapter 15 of ICD-10-CM should be used, as follows:

<b>O9A.3</b>	Physical abuse complicating pregnancy, childbirth, and the puerperium
<b>O9A.4</b>	Sexual abuse complicating pregnancy, childbirth, and the puerperium
<b>O9A.5</b>	Psychological abuse complicating pregnancy, childbirth, and the puerperium

### SCREENING

There is no specific ICD-10-CM or CPT code for domestic, sexual and interpersonal violence screening, but code **Z13.89, Encounter for screening for other disorder**, possibly could be reported.

### SUSPECTED CASE OF ABUSE, NEGLECT, OR MISTREATMENT RULED OUT

If suspected case of abuse, neglect, or mistreatment was ruled out during the visit, codes **Z04.71, Encounter for examination and observation following alleged physical abuse, ruled out**, or **Z04.41, Encounter for examination and observation following alleged adult rape, ruled out**, should be used instead of codes from category **T76**.

### PERPETRATOR

In addition to abuse diagnosis codes, codes from category **Y07, Perpetrator of assault, maltreatment and neglect**, may be reported. Codes from this category may be used only in cases of confirmed abuse (**T74.-**) (**T74-T74.92XS**).

History codes from subcategories **Z62.81, Personal history of abuse in childhood**, and **Z91.4, Personal history of psychological trauma**, not elsewhere classified, provide additional information, if applicable.

### COUNSELING FOR VICTIMS OF ABUSE

Codes from category **Z69, Encounter for mental health services for victim and perpetrator of abuse**, used as follows:

<b>Z69.1</b>	Encounter for mental health services for spousal or partner abuse problems
<b>Z69.8</b>	Encounter for mental health services for victim or perpetrator of other abuse

## Women's Preventive Services Initiative (WPSI) Counseling for Sexual Transmitted Infections

**Clinical Recommendations:** The Women's Preventive Services Initiative recommends directed behavioral counseling by a health care provider or other appropriately trained individual for sexually active adolescent and adult women at an increased risk for sexually transmitted infections (STIs).

The Women's Preventive Services Initiative recommends that health care providers use a woman's sexual history and risk factors to help identify those at an increased risk of STIs. Risk factors may include age younger than 25, a recent history of an STI, a new sex partner, multiple partners, a partner with concurrent partners, a partner with an STI, and a lack of or inconsistent condom use. For adolescents and women not identified as high risk, counseling to reduce the risk of STIs should be considered, as determined by clinical judgement.

**Implementation Considerations:** The Women's Preventive Services Initiative recommends as preventive service for women at increased risk for STIs, directed behavioral counseling that includes, but is not limited to, longer duration or multiple counseling sessions, motivational interviewing techniques, and goal setting.

The Women's Preventive Services Initiative recommends as a preventive service, STI counseling regardless of whether or not STI screening takes place during the same visit and regardless of the type of sexual activity or the partners' gender.

### NON-MEDICARE PAYERS

#### COUNSELING RISK FACTOR REDUCTION AND BEHAVIORAL CHANGE INTERVENTION (99401-99412)

Preventive medicine counseling codes are used to report services for promoting health and preventing illness and injury. That is, the patient has no current symptoms or diagnosed illness.

The counseling must be provided at a separate encounter from the preventive medicine service. These codes are selected according to the time spent counseling the patient. If a distinct problem-oriented E/M service also is provided, it may be reported separately.

These codes are not reported when the physician counsels an individual patient with symptoms or an established illness. In this case, a problem-oriented E/M service (99201-99215) is reported.

Behavioral change interventions as reported with codes 99401-99412, are for persons who have a behavior that often is considered an illness itself, such as tobacco use or substance abuse. Any additional E/M service reported on the same day must be distinct and documented distinctly. Time spent providing the behavioral change intervention services may not be used as a basis for the E/M code selection.

<b>99401</b>	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
<b>99402</b>	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
<b>99403</b>	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
<b>99404</b>	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
<b>99411</b>	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes
<b>99412</b>	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes

For counseling groups of patients with symptoms or established illness, see code 99078, **Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (eg, prenatal, obesity, or diabetic instructions)**

Possible ICD-10-CM diagnosis codes:

**Z11.3, Z11.59, Z34.00, Z34.01, Z34.02, Z34.03, Z34.80, Z34.81, Z34.82, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93, Z72.51, Z72.52, Z72.53, Z72.89, O09.90, O09.91, O09.92, and O09.93**

## Women's Preventive Services Initiative (WPSI) Screening for Urinary Incontinence

**Clinical Recommendations:** The Women's Preventive Services Initiative recommends screening women for urinary incontinence annually. Screening should ideally assess whether women experience urinary incontinence and whether it impacts their activities and quality of life. The Women's Preventive Services Initiative recommends referring women for further evaluation and treatment if indicated.

**Implementation Considerations:** The Women's Preventive Services Initiative recommends screening women for urinary incontinence as a preventive service. Factors associated with an increased risk for urinary incontinence include increasing parity, advancing age, and obesity; however, these factors should not be used to limit screening.

Several screening tools demonstrate fair to high accuracy in identifying urinary incontinence in women. Although minimum screening intervals are unknown, given the prevalence of urinary incontinence, the fact that many women do not volunteer symptoms, and the multiple, frequently changing risk factors associated with incontinence, it is reasonable to conduct annually.

The Women's Preventive Services Initiative recommends screening women for urinary incontinence annually. This screening could be performed during annual well-women examinations and billed with preventive services codes.

The Women's Preventive Services Initiative recommends referring women for further evaluation and treatment if indicated. In patients with both symptoms and physical findings of stress urinary incontinence (SUI)/prolapse, urgency urinary incontinence (UUI), mixed incontinence, or lower urinary tract symptoms (LUTS), management and treatment of the conditions can be performed using various methodologies.

### DIAGNOSIS CODES

#### NON-MEDICARE PAYERS

<b>N39.3</b>	Stress incontinence (female) (male)
<b>N39.41</b>	Urge incontinence
<b>N39.42</b>	Incontinence without sensory awareness
<b>N39.43</b>	Post-void dribbling
<b>N39.44</b>	Nocturnal enuresis
<b>N39.45</b>	Continuous leakage

<b>N39.46</b>	Mixed incontinence
<b>N39.490</b>	Overflow incontinence
<b>N39.491</b>	Coital incontinence
<b>N39.492</b>	Postural (urinary) incontinence
<b>N39.498</b>	Other specified urinary incontinence
<b>N36.42</b>	Intrinsic sphincter deficiency (ISD)
<b>O90.89</b>	Other complications of puerperium, not elsewhere classified

**Urinary Incontinence Following Delivery:** For urinary incontinence following delivery, the correct coding depends on the way the urinary incontinence was documented. If provider's records say "urinary incontinence due to pregnancy," then code **O26.892, Other specified pregnancy related conditions**, should be applied with code **R32, Unspecified urinary incontinence**.

