mln BOOKLET

KNOWLEDGE • RESOURCES • TRAINING

Screening Pap Tests & Pelvic Exams

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What's Changed?

We added 3 ICD-10 diagnosis codes: Z92.850, Z92.858, and Z92.86 (page 8).

You'll find substantive content updates in dark red font.

Important female preventive health care includes screening Pap tests and pelvic exams:

- A **screening Pap test (called a Pap smear)** is a lab test used to detect early cervical cancer. A health care provider takes a cervical cell sample and interprets the test results.
- A **screening pelvic exam** helps detect precancers, genital cancers, infections, Sexually Transmitted Infections (STIs), reproductive system abnormalities, and other genital and vaginal problems.

Note: **Human Papillomavirus (HPV) screening** is also a preventive service. The test detects the virus that causes cervical cancer and or warts. Sections 210.2 and 210.2.1 of Medicare National Coverage Determinations Manual, Chapter 1, Part 4 has more information.

Together we can advance health equity and help eliminate health disparities for all minority and underserved groups. Find resources and more from the CMS Office of Minority Health:

- Health Equity Technical Assistance Program
- Disparities Impact Statement

Female Preventive Screenings

We cover Pap smears, pelvic exams, STI, and HPV screenings. They're similar services, but separate benefits.

Coverage Information

Medicare Part B covers all female patient screening Pap tests and pelvic exams (including clinical breast exams) when ordered and performed by 1 of these medical professionals authorized under state law:

- Doctor of medicine or osteopathy
- Certified nurse-midwife
- Physician assistant
- Nurse practitioner
- Clinical nurse specialist

Part B covers an HPV screening with a Pap test once every 5 years for all female patients ages 30–65.

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Coverage Frequency

Table 1 describes how often Part B covers screening Pap tests, pelvic exams, and HPV screening.

Table 1. Medicare-Covered Screening Pap Tests, Pelvic Exams, & HPV Screening

How Often	Covered for	Additional Information
Every 24 months (at least 23 months after the most recent screening Pap test or pelvic exam)	**Any** asymptomatic female patient	N/A
Annually (at least 11 months after the most recent screening Pap test or pelvic exam)	A female patient who meets **1** of these criteria: • Evidence (based on her medical history or other findings) that she's at high risk for developing cervical or vaginal cancer **and** her physician (or authorized practitioner) recommends she have the test more frequently than every 2 years • Woman of childbearing age* who had a screening pelvic exam or Pap test during any of the previous 3 years indicating the presence of cervical or vaginal cancer or other abnormality	**High risk** factors for cervical and vaginal cancer are: • Early onset of sexual activity (under 16 years old) • Multiple sexual partners (5 or more in a lifetime) • History of STI (including Human Immunodeficiency Virus [HIV] infection) • Fewer than 3 negative Pap tests or no Pap tests within the previous 7 years • Diethylstilbestrol (DES) — exposed daughters of women who took DES during pregnancy
HPV Screening: Once every 5 years (at least 4 years and 11 months [59 months total] after the most recent HPV screening)	Any asymptomatic female patient ages 30–65 years when done with a Pap test	Refer to Cervical Cancer Screening with HPV Test service in the Medicare Preventive Services educational tool

* Premenopausal woman of childbearing age and a physician or qualified practitioner determines childbearing age based on medical history or other findings.

Coinsurance or Copayment & Deductible

We waive pap test, pelvic exam, and HPV screening coinsurance or copayment and Part B deductible if the service meets all coverage conditions. However, a charge could apply if the patient sees a non-participating provider.

Documentation

Medical records must document all coverage requirements.

Coding & Diagnosis Information

Procedure Codes & Descriptors

You can perform a screening Pap test and pelvic exam during the same patient encounter. You can also perform an HPV screening during the same encounter on any asymptomatic female patient ages 30–65 at the same time you provide a Pap test. When this happens, report both HCPCS procedure codes as separate claim line items.

