

CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 440

Department of Health &
Human Services
Center for Medicare and
&
Medicaid Services

Date: JANUARY 21,
2005

Change Request 3659

SUBJECT: Updating the Common Working File Editing for Pap Smear (Q0091) and Adding a New Low Risk Diagnosis Code (V72.31) for Pap Smear and Pelvic Examination

I. SUMMARY OF CHANGES: Claims for the collection of the Pap smear specimen (Q0091) are paying incorrectly when performed outside of Medicare's frequency edits. The Common Working File (CWF) will build a separate edit for Q0091, allowing payment of Q0091 for low risk beneficiaries every 2 years and every year for high risk beneficiaries. CWF shall also add a new diagnosis code (V72.31) to the low risk edits already established for Pap smear and pelvic examinations.

NEW/REVISED MATERIAL :

EFFECTIVE DATE : **July 01, 2005**

IMPLEMENTATION DATE : **July 05, 2005**

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)

R/N/D	Chapter / Section / SubSection / Title
R	18/Table of Contents
R	18/30.5/HCPCS Codes for Billing
R	18/30.6/Diagnoses Codes
N	18/40.4/Diagnoses Codes
R	18/40.5/Payment Method
R	18/40.6/Revenue Codes and HCPCS Codes for Billing

N	18/40.8/Remittance Advice Codes
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III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 440	Date: January 21, 2005	Change Request 3659
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SUBJECT: Updating the Common Working File (CWF) Editing for Pap Smear (Q0091) and Adding a New Low Risk Diagnosis Code (V72.31) for Pap Smear and Pelvic Examinations

NOTE: The VIPS shared system and associated Part B carriers are waived from implementing this change request (CR) due to their upcoming transition to the MCS system. Carriers are required to implement the CR once they transition to MCS.

I. GENERAL INFORMATION

A. Background: HCPCS code Q0091 (Screening Papanicolaou Smear; Obtaining, Preparing and Conveyance of Cervical or Vaginal Smear to Laboratory) is currently not part of the CWF editing for Pap smear claims. This is causing problems with physician billing for patients who are requesting a screening Pap smear to be done annually. Since Medicare only pays for one screening Pap smear every 2 years for low risk beneficiaries, claims billed outside of this frequency are paying incorrectly. CWF will build a separate edit for Q0091 that will not generate any problems with other Pap smear codes that are currently in CWF edits.

In those situations where unsatisfactory screening Pap smear specimens have been collected and conveyed to clinical labs which are unable to interpret the test results, another specimen is needed. When the physician bills for this reconveyance, the physician shall annotate the claim with Q0091 along with modifier -76 (repeat procedure by same physician). The use of this modifier will bypass the frequency editing in CWF for reconveyance billing.

B. Policy: Medicare pays for one screening Pap smear every 2 years for low risk beneficiaries and one every year for high risk beneficiaries. CWF shall create a separate Pap smear edit for Q0091 so that claims will pay appropriately.

Occasionally when physicians perform a screening Pap smear (Q0091) that they know will not be covered by Medicare because the low risk patient has already received a covered Pap smear (Q0091) in the past 2 years, the physician can bill Q0091 and the claim will deny appropriately beginning for services on and after July 1, 2005. In these instances physicians shall obtain an advance beneficiary notice as the denial will be considered a not reasonable and necessary denial. Physicians billing for reconveyances shall use Q0091 with modifier -76 in order to receive payment for reconveyances.

A new diagnosis V72.31 shall be added to the edits in CWF for low risk beneficiaries. This diagnosis code should only be annotated on the claim when the provider performs a full gynecological examination.

