AAVBC

AMERICAN ACADEMY OF VALUE BASED CARE

Cervical Cancer

Quick Reference Guide

2026

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1 CLINICAL SNAPSHOT

Definition: Cervical cancer is a malignant neoplasm arising from the epithelium of the uterine cervix, the overwhelming majority of which are caused by persistent infection with high-risk human papillomavirus (hrHPV). HPV DNA is detectable in **99.7%** of cervical cancers.[1] The 2020 WHO classification divides cervical carcinomas into HPV-associated and HPV-independent tumors; **squamous cell carcinoma** accounts for roughly **75%**[3] of cases and **adenocarcinoma** for about **20-25%**.[2,3] Diagnosis requires histopathologic confirmation from a cervical biopsy or conization specimen[3]. Because cervical cancer develops over years through well-defined precancerous stages, it is one of the most preventable solid tumors — yet it remains under-recognized in older women, in whom screening is often stopped prematurely.[4]

ICD-10 Codes:

Invasive cervical cancer is reported under the **C53** category — **C53.0** (endocervix), **C53.1** (exocervix), **C53.8** (overlapping sites), and **C53.9** (cervix uteri, unspecified). When pathology specifies an endocervical or exocervical origin, the specific subsite code **(C53.0 or C53.1)** should be assigned rather than defaulting to **C53.9**. Carcinoma in situ (**D06.0/D06.1/D06.9**) and cervical dysplasia (**N87.0** = CIN1/LSIL, **N87.1** = CIN2) are non-invasive and do **not** map to any HCC in V28. Abnormal screening results are captured with **R87.61x** (cytology) and **R87.81x** (HPV status), and the screening encounter itself with **Z12.4**. Secondary sites must be coded separately — **C78.0x** (lung), **C79.51** (bone), **C79.31** (brain) — and are frequently under-documented. **Z85.41** (personal history of malignant neoplasm of cervix) does not map to an HCC and must not be assigned until all active treatment is complete.[5]

Prevalence: Cervical cancer is commonly thought of as a disease of younger women, but more than **20%**[9] of cases and **36%** of deaths during 2014-2018 occurred in **women older than 65**.[6] The highest incidence was among 65-69 year old women at 27.4 per 100,000.[7] Older women are diagnosed at advanced stage (FIGO II-IV) **71%** of the time versus **48%** for younger women, and their 5-year relative survival is correspondingly lower at **23-37%** compared with **42-52%**. A comorbidity burden (Charlson score >=1 in **54%**of women >65 with cervical cancer) is independently associated with late-stage diagnosis (OR 1.59, 95% CI 1.21-2.08).[8]

HCC/RAF V28 Mapping

ICD-10 CODE	HCC (V28)	CNA RAF	DOCUMENTATION TRIGGER
C53.0 (Malignant neoplasm of endocervix)	**HCC 22** Bladder/ Colorectal/and Other Cancers	0.363	**Active invasive cancer**; biopsy/pathology specifying endocervical origin. Code as current until all treatment complete
C53.1 (Malignant neoplasm of exocervix)	**HCC 22** Bladder/ Colorectal/and Other Cancers	0.363	Pathology specifying **exocervical origin**

ICD-10 CODE	HCC (V28)	CNA RAF	DOCUMENTATION TRIGGER
C53.8 (Overlapping sites of cervix uteri)	**HCC 22** Bladder/ Colorectal/and Other Cancers	0.363	**Tumor spanning both endocervix and exocervix** per pathology
C53.9 (Cervix uteri, unspecified)	**HCC 22** Bladder/ Colorectal/and Other Cancers	0.363	Default **only when subsite is truly undocumented**; prompt the pathologist/ physician to specify
D06.x (Carcinoma in situ of cervix (incl. AIS))	None	—	**Non-invasive precancer**; distinct from invasive **C53.x**. No HCC value — accurate staging language matters
N87.0/N87.1 (Cervical dysplasia (CIN1/CIN2))	None	—	**Precancerous dysplasia**; not a malignancy for coding. Document grade from pathology
Z85.41 (Personal history of malignant neoplasm of cervix)	None	—	Surveillance only — assign **ONLY** after **ALL** active treatment is complete. Premature use removes the active-cancer complexity from the record

ABBREVIATIONS: C53 = malignant neoplasm of cervix uteri; AIS = adenocarcinoma in situ; CIN = cervical intraepithelial neoplasia; LSIL/HSIL = low-/high-grade squamous intraepithelial lesion; HCC = Hierarchical Condition Category; CNA = Community Non-Dual Eligible, Aged; RAF = Risk Adjustment Factor; V28 = 2026 CMS-HCC model
***RAF values represent the Community Non-Dual Eligible Aged (CNA) coefficient from the 2026 CMS-HCC model;11 values vary across patient populations based on eligibility and care setting**

Risk-Adjusted Care Resources per Patient/Year[9,10]

Risk-adjusted care resource allocation — MA base rate (~$10,402.34) × RAF coefficient

Cervical Cancer

$3,776

HCC 22 · RAF 0.363

RAF values represent the Community Non-Dual Eligible Aged (CNA) coefficient from the 2026 CMS-HCC model; values vary across patient populations based on eligibility and care setting

2 RECOGNITION AND DIAGNOSIS

Medicare Screenings and Surveillance (Adult and Geriatric)

POPULATION/SETTING	RECOMMENDED APPROACH	INTERVAL	NOTES
Average-risk women 30-65[11]	Primary **hrHPV** testing preferred (cytology or co-testing acceptable); self-collected HPV is an endorsed option	hrHPV every **5 yrs**; cytology every **3 yrs**; co-test every **5 yrs**	2026 WPSI/HRSA designates primary **hrHPV the preferred modality**; ACOG, AAFP, SGO, and ACP currently endorse the **2018 USPSTF recommendations**[12]
Adequately screened, average-risk, age >=65[13]	May stop screening **only** if exit criteria met: **negative HPV** at 60 and 65, **OR 3 consecutive** negative Pap tests, last at 65	One-time verification at the age-65 encounter	Any abnormality at or after age 65 **immediately** postpones cessation
High-risk women >=65 (CIN2+ within 25 yr; HIV/ immunosuppression; DES exposure)[13]	**Continue** surveillance regardless of age	Co-test every **3 yrs** (>=25 yr after CIN2+); annual cytology lifelong for DES; lifelong for HIV	**Post-hysterectomy with CIN2+ history**: vaginal-cuff HPV/co-test every 3 yr for >=25 yr
Inadequately/unknown prior screening at 65[13]	Continue until 2 consecutive negative HPV tests or 3 consecutive negative Pap tests obtained	Standard intervals until criteria met	Only ~**33%**of women meet documented cessation criteria at 65 — **verify, do not assume**
Medicare Part B coverage[6]	Pap collection (Q0091) + pelvic/breast exam (G0101); no upper age limit in Medicare policy	Every **24 mo** average-risk; every **12 mo** high-risk	**Medicare has no age cap**, unlike the USPSTF stop-at-65 recommendation for adequately screened women

ABBREVIATIONS: AAFP = American Academy of Family Physicians; ACOG = American College of Obstetricians and Gynecologists; ACP = American College of Physicians; hrHPV = high-risk human papillomavirus; CIN = cervical intraepithelial neoplasia; DES = diethylstilbestrol; HIV = human immunodeficiency virus; SGO = Society of Gynecologic Oncology; WPSI = Women's Preventive Services Initiative; HRSA = Health Resources and Services Administration; MA = Medicare Advantage; USPSTF = US Preventive Services Task Force

CLINICAL PEARL

Two overlapping but distinct guideline sets currently exist for cervical cancer screening: **WPSI/HRSA (2026)**, which designates primary hrHPV testing as preferred, and the professional societies (**ACOG, AAFP, SGO, ACP**), which continue to endorse the **2018 USPSTF** framework of cytology, co-testing, or hrHPV as acceptable options. Both agree on the underlying evidence; they differ on which modality to lead with. In practice, any of the three approaches (hrHPV alone, cytology alone, or co-testing) remains guideline-concordant. The choice can be individualized to patient preference and access.

