DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network®
Official CMS Information for
Medicare Fee-For-Service Providers

Screening Pap Tests

Medicare | PREVENTIVE SERVICES

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The Centers for Medicare & Medicaid Services (CMS) recognizes the crucial role that health care providers play in educating Medicare beneficiaries about potentially life-saving preventive services and screenings, and in providing these services. While Medicare pays for a variety of preventive benefits, many Medicare beneficiaries do not fully realize that using preventive services and screenings can help them live longer, healthier lives. As a health care professional, you can help your Medicare beneficiaries understand the importance of disease prevention, early detection, and lifestyle modifications that support a healthier life. This booklet can help you communicate with your beneficiaries about Medicare-covered screening Pap tests, as well as assist you in correctly billing for these services.

Overview

The Medicare-covered screening Pap test (Pap smear) is a laboratory test that consists of a routine exfoliative cytology test (Papanicolaou test) for early detection of cervical cancer. It includes collection of a sample of cervical cells and a physician's interpretation of the test results.

Removal of Barriers to Preventive Services Under the Affordable Care Act

Medicare waives the coinsurance or copayment and deductible for those Medicare-covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B for any indication or population and that are appropriate for the individual.

Coverage Information

Medicare covers a screening Pap test for all female beneficiaries when a physician (or authorized practitioner) orders the test.

Risk Factors

For purposes of this benefit, **high risk** categories for cervical and vaginal cancer include:

- Early onset of sexual activity (under 16 years of age),
- Multiple sexual partners (five or more in a lifetime),
- History of a sexually transmitted infection (STI) (including human immunodeficiency virus [HIV] infection),
- Fewer than three negative Pap tests or no Pap tests within the previous 7 years, and
- DES (diethylstilbestrol)-exposed daughters of women who took DES during pregnancy.

Frequency

Covered Once Every 24 Months

Medicare Part B covers a screening Pap test for all asymptomatic female beneficiaries **every 24 months** (i.e., at least 23 months after the most recent screening Pap test).

Covered Once Every 12 Months

Medicare Part B covers an **annual** screening Pap test (i.e., at least 11 months after the most recent screening Pap test) for female beneficiaries who meet at least **one** of the following criteria:

- Evidence (on the basis of her medical history or other findings) that she is at high risk (high risk categories described above) for developing cervical or vaginal cancer and her physician (or authorized practitioner) recommends that she have the test more frequently than every two years,
- A woman of childbearing age who has had a pap test during any of the preceding 3 years that indicated the presence of cervical or vaginal cancer or other abnormality.

Woman of Childbearing Age

A "woman of childbearing age" is one who is premenopausal and has been determined by a physician or qualified practitioner to be of childbearing age based on the medical history or other findings.

When calculating frequency to determine the annual period, 11 months must elapse following the month in which the last screening Pap test took place. Follow the same procedure to calculate frequency for the 23-month period.

EXAMPLE: A beneficiary in a high risk category gets a screening Pap test in January 2012. The count starts February 2012. The beneficiary may get another screening Pap test in January 2013.

Coinsurance or Copayment and Deductible

The beneficiary pays nothing (no coinsurance or copayment and no Medicare Part B deductible) for the screening Pap test if the provider accepts assignment. Financial responsibilities may apply for the beneficiary if the provider does not accept assignment.

Documentation

Medical records must document that all coverage requirements are met.

Coding and Diagnosis Information

Procedure Codes and Descriptors

Use the following Healthcare Common Procedure Coding System (HCPCS) codes to report screening Pap tests.

Table 1. HCPCS Codes for Screening Pap Tests

HCPCS Code	Code Descriptor
G0123	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision
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
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
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
G0147	Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision
G0148	Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening
P3000	Screening Papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision

Use the following HCPCS codes to report the physician's interpretation of screening Pap tests.

