WPSI
Women's Preventive Services Initiative

Women's Preventive Services Initiative (WPSI) 2025 Coding Guide







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Women's Preventive Services Initiative (*WPSI*) *Coding Guide 2025* was developed by WPSI's Dissemination and Implementation Steering Committee and ACOG's Coding Department.

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Introduction

Introduction to the Women's Preventive Services Initiative (WPSI)

On March 1, 2016, the American College of Obstetricians and Gynecologists (ACOG) launched the **Women's Preventive Services Initiative (WPSI)**. Through this multi-year cooperative agreement with the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), ACOG is leading a coalition of national health professional organizations and consumer and patient advocates with experts in women's health across the lifespan. The coalition develops, reviews, and updates recommendations for women's preventive health care services, including HRSA-sponsored **Women's Preventive Services Guidelines**. These HRSA-adopted recommendations help ensure that **women receive a comprehensive set of preventive services without having to pay a copayment or deductible or paying for coinsurance.**

To date, the WPSI has published 14 recommendations adopted by HRSA:

- Breast Cancer Screening for Average-Risk Women
- Breastfeeding Services and Supplies
- Contraception
- Counseling for Sexually Transmitted Infections (STIs)
- Preventing Obesity in Midlife Women
- Screening for Cervical Cancer
- Screening for Gestational Diabetes Mellitus
- Screening for Human Immunodeficiency Virus (HIV)
- Screening for Interpersonal and Domestic Violence
- Screening for Diabetes Mellitus After Pregnancy
- Screening for Urinary Incontinence
- Screening for Anxiety
- Well-Woman Preventive Visits
- Patient Navigation Services for Breast and Cervical Cancer Screening (NEW 2024)

Please see the **HRSA Women's Preventive Services Guidelines website** for more coverage information.

*Coverage provided without cost-sharing begins on January 1, 2026, for updated and new recommendations. For more information on coverage, please see the **HRSA Women's Preventive Services Guidelines website**.*

The WPSI offers several free tools to help clinicians implement the recommendations. **Recommendations for Well-Woman Care – A Well-Woman Chart** outlines preventive services recommended by the WPSI, U.S. Preventive Services Task Force (**USPSTF**), and **Bright Futures** and are based on age, health status, and risk factors. Clinical summary tables describe clinical practice considerations, risk assessment methods, and the age and frequency for delivering services To download the most up-to-date version of the chart and clinical summary tables, please visit the **WPSI website**. Additional tools include **patient pamphlet**, **patient palm card**, **WPSI mobile shortcut**, **How I Practice Video Series** and a **new free CME course worth 2 credits AMA PRA Category 1**.

Introduction to Coding

Correct medical coding for services rendered by physicians and other health care clinicians 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. For medical claims there are three primary sets: Current Procedural Terminology (CPT)®, 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-10-CM, 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-character alphanumeric codes developed and copyrighted by the American Medical Association. They constitute the primary set of codes used to describe the cognitive and procedural services provided by a physician’s practice. HCPCS Level II codes are 5-character alphanumeric codes used to report services not reportable by CPT codes, such as durable medical equipment (DME), supplies, and certain procedural services.

Some Level II codes are considered permanent national codes. These codes are maintained by the HCPCS National Panel, which consists of representatives from the Centers for Medicare and Medicaid Services (CMS), America's Health Insurance Plans (AHIP), and the Blue Cross Blue Shield Association (BCBSA). 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" codes. 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 various drugs and dosages.
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 payer 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, such as G0101 and Q0091.

CPT 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) version of the dataset, 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 was implemented in the U.S. on October 1, 2015. 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 provides greater opportunity to 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 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 second type of preventive medicine service, as it considered bundled in the preventive E/M service. The counseling codes are selected according to the amount of time spent counseling the patient. If a distinct problem-oriented E/M service is also provided at the time of a counseling service, it may be reported separately, with distinct documentation being strongly recommended.

These codes are not reported when the physician counsels a patient with symptoms or an established illness. In this case, a problem-oriented E/M service (CPT codes **99202-99215**) 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 CPT code **99078**.

2. Preventive Medicine Evaluation and Management Services (CPT Codes 99381–99397)

These services are provided to adults, children, and infants and 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 clinician. Some plans ("grandfathered plans") that existed before the

ACA are not yet required to provide this coverage, although these are increasingly rare. 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.

Modifier 33

The modifier 33 is used to indicate preventive services that are not subject to cost sharing. The modifier is not necessary designed 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 a 33 modifier 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

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).**

However, 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 hemoccult
- 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/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html**. Additional information about Medicare can be found in Appendix A of this document.

WPSI Recommendation Coding

Breast Cancer Screening for Women at Average Risk

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. Women may require additional imaging to complete the screening process or to address findings on the initial screening mammography. If additional imaging (eg, magnetic resonance imaging, ultrasound, mammography) and pathology evaluation are indicated, these services also are recommended to complete the screening process for malignancies. Screening should continue through at least age 74, and age alone should not be the basis to discontinue screening.

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

Implementation Considerations: 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 clinician. 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. Discussion and education related to screening should be culturally and linguistically congruent, particularly for patients experiencing health inequities.
Women considered at high risk of breast cancer (eg, previous diagnosis of breast or ovarian cancer, known BRCA1 or BRCA2 mutation, previous high-dose radiation to the chest) may require additional testing and closer follow-up, which are beyond the scope of this recommendation.

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

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

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. The Z12.31 diagnosis should not be used in this case and, instead, the diagnosis(es) that support the medical necessity of that service should be used. Examples of those diagnoses include codes from the N63 category (unspecified lump in breast) and the N60 category (benign mammary dysplasia).

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

CODING SCENARIOS

A 47 year old established patient presents for her annual preventive examination. During the encounter, Clinician A recommends that she have a screening mammogram. An order is written and sent to the mammography center.

Clinician A Billing-CPT	Diagnoses	Diagnosis Description
99396	Z01.419 Z12.31	Encounter for routine gynecologic exam Encounter for screening mammogram for malignant neoplasm of breast
Mammography Center Billing		
77067	Z12.31	
Billing Rationale:	The facilitation of breast cancer screening will occur most commonly in the context of preventive medicine examinations. There is no specific CPT/HCPCS code for the ordering provider to report, as ordering this service is considered part of the preventive service. A secondary diagnosis of Z12.31 can be added to the preventive service to indicate that the mammogram was specifically ordered during the encounter.	

A 58 year old new patient presents to the office with concerns about osteoporosis and possible hormone replacement therapy (HRT). While collecting her history, Clinician B learns that she has not yet had a screening mammogram. The appropriate order is placed.

Clinician B Billing-CPT	Diagnoses	Diagnosis Description
9920X	M81.0 Z79.890 Z12.31	Osteoporosis without current fracture Hormone replacement therapy Encounter for screening mammogram for malignant neoplasm of breasts
Mammography Center Billing		
77067	Z12.31	
Billing Rationale:	The final level of service will ultimately depend on the other service(s) provided and documented. The ordering of the mammogram, by itself, will typically be established at 99202/99212, based on a straightforward problem, straightforward data, and low risk.	

Breastfeeding Services and Supplies

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

Breastfeeding equipment and supplies 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 a priority to optimize breastfeeding and should not be predicated on prior failure of a manual pump. Breastfeeding equipment may also include equipment and supplies as clinically indicated to support dyads with breastfeeding difficulties and those who need additional services.

Implementation Considerations: Lactation support services include consultation, counseling and psychosocial support, education, breastfeeding equipment, and supplies. Lactation support services should be delivered and provided across the antenatal, perinatal, and postpartum periods to ensure successful preparation, initiation, and continuation of breastfeeding. Lactation support services should be respectful, appropriately patient centered, culturally and linguistically competent, and sensitive to those who are having difficulty with breastfeeding, regardless of the cause. Clinical lactation professionals providing clinical care include, but are not limited to, licensed lactation consultants, the IBCLC®, certified midwives, certified nurse-midwives, certified professional midwives, nurses, physician assistants, nurse practitioners, and physicians. Lactation personnel providing counseling, education or peer support include lactation counselors/ breastfeeding educators and peer supporters. Clinical trials of interventions including at least 5 in-person visits across antenatal, perinatal, and postpartum periods to promote and support breastfeeding showed benefit, but more visits may be required, including psychosocial counseling for breastfeeding.

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 each payer 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**:

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

On the other hand, antepartum counseling, depending on specific payer global obstetrics reimbursement policies, 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 clinicians and supported by adequate documentation.

The patient sees the lactation counselor only.
For a visit in which the patient sees only the lactation who is not 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**). If the lactation counselor is an NPP, they can report their service with the appropriate E/M code (99202-99215).

Alternatively, the lactation counselor may be able to report the following code:

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).

For group visits, the following codes would be appropriate:

98961 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

98962 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: **99202–99205** (**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 Staff

To report follow-up services provided by a nonclinical staff member to treat a lactation problem diagnosed by a physician, you may consider reporting from code series **96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171** (**Health and behavior assessment/intervention**). Before reporting these codes to a payer, the payer should be queried to clarify whether these codes represent payable services for that payer.

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

For breast pumps, report the following supply codes:

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

Women can contact their insurance company to identify their insurance contractor for medical supplies.

Replacement Codes

A4281	Tubing for breast pump, replacement
A4282	Adapter for breast pump, replacement
A4283	Cap for breast pump bottle, replacement
A4284	Breast shield and splash protector for use with breast pump, replacement
A4285	Polycarbonate bottle for use with breast pump, replacement
A4286	Locking ring for breast pump, replacement
A4287	Disposable collection and storage bag for breast milk, any size, any type, each

ICD-10-CM codes

Breast and Nipple Issues:

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

CODING SCENARIOS

A 25 year old established patient has been diagnosed with a new pregnancy. She is highly anxious about breastfeeding and seeks advice from her physician. At 16 weeks gestation, she schedules an appointment with Clinician C to discuss her concerns. They discuss this matter for a total of 28 minutes.