If documentation does not state that urinary incontinence was caused by pregnancy, then codes **O99.89, Other specified diseases and conditions complicating pregnancy, childbirth and puerperium**, and **R32**, should be applied.

Postpartum urinary incontinence may be caused by urinary tract infection. The following codes from category **O86.2-, Urinary tract infection following delivery**, may be applied:

<b>O86.20</b>	Urinary tract infection following delivery, unspecified
<b>O86.21</b>	Infection of kidney following delivery
<b>O86.22</b>	Infection of bladder following delivery
<b>O86.20</b>	Other urinary tract infection following delivery

Use additional code **B95-97** to identify infectious agent (if known).

#### CURRENT PROCEDURAL TERMINOLOGY (CPT) CODES

<b>51725</b>	Simple cystometrogram (CMG) (eg, spinal manometer)
<b>51726</b>	Complex cystometrogram (ie, calibrated electronic equipment)
<b>51727</b>	Complex cystometrogram (ie, calibrated electronic equipment); with urethral pressure profile studies (ie, urethral closure pressure profile), any technique
<b>51728</b>	Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (ie, bladder voiding pressure), any technique
<b>51729</b>	Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (ie, bladder voiding pressure) and urethral pressure profile studies (ie, urethral closure pressure profile), any technique
<b>+51797</b>	Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)

- 51736** Simple uroflowmetry (UFR) (eg, stop-watch flow rate, mechanical uroflowmeter)
- 51741** Complex uroflowmetry (ie, calibrated electronic equipment)
- 51784** Electromyography studies (EMG) of anal or urethral sphincter, other than needle, any technique
- 51785** Needle electromyography studies (EMG) of anal or urethral sphincter, any technique
- 51798** Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, nonimaging

Please note that all listed above codes include two components:

- ✔ A professional component

AND

- ✔ A technical component

Together, these two components comprise the total service.

**PROFESSIONAL COMPONENT**

The professional component includes that portion of the test that is provided by the physician:

- ✔ The supervision of the test (if any)
- ✔ The interpretation
- ✔ The written report

**TECHNICAL COMPONENT**

The technical component includes costs associated with:

- ✔ The technician salary/benefits (if any)
- ✔ The equipment
- ✔ Any necessary supplies

CATEGORY II CODES

These codes are used to collect information about the quality of care being provided, using nationally established performance measures. They are alphanumeric, with four numbers followed by letter “F.” Category II codes are updated biannually in January and July. The use of these codes is optional. They may not be used as a substitute for Category I codes and are not required for correct coding.

MANAGEMENT OF URINARY INCONTINENCE CATEGORY II CODES

- 0509F** Urinary incontinence plan of care documented
- 1090F** Presence or absence of urinary incontinence

HCPCS LEVEL II PROCEDURE AND SUPPLY CODES

These codes are used to report services not covered by CPT codes, such as durable medical equipment (DME) and supplies. The Centers for Medicare and Medicaid Services updates these codes annually. Level II codes must be used for services reported to Medicare and Medicaid. Other payers may or may not recognize Level II codes for reimbursement. It is advisable to check with specific payers regarding their billing and reimbursement policies.

- G8060** Patient documented for the assessment of urinary incontinence



## Women's Preventive Services Initiative (WPSI)

### Well-Woman Preventive Visits

**Clinical Recommendations:** The Women's Preventive Services Initiative recommends that women receive at least one preventive care visit per year beginning in adolescence and continuing across the lifespan to ensure that the recommended preventive services, including preconception and many services necessary for prenatal and interconception care, are obtained. The primary purpose of these visits should be the delivery and coordination of recommended preventive services as determined by age and risk factors.

**Implementation Considerations:** The Women's Preventive Services Initiative recommends as a preventive service for women, that women receive at least one preventive care visit per year. Additional well-woman visits may be needed to obtain all necessary services depending on a woman's age, health status, reproductive health needs, pregnancy status, and risk factors. Visits should allow sufficient time to address and coordinate services, and a team-based approach may facilitate delivery of services.

Well-woman preventive services may include, but are not limited to, assessment of physical and psychosocial function, primary and secondary prevention and screening, risk factor assessments, immunizations, counseling, education, preconception care, and many services necessary for prenatal and interconception care. Recommended services are evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force, immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved, with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration, and with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

The Women's Preventive Services Initiative recommends that women receive at least one preventive care visit per year beginning in adolescence and continuing across their lifespan.

## PROCEDURE CODES

### NON-MEDICARE PAYERS

Preventive medicine services are reported for comprehensive E/M services provided to patients who have no current symptoms or diagnosed illness. Preventive codes are used to report annual well-woman examinations and include:

- Counseling/anticipatory guidance/risk factor reduction interventions
- Age and gender-appropriate comprehensive history
- Age and gender-appropriate comprehensive physical examination including in most cases but not limited to
  - gynecological exam
  - breast exam
  - collection of Pap smear specimen
- Discussions about the status of previously diagnosed stable conditions
- Ordering of appropriate laboratory and diagnostic procedures and immunizations
- Discussions about issues related to the patient's age or lifestyle

Preventive medicine codes (**99381-99387** and **99391-99397**) are used to report annual well-woman examinations and determined by the age of the patient and whether she is considered a new or established patient to the physician or practice. Preventive codes do not require a chief complaint, history of present illness or medical decision making, cannot be reported using time, and may be performed in any setting. The Centers for Medicare and Medicaid E/M documentation guidelines do not apply to preventive services codes.



## Women's Preventive Services Initiative (WPSI) Breast Cancer Screening for Average-Risk Women

**Clinical Recommendations:** The Women's Preventive Services Initiative recommends that average-risk women initiate mammography screening no earlier than age 40 and no later than age 50. Screening mammography should occur at least biennially and as frequently as annually. Screening should continue through at least age 74 and age alone should not be the basis to discontinue screening.

These screening recommendations are for women at average risk of breast cancer. Women at increased risk should also undergo periodic mammography screening; however, recommendations for additional services are beyond the scope of this recommendation.

**Implementation Considerations:** The Women's Preventive Services Initiative recommends, as a preventive service, that women initiate mammography screening no earlier than age 40 and no later than age 50 and continue through at least age 74. Screening mammography should occur at least biennially and as frequently as annually.

