Cervical Cancer Screening

Policy Number: **APEA – G2002** – Cervical Cancer Screening

Initial Presentation Date: 7/01/2020
Revision Date: 7/01/2020

Policy Description

Cervical cancer screening detects cervical precancerous lesions and cancer through cytology, HPV testing, and if needed, colposcopy (Feldman, Goodman, & Peipert, 2019). The principal screening test to detect cancer in asymptomatic women is the Papanicolaou (Pap) smear. It involves cells being scraped from the cervix during a pelvic examination and spread onto a slide. The slide is then sent to an accredited laboratory to be stained, observed, and interpreted (Feldman & Crum, 2019).

Human papilloma virus (HPV) has been associated with development of cervical intraepithelial neoplasia, and FDA approved HPV tests detecting the presence of viral DNA from high risk strains have been developed and validated as an adjunct primary cancer screening method (Feldman & Crum, 2019).

For more information specifically regarding HPV, please refer to AHS-G2157 Diagnostic Testing of STIs.

Related Policies

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Policy Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>APEA-G2157</td>
<td>Diagnostic Testing of Common Sexually Transmitted Infections</td>
</tr>
</tbody>
</table>

Indications and/or Limitations of Coverage

Application of coverage criteria is dependent upon an individual’s benefit coverage at the time of the request.

The criteria below are based on recommendations by the U.S. Preventive Services Task Force, The National Cancer Institute, NCCN, The American Society for Colposcopy and Cervical Pathology, The American Cancer Society, The American Society for Clinical Pathology, and the American College of Obstetricians and Gynecologists.

1. Women under 21 years of age **DO NOT MEET COVERAGE CRITERIA** for cervical cancer screening unless one of the following criteria are met:
a. History of HIV and other immunocompromised conditions,
b. Previous diagnosis of cervical cancer
c. Previous diagnosis of cervical dysplasia
d. History of an organ transplant

2. For women 21 - 29 years of age, cervical cancer screening using conventional or liquid based Papanicolaou (Pap) smears MEETS COVERAGE CRITERIA at a frequency of every 3 years.

3. For women 30 - 65 years of age, cervical cancer screening using conventional or liquid based Pap smear at a frequency of every 3 years, or cervical cancer screening using the high-risk HPV test alone at a frequency of every 5 years, or co-testing (cytology with concurrent high-risk HPV testing) at a frequency of every 5 years, MEETS COVERAGE CRITERIA.

4. Testing for high-risk strains HPV-16 and HPV-18 MEETS COVERAGE CRITERIA if BOTH of the following co-testing criteria are present:
   a. Cytology negative AND
   b. HPV positive

5. Cervical cancer screening MEETS COVERAGE CRITERIA for women >65 years of age who are considered high-risk (women with a high-grade precancerous lesion or cervical cancer, women with in utero exposure to diethylstilbestrol, or women who are immunocompromised)

6. Routine cervical cancer screening DO NOT MEET COVERAGE CRITERIA in women >65 years of age who are not considered high-risk and have an adequate screening history:
   a. 3 consecutive negative Pap smears, or
   b. 2 consecutive negative HPV tests within 10 years before cessation of screening, with the most recent test occurring within 5 years

7. Repeat cervical cancer screening by Pap smear or HPV testing in one year MEETS COVERAGE CRITERIA if a previous cervical cancer screen had an abnormal cytology and/or was positive for HPV or women is at high risk for cervical cancer (organ transplant, exposure to the drug DES, immunocompromised women).

8. Cervical cancer screening (at any age) DO NOT MEET COVERAGE CRITERIA for women who have undergone surgical removal of uterus and cervix and have no history of cervical cancer or pre-cancer.

   The following does not meet coverage criteria due to a lack of available published scientific literature confirming that the test(s) is/are required and beneficial for the diagnosis and treatment of a patient’s illness.

