CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3522	**Date: May 13, 2016**
	Change Request 9606

SUBJECT: Update to Internet-Only-Manual Publication 100-04, Chapter 18, Section 30.6

I. SUMMARY OF CHANGES: This change request replaces ICD-10 diagnosis code Z12.92 with ICD-10 diagnosis code Z12.72 in Pub. 100-04, chapter 18, section 30.6. In addition, section 30.6 is revised and updated for clarity.

EFFECTIVE DATE: June 14, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 14, 2016

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	18/30/30.6/Screening Pap Smears: Diagnoses Codes

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3522	Date: May 13, 2016	Change Request: 9606

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I. GENERAL INFORMATION

A. Background: Section 30.6 of Pub. 100-04, chapter 18 incorrectly lists ICD-10 diagnosis code Z12.92 as a valid diagnosis code for screening Pap smears. The correct diagnosis code is Z12.72. This CR updates the manual by replacing diagnosis code Z12.92 with diagnosis code Z12.72.

B. Policy: No change in policy. This CR only replaces ICD-10 diagnosis code Z12.92 with ICD-10 diagnosis code Z12.72.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9606.1	Contractors shall note the revisions made to Pub. 100-04, chapter 18, section 30.6.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9606.2	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the	X	X			

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Bill Ruiz, 410-786-9283 or william.ruiz@cms.hhs.gov , Wendy Knarr, 410-786-0843 or wendy.knarr@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0

30.6 - Screening Pap Smears: Diagnoses Codes

(Rev.3522, Issued: 05-13-16, Effective: 06-14-16, Implementation: 06-14-16)

Below is the current diagnoses that should be used when billing for screening Pap smear services. Effective July 1, 2005, ICD-9 V72.31 is being added to the CWF edit as an additional low-risk diagnosis. The following chart lists the diagnosis codes that CWF must recognize for low-risk or high-risk patients for screening Pap smear services.

Low Risk Diagnosis Codes	**Definitions**
V76.2	Special screening for malignant neoplasms, cervix
V76.47	Special screening for malignant neoplasm, vagina
V76.49	Special screening for malignant neoplasm, other sites **NOT**E: providers use this diagnosis for women without a cervix.
V72.31	Routine gynecological examination **NOTE**: This diagnosis should only be used when the provider performs a full gynecological examination.
High Risk Diagnosis Code	
V15.89	Other *specified personal history presenting hazards to health*

A. Screening Pap Smears: Applicable Diagnoses for Billing A/B MAC (B)

There are a number of appropriate diagnosis codes that can be used in billing for screening Pap smear services that the provider can list on the claim to give a true picture of the patient's condition. Those diagnoses can be listed in Item 21 of Form CMS-1500 or the electronic equivalent (see Chapter 26 for electronic equivalent formats). In addition, one of the following diagnoses shall appear on the claim: the low-risk diagnosis of V76.2, V76.47, V76.49 and (effective July 1, 2005, V72.31) or the high-risk diagnosis of V15.89 (for high risk patients). One of the above diagnoses must be listed in item 21of the Form CMS-1500 or the electronic equivalent to indicate either low risk or high risk depending on the patient's condition. Then either the low-risk or high-risk diagnosis must also be pointed to in Item 24E of Form CMS-1500 or the electronic equivalent. Providers must make sure that for screening Pap smears for a high-risk beneficiary, that the high-risk diagnosis code of V15.89 appears in Item 21 and V15.89 is the appropriate diagnosis code that must be pointed to in Item 24E or the electronic equivalent. If Pap smear claims do not point to one of these specific diagnoses in Item 24E or the electronic equivalent, the claim will reject in the CWF. **Periodically, A/B MACs (B) should do provider education on diagnosis coding of Pap smear claims.**

B. *Screening Pap Smears:* Applicable Diagnoses for Billing A/B MACs (A)

*Providers report one of the following diagnosis codes in Form CMS-1450 or the electronic equivalent (**NOTE:** Information regarding the form locator numbers that correspond to the diagnosis codes and a table to crosswalk its CMS-1450 form locator to the 837 transaction is found in Chapter 25.):*

Low-risk diagnosis codes:

ICD-9 V76.2, special screening for malignant neoplasms, cervix, or,
ICD-9 V76.47, special screening for malignant neoplasms, vagina, or,
ICD-9 V76.49, special screening for malignant neoplasms, other sites (used for women without a cervix), or,
ICD-9 V72.31, routine gynecological exams

ICD-10 Z12.4, encounter for screening for malignant neoplasm of the cervix
ICD-10 Z12.72, encounter for screening for malignant neoplasm of the vagina
ICD-10 Z12.79, encounter for screening for malignant neoplasm of other genitourinary organs, or,

ICD-10 Z12.89, encounter for screening for malignant neoplasm of other sites
ICD-10 Z01.411, encounter for gynecological exam (general)(routine) with abnormal findings, or,
ICD-10 Z01.419, encounter for gynecological exam (general)(routine) without abnormal findings

High-risk diagnosis codes

ICD-9 V15.89, other specified personal history hazardous to health
ICD-9 V87.39, contact with and (suspected) exposure to other potentially hazardous substances
ICD-9 V69.2, high-risk sexual behavior

ICD-10 Z77.9, other contact with and (suspected) exposures hazardous to health, or,
ICD-10 Z91.89, other specified personal risk factors, not elsewhere classified, or,
ICD-10 Z92.89, personal history of other medical treatment, or,
ICD-10 Z77.29, contact with and (suspected) exposure to other hazardous substances
ICD-10 Z72.51, high-risk heterosexual behavior, or,
ICD-10 Z72.52, high-risk homosexual behavior, or,
ICD-10 Z72.53, high-risk bisexual behavior.

Periodically provider education should be done on diagnosis coding of Pap smear claims.

C. *HPV Screening:* Applicable Diagnoses for Billing A/B MAC *(A/B)*

Effective for claims with dates of service on or after July 9, 2015, providers shall report the following diagnosis codes when submitting claims for HCPCS G0476 - Cervical cancer screening, all-inclusive HPV co-test with cytology (Pap smear) to detect HPV DNA or RNA sequences:

ICD-9: V73.81, special screening exam, HPV (as primary), and V72.31, routine gynecological exam (as secondary)

ICD-10: Z11.51, encounter for screening for HPV, and Z01.411, encounter for gynecological exam (general)(routine) with abnormal findings, OR, Z01.419, encounter for gynecological exam (general)(routine) without abnormal findings.