A separate and more consequential issue involves **age-65 cessation**. The USPSTF recommends stopping routine screening at 65 for women who are adequately screened and average-risk. However, research from Boston Medical Center found that **fewer than 1 in 3 women aged 64-66** actually met the documented exit criteria required to stop. The result is a population exiting surveillance prematurely, without verified eligibility.

The takeaway for primary care: **guideline-driven cessation, applied without confirming individualized exit criteria, creates a silent late-life diagnostic gap.** Before deferring or stopping screening at 65, **confirm** that the documented negative-HPV or negative-Pap history actually meets exit criteria.

Subtle Early Signs in Older Adults

WARNING SIGN	CLINICAL SIGNIFICANCE	RISK SIGNAL	COMMON MISATTRIBUTION
Any postmenopausal vaginal bleeding (even a single spot)[14]	**Strongest symptomatic predictor of cervical cancer in older women** — warrants speculum exam and prompt evaluation	OR **43** (95% CI 25-75); PPV **4.6%** in women >=55	Atrophic vaginitis, HRT breakthrough bleeding, “normal aging”
Vaginal discharge (watery, pink, or foul-smelling)[14]	**Second most common** presenting symptom	OR **8.8** (95% CI 5.2-15)	Bacterial vaginosis, yeast infection
Intermenstrual/irregular bleeding (peri-cessation)[14]	Associated with **cervical pathology**	OR **4.7** (95% CI 1.6-14)	Hormonal irregularity
Hematuria[14]	May indicate **bladder invasion**	OR **4.6** (95% CI 2.1-10)	UTI, bladder atrophy
Persistent pelvic/ abdominal pain[14]	Suggests parametrial or pelvic-sidewall extension	OR **1.8** (95% CI 1.4-2.5)	Musculoskeletal/ degenerative disease

WARNING SIGN	CLINICAL SIGNIFICANCE	RISK SIGNAL	COMMON MISATTRIBUTION
Unilateral leg swelling + pelvic pain[3]	**Pelvic-sidewall invasion** with venous/lymphatic obstruction — sign of advanced (>=IIIB) disease	Clinical sign of advanced disease	DVT, lymphedema from other causes
Unexplained low hemoglobin[14]	May reflect **chronic blood loss** from a cervical lesion	OR **2.6** (95% CI 1.8-3.8)	Anemia of chronic disease, nutritional

ABBREVIATIONS: OR = odds ratio; CI = confidence interval; PPV = positive predictive value; HRT = hormone replacement therapy; UTI = urinary tract infection; DVT = deep vein thrombosis; FIGO = International Federation of Gynecology and Obstetrics

Geriatric Risk Factors

RISK FACTOR	EFFECT ESTIMATE	GERIATRIC RELEVANCE
Persistent high-risk HPV infection	Necessary cause; HPV in **99.7%** of cervical cancers[15]	Immune senescence may permit reactivation of latent HPV **after menopause** — biologically plausible but incompletely quantified
HIV/immunosuppression	RR **2.20** (95% CI 1.89-2.54); immunosuppressive medication RR 1.33 (95% CI 1.27-1.39)[16]	**Transplant or autoimmune-disease** therapy in older adults raises risk; mandates lifelong screening
Current smoking (>=1 pack/day)	Adjusted RR **4.3** (95% CI 2.0-9.3) for CIN3+/cancer in HPV-positive women[17]	**Long cumulative exposure**
Inadequate prior screening[13]	Single most important modifiable factor; **~two-thirds** of cancers occur in never/under-screened women	Gaps in documented cervical cytology or hrHPV testing history are common in the **65+ MA population**
Comorbidity burden (Charlson >=1)	Present in **54%** of women >65; OR 1.59 (95% CI 1.21-2.08) for late-stage diagnosis[8]	Independently **drives advanced-stage** presentation and constrains treatment tolerance
Altered vaginal microbiome	RR **1.59** (95% CI 1.40-1.81)[16]	An emerging cofactor; **relevant across age groups**

ABBREVIATIONS: HPV = human papillomavirus; RR = relative risk; CI = confidence interval; CIN3+ = cervical intraepithelial neoplasia grade 3 or worse; HIV = human immunodeficiency virus; hrHPV = high-risk human papillomavirus; MA = Medicare Advantage; Charlson = Charlson Comorbidity Index

Diagnostic Thresholds (FIGO 2018 Bethesda ASCCP)

SYSTEM/THRESHOLD	DEFINITION	CLINICAL USE
FIGO 2018 staging[18,19]	Stage IB subdivided into **IB1 (<=2 cm)**, **IB2 (>2-4 cm)**, **IB3 (>4 cm)**; new **Stage IIIC** for nodal disease (IIIC1 pelvic, IIIC2 para-aortic); imaging (MRI, PET/CT) formally incorporated	Primary US staging system for treatment selection. **5-yr survival: IB1 91.6% IB2 83.3%, IB3 76.1%; IIIC1 60.8% vs IIIC2 37.5%**; FIGO 2018 improves stage-I discrimination
AJCC TNM, 8th ed.[3]	**Parallels FIGO with tumor/node/ metastasis classification**	Used primarily for cancer-registry reporting and epidemiology rather than bedside decisions
Bethesda System (2014)[20]	Cytology categories: ASC-US, ASC-H, LSIL, HSIL, AGC, carcinoma	Reports screening cytology; drives the ASCCP risk-based algorithms
ASCCP 2019 risk-based management[13]	Action keyed to immediate CIN3+ risk: >=4% → colposcopy; **>=25%** → treatment or colposcopy; **>=60%** → expedited treatment	Applies regardless of age; prior negative HPV lowers risk by ~**50%**for low-grade abnormalities
CIN histologic grading[13]	CIN1 (LSIL), CIN2, CIN3 (HSIL)	**CIN3** has >**80%** inter-pathologist agreement (most reliable); CIN2 is heterogeneous and may regress