Decisions regarding when to initiate screening, how often to screen, and when to stop screening should be based on a periodic shared decision-making process involving the woman and her health care provider. The shared decision-making process assists women in making an informed decision and includes, but is not limited to, a discussion about the benefits and harms of screening, an assessment of the woman's values and preferences, and consideration of factors such as life expectancy, comorbidities, and health status.

### MEDICARE PAYERS

#### PROCEDURE CODES

- |        |  |
|--------|--|
| 77067  | Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed  |
| +77063 | Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure) (Use this as an add-on code when tomosynthesis is performed and is medically necessary in addition to 2-dimensional mammography) |

## DIAGNOSIS CODES

ICD-10-CM diagnosis code(s) **Z12.31 (Encounter for screening mammogram for malignant neoplasm of breast)** should be linked to the appropriate Current Procedural Technology (CPT) mammography code reported. Both the Medicare deductible and co-pay/coinsurance are waived for this service.

Effective October 1, 2019, new codes for overlapping quadrants **N63.15, Unspecified lump in the right breast, overlapping quadrants**, and **N63.25, Unspecified lump in the left breast, overlapping quadrants**, were added by the Centers for Medicare and Medicaid Services (CMS) as possible diagnosis codes, whereas codes N63.10, Unspecified lump in the right breast, unspecified quadrant, and **N63.20, Unspecified lump in the left breast, unspecified quadrant**, were deleted by CMS as possible diagnosis codes effective December 31, 2019.

A diagnostic mammogram (when the patient has an illness, disease, or symptoms that indicates the need for a mammogram) is covered whenever it is medically necessary.

When it is appropriate to report a screening and a diagnostic mammogram on the same day, use modifier **-GG** to indicate a screening mammography turned into a diagnostic mammography.

## Women's Preventive Services Initiative (WPSI)

### Screening for Anxiety

**Clinical Recommendations:** The Women's Preventive Services Initiative recommends screening for anxiety in adolescent and adult women, including those who are pregnant or postpartum. Optimal screening intervals are unknown and clinical judgement should be used to determine screening frequency. Given the high prevalence of anxiety disorders, lack of recognition in clinical practice, and multiple problems associated with untreated anxiety, clinicians should consider screening women who have not been recently screened.

**Implementation Considerations:** Clinicians may consider screening for anxiety in conjunction with screening for depression, which is recommended by the USPSTF, because of the frequent co-occurrence of anxiety and depressive disorders. Validated instruments that screen simultaneously for both disorders may be clinically efficient in practice settings, such instruments include the EPDS (specifically for pregnant and postpartum women), PHQ-4, and the HADS in adult women and the Bright Futures Y-PSC in adolescents and young women. Several additional screening instruments demonstrate moderate to high accuracy in identifying anxiety disorders in women (GAD, HADS, BAI) and adolescents and young adult women (5-item SCARED). Although not evaluated in research studies of adolescents, the GAD-7 and Bright Futures youth self-report PSC (Y-PSC) are commonly used in clinical practice.

While no studies have evaluated the benefits and harms of population screening for anxiety, trials among patients with clinically diagnosed anxiety support the effectiveness of treatment with cognitive behavioral therapy, medications, or both. When screening suggests the presence of anxiety, further evaluation is necessary to establish the diagnosis and determine appropriate treatment. Screening should ideally be implemented in conjunction with collaborative and team-based approaches to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

### MEDICARE PAYERS

For new Medicare beneficiaries, depression risk assessment is part of the Initial Preventive Physical Examination (IPPE or the "Welcome to Medicare Exam"). This service is reported using HCPCS code **Go402, Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment.**

The depression risk assessment included in the IPPE is a review of the patient's risk factors for depression, including current or past experience with depression or other mood disorders. Patients cannot have a current diagnosis of depression. The provider may use one of the standardized screening tests designed for this purpose and recognized by national medical professional organizations—such as the PHQ-9.

For Medicare patients who have already had their IPPE, depression screening is considered an included component of the Medicare annual and subsequent wellness visit (as reported with codes **Go438** and **Go439**) and may not be reported with any modifier.

Medicare patients who have already had their IPPE, are eligible for screening once a year with HCPCS code **Go444:**

**Go444** Annual depression screening, 15 minutes

## Women's Preventive Services Initiative (WPSI) Screening for Cervical Cancer

**Clinical Recommendations:** The Women's Preventive Services Initiative recommends cervical cancer screening for average-risk women aged 21 to 65 years. For women aged 21 to 29 years, the Women's Preventive Services Initiative recommends cervical cancer screening using cervical cytology (Pap smear) every 3 years. Cotesting with cytology and human papillomavirus testing is not recommended for women younger than 30 years. Women aged 30 to 65 years should be screened with cytology and human papillomavirus testing every 5 years or cytology alone every 3 years. Women who are at average risk should not be screened more than once every 3 years.

**Implementation Considerations:** The Women's Preventive Services Initiative recommends as a preventive service, cervical cancer screening for average-risk women aged 21 to 65 years. For average-risk women aged 30 to 65 years, informed shared decision making between the patient and her clinician regarding the preferred screening strategy is recommended.

Women who have received the human papillomavirus vaccine should be screened according to the same guidelines as women who have not received the vaccine.

These recommendations are for routine screening in average-risk women and do not apply to women infected with human immunodeficiency virus, women who are immunocompromised because of another etiology (such as those who have received solid organ transplantation), women exposed to diethylstilbestrol in utero, or women treated for cervical intraepithelial neoplasia grade 2 or higher within the past 20 years. Screening strategies for high-risk women are outside the scope of these recommendations.

Cervical cancer screening is not recommended for women younger than 21 years or those older than 65 years who have had adequate prior screening and are not otherwise at high risk of cervical cancer. Adequate prior negative screening is defined as documentation (or a reliable patient report) of three consecutive negative cytology results or two consecutive negative cotest results within the previous 10 years with the most recent test within the past 5 years. Cervical cancer screening is also not recommended for women who have had a hysterectomy with removal of the cervix and who do not have a history of a high-grade precancerous lesions (eg, cervical intraepithelial neoplasia grade 2 or grade 3 or cervical cancer within the past 20 years).

### MEDICARE PAYERS

#### COLLECTION OF SCREENING PAP SMEAR SPECIMEN

Medicare reimburses for collection of a screening Pap smear every 2 years in most cases.

This service is reported using Healthcare Common Procedure Coding System (HCPCS) code **Q0091 (Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory)**. Both the deductible and co-pay/coinsurance are waived for the laboratory's interpretation of the test.