Clinician C Billing-CPT	Diagnoses	Diagnosis Description
99402	Z71.89	Other specified counseling
Billing Rationale:	Because she is not currently lactating or breastfeeding, the only option to report this service is a "counseling" code, based on time. It is highly probable that her insurance will not separately cover this particular service—it would typically be considered part of the routine antepartum care.	

A 29 year old established patient delivered 5 days ago. She has contacted the office and notified them that she is having challenges with breast feeding. An appointment is made for her to see Lactational Consultant D, in an effort address any issues and further educate the patient. The lactation consultant spends 58 minutes in meeting with the patient.

Lactation Consultant D Billing-CPT	Diagnoses	Diagnosis Description
98960 x 2	Z39.1	Encounter for care and examination of lactating mother
Billing Rationale:	The practice may need to consult with the payer to determine how this service should be billed to the specific payer. Not all payers contract with lactation consultants and/or may not allow physicians to report these specific CPT codes.	

Screening for Cervical Cancer

This topic is currently being updated. Please refer to WPSI's website for the latest information.

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 may 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 after it has been collected 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** (**Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory**) was developed for a specific benefit within the Medicare program. A limited number of other payers may reimburse for this code. You should verify coverage for this code with the payer, including its specific application with the insurer. Be sure to obtain a payer reimbursement policy regarding this code in writing. Historically, payers have recouped prior payments 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. These codes are used by the pathologist to report their interpretive laboratory service. Having the collection physician report these codes 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 clinician is billing for the interpretation of the Pap smear on behalf of the laboratory, they 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 clinician'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 clinician is reporting interpretation of Pap smears on behalf of the laboratory, he or she should find out which code represents the precise service provided (eg, thin prep, manual screening, computer-assisted rescreening, etc.). 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/**. 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:

Z01.411	Encounter for gynecological exam with abnormal findings
Z01.419	Encounter for gynecological exam without abnormal findings
Z12.4	Encounter for screening for malignant neoplasms of cervix
Z12.72	Encounter for screening for malignant neoplasm of vagina
Z08	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.

For Medicare, this service is reported with the following HCPCS code:

G0476	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

The following diagnosis codes are reported to Medicare for this service:

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

Other payers may also recognize the G0476 code, but it is more common that they would reimburse one of the following codes:

87624 Human Papillomavirus (HPV), high-risk types (eg, 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68)

87625 Human Papillomavirus (HPV), types 16 and 18 only, includes type 45, if performed

These codes do not necessarily need to be performed in connection with a Pap smear, although they can be performed at the same time. These codes, as well as G0476, represent laboratory service codes and not collection services. Non-Medicare payers may have varying requirements for diagnoses, although following the Medicare guidelines would be acceptable to most.

CODING SCENARIOS

A 32-year-old new patient presents for her annual preventive medicine service. During this service, Clinician E determines that the patient should have an appropriate Pap test. This specimen is collected.

Clinician. E Billing-CPT	Diagnoses	Diagnosis Description
99385	Z01.419	Encounter for routine gynecologic exam without abnormal finding
Billing Rationale:	This service will be covered with no cost sharing or out of pocket cost from the patient. Because this service is happening in the context of a preventive medicine service, the diagnosis should be reported as Z01.41- and not Z12.4 (Encounter for screening of malignant neoplasm of cervix), because coding rules prevent reporting both of these codes during the same encounter.	

Contraception

Clinical Recommendations: The Women's Preventive Services Initiative (WPSI) recommends that adolescent and adult women have access to the full range of contraceptives and contraceptive care to prevent unintended pregnancies and improve health outcomes. Contraceptive care includes screening, education, counseling, and provision of contraceptives (including in the immediate postpartum period). Contraceptive care also includes follow-up care (eg, management, evaluation, and changes, including the removal, continuation, and discontinuation of contraceptives).

The WPSI recommends that the full range of U.S. Food and Drug Administration (FDA)-approved, -granted, or -cleared contraceptives, effective family planning practices, and sterilization procedures be available as part of contraceptive care. The full range of contraceptives currently includes those listed in the FDA's **Birth Control Guide**: 1) sterilization surgery for women, 2) implantable rods, 3) copper intrauterine devices, 4) intrauterine devices with progestin (all durations and doses), 5) injectable contraceptives, 6) oral contraceptives (combined pill), 7) oral contraceptives (progestin only), 8) oral contraceptives (extended or continuous use), 9) the contraceptive patch, 10) vaginal contraceptive rings, 11) diaphragms, 12) contraceptive sponges, 13) cervical caps, 14) condoms, 15) spermicides, 16) emergency contraception (levonorgestrel), and 17) emergency contraception (ulipristal acetate); and any additional contraceptives approved, granted, or cleared by the FDA.

Implementation Considerations: The WPSI recommends access to and provision of the full range of FDA-approved, – granted, or -cleared contraceptives. Individualized effective family planning practices and related services are also recommended as part of contraceptive preventive services.

Contraceptive counseling should be between an individual and clinician or appropriately trained professional, emphasizing patient-centered decision making and allowing for discussion of the benefits, risks, and preferences of the full range of contraceptive options. Although less effective as a standalone approach, it is reasonable to provide counseling in fertility awareness–based methods, including the lactation amenorrhea method, for individuals for whom other methods are not acceptable. While beyond the scope of the WPSI, male sterilization is extremely effective and should be included in discussions about contraception. The WPSI strongly supports equitable access to permanent contraception for all individuals.

The WPSI recommends providing alternative contraceptives when a particular drug or device is not tolerated or is inappropriate as determined by the individual and the clinician. This includes initiation, discontinuation, and timely removal of contraceptives. More than one visit may be necessary to identify appropriate contraceptive methods, manage contraceptive side effects, achieve effective contraception, and optimize use as determined through shared decision making. Research indicates that delayed initiation or disruption of contraceptive use increases the risk of unintended pregnancy; therefore, removal of preapproval requirements for contraceptive care, including in the immediate postpartum period, is recommended. The WPSI recommends that emergency contraception, including advanced provision, should be broadly available and provided to all women who may benefit.

Clinicians should consider the cultural and linguistic needs and priorities of each individual, and counseling should be consistent, respectful, affirming, and nonstigmatizing.


THE SKELETAL SYSTEM

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 (**99384–99387 or 99394–99397**), 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 (99202–99215), an E/M services code may be reported if an E/M service (including number and complexity of problems addressed, amount and/or complexity of data to be reviewed and analyzed, or risk of complications and/or morbidity or mortality of patient management OR time spent working on behalf of the patient) 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, with appropriate documentation and diagnosis assignment.
- 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 and are included in the procedural service.
- 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. Under the current E/M guidelines, time may be used to select a code level regardless of whether counseling or coordination of care is the primary office or other outpatient service (**99202-99215**). If you are reporting based on time it is required that the time be clearly documented. Note that each E/M code has a minimum amount of time that must be met. Although it will not influence code level selection, clinicians should also continue to perform and document a clinically relevant history and physical exam as a best practice.

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 two ways that sterilization for women can be performed: 1) minilaparotomy or 2) laparoscopy, the following codes can be used:

1) **Minilaparotomy or Laparotomy**

The following codes can be used

Type	CPT/HCPCS	Modifier	ICD-10-CM Diagnosis
Minilaparotomy or Laparotomy	**58600** Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral		**Z30.2** Encounter for sterilization
	58605 Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure)		**Z30.2** Encounter for sterilization
	58611 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)		**Z30.2** Encounter for sterilization
	58615 Occlusion of fallopian tube(s) by device (eg, band, clip, Falope ring), vaginal or suprapubic approach		**Z30.2** Encounter for sterilization

2) **Laparoscopy**

PROCEDURE CODES

- When performing an elective sterilization in a traditional manner (eg, burning, transection, etc.), report code **58670** (**Laparoscopy, surgical, with fulguration of oviducts** [**with or without transection**]).
- When performing a salpingectomy for sterilization, code **58661** (**Laparoscopy, surgical; with removal of adnexal structures** (**partial or total oophorectomy and/or salpingectomy**) is appropriate. If the salpingectomy for sterilization is performed bilaterally, CPT coding guidelines instruct that a 50 modifier (**Bilateral Procedure**) should be applied. However, not every payer recognizes the 50 modifier in connection with **58661**.

DIAGNOSIS CODES

Z30.2 Encounter for sterilization

Type	CPT/HCPCS	Modifier	ICD-10-CM Diagnosis
Laparoscopy Elective sterilization via traditional methods	**58670** Laparoscopy, surgical, with fulguration of oviducts (with or without transection)		**Z30.2** Encounter for sterilization
Laparoscopy Elective sterilization via salpingectomy	**58661** Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)	50 (if performed bilaterally)	**Z30.2** Encounter for sterilization

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, drug-delivery implant (ie, bioresorbable, biodegradable, non-biodegradable)

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
Implantable Rods	**11981** Insertion, drug delivery implant (ie, bioresorbable, biodegradable, non-biodegradable)		**Z30.017** Encounter for initial prescription of implantable subdermal contraceptive
	11982 Removal, non-biodegradable drug delivery implant		**Z30.46** Encounter for surveillance of implantable subdermal contraceptive
	11983 Removal with reinsertion, non-biodegradable drug delivery implant		**Z30.46** Encounter for surveillance of implantable subdermal contraceptive
Supply	**J7307** 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

There is no combined code for removal and reinsertion. If both procedures occur during the same encounter, then both CPT codes should be reported.

