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Preventive Services: Screening for Mammography, Pap Test and Pelvic Exam

10/17/2023

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CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

Provider Outreach and Education Consultants

- Arlene Dunphy, CPC
- Michele Poulos

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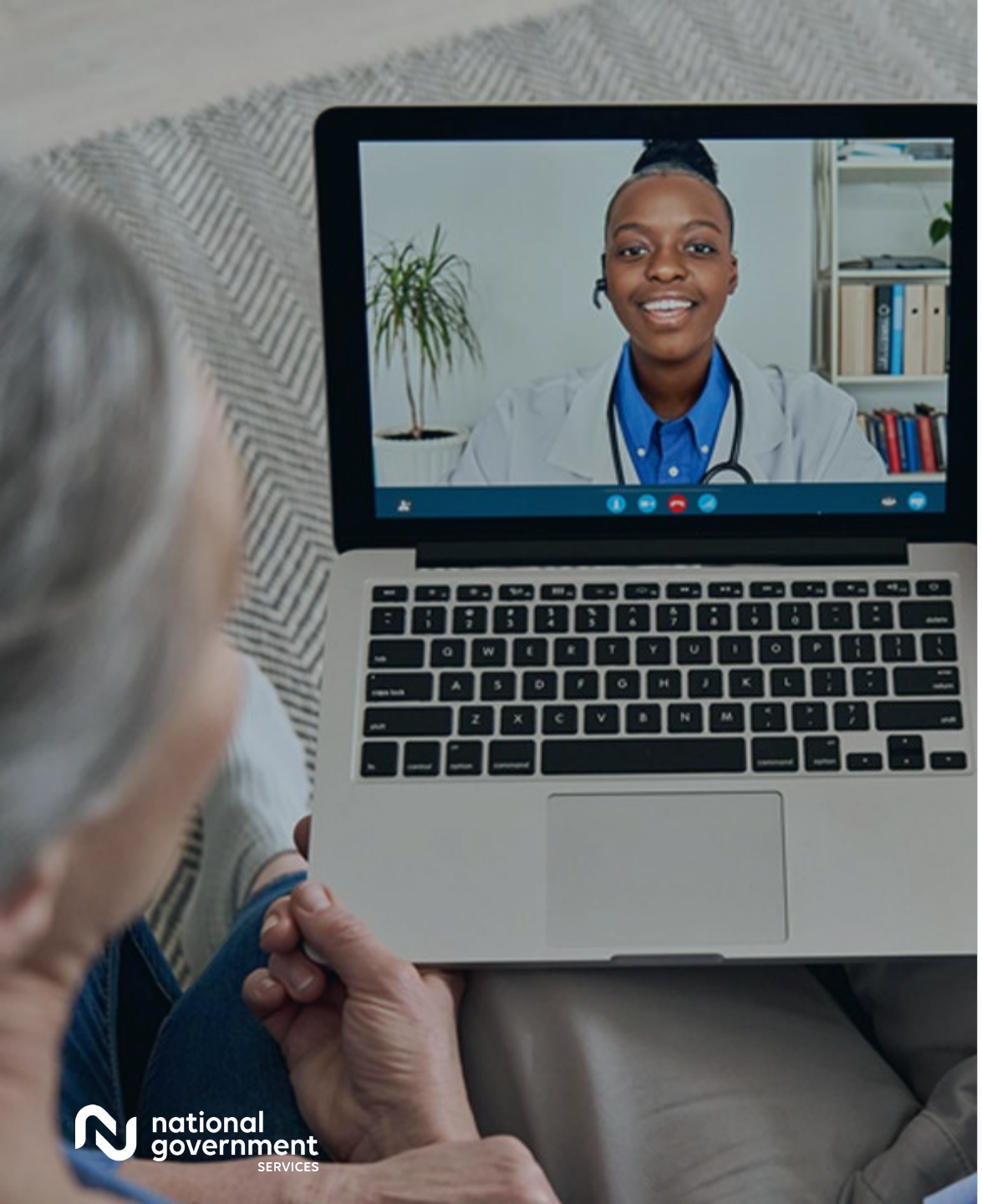

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Objective

Promote awareness of the preventive benefits covered by Medicare and assist providers in correct billing and coding for the services.

