

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



Official CMS Information for
Medicare Fee-For-Service Providers

Screening Pelvic Examinations



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The Centers for Medicare & Medicaid Services (CMS) recognizes the crucial role that health care providers play in educating Medicare beneficiaries about potentially life-saving preventive services and screenings, and in providing these services. While Medicare pays for a variety of preventive benefits, many Medicare beneficiaries do not fully realize that using preventive services and screenings can help them live longer, healthier lives. As a health care professional, you can help your Medicare beneficiaries understand the importance of disease prevention, early detection, and lifestyle modifications that support a healthier life. This booklet can help you communicate with your beneficiaries about Medicare-covered screening pelvic examinations, as well as assist you in correctly billing for these services.

Overview

A screening pelvic examination is an important part of preventive health care for adult women. A screening pelvic examination helps detect pre-cancers, genital cancers, infections, Sexually Transmitted Infections (STIs), reproductive system abnormalities, and other genital and vaginal problems. STIs in women may be associated with cervical cancer. One STI in particular, human papillomavirus (HPV), causes genital warts and cervical and other genital cancers. The screening pelvic examination also helps find fibroids or ovarian cancers, as well as evaluate the size and position of a woman's pelvic organs.

Removal of Barriers to Preventive Services Under the Affordable Care Act

Medicare waives the coinsurance or copayment and deductible for those Medicare-covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B for any indication or population and that are appropriate for the individual.

NOTE: The screening pelvic examination is a separate preventive service from the screening Pap test. For more information on the screening Pap test, refer to the “Screening Pap Tests” booklet at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Screening-Pap-Tests-Booklet-ICN907791.pdf> on the CMS website.

Coverage Information

Medicare Part B covers a screening pelvic examination (including clinical breast examination) for all female beneficiaries if one of the following who are authorized under state law performs the examination:

- ▶ A doctor of medicine or osteopathy,
- ▶ A certified nurse-midwife,

- ▶ A physician assistant,
- ▶ A nurse practitioner, or
- ▶ A clinical nurse specialist.

Screening Pelvic Examination Elements

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

- ▶ Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge;
- ▶ Digital rectal examination including sphincter tone, presence of hemorrhoids, and rectal masses;
- ▶ External genitalia (for example, general appearance, hair distribution, or lesions);
- ▶ Urethral meatus (for example, size, location, lesions, or prolapse);
- ▶ Urethra (for example, masses, tenderness, or scarring);
- ▶ Bladder (for example, fullness, masses, or tenderness);
- ▶ Vagina (for example, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, or rectocele);
- ▶ Cervix (for example, general appearance, lesions, or discharge);
- ▶ Uterus (for example, size, contour, position, mobility, tenderness, consistency, descent, or support);
- ▶ Adnexa/parametria (for example, masses, tenderness, organomegaly, or nodularity); or
- ▶ Anus and perineum.

For purposes of this benefit, **high risk** factors for cervical and vaginal cancer are:

- ▶ Early onset of sexual activity (under 16 years of age),
- ▶ Multiple sexual partners (five or more in a lifetime),
- ▶ History of an STI (including human immunodeficiency virus [HIV] infection),
- ▶ Fewer than three negative or any pap smears within the previous 7 years, or
- ▶ DES (diethylstilbestrol)-exposed daughters of women who took DES during pregnancy.

Stand Alone Benefit

The screening pelvic examination benefit 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 encounter.

Frequency

Covered Once Every 24 Months

Medicare Part B covers a screening pelvic examination for all asymptomatic female beneficiaries **every 24 months** (i.e., at least 23 months after the most recent screening pelvic examination).



Covered Once Every 12 Months

Medicare Part B covers an **annual** screening pelvic examination (i.e., at least 11 months after the most recent screening pelvic examination) for female beneficiaries who meet at least **one** of the following criteria:

- ▶ Evidence (based on her medical history or other findings) that she is at high risk (as described above) for 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.

Woman of Childbearing Age

A “woman of childbearing age” is one who is premenopausal and has been determined by a physician or qualified non-physician practitioner to be of childbearing age based on her medical history or other findings.

When calculating frequency to determine the annual period, 11 months must elapse following the month in which the last screening pelvic examination took place. Follow the same procedure to calculate frequency for the 23-month period.

EXAMPLE: A beneficiary in a high risk category gets a screening pelvic examination in January 2012. The count starts February 2012. The beneficiary may get another screening pelvic examination in January 2013.

Coinsurance or Copayment and Deductible

The beneficiary pays nothing (no coinsurance or copayment and no Medicare Part B deductible) for the screening pelvic examination if conditions of coverage are met. Financial responsibilities may apply for the beneficiary if the provider does not accept assignment.

Documentation

Medical records must document that all coverage requirements are met.

Coding and Diagnosis Information

Procedure Codes and Descriptors

Use the following Healthcare Common Procedure Coding System (HCPCS) code to report screening pelvic examinations.

