Annual gynecological exam
Applies to:

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

☐ Medicare Plus Blue℠ PPO ☐ Medicare Plus Blue℠ Group PPO ☒ Both

Annual gynecological exam

A screening pelvic examination is an exam performed when there is no specific complaint or symptom present. Such a screening pelvic exam may also be commonly referred to as an annual gynecological exam. The two terms are used interchangeably in this document. A screening pelvic examination helps detect pre-cancers, genital cancers (ovarian and endocervical), infections such as Sexually Transmitted Infections (STIs), fibroid uterus, and other genital, vaginal or reproductive abnormalities. STIs in women, particularly certain strains of genital warts, may increase the risk of cervical cancer. The screening pelvic examination evaluates the size and position of a woman's pelvic organs and can identify problems such as urinary incontinence.

Original Medicare

Original Medicare covers a broad range of preventive services, including a screening pelvic examination once every 24 months for all women.

The screening pelvic examination covered by Medicare is a stand-alone billable service. It is separate from the Initial Preventive Physical Examination (IPPE) or the Annual Wellness Visit (AWV). Medicare beneficiaries may obtain a screening pelvic examination at any time following Medicare Part B enrollment, including during their IPPE or AWV.

Frequency

- Medicare Part B covers a screening pelvic examination for all asymptomatic female beneficiaries at normal risk every 24 months (i.e., at least 23 months after the most recent screening pelvic examination).
- Medicare Part B covers an annual screening pelvic examination for female beneficiaries at high risk (i.e., at least 11 months after the most recent screening pelvic examination). High risk female beneficiaries must meet at least one of the following criteria:
  - — Evidence (based on her medical history or other findings) that she is at high risk of developing cervical or vaginal cancer.
  - — A woman of childbearing age who has had a pelvic examination during any of the preceding 3 years that indicated the presence of cervical or vaginal cancer or other abnormality.

Examination elements

A screening pelvic examination with or without specimen collection for smears or cultures should include at least seven of the following elements:

- Inspection and palpitation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge
- Digital rectal examination including sphincter tone, presence of hemorrhoids, or rectal masses
- Inspection of the external genitalia (general appearance, hair distribution, or lesions)
- Inspection of the urethral meatus (size, location, lesions, or prolapse)
- Urethra (masses, tenderness or scarring)

- Bladder (fullness, masses or tenderness)
- Vagina (general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele or rectocele)
- Cervix (general appearance, lesions or discharge)
- Uterus (size, contour, position, mobility, tenderness, consistency, descent or support)
- Adnexa/parametria (masses, tenderness, organomegaly or nodularity)
- Anus and perineum

Medicare Plus Blue PPO Enhanced Benefit

Medicare Plus Blue is a Medicare Advantage Plan, which provides at least the same level of benefit coverage as Original Medicare (Part A and Part B) and may provide enhanced benefits beyond the scope of Original Medicare within a single health care plan. This flexibility allows Blue Cross to offer enriched plans by using Original Medicare as the base program and adding desired benefit options.

Coverage for an annual gynecological exam (see examination elements under Original Medicare heading above) is provided under all individual Medicare Plus Blue PPO plans and under select Medicare Plus Blue Group plans. This exam may be provided up to once in any benefit year (i.e., at least 11 months have passed since the most recent screening pelvic exam). The scope of the benefit, reimbursement methodology, maximum payment amounts, and the member's cost sharing are determined by Blue Cross for individual coverage and by the group for those with group-based coverage.

Conditions for payment

Conditions for payment	
Eligible provider	MD, DO, Nurse Practitioner, Physician Assistant
Payable location	Office
Frequency	Once annually
HCPCS codes	G0101, P3000, P3001, Q0091, G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, 99383 – 99387, 99393 – 99397
Diagnosis restrictions	Z01.411, Z01.419, Z12.4, Z12.72, Z12.79, Z12.89, Z72.51 – Z72.53, Z77.21, Z77.22, Z77.9, Z91.89
Age restrictions	No restrictions

Reimbursement

The provider will be paid the lesser of the allowed amount of the provider's charge, minus the member's cost share. This represents payment in full and providers are not allowed to balance bill the member for the difference between the allowed amount and the charge.

Member cost sharing

- All individual Medicare Plus Blue PPO members receive one Annual Gynecological Exam at no cost. Cost share may apply to any test that is outside the scope of the Annual Gynecological Exam as defined under the Conditions for Payment section.
- Coverage for one Annual Gynecological Exam for Medicare Plus Blue PPO group members is determined by the member's group. Cost share may apply to any test that is outside the scope of the Annual Gynecological Exam as defined under the Conditions for Payment section.
- Medicare Plus Blue PPO providers should collect the applicable cost sharing from the member at the time of the service when possible. Cost sharing refers to a flat-dollar copayment a percentage coinsurance or a deductible. Providers can only collect the appropriate Medicare Plus Blue PPO cost sharing amounts from the member.
- If the member elects to receive a non-covered service, he or she is responsible for the entire charge associated with the non-covered service.

To verify benefits and cost share, providers may utilize web-Denis or call 1-866-309-1719.

Billing instructions for providers

1. Bill services on the CMS 1500 (02/12) claim form.
2. Use the Medicare Advantage PPO unique billing requirements.
3. Report CPT/HCPCS codes and diagnosis codes to the highest level of specificity.
4. Include your National Provider Identifier number on all claims.
5. Send your claims to your local BCBS plan.
6. Use electronic billing:
   a. Michigan providers
      Copies of the ANSI ASC X 12N 837 and 835 Institutional Health Care Claim and Health Care Claim Payment/Advice (BCBSM Electronic Data Interchange (EDI) Institutional 837/835 Companion Documents) are available on the BCBSM website under the reference library section at: **http://www.bcbsm.com/providers/help/faqs/electronic-connectivity-edi.html**.
   b. Providers outside of Michigan should contact their local BCBS plan.

Revision history

Policy number: MAPPO 1029

Revised: 11/21/2016, 8/2/2015, 2012

11/21/2016: p1 removed 'fibroid uterus and', added codes 99383 – 99387, 99393 – 99397, Z77.21, Z77.22, Z77.9 and Z91.89

Effective: 1/1/2016

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