C. Provider Education: A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider

education article must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

II. BUSINESS REQUIREMENTS

“Shall” denotes a mandatory requirement

“Should” denotes an optional requirement

Requirement Number	Requirements	Responsibility (place an “X” in the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3659.1	Effective for dates of service on and after July 1, 2005, CWF shall add a separate edit for Q0091. Medicare pays for a screening Pap smear for low risk beneficiaries every 2 years and every year for beneficiaries who are considered high risk.	X				X			X	
3659.2	Effective for dates of service on and after July 1, 2005, CWF shall bypass the frequency edit for Q0091 when modifier 76 is present.								X	
3659.3	Contractors shall continue to use the appropriate Medicare Summary Notices and Remittances advice messages when CWF rejects a service billed outside of Medicare’s frequency limits for Pap smears. See Pub-100-04, Chapter 18, Sections 30.8 and 30.9.	X		X						
3659.4	Effective for dates of service on and after July 1, 2005, CWF shall add diagnosis code V72.31 to the low risk diagnosis edits for Pap smear and pelvic examinations.					X			X	
3659.5	Contractors shall educate providers via the Medlearn Matters Article to bill for reconveyances using Q0091 with modifier -76. See Background and Policy for more information.	X		X						

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3659.6	Contractors shall educate providers via the Medlearn Matters Article that V72.31 is an appropriate diagnosis that can be used on Pap smear and pelvic examination claims to indicate the beneficiary is considered a low risk patient. However, this diagnosis should only be used when the provider performs a full gynecological examination.	X		X						
3659.7	Contractors shall educate providers via the Medlearn Matters Article that an Advance Beneficiary Notice (ABN) is necessary when providers expect the claim to be denied because the beneficiary has already received a screening Pap smear (Q0091) within the last 2 years for low risk patients.	X		X						

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: July 1, 2005 Implementation Date: July 5, 2005 Post-Implementation Contact(s): Appropriate Regional Office	No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.
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***Unless otherwise specified, the effective date is the date of service.**

Medicare Claims Processing Manual

Chapter 18 - Preventive and Screening Services

Table of Contents

(Rev. 440, 01-21-05)

Crosswalk to Old Manuals

40.4 – Diagnosis codes

40.5 – Payment Method

40.6 – Revenue Code and HCPCS Codes for Billing

40.7 – MSN Messages

40.8 – Remittance Advice Codes

30.5 - HCPCS Codes for Billing

(Rev. 440, Issued: 01-21-05, Effective: 07-01-05, Implementation: 07-05-05)

The following HCPCS codes can be used for screening Pap smear:

A – Codes Billed to the Carrier and Paid Under the Physician Fee Schedule

The following HCPCS codes are submitted by those *providers/entities* that submit claims to carriers. *The deductible is waived for these services effective January 1, 1998, however, coinsurance applies.*

NOTE: These codes are not billed on FI claims except *for HCPCS code Q0091 which may be submitted to FIs. Payment for code Q0091 performed in a hospital outpatient department is under OPSS, (see 30.5C).*

- Q0091 - Screening Papanicolaou (Pap) 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 a physician;
- G0124 - Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician; and
- G0141 - Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual re-screening, requiring interpretation by physician.

B - Codes Paid Under the Clinical Lab Fee Schedule by FI and Carriers

The following codes are billed to FIs by providers they serve, or billed to carriers by the physicians/suppliers they service. Deductible and coinsurance do not apply.

- P3000 - Screening Papanicolaou smear, cervical or vaginal, up to three smears, by a technician under the physician supervision;
- 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 re-screening, 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;
- G0145 - Screening cytopathology, cervical or vaginal, (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual re-screening under physician supervision;
- G0147 - Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision; and
- G0148 - Screening cytopathology smears, cervical or vaginal, performed by automated system with manual reevaluation.

C - *Payment of Q0091 When Billed to FIs*

Payment for code Q0091 in a hospital outpatient department is under OPSS. A SNF is paid using the technical component of the MPFS. For a CAH, payment is on a reasonable cost basis. For RHC/FQHCs payment is made under the all inclusive rate for the professional component. Deductible is not applicable, however, coinsurance applies.