9. The following DO NOT MEET COVERAGE CRITERIA:
   a. Inclusion of low-risk strains of HPV in co-testing, as the clinical utility has not been established.
   b. Other technologies for cervical cancer screening because of insufficient evidence of clinical utility.
**Scientific Background**

The American Cancer Society estimates that 13,170 new cases of cervical cancer will be diagnosed in 2019 with approximately 4,250 women dying from cervical cancer (ACS, 2019). To screen for cervical cancer, a Pap test or HPV test is performed. Co-testing with both is also a common clinical practice. To obtain the cell sample for cytology, during a speculum exam cells are scraped from both the ectocervix (external surface) and endocervix (cervical canal) to evaluate the squamocolumnar junction where most neoplasia occur. Cytological examination can be performed as either a traditional Pap smear where the swab is rolled directly on the slide for observation or liquid-based thin layer cytology examination where the swab is swirled in a liquid solution so that the free cells can be trapped and plated as a monolayer on the glass slide. One advantage of the liquid cytology assay is that the same sample can be used for HPV testing whereas a traditional Pap smear requires a second sample to be taken. HPV testing is typically a nucleic acid-based assay that checks for the presence of high-risk types of HPV, especially types 16 and 18. HPV testing can be performed on samples obtained during a cervical exam; furthermore, testing on samples obtained from vaginal swabs, tampons, and urine samples have been reported (Feldman & Crum, 2019).

**Analytical Validity**

A study by Marchand and colleagues explored the optimal collection technique for Pap testing. Their study consisted of two different cytology labs and 128 clinicians over the course of one year. They discovered that in conventional Pap testing the sequence of collection—the cytobrush for the endocervix and the spatula for the ectocervix—had no effect on the quality of the assay. 47% of the clinicians who had high levels of absent endocervical cells on their samples used the cytobrush method alone. The authors conclude, “The combination of the Cytobrush (endocervix) and spatula (ectocervix) is superior for a quality Pap smear. The sequence of collection was not important in conventional Pap smears. The broom alone performs poorly (Marchand, Mundt, Klein, & Agarwal, 2005).”

Urine-based HPV DNA testing as a screening tool would be a less invasive method than cervical examinations and swabs. A 2014 study by Mendez et al. using both urine samples and cervical swabs from 52 female patients, however, showed that there was only 76% agreement between the two methodologies. The urine testing correctly identified 100% of the uninfected individuals but only 65% of the infected as compared to the cervical swab controls (Mendez et al., 2014). An extensive meta-analysis of 14 different studies using urinary testing, on the other hand, reported an 87% sensitivity and 94% specificity of the urine-based methodology for all strains of HPV, but the sensitivity for high-risk strains alone was only 77%. The specificity for the high-risk strains alone was reported to be higher at 98%. “The major limitations of this review are the lack of a strictly uniform method for the detection of HPV in urine and the variation in accuracy between individual studies. Testing urine for HPV seems to have good accuracy for the detection of cervical HPV, and testing first void urine samples is more accurate than random or midstream sampling. When cervical HPV detection is considered difficult in particular subgroups, urine testing should be regarded as an acceptable alternative (Pathak, Dodds, Zamora, & Khan, 2014).”

**Clinical Validity and Utility**

The National Cancer Institute reports that “Regular Pap screening decreases cervix cancer incidence and mortality by at least 80% (NCI, 2019).” They do note that Pap testing can result in the possibility of additional diagnostic testing, especially in younger women, when unwarranted, especially in cases of possible low-grade squamous intraepithelial lesions (LSILs); however, even though 50% of women undergoing Pap testing required additional, follow-up diagnostic procedures, only 5% were treated for LSILs. The NCI also reports that “HPV-based screening provides 60% to 70% greater protection against invasive cervical carcinoma, compared with cytology (NCI, 2019).”

The National Comprehensive Cancer Network (NCCN) in their guidelines for cervical cancer (NCCN, 2019) states that, although the rates of both incidence and mortality of squamous cell
carcinoma of the cervix has been declining over the last thirty years, “adenocarcinoma of the cervix has increased over the past 3 decades, probably because cervical cytologic screening methods are less effective for adenocarcinoma.” A study in the United Kingdom supports this because the risk-reduction associated with 3-yearly screening was reduced by 75% for squamous carcinoma and 83% for adenosquamous carcinoma, but adenocarcinoma was reduced only by 43% (Sasieni, Castanon, & Cuzick, 2009). Another extensive study of more than 900,000 women in Sweden showed that PCR-based HPV testing for the high-risk types 16 and 18 is better at predicting the risk of both in situ and invasive adenocarcinoma. The authors conclude, “infections with HPV 16 and 18 are detectable up to at least 14 years before diagnosis of cervical adenocarcinoma. Our data provide prospective evidence that the association of HPV 16/18 with cervical adenocarcinoma is strong and causal (Dahlstrom et al., 2010).”