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

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, 6-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 previous 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
Initial	E/M code		**Z30.011** Encounter for initial prescription of contraceptive pills
Surveillance	E/M code		**Z30.041** Encounter for surveillance of contraceptive pills
Supply (if supplied and billed by clinician)	**S4993** 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
Initial	E/M code		**Z30.015** Encounter for initial prescription of vaginal ring hormonal contraceptive **Z30.016** Encounter for initial prescription of transdermal patch hormonal contraceptive device
Surveillance	E/M code		**Z30.44** Encounter for surveillance of vaginal ring hormonal contraceptive device **Z30.45** Encounter for surveillance of transdermal patch hormonal contraceptive device
Supply (if supplied and billed by clinician)	**J7303** Contraceptive supply, hormone containing vaginal ring, each **J7304** Contraceptive supply, hormone containing patch, each		Note: Check with payer for appropriate codes and whether separately reimbursed

Coding for Diaphragms, Cervical Caps

Type	CPT/HCPCS	Modifier	ICD-10-CM Diagnosis
Initial	57170 Diaphragm or cervical cap fitting with instructions		**Z30.018** Encounter for initial prescription of other contraceptives
	992XX E/M based either on the key elements 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 elements or time		**Z30.049** Encounter for surveillance of other contraceptives
Supply (if supplied and billed by clinician)	**A4261** Cervical cap for contraceptive use **A4266** 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		**Z30.018** Encounter for initial prescription of other contraceptives
Surveillance	E/M code		**Z30.049** Encounter for surveillance of other contraceptives
Supply (if supplied and billed by clinician)	**A4268** Contraceptive supply, condom, female, each **A4269** 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		**Z30.012** Encounter for prescription of emergency contraception
Supply (if supplied and billed by clinician)	**J3490** Unclassified drugs **S4993** 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		**Z30.02** Counseling and instruction in natural family planning to avoid pregnancy
Surveillance	E/M code		**Z30.02** Counseling and instruction in natural family planning to avoid pregnancy

CODING SCENARIOS

A 19 year old new patient presents to the office for her preventive medicine service. Clinician G initiates a discussion about the various birth control options. The patient decides on the use of oral contraceptives.

Clinican G Billing-CPT	Diagnoses	Diagnosis Description
99385	Z01.419	Encounter for routine gynecologic exam without abnormal finding
	Z30.011	Encounter for initial prescription of oral contraceptives
Billing Rationale:	Discussion of birth control is a component part of all preventive medicine services for women of child-bearing age. A separate CPT code is not reportable, but the reporting of the type of birth control started or continued should be communicated with the appropriate ICD-10-CM code.	

A 38-year-old established patient presents to the office with dissatisfaction with her oral contraceptives and she would like to change to a method that requires less daily intervention. Clinician H recommends a non-hormonal intrauterine contraceptive device (IUC). She agrees and they proceed to insert the device during this encounter.

Clinician H Billing-CPT	Diagnoses	Diagnosis Description
58300	Z30.430	IUD Insertion
J7300	Z30.430	Copper IUD device
Billing Rationale:	A separate E/M service could be billed if a variety of options had been discussed and the conversation had been documented. The patient has no financial (cost-sharing) responsibility for these services , although they may have financial responsibility for a separate E/M service if it is reported.	

Obesity Prevention in Midlife Women

Clinical Recommendations: The Women's Preventive Services Initiative (WPSI) recommends counseling midlife women aged 40 to 60 years with normal or overweight body mass index (BMI) (18.5–29.9 kg/m2) to maintain weight or limit weight gain to prevent obesity. Counseling may include individualized discussion of healthy eating and physical activity.

Implementation Considerations: Midlife women between 40 and 60 years of age are at increased risk of weight gain, some gaining an average of 1.5 lbs (0.7 kg) per year. Preventing obesity reduces risk of chronic health conditions such as heart disease, diabetes mellitus, arthritis, and certain cancers. Although clinical guidelines have been issued by the United States Preventive Services Task Force (USPSTF) for individuals with obesity or cardiovascular disease risk factors, no current guidelines include prevention of obesity among women with normal or overweight BMI.

Clinical trials of counseling interventions indicate the effectiveness of counseling on weight maintenance or weight loss in midlife women with normal or overweight BMI. Although all trials included dietary and physical activity counseling as interventions, specific components varied. Weight maintenance or loss was reported at follow-up times ranging from 1 to 7.5 years. Studies suggest more frequent counseling may be more effective, although the optimal type, intensity, periodicity, delivery method of counseling, and its effect on long-term health outcomes were not evaluated. In addition to clinical trials of counseling, the WPSI bases its recommendation on the known health benefits of preventing obesity, as well as national guidelines outlining standards for physical activity and diet in the United States.

The WPSI suggests clinicians offer or refer women to individualized counseling based on assessment of a patient's BMI and diet and exercise habits. Patients with normal weight and healthy habits can receive positive reinforcement. Women with overweight BMI and with unhealthy diet and exercise habits should receive at least brief counseling. Periodicity and intensity of reinforcement and counseling can be individualized based on the patient's BMI, previously established habits, and acceptance. The Centers for Disease Control and Prevention provides resources for diet and physical activity for patients and clinicians.

Clinicians should individualize counseling taking into consideration contributing factors associated with obesity including chronic stress, trauma, and socioeconomic conditions. Counseling should be sensitive to weight stigma, the influence of culture on body image, individual variability in body composition, accessibility to safe spaces for physical activity, financial resources, childcare, leisure time, and availability of healthy foods.

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. This will be the occasion at which most counseling concerning preventing obesity will occur.

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.

If counseling is to be separately billable, it 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 existing symptoms or an established illness. If the patient has a clinical diagnosis of obesity, an appropriate problem-oriented E/M service (**99202–99215**) is reported for any related service.

MEDICARE

Medicare does not pay separately for preventing obesity for patients that do not meet the clinical definition of "obese." If the patient has a BMI of 30 or greater, Medicare will pay for 22 visits to address the issue during the first year, on the following schedule:

G0447	Face-to-face behavioral counseling for obesity, 15 minutes
G0473	Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes
First Month:	1 face-to-face visit per week during the first month
Months 2-6:	1 face-to-face visit every other week
Months 7-12:	1 face-to-face visit every month if patient meets certain requirements (meeting defined goals)

The clinician must document that the patient is competent and alert when the counseling is delivered and it must be provided by a qualified primary care physician or other primary care practitioner counseling in a primary care setting.

In order for these services to be payable, an appropriate diagnosis from the E66 category must be applied to the claim, in addition to an appropriate diagnosis from the Z68 category (see below).

DIAGNOSIS CODES

Although there is no specific ICD-10-CM diagnosis code available to report "normal" body weight, there are codes available to report the patient's current Body Mass Index (BMI). Those codes include:

Z68.1	Body mass index [BMI] 19.9 or less, adult
Z68.2-	Body mass index [BMI] 20-29, adult
Z68.20	Body mass index [BMI] 20.0 – 20.9, adult
Z68.21	Body mass index [BMI] 21.0 – 21.9, adult
Z68.22	Body mass index [BMI] 22.0 – 22.9, adult
Z68.23	Body mass index [BMI] 23.0 – 23.9, adult
Z68.24	Body mass index [BMI] 24.0 – 24.9, adult
Z68.25	Body mass index [BMI] 25.0 – 25.9, adult
Z68.26	Body mass index [BMI] 26.0 – 26.9, adult
Z68.27	Body mass index [BMI] 27.0 – 27.9, adult
Z68.28	Body mass index [BMI] 28.0 – 28.9, adult
Z68.29	Body mass index [BMI] 29.0 – 29.9, adult
Z68.3-	Body mass index [BMI] 30-39, adult
Z68.30	Body mass index [BMI] 30.0 – 30.9, adult
Z68.31	Body mass index [BMI] 31.0 – 31.9, adult
Z68.32	Body mass index [BMI] 32.0 – 32.9, adult

Z68.33	Body mass index [BMI] 33.0 – 33.9, adult
Z68.34	Body mass index [BMI] 34.0 – 34.9, adult
Z68.35	Body mass index [BMI] 35.0 – 35.9, adult
Z68.36	Body mass index [BMI] 36.0 – 36.9, adult
Z68.37	Body mass index [BMI] 37.0 – 37.9, adult
Z68.38	Body mass index [BMI] 38.0 – 38.9, adult
Z68.39	Body mass index [BMI] 39.0 – 39.9, adult
Z68.4-	Body mass index [BMI] 40 or greater, adult
Z68.41	Body mass index [BMI] 40.0 – 44.9, adult
Z68.42	Body mass index [BMI] 45.0 – 49.9, adult
Z68.43	Body mass index [BMI] 50.0 – 59.9, adult
Z68.44	Body mass index [BMI] 60.0 – 69.9, adult
Z68.45	Body mass index [BMI] 70 or greater, adult

None of these diagnoses can ever be used as a primary diagnosis. If the patient's BMI is to be reported, it must be reported as a secondary diagnosis. The primary diagnosis assigned will best describe the clinical indication for the encounter. Possible diagnosis examples in the context of this recommendation include:

Z01.419	Encounter for routine gynecologic examination (general) (routine) without abnormal findings
Z01.411	Encounter for routine gynecologic examination (general) (routine) with abnormal findings
Z71.3	Dietary counseling and surveillance
Z71.89	Other specified counseling
Z72.3	Lack of physical exercise
Z72.4	Inappropriate diet and eating habits

If the patient does, in fact, have a diagnosis of "overweight" or "obesity," the diagnoses would be as follows:

E66.0	Obesity due to excess calories
E66.01	Morbid (severe obesity) due to excess calories
E66.09	Other obesity due to excess calories
E66.1	Drug-induced obesity
E66.2	Morbid (severe) obesity with alveolar hypoventilation
E66.3	Overweight
E66.8	Other obesity
E66.811	Obesity, class 1

E66.812 Obesity, class 2

E66.813 Obesity, class 3

E66.89 Other obesity not elsewhere classified

E66.9 Obesity, unspecified

In general, these diagnoses are used based on the following BMI's:

BMI	ICD-10-CM Codes	Further Classification
25.0-29.9	E66.3	
30.0-39.9	E66.9	E66.811 (BMI 30.0 – 34.9) E66.812 (BMI 35.0 – 39.9)
Greater than or equal to 40.0	E66.01	E66.813

CODING SCENARIOS

A 56-year-old established patient presents for her annual preventive medicine service. During this service, Clinician R provides counseling concerning preventing obesity.