Table 1. HCPCS Code for Screening Pelvic Examinations

HCPCS Code	Code Descriptor
G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination

Diagnosis Requirements

You must report one of the following International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) screening (“V”) diagnosis codes for a screening pelvic examination.

Coming Soon!
International Classification of Diseases, 10th Revision, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS)

For more information, visit <http://www.cms.gov/Medicare/Coding/ICD10> on the CMS website.

Table 2. Diagnosis Codes for Low Risk Screening Pelvic Examinations

Low Risk ICD-9-CM Diagnosis Code	Code Descriptor
V72.31	Routine gynecological examination NOTE: This diagnosis should only be used when the provider performs a full gynecological examination.
V76.2	Special screening for malignant neoplasms, cervix
V76.47	Special screening for malignant neoplasms, other sites, vagina
V76.49	Special screening for malignant neoplasms, other sites NOTE: Providers use this diagnosis for women without a cervix.



Table 3. Diagnosis Code for High Risk Screening Pelvic Examinations

High Risk ICD-9-CM Diagnosis Code	Code Descriptor
V15.89	Other specified personal history presenting hazards to health, other

Billing Requirements

Billing and Coding Requirements When Submitting Professional Claims

When you submit professional claims to carriers or A/B Medicare Administrative Contractors (MACs), report HCPCS code G0101 and the corresponding ICD-9-CM diagnosis code in the X12 837-P (Professional) electronic claim format. You must also include Place of Service (POS) codes on all professional claims to indicate where you provided the service. For more information on POS codes, visit <http://www.cms.gov/Medicare/Coding/place-of-service-codes> on the CMS website.

Coding Tip

You may perform a screening pelvic examination and a screening Pap test during the same encounter. When this happens, report both procedure codes as separate line items on the claim.

NOTE: If you qualify for an exception to the Administrative Simplification Compliance Act (ASCA) requirement, you may use Form CMS-1500 to submit these claims on paper. All providers must use Form CMS-1500, version 08-05, when submitting paper claims. For more information on Form CMS-1500, visit http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/16_1500.html on the CMS website.

Electronic Claims Requirements

ASCA requires providers to submit claims to Medicare electronically, with limited exceptions. For more information about the electronic formats, visit <http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/HealthCareClaims.html> on the CMS website.

Billing and Coding Requirements When Submitting Institutional Claims

When you submit institutional claims to Fiscal Intermediaries (FIs) or A/B MACs, report HCPCS code G0101, the appropriate revenue code, and the corresponding ICD-9-CM diagnosis code in the X12 837-I (Institutional) electronic claim format.

NOTE: If an institution qualifies for an exception to the ASCA requirement, it may use Form CMS-1450 to submit these claims on paper. All providers must use Form CMS-1450 (UB-04) when submitting paper claims. For more information on Form CMS-1450, visit http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/15_1450.html on the CMS website.

Types of Bill (TOBs) for Institutional Claims

The FI or A/B MAC pays for a screening pelvic examination when submitted on the following TOBs and associated revenue codes.

Table 4. Facility Types, TOBs, and Revenue Codes for Screening Pelvic Examinations

Facility Type	TOB	Revenue Code
Hospital Inpatient (Part B)	12X	0770
Hospital Outpatient	13X	0770
Skilled Nursing Facility (SNF) Inpatient Part B	22X	0770
SNF Outpatient	23X	0770
Rural Health Clinic (RHC)	71X	052X
Federally Qualified Health Center (FQHC)	77X	052X
Critical Access Hospital (CAH)	85X	0770

Additional Billing Instructions for FQHCs and RHCs

The professional component of preventive services is within the scope of covered FQHC or RHC services. The professional component is a physician's interpretation of the results of an examination. For instructions on billing the professional component, visit <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1039.pdf> on the CMS website.

The technical component is services rendered outside the scope of the physician's interpretation of the results of an examination. If you perform technical components or services, not within the scope of covered FQHC or RHC services, in association with professional components, how you bill depends on whether the FQHC or RHC is independent or provider-based:

- ▶ **For Provider-Based FQHCs or RHCs:** Bill the technical component of the service on the TOB for the base provider and submit to the FI or A/B MAC in the 837-I format. For more information on billing instructions for provider-based FQHCs or RHCs, visit <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html> on the CMS website and choose the appropriate chapter based on your facility type.
- ▶ **For Independent FQHCs or RHCs:** Bill the technical component of the service to the carrier or A/B MAC in the 837-P format. For more information on billing instructions for independent FQHCs or RHCs, visit <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf> and <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf> on the CMS website.



Payment Information

Professional Claims

When you bill your carrier or A/B MAC, Medicare pays for the screening pelvic examination service under the Medicare Physician Fee Schedule (MPFS).

As with other MPFS services, the non-participating provider reduction and limiting charge provisions apply to all screening pelvic examination services.

Providers Must Use EFT

All providers enrolling in the Medicare Program for the first time, changing existing enrollment data, or revalidating enrollment must use Electronic Funds Transfer (EFT) to get payments. For more information about EFT, visit <http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/EFT.html> on the CMS website.

