

PAP Test and HPV Screening Guidelines For Medicare Patients

Medicare has adopted some very specific guidelines as to when a Pap smear will be considered a medically necessary laboratory test and thus a "covered service" for Medicare beneficiaries.

Information required to submit a Pap smear claim to Medicare:

1. The referring physician (not the laboratory) must designate all Pap smears in one of the following categories:
 - **Screening - low risk**
 - **Screening - high-risk**
 - **Diagnostic**
2. An appropriate diagnosis code (ICD-10) must be submitted to indicate the medical necessity of the Pap smear. The diagnosis code submitted must be documented in the patient medical record.
3. Advanced Beneficiary Notice must be completed **if**:
 - Screening – low risk and patient has had a Pap smear within the last 2 years.
 - Screening – high risk and the patient has had a Pap smear within the last year.

Screening PAP – LOW RISK: Screening PAP, low risk is generally defined as no suspicion of current atypia and no history in medically relevant prior years of atypical findings. Medicare will cover a low risk screening Pap once every 2 years. An Advanced Beneficiary Notice must be completed if the patient has had a Pap smear within the last 2 years.

A low risk screening Pap is indicated by 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, which indicate the Pap should be done on a more frequent basis. Medicare will cover a high risk screening Pap on an annual basis. An Advanced Beneficiary Notice must be completed **if**: the patient has had a Pap smear within the last year. High risk patients are those who are at high risk to develop cervical or vaginal cancer due to risk factors below:

- Early onset of sexual activity (under 16 years)
- Multiple sexual partners (5 or more in a lifetime)
- History of sexually transmitted disease (including HIV)
- Fewer than 3 negative Pap smears within the last 7 years

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- DES exposed daughters
- Is of childbearing age and has had a Pap smear during the preceding 3 years indicating the presence of cervical or vaginal cancer or other abnormalities.

A high risk screening Pap is indicated by the following ICD-10-CM code:

- **Z77.22**= Contact with and (suspected) exposure to environmental tobacco smoke (acute) (chronic)
- **Z72.51**=High risk heterosexual behavior
- **Z72.52**=High risk homosexual behavior
- **Z72.53**=High risk bisexual behavior
- **Z77.9**=Other contact with and (suspected) exposures hazardous to health
- **Z91.89**=Other specified personal risk factors, not otherwise classified
- **Z92.89**=Personal history of other medical treatment

Diagnostic PAP

Is ordered by the referring physician when one or more of the following circumstances apply:

- The patient has been previously diagnosed with cancer of the vagina, cervix, or uterus that has been or is presently being treated.
- The patient has had a previously abnormal Pap smear.
- The patient presents any current abnormal findings of the vagina, cervix, uterus, ovaries, or adnexa.
- The patient presents any significant complaint referable to the female reproductive system
- The patient shows any sign or symptom that might reasonably be related to a gynecologic disorder.

Medicare covers Pap smears ordered as diagnostic with no time restrictions. **Use the diagnosis code(s) that best describes the patient's acute problem.**