Priority Health	BILLING POLICY No. 140
Cervical Cancer Screening	
Date of origin: Sept 2025	**Review dates: None yet recorded**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise stated
- Medicaid follows MDHHS unless otherwise stated

DEFINITION

Cervical cancer screening aims to detect precancerous changes in the cervix or early-stage cervical cancer, allowing for timely treatment and prevention of invasive cancer. Screening typically involves Pap tests, HPV tests, or a combination of both (co-testing).

- The **HPV test** looks for the virus (human papillomavirus) that can cause cell changes on the cervix.

- The **Pap test** (or Pap smear) looks for precancers, cell changes on the cervix that might become cervical cancer if they are not treated appropriately.

Associated Billing POLICY

Lab and pathology billing policy no 015

Preventive Services Billing Policy No. 094

For Medicare

For indications that do not meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Click here for additional details on PSOD.

POLICY SPECIFIC INFORMATION

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. Go to the fee schedules (login required).

Reimbursement specifics

Priority Health follows USPSTF recommendations for cervical cancer screening. Please visit our preventative services page here for additional information.

Coding specifics

The following list(s) of procedure codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy 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:

87623: Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), low-risk types (eg, 6, 11, 42, 43, 44)

87624: Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), high-risk types (eg, 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68), pooled result

87625: Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), types 16 and 18 only, includes type 45, if performed

87626: Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), separately reported high-risk types (eg, 16, 18, 31, 45, 51, 52) and high-risk pooled result(s)

88141: Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician

Report 88141 in addition 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88164-88167, 88174 and 88175.

88142: Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision

88143: Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with manual screening and rescreening under physician supervision

88147: Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision

88148: Cytopathology smears, cervical or vaginal; screening by automated system with manual rescreening under physician supervision

88150: Cytopathology, slides, cervical or vaginal; manual screening under physician supervision

88152: Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening under physician supervision

88153: Cytopathology, slides, cervical or vaginal; with manual screening and rescreening under physician supervision

88155: Cytopathology, slides, cervical or vaginal, definitive hormonal evaluation (eg, maturation index, karyopyknotic index, estrogenic index) (List separately in addition to code[s] for other technical and interpretation services)

Code first (88142-88153, 88164-88167, 88174-88175)

88164: Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision

88165: Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and rescreening under physician supervision

88166: Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening under physician supervision

88167: Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening using cell selection and review under physician supervision

88174: Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision

88175: Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening or review, under physician supervision

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

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

G0476: Infectious agent detection by nucleic acid (DNA or RNA); human papillomavirus HPV), high-risk types (e.g., 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68) for cervical cancer screening, must be performed in addition to pap test

Molecular pathology procedures (81161, 81200–81408) should not be reported in combination with, or instead of, the infectious agent detection by nucleic acid procedures (87471–87801).

Report 87624 for a singular, pooled result for high-risk HPV types or when both low-risk and high-risk types are performed in a single assay.

For HPV detection of more than four high-risk types reported separately, see 87626.

It is important to note that negative Pap smears, including smears reviewed for quality control purposes, that do not require physician interpretation should not be coded with the physician interpretation code (88141). There is no separate listing in the CPT book to report Pap smears reviewed for quality control purposes.

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

Accurate documentation is essential for proper billing of Pap smears. To support correct coding and reimbursement, medical records should include the following key elements:

1. Reason for Screening: Clearly document the purpose of the Pap smear, such as routine preventive care or evaluation of specific symptoms or risk factors.
2. Screening Results: Record the outcomes of the Pap smear, noting whether the results were normal or if any abnormalities were detected.
3. Follow-Up and Additional Services: If further evaluation, diagnostic procedures, or treatments are recommended or performed based on the results, these should be thoroughly documented.
4. Specimen Collection Details: Include information about the specimen collection process, such as the date, technique used, and any instructions provided to the patient.
5. Slide Preparation: Document the preparation and handling of the specimen, including any laboratory procedures, to ensure accurate coding and billing.

The ordering practitioner's documentation must support the test(s) ordered. Each lab service ordered should be documented in the member's medical record and detailed on the lab order. The medical records should also detail the reasons each test is indicated and ordered to support management of the member's specific medical condition. Such documentation must indicate how the test results will impact clinical care.

- Orders must be signed and dated by the ordering practitioner.
- Standard orders and/or routine screenings as part of a practitioner's protocol aren't payable without supporting documentation to support member's specific medical assessment and treatment.
- Our preventive health guidelines detail services that are considered preventive health services; provider defined protocols may not align are subject to applicable benefit and supporting documentation requirements.

Modifiers
Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Please see our provider manual page for modifier use here.

- Modifier 90 - Reference (Outside) Laboratory

Billing details

Place of Service
Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Click here for additional information.

Type of bills
- 12x – Hospital Inpatient
- 13x – Hospital Outpatient
- 22x – Skilled Nursing Inpatient (Medicare Part B Only)
- 23x – Skilled Nursing Outpatient
- 85x – Critical Access Hospital

Revenue codes
- 0310 Laboratory Pathology-General Classification
- 0311 Laboratory Pathology-Cytology
- 0319 Laboratory Pathology-Other Laboratory Pathology
- 0923 Other Diagnostic Services-Pap Smear

Ensure that you select the appropriate revenue code based on the type of facility and the specific service provided.

REFERENCES

Coding for preventive services | Priority Health

https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=185&ncdver=3&bc=0

https://www.cms.gov/files/document/mln909032-screening-pap-tests-pelvic-exams.pdf

https://www.wpsgha.com/uploads/2025_02_05_Preventive_Services_Women_s_Health_b3813f355c.pptx
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening

https://www.cdc.gov/cervical-cancer/screening/index.html

https://www.womenspreventivehealth.org/wp-content/uploads/FINAL_WPSI_CodingGuide_2021_ScreeningCervicalCancer.pdf

https://www.wpsgha.com/guides-resources/view/120

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made