Table 2. Screening Pap & HPV Tests HCPCS Codes

HCPCS Code	Code Descriptor
G0123	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision
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
G0476	Infectious agent detection by nucleic acid (dna or rna); human papillomavirus (hpv), high-risk types (e.g., 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68) for cervical cancer screening, must be performed in addition to pap test
P3000	Screening papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision

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Table 3. Physician's Interpretation: Screening Pap Tests HCPCS Codes

HCPCS Code	Code Descriptor
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
P3001	Screening papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician

Table 4. Lab Specimen: Screening Pap Test HCPCS Code

HCPCS Code	Code Descriptor
Q0091	Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory **Note:** You may collect another specimen when a previously collected Pap smear screening specimen sent to the clinical lab proves unsatisfactory and the lab can't interpret the test results. To bill this re-test, annotate the claim using HCPCS code Q0091 and modifier –76 (repeat procedure or service by same physician or other qualified health care professional).

Table 5. Screening Pelvic Exam HCPCS Code

HCPCS Code	Code Descriptor
G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination

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Diagnosis Codes & Descriptors

Report 1 of the Pap tests, pelvic exams, and HPV ICD-10-CM screening diagnosis codes listed in Table 6. Use the appropriate code to indicate the patient's low- or high-risk status.

Table 6. Screening Pap Tests & Pelvic Exams Diagnosis Codes

Risk Level	ICD-10-CM Diagnosis Code	Code Descriptor
Low	Z01.411	Encounter for gynecological examination (general) (routine) with abnormal findings [Use additional code(s) to identify abnormal findings]
Low	Z01.419	Encounter for gynecological examination (general) (routine) without abnormal findings
Low	Z11.51	Encounter for screening for HPV (primary)
Low	Z12.4	Encounter for screening for malignant neoplasm of cervix
Low	Z12.72	Encounter for screening for malignant neoplasm of vagina
Low	Z12.79	Encounter for screening for malignant neoplasm of other genitourinary organs
Low	Z12.89	Encounter for screening for malignant neoplasm of other sites
High	Z72.51	High risk heterosexual behavior
High	Z72.52	High risk homosexual behavior
High	Z72.53	High risk bisexual behavior
High	Z77.29	Contact with and (suspected) exposure to other hazardous substances
High	Z77.9	Other contact with and (suspected) exposures hazardous to health
High	Z91.89	Other specified personal risk factors, not elsewhere classified
High	Z92.89	Personal history of other medical treatment
High	Z92.850	Personal history of Chimeric Antigen Receptor T-cell therapy
High	Z92.858	Personal history of other cellular therapy
High	Z92.86	Personal history of gene therapy

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Billing Requirements

Professional Claims

Report the appropriate HCPCS code and corresponding ICD-10-CM diagnosis code when submiting professional claims. Include Place of Service (POS) codes on all professional claims to indicate where you provided the service.

Institutional Claims

Report the appropriate HCPCS code, Types of Bill (TOB), revenue code, and the corresponding ICD-10-CM diagnosis code when submitting institutional claims.

Type of Bills for Institutional Claims

Submit the claim with the appropriate TOB and associated revenue code listed in Table 7.

Table 7. Screening Pap Tests & Pelvic Exams Facility Types, TOBs, & Revenue Codes

Facility Type	TOB	Pap Test Revenue Code	Pelvic Exam Revenue Code
Hospital Inpatient (Part B)	12X	0311	0770
Hospital Outpatient	13X	0311	0770
Hospital Other Part B (Non-Patient Laboratory Specimens, including Critical Access Hospital [CAH])*	14X	0311	N/A
Skilled Nursing Facility (SNF) Inpatient Part B	22X	0311	0770
SNF Outpatient	23X	0311	0770
Rural Health Clinic (RHC)	71X or 73X	052X	052X
Federally Qualified Health Center (FQHC)	77X	052X	052X
CAH**	85X	0311, 096X, 097X, or 098X	0770

* We don’t require your CAH patients be physically present when you collect the specimen, but they must be a CAH outpatient. Patients must get CAH outpatient services on the same day you or a CAH employee collect the specimen, or a CAH provider-based entity must collect the specimen.