Table 2. HCPCS Codes for Physician's Interpretation of Screening Pap Tests

HCPCS Code	Code Descriptor
G0124	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician
G0141	Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician
P3001	Screening Papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician

Use the following HCPCS code to report when the physician obtains, prepares, conveys the test, and sends the specimen to a laboratory.

Table 3. HCPCS Code for Laboratory Specimen of Screening Pap Tests

HCPCS Code	Code Descriptor
Q0091	Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory **NOTE:** In those situations where unsatisfactory screening Pap smear specimens have been collected and conveyed to clinical laboratories unable to interpret the test results, another specimen may be collected. To bill for this reconveyance, annotate the claim with HCPCS code Q0091 along with modifier -76 (repeat procedure or service by same physician or other qualified health care professional).

Diagnosis Requirements

You must report one of the following International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) screening ("V") diagnosis codes for a screening Pap test.

Coming Soon!
International Classification of Diseases, 10th Revision, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS)

For more information, visit http://www.cms.gov/Medicare/Coding/ICD10 on the CMS website.

Table 4. Diagnosis Codes for Low Risk Screening Pap Tests

Low Risk ICD-9-CM Diagnosis Code	Code Descriptor
V72.31	Routine gynecological examination **NOTE:** This diagnosis should only be used when the provider performs a full gynecological examination.
V76.2	Special screening for malignant neoplasms, cervix
V76.47	Special screening for malignant neoplasms, other sites, vagina
V76.49	Special screening for malignant neoplasms, other sites **NOTE:** Providers use this diagnosis for women without a cervix.

Table 5. Diagnosis Code for High Risk Screening Pap Tests

High Risk ICD-9-CM Diagnosis Code	Code Descriptor
V15.89	Other specified personal history presenting hazards to health, other

Billing Requirements

Billing and Coding Requirements When Submitting Professional Claims

When you submit professional claims to carriers or A/B Medicare Administrative Contractors (MACs), report the appropriate HCPCS code and the corresponding ICD-9-CM diagnosis code in the X12 837-P (Professional) electronic claim format. You must also include Place of Service (POS) codes on all professional claims, to indicate where you provided the service. For more information on POS codes, visit http://www.cms.gov/Medicare/Coding/place-of-service-codes on the CMS website.

Coding Tip

You may perform a screening Pap test and a screening pelvic examination during the same encounter. When this happens, report both procedure codes as separate line items on the claim.

NOTE: If you qualify for an exception to the Administrative Simplification Compliance Act (ASCA) requirement, you may use Form CMS-1500 to submit these claims on paper. All providers must use Form CMS-1500, version 08-05, when submitting paper claims. For more information on Form CMS-1500, visit http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/16_1500.html on the CMS website.

Electronic Claims Requirements

ASCA requires providers to submit claims to Medicare electronically, with limited exceptions. For more information about the electronic formats, visit http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/HealthCareClaims.html on the CMS website.

Billing and Coding Requirements When Submitting Institutional Claims

When you submit institutional claims to Fiscal Intermediaries (FIs) or A/B MACs, report the appropriate HCPCS code, the appropriate revenue code, and the corresponding ICD-9-CM diagnosis code in the X12 837-I (Institutional) electronic claim format.

NOTE: If an institution qualifies for an exception to the ASCA requirement, it may use Form CMS-1450 to submit these claims on paper. All providers must use Form CMS-1450 (UB-04) when submitting paper claims. For more information on Form CMS-1450, visit http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/15_1450.html on the CMS website.

Types of Bill (TOBs) for Institutional Claims

The FI or A/B MAC pays for screening Pap tests when you submit the claim on the following TOBs and associated revenue codes.

Table 6. Facility Types, TOBs, and Revenue Codes for Screening Pap Tests

Facility Type	TOB	Revenue Code
Hospital Inpatient (Part B)	12X	0311
Hospital Outpatient	13X	0311
Hospital Other Part B (Non-Patient Laboratory Specimens including Critical Access Hospital [CAH])*	14X	030X
Skilled Nursing Facility (SNF) Inpatient Part B	22X	0311
SNF Outpatient	23X	0311
Rural Health Clinic (RHC)	71X	052X
Federally Qualified Health Center (FQHC)	77X	052X
CAH	85X	0311

* A beneficiary does not have to be physically present in a CAH when the specimen is collected, but must be an outpatient of the CAH. Either the beneficiary must get outpatient services in the CAH on the same day the specimen is collected, or an employee of the CAH or an entity that is provider-based to the CAH must collect the specimen.