A report by Chen and colleagues in 2011 reviewed HPV testing and the risk of the development of cervical cancer. Of the 11,923 women participating in the study, 86% of the women who tested positive for HPV did not develop cervical cancer with ten years. The authors concluded, “HPV negativity was associated with a very low long-term risk of cervical cancer. Persistent detection of HPV among cytologically normal women greatly increased risk. Thus, it is useful to perform repeated HPV testing following an initial positive test (Chen et al., 2011).”

In 2018, the results of the multi-year HPV FOCAL randomized clinical trial testing of the use of HPV testing alone for detection of cervical intraepithelial neoplasia (CIN) grade 3 or worse (CIN3+) were published. More than 19,000 women participated in the study split between the intervention group (HPV testing alone) and the control group (liquid-based cytology). “Baseline HPV-negative women had a significantly lower cumulative incidence of CIN3+ at 48 months than cytology-negative women (CIN3+ incidence rate, 1.4/1000 [95% CI, 0.8-2.4]; CIN3+ risk ratio, 0.25 [95% CI, 0.13-0.48]). Among women undergoing cervical cancer screening, the use of primary HPV testing compared with cytology testing resulted in a significantly lower likelihood of CIN3+ at 48 months. Further research is needed to understand long-term clinical outcomes as well as cost-effectiveness (Ogilvie et al., 2018).” In a commentary concerning the findings of this trial, the author notes that multiple randomized trials have shown that primary HPV screening linked to subsequent identification and treatment of cervical precancer is more effective than Pap testing in reducing the incidence of cervical cancer and precancer, at the cost of lower specificity and more false-negative subsequent colposcopic assessments (Massad, 2018).” The author does address the limitations of the FOCAL study, including that the study concluded prior to seeing what effects, if any, women vaccinated against HPV 16 and HPV 18 would have since the adolescents vaccinated upon FDA approval of the vaccine would not have necessarily been included within the study. They also state that a limitation of the FOCAL trial is “the use of a pooled HPV test for screening, incorporating all carcinogenic HPV types in a single positive or negative result (Massad, 2018).”

Melnikow et al performed a review for the USPSTF regarding cervical cancer screening through high-risk (hr) HPV testing. The authors reviewed the following studies: “8 randomized clinical trials (n = 410556), 5 cohort studies (n = 402615), and 1 individual participant data (IPD) meta-analysis (n = 176464)“. Primary hr-HPV testing was found to detect cervical intraepithelial neoplasia (CIN) 3+ at an increased rate (relative risk rate ranging from 1.61 to 7.46) in round 1 screening. False positive rates for primary hr-HPV testing ranged from 6.6% to 7.4%, compared with 2.6% to 6.5% for cytology, whereas in cotesting, false-positives ranged from 5.8% to 19.9% in the first round of screening, compared with 2.6% to 10.9% for cytology. Overall, the authors concluded that “primary hrHPV screening detected higher rates of CIN 3+ at first-round screening compared with cytology. Cotesting trials did not show initial increased CIN 3+ detection (Melnikow et al., 2018).”

Guidelines and Recommendations

2018 US Preventive Services Task Force (USPSTF, 2018a)
The USPSTF updated their recommendations in 2018. The recommendations are outlined in the table below. The USPSTF did change the recommendation concerning women aged 30-65 to
now include the possibility of high-risk HPV testing alone once every 5 years as a screening. They still allow the possibility of co-testing every 5 years or for Pap testing alone every 3 years.

The USPSTF notes certain risk factors that may increase the risk of cervical cancer, such as “HIV infection, a compromised immune system, in utero exposure to diethylstilbestrol, and previous treatment of a high-grade precancerous lesion or cervical cancer”. Cytology, primary testing for high-risk HPV alone, or both methods simultaneously may detect the high-risk lesions that are precursors to cervical cancer (USPSTF, 2018b).

ACOG endorses these recommendations from the USPSTF (ACOG, 2018a).

