Related MLN Matters Article #: MM3659

Date Posted: January 25, 2005

Related Change Request #: 3659

Updating the Common Working (CWF) Editing for Pap Smear (Q0091) and Adding a New Low Risk Diagnosis Code (v72.31) for Pap Smear and Pelvic Examination

Key Words

CR3659, MM3659, Q0091, Pap Smear, Pelvic Examination, Low Risk Beneficiaries, Diagnosis Code, V72.31, GA Modifier

Provider Types Affected

Physicians billing Medicare carriers and providers billing Medicare fiscal intermediaries (FIs) for screening Pap smears and pelvic examinations

Key Points

- The effective date of the instruction is July 1, 2005.
- The implementation date is July 5, 2005.
- Medicare pays for one screening Pap smear every two years for low risk beneficiaries and one screening Pap smear every year for high risk beneficiaries.
- To ensure accurate Medicare processing of claims for these services, effective July 1, 2005, Medicare is establishing a separate edit for Healthcare Common Procedure Coding System (HCPCS) code Q0091 (screening Papanicolaou (Pap) smear, obtaining, preparing and sending cervical or vaginal smear to laboratory) to prevent incorrectly paying for claims submitted outside of the frequency, one screening every two year for low risk beneficiaries and one screening every year for high risk beneficiaries.
- If the clinical laboratory is unable to interpret the test results, the physicians should use HCPCS code Q0091 along with modifier 76, which will bypass the frequency editing and allow payment to be made for reconveyance of another specimen.
- Medicare will accommodate a new diagnosis code, V72.31, in Medicare system edits that are in place for Pap smear and pelvic examination for low risk beneficiaries.
- Effective for services rendered on and after July 1, 2005, where physicians must perform a screening Pap smear that they know will not be covered by Medicare because the low risk beneficiary has

already received a covered screening Pap smear in the past two years, the physician can bill Q0091; the claim will be denied appropriately as being not reasonable and necessary.

- An Advance Beneficiary Notice (ABN) is necessary, since the claim will be denied. The physician/provider should use the GA modifier on the claim to indicate that an ABN has been obtained.
- A list of the current diagnoses that should be used when billing for screening Pap smear Services may be found on page 2 of MLN Matters article MM3659.
- The list represents the diagnosis codes that will be recognized for low risk or high risk patients for screening Pap smear services.

Important Links

http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3659.pdf

The official instruction issued to carriers/intermediaries regarding this change may be found by going to http://www.cms.hhs.gov/Transmittals/downloads/R440CP.pdf on the CMS web site.

If affected providers have any questions, they may contact their carrier/intermediary at their toll-free number, which may be found at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.pdf on the CMS web site.