Medicare Hospital Manual

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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CHANGE REQUEST 2586

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
437.1 – 437.1 (Cont.)	4-265 – 4-268a (5 pp.)	4-265 - 4-268 (4 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: July 1, 2003*
IMPLEMENTATION DATE: July 1, 2003

Section 437.1, Screening Pap Smears and Screening Pelvic Examinations, is being updated to include code Q0091 for the billing of screening Pap smears which was inadvertently left out of prior instructions. It also lists appropriate payment for this code and appropriate revenue code. Definitions for the other allowable HCPCS codes are being updated for definition clarification.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

437.1 Screening Pap Smears and Screening Pelvic Examinations.--

A. Screening Pap Smear.--Effective January 1, 1998, §4102 of the Balanced Budget Act (BBA) of 1997 (P.L. 105-33) amended §1861 (nn) of the Social Security Act (the Act) (42 USC 1395X(nn) to include coverage every 3 years for a screening Pap smear or more frequent coverage for women (1) at high risk for cervical or vaginal cancer, or (2) of childbearing age who have had a Pap smear during any of the preceding 3 years indicating the presence of cervical or vaginal cancer or other abnormality. Effective July 1, 2001, the Consolidated Appropriations Act of 2001 (P.L. 106-554) modifies §1861(nn) to provide Medicare coverage for biennial screening Pap smears. Specifications for frequency limitations are defined below.

1. Coverage.--For claims with dates of service from January 1, 1998, through June 30, 2001, screening Pap smears are covered when ordered and collected by a doctor of medicine or osteopathy (as defined in §1861(r)(l) of the Act), or other authorized practitioner (e.g., a certified nurse midwife, physician assistant, nurse practitioner, or clinical nurse specialist, who is authorized under State law to perform the examination) under one of the following conditions:

o The beneficiary has not had a screening Pap smear test during the preceding 3 years (i.e., 35 months have passed following the month that the woman had the last covered Pap smear). (Use ICD-9-CM code V76.2, special screening for malignant neoplasm, cervix); or

o There is evidence (on the basis of her medical history or other findings) that she is of childbearing age and has had an examination that indicated the presence of cervical or vaginal cancer or other abnormalities during any of the preceding 3 years; or that she is at high risk of developing cervical or vaginal cancer (use ICD-9-CM code V15.89, other specified personal history presenting hazards to health). The high risk factors for cervical and vaginal cancer are:

Cervical Cancer High Risk Factors:

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

Vaginal Cancer High Risk Factors:

-- DES (diethylstilbestrol) - exposed daughters of women who took DES during pregnancy.

The term “woman of childbearing age” means a woman who is premenopausal, and has been determined by a physician, or qualified practitioner, to be of childbearing age, based on her medical history or other findings. Payment is not made for a screening Pap smear for women at high risk or who qualify for coverage under the childbearing provision more frequently than once every 11 months after the month that the last screening Pap smear covered by Medicare was performed.

For claims with dates of service on or after July 1, 2001, when the beneficiary does not meet the criteria noted above for an annual screening Pap smear, pay for a screening Pap smear only after at least 23 months have passed following the month during which the beneficiary received her last covered screening Pap smear. All other coverage and payment requirements remain the same.

2. HCPCS Coding.--The following HCPCS codes are used for screening Pap smears:

o P3000--Screening papanicolaou smear, cervical or vaginal, up to three smears, by a technician under physician supervision.

o Q0091--Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory. (See item 4 below for payment of this code.)

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

o 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.

o 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.

o 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.

o G0147--Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision.

o G0148--Screening cytopathology smears, cervical or vaginal, performed by automated system with manual reevaluation.

3. Payment for Other than Code Q0091.--Screening Pap smears are paid under the clinical diagnostic laboratory fee schedule with the exception of hospital-based RHCs/FQHCs which are paid as follows:

o On an all inclusive rate for the professional component or;

o Under the clinical diagnostic laboratory fee schedule for the technical component.

Deductible and coinsurance do not apply.

4. Payment for Code Q0091.--Payment for code Q0091 is as follows:

o Hospital outpatient departments payment is made under OPPS;

o CAHs payment is made on a reasonable cost basis unless the CAH elects Method II. Payment is made under Method II as indicated in §415.22 of the Medicare Hospital Manual.

Medicare deductible is not applicable. However, coinsurance applies.

5. Billing Requirements.--The applicable bill types for screening Pap smears are 13X, 14X, and 85X. The applicable revenue code for codes P3000, G0123, G0143, G0144, G0145, G0147 and G0148 is 0311. The applicable revenue code for Q0091 is 0923. For proper reporting of revenue codes for CAHs, see §415.22.

Hospitals sometimes operate multi-purpose outpatient facilities based in the hospital, all or part of which may be certified by Medicare as an RHC/FQHC. These multi-purpose outpatient facilities bill for the professional component of the screening Pap smear under bill type 71X or 73X along with revneue code 052X and the technical component under bill type 13X, 14X, or 85X along with their outpatient provider number (not the RHC/FQHC provider number since these services are not

covered as RHC/FQHC services) and revenue code 0311 when billing their intermediary for this service.

