Medicare Hospital Manual

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal 760 **Date: AUGUST 31, 2000**

REFER TO CHANGE REQUEST 1254

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
437.1 (Cont.) – 437.2	4-267 – 4-268 (2 pp.)	4-267 – 4-268 (2 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: January 1, 2001*
IMPLEMENTATION DATE: January 1, 2001

Section 437.1, Screening Pap Smears and Screening Pelvic Examinations, is revised to include an additional low risk diagnosis code for screening pelvic examinations. ICD-9-CM code V76.49 will be recognized by the common working file as a low risk diagnosis for women who have undergone screening pelvic examinations that do not have a uterus or cervix.

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

These instructions should be implemented within your current operating budget.

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

o Anus and perineum.

1. Coverage.--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 36 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.

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 on a reasonable cost basis. 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 (hospital outpatient, 14X (hospital other, diagnostic clinical laboratory services to "nonpatients"). The applicable revenue code is 770.

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 than once in 3 years and high risk factors are not present.

2. Medicare Summary Notices (MSN) and Explanation of Your Medicare Benefits (EOMB) Messages.--If a screening Pap smear and/or screening pelvic examination is being denied because the procedure/examination is performed more than once in 3 years and no high risk factors are present, use the following MSN or EOMB message:

"Medicare pays for screening Pap smear and/or screening pelvic examination only once every 3 years unless high risk factors are present." (MSN Message 18-17, EOMB Message 18.26.)

3. Remittance Advice Notices.--If the screening Pap smear and/or screening pelvic examination is being denied because the procedure/examination is performed more than once in 3 years and no high risk factors are present, use existing American National Standard Institute (ANSI) X12-835 claim adjustment reason code 119, "Benefit maximum for this time period has been reached" at the line level, along with line level remark code M83, "service is not covered unless the beneficiary is classified as at high risk."

437.2 Clinical Laboratory Improvement Amendments (CLIA).--CLIA of 1988 changes clinical laboratories' certification. Effective September 1, 1992, clinical laboratory services are paid only if the entity furnishing the services has been issued a CLIA number.

However, pay laboratories for a limited number of laboratory services if they have a CLIA certificate of waiver or certificate for physician-performed microscopy procedures. These laboratories are not subject to routine on-site surveys.

A. Verification Responsibilities.--You are responsible for verifying CLIA certification prior to ordering laboratory services under arrangements. The survey process validates that laboratory services are provided by approved laboratories.

B. CLIA Numbers.--Use the following CLIA positions:

o Positions 1 and 2 of the CLIA number are the State code (based on the laboratory's physical location at time of registration);

o Position 3 is an alpha letter "D"; and