Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-021		
Subject:	Annual Gynecological and Rectal Exams		
Effective Date:	January 29, 2018	**End Date:**	
Issue Date:	January 20, 2025	**Revised Date:**	January 2025
Date Reviewed:	January 2025		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐	**DE**	☐	**NY** ☐
Applicable Claim Type	**UB**	☒	**1500**	☒			

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

REIMBURSEMENT GUIDELINES:

Gynecological Examinations

Standard Preventive Schedule benefit reimbursement will be made for one (1) annual gynecological examination office visit (G0101, S0610, S0612, S0613) and one (1) routine pap smear (G0123, G0143, G0144, G0145, G0147, G0148) per calendar year for all females. One (1) HPV screening (87623, 87624, 87625) screening will be reimbursed once every 3 years (87623, 87624, 876250) for ages 30 and older.

Note: If the specialist (not the member's primary care provider) is reporting the preventive exam service, the provider should advise the member to not also schedule a preventive exam/visit with their primary care provider. Typically, only one preventive medicine visit is typically eligible per benefit year.

For those following the Woman's Health Federal Mandate reimbursement will be made for a total of two (2) gynecological examination office visits (G0101, S0610, S0612, S0613) per calendar year and one (1) routine pap smear G0123, G0143, G0144, G0145, G0147, G0148) per calendar year for all females. One (1) HPV screening will be reimbursed once every 3 years (87623, 87624, 876250) for ages 30 and older.

Note: (*New York only*) When reported, reimbursement may be made for the physician interpretation (G0124, G0141) in addition to pap smear codes (G0123, G0143, G0144, G0145, G0147, G0148).

Gynecological Exam and E&M Performed on the Same Day

When a physician performs a systemic physical examination as part of an annual gynecological examination, a medically focused condition may be encountered. In some instances, treatment for a medically focused condition may require more extensive medical evaluation, treatment, and/or management. This treatment may result in significant additional work requiring the key components associated with a problem-oriented evaluation and management (E/M) service. In these cases, the appropriate medical E/M new/established patient office visit code (99202 through 99215) may be reported in addition to the gynecological examination (G0101, S0610, S0612, or S0613).

Should the reporting of more than one visit per day by the same physician, or physician group occur on the same day be necessary, the patient's records must contain:

1. Sufficient documentation regarding the appropriateness of performing both services and,
2. Documentation of the key components that the service(s) were met

If the reported service(s) do not meet the component requirements, the codes will not be eligible for reimbursement or retainment of previous reimbursement. Payment for the service(s) will also be subject to coverage limitations specified within the individual member's benefits. The Plan will not reimburse a service that does not represent a significant separately identifiable service and that is not submitted appended with modifier 25. Payment for the E/M service will also be subject to coverage limitations specified within the individual member's benefits.

Note: Providers on the OPPS methodology would report G0463 instead of 99202 through 99215 for E/M (clinic) services.

Gynecological Exam and Preventive Exam Performed on the Same Day

When a physician performs an annual gynecological exam and a preventive exam (99381-99387, 99391-99397) on the same day, there is significant overlap of the components of these two services (i.e., history, blood pressure, weight checks, and/or physical examination). However, the preventive exam may include services beyond the scope of the gynecological exam, such as counseling and anticipatory guidance, risk factor intervention, age-appropriate lab work, and certain screening tests.

Should the reporting of preventive medicine and Office/Outpatient E/M service(s) by the same physician or physician group occur on the same day be necessary, the patient's records must contain:

1. Sufficient documentation regarding the appropriateness of performing both services and,
2. Documentation the key components of the Office/Outpatient E/M service have been met

If the reported Office/Outpatient E/M service does not meet the component requirements, it will not be eligible for reimbursement or retainment of previous reimbursement. Payment for the Office/Outpatient E/M service and/or the preventive medicine service will also be subject to coverage limitations specified within the individual member's benefits.

Pap Smear

When a pap smear code Q0091 (obtaining the specimen, preparing the slide, and conveyance) is reported on the same day as a gynecological examination (G0101, S0610, S0612, or S0613), or E/M service (99202 through 99215, 99381 through 99387, 99391 through 99397), and the charges are itemized, the Plan will combine the charges and pay only the gynecological examination or E/M service. Reimbursement for the gynecological examination or E/M service performed on the same date of service includes the allowance for the pap smear. A pap smear is <u>not</u> eligible as a distinct and separate service. A participating or network provider cannot bill the member separately for the pap smear in this case.

If the pap smear is performed independently, bill the procedure using the appropriate code(s). Charges for obtaining the specimen, preparing the slide, and conveyance of the pap smear (Q0091) are not eligible for separate reimbursement when reported independently of the gynecological examination or E/M service. A participating or contracted network provider cannot bill the member for the denied service.

Modifier 25, as appropriate, may be reported with medical care to identify the procedure as a significant, separately identifiable service from the pap smear.

Modifier FT, as appropriate, may be reported to identify to the service to indicate as an unrelated (E/M) visit during a postoperative period, or on the same day as a procedure or another E/M visit.

When the 25 or FT modifier(s) are reported, the patient's records must clearly document separately identifiable medical care was rendered.

Rectal Examinations

A digital rectal exam (DRE) is a routine exam in which a physician inserts a lubricated, gloved finger into the rectum and feels for abnormal areas. This is performed to detect rectal cancer nerve problems indicated by reduction of the normal tone of the muscles of the rectal sphincter and, in a man, inflammation, enlargement, or cancer of the prostate. Proctoscopy is a common medical procedure in which an instrument called a proctoscope (also known as a rectoscope, although the latter may be a bit longer) is used to examine the anal cavity, rectum, or sigmoid colon.

Rectal examinations (digital or with the use of a proctoscope) can be performed on patients with no signs or symptoms of disease or on symptomatic patients to aid in diagnosis or treatment. Rectal examinations performed on asymptomatic patients are considered screening procedures. Coverage for screening rectal examinations is determined according to individual or group customer benefits.

Report these codes for screening rectal examinations: G0102 *S0601 S0610 S0612 G0463

***Note**: New York's member benefit structure requires the use of other screening codes for services represented by code S0601. Another appropriate sigmoidoscopy or colonoscopy screening code should be submitted.

When services are covered as part of a member's benefit, a screening rectal examination is considered part of a covered (E/M) service or gynecological examination. Therefore, when a covered screening rectal examination is reported on the same day as a covered E/M service or gynecological examination, the Plan will combine the charges for the rectal examination with the charges for the E/M service or gynecological examination and reimburse only the E/M service or gynecological examination procedure(s).

Reimbursement for the E/M service or gynecological examination includes the allowance for the rectal examination. However, when a covered screening rectal examination is performed independently, it may be reimbursed.

