NCD:	210.2
NCD Title:	Screening Pap Smears and Pelvic Examinations for Early Detection of Cervical or Vaginal Cancer
IOM:	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf#page=106
MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=185&ncdver=3&bc=AgAAgAAAAAAA&

ICD-9-CM	ICD-9 DX Description	ICD-10 CM	ICD-10 DX Description
PAP High Risk every year			
V15.89	Other specified personal history presenting hazards to health		NA
V69.2	High-risk sexual behavior	Z72.51	High risk heterosexual behavior
V69.2	High-risk sexual behavior	Z72.52	High risk homosexual behavior
V69.2	High-risk sexual behavior	Z72.53	High risk bisexual behavior
PAP Low Risk every 2 years			
V72.31	Routine gynecological examination	Z01.411	Encounter for gynecological examination (general) (routine) with abnormal findings
V72.31	Routine gynecological examination	Z01.419	Encounter for gynecological examination (general) (routine) without abnormal findings
V76.2	Screening for malignant neoplasms of the cervix	Z12.4	Encounter for screening for malignant neoplasm of cervix
V76.47	Special screening for malignant neoplasms, vagina	Z12.72	Encounter for screening for malignant neoplasm of vagina
V76.49	Special screening for malignant neoplasms, other sites	Z12.79	Encounter for screening for malignant neoplasm of other genitourinary organs
V76.49	Special screening for malignant neoplasms, other sites	Z12.89	Encounter for screening for malignant neoplasm of other sites
Pelvic Exam			
V72.31	Routine gynecological examination	Z01.411	Encounter for gynecological examination (general) (routine) with abnormal findings
V72.31	Routine gynecological examination	Z01.419	Encounter for gynecological examination (general) (routine) without abnormal findings
V76.2	Screening for malignant neoplasms of cervix	Z12.4	Encounter for screening for malignant neoplasm of cervix
V76.47	Special screening for malignant neoplasms of vagina	Z12.72	Encounter for screening for malignant neoplasm of vagina
V764.9	Special screening for malignant neoplasms of other sites	Z12.79	Encounter for screening for malignant neoplasm of other genitourinary organs
V764.9	Special screening for malignant neoplasms of other sites	Z12.89	Encounter for screening for malignant neoplasm of other sites
V69.2	High-risk sexual behavior	Z72.51	High risk heterosexual behavior
V69.2	High-risk sexual behavior	Z72.52	High risk homosexual behavior
V69.2	High-risk sexual behavior	Z72.53	High risk bisexual behavior
V15.89	Other specified personal history presenting hazards to health		NA

ICD-9-CM	ICD-9 DX Description	ICD-10 CM	ICD-10 DX Description

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ICD-9	ICD-9 Px Description	ICD-10 PCS	ICD-10 PCS Description
N/A	N/A	N/A	N/A

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MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=185&ncdver=3&bc=AgAAgAAAAAAA&

Part A	Rule Description Part A	Proposed HCPCS/CPT Part A	Frequency Limitations	TOB (Part A)	Revenue Code Part A	Modifier Part A	Provider Specialty	Proposed MSN Message Part A	Proposed CARC Message Part A	Proposed RARC Message Part A
Part A	**A/MACs & CWF:** To be covered screening Pap smears must be 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 conditions identified in §30.1, below. 1. 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. If Pap smear claims do not point to one of the specific diagnoses in Item 24E or the electronic equivalent, the claim will reject in the CWF. CWF is currently performing and will continue to perform all frequency editing for this NCD.	P3000 G0123 G0143 G0144 G0145 G0147 G0148 Q0091	3 years passed since the last covered test.	12X 13X 22X 23X 85X	0311	N/A	N/A	18.17	119	M83 N362
Part A	**A/MACs & CWF:** 2. 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 orvaginal cancer or other abnormalitites during any of the preceding 3 years. If Pap smear claims do not point to one of the specific diagnoses in Item 24E or the electronic equivalent, the claim will reject in CWF. CWF is currently performing and will continue to perform all frequency editing for this NCD.	P3000 G0123 G0143 G0144 G0145 G0147 G0148 Q0091	1 every year for high risk and 1 every 2 years for low risk	N/A	N/A	N/A	N/A	18.17	119	M83 N362
Part A	**A/MACs & CWF:** 3. She is at high risk of developing cervical orvaginal cancerand at least 11 months have passed following the month that the last covered screening Pap smear was performed. If Pap smear claims do not point to one of the specific diagnoses in Item 24E or the electronic equivalent, the claim will reject in CWF. CWF is currently performing and will continue to perform all frequency editing for this NCD.	P3000 G0123 G0143 G0144 G0145 G0147 G0148 Q0091	1 every year	N/A	N/A	N/A	N/A	18.17	119	M83 N362

