

Coding Guidelines

LCD Title:

Diagnostic PAP Smears

Contractor's Determination Number

GU-020

CMS National Coverage Policy

Title XVIII of the Social Security Act section 1862 (a)(1)(A). This section allows coverage and payment of those services that are considered to be medically reasonable and necessary.

Title XVIII of the Social Security Act section 1833 (e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Medicare Manual:

190.2 - Diagnostic Pap Smears

(Rev. 1, 10-03-03) Formerly CIM 50-20, CIM 50-20.1

A diagnostic pap smear and related medically necessary services are covered under Medicare when ordered by a physician under one of the following conditions:

- *Previous cancer of the cervix, uterus, or vagina that has been or is presently being treated;*
- *Previous abnormal pap smear;*
- *Any abnormal findings of the vagina, cervix, uterus, ovaries, or adnexa;*
- *Any significant complaint by the patient referable to the female reproductive system; or*
- *Any signs or symptoms that might in the physician's judgment reasonably be related to a gynecologic disorder.*

Coding

1. Determine if the test is screening or diagnostic.
2. Choose the code that best describes the method of testing, i.e. Thin Prep, Bethesda, or other. Summary CPT section for cervicovaginal cytology (c/v):

88150-88154- c/v, conventional smear, "other" (non-Bethesda) reporting system
88164-88167- c/v, conventional smear, Bethesda reporting system
88142-88143- c/v, liquid-based cytology, any reporting system
88174-88175- c/v, liquid-based cytology, computer-assisted screening, any reporting system
3. Use procedure code 88199 only to indicate the service was provided with a system that is considered investigational. When services are provided by a method that is not FDA-approved, the entire service is considered non-covered.
 - a. Liquid based monolayer cell preparation technique is considered "investigational" when provided with systems that have not received FDA approval.
 - b. Do not list the pap test procedure code. List the description of the service "Investigational - (name of system,)", in Box 19 of the HCFA 1500 form or on an attachment. This information is placed in the Narrative Record (HA0 record) for EMC submitters.
4. Liquid based prep services are no longer paid in addition to a Pap smear performed by another method, instead, they are available as another method of performing the test.

5. When appropriate, choose a code based on who performs the screening under physician supervision, i.e. the cytotechnologist or an automated system.
6. *For services on or after January 1, 1999, separate payment is allowed under the physician fee schedule for patients in any setting if the laboratory screening personnel suspect an abnormality, and the physician reviews and interprets the Pap smear.*
7. Codes are subject to correct coding edits.
8. Any re-screening of slides done for quality assurance purposes is not billable to Medicare. These would include: 88143, 88153, 88165 and G0143. These will be denied as not medically necessary.
9. List the ICD-9 diagnosis code.
10. List the CPT procedure code
 - 88142, 88147, 88148, 88150, 88152, 88154, 88155, 88164, 88166, 88167
 - the physician interpretation of a diagnostic Pap smear is reported using code 88141.
 - Code 88141 can be used with either 88142 **or** 88147 **or** 88148 **or** 88150 **or** 88152 **or** 88154 **or** 88164 **or** 88166 **or** 88167

Original Determination Effective Date

11/15/2010

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(Published)

10/01/2010

Revision Effective Date

07/16/2012

Revision History Number/Explanation

06/01/2012 -This guideline is effective for J-8 providers in Michigan MAC B 07/16/12, Michigan MAC A 07/23/12, Indiana MAC A 07/23/12 and Indiana MAC B 08/20/12.