USPSTF Summary of Recommendations and Evidence (USPSTF, 2018b)

<table>
<thead>
<tr>
<th>Population</th>
<th>Recommendation</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women 21 to 29</td>
<td>Screen for cervical cancer every 3 years with cytology alone. For women 30-65 years, screen for cervical cancer every 3 years with cytology alone, every 5 years with high-risk (hr) HPV testing alone, or every 5 years with cotesting.</td>
<td>The USPSTF recommends the service. There is high certainty that the net benefit is substantial. Offer or provide this service. Grade A</td>
</tr>
<tr>
<td>Women younger than 21, older than 65, who have had adequate prior screening, or who have had a hysterectomy</td>
<td>Do not screen for cervical cancer.</td>
<td>The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits. Discourage the use of this service. Grade D</td>
</tr>
</tbody>
</table>

2017 US Preventive Services Task Force (Bibbins-Domingo et al., 2017)

In 2017, “The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of performing screening pelvic examinations in asymptomatic, nonpregnant adult women. (I statement) This statement does not apply to specific disorders for which the USPSTF already recommends screening (ie, screening for cervical cancer with a Papanicolaou smear, screening for gonorrhea and chlamydia).”

2019 National Comprehensive Cancer Network (NCCN, 2019):

Concerning cervical cancer, the NCCN states, “Persistent human papillomavirus (HPV) infection is the most important factor in the development of cervical cancer. The incidence of cervical cancer appears to be related to the prevalence of HPV in the population.... Screening methods using HPV testing may increase detection of adenocarcinoma.” The NCCN lists chronic, persistent HPV infection along with persistently abnormal Pap tests as criteria to be considered for women contemplating hysterectomy.

2019 National Cancer Institute (NCI, 2019)

Concerning the use of Pap testing in screening, the NCI recommends: “Based on solid evidence, regular screening of appropriate women for cervical cancer with the Pap test reduces mortality from cervical cancer. The benefits of screening women younger than 21 years are small
because of the low prevalence of lesions that will progress to invasive cancer. Screening is not beneficial in women older than 65 years if they have had a recent history of negative test results. Based on solid evidence, regular screening with the Pap test leads to additional diagnostic procedures (e.g., colposcopy) and treatment for low-grade squamous intraepithelial lesions (LSILs), with long-term consequences for fertility and pregnancy. These harms are greatest for younger women, who have a higher prevalence of LSILs, lesions that often regress without treatment. Harms are also increased in younger women because they have a higher rate of false-positive results.

Concerning the use of HPV DNA testing, the NCI states: “Based on solid evidence, screening with the HPV DNA or HPV RNA test detects high-grade cervical dysplasia, a precursor lesion for cervical cancer. Additional clinical trials show that HPV testing is superior to other cervical cancer screening strategies. In April 2014, the U.S. Food and Drug Administration approved an HPV DNA test that can be used alone for the primary screening of cervical cancer risk in women aged 25 years and older. Based on solid evidence, HPV testing identifies numerous infections that will not lead to cervical dysplasia or cervical cancer. This is especially true in women younger than 30 years, in whom rates of HPV infection may be higher.”

Concerning co-testing, they recommend: “Based on solid evidence, screening every 5 years with the Pap test and the HPV DNA test (cotesting) in women aged 30 years and older is more sensitive in detecting cervical abnormalities, compared with the Pap test alone. Screening with the Pap test and HPV DNA test reduces the incidence of cervical cancer. Based on solid evidence, HPV and Pap cotesting is associated with more false-positives than is the Pap test alone. Abnormal test results can lead to more frequent testing and invasive diagnostic procedures.”

2017 Choosing Wisely (ASCCP, 2017b)

The ASCCP recommends: “Don’t perform cervical cytology (Pap tests) or HPV screening in immunocompetent women under age 21. Cervical cancer is rare in adolescents and screening does not appear to lower that risk. Screening adolescents for cervical cancer exposes them to the potential harms of tests, biopsies, and procedures, without proven benefit.”

The ASCCP also recommends against screening for low-risk HPV types (ASCCP, 2017a).

2015 Society of Gynecologic Oncology, American Society for Colposcopy and Cervical Pathology, American College of Obstetricians and Gynecologists, American Cancer Society, American Society of Cytopathology, College of American Pathologists, and the American Society for Clinical Pathology (Huh et al., 2015)

Since the 2011 joint guidelines issued by ACS, ASCCP, and ASCP concerning cervical cancer screening, additional reports concerning the use of primary hrHPV testing so that representatives from the Society of Gynecologic Oncology, American Society for Colposcopy and Cervical Pathology, American College of Obstetricians and Gynecologists, American Cancer Society, American Society of Cytopathology, College of American Pathologists, and the American Society for Clinical Pathology convened to issue interim clinical guidance in 2015. In the 2011 statement, primary hrHPV testing was not recommended. The 2015 recommendations include:

- “Because of equivalent or superior effectiveness, primary hrHPV screening can be considered as an alternative to current US cytology-based cervical cancer screening methods. Cytology alone and cotesting remain the screening options specifically recommended in major guidelines.”
- “A negative hrHPV test provides greater reassurance of low CIN3+ risk than a negative cytology result.”
- “Rescreening after a negative primary hrHPV screen should occur no sooner than every 3 years.”
- “Primary hrHPV screening should not be initiated prior to 25 years of age.”