ABBREVIATIONS: FIGO = International Federation of Gynecology and Obstetrics; AJCC = American Joint Committee on Cancer; TNM = tumor-node-metastasis; ASC-US/ASC-H = atypical squamous cells of undetermined significance/cannot exclude HSIL; LSIL/HSIL = low-/high-grade squamous intraepithelial lesion; AGC = atypical glandular cells; ASCCP = American Society for Colposcopy and Cervical Pathology; CIN = cervical intraepithelial neoplasia

CLINICAL PEARL : FIGO 2018 SHARPENS PROGNOSIS

Survival drops sharply with each substage: **91.6%** (IB1) → **83.3%** (IB2) → **76.1%** (IB3), and nodal disease splits even further — **60.8%** (IIIC1, pelvic nodes) vs. **37.5%** (IIIC2, para-aortic nodes). By separating tumor size and nodal location this precisely, FIGO 2018 gives a much sharper read on stage-I prognosis than prior staging systems. A small difference in substage can mean a very different survival curve.[18,19]

Clues to Dig Deeper

CLUE/FINDING	WHY IT MATTERS	ACTION
Atrophic transformation zone after menopause[21]	**Squamocolumnar junction recedes into the canal**, lowering Pap sensitivity and complicating colposcopy	Favor primary **hrHPV** testing — specificity **89.6%**vs **67.4%**for co-testing in this group
ASC-US reported on an atrophic smear[21]	**Misread atrophy** is among the most common cytology errors in postmenopausal women	**Reflex hrHPV**; a negative HPV result is more reassuring than negative cytology here
Bleeding attributed to "resumption of menses" by the patient[22]	**Patients themselves often normalize postmenopausal bleeding**, delaying care by months to years	Educate that **any postmenopausal bleeding needs evaluation**; document the cervical exam
HPV 16/18 positive in a woman >65[13]	Carries high **CIN3+ risk** independent of cytology	**Expedited colposcopy regardless of the Pap result**
New hydronephrosis on imaging with known cervical pathology[3]	Suggests **parametrial/sidewall extension** (Stage IIIB)	**Urgent gyn-onc evaluation;**[4] assess renal function and ureteral patency

ABBREVIATIONS: hrHPV = high-risk human papillomavirus; ASC-US = atypical squamous cells of undetermined significance; CIN3+ = cervical intraepithelial neoplasia grade 3 or worse; gyn-onc = gynecologic oncology

Common Oversights

CLINICAL OVERSIGHT	CONSEQUENCE	BETTER PRACTICE
Treating age 65 as an automatic screening stop[13]	Misses the **~two-thirds** of women who have not met exit criteria; only **one-third aged 64-66** actually qualify	Verify adequate-screening criteria at the age-65 encounter **before stopping**
Attributing postmenopausal bleeding to atrophy or UTI[14]	Delays diagnosis of the highest-OR predictor (OR **43**) and shifts presentation to advanced stage	Perform a speculum exam and refer urgently for any postmenopausal bleeding
Relying on Pap cytology alone in older women[21]	**Reduced sensitivity from atrophic sampling**; missed high-grade lesions	Use primary hrHPV testing, which has **higher specificity** in this population
Not flagging high-risk patients who must continue past 65[13]	CIN2+, HIV/immunosuppression, and DES-exposed women go unscreened	**Build EHR registries** to identify patients needing continued surveillance

CLINICAL OVERSIGHT	CONSEQUENCE	BETTER PRACTICE
Overlooking comorbidity-driven late presentation[8]	**Charlson >=1 (54%**[6] **of >65)** independently predicts advanced stage	**Lower the threshold** to evaluate symptoms in medically complex older women
Missing pelvic-sidewall signs (leg edema, sciatica, hydronephrosis)[3]	Advanced (IIIB+) disease mistaken for DVT, radiculopathy, or musculoskeletal pain	Recognize the **edema-pain-hydronephrosis triad** as a marker of sidewall invasion

ABBREVIATIONS: UTI = urinary tract infection; OR = odds ratio; hrHPV = high-risk human papillomavirus; CIN2+ = cervical intraepithelial neoplasia grade 2 or worse; HIV = human immunodeficiency virus; DES = diethylstilbestrol; EHR = electronic health record; DVT = deep vein thrombosis; Charlson = Charlson Comorbidity Index

Key Differentials in Elderly

DIFFERENTIAL	DISTINGUISHING FEATURES	HOW TO RESOLVE
Atrophic vaginitis[21]	**Diffuse thin/friable mucosa** vs. **bleeding** usually with intercourse or exam vs. no discrete lesion	Speculum exam +/- cytology/ hrHPV; treat atrophy but still **evaluate the cervix for any bleeding**
Endometrial carcinoma[23]	**Postmenopausal bleeding** with thickened endometrium on ultrasound	Transvaginal ultrasound and endometrial sampling; **both** cancers present with postmenopausal bleeding
Cervical polyp/benign lesion[3]	Smooth, pedunculated, typically non-friable	Visualize and biopsy any suspicious or friable lesion to exclude malignancy
Vaginal or vulvar carcinoma[3]	Lesion located in the vagina/vulva rather than the cervix	**Careful full pelvic exam** and directed biopsy
Recurrent UTI/cystitis[14]	Dysuria and frequency; **may coexist with hematuria**	If hematuria persists after treatment, evaluate for bladder/ cervical pathology
Pelvic DVT/lymphedema[4]	**Leg swelling without a pelvic mass**	Imaging to distinguish primary vascular cause from tumor-related sidewall obstruction

ABBREVIATIONS: hrHPV = high-risk human papillomavirus; UTI = urinary tract infection; DVT = deep vein thrombosis

AAVBC PERSPECTIVE

*Cervical cancer risk in older women is compounded by **physiological changes that complicate both detection and recognition**. After menopause, the cervical transformation zone migrates higher into the cervical canal, reducing Pap test sensitivity, increasing false-positive rates, and making colposcopy technically more difficult due to cervical atrophy.*
*These physiological changes are frequently compounded by **symptom misattribution**. Postmenopausal bleeding, new vaginal discharge, and pelvic pain, hallmark warning signs of cervical cancer, are commonly attributed to urinary tract infection, genitourinary syndrome of menopause, or tissue thinning.*
*AAVBC's mission is to ensure primary care physicians distinguish expected findings of menopause from findings requiring evaluation. **Any postmenopausal bleeding, including a single episode, warrants cervical evaluation**. Diagnostic vigilance must account for the added technical and clinical complexity of screening and symptom assessment in this population.*

Comorbidity Screening

COMORBIDITY	SCREEN/MONITOR	WHY IT MATTERS
HIV/immunosuppression[4]	Document the immunosuppressive condition	Risk for cervical cancer; **mandates lifelong screening** and captures full complexity[57]
Renal insufficiency/CKD	Baseline and serial GFR before and during cisplatin	**Cisplatin is nephrotoxic**; CKD or stage-IIIB hydronephrosis may require carboplatin substitution or ureteral stenting[3]
Diabetes mellitus	Glucose control; monitor for neuropathy on taxanes	**Raises hospitalization risk** during chemotherapy and **worsens taxane neuropathy**
Anemia	Pre-treatment hemoglobin	**Low pre-treatment hemoglobin** is an independent adverse prognostic factor for OS in elderly patients receiving radiotherapy
VTE risk[3]	Assess for DVT/PE; consider prophylaxis during treatment	Cervical cancer is a **high-VTE** malignancy; sidewall disease compounds risk
Osteoporosis	Bone-density testing before pelvic radiation	**Prior pelvic RT increases pelvic-fracture risk**; consider bone-density testing and bisphosphonates

