DEPARTMENT OF HEALTH AND HUMAN SERVICES • Centers for Medicare & Medicaid Services

PREVENTIVE SERVICES

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SELECT A SERVICE FOR CODES AND BILLING INFORMATION

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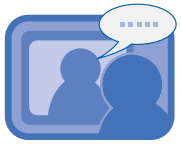
Some of the services listed include codes that you may provide via telehealth – this symbol designates these services.

This educational tool provides the following information on Medicare preventive services: Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes; International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis codes; coverage requirements; frequency requirements; and beneficiary liability for each Medicare preventive service.

Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).



Alcohol Misuse Screening and Counseling

Also referred to as the Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse

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HCPCS/CPT Codes

G0442 – Annual alcohol misuse screening, 15 minutes

G0443 – Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes

ICD-9-CM Codes

No specific diagnosis code

Contact local Medicare Administrative Contractor (MAC) for guidance

Who Is Covered

All Medicare beneficiaries are eligible for alcohol screening.

Medicare beneficiaries who screen positive (those who misuse alcohol but whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence) are eligible for counseling if:

- They are competent and alert at the time that counseling is provided; **and**
- Counseling is furnished by qualified primary care physicians or other primary care practitioners in a primary care setting.

Frequency

- Annually for G0442; **or**
- For those who screen positive, 4 times per year for G0443

Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

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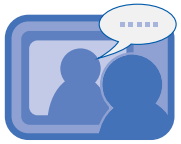

Annual Wellness Visit (AWV)

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HCPCS/CPT Codes

G0438 – Initial visit

G0439 – Subsequent visit

ICD-9-CM Codes

No specific diagnosis code

Contact local Medicare Administrative Contractor (MAC) for guidance

Who Is Covered

All Medicare beneficiaries:

- Who are not within 12 months after the effective date of their first Medicare Part B coverage period; **and**
- Who have not received an Initial Preventive Physical Examination (IPPE) or AWV within the past 12 months

Frequency

- Once in a lifetime for G0438 (first AWV); **or**
- Annually for G0439 (subsequent AWV)

Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

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Bone Mass Measurements

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HCPCS/CPT Codes

76977 – Ultrasound bone density measurement and interpretation, peripheral site(s), any method

77078 – Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)

77080 – Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)

77081 – DXA, bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)

G0130 – Single energy X-ray absorptiometry (SEXA) bone density study, 1 or more sites, appendicular skeleton (peripheral) (eg, radius, wrist, heel)

ICD-9-CM Codes

No specific diagnosis code

Contact local Medicare Administrative Contractor (MAC) for guidance

Who Is Covered

Certain Medicare beneficiaries who fall into at least one of the following categories:

- Women determined by their physician or qualified non-physician practitioner (NPP) to be estrogen deficient and at clinical risk for osteoporosis;
- Individuals with vertebral abnormalities;
- Individuals getting (or expecting to get) glucocorticoid therapy for more than 3 months;
- Individuals with primary hyperparathyroidism; **or**
- Individuals being monitored to assess response to U.S. Food and Drug Administration (FDA)-approved osteoporosis drug therapy

Frequency

- Every 2 years; **or**
- More frequently if medically necessary

Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

Cardiovascular Disease Screening Tests

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HCPCS/CPT Codes

80061 – Lipid panel, this panel must include the following:

82465 – Cholesterol, serum, total

83718 – Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol)

84478 – Triglycerides

ICD-9-CM Codes

Report one or more of the following codes: V81.0, V81.1, V81.2

Who Is Covered

All Medicare beneficiaries without apparent signs or symptoms of cardiovascular disease

Frequency

Once every 5 years

Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

For more information, refer to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN907784.html on the Centers for Medicare & Medicaid Services (CMS) website.

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Colorectal Cancer Screening

Expanded Coverage! Medicare began covering the Cologuard™ Multitarget Stool DNA (sDNA) Test effective October 9, 2014.

