The Guide to Preventive Medicare Services

Screening Pelvic Examination

Overview

A screening pelvic examination is an important part of preventive health care for all adult women. A pelvic examination is performed to help detect pre-cancers, genital cancers, infections, sexually transmitted diseases (STDs), other reproductive system abnormalities, and genital and vaginal problems. STDs in women may be associated with cervical cancer. In particular, one STD, Human Papillomavirus (HPV), causes genital warts, and cervical and other genital cancers.

The pelvic examination is also used to help find fibroids or ovarian cancers, as well as to evaluate the size and position of a woman’s pelvic organs. In addition, a Medicare screening pelvic examination includes a breast examination, which can be used as a tool for detecting, preventing, and treating breast masses, lumps, and breast cancer. The screening pelvic examination benefit covered by Medicare can help beneficiaries maintain their general overall health of the lower genitourinary tract.

Medicare’s coverage of the screening pelvic examination was created as a result of the implementation of the Balanced Budget Act of 1997 (BBA). The BBA includes coverage of a screening pelvic examination for all female beneficiaries, effective January 1, 1998.

Risk Factors

The high risk factors for cervical and vaginal cancer include the following:
- 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 Human papillomavirus and/or Human Immunodeficiency Virus (HIV) infection]
- Fewer than three negative Pap tests within the previous seven years
- DES (diethylstilbestrol)-exposed daughters of women who took DES during pregnancy

Coverage Information

Medicare provides coverage of a screening pelvic examination for all female beneficiaries when performed by a doctor of medicine or osteopathy, or by a certified nurse midwife, physician assistant, nurse practitioner, or clinical nurse specialist 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). Frequency of coverage is provided as follows:

**Covered once every 12 months:**
Medicare provides coverage of a screening pelvic examination annually (i.e., at least 11 months have passed following the month in which the last Medicare-covered pelvic examination was performed) for beneficiaries that meet one (or both) of the following criteria:

- There is evidence that the woman is in one of the high risk categories (previously identified) for developing cervical or vaginal cancer, other specified personal history presenting hazards to health and at least 11 months have passed following the month that the last covered screening pelvic examination was performed.
- A woman of childbearing age had an examination that indicated the presence of cervical or vaginal cancer or other abnormality during the preceding 3 years.

**Covered once every 24 months:**
Medicare provides coverage of a screening pelvic examination for all asymptomatic female beneficiaries every two years (i.e., at least 23 months have passed following the month in which the last Medicare-covered pelvic examination was performed). Medicare’s covered pelvic examination includes a complete physical examination of a woman’s external and internal reproductive organs by a physician or qualified non-physician practitioner. In addition, the pelvic examination includes a clinical breast examination, which aids in helping to detect and find breast cancer or other abnormalities.

**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.*

A screening pelvic examination should include at least seven of the following elements:

- Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge.
- Digital rectal examination including for sphincter tone, presence of hemorrhoids, and rectal masses.
- Pelvic examination (with or without specimen collection for smears and cultures) including:
  - External genitalia (i.e., general appearance, hair distribution, or lesions)
  - Urethral meatus (i.e., size, location, lesions, or prolapse)
  - Urethra (i.e., masses, tenderness, or scarring)
  - Bladder (i.e., fullness, masses, or tenderness)
  - Vagina (i.e., general appearance, estrogen effect, discharge lesions, pelvic support, cystocele, or rectocele)
- Cervix (i.e., general appearance, discharge, or lesions)
Uterus (i.e., size, contour, position, mobility, tenderness, consistency, descent, or support)
- Adnexa/parametria (i.e., masses, tenderness, organomegaly, or nodularity)
- Anus and perineum

Coverage for the screening pelvic examination is provided as a Medicare Part B benefit. The coinsurance or copayment applies for the pelvic and breast examinations. There is no Medicare Part B deductible.

**Coding and Diagnosis Information**

**Procedure Codes and Descriptors**
The following Healthcare Common Procedure Coding System (HCPCS) code listed in Table 1 is used to report Medicare-covered screening pelvic examination services:

The Type of Service (TOS) code to report with screening pelvic examination services is TOS 1.

**Diagnosis Requirements**
When a claim is filed for a screening pelvic examination and/or a screening Pap test, one of the screening (“V”) diagnosis codes listed in Table 2 must be used. Code selection depends on whether the beneficiary is classified as low risk or high risk. This diagnosis code, along with other applicable diagnosis codes, must also be reported. Failure to report the V72.31, V76.2, V76.47, V76.49, or V15.89 diagnosis code will result in denial of the claim.

**Table 1** - HCPCS Code for the Screening Pelvic Examination Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>G0101</td>
<td>Cervical or vaginal cancer screening; pelvic and clinical breast examination</td>
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</tbody>
</table>

**Table 2** - Diagnosis Codes for Screening Pelvic Examination Services

**Low-Risk Diagnosis Codes**

**Definitions**

**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; Routine cervical Papanicolaou smear. *Excludes: that as part of a general gynecological examination (V72.3)*

**V76.47**
Special screening for malignant neoplasms; Other sites; Vagina; Vaginal pap smear status-post hysterectomy for non-malignant condition. Use additional code to identify
acquired absence of uterus (V45.77). Excludes: vaginal pap-smear status-post hysterectomy for malignant condition (V67.01)

V76.49
Special screening for malignant neoplasms; Other sites.
NOTE: Providers use this diagnosis for women without a cervix.