Agenda

- Screening Mammography
- Screening Pap Test
- Screening Pelvic Exam
- Resources

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Screening Mammography

Coverage

- Covered for **female** beneficiaries with no signs or symptoms of breast cancer
  - Age 40 and older: covered annually
    - ✓ At least 11 months since last covered screening
  - Age 35-39: one baseline screening covered
  - No screening mammogram coverage if under 35 years of age

Coverage 2

- Screening mammogram components
  - Radiographic test (mammogram)
  - Interpretation and report
  - Communication of results to patient
- Physician referral/order is not required
  - If provided the physician should indicate
    - ✓ Type
    - ✓ ICD-10-CM code
    - ✓ Date of the last screening mammogram

Who Can Perform?

- Must be provided in FDA-certified radiological facility under Mammography Quality Standards Act
  - Qualified physician directly associated with facility where mammogram taken must interpret results
- Covered when provided by hospital, IDTF or physician (office or clinic)
  - Cannot be performed by portable X-ray supplier

FDA Certification

- Claims for mammography services will deny or reject if
  - no FDA certification number reported
  - facility is not certified for the type of mammogram
  - facility's certification is suspended or revoked
  - no FDA certification number on the Mammography Quality Standards Act (MQSA) file

CPT Codes

- CPT code 77063 – Screening digital breast tomosynthesis, bilateral (list separately in addition to code for primary procedure)
  - Use 77063 as an add-on code to 77067 when tomosynthesis is used in addition to 2-D mammography
- CPT code 77067 – Screening mammography, bilateral (2-view study of each breast), including computer-aided detection when performed

ICD-10-CM Codes

ICD-10-CM Code	Description
C84.7A	Anaplastic large cell lymphoma, ALK-negative, breast
N61.21	Granulomatous mastitis, right breast
N61.22	Granulomatous mastitis, left breast
N61.23	Granulomatous mastitis, bilateral breast
N63.15	Unspecified lump in the right breast, overlapping quadrants
N63.25	Unspecified lump in the left breast, overlapping quadrants
Z12.31	Encounter for screening mammogram for malignant neoplasm of breast

Billing Tips

- Cannot bill add-on code without appropriate mammography code
- Submit rendering NPI as referring physician if self-referred
- In Item 32 (or electronic equivalent), enter six-digit FDA-approved certification number
- When screening turns into diagnostic mammography (same day, same beneficiary)
  - Add GG modifier to diagnostic code
  - Bill both screening and diagnostic codes on same claim

Advance Beneficiary Notice of Noncoverage

- Mandatory ABN
  - Performed more frequently than allowed
  - Not provided in FDA-certified radiological facility under MQSA
- Voluntary ABN
  - Out of scope of benefit
    - ✓ Examples: male patient, female patient under 35 years of age

Cost Sharing and Reimbursement

- Cost sharing
  - Deductible waived
  - Coinsurance waived
- Reimbursement
  - Lower of actual charge or MPFS amount
  - Nonparticipating providers
    - ✓ Nonparticipating reduction applies
    - ✓ Limiting charge provision applies

Common Claim Denial Reasons

- Male beneficiary
- Age requirement not met
- Covered screening mammogram received within past year
- Non FDA-certified mammography provider

References

- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 280.3
- CMS IOM Publication 100-03, *Medicare National Coverage Determinations Manual*, Chapter 1, Part 4, Section 220.4
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 18, Section 20
- U.S. Food & Drug Administration: Mammography Quality Standards Act (MQSA)
- U.S. Food & Drug Administration: Searchable Mammography Facility Database
- CMS ICD-10

Local Coverage Determinations

- Breast Imaging Mammography/Breast Echography (Sonography)/Breast MRI/ Ductography
  - Local Coverage Determination L33585
  - Local Coverage Article A52849
- Reduction Mammaplasty
  - Local Coverage Determination L35001
  - Local Coverage Article A56837