ABBREVIATIONS: HIV = human immunodeficiency virus; RR = relative risk; CKD = chronic kidney disease; GFR = glomerular filtration rate; OS = overall survival; VTE = venous thromboembolism; DVT = deep vein thrombosis; PE = pulmonary embolism; RT = radiotherapy

⚠ RED FLAG — EMERGENCY/ACTIVATE CRISIS RESPONSE

- **Massive vaginal hemorrhage** requiring stabilization, transfusion, or vaginal packing
- **Urosepsis** from obstructive uropathy (hydronephrosis in **Stage IIIB** disease) with fever, altered mental status, or hemodynamic instability
- **Acute renal failure with anuria** from bilateral ureteral obstruction
- **Pulmonary embolism or acute DVT** with hemodynamic compromise (cervical cancer is a high-VTE malignancy)

⚠ RED FLAG — URGENT (24-72 HOURS)

- **Any postmenopausal vaginal bleeding** — even a single episode warrants urgent gynecologic evaluation to exclude cervical cancer
- **HSIL, ASC-H, or cytologic malignancy** on Pap (expedited colposcopy)
- **HPV 16/18 positive** in a woman **>65** (expedited colposcopy regardless of cytology)
- **New-onset hydronephrosis** with known cervical pathology
- **Leg swelling with pelvic pain** suggesting sidewall involvement
- **Friable, ulcerated, or mass lesion** on speculum exam — biopsy and gyn-onc referral within days

3 MEAT DOCUMENTATION ESSENTIALS

MEAT documentation (Monitor, Evaluate, Assess/Address, Treat) supports the clinical complexity of cervical cancer in the medical record. The most important coding decision in this disease is knowing when to transition from active malignancy (**C53.x**) to history of malignancy (**Z85.41**): keep the diagnosis active until all treatment is complete and the patient has moved into surveillance only. Coding this transition too early is the most consequential documentation error in cervical cancer management.

*Case vignette: A female patient, 74, with stage IB2 squamous cell carcinoma of the exocervix completed radical hysterectomy and is now receiving adjuvant chemoradiation. Because active treatment is ongoing, the record continues to carry **C53.1** (active cancer) with MEAT support at each visit; **Z85.41** is not yet appropriate. Her CKD prompted carboplatin substitution for cisplatin, and her tobacco use and anemia are co-documented as contributors to clinical complexity.*

MONITOR: "Treatment status: adjuvant chemoradiation ongoing — radical hysterectomy completed (date). Hemoglobin trend: monitored each cycle; baseline anemia documented as contributor to clinical complexity. Renal function: BMP drawn each platinum cycle; **CrCl** at baseline prompted carboplatin substitution for cisplatin. Functional status: ECOG [#]. Tobacco use: active/former — cessation counseling documented this visit. Weight: stable/[change noted]. Imaging: post-treatment CT/PET-CT scheduled per oncology protocol. Surveillance plan not yet initiated — active treatment ongoing; HPV-based testing at **6**, **18**, and **30** months post-treatment, then every **3 years** for ≥**25 years**, to begin at completion of all active therapy"

EVALUATE: "Radical hysterectomy pathology (date): squamous cell carcinoma, exocervix, FIGO 2018 stage **IB2** (tumor **>2 cm** and **≤4 cm**). LVSI: [documented]. Margins: [documented]. Nodal status: [documented]. Adjuvant chemoradiation initiated (date) for high-intermediate risk features. PD-L1 CPS: [result or pending] — relevant if systemic therapy escalation is considered. Histology confirmed squamous cell (approximately **75%** of cervical cancers); adenocarcinoma excluded. **C53.1** assigned (exocervix, active malignancy); **Z85.41** not appropriate while active treatment is ongoing. Vague language such as 'consistent with' or 'suspicious for' avoided — definitive histologic confirmation in record."

ASSESS: "Squamous cell carcinoma of the exocervix, FIGO 2018 stage **IB2**, active treatment ongoing = **C53.1**. No documented metastatic disease (**C78.x/C79.x** not applicable at this time). Comorbidities affecting treatment tolerance: CKD (**N18.x**) — drove carboplatin substitution, nephrology co-managing; anemia (**D64.9**) — hemoglobin monitored each cycle; tobacco use disorder (**F17.21x**) — cessation counseling active; VTE risk elevated (high-VTE malignancy) — prophylaxis and monitoring documented. Geriatric consideration: age **74** — functional status and treatment intensity decision documented at multidisciplinary tumor board."

TREAT: "Radical hysterectomy (date) followed by adjuvant chemoradiation (start date); carboplatin substituted for cisplatin — rationale: CKD with renal impairment, documented in record. Treatment status — not date of surgery — governs current coding: **C53.1** remains active until all modalities complete and surveillance-only phase initiated. Supportive care: tobacco cessation reinforcement; anemia management (iron supplementation vs. transfusion threshold documented); VTE prophylaxis per protocol; nutritional support. Referrals: gynecologic oncology (primary), radiation oncology (concurrent), nephrology (CKD/platinum monitoring). Surveillance plan to begin post-treatment: HPV-based testing at **6**, **18**, and **30** months, then every **3 years** for ≥**25 years**. ACP documented (CPT **99497**): surrogate named, goals of care addressed given age and treatment intensity."

Clinical Documentation Elements

- **Anatomic subsite from pathology** (endocervix vs exocervix vs overlapping) to support **C53.0/C53.1/C53.8** rather than defaulting to **C53.9**
- **Histologic type** (squamous cell carcinoma vs adenocarcinoma) and FIGO 2018 substage with node status(e.g., **Stage IIIC2**, para-aortic node involvement, vs **Stage IIIC1**, pelvic node involvement only)
- **Active-treatment status** — surgery, chemotherapy, radiation, immunotherapy — and whether the patient remains under active treatment or is in surveillance
- **All secondary/metastatic sites coded separately** (**C78.x** lung, **C79.51** bone, **C79.31** brain), which are frequently under-documented
- **Hysterectomy type** — **total vs supracervical** — because a supracervical hysterectomy leaves a cervix and continued screening is needed
- **Co-testing detail:** when both Pap and HPV are performed, list both explicitly
- **Comorbidities affecting chemotherapy tolerance** (CKD, diabetes, anemia, VTE) with their ICD-10 codes

Reframing Common Documentation Shortcuts

COMMON SHORTCUT	WHY IT FALLS SHORT	REFRAME
"History of cervical cancer" coded right after surgery	**Z85.41** assigned while adjuvant chemoradiation is ongoing removes the active-cancer complexity (HCC 22) and misrepresents disease burden	Code **C53.x** until ALL active treatment is complete; transition to **Z85.41** only in surveillance
"Cervical cancer" with no subsite	Defaults to **C53.9** and loses anatomic specificity	Document endo- vs exocervical origin from pathology → **C53.0/C53.1**
Metastatic sites omitted	Distant disease (lung, bone, brain) under-coded even when known	Code each secondary site **(C78.x, C79.x)** separately alongside the primary
"Consistent with"/"suspicious for" malignancy	Tentative language blocks a definitive **C53.x** code	Record the confirmed histologic diagnosis once pathology returns
"Screening normal" without test detail	Co-testing components not captured	List Pap and HPV results separately, with the screening encounter **(Z12.4)** where applicable

ABBREVIATIONS: HCC = Hierarchical Condition Category; C53.x = malignant neoplasm of cervix; Z85.41 = personal history of cervical cancer; C78.x/C79.x = secondary malignant neoplasm

DOCUMENTATION IS COMPREHENSIVE CODING

Documentation that names the **subsite**, the **histology**, the **FIGO substage**, every **metastatic site**, and the **active-treatment status** is simply an accurate clinical record. Coding completeness follows from good care: it supports the **surveillance and coordination** these patients need, and it keeps the **active-versus-history transition** tied to clinical reality.