The technical component of a screening Pap smear is outside the RHC/FQHC benefit. If the technical component of a screening Pap smear is furnished within a provider-based RHC/FQHC, the provider of that service bills the FI under the bill type 13X, 14X, 22X, 23X, or 85X as appropriate using their base provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services). For independent RHCs/FQHCs, the practitioner bills the technical component to the carrier on Form CMS-1500 or 837 P.

D – *Payment of Q0091 When Billed to Carriers*

Payment for Q0091 is paid under the Medicare physician fee schedule. Deductible is not applicable, however the coinsurance applies.

Effective for services on and after July 1, 2005, on those occasions when physicians must perform a screening Pap smear (Q0091) that they know will not be covered by Medicare because the low risk patient has already received a covered Pap smear (Q0091) in the past 2 years, the physician can bill Q0091 and the claim will be denied appropriately. The physician shall obtain an advance beneficiary notice (ABN) in these situations as the denial will be considered a not reasonable and necessary denial. The physician indicates on the claim that an ABN has been obtained by using the GA modifier.

Effective for services on or after April 1, 1999, a covered evaluation and management (E/M) visit and code Q0091 may be reported by the same physician 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 reported. Both procedure codes should be shown as separate line

items on the claim. These services can also be performed separately on separate office visits.

E - Common Working File (CWF) Editing for Q0091

The CWF will edit for claims containing the HCPCS code Q0091 effective for dates of service on and after July 1, 2005. Previously, the editing for Q0091 had been removed from the CWF. Medicare pays for a screening Pap smear every 2 years for low risk patients based on the low risk diagnoses, see sections 30.2 and 30.6. Medicare pays for a screening Pap smear every year for a high risk patient based on the high risk diagnosis, see sections 30.1 and 30.6. This criteria will be the CWF parameters for editing Q0091.

In those situations where unsatisfactory screening Pap smear specimens have been collected and conveyed to clinical labs that are unable to interpret the test results, another specimen will have to be collected. When the physician bills for this reconveyance, the physician should annotate the claim with Q0091 along with modifier -76, (repeat procedure by same physician).

30.6 - Diagnoses Codes

(Rev. 440, Issued: 01-21-05, Effective: 07-01-05, Implementation: 07-05-05)

*Below is the current diagnoses that should be used when billing for screening Pap smear services. Effective, July 1, 2005, 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	<i>Special screening for malignant neoplasms, cervix</i>
V76.47	Special screening for malignant neoplasm, vagina
V76.49	Special screening for malignant neoplasm, other sites <i>NOTE: providers use this diagnosis for women without a cervix.</i>
<i>V72.31</i>	<i>Routine gynecological examination</i> <i>NOTE: This diagnosis should only be used when the provider performs a full gynecological examination.</i>
High Risk Diagnosis Code	
V15.89	Other

A - Applicable Diagnoses for Billing a Carrier

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 21 of 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, carriers should do provider education on diagnosis coding of Pap smear claims.*

If these pointers are not present on *claims submitted to carriers*, CWF will reject the record.

B - Applicable Diagnoses for Billing an FI

Providers report one of the following diagnosis codes in FL 67 of Form CMS-1450 or the electronic equivalent (see Chapter 25 for electronic equivalent format):

Low risk diagnosis codes:

V76.2

V76.47

V76.49

V72.31

High risk diagnosis codes

V15.89

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

40.4 - Diagnoses Codes

(Rev. 440, Issued: 01-21-05, Effective: 07-01-05, Implementation: 07-05-05)

Below is the current diagnoses that should be used when billing for screening pelvic examination services. Effective, July 1, 2005, 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 pelvic examination services.