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HCPCS/CPT Codes

00810 – Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum

82270 – Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided 3 cards or single triple card for consecutive collection)

G0104 – Flexible Sigmoidoscopy

G0105 – Colonoscopy (high risk)

G0106 – Barium Enema (alternative to G0104)

G0120 – Barium Enema (alternative to G0105)

G0121 – Colonoscopy (not high risk)

G0328 – Fecal Occult Blood Test (FOBT), immunoassay, 1-3 simultaneous

G0464 – Colorectal cancer screening; stool-based DNA and fecal occult hemoglobin (e.g., KRAS, NDRG4 and BMP3)

ICD-9-CM Codes

No specific diagnosis code

Contact local Medicare Administrative Contractor (MAC) for guidance

Who Is Covered

For colorectal cancer screening using Cologuard™—a Multitarget Stool DNA (sDNA) Test:

All Medicare beneficiaries:

- Aged 50 to 85 years;
- Asymptomatic; **and**
- At average risk of developing colorectal cancer

For screening colonoscopies, FOBTs, flexible sigmoidoscopies, and barium enemas:

All Medicare beneficiaries:

- Aged 50 and older who are at normal risk of developing colorectal cancer; **or**
- At high risk of developing colorectal cancer

"High risk for developing colorectal cancer" is defined in the Code of Federal Regulations (CFR) at 42 CFR 410.37(a)(3).

NOTE: For coverage of screening colonoscopies, there is no age limitation.

Frequency

Normal Risk:

- Cologuard™ Multitarget Stool DNA (sDNA) Test: once every 3 years;
- Screening FOBT: every year;
- Screening flexible sigmoidoscopy: once every 4 years (unless a screening colonoscopy has been performed and then Medicare may cover a screening flexible sigmoidoscopy only after at least 119 months);
- Screening colonoscopy: every 10 years (unless a screening flexible sigmoidoscopy has been performed and then Medicare may cover a screening colonoscopy only after 47 months); **and**
- Screening barium enema (as an alternative to covered screening flexible sigmoidoscopy)

High Risk:

- Screening FOBT: every year;
- Screening flexible sigmoidoscopy: once every 4 years;
- Screening colonoscopy: every 2 years (unless a screening flexible sigmoidoscopy has been performed and then Medicare may cover a screening colonoscopy only after at least 47 months); **and**
- Screening barium enema (as an alternative to covered screening flexible sigmoidoscopy or colonoscopy)

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Colorectal Cancer Screening (continued)

Expanded Coverage! Medicare began covering the Cologuard™ Multitarget Stool DNA (sDNA) Test effective October 9, 2014.

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Beneficiary Pays

82270, G0104, G0105, G0121, and G0328:

- Copayment/coinsurance waived
- Deductible waived

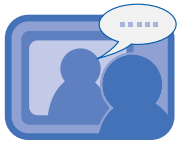
Append modifier -33 to the anesthesia CPT code 00810 when you furnish a separately payable anesthesia service in conjunction with a screening colonoscopy (G0105 and G0121) to waive beneficiary copayment/ coinsurance and deductible.

G0106 and G0120:

- Copayment/coinsurance applies
- Deductible waived

No deductible for all surgical procedures (CPT code range of 10000 to 69999) furnished on the same date and in the same encounter as a screening colonoscopy, flexible sigmoidoscopy, or barium enema initiated as colorectal cancer screening services.

Append modifier -PT to CPT code in the surgical range of 10000 to 69999 in this scenario.



Counseling to Prevent Tobacco Use (for Asymptomatic Beneficiaries)

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HCPCS/CPT Codes

G0436 – Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes

G0437 – Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes

ICD-9-CM Codes

Report one of the following codes: 305.1 or V15.82

Who Is Covered

Outpatient and hospitalized Medicare beneficiaries:

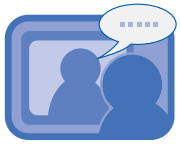
- Who use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease;
- Who are competent and alert at the time of counseling; **and**
- Who get counseling furnished by a qualified physician or other Medicare-recognized practitioner

Frequency

Two cessation attempts per year. Each attempt may include a maximum of 4 intermediate or intensive sessions, with the total annual benefit covering up to 8 sessions per year

Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived



Depression Screening

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HCPCS/CPT Codes

G0444 – Annual depression screening, 15 minutes

ICD-9-CM Codes

No specific diagnosis code

Contact local Medicare Administrative Contractor (MAC) for guidance

Who Is Covered

All Medicare beneficiaries

Must be furnished in a primary care setting that has staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up

Frequency

Annually

Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

For more information, refer to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN907799.html on the Centers for Medicare & Medicaid Services (CMS) website.

