Medicare has very specific Pap test coverage guidelines for medical necessity. Information required for submission to Medicare:

1. The referring physician (not the laboratory) must designate PAPs in one of the following categories:
   - Screening - low risk
   - Screening - high-risk
   - Diagnostic

2. A diagnosis code (ICD-10) indicates the PAP’s medical necessity and must be documented in the patient medical record.

3. **Advanced Beneficiary Notice must be completed if:**
   - Screening – low risk and patient had a Pap test within the last 2 years or is a woman of childbearing age.
   - Screening – high risk and the patient has had a Pap test within the last year.

**Screening PAP – LOW RISK:** is generally defined as no suspicion of current atypia and no history in medically relevant prior years of atypical findings.

Low risk screening is indicated using one of the following ICD-10-CM Codes:
- Z01.411 Encounter for gynecological examination (general)( routine) with abnormal findings
- Z01.419 Encounter for gynecological examination (general) (routine) without abnormal findings
- Z12.4 Encounter for screening for malignant neoplasm of cervix
- Z12.72 Encounter for screening for malignant neoplasm of vagina
- Z12.79 Encounter for screening for malignant neoplasm of other genitourinary organs
- Z12.89 Encounter for screening for malignant neoplasm of other sites

**Screening PAP – HIGH RISK:** is based on the physician’s recommendation and the patient’s medical history or other findings. Medicare covers high risk screening PAPs annually.

High risk factors for cervical and vaginal cancer are:
- Early onset of sexual activity (under 16 years of age)
- Multiple sexual partners (5 or more in a lifetime)
- History of sexually transmitted disease (including HIV)
- Fewer than 3 negative or any Pap tests within the previous 7 years
- DES exposed daughters

A high risk screening Pap is indicated by the following ICD-10-CM code:
- Z77.29 Contact with and (suspected) exposure to other hazardous substances
- Z77.9 Other contact with and (suspected) exposures hazardous to health
- Z91.89 Other specified personal risk factors, not otherwise classified
- Z92.850 Personal history of Chimeric Antigen Receptor T-Cell Therapy
- Z92.858 Personal history of other cellular therapy
- Z92.86 Personal history of gene therapy
- Z92.89 Personal history of other medical treatment
- Z72.51 High risk heterosexual behavior
- Z72.52 High risk homosexual behavior
- Z72.53 High risk bisexual behavior
Diagnostic PAP – ordered by the referring physician when one or more of the following circumstances apply:

- Previously diagnosed with cancer of the vagina, cervix, or uterus that has been or is presently being treated.
- Previous abnormal Pap test.
- Presents with any abnormal findings of the vagina, cervix, uterus, ovaries, or adnexa.
- Presents with any significant complaint referable to the female reproductive system
- Shows any sign or symptom that might reasonably be related to a gynecologic disorder.

Medicare covers Pap tests ordered as diagnostic with no time restrictions.

Use diagnosis code(s) that best describe the patient’s acute problem.

HPV Screening – Medicare Coverage:

- Once every 5 years in conjunction with a Pap test
- Patient must be an asymptomatic female aged 30-65 years of age
- Must code Z11.51=Encounter for screening for human papillomavirus (HPV) and
  Z01.411= Encounter for gynecological examination (general) (routine) with abnormal findings
  Or
  Z01.419= Encounter for gynecological examination (general) (routine) without abnormal findings