Low Risk Diagnosis Codes	Definitions
V76.2	<i>Special screening for malignant neoplasm, cervix</i>
V76.47	Special screening for malignant neoplasm, vagina
V76.49	Special screening for malignant neoplasm, other sites NOTE: <i>Providers use this diagnosis for women without a cervix.</i>
<i>V72.31</i>	<i>Routine gynecological examination</i> NOTE: <i>This diagnosis should only be used when the provider performs a full gynecological examination.</i>
High Risk Diagnosis Code	
V15.89	Other

A - Applicable Diagnoses for Billing a Carrier

There are a number of appropriate diagnosis codes *that can be used in billing for screening pelvic examinations* 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 21 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 pelvic exams 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 electronic equivalent. If pelvic examination 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, carriers should do provider education on diagnosis coding of screening pelvic examination claims.*

If these pointers are not present on claims submitted to carriers, CWF will reject the record.

B – Applicable Diagnoses for Billing an FI

Providers report one of the following diagnosis codes in FL 67 of Form CMS-1450 or the electronic equivalent (see Chapter 25 for electronic equivalent format):

Low risk diagnosis codes:

V76.2

V76.47

V76.49

V72.31

High risk diagnosis code

V15.89

Periodically provider education should be done on diagnosis coding of pelvic exam claims.

40.5 - Payment Method

(Rev 440, Issued: 01-21-05, Effective: 07-01-05, Implementation: 07-05-05)

Pelvic examinations are paid under the MPFS, whether billed to the FI or carrier **except**:

- Hospital outpatient services are paid under OPPS;
- See §40.5.B of this chapter for proper billing by RHC/FQHCs for the professional and technical components of a screening pelvic examination. RHCs/FQHCs are paid under the all-inclusive rate for the professional component; or based on the provider's payment method for the technical component;
- CAH payment is under reasonable cost.

NOTE: SNFs are paid under the MPFS and bill the FI. Physicians and other individual practitioners bill the carrier.

40.6 - Revenue Code and HCPCS Codes for Billing

(Rev. 440, Issued: 01-21-05, Effective: 07-01-05, Implementation: 07-05-05)

A - Billing to the Carrier

Code G0101 (cervical or vaginal cancer screening, pelvic and clinical breast examination) is used.

Effective for services on or after January 1, 1999, a covered evaluation and management (E/M) visit and code G0101 may be reported by the same physician 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 on separate office visits.

B - Billing to the FI

The applicable bill types for a screening pelvic examination (including breast examination) are 13X, 14X, 22X, 23X, and 85X. The applicable revenue code is 0770. (See §70.1.1.2 for RHCs and FQHCs.)

The professional component of a screening pelvic examination furnished within an RHC/FQHC by a physician or nonphysician is considered an RHC/FQHC service. RHCs and FQHCs bill the FI under bill type 71X or 73X for the professional component along with revenue code 052X.

The technical component of a screening pelvic examination is outside the scope of the RHC/FQHC benefit. If the technical component of this service is furnished within an independent RHC or freestanding FQHC, the provider of that technical service bills the carrier on Form CMS-1500.

If the technical component of a screening pelvic examination is furnished within a provider-based RHC/FQHC, the provider of that service bills the FI under bill type 13X, 14X, 22X, 23X, or 85X as appropriate using their outpatient provider number (not the RHC/FQHC provider number since these services are not covered as RHC/FQHC services). The appropriate revenue code is 0770.

40.7 - MSN Messages

(Rev. 440, Issued: 01-21-05, Effective: 07-01-05, Implementation: 07-05-05)

If there are no high risk factors, and the screening Pap smear and/or screening pelvic examination is being denied because the procedure/examination is performed more frequently than allowed, contractors use MSN 18-17:

Medicare pays for a screening Pap smear and/or screening pelvic examination only once every (2, 3) years unless high risk factors are present.

40.8 - Remittance Advice Codes

(Rev. 440, Issued: 01-21-05, Effective: 07-01-05, Implementation: 07-05-05)

If high risk factors are not present, and the screening Pap smear and/or screening pelvic examination is being denied because the procedure/examination is performed more frequently than allowed, use existing ANSI X12N 835:

- Claim adjustment reason code 119 - “Benefit maximum for this time period has been reached” at the line level, and
- Remark code M83 - “Service is not covered unless the patient is classified as at high risk.” At the line item level.