Additional Billing Instructions for FQHCs and RHCs

The professional component of preventive services is within the scope of covered FQHC or RHC services. The professional component is a physician's interpretation of the results of an examination. For instructions on billing the professional component, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1039.pdf on the CMS website.

The technical component is services rendered outside the scope of the physician's interpretation of the results of an examination. If you perform technical components or services, not within the scope of covered FQHC or RHC services, in association with professional components, how you bill depends on whether the FQHC or RHC is independent or provider-based:

- **For Provider-Based RHCs and FQHCs:** Bill the technical component of the service on the TOB for the base provider and submit to the FI or A/B MAC in the 837-I format. For more information on billing instructions for provider-based FQHCs or RHCs, visit http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html on the CMS website and choose the appropriate chapter based on your facility type.
- **For Independent RHCs and FQHCs:** Bill the technical component of the service to the carrier or A/B MAC in the 837-P format. For more information on billing instructions for independent FQHCs or RHCs, visit http://cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf and http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf on the CMS website.

Payment Information

Professional Claims

When you bill your carrier or A/B MAC, Medicare pays for the screening Pap test service under the Clinical Laboratory Fee Schedule or the Medicare Physician Fee Schedule (MPFS).

As with other MPFS services, the non-participating provider reduction and limiting charge provisions apply to all screening Pap test services.

Providers Must Use EFT

All providers enrolling in the Medicare Program for the first time, changing existing enrollment data, or revalidating enrollment must use Electronic Funds Transfer (EFT) to get payments. For more information about EFT, visit http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/EFT.html on the CMS website.

Institutional Claims

When you bill your FI or A/B MAC, Medicare payment for the screening Pap test depends on the type of facility providing the service. Table 7 lists the type of payment that facilities get.

Table 7. Facility Payment Methods for Screening Pap Tests

Facility Type	Basis of Payment
Hospital Inpatient (Part B)*	Clinical Laboratory Fee Schedule for HCPCS codes G0123, G0143, G0144, G0145, G0147, G0148, and P3000 Outpatient Prospective Payment System (OPPS) for HCPCS code Q0091
Hospital Outpatient*	Clinical Laboratory Fee Schedule for HCPCS codes G0123, G0143, G0144, G0145, G0147, G0148, and P3000 OPPS for HCPCS code Q0091
Hospital Other Part B (Non-Patient Laboratory Specimens including CAH)*	Clinical Laboratory Fee Schedule for HCPCS codes G0123, G0143, G0144, G0145, G0147, G0148, and P3000 OPPS for HCPCS code Q0091
SNF Inpatient Part B**	Clinical Laboratory Fee Schedule for HCPCS codes G0123, G0143, G0144, G0145, G0147, G0148, and P3000 MPFS for HCPCS code Q0091
SNF Outpatient	Clinical Laboratory Fee Schedule for HCPCS codes G0123, G0143, G0144, G0145, G0147, G0148, and P3000 MPFS for HCPCS code Q0091
RHC	All-Inclusive Payment Rate
FQHC	All-Inclusive Payment Rate
CAH	Method I: 101% of reasonable cost for technical component(s) of services Method II: 101% of reasonable cost for technical component(s) of services, plus 115% of MPFS non-facility rate for professional component(s) of services

* Medicare pays Maryland hospitals for inpatient or outpatient services according to the Maryland State Cost Containment Plan.

** The SNF consolidated billing provision allows separate Medicare Part B payment for screening Pap tests for beneficiaries in a skilled Part A stay; however, the SNF must submit these services on a 22X TOB. Screening Pap tests provided by other facility types for beneficiaries in a skilled Part A stay must be paid by the SNF.

