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Internal Medicine Coding Alert

News Brief: New Pap and Pelvic Exam Codes Bring Coding Dangers

In a recent Program Memorandum, the Centers for Medicare and Medicaid Services expanded its list of covered diagnosis codes for Pap smears and pelvic examinations.

Effective Oct. 1, 2003, two diagnosis codes for low-risk patients will be added to CMS'Common Working File edits for Pap smear and pelvic examinations, according to the May 2 Program Memorandum AB-03-054:

1. V76.47 Special screening for malignant neoplasms; vagina

2. V76.49 Special screening for malignant neoplasms; other sites.

According to the memorandum, V76.49 has been added for providers to use for women without a cervix. Medicare carriers are required to post on their Web sites notification that the additional codes, V76.47 and V76.49, will join V76.2 (Cervix [routine cervical Papanicolaou smear]) and V15.89 (Other specified personal history presenting hazards to health; other) as covered diagnoses for codes Q0091 (Screening Papani-colaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory), P3001 (Screening Papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician), G0124 (Screening cytopathology, cervical or vaginal, 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) and G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination).

Though the memorandum expands the list of covered diagnoses for Pap smears and pelvic exams, the frequency restrictions and general limitations still pertain. For Medicare to cover a beneficiary for a screening Pap smear, she must meet one of the following conditions:

1. She has not had a screening Pap smear test during the preceding three years (i.e., 35 months have passed following the month that the woman had the last covered Pap smear).

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 three years; and at least 11 months have passed following the month that the last covered Pap smear was performed.

3. She meets the high-risk criteria (V15.89) and at least 11 months have passed following the month that the last covered screening Pap smear was performed.

For patients who don't meet the screening Pap smear requirements, Medicare carriers will only pay for screening Pap smears after at least 23 months following the month of the patient's last covered screening, according to the MCM.

For pelvic exams, asymptomatic (low-risk) women who have not had a screening pelvic exam paid by Medicare during the last 35 months following the month of their last Medicare-covered screening pelvic exam will be covered once every three years. For patients at high risk for developing cervical or vaginal cancer for whom 11 months have passed following their last covered pelvic exam, Medicare will cover screening pelvic exams once annually.

According to CMS, patients at high risk of developing cervical cancer have had an early onset of sexual activity (under 16 years of age), have had multiple sexual partners (five or more in a lifetime), have a history of a sexually transmitted

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disease, or have had fewer than three negative or any Pap smears within the previous seven years. To be considered at high risk for vaginal cancer, the patient must be an exposed daughter of a woman who took DES (diethylstilbestrol) during pregnancy.

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