Rectal examinations or proctoscopies performed on symptomatic patients are considered part of a provider's medical care. If rectal examinations or proctoscopies are reported on the same day as medical care and the charges are itemized, the charges will be combined and only the medical care will be paid. Reimbursement for the medical care performed on the same date of service includes the allowance for the rectal examinations or proctoscopy.

Modifier 25, as appropriate, may be reported with medical care to identify it as a significant, separately identifiable service from the rectal examinations or proctoscopies or gynecological examinations.

Modifier FT, as appropriate, may be reported to identify to the service to indicate as an unrelated (E/M) visit during a postoperative period, or on the same day as a procedure or another e/m visit.

When the 25 or FT modifier(s) are reported, the patient's records must clearly document separately identifiable medical care was rendered.

Note: Providers on the OPPS methodology would report G0463 for E/M services.

DEFINITIONS:

Modifier	Definition
25	Significant, separately identifiable evaluation and management (E/M) service by the same physician or other qualified health care professional on the same day.
FT	Unrelated evaluation and management (E/M) visit during a postoperative period, or on the same day as a procedure or another E/M visit. (Report when an E/M visit is furnished within the global period but is unrelated, or when one or more additional E/M visits furnished on the same are unrelated.

RELATED POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-009: Modifiers 25, 59, XE, XP, XS, XU, FT
- RP-020: Preventive Medicine and Office or Outpatient Evaluation and Management Services
- RP-035: Correct Coding Guidelines
- RP-057: Evaluation and Management Services

POLICY UPDATE HISTORY INFORMATION:

1 / 2018	Implementation
1 / 2021	Removed Code 99201
11 / 2021	Added NY region applicable to the policy. Noted P3000, P3001 and S0601 policy variations for NY.
1 / 2022	Added modifier FT
6 / 2022	Changed G0123-G0145 to G0123, G0124. Changed 99381 through 99397) to 99381 through 99387, 99391 through 99397. Removed MP L-1 reference as it was archived.
7 / 2023	Administrative policy review with no changes in policy direction
12 / 2024	Administrative policy review with no changes in policy direction
1 / 2025	Edited verbiage under Gynecological Examinations section. No change to policy direction

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HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-021		
Subject:	Annual Gynecological and Rectal Exams		
Effective Date:	January 29, 2018	**End Date:**	
Issue Date:	December 2, 2024	**Revised Date:**	November 2024
Date Reviewed:	November 2024		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐	**DE**	☐	**NY** ☐
Applicable Claim Type	**UB**	☒	**1500**	☒			

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

REIMBURSEMENT GUIDELINES:

Gynecological Examinations

Reimbursement will be made for one (1) annual gynecological examination (G0101, S0610, S0612, or S0613) regardless of the patient's condition, and one (1) routine pap smear (G0123, G0124, G0141-G0148, *P3000, *P3001) per calendar year for all females.

Note: If the specialist (not the member's primary care provider) is reporting the preventive exam service, the provider should advise the member to not also schedule a preventive exam/visit with their primary care provider. Typically, only one preventive medicine visit is typically eligible per benefit year.

The criteria above do not apply to member groups that follow the Women's Health Federal Mandate offered, issued or renewed on or after August 1, 2012. When reported, reimbursement may be made for the physician interpretation (G0124, G0141, *P3001) in addition to pap smear codes (G0123, G0143, G0144, G0145, G0147, G0148, *P3000).

Note: (*New York only*) When reported, reimbursement may be made for the physician interpretation (G0124, G0141) in addition to pap smear codes (G0123, G0143, G0144, G0145, G0147, G0148).

Gynecological Exam and E&M Performed on the Same Day

When a physician performs a systemic physical examination as part of an annual gynecological examination, a medically focused condition may be encountered. In some instances, treatment for a medically focused condition may require more extensive medical evaluation, treatment, and/or management. This treatment may result in significant additional work requiring the key components associated with a problem-oriented evaluation and management (E/M) service. In these cases, the appropriate medical E/M new/established patient office visit code (99202 through 99215) may be reported in addition to the gynecological examination (G0101, S0610, S0612, or S0613).

Should the reporting of more than one visit per day by the same physician, or physician group occur on the same day be necessary, the patient's records must contain:

1. Sufficient documentation regarding the appropriateness of performing both services and,
2. Documentation of the key components that the service(s) were met

If the reported service(s) do not meet the component requirements, the codes will not be eligible for reimbursement or retainment of previous reimbursement. Payment for the service(s) will also be subject to coverage limitations specified within the individual member's benefits. The Plan will not reimburse a service that does not represent a significant separately identifiable service and that is not submitted appended with modifier 25. Payment for the E/M service will also be subject to coverage limitations specified within the individual member's benefits.

Note: Providers on the OPPS methodology would report G0463 instead of 99202 through 99215 for E/M (clinic) services.

Gynecological Exam and Preventive Exam Performed on the Same Day

When a physician performs an annual gynecological exam and a preventive exam (99381-99387, 99391-99397) on the same day, there is significant overlap of the components of these two services (i.e., history, blood pressure, weight checks, and/or physical examination). However, the preventive exam may include services beyond the scope of the gynecological exam, such as counseling and anticipatory guidance, risk factor intervention, age-appropriate lab work, and certain screening tests.

Should the reporting of preventive medicine and Office/Outpatient E/M service(s) by the same physician or physician group occur on the same day be necessary, the patient's records must contain:

1. Sufficient documentation regarding the appropriateness of performing both services and,
2. Documentation the key components of the Office/Outpatient E/M service have been met

If the reported Office/Outpatient E/M service does not meet the component requirements, it will not be eligible for reimbursement or retainment of previous reimbursement. Payment for the Office/Outpatient E/M service and/or the preventive medicine service will also be subject to coverage limitations specified within the individual member's benefits.

Pap Smear

When a pap smear code Q0091 (obtaining the specimen, preparing the slide, and conveyance) is reported on the same day as a gynecological examination (G0101, S0610, S0612, or S0613), or E/M service (99202 through 99215, 99381 through 99387, 99391 through 99397), and the charges are itemized, the Plan will combine the charges and pay only the gynecological examination or E/M service. Reimbursement for the gynecological examination or E/M service performed on the same date of service

includes the allowance for the pap smear. A pap smear is not eligible as a distinct and separate service. A participating or network provider cannot bill the member separately for the pap smear in this case.

If the pap smear is performed independently, bill the procedure using the appropriate code(s). Charges for obtaining the specimen, preparing the slide, and conveyance of the pap smear (Q0091) are not eligible for separate reimbursement when reported independently of the gynecological examination or E/M service. A participating or contracted network provider cannot bill the member for the denied service.

Modifier 25, as appropriate, may be reported with medical care to identify the procedure as a significant, separately identifiable service from the pap smear.

Modifier FT, as appropriate, may be reported to identify to the service to indicate as an unrelated (E/M) visit during a postoperative period, or on the same day as a procedure or another E/M visit.

