

Screening Pap Smears and Pelvic Examinations for Early Detection of Cervical or Vaginal Cancer (NCD 210.2)

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[↪ Terms and Conditions](#)

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Related Medicare Advantage Policy Guidelines
<ul style="list-style-type: none"> Clinical Diagnostic Laboratory Services Screening for Cervical Cancer with Human Papillomavirus (HPV) (NCD 210.2.1)
Related Medicare Advantage Coverage Summary
<ul style="list-style-type: none"> Preventive Health Services and Procedures

Policy Summary

[↪ See Purpose](#)

Overview

Screening Pap Smear

A screening pap smear and related medically necessary services provided to a woman for the early detection of cervical cancer (including collection of the sample of cells and a physician’s interpretation of the test results) and pelvic examination (including clinical breast examination) are covered under Medicare Part B when ordered by a physician (or authorized practitioner) under one of the following conditions:

- She has not had such a test during the preceding two years or is a woman of childbearing age (§1861(nn) of the Social Security Act (the Act)).
- There is evidence (on the basis of her medical history or other findings) that she is at high risk of developing cervical cancer and her physician (or authorized practitioner) recommends that she have the test performed more frequently than every two years.

High risk factors for cervical and vaginal cancer are:

- Early onset of sexual activity (under 16 years of age)
- Multiple sexual partners (five or more in a lifetime)
- History of sexually transmitted disease (including HIV infection)
- Fewer than three negative or any pap smears within the previous seven years; and
- DES (diethylstilbestrol) - exposed daughters of women who took DES during pregnancy.

NOTE: Claims for pap smears must indicate the beneficiary’s low or high risk status by including the appropriate diagnosis code on the line item (Item 24E of the Form CMS-1500).

Definitions

- A woman as described in §1861(nn) of the Act is a woman who is of childbearing age and has had a pap smear test during any of the preceding 3 years that indicated the presence of cervical or vaginal cancer or other abnormality, or is at high risk of developing cervical or vaginal cancer.

- A woman of childbearing age is one who is premenopausal and has been determined by a physician or other qualified practitioner to be of childbearing age, based upon the medical history or other findings.
- Other qualified practitioner, as defined in 42 CFR 410.56(a) includes a certified nurse midwife (as defined in §1861(gg) of the Act), or a physician assistant, nurse practitioner, or clinical nurse specialist (as defined in §1861(aa) of the Act) who is authorized under State law to perform the examination.

Screening Pelvic Examination

Medicare provides for coverage of screening pelvic examinations (including a clinical breast examination) for all female beneficiaries, subject to certain frequency and other limitations. A screening pelvic examination (including a clinical breast examination) 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. Pelvic examination (with or without specimen collection for smears and cultures) including:
 - External genitalia (for example, general appearance, hair distribution, or lesions).
 - Urethral meatus (for example, size, location, lesions, or prolapse).
 - Urethra (for example, masses, tenderness, or scarring).
 - Bladder (for example, fullness, masses, or tenderness).
 - Vagina (for example, general appearance, estrogen effect, discharge lesions, pelvic support, cystocele, or rectocele).
 - Cervix (for example, general appearance, lesions, or discharge).
 - Uterus (for example, size, contour, position, mobility, tenderness, consistency, descent, or support).
 - Adnexa/parametria (for example, masses, tenderness, organomegaly, or nodularity).
 - Anus and perineum.

This description is from *Documentation Guidelines for Evaluation and Management Services*, published in May 1997 and was developed by the Centers for Medicare & Medicaid Services and the American Medical Association.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPCS Code	Description
G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination
G0123	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision
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
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
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

HCPCS Code	Description
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 3 smears, by technician under physician supervision
P3001	Screening Papanicolaou smear, cervical or vaginal, up to 3 smears, requiring interpretation by physician
Q0091	Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory

References

CMS National Coverage Determinations (NCDs)

[NCD 210.2 Screening Pap Smears and Pelvic Examinations for Early Detection of Cervical or Vaginal Cancer](#)

Related NCD: [NCD 210.2.1 Screening for Cervical Cancer with Human Papillomavirus \(HPV\)](#)

CMS Benefit Policy Manual

[Chapter 15: § 280.4 Screening Pap Smears](#)

CMS Claims Processing Manual

[Chapter 18; § 1.2 Table of Preventive and Screening Services, § 30 Screening Pap Smears, § 40 Screening Pelvic Exams](#)

CMS Transmittal(s)

[Transmittal 2202, Change Request 11005, Dated 11/09/2018 \(International Classification of Diseases, 10th Revision \(ICD-10\) and Other Coding Revisions to National Coverage Determination \(NCDs\)\)](#)

MLN Matters

[Article MM8927, Payment for G0101 and Q0091 in Rural Health Clinics \(RHCs\) and Federally Qualified Health Centers \(FQHCs\) that Bill Under the AIR System](#)

[Article MM9269, Revised April 1, 2016; Required Billing Updates for Rural Health Clinics](#)

[Article MM9465, Calendar Year \(CY\) 2016 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment](#)

[Article MM9909, Dated January 2017, Calendar Year \(CY\) 2017 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment](#)

[Article MM10409, Calendar Year \(CY\) 2018 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment](#)

[Article MM11076 Revised, Calendar Year \(CY\) 2019 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment](#)

UnitedHealthcare Commercial Policy

[Preventive Services](#)

Other(s)

[Cervical Cancer: Screening, U.S. Preventive Services Task Force Website](#)

[Medicare Preventive Services, Department of Health and Human Services, CMS Website](#)

[Screening Pap Tests and Pelvic Examinations, Department of Health and Human Services, CMS Website](#)

Guideline History/Revision Information

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

Date	Summary of Changes
04/01/2021	Template Update <ul style="list-style-type: none">Reformatted policy; transferred content to new template
10/14/2020	<ul style="list-style-type: none">Routine review; no change to guidelinesArchived previous policy version MPG278.05

Purpose

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers' submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as NCDs, LCDs, LCAs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the [References](#) section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

Terms and Conditions

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided.

UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

Medicare Advantage Policy Guidelines are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the [Administrative Guide](#).