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MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=185&ncdver=3&bc=AgAAgAAAAAAA&									
Part A	**A/MACs & CWF:** If the beneficiary does not qualify for more frequent screening based on paragraphs (2) and (3) above, for services performed on or after 7/7/01, payment may be made for a screening PAP smear after 23 months have passed after the end of the month of the last covered smear. If Pap smear claims do not point to one of the specific diagnoses in Item 24E or the electronic equivalent, the claim will reject in CWF.	P3000 G0123 G0143 G0144 G0145 G0147 G0148 Q0091	1 every 2 years	N/A	N/A	N/A	N/A	18.17	119	M83 N362
Part A	The professional component of a screening Pap smear furnished within an RHC/FQHC by a physician or non physician is considered an RHC/FQHC service. See Chapter 9, for RHC/FQHC bill processing instructions.	P3000 G0123 G0143 G0144 G0145 G0147 G0148	1 every year for high risk and 1 every 2 years for low risk	71X 77X	052X	N/A	N/A	18.17	119	M83 N362
	FISS & CWF: CMS has determined that the screening pelvic/clinical breast examination, HCPCS G0101 and screening Papanicolaou smear, HCPCS Q0091, are billable visits when furnished by a RHC or FQHC practitioner to a RHC or FQHC patient. These services will be paid the AIR on RHC and FQHC claims effective for dates of service on or after 1/1/14. If other billable visits are furnished on the same DOS as G0101 or Q0091, only one visit shall be paid. G0101 or Q0091 are payable annually for women at high risk for developing cervical or vaginal cancer, and women of childbearing age who have had an abnormal Pap test within the past 3 years. It is payable every 2 years for women at normal risk. For FQHCs billing under the PPS, G0101 and Q0091 are qualifying visits when billed with FQHC payment HCPCS codes G0466 or G0467. Contractors shall add HCPCS codes G0101 & Q0091 to the list of preventive services eligible to be paid at the AIR for 71X & 77X TOBs. NOTE: Payment for G0101 & Q0091 should be effective for DOS on or after 1/1/14. Contractors shall prevent a separate payment when G0101 or Q0091 is billed on the same DOS as an encounter/visit with revenue code 052X (This does not apply to IPPE for RHC & FQHC claims and FQHC claims with DSMT, MNT or modifier 59).	G0101 Q0091	1 every year for high risk and 1 every 2 years for low risk	71X 77X	052X	N/A	N/A	16.34	97	M15

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MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=185&ncdver=3&bc=AgAAgAAAAAAA&									
Part A	**A/MACs:** If the technical component of a screening Pap smear is furnished within a provider-based RHC/FQHC, the provider of that service bills the A/MACs under TOB as appropriate using their OP provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services). Use appropriate revenue code. Effective 4/1/06 TOB 14X is for non-patient laboratory specimens. If there are no high risk factors, and the screening Pap smear and/or screening pelvic examination is being denied because the procedure/examination is performed more frequently than allowed contractors use: When an A/MAC receives a claim for a screening pelvic examination (including a clinical breast examination), performed on or after 1/1/98, it reports special override Code 1 in the Special Action Code/Override Code field of the CWF record for the line item, indicating the Part B deductible does not apply. CWF edits for screening pelvic examinations performed more frequently than allowed according to the presence of high risk factors	P3000 G0123 G0143 G0144 G0145 G0147 G0148 Q0091 or G0101	1 every year for high risk and 1 every 2 years for low risk	13X 22X 23X 85X	0311	N/A	N/A	18.17	119	M83 N362
Part A	**CWF:** will edit for claims containing HCPCS code Q0091 effective 7/1/05. Previously, the editing for Q0091 had been removed from CWF. Medicare pays for a screening Pap smear every 2 years for low-risk patients based on a low-risk dx, see sections 30.2 and 30.6. Medicare pays for a screening Pap smear every year for a high-risk patient based on the hig- risk dx, see sections 30.1 and 30.6. This criteria will be the CWF parameters for editing Q0091. In those situations where unsatisfactory screening Pap smear specimens have been collected and conveyed to clinical labs that are unable to interpret the test results, another specimen will have to be collected. When the physician bills for this reconveyance, the physician should annotate the claim with Q0091 along with modifier -76, (repeat procedure by same physician).	Q0091	1 every year for high-risk and 1 every 2 years for low-risk	N/A	N/A	76	N/A	18.17	119	M83 N362
Part A	Report the screening pap smear as a diagnostic clinical laboratory service using one of the HCPCS codes shown in §30.5.B. In addition, CAHs electing method II report professional services under revenue codes:	P3000 G0123 G0143 G0144 G0145 G0147 G0148 Q0091	1 every year for high risk and 1 every 2 years for low risk	12X 13X 22X 23X 85X	096X 097X 098X	N/A	N/A	18.17	119	M83 N362