Screening Pap Test

Coverage

- Every 24 months for asymptomatic non high-risk female patients
- Every 12 months when criteria met
  - Evidence (medical history or other findings) of high risk or other specified personal history presenting hazards to health
  - Examination indicated cervical/vaginal cancer or other abnormality during any of preceding three years (woman of childbearing age)

Cervical/Vaginal Cancer High-Risk Factors

- Include the following
  - Early onset of sexual activity (aged 16 and younger)
  - Multiple sexual partners (five + in lifetime)
  - History of a sexually transmitted disease
    - ✓ Includes human papillomavirus (HPV) and/or human immunodeficiency virus (HIV) infection
  - Fewer than three negative pap tests or no pap test within previous seven years
  - DES (diethylstilbestrol) exposed daughters of women who took DES during pregnancy

Who Can Perform?

- Must be ordered and collected by DM, DO or other qualified NPP
  - Must be authorized under state law to perform
  - Qualified NPPs
    - ✓ Certified nurse midwife
    - ✓ Physician assistant
    - ✓ Nurse practitioner
    - ✓ Clinical nurse specialist

Billing: Pap Test Procedure Code 1

HCPCS	Description
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 rescreening 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

Billing: Pap Test Procedure Code 2

HCPCS	Description
G0145	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision
G0147	Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision
G0148	Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening
P3000	Screening Papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision

Billing: Physician Interpretation Procedure Code

HCPCS	Description
G0124	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician
G0141	Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician
P3001	Screening Papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician

Billing: Sent to Laboratory Procedure Code

HCPCS	Description
Q0091	Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory

ICD-10-CM Codes Low Risk

ICD-10-CM	Description
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

ICD-10-CM Codes High Risk

ICD-10-CM	Description
Z72.51	High risk heterosexual behavior
Z72.52	High risk homosexual behavior
Z72.53	High risk bisexual behavior
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 elsewhere classified
Z92.89	Personal history of other medical treatment

Billing Tips

- Covered E/M visit can be billed on same claim as Q0091
  - Report modifier 25 on E/M service
  - Clearly document in medical record medical necessity of separately identifiable E/M service

Screening for Cervical Cancer with Human Papillomavirus Testing

Coverage

- All asymptomatic female patients age 30 to 65 years
  - Must be in conjunction with the pap test
- Once every five years

Billing: HPV Screening Procedure Code

HCPCS	Description
G0476	Infectious agent detection by nucleic acid (DNA or RNA); human papillomavirus (HPV), high-risk types (e.g., 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68) for cervical cancer screening, must be performed in addition to pap test

Billing: HPV Screening ICD-10-CM Code

ICD-10-CM	Description
Z11.51 Primary	Encounter for Screening for HPV; and
Z01.411 Secondary OR	Encounter for gynecological exam (general) (routine) with abnormal findings OR
Z01.419 Secondary	Encounter gynecological exam without abnormal findings

Cost Sharing

- Cost sharing
  - Deductible waived
  - Coinsurance waived

Cost Sharing and Reimbursement

- Reimbursement
  - Paid under different fee schedules depending on service rendered
  - NGS Website > Resources> Tools & Calculators> Fee Schedule Lookup
    - ✓ MPFS: G0124, G0141, P3001, Q0091
  - Clinical Laboratory Fee Schedule
    - ✓ G0123, G0143, G0144, G0145, G0147, G0148, P3000, G0476
  - Nonparticipating providers
    - ✓ Nonparticipating reduction applies
    - ✓ Limiting charge provision applies

Common Claim Denial Reasons

- Patient not at high risk and received covered screening within past two years
- High risk patient received covered screening within past year

Screening Pelvic Exam

Coverage

- Every 24 months for asymptomatic non high-risk female patients
- Every 12 months when one criteria met
  - Evidence (medical history or other findings) of high risk
  - Examination indicated cervical/vaginal cancer or other abnormality during any of preceding three years (woman of childbearing age)