When the 25 or FT modifier(s) are reported, the patient's records must clearly document separately identifiable medical care was rendered.

Rectal Examinations

A digital rectal exam (DRE) is a routine exam in which a physician inserts a lubricated, gloved finger into the rectum and feels for abnormal areas. This is performed to detect rectal cancer nerve problems indicated by reduction of the normal tone of the muscles of the rectal sphincter and, in a man, inflammation, enlargement, or cancer of the prostate. Proctoscopy is a common medical procedure in which an instrument called a proctoscope (also known as a rectoscope, although the latter may be a bit longer) is used to examine the anal cavity, rectum, or sigmoid colon.

Rectal examinations (digital or with the use of a proctoscope) can be performed on patients with no signs or symptoms of disease or on symptomatic patients to aid in diagnosis or treatment. Rectal examinations performed on asymptomatic patients are considered screening procedures. Coverage for screening rectal examinations is determined according to individual or group customer benefits.

Report these codes for screening rectal examinations: G0102 *S0601 S0610 S0612 G0463

***Note**: New York's member benefit structure requires the use of other screening codes for services represented by code S0601. Another appropriate sigmoidoscopy or colonoscopy screening code should be submitted.

When services are covered as part of a member's benefit, a screening rectal examination is considered part of a covered (E/M) service or gynecological examination. Therefore, when a covered screening rectal examination is reported on the same day as a covered E/M service or gynecological examination, the Plan will combine the charges for the rectal examination with the charges for the E/M service or gynecological examination and reimburse only the E/M service or gynecological examination procedure(s).

Reimbursement for the E/M service or gynecological examination includes the allowance for the rectal examination. However, when a covered screening rectal examination is performed independently, it may be reimbursed.

Rectal examinations or proctoscopies performed on symptomatic patients are considered part of a provider's medical care. If rectal examinations or proctoscopies are reported on the same day as medical care and the charges are itemized, the charges will be combined and only the medical care will be paid. Reimbursement for the medical care performed on the same date of service includes the allowance for the rectal examinations or proctoscopy.

Modifier 25, as appropriate, may be reported with medical care to identify it as a significant, separately identifiable service from the rectal examinations or proctoscopies or gynecological examinations.

Modifier FT, as appropriate, may be reported to identify to the service to indicate as an unrelated (E/M) visit during a postoperative period, or on the same day as a procedure or another e/m visit.

When the 25 or FT modifier(s) are reported, the patient's records must clearly document separately identifiable medical care was rendered.

Note: Providers on the OPPS methodology would report G0463 for E/M services.

DEFINITIONS:

Modifier	Definition
25	Significant, separately identifiable evaluation and management (E/M) service by the same physician or other qualified health care professional on the same day.
FT	Unrelated evaluation and management (E/M) visit during a postoperative period, or on the same day as a procedure or another E/M visit. (Report when an E/M visit is furnished within the global period but is unrelated, or when one or more additional E/M visits furnished on the same are unrelated.

RELATED POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-009: Modifiers 25, 59, XE, XP, XS, XU, FT
- RP-020: Preventive Medicine and Office or Outpatient Evaluation and Management Services
- RP-035: Correct Coding Guidelines
- RP-057: Evaluation and Management Services

POLICY UPDATE HISTORY INFORMATION:

1 / 2018	Implementation
1 / 2021	Removed Code 99201
11 / 2021	Added NY region applicable to the policy. Noted P3000, P3001 and S0601 policy variations for NY.
1 / 2022	Added modifier FT
6 / 2022	Changed G0123-G0145 to G0123, G0124. Changed 99381 through 99397) to 99381 through 99387, 99391 through 99397. Removed MP L-1 reference as it was archived.
7 / 2023	Administrative policy review with no changes in policy direction
12 / 2024	Administrative policy review with no changes in policy direction

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-021		
Subject:	Annual Gynecological and Rectal Exams		
Effective Date:	January 29, 2018	**End Date:**	
Issue Date:	July 24, 2023	**Revised Date:**	July 2023
Date Reviewed:	July 2023		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐	**DE**	☐	**NY** ☐
Applicable Claim Type	**UB**	☒	**1500**	☒			

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

Digital rectal exam (DRE) is a routine exam in which a physician inserts a lubricated, gloved finger into the rectum and feels for abnormal areas. This is performed to detect rectal cancer nerve problems indicated by reduction of the normal tone of the muscles of the rectal sphincter and, in a man, inflammation, enlargement, or cancer of the prostate. Proctoscopy is a common medical procedure in which an instrument called a proctoscope (also known as a rectoscope, although the latter may be a bit longer) is used to examine the anal cavity, rectum, or sigmoid colon.

REIMBURSEMENT GUIDELINES:

Gynecological Examinations

Payment will be made for one (1) annual gynecological examination (G0101, S0610, S0612, or S0613) regardless of the patient's condition, and one (1) routine pap smear (G0123, G0124, G0141-G0148, *P3000, *P3001) per calendar year for all females.

The criteria above does not apply to those groups that follow the Women's Health Federal Mandate offered, issued or renewed on or after August 1, 2012. When reported, reimbursement may be made for the physician interpretation (G0124, G0141, *P3001) in addition to pap smear codes (G0123, G0143, G0144, G0145, G0147, G0148, *P3000).

Note: (*New York only*) When reported, reimbursement may be made for the physician interpretation (G0124, G0141) in addition to pap smear codes (G0123, G0143, G0144, G0145, G0147, G0148).

Gynecological Exam and E&M Performed on the Same Day

When a physician performs a systemic physical examination as part of an annual gynecological examination, a medically focused condition may be encountered. In some instances, treatment for a medically focused condition may require more extensive medical evaluation, treatment, and/or management. This treatment may result in significant additional work requiring the key components associated with a problem-oriented evaluation and management (E/M) service. In these cases, the appropriate medical E/M new/established patient office visit code (99202 through 99215) may be reported in addition to the gynecological examination (G0101, S0610, S0612, or S0613).

Should the reporting of more than one visit per day by the same physician, or physician group occur on the same day be necessary, the patient's records must contain:

1. Sufficient documentation regarding the appropriateness of performing both services and,
2. Documentation of the key components that the service(s) were met

If the reported service(s) do not meet the component requirements, the codes will not be eligible for reimbursement or retainment of previous reimbursement. Payment for the service(s) will also be subject to coverage limitations specified within the individual member's benefits. The Plan will not reimburse a service that does not represent a significant separately identifiable service and that is not submitted appended with modifier 25. Payment for the E/M service will also be subject to coverage limitations specified within the individual member's benefits.

Note: Providers on the OPPS methodology would report G0463 instead of 99202 through 99215 for E/M (clinic) services.

