moda HEALTH	**Reimbursement Policy Manual**	**Policy #:**	**RPM044**
Policy Title:	**Gynecologic or Annual Women's Exam Visit & Use of Q0091 (Pap, Pelvic, & Breast Visit)**		
Section:	**Evaluation**	**Subsection:**	**None**

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:

Companies:	☒ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates ☐ Moda Health Plan ☐ Moda Assurance Company ☐ Summit Health Plan ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS
Types of Business:	☐ All Types ☒ Commercial Group ☒ Commercial Individual ☒ Commercial Marketplace/Exchange ☒ Commercial Self-funded ☐ Medicaid ☒ Medicare Advantage ☒ Short Term ☐ Other: _____
States:	☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington
Claim forms:	☒ CMS1500 ☒ CMS1450/UB (or the electronic equivalent or successor forms)
Date:	☒ All dates ☐ Specific date(s): _____ ☐ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☐ Facility discharge ☐ Date of processing
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network

Originally Effective:	5/23/2007	Initially Published:	10/15/2015
Last Updated:	2/6/2023	Last Reviewed:	2/8/2023
Last update payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)?			No
Last Update Effective Date for Texas:		2/8/2023	

Reimbursement Guidelines

Coding for the annual women's (gynecological) exam differs for a Medicare Advantage plan versus a Commercial health plan. Use of correct codes for the member's plan type is essential so the member receives their available benefits.

A. For Medicare Advantage plans:

1. Our Medicare Advantage plans cover four types of preventive visits. The scope, purpose, and coding for each are different, and it is important to avoid confusion.
    a. Initial Preventive Physical Exam (IPPE). Also known as the "Welcome to Medicare" exam.
        i. This is a Medicare benefit covered only once in a lifetime; must be performed within first 12 months of enrollment in Part B.
        ii. Report using G0403 or G0468 (for FQHC). (CMS[7])
    b. Annual Wellness Visit (AWV).
        i. This is a Medicare benefit covered once every 12 months. We administer this benefit on a calendar year basis.
        ii. Report using G0438, G0439, or G0468 (FQHC).

iii. For more information about the components included in the Annual Wellness Visit, see "Medicare Wellness Visits," ICN MLN6775421 (CMS[7])

c. Cervical and/or vaginal cancer screening, and clinical breast examination.
   i. These are specific components that are Medicare benefits covered once every 12 months. We administer this benefit on a calendar year basis.
      Note that the components covered by Medicare does not include all elements that may be included in a Commercial gynecological exam visit. However, in general, those are covered by Medicare in the Annual Wellness Visit.
   ii. Report using G0101 & Q0091. See below for more details and ancillary lab codes.

d. Annual routine (preventive) physical.
   i. Not covered by Original Medicare. This is an added benefit under our Medicare Advantage plans; covered once each calendar year.
   ii. Report using 99381 – 99397.

2. Coding the cervical - vaginal cancer screening/breast exam and ancillary services.

   a. The provider performing the Pap/pelvic/breast exam visit:

      i. May submit the following procedure codes.
         1) Exam: **G0101** (*Cervical or vaginal cancer screening; pelvic and clinical breast examination*)
         2) Obtaining specimen: **Q0091** (*Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory)*

      ii. If a screening rectal exam is performed as part of the Pap/pelvic/breast exam which is not combined with an Annual "Wellness" visit, the screening rectal exam is considered incidental and may not be separately reported.

      iii. Do not report using 99381 - 99397.
      Preventive medicine codes (e.g., 99397, 99397-52) will be processed as an annual routine (preventive) physical, even when billed with a gynecological diagnosis code (e.g., Z01.419).

         1) If the member has already had an annual routine (preventive) visit, the claim will deny to provider write off as a benefit exhausted.