Clinician R Billing-CPT	Diagnoses	Diagnosis Description
99396	Z01.419	Encounter for routine gynecologic exam without abnormal finding
Billing Rationale:	Most payers will not reimburse separately for this service and the patient may be responsible for the cost as it often is not a covered benefit.	

A 42-year old new patient presents with concerns about the risks associated with obesity. At this time, she is overweight (BMI of 27.5), and she is also concerned about the quality of her diet. Clinician Y counsels her for a total of 39 minutes

Clinician Y Billing-CPT	Diagnoses	Diagnosis Description
99403	E66.3 Z72.4	Overweight Inappropriate diet and eating habits.
Billing Rationale:	Most payers will not reimburse separately for this service and the patient may be responsible for the cost as it is not a covered benefit.	

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 **96160 Administration of patient-focused health risk assessment instrument** (**eg, health hazard appraisal**) **with scoring and documentation, per standardized instrument**) or 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 payer chooses 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.

Other possible procedure codes are:

99401–99404	Preventive medicine, individual counseling
99411–99412	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. Note that the "typical times" for each code have been revised to depict a range of time. For outpatient E/M visits in 2021, physicians may choose code level based on either medical decision making (MDM) or time. Time may be used to select a code level whether or not counseling or coordination of care is the primary office or other outpatient service (**99202-99215**). Time can only be used for level selection for other (time-based) E/M services when counseling and coordination of care is the primary service (for time based codes other than **99202-99215**). If you are reporting based on time, it is essential that your time be documented. As a best practice, clinicians should also continue to perform and document a clinically relevant history and physical exam, even though it will not influence code selection.

Additional possible procedure codes are:

99202–99205	New patient, office or other outpatient visit
99211–99215	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 routinely screens every patient for depression. 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 existing 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 the 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

Possible ICD-10-CM codes that may be used for this service 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

CODING SCENARIOS

An 18-year old new patient presents for her annual preventive medicine service. During this service, Clinician I conduct a screening for anxiety.

Clinician I Billing-CPT	Diagnoses	Diagnosis Description
99385	Z01.419	Encounter for routine gynecologic exam without abnormal finding
96127	Z13.31	Encounter for screening for depression
Billing Rationale:	This service will be covered with no cost-sharing or out-of-pocket cost from the patient. Because this service is happening in the context of a preventive medicine service, the diagnosis should be reported as Z01.41- with a secondary diagnosis related to the mental health screening.	

CODING SCENARIOS

A 37-year-old woman presents for her postpartum visit 6-weeks after giving birth. As part of that encounter, Dr. J performs a screening for postpartum depression.

Clinician J Billing-CPT	Diagnoses	Diagnosis Description
0503F	Z39.2	Postpartum visit
96127	Z13.32	Encounter for screening for maternal depression
Billing Rationale:	If this screening occurs at the regularly scheduled postpartum visit, then it is considered part of that visit (and not separately billable), unless a specific tool is used—as is required by CPT code 96127 or 96160.	

Screening for Diabetes After Pregnancy

Clinical Recommendations: The Women's Preventive Services Initiative (WPSI) recommends screening for type 2 diabetes in 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. Initial testing should ideally occur within the first year postpartum and can be conducted as early as 4–6 weeks postpartum.

Women who were not screened in the first year postpartum or those with a negative initial postpartum screening test result should be screened at least every 3 years for a minimum of 10 years after pregnancy. For those with a positive screening test result in the early postpartum period, testing should be repeated at least 6 months postpartum to confirm the diagnosis of diabetes regardless of the type of initial test (eg, fasting plasma glucose, hemoglobin A1C, oral glucose tolerance test). Repeat testing is also indicated for women screened with hemoglobin A1C in the first 6 months postpartum regardless of whether the test results are positive or negative because the hemoglobin A1C test is less accurate during the first 6 months postpartum.

Table 1. Preferred Testing Strategy Based on Postpartum Timeframe

	Testing Strategy		
Postpartum Timeframe	**Oral Glucose Tolerance Test**	**Fasting Plasma Glucose**	**Hemoglobin A_{1C}**
4 weeks – 6 months	Preferred	Acceptable	Consider only when recommended alternatives are not feasible
After 6 months	Acceptable	Acceptable	Acceptable

Implementation Considerations: In addition to the follow-up screening for women with a history of GDM recommended above, the WPSI recommends adherence to diabetes 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**.

Postpartum follow-up visits are **recommended** after delivery, with the initial assessment ideally within 3 weeks, a comprehensive postpartum visit by 12 weeks, and care continuing through the first year after birth. These visits provide an opportunity for screening for type 2 diabetes after GDM, especially for patients with limited access to health care after pregnancy. The WPSI recommends that postpartum visits include a discussion of future diabetes screening for women with history of GDM. Ongoing care with a primary care clinician is important to facilitate appropriate diabetes screening and prevention counseling after pregnancy.

Compared with other tests, hemoglobin A1C is less accurate in the first months after pregnancy and may be inaccurate in women with conditions such as anemia, renal failure, or certain hemoglobinopathies (eg, thalassemia and sickle cell disease or trait), or who have had a recent transfusion. However, given the low rates of postpartum testing with fasting plasma glucose and oral glucose tolerance tests, hemoglobin A1C may be considered 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 accurate 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 patients with a history of GDM, a history code **Z86.32, Personal history of gestational diabetes**, should be assigned as a secondary diagnosis to 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_{1C}

83037 Hemoglobin; glycosylated (A_{1C}) by device cleared by FDA for home use

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

CODING SCENARIOS

A 28-year old new patient presents for her annual preventive medicine service. During this service, Clinician K discovers that she has given birth two times in the last four years. Therefore, she elects to screen the patient for diabetes. A variety of laboratory tests are ordered to accomplish this task

Clinician K Billing-CPT	Diagnoses	Diagnosis Description
99385	Z01.419 Z13.1	Encounter for routine gynecologic exam without abnormal finding Encounter for screening for diabetes mellitus
Billing Rationale:	This service will be covered with no cost sharing or out of pocket cost from the patient. Because this service is happening in the context of a preventive medicine service, the diagnosis should be reported as Z01.41- with a secondary diagnosis related to the diabetes screening(s).	

A 37-year-old woman presents for her postpartum visit 6-weeks after giving birth. As part of that encounter, Clinician L elects to screen her for diabetes mellitus. A variety of laboratory tests are ordered to accomplish this task.

Clinician L Billing-CPT	Diagnoses	Diagnosis Description
0503F	Z39.2 Z13.32	Postpartum visit Encounter for screening for diabetes mellitus
Billing Rationale:	If this screening occurs at the regularly scheduled postpartum visit, then it is considered part of that visit (and not separately billable).	

Screening for Diabetes in Pregnancy

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.

The WPSI recommends screening pregnant women with risk factors for type 2 diabetes or GDM before 24 weeks of gestation—ideally at the first prenatal visit.

Implementation Considerations: The WPSI recommends screening pregnant women for GDM after 24 weeks of gestation with either the 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) or a 2-hour 75-g oral glucose tolerance test.

Risk factors that may help identify women for screening before 24 weeks include, but are not limited to, the following: overweight or obese body mass index (BMI), previous GDM, family history of first- or second-degree relatives with type 2 diabetes, maternal age of 35 years or older, previous delivery of an infant weighing 4,000 g or more, polycystic ovarian syndrome, or identifying with a racial or ethnic group with increased risk for type 2 diabetes (American Indian/Alaska Native, Asian American [at lower BMI], Black, Hispanic/Latino, Native Hawaiian/Pacific Islander).

The optimal test for screening before 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 A1C test, or a fasting plasma glucose test. If early screening is normal, screening with an oral glucose challenge test should be conducted at 24–28 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_{1C}) 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 prevention.

Category III 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 25 kg/m2; 23 kg/m2, 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_{1C}: 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 patients so that early detection and treatment can be provided for those who test positive for the disease." If the primary 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.

Z13.1 Encounter for screening for diabetes mellitus

Z36.89 Encounter for other specified antenatal screening

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

CODING SCENARIOS

A 25-year-old established patient in her first pregnancy presents for her antepartum visit at 26 weeks. During this service, Clinician M orders a Glucose Tolerance Test (GTT) to screen for gestational diabetes (GDM).

Clinician Billing-CPT	Diagnoses	Diagnosis Description
0502F 82951	Z34.02 Z13.1	Encounter for supervision of normal first pregnancy, 2nd trimester Encounter for screening for diabetes mellitus
Billing Rationale:	If this screening occurs at the regularly scheduled antepartum visit, then it is considered part of that visit (and not separately billable), although any laboratory tests performed are separately reportable.	

Screening for Human Immunodeficiency Virus Infection

Clinical Recommendations: The Women's Preventive Services Initiative (WPSI) recommends all adolescent and adult women, ages 15 and older, receive a screening test for human immunodeficiency virus (HIV) at least once during their lifetime. Earlier or additional screening should be based on risk, and rescreening annually or more often may be appropriate beginning at age 13 for adolescent and adult women with an increased risk of HIV infection.

The WPSI recommends risk assessment and prevention education for HIV infection beginning at age 13 and continuing as determined by risk.

A screening test for HIV is recommended for all pregnant women upon initiation of prenatal care with rescreening during pregnancy based on risk factors. Rapid HIV testing is recommended for pregnant women who present in labor with an undocumented HIV status.

Implementation Considerations: The WPSI recommends, as a preventive service for women, prevention education and risk assessment for HIV infection in adolescent and adult women at least annually throughout the life span. Clinicians should consider the cultural and linguistic needs of individual patients, and prevention education should be respectful, affirming, and non- stigmatizing.

This recommendation refers to routine HIV screening tests, which are different from incident-based or exposure-based HIV tests. More frequent testing 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. 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; patient or patient's sex partner(s) having more than one sex partner since last HIV test; 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 now or in the past; and having other sexually transmitted infections (STIs).

