Family PACT

Clinical Practice Alert

February 2020

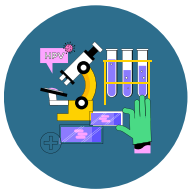
Cervical Cancer Screening

Introduction

Family PACT covers cervical cancer screening when provided in conjunction with the provision of family planning services, but not as a stand-alone service. The Program has adopted the current guidelines of the U.S. Preventive Services Task Force[1] (USPSTF) with additional recommendations from the American College of Obstetricians and Gynecologists (ACOG)[2] and the multidisciplinary partnership of the American Cancer Society, the American Society for Colposcopy and Cervical Pathology (ASCCP), and the American Society for Clinical Pathology.[3]

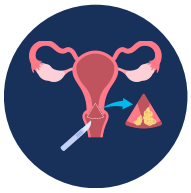
Key Recommendations

Cervical cytology screening should begin at 21 years of age and be performed every three years for females between 21-29 years of age.



For females 30 and older, options for cervical cancer screening include:

- Cervical cytology alone every 3 years.
- HPV alone testing every 5 years.
- Co-testing cervical cytology and hr-HPV testing every 5 years.

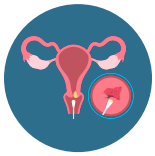


Immunocompromised females (e.g., major organ transplant recipients or long-term steroid users) and those who were exposed to diethylstilbestrol (DES) in-utero should receive cervical cytology screening annually.

Management of abnormal screening results will be discussed in a separate Clinical Practice Alert pending publication of the ASCCP Risk-Based Management Consensus Guidelines in 2020. Until then, please refer to the ASCCP 2012 Management Guidelines[4] and other evidence-based management guidelines [5,6,7] included below.

Questions and Answers

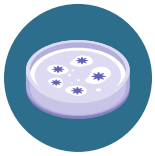
How often should cervical cytological screening be performed?



In addition to the Key Recommendations above,

- Cytology screening begins at 21 years of age, regardless of the age at first intercourse. Screening females younger than 21 for cervical cancer lacks proven benefit and is harmful to some females because of overdiagnosis and overtreatment.
- Females who have been treated for a high-grade cervical lesion remain at risk for recurrent disease for at least 20 years after treatment. Those who have been treated for CIN 2,3 or adenocarcinoma in situ (AIS) must be *regularly screened* for 20 years, even if 65 years of age or older, either with cytology every three years or co-testing every five years.

How is HPV-alone screening different from cytology alone or co-testing?



In April 2014, the FDA approved the cobas® test primary hr-HPV screening, based on the results of a large U.S.-based study known as the ATHENA trial. While primary hr-HPV screening detected 50% more CIN3+ compared with cytology, it also resulted in approximately double the number of colposcopies. Interim clinical guidance[5,6] recommends:

- When HPV type 16 or 18 is identified, perform (or refer for) colposcopy.
- A positive test for one or more of the 12 other hr-HPV types should be followed with a cervical cytology test, with the result used to triage the client to colposcopy (if ASCUS or worse) or repeat hr-HPV screening in 1 year if negative.
- Re-screening after a negative hr-HPV screen should occur every 5 years.

Do virginal females need to be screened?

Virginal females of any age should be advised that their risk of cervical cancer is extremely low, but not zero. Once counseled, either she may decline cervical cancer screening or opt to be screened routinely.

Are the screening intervals any shorter for females with multiple partners?

No. While females with multiple sexual partners are at an increased risk of acquiring HPV infection and are more likely to develop a pre-invasive cervical lesion or cancer, they do not have a faster time of progression if a lesion does develop.

What are the screening recommendations for HIV-positive females?