Gynecological Exam and Preventive Exam Performed on the Same Day

When a physician performs an annual gynecological exam and a preventive exam (99381-99387, 99391-99397) on the same day, there is significant overlap of the components of these two services (i.e., history, blood pressure, weight checks, and/or physical examination). However, the preventive exam may include services beyond the scope of the gynecological exam, such as counseling and anticipatory guidance, risk factor intervention, age-appropriate lab work, and certain screening tests.

Should the reporting of preventive medicine and Office/Outpatient E/M service(s) by the same physician or physician group occur on the same day be necessary, the patient's records must contain:

1. Sufficient documentation regarding the appropriateness of performing both services and,
2. Documentation the key components of the Office/Outpatient E/M service have been met

If the reported Office/Outpatient E/M service does not meet the component requirements, it will not be eligible for reimbursement or retainment of previous reimbursement. Payment for the Office/Outpatient E/M service and/or the preventive medicine service will also be subject to coverage limitations specified within the individual member's benefits.

Pap Smear

When a pap smear code Q0091 (obtaining the specimen, preparing the slide, and conveyance) is reported on the same day as a gynecological examination (G0101, S0610, S0612, or S0613), or evaluation and management service (99202 through 99215, 99381 through 99387, 99391 through

99397), and the charges are itemized, the Plan will combine the charges and pay only the gynecological examination or E/M service. Reimbursement for the gynecological examination or E/M service performed on the same date of service includes the allowance for the pap smear. A pap smear is not eligible as a distinct and separate service. A participating or network provider cannot bill the member separately for the pap smear in this case.

If the pap smear is performed independently, bill the procedure using the appropriate code(s). Charges for obtaining the specimen, preparing the slide, and conveyance of the pap smear (Q0091) are not eligible for separate reimbursement when reported independently of the gynecological examination or E/M service. A participating or contracted network provider cannot bill the member for the denied service.

Modifier 25, as appropriate, may be reported with medical care to identify the procedure as a significant, separately identifiable service from the pap smear.

Modifier FT, as appropriate, may be reported to identify to the service to indicate as an unrelated evaluation and management (e/m) visit during a postoperative period, or on the same day as a procedure or another e/m visit.

When the 25 or FT modifier(s) are reported, the patient's records must clearly document separately identifiable medical care was rendered.

Rectal Examinations

Rectal examinations (digital or with the use of a proctoscope) can be performed on patients with no signs or symptoms of disease or on symptomatic patients to aid in diagnosis or treatment. Rectal examinations performed on asymptomatic patients are considered screening procedures. Coverage for screening rectal examinations is determined according to individual or group customer benefits.

Report these codes for screening rectal examinations: G0102 *S0601 S0610 S0612 G0463

***Note**: New York's member benefit structure requires the use of other screening codes for services represented by code S0601. Another appropriate sigmoidoscopy or colonoscopy screening code should be submitted.

When services are covered as part of a member's benefit, a screening rectal examination is considered to be part of a covered evaluation and management (E/M) service or gynecological examination. Therefore, when a covered screening rectal examination is reported on the same day as a covered (E/M) service or gynecological examination, the Plan will combine the charges for the rectal examination with the charges for the E/M service or gynecological examination and reimburse only the E/M service or gynecological examination procedure(s).

Reimbursement for the E/M service or gynecological examination includes the allowance for the rectal examination. However, when a covered screening rectal examination is performed independently, it may be reimbursed.

Rectal examinations or proctoscopies performed on symptomatic patients are considered part of a provider's medical care. If rectal examinations or proctoscopies are reported on the same day as medical care and the charges are itemized, the charges will be combined and only the medical care will be paid. Reimbursement for the medical care performed on the same date of service includes the allowance for the rectal examinations or proctoscopy.

Modifier 25, as appropriate, may be reported with medical care to identify it as a significant, separately identifiable service from the rectal examinations or proctoscopies or gynecological examinations.

Modifier FT, as appropriate, may be reported to identify to the service to indicate as an unrelated evaluation and management (e/m) visit during a postoperative period, or on the same day as a procedure or another e/m visit.

When the 25 or FT modifier(s) are reported, the patient's records must clearly document separately identifiable medical care was rendered.

Note: Providers on the OPPS methodology would report G0463 for E/M services.

DEFINITIONS:

Modifier	Definition
25	Significant, separately identifiable E&M service by the same physician or other qualified health care professional on the same day.
FT	Unrelated evaluation and management (E/M) visit during a postoperative period, or on the same day as a procedure or another E/M visit. (Report when an E/M visit is furnished within the global period but is unrelated, or when one or more additional E/M visits furnished on the same are unrelated.

RELATED POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-009: Modifiers 25, 59, XE, XP, XS, XU, FT
- RP-035: Correct Coding Guidelines
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POLICY UPDATE HISTORY INFORMATION:

1 / 2018	Implementation
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Highmark Reimbursement Policy Bulletin

HISTORY VERSION

HIGHMARK.

Bulletin Number:	RP-021		
Subject:	Annual Gynecological and Rectal Exams		
Effective Date:	January 29, 2018	**End Date:**	
Issue Date:	July 11, 2022	**Revised Date:**	June 2022
Date Reviewed:	June 2022		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐	**DE**	☐	**NY** ☐
Applicable Claim Type	**UB**	☒	**1500**	☒			

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

Digital rectal exam (DRE) is a routine exam in which a physician inserts a lubricated, gloved finger into the rectum and feels for abnormal areas. This is performed to detect rectal cancer nerve problems indicated by reduction of the normal tone of the muscles of the rectal sphincter and, in a man, inflammation, enlargement, or cancer of the prostate. Proctoscopy is a common medical procedure in which an instrument called a proctoscope (also known as a rectoscope, although the latter may be a bit longer) is used to examine the anal cavity, rectum, or sigmoid colon.

REIMBURSEMENT GUIDELINES:

Gynecological Examinations

Payment will be made for one (1) annual gynecological examination (G0101, S0610, S0612, or S0613) regardless of the patient's condition, and one (1) routine pap smear (G0123, G0124, G0141-G0148, *P3000, *P3001) per calendar year for all females.

The criteria above does not apply to those groups that follow the Women's Health Federal Mandate offered, issued or renewed on or after August 1, 2012. When reported, reimbursement may be made for the physician interpretation (G0124, G0141, *P3001) in addition to pap smear codes (G0123, G0143, G0144, G0145, G0147, G0148, *P3000).

Note: (*New York only*) When reported, reimbursement may be made for the physician interpretation (G0124, G0141) in addition to pap smear codes (G0123, G0143, G0144, G0145, G0147, G0148).

Gynecological Exam and E&M Performed on the Same Day

When a physician performs a systemic physical examination as part of an annual gynecological examination, a medically focused condition may be encountered. In some instances, treatment for a medically focused condition may require more extensive medical evaluation, treatment, and/or management. This treatment may result in significant additional work requiring the key components associated with a problem-oriented evaluation and management (E/M) service. In these cases, the appropriate medical E/M new/established patient office visit code (99202 through 99215) may be reported in addition to the gynecological examination (G0101, S0610, S0612, or S0613).