The collection is reimbursed every year if the patient meets Medicare’s criteria for high risk.

**ICD-10-CM Codes**

High risk – **Z72.51, Z72.52, Z72.53, Z77.29, Z77.9, Z91.89, and Z92.89**

Low risk – **Z01.411, Z01.419, Z12.4, Z12.72, Z12.79, and Z12.89**

Note: Additional ICD-10-CM codes may apply. See the [CMS ICD-10-CM web page](#) for individual Change Requests (CRs) and the specific ICD-10-CM codes Medicare covers for this service, and [contact your Medicare Administrative Contractor \(MAC\)](#) for guidance.

Following are the only criteria that are accepted by Medicare to indicate a high-risk patient:

- ✔ Woman is of childbearing age, **AND**
  - Cervical or vaginal cancer is present (or was present), **OR**
  - Abnormalities were found within last 3 years, **OR**
  - Is considered high risk (as described below) of developing cervical or vaginal cancer
- ✔ Woman is not of childbearing age and has at least one of the following high-risk factors for cervical and vaginal cancer:
  - Onset of sexual activity at less than 16 years of age
  - Five or more sexual partners in a lifetime
  - History of sexually transmitted diseases (including HPV and/or HIV infection)
  - Fewer than three negative or any Pap smears within the previous 7 years
  - DES (diethylstilbestrol)-exposed daughters of women who took DES during pregnancy

DIAGNOSTIC CODING FOR THE COLLECTION OF A PAP SMEAR SPECIMEN

**ICD-10-CM Codes**

High risk – **Z72.51, Z72.52, Z72.53, Z77.29, Z77.9, Z91.89, and Z92.89**

Low risk – **Z01.411, Z01.419, Z12.4, Z12.72, Z12.79, and Z12.89**

Note: Additional ICD-10-CM codes may apply. See the [CMS ICD-10-CM web page](#) for individual Change Requests (CRs) and the specific ICD-10-CM codes Medicare covers for this service, and [contact your Medicare Administrative Contractor \(MAC\)](#) for guidance.

The collection of the screening Pap smear specimen (Q0091) is reported with one of the following ICD-10-CM diagnosis codes:

- Z01.411** Encounter for gynecological examination (general) (routine) with abnormal findings
- Z01.419** Encounter for gynecological examination (general) (routine) without abnormal findings
- Z12.4** Encounter for screening for malignant neoplasm of cervix
- Z12.72** Encounter for screening for malignant neoplasm of vagina
- Z12.79** Encounter for screening for malignant neoplasm of other genitourinary organs

- Z12.89** Encounter for screening for malignant neoplasm of other sites
- Z72.51** High-risk heterosexual behavior
- Z72.52** High-risk homosexual behavior
- Z72.53** High-risk bisexual behavior
- Z77.29** Contact with and (suspected) exposure to other hazardous substances
- Z77.9** Other contact with and (suspected) exposures hazardous to health
- Z91.89** Other specified personal risk factors, not elsewhere classified
- Z92.89** Personal history of other medical treatment

Note: Collection of a diagnostic Pap smear (performed due to illness, disease, or symptoms indicating a medically necessary reason) is included in the physical examination portion of a problem-oriented E/M service and is not reported or reimbursed separately.

**Screening for Cervical Cancer With Human Papillomavirus Tests**

**HCPCS/CPT Codes**

- G0476** Infectious agent detection by nucleic acid (DNA or RNA); HPV, high-risk types (eg, 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68) for cervical cancer screening, must be performed in addition to Pap smear

**ICD-10-CM Codes**

**Z11.51** and **either Z01.411 or Z01.419**

Note: Additional ICD-10-CM codes may apply. See the [CMS ICD-10-CM web page](#) for individual Change Requests (CRs) and the specific ICD-10-CM codes Medicare covers for this service, and [contact your Medicare Administrative Contractor \(MAC\)](#) for guidance.

## Women’s Preventive Services Initiative (WPSI) Screening for Human Immunodeficiency Virus Infection

**Clinical Recommendations:** The Women’s Preventive Services Initiative recommends prevention education and risk assessment for human immunodeficiency virus (HIV) infection in adolescents and women at least annually throughout the lifespan. All women should be tested for HIV at least once during their lifetime. Additional screening should be based on risk, and screening annually or more often may be appropriate for adolescents and women with an increased risk of HIV infection.

Screening for HIV is recommended for all pregnant women upon initiation of prenatal care with retesting during pregnancy based on risk factors. Rapid HIV testing is recommended for pregnant women who present in active labor with an undocumented HIV status. Screening during pregnancy enables prevention of vertical transmission.

**Implementation Considerations:** The Women’s Preventive Services Initiative recommends as a preventive service for women, prevention education and risk assessment for HIV infection in adolescents and women at least annually throughout the lifespan. More frequent screening for high-risk women, as determined by clinical judgment, is also recommended as a preventive service. Annual or more frequent HIV testing may be needed and is recommended as a preventive service for women who are identified or self-identify as high risk.

This recommendation refers to routine HIV screening, which is different from incident-based or exposure-based HIV testing. Risk factors for HIV infection in women include, but are not limited to, being an active injection drug user; having unprotected vaginal or anal intercourse; having multiple sexual partners; initiating a new sexual relationship; having sexual partners who are HIV-infected, bisexual, or injection drug users; exchanging sex for drugs or money; being a victim of sex trafficking; being incarcerated (currently or previously); and having other sexually transmitted infections.

Approximately 20–26% of infected patients are not identified by risk-based screening. Early detection and treatment improve outcomes for patients and reduces transmission; therefore, based on clinical best practice, screening annually or more frequently may be reasonable.

### MEDICARE PAYERS

Human immunodeficiency virus screening is recommended for all adolescents and adults at risk for HIV infection, as well as all pregnant women. The Centers for Medicare & Medicaid Services covers both standard and Food and Drug Administration-approved HIV rapid screening tests for Medicare beneficiaries at increased risk for HIV infection per U.S. Preventive Services Task Force (USPSTF) guidelines.

Medicare covers beneficiaries for HIV screening as follows:

- ✔ An annual voluntary HIV screening for beneficiaries between the ages of 15 and 65 years without regard to perceived risk
- ✔ An annual screening for beneficiaries younger than 15 and adults older than 65 who are at increased risk for HIV infection

Note: Eleven full months must elapse following the month in which the previous test was performed in order for a subsequent test to be covered.

