The pelvic exam revisited

The USPSTF says there is not enough evidence to assess the benefits and harms of the routine screening pelvic exam. These experts say that ObGyns should renew their commitment to individualized well-woman care and shared decision making.

Erin Higgins, MD, and Cheryl B. Iglesia, MD

IN THIS ARTICLE

More than 44 million pelvic examinations are performed annually in the United States.[1] In March 2017, the United States Preventive Services Task Force (USPSTF) published an updated recommendation statement regarding the need for routine screening pelvic examinations in asymptomatic adult women (18 years and older) receiving primary care: "The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of performing screening pelvic examinations in asymptomatic, nonpregnant adult women."[2]

That statement, however, was assigned a grade of I, which means that evidence is lacking, of poor quality, or conflicting, and that the balance of benefits and harms cannot be determined. This USPSTF recommendation statement thus will not change practice for ObGyn providers but likely will renew our commitment to provide individualized well-woman care. There was inadequate or poor quality evidence for benefits related to all-cause mortality, disease-specific morbidity, and quality of life, as well as inadequate evidence on harms related to false-positive findings and anxiety stemming from screening pelvic exams.

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Interpreting the new USPSTF statement

We understand the USPSTF statement to mean that pelvic exams should *not* be abandoned, but rather should be individualized to each patient for her specific visit. We agree that for visits focused on counseling and routine screening in asymptomatic, nonpregnant women, pelvic exams likely will not increase the early detection and treatment of disease and more benefit likely would be derived by performing and discussing evidence-based and age-appropriate health services. A classic example would be for initiation or maintenance of oral contraception in an 18-year-old patient for whom an exam could cause unnecessary trauma, pain, or psychological distress leading to future avoidance or barriers to seeking health care. For long-acting

The pelvic examination and insurance coverage

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Coding and billing for the care provided at a well-woman visit can be uncomplicated if you know the right codes for the right program. The information presented here concerns straightforward preventive care and assumes that the patient also has not presented with a significant problem at the same visit.

First, a patient who is not Medicare-eligible might have insurance coverage for an annual preventive care examination every year. Normally, this service would be billed using the *Current Procedural Terminology* (CPT) preventive medicine codes, but some insurers require the use of special codes for an annual gynecologic exam. These special codes are:

- **S0610**, *Annual gynecological examination, new patient*
- **S0612**, *Annual gynecological examination, established patient*
- **S0613**, *Annual gynecological examination; clinical breast examination without pelvic evaluation.*

Notably, Aetna, Cigna, and UnitedHealthcare require these codes to signify that a pelvic examination has been performed (except for code **S0613**), but many Blue Cross Blue Shield programs, for whom these codes were originally created, are now reverting to the CPT preventive medicine codes for all preventive care.

CPT outlines the requirements for use of the preventive medicine codes as: an initial or periodic comprehensive preventive medicine evaluation or reevaluation and management (E/M) service, which includes an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures. The codes are divided into new or established patient categories by age range as follows:

New patient	
CPT code	**Age range, years**
99385	18–39
99386	40–64
99387	65 or older
Established patient	
99395	18–39
99396	40–64
99397	65 or older

The Medicare E/M documentation guidelines do not apply to preventive services, and a head-to-toe examination also is not required. CPT recognizes the American College of Obstetricians and Gynecologists (ACOG) as an authoritative body to make recommendations for the expected preventive service for women, and if such a service is provided and documented, the preventive care codes are to be reported. The payers who use the S codes for a gynecologic exam will require that a pelvic examination has been performed, but such an examination would not be required when using the CPT codes or ACOG's guidelines if the physician and patient agreed that such an exam was not warranted every year. The other components of a preventive service applicable to the female patient's age, however, should be documented in order to report the CPT codes for preventive medicine services.

If a pelvic examination is not performed, say because the patient is young and not sexually active, but an examination of other areas is carried out, the diagnosis code would change from **Z01.411**, *Encounter for gynecological examination (general) (routine) with abnormal findings,* or **Z01.419**, *Encounter for gynecological examination (general) (routine) without abnormal findings, to a general health exam:* **Z00.00**, *Encounter for general adult medical examination without abnormal findings,* or **Z00.01**, *Encounter for general adult medical examination with abnormal findings.*

What about Medicare?

Medicare requirements are somewhat different. First, Medicare covers only a small portion of the preventive care service; that is, it covers a physical examination of the genital organs and breasts and the collection and conveyance of a Pap specimen to the laboratory every 2 years for a low-risk patient. Second, the codes required to get reimbursed for the examination are:

- **G0101**, *Cervical or vaginal cancer screening; pelvic and clinical breast examination*
- **Q0091**, *Screening Papanicolaou smear; obtaining, preparing, and conveyance of cervical or vaginal smear to laboratory.*

It is not necessary to perform both of these services every 2 years (for instance, the patient may not need a Pap smear every 2 years based on her age and history), but the benefit is available if the service is performed. If the woman is at high risk for developing cervical or vaginal cancer, Medicare will cover this portion of the encounter every year so long as the Medicare-defined criteria for high risk have been documented at the time of the exam.