Should the reporting of more than one visit per day by the same physician, or physician group occur on the same day be necessary, the patient's records must contain:

1. Sufficient documentation regarding the appropriateness of performing both services and,
2. Documentation of the key components that the service(s) were met

If the reported service(s) do not meet the component requirements, the codes will not be eligible for reimbursement or retainment of previous reimbursement. Payment for the service(s) will also be subject to coverage limitations specified within the individual member's benefits. The Plan will not reimburse a service that does not represent a significant separately identifiable service and that is not submitted appended with modifier 25. Payment for the E/M service will also be subject to coverage limitations specified within the individual member's benefits.

Note: Providers on the OPPS methodology would report G0463 instead of 99202 through 99215 for E/M (clinic) services.

Gynecological Exam and Preventive Exam Performed on the Same Day

When a physician performs an annual gynecological exam and a preventive exam (99381-99387, 99391-99397) on the same day, there is significant overlap of the components of these two services (i.e., history, blood pressure, weight checks, and/or physical examination). However, the preventive exam may include services beyond the scope of the gynecological exam, such as counseling and anticipatory guidance, risk factor intervention, age-appropriate lab work, and certain screening tests.

Should the reporting of preventive medicine and Office/Outpatient E/M service(s) by the same physician or physician group occur on the same day be necessary, the patient's records must contain:

1. Sufficient documentation regarding the appropriateness of performing both services and,
2. Documentation the key components of the Office/Outpatient E/M service have been met

If the reported Office/Outpatient E/M service does not meet the component requirements, it will not be eligible for reimbursement or retainment of previous reimbursement. Payment for the Office/Outpatient E/M service and/or the preventive medicine service will also be subject to coverage limitations specified within the individual member's benefits.

Pap Smear

When a pap smear code Q0091 (obtaining the specimen, preparing the slide, and conveyance) is reported on the same day as a gynecological examination (G0101, S0610, S0612, or S0613), or evaluation and management service (99202 through 99215, 99381 through 99387, 99391 through

99397), and the charges are itemized, the Plan will combine the charges and pay only the gynecological examination or E/M service. Reimbursement for the gynecological examination or E/M service performed on the same date of service includes the allowance for the pap smear. A pap smear is not eligible as a distinct and separate service. A participating or network provider cannot bill the member separately for the pap smear in this case.

If the pap smear is performed independently, bill the procedure using the appropriate code(s). Charges for obtaining the specimen, preparing the slide, and conveyance of the pap smear (Q0091) are not eligible for separate reimbursement when reported independently of the gynecological examination or E/M service. A participating or contracted network provider cannot bill the member for the denied service.

Modifier 25, as appropriate, may be reported with medical care to identify the procedure as a significant, separately identifiable service from the pap smear.

Modifier FT, as appropriate, may be reported to identify to the service to indicate as an unrelated evaluation and management (e/m) visit during a postoperative period, or on the same day as a procedure or another e/m visit.

When the 25 or FT modifier(s) are reported, the patient's records must clearly document separately identifiable medical care was rendered.

Rectal Examinations

Rectal examinations (digital or with the use of a proctoscope) can be performed on patients with no signs or symptoms of disease or on symptomatic patients to aid in diagnosis or treatment. Rectal examinations performed on asymptomatic patients are considered screening procedures. Coverage for screening rectal examinations is determined according to individual or group customer benefits.

Report these codes for screening rectal examinations: G0102 *S0601 S0610 S0612 G0463

***Note**: New York's member benefit structure requires the use of other screening codes for services represented by code S0601. Another appropriate sigmoidoscopy or colonoscopy screening code should be submitted.

When services are covered as part of a member's benefit, a screening rectal examination is considered to be part of a covered evaluation and management (E/M) service or gynecological examination. Therefore, when a covered screening rectal examination is reported on the same day as a covered (E/M) service or gynecological examination, the Plan will combine the charges for the rectal examination with the charges for the E/M service or gynecological examination and reimburse only the E/M service or gynecological examination procedure(s).

Reimbursement for the E/M service or gynecological examination includes the allowance for the rectal examination. However, when a covered screening rectal examination is performed independently, it may be reimbursed.

Rectal examinations or proctoscopies performed on symptomatic patients are considered part of a provider's medical care. If rectal examinations or proctoscopies are reported on the same day as medical care and the charges are itemized, the charges will be combined and only the medical care will be paid. Reimbursement for the medical care performed on the same date of service includes the allowance for the rectal examinations or proctoscopy.

Modifier 25, as appropriate, may be reported with medical care to identify it as a significant, separately identifiable service from the rectal examinations or proctoscopies or gynecological examinations.

Modifier FT, as appropriate, may be reported to identify to the service to indicate as an unrelated evaluation and management (e/m) visit during a postoperative period, or on the same day as a procedure or another e/m visit.

When the 25 or FT modifier(s) are reported, the patient's records must clearly document separately identifiable medical care was rendered.

Note: Providers on the OPPS methodology would report G0463 for E/M services.

RELATED HIGHMARK POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-009: Modifiers 25, 59, XE, XP, XS, XU, FT
- RP-057: Evaluation and Management Services

POLICY UPDATE HISTORY INFORMATION:

1 / 2018	Implementation
1 / 2021	Removed Code 99201
11 / 2021	Added NY region applicable to the policy. Noted P3000, P3001 and S0601 policy variations for NY.
1 / 2022	Added modifier FT
6 / 2022	Changed G0123-G0145 to G0123, G0124. Changed 99381 through 99397) to 99381 through 99387, 99391 through 99397. Removed MP L-1 reference as it was archived.

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-021		
Subject:	Annual Gynecological and Rectal Exams		
Effective Date:	January 29, 2018	**End Date:**	
Issue Date:	January 10, 2022	**Revised Date:**	January 2022
Date Reviewed:	December 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐	**DE**	☐	**NY** ☐
Applicable Claim Type	**UB**	☒	**1500**	☒			

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

Digital rectal exam (DRE) is a routine exam in which a physician inserts a lubricated, gloved finger into the rectum and feels for abnormal areas. This is performed to detect rectal cancer nerve problems indicated by reduction of the normal tone of the muscles of the rectal sphincter and, in a man, inflammation, enlargement, or cancer of the prostate. Proctoscopy is a common medical procedure in which an instrument called a proctoscope (also known as a rectoscope, although the latter may be a bit longer) is used to examine the anal cavity, rectum, or sigmoid colon.

REIMBURSEMENT GUIDELINES:

Gynecological Examinations

Payment will be made for one (1) annual gynecological examination (G0101, S0610, S0612, or S0613) regardless of the patient's condition, and one (1) routine pap smear (G0123-G0145, G0141-G0148, *P3000, *P3001) per calendar year for all females.