B. Screening Pelvic Examinations.--Section 4102 of the BBA of 1997 (P.L. 105-33) amended §1861 (nn) of the Act (42 USC 1395X(nn)) to include coverage of a screening pelvic examination for all female beneficiaries, effective January 1, 1998. Effective July 1, 2001, the Consolidated Appropriations Act of 2001 (P.L. 106-554) modifies §1861(nn) to provide Medicare coverage for biennial screening pelvic examinations. Specifications for frequency limitations are defined below. A screening pelvic examination should include at least 7 of the following 11 elements:

o Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge;

o Digital rectal examination including sphincter tone, presence of hemorrhoids, and rectal masses;

Pelvic examination (with or without specimen collection for smears and culture) including:

o External genitalia (for example, general appearance, hair distribution, or lesions);

o Urethral (for example, masses, tenderness, or scarring);

o Bladder (for example, fullness, masses, or tenderness);

o Vagina (for example, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, or rectocele);

o Cervix (for example, general appearance, lesions or discharge);

o Uterus (for example, size, contour, position, mobility, tenderness, consistency, descent, or support);

o Adnexa/parametria (for example, masses, tenderness, organomegaly, or nodularity); and

o Anus and perineum.

1. Coverage.--For claims with dates of service from January 1, 1998, through June 30, 2001, Medicare Part B pays for a screening pelvic examination if it is performed by a doctor of medicine or osteopathy (as defined in §1861(r)(1) of the Act), or by a certified nurse midwife (as defined in §1861 (gg) of the Act), or a physician assistant, nurse practitioner, or clinical nurse specialist (as defined in §1861 (aa) of the Act) who is authorized under State law to perform the examination. This examination does not have to be ordered by a physician or other authorized practitioner.

Payment may be made for a screening pelvic examination performed on an asymptomatic woman only if the individual has not had a screening pelvic examination paid for by Medicare during the preceding 35 months following the month in which the last Medicare covered screening pelvic examination was performed. (Use ICD-9-CM code V76.2, special screening for malignant neoplasm, cervix, or code V76.49 for a patient who does not have a uterus or cervix.) Exceptions are as follows:

o Payment may be made for a screening pelvic examination performed more frequently than once every 35 months if the test is performed by a physician or other practitioner and there is evidence that the woman is at high risk (on the basis of her medical history or other findings)

of developing cervical cancer, or vaginal cancer. (Use ICD-9-CM code V15.89, other specified personal history presenting hazards to health). The high risk factors for cervical and vaginal cancer are:

Cervical Cancer High Risk Factors:

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

Vaginal Cancer High Risk Factors:

-- DES (diethylstilbestrol) - exposed daughters of women who took DES during pregnancy.

o Payment may also be made for a screening pelvic examination performed more frequently than once every 36 months if the examination is performed by a physician or other practitioner, for a woman of childbearing age, who has had such an examination that indicated the presence of cervical or vaginal cancer or other abnormality during any of the preceding 3 years. The term "women of childbearing age" means a woman who is premenopausal, and has been determined by a physician, or qualified practitioner, to be of childbearing age, based on her medical history or other findings. Payment is not made for a screening pelvic examination for women at high risk or who qualify for coverage under the childbearing provision more frequently than once every 11 months after the month that the last screening pelvic examination covered by Medicare was performed.

o For claims with dates of service on or after July 1, 2001, if the beneficiary does not qualify for an annual screening pelvic exam as noted above, pay for the screening pelvic exam only after at least 23 months have passed following the month during which the beneficiary received her last covered screening pelvic exam. All other coverage and payment requirements remain the same.

2. HCPCS Coding.--The following HCPCS code is used for screening pelvic examinations:

o G0101--Cervical or vaginal cancer screening pelvic and clinical breast examination.

3. Payment.--Screening pelvic examinations are paid under the outpatient prospective payment system (OPPS) with the exception of hospital-based RHCs/FQHCs which are paid as follows:

o Payment is made on an all inclusive rate for the professional component or;

o Under the OPPS for the technical component.

The Part B deductible for screening pelvic examinations is waived effective January 1, 1998. Coinsurance applies.

4. Billing Requirements.--The applicable bill types for screening pelvic examination (including breast examination) are 13X, 14X, and 85X. The applicable revenue code is 0770.

Hospitals sometimes operate multi-purpose outpatient facilities based in the hospital, all or part of which may be certified by Medicare as an RHC/FQHC. These multi-purpose outpatient facilities bill for the professional component of the screening pelvic examinations under bill type 71X or 73X along with revenue code 052X and the technical component under bill type 13X, 14X, or 85X along

with the hospital outpatient provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services) and revenue code 0770 when billing their intermediary for this service.

When a claim is received for a screening pelvic examination (including a clinical breast examination), performed on or after January 1, 1998, report special override Code 1 in field 65j "Special Action" of the CWF record to avoid application of the Part B deductible.

C. Screening Pap Smears and Screening Pelvic Examinations.--

1. CWF Edits.--CWF will edit for screening Pap smear and/or screening pelvic examination performed more frequently than allowed according to the presence of high risk factors.