Medicare Carriers Manual Part 3 - Claims Process

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

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CHANGE REQUEST 1254

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents - Chapter IV	4-4.3 - 4-4.5 (3 pp.)	4-4.3 - 4-4.4 (2 pp.)
4603.1 - 4603.6	4-433 - 4-433.4 (5 pp.)	------------

MANUALIZATION--EFFECTIVE DATE: Not Applicable

Section 4603 Screening Pap smear and Pelvic Examination, incorporates instructions previously released in Program Memorandum B-98-16 dated April 1998. This new section allows for coverage every 3 years for a screening Pap smear or more frequent coverage for women at high risk for cervical or vaginal cancer, or 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. Section 4602 also includes screening Pap smear codes that were effective after PM B-98-16 was published.

Section 4603.1, Screening Pap Smears, has been created to reflect coverage, payment and HCPCS coding policies for screening pap smears.

Section 4603.3, Billing Requirements, has been created to reflect billing requirements.

Section 4603.4, CWF Edits, has been created to reflect the CWF edits.

Section 4603.5, Medicare Summary Notices (MSN) and Explanation of Your Medicare Benefits Message (EOMB), has been created to reflect the MSNs or EOMB messages if screening pap smear OT pelvic examination is being denied.

Seciton 4603.6, Remittance Advice Notices, has been created to reflect remittance advice notices.

CLARIFICATION--EFFECTIVE DATE: January 1, 2001
IMPLEMENTATION DATE: January 1, 2001

Section 4603.2, Screening Pelvic Examination, has been revised to include an additional low risk diagnosis code for pelvic examinations. ICD-9-CM code V75.49 will be recognized by the Common Working File as a low risk diagnosis for women who have undergone pelvic exams that do not have a uterus or cervix.

These instructions should be implemented within your current operating budget.

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.

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4603. SCREENING PAP SMEAR AND PELVIC EXAMINATIONS

4603.1 Screening Pap Smear.--Section 4102 of the Balanced Budget Act of 1997 (P.L. 105-33) amends §1861(nn) of the Social Security 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.

A. Coverage and Payment--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 (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)

-- 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.

The Part B deductible for screening Pap smear and services paid for under the physician fee schedule is being waived effective January 1, 1998.

B. HCPCS Coding--The following HCPCS codes can be used for screening Pap smear:

- o Q0091--Screening Pap smear, obtaining, preparing and conveyance of cervical or vaginal smear to laboratory.

This service is paid under physician fee schedule and, therefore, the Part B deductible for this service is waived because of the specific waiver provision in the BBA legislation.

- o *P3000--Screening Papanicolaou smear, cervical or vaginal, up to three smears, by a technician under the physician supervision, and

- o P3001--Screening Papanicolaou smear, cervical or vaginal, up to three smears requiring interpretation by a physician.

These two services (codes P3000 and P3001) are paid under the clinical diagnostic laboratory fee schedule.

- o *G0123--Screening cytopathology, cervical or vaginal collected in preservation fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision.

- o G0124--Screening cytopathology, cervical or vaginal, collected n preservation fluid, automated thin layer preparation, requiring interpretation by physician.

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

- o *G0143--Screening cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation, with manual evaluate and reevaluation by cytotechnologist under physician supervision.

- o *G0144--Screening cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation, with manual evaluation and computer-assisted reevaluation by cytotechnologist under physician supervision.

- o *G0145--Screening cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation, with manual evaluation and computer-assisted reevaluation using cell selection and review 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.

NOTE: The (*) represents services paid under the lab fee schedule.

4603.2 Screening Pelvic Examination.--Section 4102 of the Balanced Budget Act of 1997 (P.L. 105-33) amends §1861(nn) of the Social Security Act (42 USC 1395x(nn)) to include coverage of a screening pelvic examination for all female beneficiaries, effective January 1, 1998. A screening pelvic examination should include at least seven of the following eleven 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 cultures) including

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

- o Urethral meatus (for example, size, location, lesions, or prolapse);

- o Urethra (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.

A. Coverage and Payment.--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 to this statement are provided below.

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)

-- 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 "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 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.

The Part B deductible for screening pelvic examinations is being waived effective January 1, 1998. Pelvic examinations will be paid under the physician fee schedule.

B. HCPCS Coding--A new HCPCS code has been established for the pelvic and clinical breast examinations. Use code G0101 (cervical or vaginal cancer screening, pelvic and clinical breast examination). This service is paid under the physician fee schedule.

C. Diagnosis Coding--There are a number of appropriate diagnosis codes that can be listed in Item 21 of the HCFA-1500 claim form for Pap smear or pelvic exam claims in addition to V76.2 **or V76.49 (for low risk patients)** and V15.89 (for high risk patients). However, one of the diagnosis codes in item 21 for low risk beneficiaries must be V76.2 **or V76.49**, and this is the diagnosis code that must be pointed to in Item 24E of the HCFA-1500. One of the diagnosis codes that must be listed in Item 21 for high risk beneficiaries is V15.89, and V15.89 is the appropriate diagnosis code that must be pointed to in Item 24E. If Pap smear or pelvic examination claims do not point to one of these specific diagnosis in Item 24E, the claim will reject in the common working file. **Periodically provider education should be done on diagnosis coding of pap or pelvic claims.**

4603.3 Billing Requirements.--A separately identifiable Evaluation and Management service and Q0091 or G0101 can be billed by the same physician on the same date of service. Modifier 25 must be utilized in these situations (see below). When this happens both procedure codes should be shown as separate line items on the claim. These services can also be performed separately on separate office visits.

- o Effective for services on or after April 1, 1999, a covered evaluation and management visit and code Q0091 may be reported by the same physician for the same date of service if the evaluation and management visit is for a separately identifiable service. In this case, the 25 modifier must be reported with the evaluation and management service and the medical records must clearly document the evaluation and management service reported.

- o Effective for services on or after January 1, 1999, a covered evaluation and management visit and code G0101 may be reported by the same physician for the same date of service if the evaluation and management visit is for a separately identifiable service. In this case, the 25 modifier must be reported with the evaluation and management service and the medical records must clearly document the evaluation and management service reported.

When you receive a claim for either a screening Pap smear or pelvic examination, performed on or after January 1, 1998, enter a deductible indicator of 1 (not subject to deductible) in field 67 of the HUBC record.

4603.4 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.

4603.5 Medicare Summary Notices (MSN) and Explanation of Your Medicare Benefits Messages (EOMB).--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, OMB Message 18.26.)

4603.6 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."