Cervical/Vaginal Cancer High Risk Factors

- Include the following
  - Early onset of sexual activity (under age 16)
  - Multiple sexual partners (five+ in lifetime)
  - History of a sexually transmitted disease
    - ✓ Includes HPV and/or HIV infection
  - Fewer than three negative pap tests or no pap test within previous seven years
  - DES (diethylstilbestrol) exposed daughters of women who took DES during pregnancy

Screening Pelvic Exam (including clinical breast exam) Elements

- Should include at least **seven** of the following eleven elements
  - Inspection and palpation of breasts for masses or lumps, tenderness, symmetry or nipple discharge
  - Digital rectal examination including sphincter tone, presence of hemorrhoids and rectal masses
  - External genitalia
    - ✓ General appearance, hair distribution, lesions

Screening Pelvic Exam Elements 1

- Urethral meatus
  - ✓ Size, location, lesions, prolapse
- Urethra
  - ✓ Masses, tenderness, scarring
- Bladder
  - ✓ Fullness, masses, tenderness
- Vagina
  - ✓ General appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele

Screening Pelvic Exam Elements 2

- Cervix
  - ✓ General appearance, lesions, discharge
- Uterus
  - ✓ Size, contour, position, mobility, tenderness, consistency, descent, support
- Adnexa/parametria
  - ✓ Masses, tenderness, organomegaly, nodularity
- Anus and perineum

Who Can Perform?

- Physician referral not required
- Must be performed by DM, DO or other qualified NPP
  - Must be authorized under state law to perform
  - Qualified NPPs
    - ✓ Certified nurse midwife
    - ✓ Physician assistant
    - ✓ Nurse practitioner
    - ✓ Clinical nurse specialist

Billing: Procedure Code

HCPCS Code	Description
G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination

Additional Services

- Screening pelvic examination and screening pap test can be performed during same encounter
  - Both procedure codes entered as separate line items on claim

ICD-10-CM Codes – High Risk

ICD-10-CM	Description
Z72.51	High risk heterosexual behavior
Z72.52	High risk homosexual behavior
Z72.53	High risk bisexual behavior
Z77.29	Contact with and (suspected) exposure to other hazardous substances
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ICD-10-CM Codes – Low Risk

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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

ABN

- Mandatory ABN
  - Performed more frequently than allowed
- Voluntary ABN
  - May be presented to patient if performing a preventive wellness visit, beneficiary will be financially liable (statutorily exclusion)

Cost Sharing and Reimbursement

- Cost sharing
  - Deductible waived
  - Coinsurance waived
- Reimbursement
  - MPFS
    - ✓ Our Website > Resources> Tools & Calculators> Fee Schedules
  - Nonparticipating providers
    - ✓ Nonparticipating reduction applies
    - ✓ Limiting charge provision applies

Common Claim Denial Reasons

- Patient not at high risk and received covered screening within past two years
- High risk patient received covered screening within past year

FAQs

- Q. Is the annual wellness visit (G0402 and G0403) payable on same day with the G0101 and Q0091?
  - A. Yes, according to the NCCI, a pap test and pelvic exam are payable on the same day with an annual wellness visit. Please make sure to check for any edit changes.
- Q. Is a pap test and pelvic exam payable on same day as a routine women's wellness preventive exam?
  - A. The pap test and pelvic exam are reimbursable; however, the beneficiary will be financially responsible for the preventive exam.
- Q. Can G0101 be billed if 7 of the 11 elements are not performed?
  - A. Provider needs to document the reason why the minimum seven has not been met. The documentation needs to support the service being billed if asked upon review or an audit.