         2) If the member has not yet had an annual routine (preventive) visit, this claim will exhaust that benefit, and the member will not be able to have a preventive visit with their PCP until the following calendar year. This creates the potential for an appeal and request for your office to submit a corrected claim.

   b. The laboratory performing the Pap test and cervical cancer screening test may bill:

      i. The appropriate lab procedure for the screening Pap test:
         1) **G0123** *(Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision)*
         2) **G0124** (Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician)

3) **G0141** (Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician)
4) **G0143** (Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision)
5) **G0144** (Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision)
6) **G0145** (Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision)
7) **G0147** (Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision)
8) **G0148** (Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening)
9) **P3000** (Screening papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision)
10) **P3001** (Screening papanicolaou smear, cervical or vaginal, up to three smears, r*equiring interpretation by physician)*

ii. Screening for cervical cancer:

G0476 *(Infectious agent detection by nucleic acid (DNA or RNA); human papillomavirus (HPV), high-risk types (e.g., 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68) for cervical cancer screening, must be performed in addition to pap test)*

c. Additional preventive services (e.g., a screening rectal exam, a health risk assessment, ordering covered preventive/screening labs and tests, or other assessment of a non-symptomatic Member) are covered as part of an annual comprehensive preventive exam under the Member's Annual "Wellness" visit benefit.

i. Do not request a pre-service organizational determination of non-coverage in order to have the member pay for these services out-of-pocket, as these are not non-covered services.

ii. These services *are covered* as part of the Annual "Wellness" visit (which may be coded separately when performed) but are not part of a Pap/pelvic/breast exam.

d. If the annual Pap/pelvic/breast exam has not yet renewed after being used and an additional clinical breast exam is deemed clinically necessary, report the additional exam with the appropriate problem-oriented E/M service code and diagnosis codes to indicate the Medical conditions or symptoms creating the clinical need.

e. Benefit Limits and Benefit Periods
Providers are expected to know when the Medicare Advantage member last utilized limited benefits and reschedule the visit with the member if the benefit is being utilized too soon. Access Benefit Tracker or contact our Customer Service team to verify whether the Pap/pelvic/breast exam and/or annual preventive visit is exhausted or still available.

B. For Commercial plans:

1. Report a gynecologic or annual women's exam using the age-appropriate preventive medicine visit procedure code and a gynecological diagnosis code (e.g., Z01.419). Do not report using S0610-S0613.

2. If an abnormality or another medical problem is encountered and is significant enough to require the additional work of a problem-oriented E/M service, then the appropriate office/outpatient E/M code (99201 – 99215) may also be reported with modifier 25 appended. (AMA[1])

3. Do not report an insignificant or trivial problem/abnormality that is encountered which does not require the performance of the key components of a problem-oriented E/M service. (AMA[1])

4. <u>Do Not Use Q0091 for Commercial plans:</u>
   a. Effective for dates of service October 12, 2015 and following, HCPCS code Q0091 will no longer be considered valid procedure codes for our Commercial claims and will be denied to provider write off with an explanation code that maps to:
      CARC 16 (Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.)
      RARC M51 (Missing/incomplete/invalid procedure code(s).)

   b. Q0091 is a Medicare-specific code; do not report on a Commercial claim. Instead, please use the age-appropriate preventive medicine visit procedure code with diagnosis Z01.411 or Z01.412.

Codes, Terms, and Definitions

<u>Acronyms & Abbreviations Defined</u>

Acronym or Abbreviation		Definition
AMA	=	American Medical Association
AWV	=	Annual Wellness Visit
CARC	=	Claim Adjustment Reason Code
CCI	=	Correct Coding Initiative (see "NCCI")
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
E/M E&M E & M	=	Evaluation and Management (services, visit) (Abbreviated as "E/M" in CPT book guidelines, sometimes also abbreviated as "E&M" or "E & M" in some CPT Assistant articles and by other sources.)
FCHC	=	Federally Qualified Health Center

Acronym or Abbreviation		Definition
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	=	Health Insurance Portability and Accountability Act
IPPE	=	Initial Preventive Physical Exam
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	=	National Correct Coding Initiative (aka “CCI”)
RARC	=	Remittance Advice Remark Code
RPM	=	Reimbursement Policy Manual (e.g., in context of “RPM052” policy number, etc.)
UB	=	Uniform Bill

