Cervical Cancer Screening Tips

Measure: Women ages 21–64 who were screened for cervical cancer and who meet any 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 along does not meet the criteria because it is not sufficient evidence that the cervix was removed.

Coding	CPT® Codes	Exclusion Codes	Lab Extracts
Cervical Cytology (ages 24–64)	• 88141-88143 • 88147 • 88148 • 88150 • 88164-88167 • 88174 • 88175	**Abdominal hysterectomy:** 0UT90ZZ, 0UT94ZL, 0UT94ZZ, 0UTC0ZZ, 0UTC4ZZ **Absence of cervix:** Q51.5, Z90.710, 790.712, 0UTC0ZZ, 0UTC4ZZ, 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 with HPV cotesting (ages 30–64)	• 87621* • 87624* • 87625*		**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 with cervical cytology codes above; these are not standalone codes.

For additional resources, contact our provider relations team at Providers@ArkansasTotalCare.com.

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

Cervical Cancer Screening Tips

Physician Best Practices

- Stop screening average-risk women older than 65 who have had three consecutive negative cytology results or two consecutive negative cytology with HPV results within 10 years, with the most recent test having been performed within five years.
- A member's medical record must have the cervical cytology test results and HPV results documented, even if the patient 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 screenings are a covered preventive service. Cost should not be a barrier to a member getting screened for cervical cancer.

General Coding Tips

- Ensure the signature on the medical record is legible and includes the signee's credentials.
- For electronic health records, confirm that all electronic signature, date and time fields have been completed. Include qualifying phrases such as "authenticated by," "verified by" or "generated by."
- Make sure the physician documents to the highest degree of specificity in the medical record.
- Assign the ICD-10 code that includes the highest degree of specificity.
- Include appropriate causal or link language to support the highest degree of specificity in diagnosis and coding.
- Verify that the billed diagnosis codes are consistent with the written description on the medical record.
- Include whether the diagnoses are being monitored, evaluates, assessed/addressed and treated (MEAT) in the documentation.
- If a chronic condition is currently present in a member, do not use language such as "history of."
- On the medical record, document all chronic conditions present in the member during each visit.
- At least once per year, submit all chronic diagnosis codes based on documentation in a claim.