Diabetes Screening

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HCPCS/CPT Codes

82947 – Glucose; quantitative, blood (except reagent strip)

82950 – Glucose; post glucose dose (includes glucose)

82951 – Glucose; tolerance test (GTT), 3 specimens (includes glucose)

ICD-9-CM Codes

V77.1

Who Is Covered

Medicare beneficiaries with certain risk factors for diabetes or diagnosed with pre-diabetes

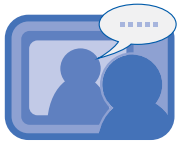
NOTE: Beneficiaries previously diagnosed with diabetes are **not** eligible for this benefit

Frequency

- Two screening tests per year for beneficiaries diagnosed with pre-diabetes; **or**
- One screening per year if previously tested but not diagnosed with pre-diabetes or if never tested

Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived



Diabetes Self-Management Training (DSMT)

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HCPCS/CPT Codes

G0108 – DSMT, individual, per 30 minutes

G0109 – DSMT, group (2 or more), per 30 minutes

ICD-9-CM Codes

No specific diagnosis code

Contact local Medicare Administrative Contractor (MAC) for guidance

Who Is Covered

Certain Medicare beneficiaries who:

- Are diagnosed with diabetes; **and**
- Who receive an order for DSMT from the physician or qualified non-physician practitioner (NPP) treating the beneficiary's diabetes

Frequency

- Initial year: Up to 10 hours of initial training within a continuous 12-month period; **or**
- Subsequent years: Up to 2 hours of follow-up training each year after the initial year

Beneficiary Pays

- Copayment/coinsurance applies
- Deductible applies

Glaucoma Screening

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HCPCS/CPT Codes

G0117 – By an optometrist or ophthalmologist

G0118 – Under the direct supervision of an optometrist or ophthalmologist

ICD-9-CM Codes

V80.1

Who Is Covered

Medicare beneficiaries who:

- Have diabetes mellitus;
- Have a family history of glaucoma;
- Are African-Americans aged 50 and older; **or**
- Are Hispanic-Americans aged 65 and older

Frequency

Annually for covered beneficiaries

Beneficiary Pays

- Copayment/coinsurance applies
- Deductible applies

PREVENTIVE SERVICES

Hepatitis B Virus (HBV) Vaccine and Administration

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HCPCS/CPT Codes

90739 – Hepatitis B vaccine, adult dosage (2 dose schedule), for intramuscular use

90740 – Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use

90743 – Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use

90744 – Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use

90746 – Hepatitis B vaccine, adult dosage (3 dose schedule), for intramuscular use

90747 – Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use

G0010 – Administration

ICD-9-CM Codes

V05.3

Who Is Covered

Certain Medicare beneficiaries at intermediate or high risk for contracting hepatitis B

NOTE: Medicare beneficiaries who are currently positive for antibodies for hepatitis B are **not** eligible for this benefit

Frequency

Scheduled dosages required

Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

For more information, refer to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243321.html on the Centers for Medicare & Medicaid Services (CMS) website.

Hepatitis C Virus (HCV) Screening

New Service! Medicare began covering HCV screening effective June 2, 2014.

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HCPCS/CPT Codes

G0472 – Hepatitis C antibody screening, for individual at high risk and other covered indication(s)

ICD-9-CM Codes

Report one of the following codes for high risk beneficiaries:

- V69.8 - initial claim;
- V69.8 and 304.91-subsequent claims for high risk beneficiaries with continued illicit injection drug use since prior negative screening

Who Is Covered

Certain adult Medicare beneficiaries who:

- Are at high risk for HCV infection; **or**
- Were born between 1945 and 1965

Frequency

- Annually only for high risk beneficiaries with continued illicit injection drug use since the prior negative screening test; **or**
- Once in a lifetime for beneficiaries born between 1945 and 1965 who are not considered high risk.

Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

PREVENTIVE SERVICES

Human Immunodeficiency Virus (HIV) Screening

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HCPCS/CPT Codes

G0432 – Infectious agent antibody detection by enzyme immunoassay (EIA) technique

G0433 – Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique

G0435 – Infectious agent antibody detection by rapid antibody test

ICD-9-CM Codes

Beneficiaries reporting increased risk:

- V73.89 – Primary; and
- V69.8 – Secondary, as appropriate

Pregnant beneficiaries:

- V73.89 – Primary; and
- V22.0, V22.1, or V23.9 – Secondary, as appropriate

Who Is Covered

Certain Medicare beneficiaries who are at increased risk for HIV infection, including anyone who asks for the test, or pregnant women

NOTE: "Increased risk for HIV infection" is defined in the Medicare National Coverage Determinations Manual, Publication 100-03, Chapter 1, Section 210.7.

Frequency

Annually for beneficiaries at increased risk, including anyone who asks for the test

For beneficiaries who are pregnant, 3 times per pregnancy:

- First, when a woman is diagnosed with pregnancy;
- Second, during the third trimester; **and**
- Third, at labor, if ordered by the woman's clinician

Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

Influenza Virus Vaccine and Administration

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HCPCS/CPT Codes

90653, 90654, 90655, 90656, 90657, 90660, 90661, 90662, 90672, 90673, 90685, 90686, 90687, 90688, Q2034, Q2035, Q2036, Q2037, Q2038, Q2039 – Influenza Virus Vaccine

G0008 – Administration

ICD-9-CM Codes

Report one of the following codes:

- V04.81 – Influenza
- V06.6 – Pneumococcus and Influenza

Who Is Covered

All Medicare beneficiaries

Frequency

Once per influenza season

Medicare covers additional flu shots if medically necessary

Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

For more information, refer to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243321.html on the Centers for Medicare & Medicaid Services (CMS) website.

PREVENTIVE SERVICES

Initial Preventive Physical Examination (IPPE)

Also known as the "Welcome to Medicare Preventive Visit"

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HCPCS/CPT Codes

G0402 – IPPE
G0403 – EKG for IPPE
G0404 – EKG tracing for IPPE
G0405 – EKG interpret & report for IPPE

ICD-9-CM Codes

No specific diagnosis code

Contact local Medicare Administrative Contractor (MAC) for guidance

Who Is Covered

All new Medicare beneficiaries who are within the first 12 months of their first Medicare Part B coverage period

Frequency

Once in a lifetime

Must furnish no later than 12 months after the effective date of the first Medicare Part B coverage period

Beneficiary Pays

G0402:

- Copayment/coinsurance waived
- Deductible waived

G0403, G0404, and G0405:

- Copayment/coinsurance applies
- Deductible applies

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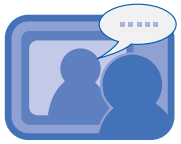

Intensive Behavioral Therapy (IBT) for Cardiovascular Disease (CVD)

Also known as a CVD risk reduction visit

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HCPCS/CPT Codes

G0446 – Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes

ICD-9-CM Codes

No specific diagnosis code

Contact local Medicare Administrative Contractor (MAC) for guidance

Who Is Covered

All Medicare beneficiaries:

- Who are competent and alert at the time counseling is provided; **and**
- Whose counseling is furnished by a qualified primary care physician or other primary care practitioner and in a primary care setting

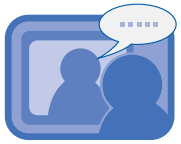
Frequency

One CVD risk reduction visit annually

Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

For more information, refer to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN907784.html on the Centers for Medicare & Medicaid Services (CMS) website.