High-Risk Diagnosis Codes
Definitions

V15.89
Other specified personal history presenting hazards to health; Other.

Coding Tips
A screening pelvic examination and a screening Pap test can be performed during the same encounter. When this happens, both procedure codes should be shown as separate line items on the claim.

The same physician may report a covered Evaluation and Management (E/M) visit and code Q0091 for the same date of service if the E/M visit is for a separately identifiable service. In this case, the modifier -25 must be reported with the E/M service and the medical records must clearly document the E/M service reported. Both procedure codes should be shown as separate line items on the claim. These services can also be performed separately during separate office visits.

Screening Pap Tests

Overview
In 2006, an estimated 9,710 cases of invasive cervical cancer are expected to occur in the United States, with about 3,700 women dying from this disease. Additionally, cervical cancer mortality increases with age; women ages 65 and older account for nearly 25 percent of all cervical cancer cases and 41 percent of cervical cancer deaths in the United States. Among these women over age 65, cervical cancer mortality for African-American women is more than 2.5 times higher than it is for Caucasian women.

However, incidence and mortality rates of cervical cancer are declining over time. This positive trend is largely attributed to cervical screening with the Pap smear/test. Screening Pap smears are laboratory tests consisting of a routine exfoliative cytology test (Papanicolaou test) provided for the purpose of early detection of cervical cancer. It includes a collection of the sample of cells and a physician’s interpretation of the test. A cervical screening detects significant abnormal cell changes that may arise before cancer develops, therefore, if diagnosed and treated early, any abnormal cell changes that may occur over time can be reduced or prevented. The cervical screening benefit covered by Medicare can aid in reducing illness and death associated with abnormal cell changes that may lead to cervical cancer.
Medicare’s coverage of the screening Pap test was created as a result of the implementation of the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989). This Act authorized Medicare to begin covering screening Pap tests provided to female beneficiaries on or after July 1, 1990.

Risk Factors
The high risk factors for cervical and vaginal cancer include the following:
- 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 Human papillomavirus and/or Human Immunodeficiency Virus (HIV) infection]
- Fewer than three negative Pap tests within the previous seven years
- DES (diethylstilbestrol)-exposed daughters of women who took DES during pregnancy

Coverage Information
Medicare provides coverage of a screening Pap test for all female beneficiaries when the test is ordered and collected by a doctor of medicine or osteopathy or other authorized practitioner (i.e., 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:

Covered once every 12 months:
- There is evidence (on the basis of her medical history or other findings) that the woman 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 test was performed.
- There is evidence that the woman is in one of the high risk categories (previously identified) for developing cervical or vaginal cancer, other specified personal history presenting hazards to health and at least 11 months have passed following the month that the last covered screening Pap test was performed.

Covered once every 24 months:
- Medicare provides coverage of a screening Pap test for all other female beneficiaries (low risk) every 2 years (i.e., at least 23 months have passed following the month in which the last covered screening Pap test was performed).

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.

Coverage for a Pap test is provided as a Medicare Part B benefit. The coinsurance or copayment applies for the Pap test collection; however, there is no Medicare Part B deductible for test collection. The beneficiary will pay nothing for the Pap laboratory test (there is no deductible and no coinsurance or copayment for the Pap laboratory test).
Coding and Diagnosis Information

Procedure Codes and Descriptors

The following Healthcare Common Procedure Coding System (HCPCS) codes listed in Table 1 are used to report screening Pap tests. Code selection depends on the reason for performing the test, the methods of specimen preparation and evaluation, and the reporting system used.

Table 1 - HCPCS Codes for Screening Pap Tests

**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.

The Type of Service (TOS) code for screening Pap test services is 5, except for Q0091, the TOS code is 1.

Table 1 - HCPCS Codes for Screening Pap Tests

**Q0091**
Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory

Diagnosis Requirements
When a claim is filed for a screening Pap test, one of the screening (“V”) diagnosis codes listed in Table 4 must be used. Code selection depends on whether the beneficiary is classified as low risk or high risk. This diagnosis code, along with other applicable diagnosis codes, must also be reported. Failure to report the V72.31, V76.2, V76.47, V76.49, or V15.89 diagnosis code will result in denial of the claim.

Billing Requirements

Billing and Coding Requirements When Submitting Claims to Carriers
When physicians or qualified non-physician practitioners are submitting claims to carriers, the appropriate HCPCS code, the corresponding diagnosis code, and the TOS must be reported in the HIPAA 837 Professional electronic claim format.

**NOTE:** In those cases where a supplier qualifies for an exception to the ASCA requirement, Form CMS-1500 may be used to submit these claims on paper. Form CMS-1500 has been revised to accommodate the reporting of the National Provider Identifier (NPI). All providers must use Form CMS-1500 (08-05) when submitting paper claims. Additional information on Form

**Low-Risk Diagnosis Codes**

**Definitions**

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**V76.49**
Special screening for malignant neoplasms; Other sites.

**NOTE:** Providers use this diagnosis for women without a cervix.

**High-Risk Diagnosis Codes**

**Definitions**

**V15.89**
Other specified