** CAHs electing Method II report services under revenue codes 096X, 097X, or 098X.

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Payment Information

Professional Claims

We pay screening Pap tests and HPV screening under the Clinical Laboratory Fee Schedule (CLFS), and screening pelvic exams under Medicare's Physician Fee Schedule (PFS).

Like other Medicare PFS services, the non-participating provider reduction and limiting charge provisions apply to all screening Pap test and pelvic exam services.

Institutional Claims

Screening Pap test or pelvic exam payment depends on the facility type providing the service. Except RHCs, FQHCs, and CAHs, we pay HCPCS codes G0123, G0143, G0144, G0145, G0147, G0148, G0476, and P3000 under the CLFS. Table 8 lists the other payment types depending on setting.

Table 8. Screening Pap Tests & Pelvic Exams Facility Payment Methods

Facility Type	Pap & HPV Tests Payment System	Pelvic Exams Payment System
Hospital Inpatient (Part B)*	Outpatient Prospective Payment System (OPPS) HCPCS code Q0091	OPPS
Hospital Outpatient*	OPPS HCPCS code Q0091	OPPS
Hospital Other Part B (Nonpatient Lab Specimens, including CAH)*	OPPS HCPCS code Q0091	N/A
SNF Inpatient Part B**	Medicare PFS HCPCS code Q0091	Medicare PFS
SNF Outpatient	Medicare PFS HCPCS code Q0091	Medicare PFS
RHC	Part of the All-Inclusive Rate (AIR) payment	Part of AIR payment
FQHC	FQHC Prospective Payment System (PPS)	FQHC PPS

Table 8. Screening Pap Tests & Pelvic Exams Facility Payment Methods (cont.)

Facility Type	Pap & HPV Tests Payment System	Pelvic Exams Payment System
CAH	Method I: 101% of reasonable technical component(s) services cost Method II: 101% of reasonable technical component(s) services cost for, plus 115% of Medicare PFS professional component(s) services non-facility rate	Method I: 101% of reasonable cost technical component(s) services Method II: 101% of reasonable technical component(s) services, plus 115% of Medicare PFS professional component(s) services non-facility rate

* We pay Maryland inpatient or outpatient hospital services according to the Maryland State Cost Containment Plan.

** The SNF Consolidated Billing provision allows separate Medicare Part B screening Pap tests, pelvic exams, and HPV screenings payment for patients in a skilled Part A stay; however, the SNF must submit these services on TOB 22X. The SNF must pay the screening Pap tests and pelvic exams other facility types provide for patients in a skilled Part A stay.

Claim Denial Reasons

We may deny screening Pap tests, pelvic exams, and HPV screenings in several situations, including:

- Patient (not high risk) got a covered screening within the past 2 years
- Patient (high risk) got a covered screening within the past year
- Patient (high risk) got a covered HPV screening within the past 5 years (at least 4 years and 11 months [59 months total] after the most recent HPV screening)

You may find specific payment decision information on the Remittance Advice (RA). The RA gives additional payment adjustment codes information. For more claims information, find your MAC's website.

Remittance Advice Information

Health Care Payment and Remittance Advice has more information.

Resources

- CMS Beneficiary Notices Initiative (BNI)
- How to Use the MPFS Look-Up Tool
- National Cancer Institute: Cervical Cancer Information for Health Professionals
- Section 280.4 of Medicare Benefit Policy Manual, Chapter 15 (Screening Pap Smears)
- Sections 30 and 40 of Medicare Claims Processing Manual, Chapter 18, (Screening Pap Smears and Screening Pelvic Exams)
- United States Preventive Services Task Force (USPSTF) Screening for Cervical Cancer Recommendations

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