- ✔ Three voluntary HIV screenings of pregnant Medicare beneficiaries:
  - (1) When the diagnosis of pregnancy is known,
  - (2) During the third trimester, and
  - (3) At labor, if ordered by the woman’s physician

Note: A maximum of three tests will be covered for each pregnancy beginning with the date of the 1st test.

### PROCEDURE CODES

The following codes are reported for this service:

<b>G0432</b>	Infectious agent antibody detection by enzyme immunoassay (EIA) technique, HIV-1 and/or HIV-2, screening
<b>G0433</b>	Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening
<b>G0435</b>	Infectious agent antibody detection by rapid antibody test, HIV-1 and/or HIV-2 screening.
<b>G0475</b>	HIV antigen/antibody, combination assay, screening
<b>80081</b>	Obstetric panel (includes HIV testing)

Patients with any known prior diagnosis of HIV-related illness are not eligible for this screening test.

More information on HIV screening may be found in the MLN Matters article at: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6786.pdf>

### DIAGNOSIS CODES

#### GENERAL

For human immunodeficiency screening (HIV), use diagnosis code **Z11.4 (Encounter for screening for human immunodeficiency virus [HIV])**, when increased risk factors not reported. When increased risk factors reported, use diagnosis code **Z11.4** as primary and **Z72.89, Z72.51, Z72.52, or Z72.53** as secondary. Pregnant patients would also have a pregnancy status code reported (such as **Z34.-** or **O09.9-**), in addition to the appropriate **Z11.4** as primary and **Z34.0-, Z34.8,-** or **O09.9-** as appropriate).

For the purposes of incident-based or exposure-based HIV testing, ICD-10-CM code **Z20.2, Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission**, or **Z20.6, Contact with and (suspected) exposure to human immunodeficiency virus (HIV)**, can be reported.

*Additional codes for HIV screening:*

High-Risk Sexual Behavior	
Code Description	Code
High-risk heterosexual behavior	Z72.51
High-risk homosexual behavior	Z72.52
High-risk bisexual behavior	Z72.53
Other problems related to lifestyle	Z72.89
Drug Use	
Drug use complicating pregnancy, childbirth, and puerperium	O99.32-
Opioid use, uncomplicated	F11.9-
Opioid abuse, uncomplicated	F11.1-
Opioid dependence, uncomplicated	F11.2-
Sex Trafficking	
Beginning October 1st, 2018, the National Center for Health Statistics at the CDC added new codes for patients experiencing sexual trafficking.	
Adult forced sexual exploitation, confirmed	T74.51-
Child sexual exploitation, confirmed	T74.52-
Adult forced sexual exploitation, suspected	T76.51-
Child sexual exploitation, suspected	T76.52-
Personal history of forced labor or sexual exploitation in childhood	Z62.813
Personal history of forced labor or sexual exploitation	Z91.42
Imprisonment	
Imprisonment and other incarceration	Z65.1

**Sexually Transmitted Infections**

Codes for infections with a sexual way of transmission could be found in categories **A50-A64**.

**Personal History of Drug Use or Other Specified Conditions**

To document history of drug use, **ICD-10-CM code Z86.59, Personal history of other mental and behavioral disorders**, should be assigned.

For a history of drug use, non-dependent, in remission, use code **Z87.898, Personal history of other specified conditions**.

Additional HIV-Related Codes	
Code Description	Code
Asymptomatic human immunodeficiency virus [HIV] infection status	Z21
Human immunodeficiency virus [HIV] disease	B20
Inconclusive laboratory evidence of human immunodeficiency virus [HIV]	R75
Human immunodeficiency virus [HIV] disease complicating pregnancy	O98.71-
Human immunodeficiency virus [HIV] disease complicating childbirth	O98.72
Human immunodeficiency virus [HIV] disease complicating the puerperium	O98.73
Inconclusive laboratory evidence of human immunodeficiency virus [HIV]	R75

## Women’s Preventive Services Initiative (WPSI) Counseling for Sexually Transmitted Infections

**Clinical Recommendations:** The Women’s Preventive Services Initiative recommends directed behavioral counseling by a health care provider or other appropriately trained individual for sexually active adolescent and adult women at an increased risk for sexually transmitted infections (STIs).

The Women’s Preventive Services Initiative recommends that health care providers use a woman’s sexual history and risk factors to help identify those at an increased risk of STIs. Risk factors may include age younger than 25, a recent history of an STI, a new sex partner, multiple partners, a partner with concurrent partners, a partner with an STI, and a lack of or inconsistent condom use. For adolescents and women not identified as high risk, counseling to reduce the risk of STIs should be considered, as determined by clinical judgement.

**Implementation Considerations:** The Women’s Preventive Services Initiative recommends as preventive service for women at increased risk for STIs, directed behavioral counseling that includes, but is not limited to, longer duration or multiple counseling sessions, motivational interviewing techniques, and goal setting.

The Women’s Preventive Services Initiative recommends as a preventive service, STI counseling regardless of whether or not STI screening takes place during the same visit and regardless of the type of sexual activity or the partners’ gender.

### MEDICARE PAYERS

#### HIGH-INTENSITY BEHAVIORAL COUNSELING

Medicare will cover High-Intensity Behavioral Counseling (HIBC) to prevent STIs in addition to screening for STIs—specifically chlamydia, gonorrhea, syphilis, and hepatitis B.

Coverage for HIBC consist of up to two individual, 20-minute to 30-minute, face-to-face counseling sessions annually for Medicare beneficiaries to prevent STIs for all sexually active adolescents and for adults at increased risk for STIs. This service is covered for sexually active adolescents and adults at increased risk for STIs and referred by a primary care provider and provided by a Medicare eligible primary care provider in a primary care setting.

The high/increased risk individual sexual behaviors, based on the USPSTF guidelines, include any of the following:

- ✔ Multiple sex partners
- ✔ Using barrier protection inconsistently
- ✔ Having sex under the influence of alcohol or drugs
- ✔ Having sex in exchange for money or drugs

- ✔ Age (24 years of age or younger and sexually active for women for chlamydia and gonorrhea)
- ✔ Having an STI within the past year
- ✔ Intravenous drug use (hepatitis B only) and
- ✔ In addition, for men – men having sex with men and engaged in high-risk sexual behavior, but no regard to age.

The following HCPCS code is used to report this service:

**G0445** High intensity behavioral counseling to prevent STIs, individual, face-to-face, includes education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes

#### POSSIBLE ICD-10-CM DIAGNOSIS CODES

**Z11.3, Z11.59, Z34.00, Z34.01, Z34.02, Z34.03, Z34.80, Z34.81, Z34.82, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93, Z72.51, Z72.52, Z72.53, Z72.89, O09.90, O09.91, O09.92, and O09.93**

**Note:** Additional ICD-10-CM codes may apply. See the [CMS ICD-10-CM web page](#) for individual Change Requests (CRs) and the specific ICD-10-CM codes Medicare covers for this service, and [contact your Medicare Administrative Contractor \(MAC\)](#) for guidance.