They give the following algorithm concerning screening (Huh et al., 2015):
In Practice Bulletin #168, ACOG updated their recommendations concerning cervical cancer screening based on new studies. The table below outlines their recommendation concerning screening:

A diagram illustrating the recommended primary HPV screening algorithm is included, showing the flow from primary HPV screening to cytology, then to colposcopy or follow-up based on test results.

ACOG does state that women who immunocompromised, including those who are HIV-positive, should start screening younger than age 21. Even though in their table, they do not recommend screening by HPV testing alone, they include the following noted caveat: "After the Joint Recommendations were published, a test for screening with HPV testing alone was approved by the U.S. Food and Drug Administration. Gynecologic care providers using this test should follow the interim guidance developed by the American Society for Colposcopy and Cervical Pathology and the Society for Gynecologic Oncology (Huh et al., 2015) (Chelmow & ACOG, 2016)."
The following table outlines the ACOG recommendation concerning the management of cervical cancer screening (Chelmow & ACOG, 2016):

<table>
<thead>
<tr>
<th>Screening Method</th>
<th>Cytology negative</th>
<th>ASC-US cytology/ reflex HPV negative</th>
<th>All others</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cytology screening alone</td>
<td>Screen again in 3 years</td>
<td>Cost in 3 years</td>
<td>Refer to ASCCP guidelines*</td>
<td></td>
</tr>
<tr>
<td>Cotesting</td>
<td>Cytology negative, HPV negative</td>
<td>ASC-US cytology, HPV negative</td>
<td>Cytology negative, HPV positive</td>
<td>Option 1: 12-month follow-up with cotesting Option 2: Test for HPV-16 or HPV-18 genotypes • If positive results from test for HPV-16 or HPV-18, referral for colposcopy • If negative results from test for HPV-16 and HPV-18, 12-month follow-up with cotesting Refer to ASCCP guidelines*</td>
</tr>
<tr>
<td>All others</td>
<td>Screen again in 3 years</td>
<td>Screen again in 3 years</td>
<td>Refer to ASCCP guidelines*</td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations: ASCCP, American Society for Colposcopy and Cervical Pathology; ASC-US, atypical squamous cells of undetermined significance; HPV, human papillomavirus.


This guideline was reaffirmed in 2018 (ACOG, 2018b).

**State and Federal Regulations, as applicable**

The FDA has approved the APTIMA HPV 16 18/45 Genotype Assay, a nucleic acid amplification test (NAAT), for the qualitative detection of mRNA for HPV 16, 18, and 45 from Gen-Probe Incorporated on 10/12/2012; however, this test cannot distinguish between 18 and 45. Previously, on 10/28/2011, the FDA approved Gen-Probe Incorporated’s APTIMA HPV Assay, an NAAT that tests for 14 high-risk types of HPV but is unable to distinguish between the 14 types. The COBAS HPV test by Roche Molecular Systems, Inc. was approved by the FDA on 04/19/2011 as a NAAT for 14 high-risk types of HPV. This test can specifically identify HPV 16 and 18 but cannot distinguish from the other 12 types of HPV. Hologic, Inc. has two FDA-approved HPV NAAT tests—Cervista HPV 16/18 and Cervista HPV HR and GENFIND DNA Extraction Kit. Both were approved on 03/12/2009. The former is a fluorescent, isothermal-based reaction that detects HPV 16 and 18 whereas the latter screens for DNA from the 14 high-risk HPV strains (FDA, 2018a). A subsequent search on July 18, 2019 did not yield any new HPV-related results (FDA, 2019).

On 07/02/2018, the FDA released an approval order statement (P100020/S025) “for an expansion of the intended use for the FDA-approved cobas HPV Test to include cervical specimens collected in SurePath Preservative Fluid as a specimen type” (FDA, 2018b). This approval allows for the cobas HPV Test to be used as a first-line cervical cancer screening using the SurePath preservative, a medium often used for Pap tests (Rice, 2018). For more information regarding HPV, please refer to AHS-G2157 Diagnostic testing of STIs.