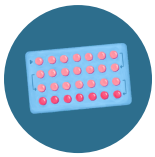
The Panel on Opportunistic Infections in HIV-Infected Adults and Adolescents[8] recommends that females who are infected with HIV should have age-based cervical cancer screening:

- HIV-positive individuals should begin screening with cytology alone within 1 year of onset of sexual activity or, if currently sexually active, within the first year after HIV diagnosis, but no later than 21 years of age. Repeating cytology in 6 to 12 months (without HPV testing) is recommended for HIV-infected females younger than 21 years with ASCUS test results.
- If the patient is younger than 30 years of age and the initial cytology screening result is normal, the next cytology screening should be in 12 months. After 3 consecutive normal annual screenings, follow-up screening should be every 3 years.
- Patients who are 30 years of age and older can be screened with cytology alone or co-testing. Once those screened with cytology alone have had 3 consecutive annual normal test results, or a single negative co-test result, screen every 3 years.

Are there any chronic medical conditions that necessitate cervical cancer screenings more often than every 3-5 years?

Females who have a compromised immune system may develop lesions more rapidly than those who are immunocompetent. This includes those with a major organ transplant with the use of an anti-rejection drug and long-term corticosteroid use. The ASCCP recommends that these clients should be screened at the same intervals as HIV-positive females (above).

If a client has an abnormal cytology or positive hr-HPV test result, should hormonal contraception be limited or withheld?



No. There is no medical evidence that the use of hormonal contraceptives will adversely affect the diagnosis and treatment of cervical abnormalities. Having an abnormal test result makes it even more important to provide effective contraception, as pregnancy would complicate, and in some cases delay, treatment for cervical abnormalities.

Some of my clients insist on having cervical cytology screening annually despite a history of prior negative results. What do I tell them?

The client should be counseled that screening intervals are designed to balance benefits and risks of screening and that being screened too often may actually be harmful to her health. Over screening results in an excess risk of false positive test results, which can lead to unnecessary colposcopy and biopsies, with attendant anxiety and inconvenience.

If cervical cytology screening is ***not*** scheduled or necessary, what about the need to perform a screening bimanual pelvic exam at the end of the well woman visit?

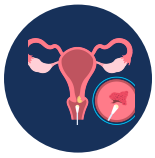
USPSTF[9] states that there is no evidence that this practice improves ovarian cancer outcomes and recommends against routine screening for ovarian cancer in low-risk females. ACOG recommends that females 21 years of age and older should be offered a *screening* pelvic exam in the context of shared decision making.[10] Family PACT Standards do not recommend a screening bimanual pelvic exam at any age.

Application of Family PACT Policies

Will family PACT cover cervical cytology for females younger than 21 years of age?

Yes, but only if she is HIV positive or is immunocompromised (such as a major organ transplant patient). The ordering provider must document on the laboratory order the indication for screening, as the pathology lab must include this on their claim.

For females 21 years of age and older, when will Family PACT cover cervical cancer screening more frequently than every 3 or 5 years?



Acceptable clinical indications for screening more frequently than every three to five years include clients who:

- Have had a previously abnormal screening test result, and consequently, are in a surveillance pathway.
- Have received treatment with cryotherapy, LEEP, or a cone biopsy for a pre-invasive cervical lesion.
- Have had a result of “insufficient specimen adequacy” or unsatisfactory for evaluation at her last cervical cytology screen.
- In utero exposure to diethylstilbestrol (DES).
- Are HIV positive, a major organ transplant with the use of an anti-rejection drug, or long-term corticosteroid use.
- Are newly enrolled in a practice and have no documentation of their most recent cervical cytology result.

Some surveillance pathways recommend an hr-HPV test alone or a repeat co-testing in 1 or 3 years. How should the visit be coded?

In addition to the ICD-10-CM codes for the client’s method of contraception, follow-up encounters for HPV-alone and co-testing screening visits are reimbursable with the ICD-10-CM diagnosis codes listed in the PPBI manual (*ben fam rel*, pages 29-31).

Should I ever check the CPT code for an HPV test on the encounter form (or superbill)?

No, unless your clinic or practice does this solely for record keeping purposes. The codes for HPV testing will be billed by the lab that performs the test. Family PACT covers CPT code 87624 (hr-HPV; 14 types), as well as CPT code 87625 (hr-HPV, types 16 and 18 only) as a reflex test when 87624 is positive.

Providers should refer to the Family PACT Policies, Procedures, and Billing Instructions (PPBI) Manual for the complete text of the Family PACT policies and billing information.

References

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