**Note:** The use of the correct diagnosis code(s) on the claims is imperative to identify these services as preventive services and to show that the services were provided within the guidelines for coverage as preventive services. The patient’s medical record must clearly support the diagnosis of high/increased risk for STIs and clearly reflect the components of the HIBC service provided – education, skills training, and guidance on how to change sexual behavior – as required for coverage.

## Women’s Preventive Services Initiative (WPSI)

### Well-Woman Preventive Visits

**Clinical Recommendations:** The Women’s Preventive Services Initiative recommends that women receive at least one preventive care visit per year beginning in adolescence and continuing across the lifespan to ensure that the recommended preventive services, including preconception and many services necessary for prenatal and interconception care, are obtained. The primary purpose of these visits should be the delivery and coordination of recommended preventive services as determined by age and risk factors.

**Implementation Considerations:** The Women’s Preventive Services Initiative recommends as a preventive service for women, that women receive at least one preventive care visit per year. Additional well-woman visits may be needed to obtain all necessary services depending on a woman’s age, health status, reproductive health needs, pregnancy status, and risk factors. Visits should allow sufficient time to address and coordinate services, and a team-based approach may facilitate delivery of services.

Well-woman preventive services may include, but are not limited to, assessment of physical and psychosocial function, primary and secondary prevention and screening, risk factor assessments, immunizations, counseling, education, preconception care, and many services necessary for prenatal, and interconception care. Recommended services are evidence-based items or services that have in effect a rating of ‘A’ or ‘B’ in the current recommendations of the United States Preventive Services Task Force, immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved, with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration, and with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

The Women’s Preventive Services Initiative recommends that women receive at least one preventive care visit per year beginning in adolescence and continuing across their lifespan.

### MEDICARE PAYERS

Medicare and other payers have different rules for reporting and reimbursing for these services. Physicians should check with their specific commercial carrier about their rules.

Medicare does not cover the comprehensive Preventive Medicine Services as reported with CPT codes (99381-99397). However, Medicare reimburses for the collection of the Pap smear and the pelvic exam (reported with HCPCS codes) every 2 years in most cases. The remaining portions of the preventive service performed are billed to the patient. The amount paid by Medicare is subtracted from the physician’s usual fee for a preventive service. The remaining amount is the patient’s responsibility. This is referred to as a “carve out,” meaning that Medicare’s covered portion of the

preventive service is carved out of the total preventive service. The amount reimbursed by Medicare and the amount reimbursed by the patient will equal the physician’s usual fee.

Medicare covers the following services:

<b>Go438</b>	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit
<b>Go439</b>	Annual wellness visit, includes a personalized PPS, subsequent visit
<b>Go468</b>	Federally qualified health center (FQHS) visit, initial preventive physical examination (IPPE) or annual wellness visit (AWV); a FQHV visit that includes an initial IPPE or AWV and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV
<b>99497</b>	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
<b>99498</b>	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure.)

### Frequency

- Once in a lifetime for **Go438** (first AWV)
- Annually for **Go439** (subsequent AWV) and **Go468** (AWV in FQHC)
- Annually for optional **99497, 99498**

### Medicare Beneficiary Pays

#### Go438 and Go439:

- Copayment/coinsurance waived
- Deductible waived

#### Go468:

- AWV or IPPE must be provided with a standard bundle of services available to all beneficiaries; for more information about billing for this service, refer to [Medicare Claims Processing Manual, Chapter 9, Section 60.2](#)
- Copayment/coinsurance waived
- Deductible waived

**99497 and 99498:**

- Copayment/coinsurance and deductible waived for advance care planning when furnished as an optional element of an AWW

COLLECTION OF SCREENING PAP SMEAR SPECIMEN

Medicare reimburses for collection of a screening Pap smear every 2 years in most cases.

This service is reported using HCPCS code **Q0091 (Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory)**. Both the deductible and co-pay/coinsurance are waived for the laboratory’s interpretation of the test.

The collection is reimbursed every year if the patient meets Medicare’s criteria for high risk.

Following are the only criteria that are accepted by Medicare to indicate a high-risk patient:

- Woman is of childbearing age, **AND**
  - Cervical or vaginal cancer is present (or was present), **OR**
  - Abnormalities were found within last 3 years, **OR**
  - Is considered high risk (as described below) for developing cervical or vaginal cancer
- Woman is not of childbearing age **AND** has at least one of the following:
- High-risk factors for cervical and vaginal cancer
  - Onset of sexual activity at less than 16 years of age
  - Five or more sexual partners in a lifetime
  - History of sexually transmitted diseases (including HPV and/or HIV infection)
  - Fewer than three negative or any Pap smears within previous 7 years
  - DES (diethylstilbestrol)-exposed daughters of women who took DES during pregnancy

SCREENING PELVIC EXAM

Medicare reimburses for screening pelvic examination every 2 years in most cases.

This service is reported using HCPCS code **G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination)**. Both the deductible and co-pay/coinsurance are waived for the laboratory’s interpretation of the test.

The collection is reimbursed every year if the patient meets Medicare’s criteria for high risk. These criteria are the same as the ones listed above for the collection of screening Pap smear specimen. The diagnosis codes for Pap smear collection and screening pelvic exam are listed below.