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

Additional recommendations about STI prevention education, counseling, and testing, along with recommendations about HIV preexposure prophylaxis (PrEP) are provided in the WPSI **Sexually Transmitted Infection (STI) Counseling** recommendation, the **Recommendations for Well-Woman Care: A Well-Woman Chart**, and the **Clinical Summary Tables**.

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.

If counseling is to be separately billable, it 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 existing symptoms or an established illness. In this case, an appropriate problem-oriented E/M service (**99202–99215**) is reported.

Time may be used to select a code level regardless of whether counseling or coordination of care is the primary office component of the office or other outpatient service (**99202-99215**). If you are reporting based on time it is essential that the total time be documented. Although it will not influence code selection, clinicians should also continue to perform a clinically relevant history and physical exam, as a best practice.

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 diagnoses. 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	
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 method of transmission are 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
Encounter for HIV pre-exposure prophylaxis	Z29.81
Human immunodeficiency virus [HIV] disease complicating pregnancy, trimester	O98.71
Human immunodeficiency virus [HIV] disease complicating childbirth	O98.72
Human immunodeficiency virus [HIV] disease complicating the puerperium	O98.73

CODING SCENARIOS

A 33-year-old established patient presents for her annual preventive medicine service. During this service, Clinician N screens for an HIV infection.

Clinician N Billing-CPT	Diagnoses	Diagnosis Description
99385 86703	Z01.419 Z11.4	Encounter for routine gynecologic exam without abnormal finding Encounter for screening for HIV
Billing Rationale:	Because this service is happening in the context of a preventive medicine service, the diagnosis should be reported as Z01.41- with a secondary diagnosis related to HIV testing. If the clinician is billing for the laboratory services, they would report 86701, 86702, or 86703, depending on the precise test performed.	

A 32-year-old established patient presents for the initial obstetric visit in her third pregnancy. During this service, Doctor O conducts a screening for an HIV infection, which is part of the standard obstetric lab panel. She is currently at 9 weeks gestation.

DR. O Billing-CPT	Diagnoses	Diagnosis Description
0500F 80081 (Obstetric panel)	Z34.81 Z11.4	Encounter for supervision of other normal pregnancy, 1st trimester. Encounter for screening for HIV
Billing Rationale:	The clinician will not bill separately for the encounter if the patient's insurer desires for the pregnancy to be billed in global fashion. However, the HIV test will be reported as part of the obstetric panel, which is reported at the time the test is done.	

Screening and Counseling for Intimate Partner and Domestic Violence

Clinical Recommendations: The Women's Preventive Services Initiative recommends screening adolescent and adult women for intimate partner and domestic violence, at least annually, and, when needed, providing intervention services. Intimate partner 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 appropriate supportive services.

Implementation Considerations: The Women's Preventive Services Initiative recommends screening patients when privacy is assured (eg, alone or unaccompanied) whether at an in-person or virtual visit. All patients may benefit from universal education and resources about intimate partner and domestic violence regardless of disclosure. Rates are high among all women of all ages, and in particular highest among American Indian and Alaska Native, Black, and multiracial women; pregnant and postpartum women, particularly those with unintended pregnancies; adolescent girls; and members of the LGBTQ+ community. Several physical, mental health, and social conditions predispose women to additional vulnerability, such as disability, immigration status, food and housing insecurity, illicit drug use, HIV infection, and involvement in sex work. There are multiple screening tools that have shown adequate sensitivity and specificity for identifying intimate partner and domestic violence in specific populations of women. Minimum screening intervals are unknown; however, based on the prevalence of intimate partner 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 **99384–99397** include age-appropriate counseling, anticipatory guidance, and risk factor reduction interventions provided at the time of the initial or periodic comprehensive preventive medicine examinations.

If the encounter for screening occurs during a visit other than a comprehensive preventive medicine visit and the 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
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 (**99202–99215**) is reported. Note that the "typical times" for each code have been revised to depict a range of time. When reporting based on time, it is essential that the time be clearly documented. As a best practice, clinicians should also continue to perform and document a clinically relevant history and physical exam, even though it will not influence code selection.

DIAGNOSIS CODES

ABUSE AND NEGLECT

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

Confirmed

T74.0-	Neglect or abandonment, confirmed
T74.1 -	Physical abuse, confirmed
T74.2-	Sexual abuse, confirmed [Rape, confirmed; Sexual assault, confirmed]
T74.3-	Psychological abuse, confirmed [Bullying and intimidation, confirmed; Intimidation through social media, confirmed]
T74.5-	Forced sexual exploitation, confirmed
T74.6-	Forced labor exploitation, confirmed
T74.9-	Unspecified maltreatment, confirmed

Suspected

T76.0-	Neglect or abandonment, suspected
T76.1-	Physical abuse, suspected
T76.2-	Sexual abuse, suspected
T76.3-	Psychological abuse, suspected [Bullying and intimidation, confirmed; Intimidation through social media, confirmed]
T76.5-	Forced sexual exploitation, suspected
T76.6-	Forced labor exploitation, suspected
T76.9-	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:

O9A.31-	Physical abuse complicating pregnancy, childbirth, and the puerperium
O9A.41-	Sexual abuse complicating pregnancy, childbirth, and the puerperium
O9A.51-	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**, could possibly be reported.

SUSPECTED CASE OF ABUSE, NEGLECT, OR MISTREATMENT RULED OUT

If a 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.-**).

History codes from subcategories **Z62.81-, Personal history of abuse in childhood**, and **Z91.41-, Personal history of adult abuse**, 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:

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

CODING SCENARIOS

A 38-year-old established patient presents for her annual preventive medicine service. During this service, Clinician P screens for domestic violence.

Clinician N Billing-CPT	Diagnoses	Diagnosis Description
99395	Z01.419 Z13.89	Encounter for routine gynecologic exam without abnormal finding Encounter for screening for other disorder
Billing Rationale:	There is no separate procedural service that is billable for domestic violence screening, nor is there a specific diagnosis to report the service. The only available option is the more generic code for "other screening.	

A 28-year-old established patient presents for STI screening, in the absence of any signs, symptoms, or known exposure. During this service, Clinician Q also screens for domestic violence.

Clinician Q Billing-CPT	Diagnoses	Diagnosis Description
99213	Z11.3 Z13.89	Encounter for screening for infections with a predominantly sexual mode of transmission Encounter for screening for other disorder
Billing Rationale:	There is no separate procedural service that is billable for domestic violence screening, nor is there a specific diagnosis to report the service. The only available option is the more generic code for "other screening. The level of service would be level 3, based on "low" problems (2 self-limited or minor problems—STI and DV screening), "moderate" data (3 laboratory tests for STI screening) and "straightforward" risk.	

Counseling for Sexually Transmitted Infections

Clinical Recommendations: The Women's Preventive Services Initiative recommends behavioral counseling by a health care clinician 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 clinicians review a woman's sexual history and risk factors to identify those at increased risk for STIs. Risk factors include, but are not limited to, age younger than 25 years, 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 those without identified risk factors, counseling to reduce the risk of STIs should be considered on an individual basis as determined by clinical judgment.

Implementation Considerations: The Women's Preventive Services Initiative recommends as a preventive service for adolescent and adult women at increased risk for STIs, behavioral counseling that includes, but is not limited to, counseling sessions with adequate contact time (effectiveness is greatest with high- contact interventions), and may include multiple counseling sessions, group sessions, in-person and tech-based encounters, and educational and behavioral change components using motivational interviewing techniques and goal setting.

The Women's Preventive Services Initiative recommends as a preventive service, STI counseling regardless of whether STI screening takes place during the same visit and regardless of the type of sexual activity or gender of sexual partner(s). Counseling may occur annually, or more frequently based on individual risk factors. Intensity of counseling may be individualized based on risk factors. Preventive counseling may be considered in women without identified risk factors. Clinicians should consider the cultural and linguistic needs of individual patients and maintain their privacy and confidentiality. Counseling should be respectful, affirming, and non- stigmatizing.

Additional recommendations about Human Immunodeficiency Virus (HIV) risk assessment, counseling, and testing, are provided in the WPSI HIV recommendation, the Recommendations for Well-Woman Care: A Well-Woman Chart, and the Clinical Summary Tables.

NON-MEDICARE PAYERS

PROCEDURE CODES

INITIAL OR PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE EXAMINATIONS (**99384 – 99397**)

In most cases, counseling for STI infections will occur in connection with initial or periodic comprehensive preventive medicine services. This service is reported with CPT codes **99384–99397**, which includes age-appropriate counseling, anticipatory guidance, and risk factor reduction interventions provided at the time of this visit.

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 during the same encounter, it may be reported separately.

These codes are not reported when the physician counsels a patient with existing symptoms or an established illness. In this case, a problem-oriented E/M service (**99202–99215**) 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.

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

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)

DIAGNOSIS CODES

Possible ICD-10-CM diagnosis codes used at the time of this service:
Z11.3, Z11.4, Z11.59, Z11.6, Z11.8, 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, or **O09.93**

CODING SCENARIOS

A 42-year-old established patient presents for her annual preventive medicine service. During this service, Clinician R screens for STI's.

Clinician R Billing-CPT	Diagnoses	Diagnosis Description
99396	Z01.419	Encounter for routine gynecologic exam without abnormal finding
Various lab codes	Z11.3	Encounter for screening for infections with a predominantly sexual mode of transmission
Billing Rationale:	The counseling component of this service is a part of the preventive medicine service. If the clinician is billing for the STI laboratory tests, those services would be reported independently.	

A 21-year-old new patient presents for education concerning the risk associated with sexually transmitted infections. She is not yet sexually active, but she wishes to better understand the actions that she can take to avoid exposure when she does become sexually active. Clinician S counsels her for a total of 15 minutes.

Clinician S Billing-CPT	Diagnoses	Diagnosis Description
99401	Z71.89	Other specified counseling
Billing Rationale:	Since the patient has no specific complaints and is only seeking education, the appropriate code for preventive medicine counseling is indicated here.	