The criteria above does not apply to those groups that follow the Women's Health Federal Mandate offered, issued or renewed on or after August 1, 2012. When reported, reimbursement may be made for the physician interpretation (G0124, G0141, *P3001) in addition to pap smear codes (G0123, G0143, G0144, G0145, G0147, G0148, *P3000).

Note: (*New York only*) When reported, reimbursement may be made for the physician interpretation (G0124, G0141) in addition to pap smear codes (G0123, G0143, G0144, G0145, G0147, G0148).

Gynecological Exam and E&M Performed on the Same Day

When a physician performs a systemic physical examination as part of an annual gynecological examination, a medically focused condition may be encountered. In some instances, treatment for a medically focused condition may require more extensive medical evaluation, treatment, and/or management. This treatment may result in significant additional work requiring the key components associated with a problem-oriented evaluation and management (E/M) service. In these cases, the appropriate medical E/M new/established patient office visit code (99202 through 99215) may be reported in addition to the gynecological examination (G0101, S0610, S0612, or S0613).

Should the reporting of more than one visit per day by the same physician, or physician group occur on the same day be necessary, the patient's records must contain:

1. Sufficient documentation regarding the appropriateness of performing both services and,
2. Documentation of the key components that the service(s) were met

If the reported service(s) do not meet the component requirements, the codes will not be eligible for reimbursement or retainment of previous reimbursement. Payment for the service(s) will also be subject to coverage limitations specified within the individual member's benefits. The Plan will not reimburse a service that does not represent a significant separately identifiable service and that is not submitted appended with modifier 25. Payment for the E/M service will also be subject to coverage limitations specified within the individual member's benefits.

Note: Providers on the OPPS methodology would report G0463 instead of 99202 through 99215 for E/M (clinic) services.

Gynecological Exam and Preventive Exam Performed on the Same Day

When a physician performs an annual gynecological exam and a preventive exam (99381 through 99397) on the same day, there is significant overlap of the components of these two services (i.e., history, blood pressure, weight checks, and/or physical examination). However, the preventive exam may include services beyond the scope of the gynecological exam, such as counseling and anticipatory guidance, risk factor intervention, age-appropriate lab work, and certain screening tests.

Should the reporting of preventive medicine and Office/Outpatient E/M service(s) by the same physician or physician group occur on the same day be necessary, the patient's records must contain:

1. Sufficient documentation regarding the appropriateness of performing both services and,
2. Documentation the key components of the Office/Outpatient E/M service have been met

If the reported Office/Outpatient E/M service does not meet the component requirements, it will not be eligible for reimbursement or retainment of previous reimbursement. Payment for the Office/Outpatient E/M service and/or the preventive medicine service will also be subject to coverage limitations specified within the individual member's benefits.

Pap Smear

When a pap smear code Q0091 (obtaining the specimen, preparing the slide, and conveyance) is reported on the same day as a gynecological examination (G0101, S0610, S0612, or S0613), or evaluation and management service (99202 through 99215, 99381 through 99397), and the charges are

itemized, the Plan will combine the charges and pay only the gynecological examination or E/M service. Reimbursement for the gynecological examination or E/M service performed on the same date of service includes the allowance for the pap smear. A pap smear is not eligible as a distinct and separate service. A participating or network provider cannot bill the member separately for the pap smear in this case.

If the pap smear is performed independently, bill the procedure using the appropriate code(s). Charges for obtaining the specimen, preparing the slide, and conveyance of the pap smear (Q0091) are not eligible for separate reimbursement when reported independently of the gynecological examination or E/M service. A participating or contracted network provider cannot bill the member for the denied service.

Modifier 25, as appropriate, may be reported with medical care to identify the procedure as a significant, separately identifiable service from the pap smear.

Modifier FT, as appropriate, may be reported to identify to the service to indicate as an unrelated evaluation and management (e/m) visit during a postoperative period, or on the same day as a procedure or another e/m visit.

When the 25 or FT modifier(s) are reported, the patient's records must clearly document separately identifiable medical care was rendered.

Rectal Examinations

Rectal examinations (digital or with the use of a proctoscope) can be performed on patients with no signs or symptoms of disease or on symptomatic patients to aid in diagnosis or treatment. Rectal examinations performed on asymptomatic patients are considered screening procedures. Coverage for screening rectal examinations is determined according to individual or group customer benefits.

Report these codes for screening rectal examinations: G0102 *S0601 S0610 S0612 G0463

***Note**: New York's member benefit structure requires the use of other screening codes for services represented by code S0601. Another appropriate sigmoidoscopy or colonoscopy screening code should be submitted.

When services are covered as part of a member's benefit, a screening rectal examination is considered to be part of a covered evaluation and management (E/M) service or gynecological examination. Therefore, when a covered screening rectal examination is reported on the same day as a covered (E/M) service or gynecological examination, the Plan will combine the charges for the rectal examination with the charges for the E/M service or gynecological examination and reimburse only the E/M service or gynecological examination procedure(s).

Reimbursement for the E/M service or gynecological examination includes the allowance for the rectal examination. However, when a covered screening rectal examination is performed independently, it may be reimbursed.

Rectal examinations or proctoscopies performed on symptomatic patients are considered part of a provider's medical care. If rectal examinations or proctoscopies are reported on the same day as medical care and the charges are itemized, the charges will be combined and only the medical care will be paid. Reimbursement for the medical care performed on the same date of service includes the allowance for the rectal examinations or proctoscopy.

Modifier 25, as appropriate, may be reported with medical care to identify it as a significant, separately identifiable service from the rectal examinations or proctoscopies or gynecological examinations.

Modifier FT, as appropriate, may be reported to identify to the service to indicate as an unrelated evaluation and management (e/m) visit during a postoperative period, or on the same day as a procedure or another e/m visit.

When the 25 or FT modifier(s) are reported, the patient's records must clearly document separately identifiable medical care was rendered.

Note: Providers on the OPPS methodology would report G0463 for E/M services.

RELATED HIGHMARK POLICIES:

Refer to the following Commercial Medical Policies for additional information:

- L-1: Pap Smears with Medical Conditions

Refer to the following Reimbursement Policies for additional information:

- RP-009: Modifiers 25, 59, XE, XP, XS, XU, FT
- RP-057: Evaluation and Management Services

POLICY UPDATE HISTORY INFORMATION:

1 / 2018	Implementation
1 / 2021	Removed Code 99201
11 / 2021	Added NY region applicable to the policy. Noted P3000, P3001 and S0601 policy variations for NY.
1 / 2022	Added modifier FT

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP- 021		
Subject:	Annual Gynecological and Rectal Exams		
Effective Date:	January 29, 2018	**End Date:**	
Issue Date:	November 1, 2021	**Revised Date:**	September 2021
Date Reviewed:	September 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐	**DE**	☐	**NY** ☐
Applicable Claim Type	**UB**	☒	**1500**	☒			

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this Policy.