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MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=185&ncdver=3&bc=AgAAgAAAAAAA&									
Part A	**A/MACs & CWF:** If the technical component of a screening pelvic examination is furnished within a provider-based **RHC/FQHC**, the provider of that service bills the A/MAC under TOB & OP provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services). CWF will edit for screening pelvic examinations performed more frequently than allowed according to the presence of high-risk factors.	G0101	1 every year	71X 73X	052X	N/A	N/A	18.17	119	M83 N362

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Part B	Rule Description Part B	Proposed HCPCS/CPT Part B	Frequency Limitations	POS (Part B)	n/a	Modifier Part B	Provider Specialty	Proposed MSN Message Part B	Proposed CARC Message Part B	Proposed RARC Message Part B
Part B	**B/MACs & CWF:** To be covered screening Pap smears must be ordered/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 conditions identified in §30.1, below. 1. 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. If Pap smear claims do not point to one of the specific diagnoses in Item 24E or the electronic equivalent, the claim will reject in the CWF. CWF is currently performing and will continue to perform all frequency editing for this NCD.	P3000 P3001 G0123 G0124 G0141 G0143 G0144 G0145 G0147 G0148 Q0091	3 years passed since the last covered test.	N/A	N/A	N/A	N/A	18.17	119	M83 N362
Part B	**B/MACs & CWF:** 2. There is evidence (on the basis of 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 abnormalitites during any of the preceding 3 years: If Pap smear claims do not point to one of the specific diagnoses in Item 24E or the electronic equivalent, the claim will reject in the CWF. CWF is currently performing and will continue to perform all frequency editing for this NCD.	P3000 P3001 G0123 G0124 G0141 G0143 G0144 G0145 G0147 G0148 Q0091	1 every year for high-risk and 1 every 2 years for low-risk	N/A	N/A	N/A	N/A	18.17	119	M83 N362

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NCD Title:	Screening Pap Smears and Pelvic examinations for Early Detection of Cervical or Vaginal Cancer									
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MCD:	http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=185&ncdver=3&bc=AgAAgAAAAAAA&									
Part B	**B/MACs & CWF:** 3. She is at high risk of developing cervical or vaginal cancerand at least 11 months have passed following the month that the last covered screening Pap smear was performed. If Pap smear claims do not point to one of the specific diagnoses in Item 24E or the electronic equivalent, the claim will reject in CWF.	P3000 P3001 G0123 G0124 G0141 G0143 G0144 G0145 G0147 G0148 Q0091	1 every year	N/A	N/A	N/A	N/A	18.17	119	M83 N362
Part B	**B/MACs & CWF:** If the beneficiary does not qualify for more frequent screening based on paragraphs (2) and (3) above, effective 7/101, payment may be made for a screening PAP smear after 23 months have passed after the end of the month of the last covered smear. If Pap smear claims do not point to one of the specific diagnoses in Item 24E or the electronic equivalent, the claim will reject in CWF.	P3000 P3001 G0123 G0124 G0141 G0143 G0144 G0145 G0147 G0148 Q0091	1 every 2 years	N/A	N/A	N/A	N/A	18.17	119	M83 N362
Part B	**CWF** will edit for screening pelvic examinations performed more frequently than allowed according to the presence of high-risk factors	G0101	1 every year	N/A	N/A	N/A	N/A	18.17	119	M83 N362
Part B	**B/MACs & CWF:** Payment for Q0091 is paid under the Medicare physician fee schedule. Deductible is not applicable, coinsurance applies. Effective 7/1/05, on those occasions when physicians must perform a screening Pap smear (Q0091) that they know will not be covered by Medicare because the low-risk patient has already received a covered Pap smear (Q0091) in the past 2 years, the physician can bill Q0091 and the claim will be denied appropriately. The physician shall obtain an ABN in these situations as the denial will be considered an R&N denial. Effective 4/1/99, a covered E/M visit and code Q0091 may be reported by the same physician for the same DOS if the E/M visit is for a separately identifiable service. If Pap smear claims do not point to one of the specific diagnoses in Item 24E or the electronic equivalent, the claim will reject in CWF.	Q0091	1 every 2 years	N/A	N/A	Denial - GA E/M - 25	N/A	18.17	119	M83 N362