Screening for Urinary Incontinence

Clinical Recommendations: The Women's Preventive Services Initiative recommends screening women for urinary incontinence annually. Screening should assess whether women experience urinary incontinence and whether it impacts their activities and quality of life. If indicated, facilitating further evaluation and treatment is recommended.

Implementation Considerations: Approximately 50% of women in the US experience urinary incontinence that can adversely affect health, quality of life, and function. Factors associated with urinary incontinence include increased parity, advancing age, and obesity; however, these factors are common and should not be used to limit screening. Because of the high prevalence of urinary incontinence in women and the potential benefits of early identification and intervention, education on urinary incontinence provided in the clinical setting may be appropriate.

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 screen annually.

PROCEDURE CODES

INITIAL OR PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE EXAMINATIONS (**99384 – 99397**)

In many cases, screening for urinary incontinence will occur in connection with initial or periodic comprehensive preventive medicine services. This service is reported with CPT codes 99384–99397, which includes age-appropriate counseling, anticipatory guidance, and risk factor reduction interventions provided at the time of this visit.

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 during the same encounter, it may be reported separately.

These codes are not reported when the physician counsels a patient with existing symptoms or an established illness. In this case, a problem-oriented E/M service (**99202–99215**) 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.

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

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**).

DIAGNOSIS CODES

NON-MEDICARE PAYERS

N39.3	Stress incontinence (female) (male)
N39.41	Urge incontinence
N39.42	Incontinence without sensory awareness
N39.43	Post-void dribbling
N39.44	Nocturnal enuresis
N39.45	Continuous leakage
N39.46	Mixed incontinence
N39.490	Overflow incontinence
N39.491	Coital incontinence
N39.492	Postural (urinary) incontinence
N39.498	Other specified urinary incontinence
N36.42	Intrinsic sphincter deficiency (ISD)
O90.89	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 clinician's records indicate "urinary incontinence due to pregnancy," then code **O90.89 Other complications of the puerperium**, **not elsewhere classified**, should be applied with a secondary diagnosis that describes the nature of the patient's incontinence. If the nature of the incontinence is not explicitly documented, then report diagnosis code **R32, Unspecified urinary incontinence**.

If documentation does not explicitly state that urinary incontinence was caused by pregnancy, then then the most appropriate diagnosis from the list above should be applied.

In some cases, postpartum urinary incontinence may be caused by a urinary tract infection. The following codes from category **O86.2-, Urinary tract infection following delivery**, may be applied:

O86.20	Urinary tract infection following delivery, unspecified
O86.21	Infection of kidney following delivery
O86.22	Infection of bladder following delivery
O86.29	Other urinary tract infection following delivery

Use an additional code from the range of **B95-B97** to identify the infectious agent (if known).

CODING SCENARIOS

A 56-year-old established patient presents for her annual preventive medicine service. During this service, Clinician T screens for urinary incontinence.

Clinician Billing-CPT	Diagnoses	Diagnosis Description
99396	Z01.419 Z13.89	Encounter for routine gynecologic exam without abnormal finding Encounter for screening for other disorder
Billing Rationale:	The counseling component of this service is a part of the preventive medicine service. There is no specific procedural service or specific diagnosis that allows distinct reporting of this screening.	

A 28-year-old established patient presents with continuing complaints of genitourinary prolapse. During this service, Clinician U also screens for urinary incontinence.

Clinician Billing-CPT	Diagnoses	Diagnosis Description
99214	N81.4 Z13.89	Uterovaginal prolapse, unspecified Encounter for screening for other disorder
Billing Rationale:	There is no separate procedural service that is billable for urinary incontinence screening, nor is there a specific diagnosis to report the service. The only available option is the more generic code for "other screening. The level of service would be level 4, based on "moderate" problems (1 chronic problem with exacerbation), "straightforward" data and "moderate" risk (discussion of possible surgery).	

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 the provision of all recommended preventive services. The primary purpose of well-woman visits is the delivery and coordination of recommended preventive services as determined by age and risk factors. These services may be completed at a single visit or as part of a series of visits that take place over time to obtain all necessary services depending on a woman's age, health status, reproductive health needs, pregnancy status, and risk factors. Well-women visits also include prepregnancy, prenatal, postpartum and interpregnancy visits.

Implementation Considerations: 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, prepregnancy care, and many services necessary for prenatal, postpartum and interpregnancy care. Visits should allow sufficient time to address and coordinate services, and a team-based approach may facilitate delivery of services. 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, and immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Recommended services for adolescents also include evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration, and for women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

The ***Recommendations for Well-Woman Care – A Well-Woman Chart*** provides a framework for incorporating preventive health services for women into clinical practice.

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 (**99384–99387** and **99394–99397**) 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, except for inpatient. The Centers for Medicare and Medicaid E/M documentation guidelines do not apply to preventive services codes.

DIAGNOSIS CODES

NON-MEDICARE PAYERS

Z01.419	Encounter for gynecological examination (general) (routine) without abnormal finding
Z01.411	Encounter for gynecological examination (general) (routine) with abnormal finding

The codes for routine health examinations distinguish between "with" and "without" abnormal findings. The specific code is selected based on what is known at the time the encounter is being coded.

An additional code(s) is reported to identify any abnormal finding. If there are no abnormal findings during the exam, but the subsequent test results are abnormal, the encounter is still reported using the code without abnormal findings (Z01.419). Any follow-up visits to address the abnormality are reported using the code for the identified condition.

ICD-10-CM instructs that for the purpose of assigning codes from this category, an "abnormal finding" is a newly discovered condition, or a known/chronic condition that has increased in severity, (e.g., uncontrolled, and/or acuted exacerbated).

ACOG's Committee on Health Economics and Coding suggests the following:

In general, most well woman visits will be linked to Z01.419. Use Z01.411 for a significant physical finding, symptom, or complaint that requires additional evaluation above the typical "well woman visit." This includes the ordering and interpretation of additional ancillary services.

CODING SCENARIOS

A 56-year-old established patient presents for her annual preventive medicine service. During this service, Clinician T screens for urinary incontinence.

Clinician Billing-CPT	Diagnoses	Diagnosis Description
99396	Z01.419 Z13.89	Encounter for routine gynecologic exam without abnormal finding Encounter for screening for other disorder
Billing Rationale:	The counseling component of this service is a part of the preventive medicine service. There is no specific procedural service or specific diagnosis that allows distinct reporting of this screening.	

A 28-year-old established patient presents with continuing complaints of genitourinary prolapse. During this service, Clinician U also screens for urinary incontinence.

Clinician Billing-CPT	Diagnoses	Diagnosis Description
99214	N81.4 Z13.89	Uterovaginal prolapse, unspecified Encounter for screening for other disorder
Billing Rationale:	There is no separate procedural service that is billable for urinary incontinence screening, nor is there a specific diagnosis to report the service. The only available option is the more generic code for "other screening. The level of service would be level 4, based on "moderate" problems (1 chronic problem with exacerbation), "straightforward" data and "moderate" risk (discussion of possible surgery).	

Patient Navigation Services for Breast and Cervical Cancer Screening

Clinical Recommendations: The Women's Preventive Services Initiative recommends patient navigation services for breast and cervical cancer screening and follow-up, as relevant, to increase utilization of screening recommendations based on an assessment of the patient's needs for navigation services. Patient navigation services involve person-to-person (eg, in-person, virtual, hybrid models) contact with the patient. Components of patient navigation services should be individualized. Services include, but are not limited to, person-centered assessment and planning, health care access and health system navigation, referrals to appropriate support services (eg, language translation, transportation, and social services), and patient education.

Implementation Considerations: Patient navigation services may be provided by support staff in specific clinical settings or centralized within health systems. Patient navigators provide services to help guide the patient through their course of care, including any unmet social needs that significantly limit the clinician's ability to deliver recommended breast and cervical cancer screening and follow-up. Services include the following activities:

- Person-centered assessment and planning to understand the patient's barriers to effective breast and cervical cancer screening and follow-up, including understanding cultural and linguistic factors as well as unmet social determinants of health needs.
- Health care access and health system navigation to help the patient access care, including identifying appropriate services and providers for breast and cervical cancer screening and follow-up care and securing appointments with them.
- Identifying or referring the patient to appropriate support services, such as language translation, transportation, and social services, among others.
- Patient education to help the patient understand breast and cervical cancer screening and follow-up and to improve their ability to interact with the health care team.

The clinician initiates patient navigation services when they identify the patient's need for facilitation of breast and cervical cancer screening and follow-up, as relevant. Clinicians may provide or refer for the subsequent navigation services that support staff may provide. Personal interaction is vital to successful navigation services and should be culturally and linguistically appropriate to reduce health disparities.

PROCEDURE CODES

There are no specific procedural codes available to separately report patient navigation services. This work is considered incidental to the other procedures previously outlined in the sections concerning Breast Cancer Screening and Cervical Cancer Screening. Please refer to those sections for specific guidance concerning procedural coding for these services.

DIAGNOSIS CODES

There are no specific diagnosis codes available to separately report diagnoses related to patient navigation services. Any diagnoses associated with this activity would be identical to those assigned to the screening service(s). Please refer to the Breast Cancer Screening and Cervical Cancer Screening sections for specific guidance concerning diagnosis coding for these services.

Appendix A — Medicare

Breast Cancer Screening for Women at Average Risk

Clinical Recommendations: The Women's Preventive Services Initiative recommends that women at average risk of breast cancer initiate mammography screening no earlier than age 40 years and no later than age 50 years. Screening mammography should occur at least biennially and as frequently as annually. Women may require additional imaging to complete the screening process or to address findings on the initial screening mammography. If additional imaging (eg, magnetic resonance imaging, ultrasound, mammography) and pathology evaluation are indicated, these services also are recommended to complete the screening process for malignancies. Screening should continue through at least age 74 years, and age alone should not be the basis for discontinuing screening.

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

Implementation Considerations: 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 clinician. The shared decision-making process assists women in making informed decisions 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. Discussion and education related to screening should be culturally and linguistically congruent, particularly for patients experiencing health inequities.

