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).

This policy position applies to all commercial and/or Medicare Advantage lines of business as indicated above. Reimbursement policies are intended only to establish general guidelines for reimbursement under Highmark plans. Highmark retains the right to review and update its reimbursement policy guidelines at its sole discretion.
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 retention 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 retention 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.

This policy position applies to all commercial and/or Medicare Advantage lines of business as indicated above. Reimbursement policies are intended only to establish general guidelines for reimbursement under Highmark plans. Highmark retains the right to review and update its reimbursement policy guidelines at its sole discretion.
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 procedures.

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

*This policy position applies to all commercial and/or Medicare Advantage lines of business as indicated above. Reimbursement policies are intended only to establish general guidelines for reimbursement under Highmark plans. Highmark retains the right to review and update its reimbursement policy guidelines at its sole discretion.*
Refer to the following Reimbursement Policies for additional information:

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