Pap Testing
Some third party payers distinguish between screening and diagnostic pap tests in making reimbursement decisions; therefore, it is important that these tests be properly identified to ensure compliance with billing regulations. Effective January 15, 2005, all pap testing requests must indicate if the pap is ordered for screening or diagnostic reasons. The distinction between a screening and a diagnostic pap test is a clinical decision. The decision to order as a screening or diagnostic pap test must be made by the ordering provider based on patient history and physical findings. The following are guidelines to assist providers in appropriate ordering.

The Centers for Medicare and Medicaid Services (CMS) define a diagnostic pap test as one ordered under the following conditions:

- History of cervical, uterine, or vaginal cancer that is or has been under treatment
- History of abnormal pap test
- Abnormal physical findings of the uterus, cervix, vagina, ovaries, or adnexa
- Significant patient complaint referable to the female reproductive system
- Any signs or symptoms which, in the judgment of the provider, may reasonably be related to a gynecologic disorder

To qualify as a diagnostic pap test, the order must be accompanied by an appropriate ICD-9 code designating the indication for testing.

A screening pap test is generally covered under Medicare once every two years; however, more frequent screening (i.e., annual), may be covered in childbearing age women, or if one of the following CMS defined high risk indicators is present:

- Early onset of sexual activity (under age 16 years)
- Multiple sexual partners (more than five in a lifetime)
- History of sexually transmitted disease (including HIV)
- Fewer than three negative pap tests within the past seven years
- History of in utero DES exposure

Screening pap test orders must be accompanied by ICD-9 code V76.2 (for low risk) or V15.89 (for high risk).

The type of pap test order (screening or diagnostic) should be indicated in the appropriate box on the Anatomic pathology/cytology request form (temporarily, at the bottom of the form), with appropriate ICD-9 code(s) entered in the ICD-9 boxes.

The CPT code for diagnostic for all payers (including Medicare): Conventional Pap Smear: 88164 Liquid-base Pap: 88142.

The CPT code for screening for all payers (except Medicare) are the same as the CPT code for the diagnostic pap.

The CPT code for screening for Medicare patients: Conventional Pap: P3000 Liquid-base Pap: G0123.