Procedure codes (CPT & HCPCS):

Code	Procedure Code Description	Valid for Dates of Service:
G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	All
G2212	Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services) (do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416). (do not report G2212 for any time unit less than 15 minutes)	1/1/2021 and following
G0316	Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact	1/1/2023 and following
G0317	Prolonged nursing facility evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact	1/1/2023 and following

Code	Procedure Code Description	Valid for Dates of Service:
G0318	Prolonged home or residence evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact	1/1/2023 and following
Q0091	Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory	All
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.	All (Description listed effective 1/1/2021)
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.	All (Description listed effective 1/1/2021)
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.	All (Description listed effective 1/1/2021)
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter. (For services 75 minutes or longer, see Prolonged Services 99417)	All (Description listed effective 1/1/2021)
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.	All (Description listed effective 1/1/2021)
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.	All (Description listed effective 1/1/2021)

Code	Procedure Code Description	Valid for Dates of Service:
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.	All (Description listed effective 1/1/2021)
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.	All (Description listed effective 1/1/2021)
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter. (For services 55 minutes or longer, see Prolonged Services 99417)	All (Description listed effective 1/1/2021)
99381	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)	All
99382	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)	All
99383	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years)	All
99384	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)	All

Code	Procedure Code Description	Valid for Dates of Service:
99385	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years	All
99386	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years	All
99387	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older	All
99391	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year)	All
99392	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)	All
99393	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years)	All
99394	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)	All
99395	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years	All

Code	Procedure Code Description	Valid for Dates of Service:
99396	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 40-64 years	All
99397	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 65 years and older	All
99417	Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services) (See RPM076, "Office or Other Outpatient Evaluation and Management (E/M) Visits and Prolonged Services." Moda[A])	1/1/2021 – 12/31/2022 For 1/1/2023 and following, see/use G0316, G0317, or G0318

Diagnosis codes (ICD-10):

Code	Code Description
Z01.411	Encounter for gynecological examination (general) (routine) with abnormal findings
Z01.419	Encounter for gynecological examination (general) (routine) without abnormal findings
Z11.51	Encounter for screening for human papillomavirus (HPV)
Z12.4	Encounter for screening for malignant neoplasm of cervix
Z12.72	Encounter for screening for malignant neoplasm of vagina
Z12.79	Encounter for screening for malignant neoplasm of other genitourinary organs
Z12.89	Encounter for screening for malignant neoplasm of other sites
Z72.51	High risk heterosexual behavior
Z72.52	High risk homosexual behavior
Z72.53	High risk bisexual behavior
Z77.29	Contact with and (suspected) exposure to other hazardous substances
Z77.9	Other contact with and (suspected) exposures hazardous to health
Z91.89	Other specified personal risk factors, not elsewhere classified
Z92.89	Personal history of other medical treatment

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

"If an abnormality is encountered or a preexisting problem is addressed in the course of performing this preventive medicine evaluation and management service, and if the problem or abnormality is significant enough to require the additional work of a problem-oriented E/M service, then the appropriate Office/Outpatient E/M code 99201 – 99215 should also be reported. Modifier 25 should be added to the Office/Outpatient code to indicate that a significant, separately identifiable evaluation and management service was provided on the same day as the preventive medicine service. The appropriate preventive medicine service is additionally reported.

An insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine evaluation and management service and which does not require additional work and the performance of the key components of a problem-oriented E/M service should not be reported." (AMA[1])

"HCPCS code Q0091 (Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory) describes the services necessary to procure and transport a pap smear specimen to the laboratory. If an evaluation and management (E&M) service is performed at the same patient encounter solely for the purpose of performing a screening pap smear, the E&M service is not separately reportable. However, if a significant, separately identifiable E&M service is performed to evaluate other medical problems, both the screening pap smear and the E&M service may be reported separately. Modifier 25 should be appended to the E&M CPT code indicating that a significant, separately identifiable E&M service was rendered." (CMS[2])

