CLINICAL PRACTICE ALERT
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 Family PACT Program has adopted the current guidelines of the United States Preventive Services Task Force[1] (USPSTF) with additional recommendations from the American Cancer Society.[2]

In this document, the term "individuals" is used to refer to *individuals with a cervix*. When a guideline is quoted directly, the original terms of "woman" or "female" are used.

Key Recommendations

The USPSTF[1] recommends that cervical cytology screening should begin no sooner than 21 years of age and be performed every 3 years for individuals between 21-29 years of age.

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

- Cervical cytology alone every 3 years
- High risk human papillomavirus (hr-HPV) alone testing every 5 years
- Co-testing (cervical cytology plus hr-HPV testing) every 5 years

Immunocompromised individuals (e.g., major organ transplant recipients and long-term users of corticosteroids or immunosuppressive drugs) should be screened with the same recommendations as individuals who are human immunodeficiency virus (HIV) positive[3] (see page 3).

Management of individuals with abnormal screening results should be based on the *2019 American Society for Colposcopy and Cervical Pathology (ASCCP) Risk-Based Management Consensus Guidelines*. Clinicians who perform colposcopy and staff who provide follow-up of individuals with abnormal screening results are encouraged to purchase and download the ASCCP mobile app to guide management decisions.

Questions and Answers

How often should cervical cancer screening be performed?

In addition to the Key Recommendations above:

- Except for individuals who are HIV positive, cytology screening begins at 21 years of age, regardless of the age at first intercourse. Screening those younger than 21 for cervical cancer lacks proven benefit and is harmful to some individuals because of overdiagnosis and overtreatment.
- Continued surveillance with HPV-alone testing or co-testing at 3-year intervals for at least ***25 years*** is recommended after treatment of histologic high-grade squamous intraepithelial lesion (HSIL), cervical intraepithelial neoplasia (CIN) 2, CIN 3, or adenocarcinoma in situ (AIS) even if 65 years of age or older. Continued surveillance at 3-year intervals beyond 25 years is acceptable as long as the individual's life expectancy and ability to be screened are not significantly compromised by serious health issues.

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

Screening for 14 types of hr-HPV alone is called primary hr-HPV screening. This option requires use of a U.S. Food and Drug Administration (FDA)-approved test for stand-alone use, either the Cobas® or the Onclarity hr-HPV Test. Both tests are FDA-approved for screening individuals 25 years or older. While primary hr-HPV screening detected 50% more CIN3+ lesions compared with cytology, it also resulted in double the number of colposcopies.

Recommendations for primary hr-HPV screening for cervical cancer:

- Re-screening after a negative hr-HPV screen should occur every 5 years.
- When the hr-HPV test is positive, the lab will perform a reflex genotype test (for HPV 16 and 18) *and* a reflex cervical cytology test on the original sample.
  - If HPV 16 or 18 is detected, perform (or refer for) colposcopy.
  - If one or more of the *other* 12 hr-HPV types are detected, the cervical cytology test result is used to triage the individual either to colposcopy (if the cytology result is atypical squamous cells of undetermined significance [ASCUS] or worse) or to repeat hr-HPV screening in 1 year (if the cytology result is negative).

Do individuals who have never had genital-to-genital contact need to be screened?

Individuals of any age who have never had intimate genital-to-genital contact should be advised that their risk of cervical cancer is extremely low, but not zero. Once counseled, either they may decline cervical cancer screening or opt to be screened routinely.

Are the screening intervals different for individuals with multiple partners?

No. While individuals 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 progression if a lesion does develop. There is no benefit to more frequent screening which is likely to detect incident infections that are transient and are usually

destined to resolve on their own without causing harm. The recommended routine screening interval maximizes the likelihood that screening will detect *persistent* hr-HPV infection which is the cause of pre-invasive high-grade lesions and cervical cancer.

What are the screening recommendations for individuals living with HIV?

The Federal Office of Acquired Immunodeficiency Syndrome (AIDS) Research[3] and the United States Centers for Disease Control and Prevention (CDC)[4] recommend that females who have HIV should have age-based cervical cancer screening:

- Adolescents with HIV should be screened 1 year after onset of sexual activity, regardless of age or mode of HIV acquisition, but no later than age 21 years.
- Individuals ages 21 to 29 years should have a cytology test at the time of initial diagnosis with HIV.
  - Provided the initial cytology test is negative, the next cytology test should occur in 12 months.
  - If the results of three consecutive cytology tests are normal, follow-up cytology tests should be performed every 3 years.
  - Co-testing (cytology and hr-HPV test) is not recommended for those < 30 years of age.
- For individuals 30 years of age and older, cervical cancer screening can be done either with cytology testing only or with co-testing (cytology test and hr-HPV test). If the result of the cytology test is negative and hr-HPV co-testing is negative, follow-up cytology and hr-HPV co-testing can be performed every 3 years.

