Applicable To:
- ☑ Medicare
- ☑ Medicaid (excluding AZ and KY)

Claims and Payment Policy:
Cervical Cancer Screening

Policy Number: CPP-104

Original Effective Date: 1/10/2019
Revised Effective Date(s): 12/17/2019

BACKGROUND

Cervical cancer screening is used to find changes in the cells of the cervix that could lead to cancer. Screening includes cervical cytology (also called Pap test or Pap smear) and, for some women, testing for human papillomavirus (HPV). Cells are removed from the cervix with a brush or other sampling instrument. The cells are transported in a preservative fluid and sent to the laboratory for testing. For a Pap test, the sample is examined to see if abnormal cell are present. For an HPV test, the sample is tested for the presence of 13-14 of the most common high-risk HPV types.

Cancer occurs when cervical cells become mutated and increase in number over time. The cancer cells continue to proliferate and embed themselves deep into the cervical tissue. In advanced cases, cancer cells metastasize or spread to other parts of the body. There are two main types of cervical cancer inclusive of squamous cell carcinoma and adenocarcinoma. Most cases of cervical cancer are caused by infection with HPV.

HPV is the most commonly sexually transmitted infection in the United States. Many people may never develop symptoms or health problems from it. As a result, it can go undetected for many years. According to the Centers for Disease Control and Prevention (CDC), 79 million Americans are currently infected with 14 million people becoming newly infected every year. It usually takes 3–7 years for high-grade changes in cervical cells to become cancer after being infected with HPV. Cervical cancer screening may detect these changes before they become cancer. Women with low-grade changes can be tested more frequently to see if their cells go back to normal. Women with high-grade changes can get treatment to have the cells removed.

POSITION STATEMENT

Per the American College of Obstetricians and Gynecologists (ACOG), WellCare recommends the following for cervical cancer screening and HPV co-testing**:**

- Women aged 21–29 years should have a Pap test alone every 3 years. HPV testing is not recommended.
- Women aged 30–65 years should have a Pap test and an HPV test (***co-testing***) every 5 years (preferred). It also is acceptable to have a Pap test alone every 3 years.

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Wellcare recommends that members older than 65 years stop having cervical cancer screenings if

- Members do not have a history of moderate or severe abnormal cervical cells or cervical cancer
- Members have had either three negative Pap test results in a row or two negative co-test results in a row within the past 10 years, with the most recent test performed within the past 5 years

Per CMS guidelines, Wellcare will

- **deny** claims for HPV codes 87623, 87624, 87625, G0476 for asymptomatic women with a diagnosis of Z11.51 [Encounter for screening for human papillomavirus (HPV)] and **either** Z01.411 [Encounter for gynecological exam (general) (routine) with abnormal findings], **or** Z01.419 [Encounter for gynecological exam (general) (routine) without abnormal findings]
- to **deny** claims **outside** of age ranges 30 to 65 years with a frequency no more than (1) unit every five years
- to **deny** POS **other than** 11 (home) and 81 (outside laboratory)

CODING & BILLING

The following list(s) of codes is provided for reference purposes only and may not be all inclusive.

The following ICD-10 CM codes are considered **covered** and **medically necessary**:

Z00.00	Encounter for general adult medical examination without abnormal findings
Z00.01	Encounter for general adult medical examination with abnormal findings
Z01.411	Encounter for gynecological examination (general) (routine) with abnormal findings
Z01.419	Encounter for gynecological examination (general) (routine) without abnormal Findings
Z11.51	Encounter for screening for human papillomavirus (HPV)
Z12.4	Encounter for screening for malignant neoplasm of cervix

The following CPT/HCPCS codes are considered **covered** and **medically necessary**:

87623	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), low-risk types (e.g., 6, 11, 42, 43, 44)
87624	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)
87625	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), types 16 and 18 only, includes type 45, if performed
88141	Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician
88142	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision
88143	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with manual screening and rescreening under physician supervision
88147	Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision
88148	Cytopathology smears, cervical or vaginal; screening by automated system with manual rescreening under physician supervision
88150	Cytopathology, slides, cervical or vaginal; manual screening under physician supervision

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88152	Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening under physician supervision
88153	Cytopathology, slides, cervical or vaginal; with manual screening and rescreening under physician supervision
88164	Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision
88165	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and rescreening under physician supervision
88166	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening under physician supervision
88167	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening using cell selection and review under physician supervision
88174	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision
88175	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening or review, under physician supervision
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

Note:HCPCS code G0476 is used only for crossover claims in Fee For Service (FFS) for Nebraska Medicaid.