Reasons for Claim Denial

Medicare may deny coverage of screening Pap tests in several situations, including:

- The beneficiary not at high risk got a covered screening Pap test within the past 2 years.
- The beneficiary at high risk got a covered screening Pap test within the past year.

You may find specific payment decision information on the Remittance Advice (RA). The RA includes Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide additional information on payment adjustments. For the most current listing of these codes, visit http://www.wpc-edi.com/reference on the Internet. You can obtain additional information about claims from your carrier, FI, or A/B MAC.

Medicare Contractor Contact Information

For carrier, FI, or A/B MAC contact information, visit http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Provider-Compliance-Interactive-Map on the CMS website.

RA Information

For more information about the RA, visit http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/Remittance.html on the CMS website.

Resources

For more information about screening Pap tests, refer to the resources listed in Tables 8 and 9. For educational products for Medicare Fee-For-Service health care professionals and their staff, information on coverage, coding, billing, payment, and claim filing procedures, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html on the CMS website, or scan the Quick Response (QR) code to the right with your mobile device.

Table 8. Provider Resources

Resource	Website
Clinical Laboratory Fee Schedule	http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched
CMS Beneficiary Notices Initiative (BNI)	http://www.cms.gov/Medicare/Medicare-General-Information/BNI
"CMS Electronic Mailing Lists: Keeping Medicare Fee-For-Service Providers Informed"	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MailingLists_FactSheet.pdf
"Medicare Benefit Policy Manual" Publication 100-02, Chapter 15, Section 280.4	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf
"Medicare Claims Processing Manual" – Publication 100-04, Chapter 18, Section 30	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf
Medicare Learning Network® (MLN) Guided Pathways to Medicare Resources	The MLN Educational Web Guides MLN Guided Pathways to Medicare Resources help providers gain knowledge on resources and products related to Medicare and the CMS website. For more information about preventive services, refer to the "Coverage of Preventive Services" section in the "MLN Guided Pathways to Medicare Resources – Basic Curriculum for Health Care Professionals, Suppliers, and Providers" booklet at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Basic_Booklet.pdf on the CMS website. For all other "Guided Pathways" resources, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Guided_Pathways.html on the CMS website.
"Medicare National Coverage Determinations Manual" – Publication 100-03, Chapter 1, Part 4, Section 210.2	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf
Medicare Preventive Services General Information	http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo
MLN Matters® Articles Related to Medicare-covered Preventive Benefits	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNPrevArticles.pdf

Table 8. Provider Resources (cont.)

Resource	Website
MPFS	http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched
National Cancer Institute Cervical Cancer Information	http://www.cancer.gov/cancertopics/types/cervical
OPPS	http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS
USPSTF Screening for Cervical Cancer Recommendations	For a summary of the USPSTF written recommendations on screening for cervical cancer, visit http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm on the Internet.

Table 9. Beneficiary Resources

Resource	Website/Contact Information
"Medicare & You: Stay Healthy with Medicare's Preventive Benefits" Video	http://www.youtube.com/watch?v=mBCF0V4R4A0&feature=relmfu
Medicare & You: Women's Preventive Health" Video	http://www.youtube.com/watch?v=dCav0hGLFuA&feature=relmfu
Medicare Beneficiary Help Line and Website	Telephone: Toll-Free: 1-800-MEDICARE (1-800-633-4227) TTY Toll-Free: 1-877-486-2048 Website: http://www.medicare.gov
"Publications for Medicare Beneficiaries"	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BenePubFS-ICN905183.pdf
Women's Health	http://www.womenshealth.gov
Your Medicare Coverage: Pap Tests/Pelvic Exams (Screening)	http://www.medicare.gov/coverage/pap-tests-pelvic-exams-screening.html
Your Medicare Coverage: Preventive & Screening Services	http://www.medicare.gov/coverage/preventive-and-screening-services.html

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