Medicare Learning Network
MLN Matters
CMS
CENTERS for MEDICARE & MEDICAID SERVICES
Information for Medicare Fee-for-Service Health Care Professionals

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Implementation Date: July 5, 2005

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 Examination

Provider Types Affected

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

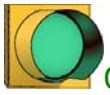
Provider Action Needed

STOP – Impact to You

Medicare is modifying its claims processing edits for claims for screening Pap smears and pelvic examinations.

CAUTION – What You Need to Know

To ensure accurate Medicare processing of claims for these services, effective July 1, 2005, Medicare is establishing a separate edit for 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. Also, 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.



GO – What You Need to Do

Be aware of the specifics in this article to assure accurate and timely processing of your Medicare claims for screening Pap smears and pelvic examination.

Background

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.

Currently, HCPCS code Q0091 is not part of the Medicare system editing for screening Pap smear claims. Since Medicare only pays for one screening Pap smear every two years for low risk beneficiaries, claims billed outside of this frequency have been processed incorrectly. This has happened on those occasions when physicians perform a screening Pap smear (Q0091) that should not be covered by Medicare because the low risk patient has already received a covered screening Pap smear (Q0091) in the past 2 years but requests that the physician perform a screening Pap smear each year. Beginning for dates of service on and after July 1, 2005, these types of claims will deny appropriately. Medicare is establishing a separate edit for Q0091 to capture and reject claims submitted outside of this frequency.

In instances where unsatisfactory screening Pap smear specimens have been collected and sent to the clinical laboratory and the clinical laboratory is unable to interpret the test results, another specimen is needed. When billing for sending another specimen to the clinical laboratory, 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 the specimen.

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 physicians can bill Q0091. The claim will be denied appropriately as being not reasonable and necessary. Thus, in these instances, the physician/provider should be aware that 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.

Finally, physicians/providers should note that a new diagnosis code V72.31 will be added to the edits in Medicare system for low risk beneficiaries. The V72.31 diagnosis code is to be used on Pap Smear and Pelvic Examination claims to indicate the beneficiary is a low risk patient, but only when a full gynecological examination is performed.

The following chart lists the diagnosis codes that Medicare recognizes for low risk or high risk patients for screening Pap smear services with V72.31 recognized as of July 1, 2005.

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

Implementation Date

The implementation date for this instruction is July 5, 2005.

Additional Information

The official instruction issued to your carrier/intermediary regarding this change may be found by going to *http://www.cms.hhs.gov/Transmittals/downloads/R440CP.pdf* on the CMS website.

If you have any questions, please contact your carrier/intermediary on their toll free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.