Cervical Cancer Screening Tips

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Cervical Cancer Screening HEDIS Measure: Women ages 21 to 64 should be screened for cervical cancer using either of the following criteria[1] :

- Women ages 21 to 64 should have cervical cytology performed every 3 years.
- Women ages 30 to 64 should have cervical cytology/human papillomavirus (HPV) co-testing performed every five years.

Not Recommended for: Women with evidence of hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix. Documentation of complete, total or radical abdominal or vaginal hysterectomy meets the criteria for hysterectomy with no residual cervix. Please ensure proper documentation.

Coding	CPT Codes	HCPCS	ICD 10	Lab Extracts
Cervical Cytology codes (ages 21-64)	88141-88143, 88147, 88148, 88150, 88152-88154, 88155 88164-88167, 88174, 88175	G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091	**Abdominal hysterectomy:** 0UT90ZZ, 0UT94ZL, 0UT94ZZ, 0UTC0ZZ, 0UTC4ZZ **Absence of cervix:** Q51.5, Z90.710, 790.712, 0UTC0ZZ, 0UTC7ZZ, 0UTC8ZZ **Cervical Cancer:** C53.0, C53.1, C53.8, C53.9, D06.0, D06.1, D06.7, D06.9, Z85.41	Cervical cytology: 10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5,19774-9, 33717-0, 47527-7, 47528-5
Cervical cytology plus HPV co-testing codes (ages 30-64)	87620*, 87621*, 87622*, 87623*, 87624*, 87625*	Same as above		HPV test*: 21440-3, 30167-1, 38372-9, 42481-2, 49896-4, 59263-4, 592642, 59420-0, 69002-4, 71431-1, 75406-9, 75694-0, 77379-6, 77399-4, 77400-0, 82354-2, 82456-5, 82675-0

*To be billed along with cervical cytology codes above; these are not standalone codes.

NOTE: The information listed here is not all inclusive and is to be used as a reference only. Please refer to current IDC-10/CPT/HCPCS Coding and Documentation Guidelines found at www.cms.gov. HEDIS Measures can be found at www.ncqa.com

If you would like additional resources, contact our Provider Relations team at Providers@ARHealthWellness.com

1 U.S. Cancer Statistics Working Group. United States Cancer Statistics: 1999-2011 Incidence and Mortality Web-based Report. Atlanta (GA): Department of Health and Human Services, Centers for Disease Control and Prevention, and National Cancer Institute; 2014

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Physician Best Practices

- Stop screening average-risk women older than 65 who have had three consecutive negative cytology results or two consecutive negative cytology results plus HPV test results within 10 years, with the most recent test performed within five years.
- A member's medical record must have the cervical cytology test results and HPV results documented, even if the patient self-reports having been previously screened by another provider.
- Document the date and results of the completed screening in the member's medical record.
- Submit claims and encounter data in a timely manner. Refer to the coding table above for codes related to cervical cancer screening.
- Audit claims for proper codes and provide education to staff on correct coding.
- Let members know that cervical cancer screening is a covered preventative service; cost should not be a barrier to a member being screened for cervical cancer.

General Coding Tips

1. Ensure the signature on the medical record (such as chart notes and progress notes) is legible and includes the signee's credentials.
2. For Electronic Health Records, confirm all electronic signature, date, and time fields are completed. Include qualifying words such as "Authenticated by", "Verified by", or "Generated by".
3. Make sure the physician documents to the highest degree of specificity in the medical record.
4. Assign the ICD-10 code that includes the highest degree of specificity.
5. Include proper causal or link language to support the highest degree of specificity in diagnosis and coding.
6. Verify that the billed diagnosis codes are consistent with the written description on the medical record.
7. Include weather the diagnoses are being monitored, evaluated, assessed/addressed, and treated (MEAT) in the documentation.
8. If a chronic condition is currently present in a member, do not use language such as "history of".
9. On the medical record, document all chronic conditions present in the member during each visit.
10. At least once per year, submit all chronic diagnosis codes based on documentation in a claim.