PURPOSE:

Digital rectal exam (DRE) is a routine exam in which a physician inserts a lubricated, gloved finger into the rectum and feels for abnormal areas. This is performed to detect rectal cancer nerve problems indicated by reduction of the normal tone of the muscles of the rectal sphincter and, in a man, inflammation, enlargement, or cancer of the prostate. Proctoscopy is a common medical procedure in which an instrument called a proctoscope (also known as a rectoscope, although the latter may be a bit longer) is used to examine the anal cavity, rectum, or sigmoid colon.

REIMBURSEMENT GUIDELINES:

Gynecological Examinations

Payment will be made for one (1) annual gynecological examination (G0101, S0610, S0612, or S0613) regardless of the patient's condition, and one (1) routine pap smear (G0123-G0145, G0141-G0148, *P3000, *P3001) per calendar year for all females.

The criteria above does not apply to those groups that follow the Women's Health Federal Mandate offered, issued or renewed on or after August 1, 2012. When reported, reimbursement may be made for the physician interpretation (G0124, G0141, *P3001) in addition to pap smear codes (G0123, G0143, G0144, G0145, G0147, G0148, *P3000).

Note: (*New York only*) When reported, reimbursement may be made for the physician interpretation (G0124, G0141) in addition to pap smear codes (G0123, G0143, G0144, G0145, G0147, G0148).

Gynecological Exam and E&M Performed on the Same Day

When a physician performs a systemic physical examination as part of an annual gynecological examination, a medically focused condition may be encountered. In some instances, treatment for a medically focused condition may require more extensive medical evaluation, treatment, and/or management. This treatment may result in significant additional work requiring the key components associated with a problem-oriented evaluation and management (E/M) service. In these cases, the appropriate medical E/M new/established patient office visit code (99202 through 99215) may be reported in addition to the gynecological examination (G0101, S0610, S0612, or S0613).

Should the reporting of more than one visit per day by the same physician, or physician group occur on the same day be necessary, the patient's records must contain:

1. Sufficient documentation regarding the appropriateness of performing both services and,
2. Documentation of the key components that the service(s) were met

If the reported service(s) do not meet the component requirements, the codes will not be eligible for reimbursement or retainment of previous reimbursement. Payment for the service(s) will also be subject to coverage limitations specified within the individual member's benefits. The Plan will not reimburse a service that does not represent a significant separately identifiable service and that is not submitted appended with modifier 25. Payment for the E/M service will also be subject to coverage limitations specified within the individual member's benefits.

Note: Providers on the OPPS methodology would report G0463 instead of 99202 through 99215 for E/M (clinic) services.

Gynecological Exam and Preventive Exam Performed on the Same Day

When a physician performs an annual gynecological exam and a preventive exam (99381 through 99397) on the same day, there is significant overlap of the components of these two services (i.e., history, blood pressure, weight checks, and/or physical examination). However, the preventive exam may include services beyond the scope of the gynecological exam, such as counseling and anticipatory guidance, risk factor intervention, age-appropriate lab work, and certain screening tests.

Should the reporting of preventive medicine and Office/Outpatient E/M service(s) by the same physician or physician group occur on the same day be necessary, the patient's records must contain:

1. Sufficient documentation regarding the appropriateness of performing both services and,
2. Documentation the key components of the Office/Outpatient E/M service have been met

If the reported Office/Outpatient E/M service does not meet the component requirements, it will not be eligible for reimbursement or retainment of previous reimbursement. Payment for the Office/Outpatient E/M service and/or the preventive medicine service will also be subject to coverage limitations specified within the individual member's benefits.

Pap Smear

When a pap smear code Q0091 (obtaining the specimen, preparing the slide, and conveyance) is reported on the same day as a gynecological examination (G0101, S0610, S0612, or S0613), or evaluation and management service (99202 through 99215, 99381 through 99397), and the charges are itemized, the Plan will combine the charges and pay only the gynecological examination or E/M service.

Reimbursement for the gynecological examination or E/M service performed on the same date of service includes the allowance for the pap smear. A pap smear is not eligible as a distinct and separate service. A participating or network provider cannot bill the member separately for the pap smear in this case.

If the pap smear is performed independently, bill the procedure using the appropriate code(s). Charges for obtaining the specimen, preparing the slide, and conveyance of the pap smear (Q0091) are not eligible for separate reimbursement when reported independently of the gynecological examination or E/M service. A participating or contracted network provider cannot bill the member for the denied service.

Modifier 25, as appropriate, may be reported with medical care to identify the procedure as a significant, separately identifiable service from the pap smear. When the 25 modifier is reported, the patient's records must clearly document separately identifiable medical care was rendered during the visit.

Rectal Examinations

Rectal examinations (digital or with the use of a proctoscope) can be performed on patients with no signs or symptoms of disease or on symptomatic patients to aid in diagnosis or treatment. Rectal examinations performed on asymptomatic patients are considered screening procedures. Coverage for screening rectal examinations is determined according to individual or group customer benefits.

Report these codes for screening rectal examinations: G0102 *S0601 S0610 S0612 G0463

***Note**: New York's member benefit structure requires the use of other screening codes for services represented by code S0601. Another appropriate sigmoidoscopy or colonoscopy screening code should be submitted.

When services are covered as part of a member's benefit, a screening rectal examination is considered to be part of a covered evaluation and management (E/M) service or gynecological examination. Therefore, when a covered screening rectal examination is reported on the same day as a covered (E/M) service or gynecological examination, the Plan will combine the charges for the rectal examination with the charges for the E/M service or gynecological examination and reimburse only the E/M service or gynecological examination procedure(s).

Reimbursement for the E/M service or gynecological examination includes the allowance for the rectal examination. However, when a covered screening rectal examination is performed independently, it may be reimbursed.

Rectal examinations or proctoscopies performed on symptomatic patients are considered part of a provider's medical care. If rectal examinations or proctoscopies are reported on the same day as medical care and the charges are itemized, the charges will be combined and only the medical care will be paid. Reimbursement for the medical care performed on the same date of service includes the allowance for the rectal examinations or proctoscopy.

Modifier 25 may be reported with medical care to identify it as a significant, separately identifiable service from the rectal examinations or proctoscopies or gynecological examinations. When the 25 modifier is reported, the patient's records must clearly document separately identifiable medical care was rendered.

Note: Providers on the OPPS methodology would report G0463 for E/M services.

RELATED HIGHMARK POLICIES:

Refer to the following Commercial Medical Policies for additional information:

- L-1: Pap Smears with Medical Conditions

Refer to the following Reimbursement Policies for additional information:

- RP-009: Modifiers 25, 59, XE, XP, XS and XU
- RP-057: Evaluation and Management Services

POLICY UPDATE HISTORY INFORMATION:

1 / 2018	Implementation
1 / 2021	Removed Code 99201
11 / 2021	Added NY region applicable to the policy. Noted P3000, P3001 and S0601 policy variations for NY.