Intensive Behavioral Therapy (IBT) for Obesity

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HCPCS/CPT Codes

G0447 – Face-to-face behavioral counseling for obesity, 15 minutes

G0473 – Face-to-face behavioral counseling for obesity, group (2–10), 30 minutes

ICD-9-CM Codes

Report one of the following codes: V85.30–V85.39, V85.41–V85.45

Who Is Covered

Medicare beneficiaries:

- With obesity (Body Mass Index [BMI] ≥ 30 kilograms [kg] per meter squared);
- Who are competent and alert at the time counseling is provided; **and**
- Whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting

Frequency

- First month: one visit every week;
- Months 2 – 6: one visit every other week; **and**
- Months 7 – 12: one visit every month if certain requirements are met

At the 6-month visit, a reassessment of obesity and a determination of the amount of weight loss must be performed.

To be eligible for additional face-to-face visits occurring once a month for an additional 6 months, beneficiaries must have lost at least 3kg.

For beneficiaries who do not achieve a weight loss of at least 3 kg during the first 6 months, a reassessment of their readiness to change and BMI is appropriate after an additional 6-month period.

Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

Lung Cancer Screening Counseling and Annual Screening for Lung Cancer with Low Dose Computed Tomography

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Effective February 5, 2015, Medicare began covering lung cancer screening counseling and a shared decision making visit, and for appropriate beneficiaries, annual screening for lung cancer with low dose computed tomography (LDCT). For more information, refer to http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=274 on the Centers for Medicare & Medicaid Services (CMS) website. This product will be updated with more information as it becomes available.

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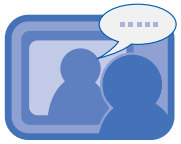

Medical Nutrition Therapy (MNT)

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HCPCS/CPT Codes

97802 – MNT; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes

97803 – MNT; re-assessment and intervention, individual, face-to-face with the patient each 15 minutes

97804 – MNT; group (2 or more individual(s)), each 30 minutes

G0270 – MNT reassessment and subsequent intervention(s) for change in diagnosis, individual, each 15 minutes

G0271 – MNT reassessment and subsequent intervention(s) for change in diagnosis, group (2 or more), each 30 minutes

ICD-9-CM Codes

No specific diagnosis code

Contact local Medicare Administrative Contractor (MAC) for guidance

Who Is Covered

Certain Medicare beneficiaries:

- Who receive a referral from their treating physician; **and**
- Are diagnosed with diabetes, renal disease, or who have received a kidney transplant within the last 3 years; **and**
- A registered dietitian or nutrition professional must provide the services

Frequency

- First year: 3 hours of one-on-one counseling; **or**
- Subsequent years: 2 hours

Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

PREVENTIVE SERVICES

Pneumococcal Vaccine and Administration

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HCPCS/CPT Codes

90670 – Pneumococcal Conjugate Vaccine
90732 – Pneumococcal polysaccharide vaccine
G0009 – Administration

ICD-9-CM Codes

Report one of the following codes:

- V03.82 – Pneumococcus
- V06.6 – Pneumococcus and Influenza

Who Is Covered

All Medicare beneficiaries

Frequency

- An initial pneumococcal vaccine to Medicare beneficiaries who never received the vaccine under Medicare Part B; **and**
- A different, second pneumococcal vaccine 1 year after the first vaccine was administered

Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

For more information, refer to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243321.html on the Centers for Medicare & Medicaid Services (CMS) website.

Prostate Cancer Screening

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HCPCS/CPT Codes

G0102 – Digital Rectal Exam (DRE)

G0103 – Prostate Specific Antigen Test (PSA)

ICD-9-CM Codes

V76.44

Who Is Covered

All male Medicare beneficiaries aged 50 and older (coverage begins the day after their 50th birthday)

Frequency

Annually for covered beneficiaries

Beneficiary Pays

G0102:

- Copayment/coinsurance applies
- Deductible applies

G0103:

- Copayment/coinsurance waived
- Deductible waived

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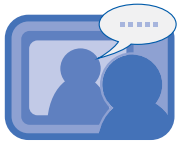

Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling (HIBC) to Prevent STIs

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HCPCS/CPT Codes

86631, 86632, 87110, 87270, 87320, 87490, 87491, 87810 – Chlamydia

87590, 87591, 87850 – Neisseria gonorrhoeae

87800 – Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique

86592 – Syphilis test, non-treponemal antibody; qualitative (eg, VDRL, RPR, ART)

86593 – Syphilis test, non-treponemal, quantitative

86780 – Treponema pallidum

87340, 87341 – Hepatitis B (hepatitis B surface antigen)

G0445 – Semiannual high intensity behavioral counseling to prevent STIs, individual, face-to-face, includes education skills training & guidance on how to change sexual behavior, 30 minutes

ICD-9-CM Codes

For screening for chlamydia, gonorrhea, and syphilis in women at increased risk for STIs who are not pregnant report V74.5 **and** V69.8

For screening for syphilis in men at increased risk, report V74.5 **and** V69.8

For screening for chlamydia and gonorrhea in pregnant women at increased risk for STIs, report:

- V74.5, V69.8; **and**
- V22.0, V22.1, or V23.9

For screening for syphilis in pregnant women, report:

- V74.5, V22.0; **and**
- V22.1 or V23.9

For screening for syphilis in pregnant women at increased risk for STIs, report:

- V74.5, V69.8; **and**
- V22.0, V22.1, or V23.9

For screening for hepatitis B in pregnant women, report

- V73.89; **and**
- V22.0, V22.1, or V23.9

For screening for hepatitis B in pregnant women at increased risk for STIs, report:

- V73.89, V69.8; **and**
- V22.0, V22.1, or V23.9

For HIBC: No specific diagnosis code

Contact local Medicare Administrative Contractor (MAC) for guidance

Who Is Covered

Certain Medicare beneficiaries who are:

- Sexually active adolescents and adults at increased risk for STIs; **and**
- Referred for this service by a primary care provider and provided by a Medicare-eligible primary care provider in a primary care setting

NOTE: More information on covered beneficiaries and a definition of "increased risk for STIs" can be found in the Medicare National Coverage Determinations Manual, Publication 100-03, Chapter 1, Section 210.10.

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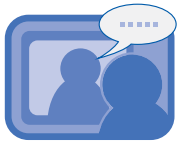

Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling (HIBC) to Prevent STIs (continued)

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Frequency

- One annual occurrence of screening for chlamydia, gonorrhea, and syphilis in women at increased risk who are not pregnant
- One annual occurrence of screening for syphilis in men at increased risk
- Up to two occurrences per pregnancy of screening for chlamydia and gonorrhea in pregnant women who are at increased risk for STIs and continued increased risk for the second screening
- One occurrence per pregnancy of screening for syphilis in pregnant women; up to two additional occurrences in the third trimester and at delivery if at continued increased risk for STIs
- One occurrence per pregnancy of screening for hepatitis B in pregnant women; one additional occurrence at delivery if at continued increased risk for STIs
- Up to two 20-30 minute, face-to-face HIBC counseling sessions annually

Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

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Screening Mammography

Update: Medicare now requires an add-on code when you furnish a mammography using 3-D mammography in conjunction with a 2-D digital mammography, effective January 1, 2015.

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HCPCS/CPT Codes

77052 – Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further review for interpretation; screening mammography (List separately in addition to code for primary procedure)

77057 – Screening mammography, bilateral (2-view film study of each breast)

77063 – Screening digital breast tomosynthesis; bilateral (List separately in addition to code for primary procedure) (Use this as an add-on code to G0202 when tomosynthesis is used in addition to 2-D mammography)

G0202 – Screening mammography, producing direct 2-D digital image, bilateral, all views

NOTE: If billing a screening mammogram and a diagnostic mammogram on the same day, use modifier –GG to show a screening mammogram turned into a diagnostic mammogram.