4 TREATMENT AND REFERRAL QUICK GUIDE

Treatment is stratified by **FIGO 2018 stage**. Performance status and geriatric fitness should drive treatment intensity decisions. SEER data show that older women derive comparable benefit from standard-intensity treatment when fitness allows, and the **NCCN Older Adult Oncology** guidelines support this approach.[18,24,25]

Therapy Escalation Criteria

TRIGGER	ACTION*	RATIONALE
Biopsy-confirmed invasive cancer (any FIGO stage)[18]	Refer to **gynecologic oncology**; stage with exam +/- MRI/PET-CT	Stage-directed therapy requires accurate **FIGO 2018 substaging**
Locally advanced disease (IB3-IVA)	Chemoradiation within **56 days** of initiation[26]	Completing definitive chemoradiation within **56 days** is a validated quality benchmark
FIGO 2014 stage III-IVA, high-risk LACC	Add concurrent + maintenance **pembrolizumab** to chemoradiation (NCCN category 1)	KEYNOTE-A18: **progression reduced 30%** (HR 0.70, 95% CI 0.55-0.89); death reduced 33% (HR 0.67, 95% CI 0.50-0.90)[27]
Recurrent/metastatic (IVB)[28]	Systemic therapy by **PD-L1 CPS**; biomarker testing required	**Pembrolizumab combination if CPS >=1**; document staging and CPS before therapy
Medically inoperable early-stage older patient[25]	Curative RT +/- concurrent cisplatin; geriatric assessment (4Ms, CARG/CRASH)	Chronologic age alone **should not** preclude curative intent

ABBREVIATIONS: FIGO = International Federation of Gynecology and Obstetrics; LACC = locally advanced cervical cancer; HR = hazard ratio; CI = confidence interval; PD-L1 = programmed death-ligand 1; CPS = combined positive score; RT = radiotherapy; CARG/CRASH = Cancer and Aging Research Group/Chemotherapy Risk Assessment Scale for High-Age patients; 4Ms = What Matters, Mobility, Medication, Mentation
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

NCCN-Aligned Treatment by FIGO 2018 Stage and Patient Profile

FIGO STAGE/SETTING	APPROACH*	NOTES
Stage IA1 (no LVSI)[29]	**Conization** with negative margins **OR extrafascial** (Type A) hysterectomy	Lymphatic-metastasis risk <**1%**[3]
Stage IA2-IB1[29]	Radical **hysterectomy** (Type C1) **with SLN mapping** or pelvic **lymphadenectomy** (category 1)	**Open abdominal approach is standard**; MIS was inferior for DFS/OS in the LACC trial. Select tumors (<=2 cm, no LVSI, margins clear, depth <10 mm) may have simple hysterectomy + SLN[30]

FIGO STAGE/SETTING	APPROACH*	NOTES
Stage IB2-IIA1[29]	Radical **hysterectomy with lymphadenectomy** (category 1) **OR** pelvic **EBRT** + concurrent **cisplatin** + **brachytherapy**	Both are NCCN category 1; choice depends on **operability and patient goals**
Stage IB3-IVA (locally advanced)[26]	Pelvic EBRT + concurrent weekly **cisplatin** 40 mg/m^2 (capped 70 mg) + brachytherapy within **56 days**; add **pembrolizumab** for FIGO 2014 III-IVA	Carboplatin substitution for cisplatin-intolerant patients; **induction** carboplatin/paclitaxel (INTERLACE) **may precede chemoradiation**[29]
Stage IVB/recurrent/ metastatic[29]	CPS >=1: **pembrolizumab** + platinum/ paclitaxel +/- **bevacizumab** (KEYNOTE-826). CPS <1: **platinum/ paclitaxel** + **bevacizumab** (GOG 240: OS 17.5 vs 15 mo; HR 0.73)[3]	Second-line: **tisotumab vedotin** or **single-agent** pembrolizumab (CPS >=1)
Older patients receiving radiotherapy	**Add chemotherapy to RT when fitness allows**, older patients are commonly **under-offered standard treatment**	SEER (n=2,958, >=65): **chemo** + **RT** improved 5-yr OS **47.8%** vs **26.9%** (HR 0.55, 95% CI 0.49-0.61) and cancer-specific survival 58.7% vs 43.8% (HR 0.64)[31]

ABBREVIATIONS: FIGO = International Federation of Gynecology and Obstetrics; LVSI = lymphovascular space invasion; SLN = sentinel lymph node; MIS = minimally invasive surgery; DFS/OS = disease-free/overall survival; EBRT = external-beam radiotherapy; CPS = combined positive score; RT = radiotherapy; HR = hazard ratio; CI = confidence interval; mo = months
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

CLINICAL PEARL

Performance status and geriatric fitness should drive treatment intensity. A SEER analysis of women aged 65 and older showed that adding chemotherapy to radiotherapy raised **5-year overall survival from 26.9% to 47.8%**.[31] The **NCCN Older Adult Oncology 4Ms framework** and **CARG/ CRASH tools** provide structured approaches to therapy planning in this population. **Dose modification should be reserved for genuine organ-function limitations**, not applied reflexively based on age alone. When standard-intensity treatment is delivered, disease-specific survival is comparable to that of younger women.