Women considered at high risk of breast cancer (eg, previous diagnosis of breast or ovarian cancer, known BRCA1 or BRCA2 mutation, previous high-dose radiation to the chest) may require additional testing and closer follow-up, which are beyond the scope of this recommendation.

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.

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, although the patient may be responsible for a co-pay/coinsurance and the Medicare deductible. The **Z12.31** diagnosis should not be used in this case and, instead, the diagnosis(es) that support the medical necessity of that service should be used. Examples of those diagnoses include codes from the **N63** category (unspecified lump in breast) and the **N60** category (benign mammary dysplasia).

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.

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 **G0402, 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 clinician 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 **G0438** and **G0439**) 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 **G0444**:

G0444 Annual depression screening, 15 minutes

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

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

Low risk diagnoses – **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 as part 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/or **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.

CODING SCENARIOS

A 68-year-old woman presents for her Medicare preventive screening service. Clinician F determines that a Pap smear is indicated. The patient's problems (eg, hypertension, HRT, and osteoporosis) are addressed.

Clinician F Billing-CPT	Diagnoses	Diagnosis Description
9921X-25 G0101 Q0091	I10 M81.0 Z79.890 Z01.419 Z12.4	Hypertension Osteoporosis without current fracture HRT Encounter for routine gynecologic exam without abnormal finding Encounter for screening for malignant neoplasm of the cervix
Billing Rationale:	Medicare does not pay for the standard preventive medicine service codes. Instead, a series of specific HCPCS codes is used to report these services. These services are payable every two years unless the patient meets defined high-risk standards. If the patient meets those standards, appropriate diagnoses must be used to reflect the patient's status.	

Screening for Human Immunodeficiency Virus Infection

Clinical Recommendations: The Women's Preventive Services Initiative (WPSI) recommends all adolescent and adult women, ages 15 and older, receive a screening test for human immunodeficiency virus (HIV) at least once during their lifetime. Earlier or additional screening should be based on risk, and rescreening annually or more often may be appropriate beginning at age 13 for adolescent and adult women with an increased risk of HIV infection.

The WPSI recommends risk assessment and prevention education for HIV infection beginning at age 13 and continuing as determined by risk.

A screening test for HIV is recommended for all pregnant women upon initiation of prenatal care with rescreening during pregnancy based on risk factors. Rapid HIV testing is recommended for pregnant women who present in labor with an undocumented HIV status.

Implementation Considerations: The WPSI recommends, as a preventive service for women, prevention education and risk assessment for HIV infection in adolescent and adult women at least annually throughout the life span. Clinicians should consider the cultural and linguistic needs of patients, and prevention education should be respectful, affirming, and non-stigmatizing.

This recommendation refers to routine HIV screening tests, which are different from incident-based or exposure-based HIV tests. More frequent testing 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. 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; patient or patient's sex partner(s) having more than one sex partner since last HIV test; 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 now or in the past; and having other sexually transmitted infections (STIs).

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

Additional recommendations about STI prevention education, counseling, and testing, along with recommendations about HIV preexposure prophylaxis (PrEP) are provided in the WPSI **Sexually Transmitted Infection (STI) Counseling** recommendation, the **Recommendations for Well-Woman Care: A Well-Woman Chart**, and the **Clinical Summary Tables**.

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:

G0432	Infectious agent antibody detection by enzyme immunoassay (EIA) technique, HIV-1 and/or HIV-2, screening
G0433	Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening
G0435	Infectious agent antibody detection by rapid antibody test, HIV-1 and/or HIV-2 screening.
G0475	HIV antigen/antibody, combination assay, screening
80081	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 at: **https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#HIV**

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 **O09.89**-), in addition to the appropriate **Z11.4** as primary and **Z34.0**-, **Z34.8,**- or **O09.89**- - as appropriate).

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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	
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
Encounter for HIV pre-exposure prophylaxis	Z29.13
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

Counseling for Sexually Transmitted Infections

Clinical Recommendations: The Women's Preventive Services Initiative recommends behavioral counseling by a health care clinician 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 clinicians review a woman's sexual history and risk factors to identify those at increased risk for STIs. Risk factors include, but are not limited to, age younger than 25 years, 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 those without identified risk factors, counseling to reduce the risk of STIs should be considered on an individual basis as determined by clinical judgment.

Implementation Considerations: The Women's Preventive Services Initiative recommends as a preventive service for adolescent and adult women at increased risk for STIs, behavioral counseling that includes, but is not limited to, counseling sessions with adequate contact time (effectiveness is greatest with high- contact interventions), and may include multiple counseling sessions, group sessions, in-person and tech-based encounters, and educational and behavioral change components using motivational interviewing techniques and goal setting.

The Women's Preventive Services Initiative recommends as a preventive service, STI counseling regardless of whether STI screening takes place during the same visit and regardless of the type of sexual activity or gender of sexual partner(s). Counseling may occur annually, or more frequently based on individual risk factors. Intensity of counseling may be individualized based on risk factors. Preventive counseling may be considered in women without identified risk factors. Clinicians should consider the cultural and linguistic needs of individual patients and maintain their privacy and confidentiality. Counseling should be respectful, affirming, and non- stigmatizing.

Additional recommendations about Human Immunodeficiency Virus (**HIV**) risk assessment, counseling, and testing, are provided in the WPSI HIV recommendation, the **Recommendations for Well-Woman Care: A Well-Woman Chart**, and the **Clinical Summary Tables**.

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 consists 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 clinician and provided by a Medicare eligible primary care clinician 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, Z11.4, Z11.59, Z11.6, Z11.8, 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, O09.890, O09.891, O09.892, and **O09.893**

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.

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 the provision of all recommended preventive services. The primary purpose of well-woman visits is the delivery and coordination of recommended preventive services as determined by age and risk factors. These services may be completed at a single visit or as part of a series of visits that take place over time to obtain all necessary services depending on a woman's age, health status, reproductive health needs, pregnancy status, and risk factors. Well-women visits also include prepregnancy, prenatal, postpartum and interpregnancy visits.

Implementation Considerations: 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, prepregnancy care, and many services necessary for prenatal, postpartum and interpregnancy care. Visits should allow sufficient time to address and coordinate services, and a team-based approach may facilitate delivery of services. 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, and immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Recommended services for adolescents also include evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration, and for women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

*The **Recommendations for Well-Woman Care – A Well-Woman Chart*** provides a framework for incorporating preventive health services for women into clinical practice.

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 (**99384-99397**). 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:

G0438	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit
G0439	Annual wellness visit, includes a personalized PPS, subsequent visit
G0468	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
99497	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
99498	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 **G0438** (first AWV)
- Annually for **G0439** (subsequent AWV) and **G0468** (AWV in FQHC)
- Annually for optional **99497, 99498**

Medicare Beneficiary Pays

G0438 and **G0439:**

- Copayment/coinsurance waived
- Deductible waived

G0468:

- 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 AWV

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

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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/**
Clinician Resources: **https://medicaid.alabama.gov/content/7.0_Providers/**

Alaska – **https://health.alaska.gov/en/division-of-public-assistance/**

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

Arizona – **https://www.azahcccs.gov/**
Clinician Resources: **https://www.azahcccs.gov/PlansProviders/GuidesManualsPolicies/index.html**

Arkansas – **https://humanservices.arkansas.gov/**
Clinician Resources: **https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers**

California – **https://www.dhcs.ca.gov/services/medi-cal**
Clinician Resources: **https://www.medi-cal.ca.gov/**

Colorado – **https://www.healthfirstcolorado.com/**
Clinician Resources: **https://www.colorado.gov/pacific/hcpf/provider-resources**

Connecticut – **https://portal.ct.gov/HUSKY**
Clinician Resources: **https://www.huskyhealthct.org/providers.html?hhNav=|#**

Delaware – **https://dhss.delaware.gov/dhss/dmma/**
Clinician Resources: **https://medicaid.dhss.delaware.gov/provider/Home/tabid/135/Default.aspx**

District of Columbia – **https://www.dc-medicaid.com/dcwebportal/home**
Clinician Resources: **https://www.dc-medicaid.com/dcwebportal/providerSpecificInformation/providerInformation**

APPENDIX B — MEDICAID

Florida – **https://ahca.myflorida.com/Medicaid/index.shtml**
Clinician Resources: **https://ahca.myflorida.com/Medicaid/Operations/assistance/providers.shtml**

Georgia – **https://medicaid.georgia.gov/**
Clinician Resources: **https://dch.georgia.gov/providers**

Guam – **https://dphss.guam.gov/**

Hawaii – **https://medquest.hawaii.gov/**
Clinician 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**
Clinician Resources: **https://healthandwelfare.idaho.gov/Providers/tabid/284/Default.aspx**

Illinois – **https://www.illinois.gov/hfs/Pages/default.aspx**
Clinician Resources: **https://www.illinois.gov/hfs/MedicalProviders/Pages/default.aspx**

Indiana – **https://www.in.gov/medicaid/**
Clinician Resources: **https://www.in.gov/medicaid/providers/index.html**

Iowa – **https://hhs.iowa.gov/programs/welcome-iowa-medicaid**
Clinician Resources: **https://hhs.iowa.gov/about/policy-manuals/medicaid-provider**

Kansas – **https://www.kancare.ks.gov/**
Clinician Resources: **https://www.kancare.ks.gov/providers**

Kentucky – **https://chfs.ky.gov/agencies/dms/Pages/default.aspx**
Clinician Resources: **https://chfs.ky.gov/agencies/dms/provider/Pages/default.aspx**

Louisiana – **http://ldh.la.gov/index.cfm/subhome/1**
Clinician Resources: **https://www.lamedicaid.com/Provweb1/ProviderTools.htm**

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

Maryland – **https://mmcp.health.maryland.gov/Pages/home.aspx**
Clinician Resources: **https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx**

Massachusetts – **https://www.mass.gov/topics/masshealth**
Clinician Resources: **https://www.mass.gov/topics/information-for-masshealth-providers**