A screening pelvic examination (HCPCS code G0101) should include documentation of at least **seven** of the following **eleven** elements:

1. Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge
2. Digital rectal examination including sphincter tone, presence of hemorrhoids, and rectal masses
3. External genitalia (for example, general appearance, hair distribution, or lesions)

4. Urethral meatus (for example, size, location, lesions, or prolapse)
5. Urethra (for example, masses, tenderness, or scarring)
6. Bladder (for example, fullness, masses, or tenderness)
7. Vagina (for example, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, or rectocele)
8. Cervix (for example, general appearance, lesions, or discharge)
9. Uterus (for example, size, contour, position, mobility, tenderness, consistency, descent, or support)
10. Adnexa/parametria (for example, masses, tenderness, organomegaly, or nodularity) and/or
11. Anus and perineum

DIAGNOSIS CODING FOR THE COLLECTION OF A PAP SMEAR SPECIMEN AND THE SCREENING PELVIC EXAM

Both the collection of the screening Pap smear specimen (**Q0091**) and screening pelvic exam (**G0101**) are reported with one of the following ICD-10-CM diagnosis codes:

FOR G0101:

High Risk:

- Z72.51** High-risk heterosexual behavior
- Z72.52** High-risk homosexual behavior
- Z72.53** High-risk bisexual behavior
- Z77.29** Contact with and (suspected) exposure to other hazardous substances
- Z77.9** Contact with and (suspected) exposures hazardous to health
- Z91.89** Other specified personal risk factors, not elsewhere classified
- Z92.89** Personal history of other medical treatment

Low Risk:

- Z01.411** Encounter for gynecological examination (general) (routine) with abnormal findings
- Z01.419** Encounter for gynecological examination (general) (routine) without abnormal findings
- Z12.4** Encounter for screening for malignant neoplasm of cervix
- Z12.72** Encounter for screening for malignant neoplasm of vagina
- Z12.79** Encounter for screening for malignant neoplasm of other genitourinary organs
- Z12.89** Encounter for screening for malignant neoplasm of other sites

FOR PAP SMEARS:

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

LAB/PATHOLOGY CODES:

**G0123** Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision

**G0124** Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician

**G0141** Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician

**G0143** Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision

**G0144** Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision

**G0145** Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision

**G0147** Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision

**G0148** Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening

**P3000** Screening Papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision

**P3001** Screening Papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician

High Risk:

**Z72.51** High-risk heterosexual behavior

**Z72.52** High-risk homosexual behavior

**Z72.53** High-risk bisexual behavior

**Z77.29** Contact with and (suspected) exposure to other hazardous substances

**Z77.9** Contact with and (suspected) exposures hazardous to health

**Z91.89** Other specified personal risk factors, not elsewhere classified

**Z92.89** Personal history of other medical treatment

Low Risk:

**Z01.411** Encounter for gynecological examination (general) (routine) with abnormal findings

**Z01.419** Encounter for gynecological examination (general) (routine) without abnormal findings

**Z12.4** Encounter for screening for malignant neoplasm of cervix

**Z12.72** Encounter for screening for malignant neoplasm of vagina

**Z12.79** Encounter for screening for malignant neoplasm of other genitourinary organs

**Z12.89** Encounter for screening for malignant neoplasm of other sites

Note: Collection of a diagnostic Pap smear (performed due to illness, disease, or symptoms indicating a medically necessary reason) is included in the physical examination portion of a problem-oriented E/M service and is not reported or reimbursed separately.

DIAGNOSIS CODING FOR COMPREHENSIVE PREVENTIVE CARE SERVICES

The following diagnosis codes should be reported for well-woman examinations:

**Z01.411** Encounter for gynecological examination (general) (routine) with abnormal findings

**Z01.419** Encounter for gynecological examination (general) (routine) without abnormal findings





## Appendix B — Medicaid



### MEDICAID

States participating in the Patient Protection and Affordable Care Act's Medicaid Expansion program are required to provide the same level of preventive services for the expansion populations as private plans. For those who qualify for Medicaid through other pathways, states may choose to, but are not required to, cover the WPSI guidelines supported by the Health Resources and Services Administration (HRSA) (WPSI recommendations). For more information on state Medicaid programs, please see the resources below:

**State Overviews** – <https://www.medicaid.gov/state-overviews/index.html>

**Medicaid and Preventive Services** – <https://www.medicaid.gov/medicaid/benefits/prevention/index.html>

**Alabama** – <https://medicaid.alabama.gov/>

Provider Information: [https://medicaid.alabama.gov/content/7.o\\_Providers/](https://medicaid.alabama.gov/content/7.o_Providers/)

**Alaska** – <http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx>

**American Samoa** – <https://medicaid.as.gov/>

**Arizona** – <https://www.azahcccs.gov/>

Provider Resources: <https://www.azahcccs.gov/PlansProviders/GuidesManualsPolicies/index.html>

**Arkansas** – <https://medicaid.mmis.arkansas.gov/>

Provider Resources: <https://medicaid.mmis.arkansas.gov/Provider/Provider.aspx>

**California** – <https://www.medi-cal.ca.gov/>

Provider Resources: [http://files.medi-cal.ca.gov/pubsdoco/bulletins\\_menu.asp](http://files.medi-cal.ca.gov/pubsdoco/bulletins_menu.asp)

**Colorado** – <https://www.healthfirstcolorado.com/>

Provider Resources: <https://www.colorado.gov/pacific/hcpf/provider-resources>

**Connecticut** – <https://portal.ct.gov/HUSKY>

Provider Resources: <https://www.huskyhealthct.org/providers.html?hhNav=#>

**Delaware** – <https://dhss.delaware.gov/dhss/dmma/>

**District of Columbia** – <https://www.dc-medicaid.com/dcwebportal/home>

Provider Resources: <https://www.dc-medicaid.com/dcwebportal/providerSpecificInformation/providerInformation>

**Florida** – <https://ahca.myflorida.com/Medicaid/index.shtml>

Provider Resources: <https://ahca.myflorida.com/Medicaid/Operations/assistance/providers.shtml>

**Georgia** – <https://medicaid.georgia.gov/>

Provider Resources: <https://dch.georgia.gov/providers>

**Guam** – <https://dphss.guam.gov/>

**Hawaii** – <https://medquest.hawaii.gov/>

Provider Resources: <https://medquest.hawaii.gov/en/plans-providers/fee-for-service/provider-manual.html>

**Idaho** – <https://healthandwelfare.idaho.gov/Medical/Medicaid/tabid/123/Default.aspx>

Provider Resources: <https://healthandwelfare.idaho.gov/Providers/tabid/284/Default.aspx>

**Illinois** – <https://www.illinois.gov/hfs/Pages/default.aspx>

Provider Resources: <https://www.illinois.gov/hfs/MedicalProviders/Pages/default.aspx>

**Indiana** – <https://www.in.gov/medicaid/>

Provider Resources: <https://www.in.gov/medicaid/providers/index.html>

**Iowa** – <https://dhs.iowa.gov/ime/members>

Provider Resources: <https://dhs.iowa.gov/ime/providers>

**Kansas** – <https://www.kancare.ks.gov/>

Provider Resources: <https://www.kancare.ks.gov/providers/onecare-ks-providers>

**Kentucky** – <https://chfs.ky.gov/agencies/dms/Pages/default.aspx>

Provider Resources: <https://chfs.ky.gov/agencies/dms/provider/Pages/default.aspx>