Non-Pharmacologic Care and Supportive Interventions

INTERVENTION	ROLE	NOTES
Patient navigation	Increases **screening completion** and **follow-up** of abnormal results	A 2025 meta-analysis found navigation significantly increased screening vs usual care; **HRSA** now covers it as a preventive service[32,33]
Self-collected HPV testing	Reaches women facing **transportation, scheduling, or exam-discomfort barriers**[11,34]	Endorsed by the **2025 WPSI/ HRSA and ACS updates**; coverage effective Jan 2027, adoptable earlier by MA plans[11,13]
Smoking cessation	Reduces a quantified cofactor (adjusted **RR 4.3 for CIN3+/cancer**)[17]	**Offer counseling and pharmacotherapy** at every relevant encounter[35]
Bone health before pelvic RT	**Reduces pelvic-fracture risk** after radiation[36]	**Bone-density testing and bisphosphonates** where osteoporosis is present
Geriatric/functional assessment	Guides **treatment intensity and supportive needs**	4Ms framework; CARG and CRASH chemotherapy-toxicity tools[25]

ABBREVIATIONS: HPV = human papillomavirus; RR = relative risk; CIN3+ = cervical intraepithelial neoplasia grade 3 or worse; RT = radiotherapy; WPSI = Women's Preventive Services Initiative; HRSA = Health Resources and Services Administration; MA = Medicare Advantage; CARG/CRASH = chemotherapy-toxicity assessment tools

Medication Safety and Key Interactions

AGENT*	KEY SAFETY/INTERACTION IN OLDER ADULTS*
Cisplatin	**Nephrotoxic** — requires adequate renal function (e.g., **GFR ≥60 mL/min** (standard cutoff); ADDIKD permits **≤50 mg/m^2** at **eGFR 45–59** with good PS.);[37,38] substitute **carboplatin** in CKD; aggressive hydration and antiemesis[29]
Carboplatin	**Preferred substitute** for cisplatin-intolerant or renally impaired patients; monitor for myelosuppression[29]
Paclitaxel	**Peripheral neuropathy** (worse with diabetes);[39] review **CYP3A4 inhibitors** (fluconazole, clarithromycin, diltiazem, verapamil) before initiating[40]

AGENT*	KEY SAFETY/INTERACTION IN OLDER ADULTS*
Bevacizumab	**Induces hypertension in ~25%**; monitor BP each visit; bleeding/fistula risk — caution in pelvic disease[3]
Pembrolizumab	**Immune-related adverse events**; older patients derive comparable benefit but need closer toxicity monitoring. Requires PD-L1/staging documentation[25]
NSAIDs (concurrent with cisplatin)	**AVOID**; Additive nephrotoxicity with cisplatin; substitute acetaminophen for analgesia during platinum cycles[25,41]

ABBREVIATIONS: GFR = glomerular filtration rate; CKD = chronic kidney disease; CYP3A4 = cytochrome P450 3A4; BP = blood pressure; CPS = combined positive score; LACC = locally advanced cervical cancer; NSAID = nonsteroidal anti-inflammatory drug; PD-L1 = programmed death-ligand 1
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

When to Refer

SITUATION	FIRST STEP (PRIMARY CARE)	SPECIALIST/ORDER
Abnormal cytology/positive hrHPV[13]	Apply **ASCCP risk-based management**; arrange colposcopy per risk threshold	Colposcopy/biopsy; gynecology
Postmenopausal bleeding or friable cervical lesion[42]	Speculum exam; **urgent referra**l — **do not** attribute to atrophy	Gynecology; gynecologic oncology **if a mass is seen**
Biopsy-confirmed invasive cancer[29]	Coordinate staging work-up; co-document comorbidities	Gynecologic oncology for stage-directed treatment
Locally advanced or recurrent/metastatic disease	Confirm renal function, CPS testing; support timely start	Definitive chemoradiation should be completed within **56 days**; delays beyond this threshold reduce pelvic control and survival[43]
Older patient with treatment-tolerance concerns[25]	Geriatric/functional assessment **before** therapy decisions	Geriatric oncology input; 4Ms/CARG-CRASH

ABBREVIATIONS: hrHPV = high-risk human papillomavirus; ASCCP = American Society for Colposcopy and Cervical Pathology; CPS = combined positive score; 4Ms = What Matters, Mobility, Medication, Mentation; CARG/CRASH = chemotherapy-toxicity assessment tools

Follow-Up Timing

PHASE	SCHEDULE	COMPONENTS
Invasive cancer — first 2 yr[29]	Interval H&P every **3-6 months**	Symptom review, exam, stage-dependent imaging/ labs as indicated
Invasive cancer — years 3-5[29]	Every **6-12 months**	Continue surveillance; cytology of vaginal cuff as indicated
Invasive cancer — beyond 5 yr[29]	Annually	Long-term surveillance and survivorship care[44]
Post-treatment for CIN2/CIN3/AIS — initial[13]	HPV-based testing at **6, 18, and 30 months**	Most HPV-positive patients at 6 mo need colposcopy
Post-treatment precancer — long term[13]	HPV/co-test every **3 years for >=25 years**, even past 65	Post-hysterectomy: vaginal-cuff testing every **3 yr for >=25 yr**

ABBREVIATIONS: H&P = history and physical; CIN = cervical intraepithelial neoplasia; AIS = adenocarcinoma in situ; HPV = human papillomavirus; mo = months; yr = years

Comorbidity Management — Primary Care Role

COMORBIDITY	PRIMARY-CARE ROLE	COORDINATION POINT
CKD/renal impairment[37]	Monitor GFR; flag before platinum therapy	**Alert oncology for carboplatin substitution**; manage hydronephrosis/ stenting needs
Diabetes[40]	Optimize glycemic control; watch for neuropathy on taxanes	Coordinate during chemotherapy to limit hospitalization risk
Hypertension	Baseline and ongoing BP control	Tighten monitoring when bevacizumab is used **(HTN in ~28%)**[45]
Anemia[46]	Correct/monitor hemoglobin	Pre-treatment hemoglobin is **prognostic** in elderly RT patients
VTE risk/immobility[47]	Assess and educate on DVT/PE symptoms	Consider prophylaxis during active treatment in this high-VTE malignancy

COMORBIDITY	PRIMARY-CARE ROLE	COORDINATION POINT
Tobacco use[48]	Cessation support	**Reduces a quantified cofactor** and improves treatment tolerance

ABBREVIATIONS: CKD = chronic kidney disease; GFR = glomerular filtration rate; BP = blood pressure; HTN = hypertension; VTE = venous thromboembolism; DVT = deep vein thrombosis; PE = pulmonary embolism; RT = radiotherapy

Cost-Smart Options

BRAND (EST. COST)	COST-SMART OPTION	EST. SAVINGS	VALUE RATIONALE
Cisplatin 40 mg/m^2 IV weekly concurrent CRT (generic only; brand Platinol discontinued) (~$20–50/dose)[49]	Carboplatin AUC 2 IV weekly (generic only; brand Paraplatin discontinued) **(~$14–30/dose)**[50]	**~$5–20/dose** (**~$20-90/month** based on typical 4-6 week concurrent CRT course); clinical value is in avoiding nephrotoxicity-related admissions	Carboplatin appropriate when **CrCl <60 mL/min, grade ≥2** neuropathy, or ototoxicity; NCCN lists as acceptable CRT sensitizer alternative; same radiation schedule maintained[29]
Brand pembrolizumab IV Keytruda (~$12,272/200 mg dose q3wk; ~$17,700/mo WAC)[51]	No biosimilar available (patent through Jun 2028); no equivalent first-line r/m substitute	N/A	IRA caps Part D OOP at **$2,000/yr**; Merck Access Program; q6wk dosing **(~$24,544/dose)** cuts infusion visits by 50% at identical monthly cost[51]
Brand bevacizumab Avastin (~$8,700/cycle q3wk)[52]	**Biosimilar bevacizumab**: mvasi (bevacizumab-awwb; **~12%** below Avastin WAC) or zirabev (bevacizumab-bvzr; **~23%** below);[53] also alymsys (bevacizumab-maly), vegzelma (bevacizumab-adcd)	**~$1,000–2,000/cycle (~$1,300–2,600/mo)**[53]	All four biosimilars carry FDA-approved cervical cancer indication identical to Avastin; payers increasingly mandate or prefer biosimilar use; verify with infusion center formulary

