

Medicare Carriers Manual Part 3 - Claims Process

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<u>HEADER SECTION NUMBERS</u>	<u>PAGES TO INSERT</u>	<u>PAGES TO DELETE</u>
Table of Contents - Chapter IV 4603.1 – 4603.8	4-4.3 - 4-4.4 (2 pp.) 4-433 - 4-433.4 (5 pp.)	4-4.3 - 4-4.4 (2 pp.) 4-433 - 4-433.4 (5 pp.)

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

Effective July 1, 2001, the Consolidated Appropriations Act of 2001, Public Law 106-554 (enacted on December 21, 2000) changes the frequency limitations from 3 to 2 years for screening Pap smears and screening pelvic examinations performed on qualified female beneficiaries. These manual sections are revised to reflect the new frequency limitation.

Section 4603.1, Screening Pap Smear Coverage and Payment Requirements, notes the new frequency limitation and revises related information to comply with the new frequency limitation.

Section 4603.2, Screening Pelvic Examination Coverage and Payment Requirements, notes the new frequency limitation and revises related information to comply with the new frequency limitation.

Section 4603.3, Diagnosis Coding, is revised to be given its own section number; the content remains unchanged.

Section 4603.4, Billing Requirements, has been renumbered to coincide with other changes; the content remains unchanged.

Section 4603.5, Calculating Frequency Limitations, is added to explain the methodology for calculating frequency limitations associated with these benefits.

Section 4603.6, CWF Edits, broadens the description of frequency limitation to encompass all frequency limitations associated with these benefits.

Section 4603.7, Medicare Summary Notices (MSNs) and Explanations of Your Part B Medicare Benefits (EOMBs), adds a frequency limitation reference of 2 years and changes related references accordingly.

Section 4603.8, Remittance Advice Notices, changes the reference to frequency limitations.

Inform providers of coding, payment, and claims submission requirements by posting that information on your web site as soon as possible and publishing it in your next regularly scheduled bulletin.

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 previously 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 Coverage and Payment Requirements.--Effective January 1, 1998, §1861(n) of the Social Security Act (42 USC 1395x(nn)) provides coverage for a screening Pap smear for women under certain conditions. Coverage and payment requirements follow:

A. For Claims With Dates of Service from January 1, 1998, Through June 30, 2001.--Pay for screening Pap smears 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:

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. Use ICD-9-CM code V76.2, special screening for malignant neoplasm, cervix); **or**

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 or vaginal cancer or other abnormalities during any of the preceding 3 years; **and** at least 11 months have passed following the month that the last covered Pap smear was performed; **or**

3. 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) **and** at least 11 months have passed following the month that the last covered screening Pap smear was performed. The high risk factors for cervical and vaginal cancer are:

(a) Cervical Cancer High Risk Factors:

- Early onset of sexual activity (under 16 years of age)
- Multiple sexual partners (5 or more in a lifetime)
- History of a sexually transmitted disease (including HIV infection)
- Fewer than three negative or any Pap smears within the previous 7 years

(b) Vaginal Cancer High Risk Factors:

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

NOTE: 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.

B. For Claims With Dates of Service on or After July 1, 2001.--When the beneficiary does not qualify for a more frequently performed screening Pap smear as noted in §4603.1 A. 2 and 3, pay for the 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.

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

1. Codes Paid Under the Physician Fee Schedule--

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

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

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

o G0124--Screening cytopathology, cervical or vaginal, collected in 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.

2. Codes Paid Under the Clinical Lab Fee Schedule--

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

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

o G0143--Screening cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation, with manual evaluation 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.

4603.2 Screening Pelvic Examination Coverage and Payment Requirements.--Section 1861(nn) of the Social Security Act (42 USC 1395x(nn)) provides 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 elements:

- o Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge; and
- 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);
- and
- o Adnexa/parametria (for example, masses, tenderness, organomegaly, or nodularity);
 - o Anus and perineum.

A. For Claims With Dates of Service From January 1, 1998, Through June 30, 2001, Inclusive.--Pay for screening pelvic exams when 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) as follows:

1. Once every 3 years on an asymptomatic woman; that is, only if the asymptomatic woman 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.**);

2. Once a year on a woman identified as being at high risk for developing cervical or vaginal cancer based on her medical history and other findings; (i.e., at least 11 months have passed following the month that her last covered pelvic exam was performed). The following are the high risk factors for developing cervical and vaginal cancer:

(a) 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 or any Pap smears within the previous 7 years

(b) Vaginal Cancer High Risk Factors.--

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

NOTE: Use ICD-9-CM code V15.89, other specified personal history presenting hazards to health, to indicate that one or more of these factors is present.

3. Once a year on 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. As in the preceding coverage requirement, "once a year" means that at least 11 months have passed following the month that the woman had performed her last covered pelvic examination. 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.

B. For Claims With Dates of Service on or After July 1, 2001.--When the beneficiary does not qualify for a more frequently performed screening pelvic exam noted in §4603.2 A. 2 and 3, 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.

C. HCPCS Coding.-- A 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).

NOTE: The Part B deductible for screening pelvic examinations is waived effective January 1, 1998. Pelvic examinations are paid under the physician fee schedule.

4603.3 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 diagnoses 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.**

4603.4 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.

4603.5 Calculating Frequency Limitations.--To determine the 11-, 23-, and 35-month periods, start your count beginning with the month after the month in which a previous test/procedure was performed.

EXAMPLE: A beneficiary identified as being at high risk for developing cervical cancer received a screening Pap smear in January 1998. Start your count beginning with February 1998. The beneficiary is eligible to receive another screening Pap smear in January 1999 (the month after 11 full months have passed)

4603.6 CWF Edits.--CWF will edit for screening Pap smears and/or screening pelvic examinations performed more frequently than allowed according to the presence of high risk factors.

4603.7 Medicare Summary Notices (MSNs) and Explanations of Your Part B Medicare Benefits (EOMBs).--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 use the following MSN or EOMB message:

“Medicare pays for a screening Pap smear and/or screening pelvic examination only once every (2, 3) years unless high risk factors are present.” (MSN Message 18-17, EOMB Message 18.26.)

4603.8 Remittance Advice Notices.--If high risk factors are not present, and the screening Pap smear and/or screening pelvic examination is being denied because the procedure/examination is performed more frequently than allowed, 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.”