Cervical Cancer Tips

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Women ages 21–64 who were screened for cervical cancer using either of the following criteria:

- Women 21–64 years of age who had cervical cytology performed within the last three years
- Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last five years
- Women 30–64 years of age who had cervical cytology/hrHPV cotesting within the last five years

Not recommended for women with evidence of hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix. The following examples meet criteria for documentation of hysterectomy with no residual cervix:

- Documentation of **complete**, **total** or **radical** hysterectomy (abdominal, vaginal or unspecified)
- Documentation of **vaginal hysterectomy**
- Documentation of **vaginal Pap smear** in conjunction with documentation of **hysterectomy**
- Documentation of **hysterectomy** in combination with documentation that the patient no longer needs Pap testing/cervical cancer screening

NOTE: Documentation of hysterectomy alone does not meet the criteria because it is not sufficient evidence that the cervix was removed.

Coding Description	CPT® Codes	HCPCS Codes	Exclusion Codes	Lab Extracts
Cervical cytology (ages 21–64)	88141–88143, 88147, 88148, 88150, 88152–88154, 88164–88167, 88174, 88175	G0123, G0124, G0141, G0143–G0145, G0147, G0148, P3000, P3001. Q0091	**Abdominal hysterectomy:** 0UT90ZZ, 0UT94ZL, 0UT94ZZ, 0UTC0ZZ, 0UTC4ZZ, 0UT90ZL **Absence of cervix:** Q51.5, Z90.710, 790.712	**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 cotesting (ages 30–64)	87620*, 87621*, 87622*, 87624*, 87625*	G0476		**HPV test:*** 21440–3, 30167–1, 38372–9, 59263–4, 592642, 59420–0, 69002–4, 71431–1, 75694–0, 77379–6, 77399–4, 77400–0, 82354–2, 82456–5, 82675–0

* To be billed in addition to cervical cytology codes above; these are not standalone codes.

The information listed here is not all-inclusive and should be used as a reference only. Please refer to current ICD-10/CPT/HCPCS coding and documentation guidelines at cms.gov. HEDIS® measures can be found at ncqa.com.

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

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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/HPV test results within the last 10 years, with the most recent test having been performed within the last five years.
- A member's medical record must have the cervical cytology results and HPV test 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 on correct coding to staff.
- Let Ambetter members know that cervical cancer screening is a covered preventive service; cost should not be a barrier to a member getting screened for cervical cancer.

General Coding Tips

1. Ensure that the signature on the medical record (such as chart and progress notes) is legible and includes the signee's credentials.
2. For electronic health records, confirm that all electronic signature, date and time fields are completed. Include qualifying words such as "authenticated by," verified by" or "generated by."
3. Make sure that 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 whether 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.