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The pediatric and adolescent gynecologist perspective

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No literature addresses the utility of screening pelvic examination in the pediatric and adolescent population. According to the American College of Obstetricians and Gynecologists Committee on Adolescent Health Care opinion on the initial reproductive health visit for screening and preventive reproductive health care (reaffirmed in 2016), a screening internal exam is not necessary, but an external genital exam may be indicated and may vary depending on the patient's concerns and prior clinical encounters.[1] The American Academy of Pediatrics promotes annual screening external genital examination for all female patients as part of routine primary care, with internal examinations only as indicated.[2]

Age-appropriate pelvic examination for girls and nonsexually active adolescents usually is limited to an external genital exam to evaluate the anatomy and note the sexual maturity rating (Tanner stage), an important indicator of normal pubertal development. As in adults, the potential benefits of screening examination in this population include detection of benign gynecologic conditions (including vulvar skin conditions and abnormalities of hymenal or vaginal development). Additionally, early reproductive health visits are an important time for clinicians to build rapport with younger patients and to provide anticipatory education on menstruation, hygiene, and anatomy. These visits can destigmatize and demystify the pelvic examination and help young women seek care more appropriately and more comfortably if problems do arise.

Even when a pelvic exam is indicated, a patient's young age can give providers pause as to what type of exam to perform. Patients with vulvovaginal symptoms, abnormal vaginal bleeding, vaginal discharge, or pelvic or abdominal pain should receive complete evaluation with external genital examination. If external vaginal examination does not allow for complete assessment of the problem, the patient and provider can assess the likelihood of her tolerating an internal exam in the clinic versus undergoing vaginoscopy under sedation. Limited laboratory evaluation and transabdominal pelvic ultrasonography may provide sufficient information for appropriate clinical decision making and management without internal examination. If symptoms persist or do not respond to first-line treatment, an internal exam should be performed.

Patients of any age may experience anxiety or physical discomfort or may even delay or avoid seeking care because of fear of a pelvic exam. However, providers of reproductive health care for children and adolescents can offer early education, reassurance, and a more comfortable experience when pelvic examination is necessary in this population.

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reversible contraception placement, however, a pelvic exam clearly would be necessary for insertion of an intrauterine device.

Indications for pelvic examination

Remember that the pelvic examination has 3 distinct parts (and that not all parts need to be routinely conducted)[3]:

- general inspection of the external genitalia and vulva
- speculum examination and evaluation of the vagina and cervix
- bimanual examination with possible recto-vaginal examination in age-appropriate or symptomatic women.

According to the Well-Woman Task Force

of the American College of Obstetricians and Gynecologists (ACOG), "For women 21 years and older, external exam may be performed annually and that inclusion of speculum examination, bimanual examination, or both in otherwise healthy women should be a shared, informed decision between patient and provider."[4]

Indications for performing certain parts of the pelvic exam include[4]:

- routine screening for cervical cancer (Pap test)
- routine screening for gonorrhea, chlamydia infection, and other sexually transmitted infections
- evaluation of abnormal vaginal discharge
- evaluation of abnormal bleeding, pelvic pain, and pelvic floor disorders, such as prolapse, urinary incontinence, and accidental bowel leakage
- evaluation of menopausal symptoms, such as dryness, dyspareunia, and the genitourinary syndrome of menopause
- evaluation of women at increased risk for gynecologic malignancy, such as women with known hereditary breast–ovarian cancer syndromes.

In 2016, ACOG launched the Women's Preventive Services Initiative (WPSI) in conjunction with the Health Resources and Services Administration (HRSA) of the US Department of Health and Human Services. In this 5-year collaboration, the agencies are endeavoring to review and update the recommendations for women's preventive health care services, including well-woman visits, human papillomavirus testing, and contraception, among many others.[5] Once the HRSA adopts these recommendations, women will be able to access comprehensive preventive health services without incurring any out-of-pocket expenses.

How will the USPSTF statement affect practice?

In an editorial in the *Journal of the American Medical Association* commenting on the

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USPSTF statement, McNicholas and Peipert stated, "Based on the recommendation from the task force, clinicians may ask whether the pelvic examination should be abandoned. The answer is not found in this recommendation statement, but instead in a renewed commitment to shared decision making."[6] We wholeheartedly agree with this statement. The health care provider and the patient should make the decision, taking into consideration the patient's risk factors for gynecologic cancers and other conditions, her personal preferences, and her overall values.

This new USPSTF recommendation statement will not change how we currently practice, and the statement's grade I rating should not impact insurance coverage for pelvic exams. Additionally, further research is needed to better elucidate the role of the pelvic exam at well-woman visits, with hopes of obtaining more precise guidelines from the USPSTF and ACOG.

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