Michigan – **www.michigan.gov/medicaid**
Clinician Resources: **www.michigan.gov/medicaidproviders**

Minnesota – **https://mn.gov/dhs/medicaid-matters/**

Clinician Resources: **https://mn.gov/dhs/partners-and-providers/**

Mississippi – **https://medicaid.ms.gov/**
Clinician Resources: **https://medicaid.ms.gov/providers/**

Missouri – **https://mydss.mo.gov/healthcare**
Clinician Resources: **https://mydss.mo.gov/pe-resources-for-providers**

Montana – **https://dphhs.mt.gov/montanahealthcareprograms/memberservices**
Clinician Information: **https://medicaidprovider.mt.gov/**

Nebraska – **http://dhhs.ne.gov/pages/accessnebraska.aspx**
Clinician Resources: **http://dhhs.ne.gov/Pages/Medicaid-Providers.aspx**

Nevada – **https://www.medicaid.nv.gov/**
Clinician Resources: **https://www.medicaid.nv.gov/providers/BillingInfo.aspx**

New Hampshire – **https://www.dhhs.nh.gov/ombp/medicaid/**
Clinician Resources: **https://www.dhhs.nh.gov/programs-services/medicaid/medicaid-provider-relations**

New Jersey – **https://www.state.nj.us/humanservices/dmahs/clients/medicaid/**
Clinician Resources: **https://www.state.nj.us/humanservices/dmahs/info/**

New Mexico – **https://nmmedicaid.portal.conduent.com/static/index.htm**
Clinician Resources: **https://nmmedicaid.portal.conduent.com/static/ProviderInformation.htm#**

New York – **https://www.health.ny.gov/health_care/medicaid/**

North Carolina – **https://medicaid.ncdhhs.gov/medicaid**
Clinician Resources: **https://medicaid.ncdhhs.gov/providers**

North Dakota – **http://www.nd.gov/dhs/services/medicalserv/medicaid/**
Clinician Resources: **https://www.hhs.nd.gov/healthcare/medicaid/provider/manuals-and-guidelines**

Northern Marianas Islands – **http://medicaid.cnmi.mp/**
Clinician Resources: **http://medicaid.cnmi.mp/index.php/provider-information-and-updates**

Ohio – **https://medicaid.ohio.gov/**
Clinician Resources: **https://medicaid.ohio.gov/provider**

Oklahoma – **http://www.okhca.org/**
Clinician Resources: **https://oklahoma.gov/ohca/providers.html**

Oregon – **https://www.oregon.gov/oha/HSD/OHP/Pages/index.aspx**
Clinician 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#**
Clinician Resources: **https://www.dhs.pa.gov/providers/Pages/default.aspx**

Puerto Rico – **https://medicaid.pr.gov/default.aspx**
Clinician Resources: **https://www.medicaid.pr.gov/Home/ProviderEnrollmentPortal/**

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

South Carolina – **https://www.scdhhs.gov/**
Clinician Resources: **https://www.scdhhs.gov/provider**

South Dakota – **https://dss.sd.gov/medicaid/**
Clinician Resources: **https://dss.sd.gov/medicaid/providers/**

Tennessee – **https://www.tn.gov/content/tn/tenncare.html**
Clinician Resources: **https://www.tn.gov/tenncare/providers.html**

Texas – **https://hhs.texas.gov/services/health/medicaid-chip**
Clinician Resources: **https://www.hhs.texas.gov/providers/health-services-providers**

Utah – **https://medicaid.utah.gov/**
Clinician Resources: **https://medicaid.utah.gov/health-care-providers/**

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

Virginia – **https://www.dmas.virginia.gov/**
Clinician Resources: **https://www.dmas.virginia.gov/for-providers**

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

Washington – **https://www.hca.wa.gov/health-care-services-supports/apple-health-medicaid-coverage**
Clinician Resources: **https://www.hca.wa.gov/billers-providers-partners**

West Virginia – **https://dhhr.wv.gov/bms/Pages/default.aspx**
Clinician Resources: **https://dhhr.wv.gov/bms/Provider/Pages/default.aspx**

Wisconsin – **https://www.dhs.wisconsin.gov/medicaid/index.htm**
Clinician Resources: **https://www.dhs.wisconsin.gov/partners-providers.htm**

Wyoming – **https://health.wyo.gov/healthcarefin/medicaid/**
Clinician Resources: **https://health.wyo.gov/healthcarefin/medicaid/for-healthcare-providers/**

Appendix C — Coding/Billing for Preventive Telemedicine Services in the Post-Pandemic Era

Prior to the COVID-19 pandemic, telemedicine was an available, but rarely used, method to provide health care to patients. Previously, telemedicine services generally had to be initiated in specialized health care settings, using highly technical equipment, and the patient had to be located in a designated Health Professional Shortage Area (HPSA), which essentially ruled out its usage in any sort of metropolitan area.

The onset of the pandemic dramatically changed the delivery of care through telemedicine services. The Centers of Medicare and Medicaid Services (CMS) and all commercial insurers modified their telemedicine policies to ease most of the restrictions that previously existed. This included allowing the usage of technology that was previously unacceptable and even licensure restrictions were modified or completely removed.

The widespread use of telemedicine was critical during the pandemic as it allowed patients to obtain needed medical care with reduced risk to both the patient and the clinician. Its convenience was very popular for patients, who no longer had to wait long periods of time to obtain an in-person appointment.

Now that the pandemic is over, what does this mean for the use of telemedicine services? To this point, it appears that telemedicine is here to stay, with most payers retaining most of their pandemic policies for telemedicine. The biggest change is that most states have reinstituted licensing restrictions for telemedicine services, which require the clinician to be located in the same state as the patient (or in some cases, an immediately adjacent state).

Unfortunately, there is no universal set of guidelines or billing instructions that are applicable in every location. Protocols vary widely from payer to payer. Therefore, we recommend that you check with your payers and legal counsel to ensure that you are following your local governmental and payer requirements.

However, we can provide general principles concerning telemedicine service billing and coding, which will follow here.

PLACE OF SERVICE

Every healthcare claim must be assigned with a place of service (POS). During the pandemic, many payers instructed clinicians to report the POS for telemedicine services as the POS that would have ordinarily been reported, had the pandemic not occurred. In most cases, that was POS 11 (Office).

Other payers instructed clinicians to report the standard telemedicine POS codes. Prior to 2022, the only available telemedicine POS was 02. On January 1, 2022, the existing telemedicine code description was revised, and an additional telemedicine POS code was created. The new definitions are as follows:

POS Code	Place of Service Name	Place of Service Description
02	Telehealth Provided Other than in Patient's Home	The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health-related services through telecommunication technology.
10	Telehealth Provided in Patient's Home	The location where health services and health related services are provided or received, through telecommunication technology. Patient is located in their home which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health-related services through telecommunication technology.

The place of service reported should be consistent with the requirements of the individual third-party payer.

MODIFIERS

The primary method of distinguishing that a service was delivered via telemedicine was through a service modifier. The most common modifiers used to designate telemedicine services are:

Modifier	Modifier Description
95	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System
93	Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System
GT	Telehealth delivered via interactive audio and video telecommunication system. This modifier is used primarily in connection with Medicare claims, although other payers (including Medicaid programs) may also require this modifier. Those that require this modifier typically do not accept the 95 modifier.

CHANGES IN 2025

In the 2025 edition of the CPT code book, an entirely new set of codes were created explicitly to report different forms of telemedicine services. The new codes follow the same pattern for code selection as do the corresponding in-person Evaluation and Management (E/M) codes.

	New E/M	New Audio/Video	New Audio only
Straightforward	99202	98000	98008
Low	99203	98001	98009
Moderate	99204	98002	98010
High	99205	98003	98011

	Established E/M	Established Audio/Video	Established Audio only
Straightforward	99212	98004	98012
Low	99213	98005	98013
Moderate	99214	98006	98014
High	99215	98007	98015

For example, the coding and documentation requirements for CPT codes 98001 and 98009 are identical to those of 99203. The only variance is that for audio only codes (98008-98015), at least 10 minutes of the service must involve a medical discussion with the patient—even if Medical Decision Making (MDM) is used to select the level of service. That requirement does not exist for audio/video services.

Also, in 2025, CPT created a new code 98016 Brief communication technology-based service, which is used to report either audio only or audio/video services that last 5-10 minutes. This new code replaces the previous Medicare "check-in" code G2012 but otherwise follows all of the prior requirements for that code.

USING THESE CODES

- Medicare has indicated that they will not accept the new codes (98000-98015), and all previous guidelines remain in effect, including the required use of office-based E/M codes with the GT modifier.
- Some commercial payers and Medicaid plans have adopted the new telemedicine codes, while many others have not. Providers need to check with each of their payers to determine exactly what codes you need to use for patients with coverage under their plans.

REIMBURSEMENT FOR THE NEW CODES

Although some payers modified payment amounts for telemedicine services, during the pandemic (and beyond) most payers reimbursed for telemedicine services at the same rate/level as for in-person services. This was in spite of the fact that telemedicine services objectively cost less to provide than in-person services because telemedicine services do not require front desk staff members, do not have supply expenses, do not require a lobby or other overhead expenses, etc.

Part of the reason for the new telemedicine codes is to differentiate between in-person and telemedicine services, which allows payers to reimburse more easily commensurate with the cost of providing the service. In general, the work Relative Value Units (RVUs) for these new codes are equal or relatively equal to in-person E/M codes, regardless of how the service is provided. However, the total RVUs (which includes practice expense) are less for audio/video services compared to in-person services, and even less for audio-only services.

CODING ADVICE

- Check with your payers to determine exactly how they want telemedicine services to be reported—standard E/M services or new telemedicine codes? Then submit services using the desired coding method.
- Identify the POS that the payer wants for telemedicine services—11, 02, or 10 (or something else?)
- Watch payment levels for telemedicine services, regardless of which approach the payer mandates, to ensure that appropriate reimbursement is being received.

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