Additionally, many labs have developed specific tests that they must validate and perform in
These laboratory-developed tests (LDTs) are regulated by the Centers for Medicare and Medicaid (CMS) as high-complexity tests under the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88). As an LDT, the U. S. Food and Drug Administration has not approved or cleared this test; however, FDA clearance or approval is not currently required for clinical use.

### Applicable CPT/HCPCS Procedure Codes

<table>
<thead>
<tr>
<th>Code Number</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>87623</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), low-risk types (eg, 6, 11, 42, 43, 44)</td>
</tr>
<tr>
<td>87624</td>
<td>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)</td>
</tr>
<tr>
<td>87625</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), types 16 and 18 only, includes type 45, if performed</td>
</tr>
<tr>
<td>88141</td>
<td>Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician</td>
</tr>
<tr>
<td>88142</td>
<td>Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision</td>
</tr>
<tr>
<td>88143</td>
<td>Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with manual screening and rescreening under physician supervision</td>
</tr>
<tr>
<td>88147</td>
<td>Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision</td>
</tr>
<tr>
<td>88148</td>
<td>Cytopathology smears, cervical or vaginal; screening by automated system with manual rescreening under physician supervision</td>
</tr>
<tr>
<td>88150</td>
<td>Cytopathology, slides, cervical or vaginal; manual screening under physician supervision</td>
</tr>
<tr>
<td>88152</td>
<td>Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening under physician supervision</td>
</tr>
<tr>
<td>88153</td>
<td>Cytopathology, slides, cervical or vaginal; with manual screening</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
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<tr>
<td>88164</td>
<td>Cytopathology, slides, cervical or vaginal (the bethesda system); manual screening under physician supervision</td>
</tr>
<tr>
<td>88165</td>
<td>Cytopathology, slides, cervical or vaginal (the bethesda system); with manual screening and rescreening under physician supervision</td>
</tr>
<tr>
<td>88166</td>
<td>Cytopathology, slides, cervical or vaginal (the bethesda system); with manual screening and computer-assisted rescreening under physician supervision</td>
</tr>
<tr>
<td>88167</td>
<td>Cytopathology, slides, cervical or vaginal (the bethesda system); with manual screening and computer-assisted rescreening using cell selection and review under physician supervision</td>
</tr>
<tr>
<td>88174</td>
<td>Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision</td>
</tr>
<tr>
<td>88175</td>
<td>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</td>
</tr>
<tr>
<td>0500T</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA), Human Papillomavirus (HPV) for five or more separately reported high-risk HPV types (eg, 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68) (ie, genotyping)</td>
</tr>
<tr>
<td>G0123</td>
<td>Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision</td>
</tr>
<tr>
<td>G0124</td>
<td>Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician</td>
</tr>
<tr>
<td>G0141</td>
<td>Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician</td>
</tr>
<tr>
<td>G0143</td>
<td>Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
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<tr>
<td>G0144</td>
<td>Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision</td>
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<tr>
<td>G0145</td>
<td>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</td>
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<tr>
<td>G0147</td>
<td>Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision</td>
</tr>
<tr>
<td>G0148</td>
<td>Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening</td>
</tr>
<tr>
<td>G0476</td>
<td>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) for cervical cancer screening, must be performed in addition to pap test</td>
</tr>
<tr>
<td>P3000</td>
<td>Screening Papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision</td>
</tr>
<tr>
<td>P3001</td>
<td>Screening Papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician</td>
</tr>
<tr>
<td>Q0091</td>
<td>Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory</td>
</tr>
</tbody>
</table>

**Evidence-based Scientific References**

ACOG. (2018a). Practice Advisory: Cervical Cancer Screening (Update)


ASCCP. (2017a, 02/14/2017). Don’t order screening tests for low-risk HPV types.


**Policy Implementation/Update Information**

7/1/20 New Policy

State and Federal mandates and health plan contract language, including specific provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The medical policies contained herein are for informational purposes. The medical policies do not constitute medical advice or medical care. Treating health care providers are independent contractors and are neither employees nor agents Blue KC and are solely responsible for diagnosis, treatment and medical advice. No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, photocopying, or otherwise, without permission from Blue KC.