**Louisiana** – <http://ldh.la.gov/index.cfm/subhome/1>

Provider Resources: <http://ldh.la.gov/index.cfm/page/1450>

**Maine** – <https://mainecare.maine.gov/default.aspx>

**Maryland** – <https://mmcp.health.maryland.gov/Pages/home.aspx>

Provider Resources: <https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx>

**Massachusetts** – <https://www.mass.gov/topics/masshealth>

Provider Resources: <https://www.mass.gov/topics/information-for-masshealth-providers>

**Michigan** – [www.michigan.gov/medicaid](http://www.michigan.gov/medicaid)

Provider Resources: [www.michigan.gov/medicaidproviders](http://www.michigan.gov/medicaidproviders)

**Minnesota** – <https://mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/programs-and-services/medical-assistance.jsp>

Provider Resources: <https://mn.gov/dhs/partners-and-providers/>

**Mississippi** – <https://medicaid.ms.gov/>

Provider Resources: <https://medicaid.ms.gov/providers/>

**Missouri** – <https://mydss.mo.gov/healthcare>

Provider Resources: <https://mydss.mo.gov/pe-resources-for-providers>

**Montana** – <https://dphhs.mt.gov/montanahealthcareprograms/memberservices>

Provider Information: <https://medicaidprovider.mt.gov/>

**Nebraska** – <http://dhhs.ne.gov/pages/accessnebraska.aspx>

Provider Information: <http://dhhs.ne.gov/Pages/Medicaid-Providers.aspx>

**Nevada** – <https://www.medicaid.nv.gov/>

Provider Information: <https://www.medicaid.nv.gov/providers/BillingInfo.aspx>

**New Hampshire** – <https://www.dhhs.nh.gov/ombp/medicaid/>

Provider Information: <https://www.dhhs.nh.gov/ombp/medicaid/providerservices.htm>

**New Jersey** – <https://www.state.nj.us/humanservices/dmahs/clients/medicaid/>

Provider Information: <https://www.state.nj.us/humanservices/dmahs/info/>

**New Mexico** – <https://nmmedicaid.portal.conduent.com/static/index.htm>

Provider Information: <https://nmmedicaid.portal.conduent.com/static/ProviderInformation.htm#>

**New York** – [https://www.health.ny.gov/health\\_care/medicaid/](https://www.health.ny.gov/health_care/medicaid/)

**North Carolina** – <https://medicaid.ncdhhs.gov/medicaid>

Provider Information: <https://medicaid.ncdhhs.gov/providers>

**North Dakota** – <http://www.nd.gov/dhs/services/medicalserv/medicaid/>

Provider Information: <https://www.nd.gov/dhs/services/medicalserv/medicaid/provider.html>

**Northern Marianas Islands** – <http://medicaid.cnmi.mp/>

Provider Resources: <http://medicaid.cnmi.mp/index.php/provider-information-and-updates>

**Ohio** – <https://medicaid.ohio.gov/>

Provider Resources: <https://medicaid.ohio.gov/provider>

**Oklahoma** – <http://www.okhca.org/>

Provider Resources: <http://www.okhca.org/providers.aspx?id=45&parts=7437-7439-7443-7455>

**Oregon** – <https://www.oregon.gov/oha/HSD/OHP/Pages/index.aspx>

Provider Resources: <https://www.oregon.gov/oha/HSD/OHP/Pages/Provider-Splash.aspx>

## APPENDIX B — MEDICAID

**Pennsylvania** – <https://www.dhs.pa.gov/Services/Assistance/Pages/Medical-Assistance.aspx#>

Provider Resources: <https://www.dhs.pa.gov/providers/Pages/default.aspx>

**Puerto Rico** – <https://medicaid.pr.gov/default.aspx>

Provider Resources: <https://www.medicaid.pr.gov/Home/ProviderEnrollmentPortal/>

**Rhode Island** – <https://healthyrhode.ri.gov/HIXWebI3/DisplayHomePage>

**South Carolina** – <https://www.scdhhs.gov/>

Provider Resources: <https://www.scdhhs.gov/provider>

**South Dakota** – <https://dss.sd.gov/medicaid/>

Provider Resources: <https://dss.sd.gov/medicaid/providers/>

**Tennessee** – <https://www.tn.gov/content/tn/tenncare.html>

Provider Resources: <https://www.tn.gov/tenncare/providers.html>

**Texas** – <https://hhs.texas.gov/services/health/medicaid-chip>

Provider Resources: <https://hhs.texas.gov/services/health/medicaid-chip/provider-information>

**Utah** – <https://medicaid.utah.gov/>

Provider Resources: <https://medicaid.utah.gov/health-care-providers/>

**Vermont** – <https://www.greenmountaincare.org/>

**Virginia** – <https://www.dmas.virginia.gov/#/index>

Provider Resources: <https://www.dmas.virginia.gov/#/providerinformation>

**Virgin Islands** – <https://www.vimmis.com/default.aspx>

Provider Resources: <https://www.vimmis.com/User%20Guides/Forms/AllItems.aspx>

**Washington** – <https://www.hca.wa.gov/health-care-services-supports/apple-health-medicaid-coverage>

Provider Resources: <https://www.hca.wa.gov/billers-providers-partners>

**West Virginia** – <https://dhhr.wv.gov/bms/Pages/default.aspx>

Provider Resources: <https://dhhr.wv.gov/bms/Provider/Pages/default.aspx>

**Wisconsin** – <https://www.dhs.wisconsin.gov/medicaid/index.htm>

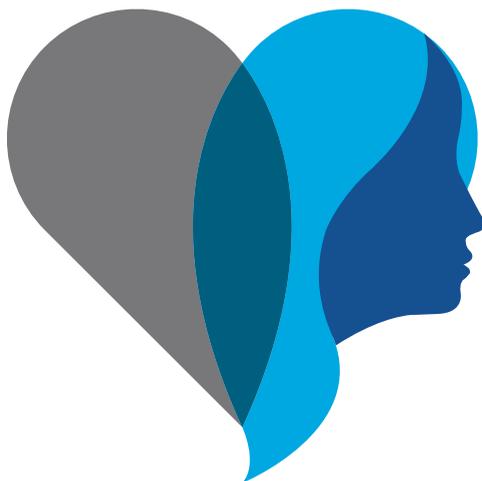
Provider Resources: <https://www.dhs.wisconsin.gov/partners-providers.htm>

**Wyoming** – <https://health.wyo.gov/healthcarefin/medicaid/>

Provider Resources: <https://health.wyo.gov/healthcarefin/medicaid/for-healthcare-providers/>







Women's Preventive Services Initiative  
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