Institutional Claims

When you bill your FI or A/B MAC, Medicare payment for the screening pelvic examination depends on the type of facility providing the service. Table 5 lists the type of payment that facilities get.



Table 5. Facility Payment Methods for Screening Pelvic Examinations

Facility Type	Basis of Payment
Hospital Inpatient (Part B)*	Outpatient Prospective Payment System (OPPS)
Hospital Outpatient*	OPPS
SNF Inpatient Part B**	MPFS
SNF Outpatient	MPFS
RHC	All-Inclusive Payment Rate
FQHC	All-Inclusive Payment Rate
CAH	Method I: 101% of reasonable cost for technical component(s) of services Method II: 101% of reasonable cost for technical component(s) of services, plus 115% of MPFS non-facility rate for professional component(s) of services

* Medicare pays Maryland hospitals for inpatient or outpatient services according to the Maryland State Cost Containment Plan.

** The SNF consolidated billing provision allows separate Medicare Part B payment for screening pelvic examinations for beneficiaries in a skilled Part A stay; however, the SNF must submit these services on a 22X TOB. Screening pelvic examinations provided by other facility types for beneficiaries in a skilled Part A stay must be paid by the SNF.

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Reasons for Claim Denial

Medicare may deny coverage of screening pelvic examination services in several situations, including:

- ▶ The beneficiary not at high risk got a covered screening pelvic examination within the past 2 years.
- ▶ The beneficiary at high risk got a covered screening pelvic examination within the past year.

You may find specific payment decision information on the Remittance Advice (RA). The RA includes Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide additional information on payment adjustments. For the most current listing of these codes, visit <http://www.wpc-edi.com/reference> on the Internet. You can obtain additional information about claims from your carrier, FI, or A/B MAC.

Medicare Contractor Contact Information

For carrier, FI, or A/B MAC contact information, visit <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Provider-Compliance-Interactive-Map> on the CMS website.

RA Information

For more information about the RA, visit <http://www.cms.gov/Medicare/Billing/ElectronicBilling/EDITrans/Remittance.html> on the CMS website.

Resources

For more information about screening pelvic examinations, refer to the resources listed in Tables 6 and 7. For educational products for Medicare Fee-For-Service health care professionals and their staff, information on coverage, coding, billing, payment, and claim filing procedures, visit <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html> on the CMS website, or scan the Quick Response (QR) code to the right with your mobile device.



Table 6. Provider Resources

Resource	Website
CMS Beneficiary Notices Initiative (BNI)	http://www.cms.gov/Medicare/Medicare-General-Information/BNI
“CMS Electronic Mailing Lists: Keeping Medicare Fee-For-Service Providers Informed”	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MailingLists_FactSheet.pdf
“Medicare Claims Processing Manual” – Publication 100-04, Chapter 18, Section 40	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf
Medicare Learning Network® (MLN) Guided Pathways to Medicare Resources	<p>The MLN Educational Web Guides MLN Guided Pathways to Medicare Resources help providers gain knowledge on resources and products related to Medicare and the CMS website. For more information about preventive services, refer to the “Coverage of Preventive Services” section in the “MLN Guided Pathways to Medicare Resources – Basic Curriculum for Health Care Professionals, Suppliers, and Providers” booklet at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Basic_Booklet.pdf on the CMS website.</p> <p>For all other “Guided Pathways” resources, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Guided_Pathways.html on the CMS website.</p>
“Medicare National Coverage Determinations Manual” – Publication 100-03, Chapter 1, Part 4, Section 210.2	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf

Table 6. Provider Resources (cont.)

Resource	Website
Medicare Preventive Services General Information	http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo
MLN Matters® Articles Related to Medicare-covered Preventive Benefits	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNPrevArticles.pdf
MPFS	http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched
National Cancer Institute Cervical Cancer Information	http://www.cancer.gov/cancertopics/types/cervical
OPPS	http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS
USPSTF Screening for Cervical Cancer Recommendations	For a summary of the USPSTF written recommendations on screening for cervical cancer, visit http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm on the Internet.

Table 7. Beneficiary Resources

Resource	Website/Contact Information
“Medicare & You: Stay Healthy with Medicare’s Preventive Benefits” Video	http://www.youtube.com/watch?v=mBCF0V4R4A0&feature=relmfu
“Medicare & You: Women’s Preventive Health” Video	http://www.youtube.com/watch?v=dCav0hGLFuA&feature=relmfu
Medicare Beneficiary Help Line and Website	Telephone: Toll-Free: 1-800-MEDICARE (1-800-633-4227) TTY Toll-Free: 1-877-486-2048 Website: http://www.medicare.gov
“Publications for Medicare Beneficiaries”	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BenePubFS-ICN905183.pdf
Women’s Health	http://www.womenshealth.gov
Your Medicare Coverage: Pap Tests/Pelvic Exams (Screening)	http://www.medicare.gov/coverage/pap-tests-pelvic-exams-screening.html
Your Medicare Coverage: Preventive & Screening Services	http://www.medicare.gov/coverage/preventive-and-screening-services.html

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