“Carve Out” Method Guidance

- G0101 and Q0091 is often rendered at the same time as a preventive medicine exam as described by CPT codes 99384-99397 (noncovered by Medicare)
  - Medicare will reimburse for the collection of the pap test and pelvic exam
- The amount paid by Medicare is subtracted from the physician’s usual fee for a preventive service, the remaining amount is the patient’s responsibility
  - This is referred to as a “carve out”, meaning that Medicare’s covered portion of the preventive service is carved out of the total preventive service
- The amount reimbursed by Medicare and the amount reimbursed by the patient will equal the physician’s usual fee

Resources

Resources

- CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 18, Section 40
- CMS IOM Publication 100-03, *Medicare National Coverage Determinations Manual,* Chapter 1, Part 4, Section 210.2
- NCD - Screening for Cervical Cancer with Human Papillomavirus (HPV) (210.2.1) (cms.gov)

Resources

- MLN Matters®
  - *MM10181 Revised: Replacement of Mammography HCPCS Codes, Waiver of Coinsurance and Deductible for Preventive and Other Services, and Addition of Anesthesia and Prolonged Preventive Services*
- MLN® Booklet: *Screening Pap Tests & Pelvic Exams*
- MLN® Educational Tool: *Medicare Preventive Services Quick Reference Chart ICN 006559*
- CMS Preventive Services Web Page
- NGS Website > Education> Specialties> Preventive Services
  - NGS Preventive Services Guide

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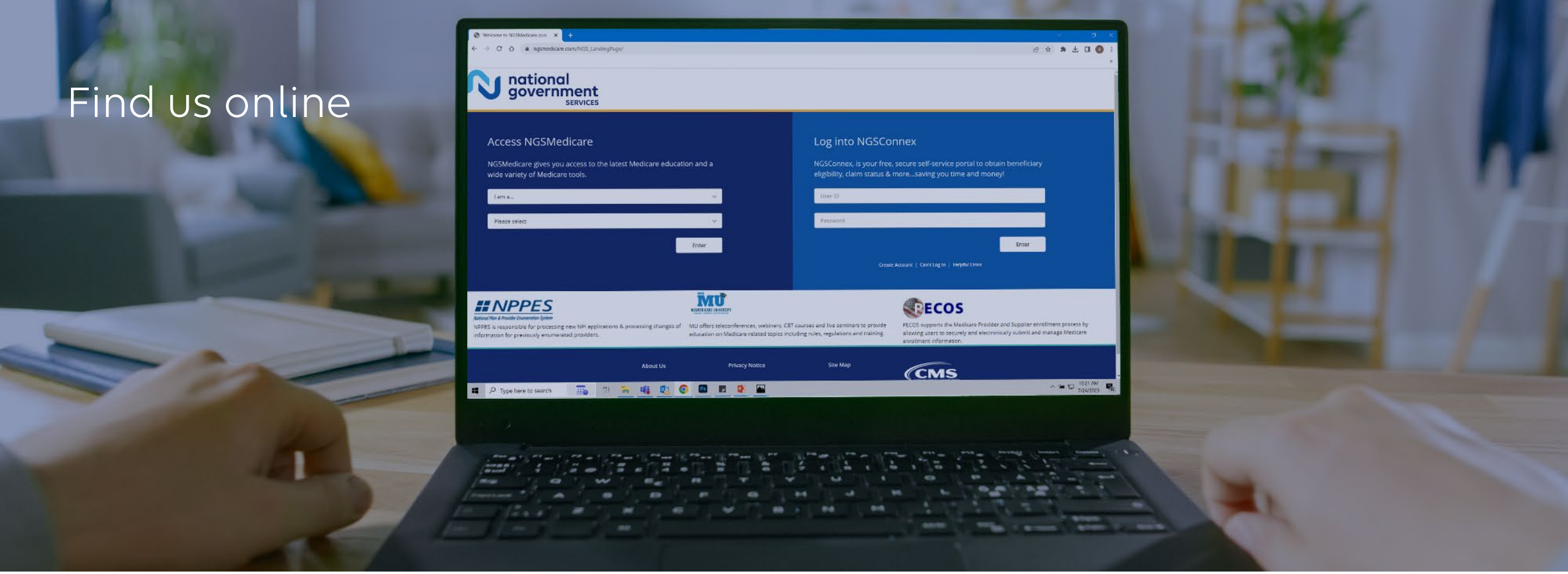

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