BRAND (EST. COST)	COST-SMART OPTION	EST. SAVINGS	VALUE RATIONALE
Brand tisotumab vedotin Tivdak (~$34,000/mo WAC; ~$7,237/40 mg vial)[54]	No biosimilar; cemiplimab Libtayo **(~$13,181/cycle q3wk; ~$17,600/mo WAC)**[52]	**~$16,000/mo** vs cemiplimab; **~$31,000/mo** vs single-agent chemo **(~$1,944/cycle)**[52]	Tivdak is NCCN Category 1 preferred 2L option; ICER **$839,107/QALY** — not cost-effective at standard **$150,000/QALY** threshold;[55] cemiplimab lower-cost NCCN-listed alternative where eligible; single-agent chemo (topotecan, gemcitabine, or vinorelbine) for poor PS — discuss with gyn-onc[52]

ABBREVIATIONS: AUC = area under the curve; CrCl = creatinine clearance; CRT = chemoradiation therapy; ICER = incremental cost-effectiveness ratio; IRA = Inflation Reduction Act; NCCN = National Comprehensive Cancer Network; OOP = out-of-pocket; PS = performance status; QALY = quality-adjusted life-year; r/m = recurrent or metastatic; WAC = wholesale acquisition cost

Patient Education and Adherence

- Older patients and their families should understand that cervical cancer does not become less relevant at age 65 — more than **20% of cases** occur in women over 65, and the disease remains a real risk after routine screening ends[6]
- **Any vaginal bleeding after menopause** requires evaluation and should not be dismissed as a normal part of aging
- For women approaching 65, frame the visit as a **one-time check of whether prior screening was adequate**, and offer **self-collection** where access or discomfort is a barrier
- When treatment is needed, emphasize that **fitness guides treatment options**, and that completing **chemoradiation on schedule** (within **56 days**) is associated with improved outcomes

DOCUMENTATION — SCREENING-EXIT DECISION

Record the screening-exit decision explicitly: note whether adequate-screening criteria were met, the high-risk category if applicable, and the plan to continue or stop. Documenting the **reason** screening continues past 65 keeps the longitudinal record accurate and supports continuity across care teams

Quality Metrics Tie-In

MEASURE/METRIC	STANDARD	APPLICABILITY TO CERVICAL CANCER
Cervical Cancer Screening (HEDIS CCS; MIPS #309)	**Denominator:** women 21-64 enrolled in health plan during MP **Numerator:** cervical cytology in last 3 years (ages 21-64); OR hrHPV testing in last 5 years (ages 30-64); OR cytology/hrHPV co-test in last 5 years (ages 30-64) **Excl:** hysterectomy with cervix removal, hospice, palliative care[56]	HEDIS CCS and MIPS #309 apply only through age 64 — **Medicare beneficiaries ≥65 are not captured by either measure**. Half of women diagnosed with cervical cancer had seen a provider in the prior **5 years** without receiving appropriate screening or follow-up[57]
Osteoporosis and Bone Density Screening *(MIPS #418/Osteoporosis Screening)*	**Denominator:** Female patients aged 50–85 **Numerator:** At least one dual-energy X-ray absorptiometry (DXA) scan of the hip and spine	**The Pelvic Radiation Hazard:** Definitive pelvic radiotherapy (EBRT + brachytherapy) for cervical cancer triggers rapid bone demineralization and causes **pelvic insufficiency fractures (PIFs) in 10% to 29% of patients**, typically within 2 years of treatment
Kidney Health Evaluation for Diabetes	**Denominator:** Patients with diabetes or hypertension on active nephrotoxic drug regimens **Numerator:** Annual eGFR and urine albumin-to-creatinine ratio (uACR)	**Cisplatin-Induced Nephrotoxicity:** Cisplatin is a standard radiosensitizer used for chemoradiation. It is highly nephrotoxic and can lead to irreversible CKD Monitor baseline and post-treatment eGFR. Perform strict medication reconciliation, avoiding NSAIDs or other nephrotoxins to preserve remaining renal reserve

MEASURE/METRIC	STANDARD	APPLICABILITY TO CERVICAL CANCER
Plan All-Cause Readmissions *(HEDIS PCR/CMS Star)*	**Denominator:** Enrollees aged 18 or older with an acute inpatient discharge **Numerator:** Unplanned readmission within 30 days (lower is better)	**Acute Treatment Toxicities:** Post-discharge readmissions for cervical cancer patients are heavily driven by pelvic radiation complications (severe radiation proctitis/ secretory diarrhea, pelvic fistulas, acute bowel obstructions, acute radiation cystitis, or cisplatin-induced AKI)
EHR-based 65+ high-risk registry	**No formal HEDIS or MIPS measure.** Suggested internal benchmark: women ≥65 with any high-risk indication (history of CIN2/3 or cervical cancer, DES exposure in utero, HIV, immunocompromise) identified in EHR registry and offered continued annual cytology. Track registry completeness and screening closure rate[13]	Fills the surveillance gap that HEDIS CCS and MIPS #309 leave in the Medicare population. USPSTF recommends against routine screening at **≥65** but explicitly preserves continued screening for high-risk patients; MA plans should build registry-based identification to operationalize this distinction

ABBREVIATIONS: ACS = American Cancer Society; AKI = acute kidney injury; CCS-E = Cervical Cancer Screening-Electronic Clinical Data Systems; CIN = cervical intraepithelial neoplasia; DXA = dual-energy X-ray absorptiometry; ECDS = Electronic Clinical Data Systems; eGFR = estimated glomerular filtration rate; hrHPV = high-risk human papillomavirus; NCQA = National Committee for Quality Assurance; PCP = primary care provider; PIF = pelvic insufficiency fracture; uACR = urine albumin-to-creatinine ratio; USPSTF = U.S. Preventive Services Task Force.

CLINICAL PEARL

Two high-yield interventions in cervical cancer care lack a corresponding HEDIS or MIPS measure, though both directly affect outcomes and warrant routine attention.

Time to treatment completion: Chemoradiation completed beyond **56 days** from initiation is associated with worse local control and survival (2025 SGO/ACOG/ASCCP/ASTRO/ABS consensus standard). The PCP's role is upstream: timely oncology referral drives time-to-treatment-start, which is the primary lever affecting whether the full course finishes on schedule.[26]

Follow-up of abnormal results: Half of women diagnosed with cervical cancer had an encounter in the prior **5 years without** documentation of screening or follow-up. Closing the loop on abnormal cytology or hrHPV results (via colposcopy referral or repeat testing within guideline-specified timeframes) is the single highest-yield primary care intervention for this disease. **MIPS #374** (Closing the Referral Loop) captures colposcopy referral closure generally but is not cervical cancer–specific, so this gap can persist even in practices performing well on that measure.