"HCPCS code G0101 (cervical or vaginal cancer screening; pelvic and clinical breast examination) may be reported with evaluation and management (E&M) services under certain circumstances. If a Medicare covered reasonable and medically necessary E&M service requires breast and pelvic examination, HCPCS code G0101 should not be additionally reported. However, if the Medicare covered reasonable and medically necessary E&M service and the screening service, G0101, are unrelated to one another, both HCPCS code G0101 and the E&M service may be reported appending modifier 25 to the E&M service CPT code. Use of modifier 25 indicates that the E&M service is significant and separately identifiable from the screening service, G0101." (CMS[3])

Cross References

A. "2021 & 2023 Updates to Evaluation and Management (E/M) Visits and Prolonged Services." Moda Health Reimbursement Policy Manual, RPM076.

B. "Preventive Medicine & Problem-Oriented E/M Visits, Same Day." Moda Health Reimbursement Policy Manual, RPM078.

References & Resources

1. American Medical Association. "Preventive Medicine Services." *Current Procedural Terminology (CPT) - 2015*. Chicago: AMA Press. Page35.

2. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 12 Supplemental Services HCPCS Level II Codes A0000 - V9999, § C.2.

3. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 12 Supplemental Services HCPCS Level II Codes A0000 - V9999, § C.3.

4. CMS. "Medicare Preventive Services Quick Reference Chart." ICN MLN006559 August 2020; last accessed November 30, 2020. https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html

5. CMS. "Screening Pap Smears." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 18 – Preventive and Screening Services, § 30.

6. CMS. "Screening Pelvic Examinations." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 18 – Preventive and Screening Services, § 40.

7. CMS. "Medicare Wellness Visits. Medicare Learning Network (MLN). ICN MLN6775421. Last updated February 2021; last accessed May 18, 2022. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html .

Background Information

A comprehensive preventive medicine exam visit is a complete physical, including:

- Health history
- A review of all health and lifestyle risk factors
- An exam of all systems including cardiovascular, respiratory, neurological, musculoskeletal, reproductive and behavioral
- Laboratory studies appropriate for age, risk and sex
- Discussion of recommended lifestyle changes.

An annual women's exam or gynecologic exam is far less extensive, limited to the female reproductive system. A gynecologic or annual women's exam can be performed by a primary care physician or non-physician provider (NPP) or an OB/GYN provider.

Medicare covers specific components of a pelvic exam, Pap smear, cervical cancer screening, and a clinical breast exam. Medicare has specific coding requirements for these covered components. Some of our gynecological providers have indicated their annual gynecological women's exam includes additional components (not specified) beyond the component codes Medicare specifically covers. If this is a concern for your office, please review the components of the covered Medicare Annual Wellness Exam (CMS[7]) or the added benefit of an annual routine (preventive) physical visit on our Medicare Advantage plans where these components can be addressed for our Medicare Advantage members.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
2/8/2023	Clarification/Update: Types of Business: Corrected to remove Medicaid. Section B.1: Added "Do not report using S0610-S0613." Procedure Code Table: Updated prolonged services codes. Cross References: One entry added.
12/14/2022	Format/Update Scope, States: Idaho added. Cross References: RPM076 title updated & hyperlinks added.
6/8/2022	Clarification/update: Change to new header. Added information for Medicare Advantage on IPPE, AWE, & annual routine (preventive) physical added benefit. Clarified results of reporting Pap/pelvic/breast exam visit with 99381-99397 for Medicare Advantage plans. Minor rewording, no policy changes. Acronym Table: Added 6 entries. Procedure code table: deleted outdated code descriptions from prior to 1/1/2021 changes. References & Resources: # 7 added. Background Information: Added ¶ # 3. Added Policy History section.
10/15/2015	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
5/23/2007	Original Effective Date (with or without formal documentation). Policy was created when Moda added Medicare Advantage plans and needed to specify coding for annual women's exams based on type of plan. (CMS[4, 5, 6])