ICD-9-CM Codes

Report one of the following codes: V76.11 or V76.12

Who Is Covered

All female Medicare beneficiaries aged 35 and older

Frequency

- Aged 35 through 39: One baseline; **or**
- Aged 40 and older: Annually

Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

Screening Pap Tests

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HCPCS/CPT Codes

G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148 – Screening cytopathology, cervical or vaginal

P3000 – Screening Pap smear by technician under physician supervision

P3001 – Screening Pap smear requiring interpretation by physician

Q0091 – Screening Pap smear; obtaining, preparing and conveyance to lab

ICD-9-CM Codes

Report one of the following codes:

- Low Risk – V72.31, V76.2, V76.47, V76.49
- High Risk – V15.89

Who Is Covered

All female Medicare beneficiaries

Frequency

- Annually if at high risk for developing cervical or vaginal cancer or childbearing age with abnormal Pap test within past 3 years; **or**
- Every 2 years for women at normal risk

Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

Screening Pelvic Examinations (includes a clinical breast examination)

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HCPCS/CPT Codes

G0101 – Cervical or vaginal cancer screening; pelvic and clinical breast examination

ICD-9-CM Codes

Report one of the following codes:

- Low Risk – V72.31, V76.2, V76.47, V76.49
- High Risk – V15.89

Who Is Covered

All female Medicare beneficiaries

Frequency

- Annually if at high risk for developing cervical or vaginal cancer, or childbearing age with abnormal Pap test within past 3 years; **or**
- Every 2 years for women at normal risk

Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)

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HCPCS/CPT Codes

G0389 – Ultrasound exam for AAA screening

ICD-9-CM Codes

No specific diagnosis code

Contact local Medicare Administrative Contractor (MAC) for guidance

Who Is Covered

Medicare beneficiaries:

- With certain risk factors for AAA; **and**
- Who receive a referral from their physician, physician assistant, nurse practitioner, or clinical nurse specialist

Frequency

Once in a lifetime

Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

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Frequently Asked Questions (FAQs)

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May CMS add new preventive services as Medicare benefits?

CMS may add coverage of "additional preventive services" through the National Coverage Determination (NCD) process if the service meets all of the following criteria. The service must be: 1) reasonable and necessary for the prevention or early detection of illness or disability; 2) recommended with a grade of A or B by the United States Preventive Services Task Force (USPSTF); and 3) appropriate for individuals entitled to benefits under Part A or enrolled under Part B of the Medicare Program. For more information on USPSTF recommendations, visit http://www.uspreventiveservicestaskforce.org/BrowseRec/Index on the Internet. For the latest information on Medicare preventive services, visit http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/News_and_Announcements.html on the CMS website.

What is a primary care setting?

A primary care setting is defined as one in which there is a provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities, and hospices are not considered primary care settings under this definition.

How do I determine the last date a beneficiary got a preventive service so I know the beneficiary is eligible to get the next service and the service will not be denied due to frequency edits?

You have different options for accessing eligibility information depending on the Medicare Administrative Contractor (MAC) jurisdiction where your practice or facility is located. You may be able to access the information through the HIPAA Eligibility Transaction System (HETS) or through the provider call center Interactive Voice Responses (IVRs). CMS suggests that providers check with their MAC to see what options are available to check beneficiary eligibility. For MAC contact information, visit http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map on the CMS website.

My patients do not follow up on routine preventive care. How can I help them remember when they are due for their next preventive service?

Medicare provides a "Preventive Services Checklist" you can give to your patients. They can use the checklist to track their preventive services. For the checklist, refer to http://www.medicare.gov/Pubs/pdf/11420.pdf on the Medicare website.

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Resources

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Preventive Services

CMS Web Page
http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo

FAQs
https://questions.cms.gov/faq.php?id=5005&rtopic=1991

Preventive Services Medicare Learning Network® (MLN) Web Page
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html or scan the Quick Response (QR) code on the right

MLN Matters® Articles Related to Medicare-Covered Preventive Benefits
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNPrevArticles.pdf

Regulations

Code of Federal Regulations
http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR

Internet-Only Manuals (IOMs)
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html

Related MLN Products

Guided Pathways (GPs)
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Guided_Pathways.html

“Resources for Medicare Beneficiaries” Fact Sheet
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN905183.html

“Telehealth Services” Fact Sheet
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243327.html

Disclaimers

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