QUALITY OUTCOME

When primary care treats the **65th-birthday visit** as a verification checkpoint, identifies **high-risk women** who require continued surveillance beyond routine screening age, and ensures **abnormal results receive timely follow-up**, the result is **earlier-stage diagnosis** and fewer preventable deaths in a population where survival is otherwise lower and post-screening-age cases remain undercharacterized. Better patient outcomes are the objective.

AAVBC PERSPECTIVE

AAVBC encourages primary care providers to treat the age-65 screening threshold as a clinical decision point requiring individualized risk assessment. *The USPSTF recommendation to discontinue routine screening at age 65 applies only to women who meet documented adequate prior screening criteria (three consecutive negative Pap tests or two negative co-tests within the prior ten years, with the most recent test within the last five years). When this documentation cannot be confirmed, screening must continue.*

AAVBC supports a longitudinal, risk-stratified approach once ***women turn 65****. Postmenopausal bleeding, unusual vaginal discharge, and pelvic pain are hallmark warning signs of cervical cancer in older women and are frequently misattributed to genitourinary syndrome of menopause, urinary tract infection, or age-related tissue changes. Any episode of postmenopausal vaginal bleeding warrants cervical evaluation, not reassurance.*

AAVBC also encourages providers to recognize that after menopause, the cervical transformation zone migrates higher into the cervical canal, reducing Pap test sensitivity and making both sample collection and colposcopy technically more challenging. ***Guideline-driven cessation applied without individualized assessment creates a silent diagnostic gap in a population that carries a disproportionate share of late-stage diagnoses and cervical cancer mortality.***

5 CODING REMINDERS AND CASE EXAMPLES

Coding Specificity

ICD-10 CODE	DESCRIPTION	SPECIFICITY GUIDANCE
C53.0/C53.1	**Malignant neoplasm** — endocervix/exocervix	**Assign the subsite-specific code when pathology states origin**; document “SCC arising from the endocervix/exocervix”

ICD-10 CODE	DESCRIPTION	SPECIFICITY GUIDANCE
C53.8	**Overlapping sites** of cervix uteri	Use when the tumor spans **both endo- and exocervix** per pathology
C53.9	Cervix uteri, **unspecified**	Default **only** when subsite is genuinely **undocumented**— prompt for specificity rather than defaulting
D06.0/D06.1/D06.9	**Carcinoma in situ** of cervix (incl. AIS)	Non-invasive precancer; do not equate with invasive **C53.x.** Specify subsite when known
N87.0/N87.1	**Cervical dysplasia** (CIN1/CIN2)	**Document grade from pathology**; not coded as malignancy
R87.61x/R87.81x/Z12.4	Abnormal **cytology/HPV status/ screening** encounter	List co-testing components separately; use **Z12.4** for the screening encounter
Z85.41	Personal **history** of malignant neoplasm of cervix	**Surveillance only** — assign **ONLY** after **ALL** active treatment (surgery, chemo, radiation, immunotherapy) is complete

ABBREVIATIONS: C53 = malignant neoplasm of cervix; AIS = adenocarcinoma in situ; CIN = cervical intraepithelial neoplasia; SCC = squamous cell carcinoma; HPV = human papillomavirus; HCC = Hierarchical Condition Category; CNA = Community Non-Dual Eligible, Aged; RAF = Risk Adjustment Factor; V28 = 2024 CMS-HCC model; ICD-10-CM = International Classification of Diseases, 10th Revision, Clinical Modification

Annual Clinical Review and Confirmation

- Cervical cancer is a chronic, risk-adjustable condition only while it is active. At least annually — and at every treatment-status change — confirm whether the patient remains under active treatment (**C53.x**, HCC 22) or has entered surveillance (**Z85.41**, no HCC). The transition is triggered by completion of all active treatment, not by the date of surgery
- Each year the active diagnosis is supported, re-document the anatomic subsite, histology, FIGO 2018 substage, and every metastatic site, with MEAT evidence at the encounter. A patient receiving adjuvant chemoradiation after hysterectomy is still in active treatment and is coded **C53.x**
- Confirm hysterectomy type in the record: A **supracervical** hysterectomy leaves a cervix, so screening and (if applicable) cancer coding continue; a **total** hysterectomy for benign disease ends routine cervical screening, but vaginal-cuff surveillance continues for a CIN2+ history

Good Documentation — EHR Tips

EHR TIP	HOW IT HELPS	EXAMPLE
Active-treatment status field	Keeps the **C53.x → Z85.41** transition tied to treatment completion	Structured flag: "Active treatment ongoing — adjuvant chemoradiation" -> retain **C53.1**
Pathology-driven subsite SmartPhrase	Prevents defaulting to **C53.9**	"SCC arising from the {endocervix/ exocervix} — assign **C53.0/C53.1**"
Metastatic-site checklist	Documents secondary sites that are otherwise under-coded	Prompt for **C78.0x** (lung), **C79.51** (bone), **C79.31** (brain) when distant disease is known·
Screening-exit verification template	Documents why screening continues **or** stops at 65	"Adequate prior screening met? Y/N; high-risk category; plan: continue/ stop"
Co-testing capture	Records both Pap and HPV components	Discrete result fields for cytology and hrHPV so both are billed/tracked

ABBREVIATIONS: EHR = electronic health record; SCC = squamous cell carcinoma; SmartPhrase = reusable documentation template; hrHPV = high-risk human papillomavirus; C53.x = malignant neoplasm of cervix; Z85.41 = personal history of cervical cancer

Brief Case Examples

SUCCESS — Postmenopausal Bleeding Worked Up, Early-Stage Diagnosis, Accurate Coding

Patient: Female patient, 68, presenting for an annual visit with a single episode of postmenopausal spotting

Documentation: Clinician documented the speculum exam, ordered primary hrHPV testing (positive 16/18), and referred for expedited colposcopy; biopsy confirmed stage IB1 SCC of the exocervix, coded **C53.1** (HCC 22) with comorbid CKD and tobacco use co-documented

Outcome: Early-stage diagnosis enabled radical hysterectomy with SLN mapping; carboplatin was planned in advance for her CKD. Active-cancer status was carried as **C53.1** throughout treatment

Why it worked: Postmenopausal bleeding was treated as a red flag rather than atrophy; hrHPV testing overcame atrophic-smear limitations; coding reflected active disease and full complexity

PITFALL — Premature History Coding and Omitted Complexity

Documentation as written: "Cervical cancer, status post hysterectomy — history of cervical cancer **(Z85.41)**." Note written while the patient was still receiving adjuvant chemoradiation; no subsite, stage, or metastatic detail recorded

Consequence: Premature **Z85.41** removed the active-cancer complexity (HCC 22) from the record while treatment was ongoing, and omitted lung metastases that were known but uncoded — misrepresenting disease burden

Coding impact: Active disease should have remained **C53.x** until all treatment was complete, with secondary sites **(C78.0x)** coded separately

Fix: Carry **C53.x** with MEAT support until surveillance begins; document subsite, FIGO substage, and every metastatic site; transition to **Z85.41** only after treatment completion

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