Commercial Reimbursement Policy

Subject: **Screening Services with Related Evaluation and Management Services – Professional**	
Policy Number: **C-12002**	Policy Section: **Evaluation and Management**
Last Approval Date: **11/17/2023**	Effective Date: **08/07/2020**

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by an Anthem Blue Cross and Blue Shield (Anthem) member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

The Health Plan does not allow reimbursement for certain screening services reported with a preventive medicine service, an annual GYN examination, and/or a problem-oriented evaluation and management (E/M) service performed on the same date of service by the same provider

(see Related Coding section below). The screening service should be considered when determining the appropriate level of E/M service to report.

In addition, the Health Plan considers annual GYN examinations to be included in the reimbursement for preventive medicine services and not eligible for separate reimbursement.

Related Coding

Code	Description	Comments
G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	Not eligible for separate reimbursement. Modifiers 25 and 59 override not allowed.
G0102	Prostate cancer screening; digital rectal examination	Not eligible for separate reimbursement. Modifiers 25 and 59 override not allowed.
Q0091	Screening Papanicolaou smear; obtaining, preparing, and conveyance of cervical or vaginal smear to laboratory	Not eligible for separate reimbursement. Modifiers 25 and 59 override not allowed.

Exemptions

There are no exemptions to this policy.

Policy History

11/17/2023	Review approved: no changes
08/07/2020	Review approved and effective: minor administrative changes
06/01/2019	Revised: policy template updated; added Definitions section and Related Coding table
09/07/2018	Review approved: examples removed; administrative updates made
10/04/2016	Review approved: minor language updates and no changes to policy criteria
08/04/2015	Review approved: removed S0613 from G0101 bullet
08/05/2014	Review approved: policy language updated without changes to the intent of the policy. • In the Description section, added paragraph: “this policy documents the Health Plan’s reimbursement position when screening services are reported with preventive medicine services, annual GYN examinations, and/or problem-oriented E/M services.”

	• Added language: “in addition, the Health Plan considers annual GYN examinations S0610, S0612, and/or S0613 to be included in the reimbursement for preventive medicine services (99381-99397) and not eligible for separate reimbursement;” added description of gyn “s” codes. • Removed the coding grid; the codes are defined in the Policy section. • Updated the policy name from “Screening Services with Evaluation & Management Services” to “Screening Services with Related Evaluation & Management Services”
07/02/2013	Review approved: minor punctuation and language updates made; added reference to our modifier 59 policy
07/12/2012	Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- American Medical Associations Current Procedural Terminology (CPT®) 2023
- CMS

Definitions

General Reimbursement Policy Definitions

Related Policies and Materials

Distinct Procedural Services, Modifiers 59 and XE, XP, XS, & XU – Professional

Modifiers 25 and 57 – Professional

Use of Reimbursement Policy

This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member’s benefits on the date of service. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.