U of M – Well-woman visit/ 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

Well-woman visit/gynecological exam

A screening pelvic examination is 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 precancers, genital cancers (ovarian and endocervical), infections such as sexually transmitted infections, or 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 screening Pap tests, screening pelvic examinations and Human Papillomavirus, or HPV, screening.

The screening Pap tests and pelvic examinations covered by Medicare are billable services separate from the initial preventive physical examination or the annual wellness visit. Medicare beneficiaries may obtain a screening Pap test and pelvic examination at any time following Medicare Part B enrollment, including during their IPPE or AWV.

Medicare Part B covers the following:

- A screening Pap test and pelvic examination for all asymptomatic female beneficiaries at normal risk every 24 months (at least 23 months after the most recent screening pelvic examination).
- A screening Pap test and pelvic examination annually for female beneficiaries at high risk (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 their medical history or other findings) that they're at high risk for developing cervical or vaginal cancer and their physician (or authorized practitioner) recommends they have the test more frequently than every two years.
  - Female of childbearing age* who had a screening Pap test or pelvic exam during any of the previous three years indicating the presence of cervical or vaginal cancer or other abnormality.
- An HPV screening for asymptomatic female beneficiaries ages 30-65 once every five years, at least four years and 11 months (59 months total) after the most recent HPV screening.

*Premenopausal female of childbearing age and a physician or qualified practitioner determines childbearing age based on medical history or other findings.

Examination elements

A screening pelvic examination (including a clinical breast examination) should include at least seven of the following eleven 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 that 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 a well-woman visit/gynecological exam (see examination elements under Original Medicare heading above) is provided to members under the University of Michigan's Medicare Plus Blue PPO group plan once per benefit year, at least 11 months after the most recent well-woman visit/gynecological exam. Since Original Medicare limits the frequency of screening Pap tests and pelvic examinations, the group determines the scope of the benefit, reimbursement methodology, maximum allowed payment amounts and member cost sharing.

Conditions for payment

The table below specifies payment conditions for a well-woman visit/gynecological exam.

Conditions for payment	
Eligible provider	Consistent with Original Medicare
Payable location	Consistent with Original Medicare
Frequency	Once annually
CPT/HCPCS codes	99383-99387, 99393-99397 For screening Pap test and pelvic examination: Consistent with Original Medicare
Diagnosis restrictions	Consistent with Original Medicare
Age restrictions	No restrictions

Reimbursement

University of Michigan Medicare Plus Blue group plan's maximum payment amount to providers for well-woman visit/gynecological exam is consistent with Original Medicare. The provider will be paid the lesser of the allowed amount or the provider's charge, minus the member's cost share. This represents payment in full and providers aren't allowed to bill the member for the difference between the allowed amount and the charge.

Member cost sharing

- Medicare Plus Blue 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 cost-sharing amounts from the member.
- If the member elects to receive a noncovered service, he or she is responsible for the entire charge associated with that service.
- Providers may not have members sign an Advance Beneficiary Notice to accept financial responsibility for noncovered items or services. If there is any question about whether an item or service is covered, seek a coverage determination from Blue Cross before providing the item or service to the member. If a provider provides a noncovered item or service to a member without first obtaining a coverage determination, the member must be held harmless for all charges except for any applicable cost share.

To verify benefits and cost share, providers may utilize our provider portal or call 1-866-309-1719.

Billing instructions for providers

1. Bill services on the CMS 1500 (02/12) claim form for all payable locations, except for Federally Qualified Health Center (FQHC) providers; which should be billed on the CMS UB-04 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. Report your National Provider Identifier number on all claims.
5. Submit claims to your local Blue Cross plan.
6. Use electronic billing:
   a. Michigan providers
      Copies of the ANSI ASCX 12N 837 and 835 Institutional Health Care Claim Payment/Advice (Blue Cross Electronic Data Interchange (EDI) Institutional 837/835 Companion Documents) are available on the Blue Cross website under the reference library section at ***bcbsm.com/providers/help/edi***.
   b. Providers outside of Michigan should contact their local Blue Cross plan.

References: MLN909032 Screening Pap Tests & Pelvic Exams (CMS, 2023)

Revision history

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