Highmark Reimbursement Policy Bulletin

Bulletin Number:	RP-021		
Subject:	Annual Gynecological and Rectal Exams		
Effective Date:	January 29, 2018	**End Date:**	
Issue Date:	January 29, 2018		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐		
Applicable Claim Type	**UB**	☒	**1500**	☒		

Reimbursement Policy designation of Professional or Facility application is respective to how the provider is contracted with The Plan. Provider contractual agreements supersede Reimbursement Policy direction and regional applicability.

Digital rectal exam (DRE) is a routine exam in which a physician inserts a lubricated, gloved finger into the rectum and feels for abnormal areas. This is performed to detect rectal cancer nerve problems indicated by reduction of the normal tone of the muscles of the rectal sphincter and, in a man, inflammation, enlargement, or cancer of the prostate.

Proctoscopy is a common medical procedure in which an instrument called a proctoscope (also known as a rectoscope, although the latter may be a bit longer) is used to examine the anal cavity, rectum, or sigmoid colon.

REIMBURSEMENT GUIDELINES:

Gynecological Examinations

Payment will be made for one (1) annual gynecological examination (G0101, S0610, S0612, or S0613) regardless of the patient's condition, and one (1) routine pap smear (G0123-G0145, G0141-G0148, P3000, P3001) per calendar year for all females.

The criteria above does not apply to those groups that follow the Women's Health Federal Mandate offered, issued or renewed on or after August 1, 2012.

When reported, payment may be made for the physician interpretation (G0124, G0141, P3001) in addition to the pap smear codes (G0123, G0143, G0144, G0145, G0147, G0148, P3000).

Gynecological Exam and E&M Performed on the Same Day

When a physician performs a systemic physical examination as part of an annual gynecological examination, a medically-focused condition may be encountered. In some instances, treatment for a medically-focused condition may require more extensive medical evaluation, treatment, and/or management. This treatment may result in significant additional work requiring the key components associated with a problem-oriented evaluation and management (E/M) service. In these cases, the appropriate medical E/M new/established patient office visit code (99201-99215) may be reported in addition to the gynecological examination (G0101, S0610, S0612, or S0613).

Should the reporting of more than one visit per day by the same physician, or physician group occur on the same day be necessary, the patient's records must contain: (a) sufficient documentation regarding the appropriateness of performing both services, and (b) documentation the key components of the services were met. If the reported service(s) do not meet the component requirements, the codes will not be eligible for reimbursement or retainment of previous reimbursement. Payment for the service(s) will also be subject to coverage limitations specified within the individual member's benefits. The Plan will not reimburse a service that does not represent a significant separately identifiable service and that is not submitted appended with modifier 25. Payment for the E/M service will also be subject to coverage limitations specified within the individual member's benefits.

Note: Providers on the OPPS methodology would report G0463 instead of 99201-99215 for E/M (clinic) services.

Gynecological Exam and Preventive Exam Performed on the Same Day

When a physician performs an annual gynecological exam and a preventive exam (99381-99397) on the same day, there is significant overlap of the components of these two services (i.e., history, blood pressure, weight checks, and/or physical examination). However, the preventive exam may include services beyond the scope of the gynecological exam, such as counseling and anticipatory guidance, risk factor intervention, age-appropriate lab work, and certain screening tests.

Should the reporting of preventive medicine and Office/Outpatient E/M services by the same physician or physician group occur on the same day be necessary, the patient's records must contain sufficient documentation regarding the appropriateness of performing both services and documentation the key components of the Office/Outpatient E/M service have been met. If the reported Office/Outpatient E/M service does not meet the component requirements, it will not be eligible for reimbursement or retainment of previous reimbursement. Payment for the Office/Outpatient E/M service and/or the preventive medicine service will also be subject to coverage limitations specified within the individual member's benefits.

Pap Smear

When a pap smear (obtaining the specimen, preparing the slide, and conveyance - Q0091) is reported on the same day as a gynecological examination (G0101, S0610, S0612, or S0613), or evaluation and management service (99201-99215, 99381-99397), and the charges are itemized, The Plan will combine the charges and pay only the gynecological examination or E/M service. Payment for the gynecological examination or E/M service performed on the same date of service includes the allowance for the pap smear. A pap smear is not eligible as a distinct and separate service. A participating or network provider cannot bill the member separately for the pap smear in this case.

If the pap smear is performed independently, bill the procedure using the appropriate code(s). Charges for obtaining the specimen, preparing the slide, and conveyance of the pap smear (Q0091) are not eligible for separate payment when reported independently of the gynecological examination or E/M service.. A participating or contracted network provider cannot bill the member for the denied service.

Modifier 25, as appropriate, may be reported with medical care to identify the procedure as a significant, separately identifiable service from the pap smear. When the 25 modifier is reported, the patient's records must clearly document *separately identifiable medical care* was rendered during the visit.

Rectal Examinations

Rectal examinations (digital or with the use of a proctoscope) can be performed on patients with no signs or symptoms of disease or on symptomatic patients to aid in diagnosis or treatment. Rectal examinations performed on asymptomatic patients are considered screening procedures. Coverage for screening rectal examinations is determined according to individual or group customer benefits.

The following codes may be reported for screening rectal examinations:

G0102 S0601 S0610 S0612 G0463

When services are covered as part of a member's benefit, a screening rectal examination is considered to be part of a covered evaluation and management (E/M) service or gynecological examination. Therefore, when a covered screening rectal examination is reported on the same day as a covered (E/M)service or gynecological examination, the Plan will combine the charges for the rectal examination with the charges for the E/M service or gynecological examination and pay only the E/M service or gynecological examination procudures.

Payment for the E/M service or gynecological examination includes the allowance for the rectal examination. However, when a covered screening rectal examination is performed independently, it may be reimbursed.

Rectal examinations or proctoscopies performed on symptomatic patients are considered part of a provider's medical care. If rectal examinations or proctoscopies are reported on the same day as medical care and the charges are itemized, the charges will be combined and only the medical care will be paid. Payment for the medical care performed on the same date of service includes the allowance for the rectal examinations or proctoscopy.

Modifier 25 may be reported with medical care to identify it as a significant, separately identifiable service from the rectal examinations or proctoscopies or gynecological examinations. When the 25 modifier is reported, the patient's records must clearly document separately identifiable medical care was rendered.

Note: Providers on the OPPS methodology would report G0463 for E/M services.

RELATED HIGHMARK POLICIES:

Refer to the following Medical Policies for additional information:

- Commercial Medical Policy L-1: Pap Smears with Medical Conditions

Refer to the following Reimbursement Policies for additional information:

- Reimbursement Policy RP-009: Modifiers 25, 59, XE, XP, XS and XU