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

DEFINITIONS

Adenocarcinoma	Adenocarcinoma is a type of cancerous tumor that can occur in several parts of the body. It is defined as neoplasia of epithelial tissue that has glandular origin, glandular characteristics, or both. Adenocarcinoma is a common form of cervical cancer.
Cervical cancer	Cervical cancer is a type of cancer that occurs in the cells of the cervix — the lower part of the uterus that connects to the vagina. Various strains of the human papillomavirus (HPV), a sexually transmitted infection, play a role in causing most cervical cancer.
Cytology	Cytology is the examination of cells from the body under a microscope. In a urine cytology exam, a doctor looks at cells collected from a urine specimen to see how they look and function.
Human papillomavirus	A viral infection that is passed between people as sexually transmitted infection (STI). HPV can cause abnormal tissue growth and other changes to cells that can lead to cervical and other types of cancer.
Pap Test	A test carried out on a sample of cells from the cervix to check for abnormalities that may be indicative of cervical cancer; a Pap smear.

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Squamous cell carcinoma	Squamous cell carcinoma (SCC) is the second most common form of skin cancer. It's usually found on areas of the body damaged by UV rays from the sun or tanning beds. Sun-exposed skin includes the head, neck, chest, upper back, ears, lips, arms, legs, and hands. SCC is also a common form of cervical cancer.

REFERENCES

1. Cervical Cancer Screening Guidelines for Average-Risk Women pdf. Centers for Disease Control and Prevention. https://www.cdc.gov/cancer/cervical/pdf/guidelines.pdf. Accessed September 20, 2019.
2. Cervical Cancer Screening. American Congress of Obstetricians and Gynecologists Website. https://www.acog.org/Patients/FAQs/Cervical-Cancer-Screening?IsMobileSet=false. FAQ085 September 2017. Accessed September 20, 2019.
3. Women's Preventive Services. Health Resources and Services Administration Web site. https://www.hrsa.gov/womens-guidelines/index.html. Accessed September 20, 2019.

IMPORTANT INFORMATION ABOUT THIS DOCUMENT

Claims and Payment Policies (CPPs) are policies regarding claims or claim line processing and/or reimbursement related to the administration of health plan benefits. They are not recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for diagnosing, treating, and making clinical recommendations to the member. CPPs are subject to, but not limited to, the following:

- State and federal laws and regulations;
- Policies and procedures promulgated by the Centers for Medicare and Medicaid Services, including National Coverage Determinations and Local Coverage Determinations;
- The health plan's contract with Medicare and/or a state's Medicaid agency, as applicable;
- Other CPPs and clinical policies as applicable including, but not limited to, *Pre-Payment and Post-Payment Review*.
- The provisions of the contract between the provider and the health plan; and
- The terms of a member's particular benefit plan, including those terms outlined in the member's Evidence of Coverage, Certificate of Coverage, and other policy documents.

In the event of a conflict between a CPP and a member's policy documents, the terms of a member's benefit plan will always supersede the CPP.

The use of this policy is neither a guarantee of payment, nor a prediction of how a specific claim will be adjudicated. Any coding information is for informational purposes only. No inference should be made regarding coverage or provider reimbursement as a result of the inclusion, or omission, in a CPP of a CPT, HCPCS, or ICD-10 code. Always consult the member's benefits that are in place at time of service to determine coverage or non-coverage. Claims processing is subject to a number of factors, including the member's eligibility and benefit coverage on the date of service, coordination of benefits, referral/authorization requirements, utilization management protocols, and the health plan's policies. Services must be medically necessary in order to be covered.

References to other sources and links provided are for general informational purposes only, and were accurate at the time of publication. CPPs are reviewed annually but may change at any time and without notice, including the lines of business for which they apply. CPPs are available at www.wellcare.com. Select the "Provider" tab, then "Tools" and then "Payment Guidelines".

RULES, PRICING & PAYMENT COMMITTEE HISTORY AND REVISIONS

Date	Action
10/30/2019	• Approved by RGC