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

Individuals who have a compromised immune system can develop pre-invasive lesions more rapidly than those who are immunocompetent. This includes those with a major organ transplant with the use of anti-rejection drugs, long-term corticosteroid use, and the use of other immunosuppressive drugs, such as those for psoriasis. The ASCCP recommends that these individuals be screened at the same intervals as individuals who are HIV positive.

If an individual 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.

What should I tell individuals who insist on having cervical cytology screening annually despite a history of prior negative results?

Individuals should be counseled that screening intervals are designed to balance benefits and risks of screening and that being screened too often may be harmful to their health.

Overscreening 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-person visit?

USPSTF[5] states that there is no evidence that this practice improves ovarian cancer outcomes and recommends against routine screening for ovarian cancer in low-risk individuals. The American College of Obstetricians and Gynecologists (ACOG)[6] recommends that females 21 years of age and older should be offered a *screening* pelvic exam in the context of shared decision-making. *Family PACT Standards* do not require a screening bimanual pelvic exam at any age, except for intrauterine device (IUD) placement and fittings of diaphragms.

Application of Family PACT Policies

Does Family PACT cover HPV immunization to prevent cervical cancer and its precursors?

Yes. Coverage for HPV vaccination is restricted to individuals 19 to 45 years of age.

- Those younger than 19 years old should seek HPV vaccination through the Vaccines for Children Program, which is widely available in California.
- For individuals 27 to 45 years of age, opt-in HPV vaccination must be based on a documented shared clinical decision-making process that includes a discussion of benefits and risks of vaccination.

Will Family PACT cover cervical cytology for individuals younger than 21 years of age?

Yes, but only if the individual is HIV positive or immunocompromised. The ordering provider must document on the laboratory order the indication for screening, as the pathology lab must include this on their claim.

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

Acceptable indications for more frequent screening include individuals who:

- Have had a previously abnormal screening test result, and consequently, are in a surveillance pathway.
- Have received treatment with cryotherapy, loop electrosurgical excision procedure (LEEP), or a cone biopsy for a pre-invasive cervical lesion.
- Have had a result of "insufficient specimen adequacy" or unsatisfactory for evaluation at the most recent cervical cytology screen.
- Have a history of in utero exposure to diethylstilbestrol (DES). In this case, cytology screening should be done annually.

- Are HIV positive, have had a major organ transplant with the use of an anti-rejection drug, or who are otherwise immunocompromised.
- 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 individual's method of contraception, follow-up encounters for hr-HPV-alone and co-testing screening visits are reimbursable with the ICD-10-CM diagnosis codes listed in the Benefits: Family Planning-Related Services section of the *Family PACT Policies, Procedures and Billing Instructions (PPBI)* manual.

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

No, unless your clinic or practice does this solely for record-keeping purposes. The codes for hr-HPV testing will be billed by the lab that performs the test. Providers should refer to the *Family PACT Policies, Procedures and Billing Instructions (PPBI)* manual for the complete text of the *Family PACT Standards*, official administrative practices, and billing information.

References

1. U.S. Preventive Services Task Force. Final Recommendation Statement: Cervical Cancer: Screening [Internet]. Rockville (MD). 2018 Aug. Available at:
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   - https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening
2. American Cancer Society. The American Cancer Society Guidelines for the Prevention and Early Detection of Cervical Cancer. https://www.cancer.org/cancer/types/cervical-cancer/detection-diagnosis-staging/cervical-cancer-screening-guidelines.html.
3. Federal Office of AIDS. Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV. https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-opportunistic-infections/human?view=full.
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5. U.S. Preventive Services Task Force, Bibbins-Domingo K, Grossman DC, et al. Screening for Gynecologic Conditions with Pelvic Examination: U.S. Preventive Services Task Force Recommendation Statement. *JAMA*. 2017 Mar 7;317:947–953. https://jamanetwork.com/journals/jama/fullarticle/2608228.
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Additional Resources

1. Perkins RB, Guido RS, Castle PE, et al. 2019 ASCCP Risk-Based Management Consensus Guidelines for Abnormal Cervical Cancer Screening Tests and Cancer Precursors. *J Low Genit Tract Dis*. 2020 Apr;24(2):102-131. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7147428/.
2. Sawaya GF, et al. Cervical Cancer Screening: More Choices in 2019. *JAMA*. 2019 May 28;321(20):2018-2019. https://jamanetwork.com/journals/jama/fullarticle/2734304.
3. Sawaya GF, Smith-McCune K. Clinical Expert Series. Cervical Cancer Screening. *Obstet Gynecol*. 2016 Mar;127:459–67. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6585413/.
4. Policar M, Sawaga G, and Cason P. Contraceptive Technology, 22nd ed. Jones & Bartlett Learning; c2023. Chapter 24: Screening for Cervical, Breast, and Ovarian Cancer; p. 667-695. https://contraceptivetechnology.org/the-book/.