ACOG
THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS

Medicare Screening Services 2013

Physicians are often confused about how to document and report preventive services provided to their Medicare patients. This is particularly true with the ongoing implementation of the Affordable Care Act (ACA). This document is designed to assist physicians in documenting, reporting and receiving reimbursement for these preventive services.

Although Medicare does not cover comprehensive preventive visits such as those reported with CPT-4 codes 99381-99397, effective January 1, 2011, Medicare began covering a new service, the annual wellness visit or AWV. Additionally, Medicare will continue to reimburse for certain screening services which are often performed during preventive service visits such as:

- Screening pelvic exam
- Collection of screening Pap smear specimen
- Interpretation of the Pap smear test (reported by the laboratory)
- Screening hemoccult
- Screening mammography
- Screening bone mass measurement
- Initial preventive physical examination (IPPE) (Welcome to Medicare examination)
- Diabetes screening
- Cardiovascular blood test
- Tobacco use cessation counseling

The ACA promotes healthier seniors by providing new benefits and services while reducing the out of pocket expense for Medicare beneficiaries. The ACA waives the deductible and coinsurance/copayment for specific preventive services with a recommendation grade of A or B by the U.S. Preventive Services Task Force (USPSTF). In addition, the ACA waives the deductible and coinsurance/copayment for the IPPE and annual wellness visit. The following link provides additional information on the deductible and coinsurance waivers for preventive services: http://www.cms.gov/Transmittals/downloads/R864OTN.pdf

The table at the end of this document provides an overview of Medicare screening services. The Centers for Medicare and Medicaid Services (CMS) have published several educational products that describe covered screening services available to Medicare patients. Physicians can either order these booklets free of charge or download a copy by visiting Medicare's website at the addresses listed below:
http://www.cms.hhs.gov/MLNProducts/Downloads/education_products_prevserv.pdf
http://www.cms.gov/MLNMattersArticles/downloads/MM7079.pdf
http://www.cms.gov/MLNProducts/downloads/Cancer_Screening.pdf

Advanced Beneficiary Notification

Medicare screening services are limited to a specific frequency (e.g., once every 2 years, once every year). A physician may not know whether a patient is eligible for a screening service in a given year. If she is not eligible, the service will be denied. Therefore, the physician should ask the patient to sign an advance beneficiary notice of non-coverage (ABN) using the form provided by Medicare. For more information on Medicare's ABN form, visit http://www.cms.gov/BNI/. Claims for Medicare patients should be submitted with the appropriate HCPCS modifier as described below.

- **GA** modifier indicates that a required ABN form has been signed and is on file.(Waiver of liability statement issued as required by payer policy, individual case)
- **GZ** modifier indicates that an ABN form has not been signed. (Item or service expected to be denied as not reasonable and necessary)
- **GX** modifier indicates that a voluntary ABN has been signed for a non-covered service. This modifier may be reported for services formerly reported with the Notice of Exclusion from Medicare Benefits (NEMB) form. The NEMB form has been discontinued. (Notice of liability issued, voluntary under payer policy)
- **GY** modifier indicates that the service provided is not a covered Medicare benefit. The service is being reported to Medicare in order to receive a denial. (Item or service statutorily excluded, does not meet the definition of any Medicare benefit or for non-Medicare insurers, is not a contract benefit)

Using the appropriate modifier ensures that the patient will receive the correct information on her Explanation of Benefits (EOB). For example, when a service is reported with a GY modifier, the EOB will state that it is not covered and therefore the patient's responsibility.

Annual Wellness Visits

Effective January 1, 2011, CMS began reimbursing for two new services:

1. The patient's first annual wellness visit, which is distinct from and must occur at least 12 months after the patient's "Welcome to Medicare" physical **AND**
2. Subsequent annual wellness visits

Personalized Prevention Plan Services (PPPS) are an essential part of the AWV service and include the following components:

- Establish or update the individual's medical and family history
- List the individual's current medical providers and suppliers and all prescribed medications
- Record measurements of height, weight, body mass index, blood pressure and other routine measurements
- Detect any cognitive impairment
- Establish or update a screening schedule for the next 5 to 10 years including screenings appropriate for the general population, and any additional screenings that may be appropriate because of the individual patient's risk factors
- Furnish personalized health advice and appropriate referrals to health education or preventive services

Medicare Part B will pay for the initial and subsequent annual wellness visits providing personalized prevention plan services that are furnished to an eligible beneficiary by a qualified provider effective for services furnished on or after January 1, 2011.

The following codes will be reported for annual wellness visits:

- G0438 - Annual wellness visit; includes a personalized prevention plan of service (PPPS), initial visit
- G0439 - Annual wellness visit; includes a personalized prevention plan of service (PPPS), subsequent visit

Per the 2011 Physician Fee Schedule Final Rule, practitioners furnishing a preventive medicine E/M service that does not meet the requirements for the Initial Preventive Physical Examination (IPPE) or the annual wellness visit (AWV) should continue to report one of the preventive medicine E/M services CPT codes (99381 - 99397) if required and as appropriate to the patient's circumstances, and these codes continue to be non-covered by Medicare.

Reporting, as always, will depend upon the services actually performed. However, it is suggested not to report these multiple services at the same visit since CMS has indicated that typically, preventive service codes are not billed on the same date as the AWV.

ACOG's Committee on Coding and Nomenclature believes that it is unlikely that most ob-gyn practices will offer the AWV or IPPE. As a result, they have developed a letter template that can be used to help explain to patients that they should seek appointments for these visits with their primary care physicians. This letter can be viewed at the end of this document.

Screening Services

NOTE: The frequency of coverage for screening services described below has not changed as a result of the advent of Medicare coverage for annual wellness visits.

Collection of Screening Pap Smear Specimen

Medicare reimburses for collection of a screening Pap smear every two years in most cases.

This service is reported using HCPCS code Q0091 (Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory).Both the deductible and co-pay/coinsurance are waived for the laboratory's interpretation of the test.

The collection is reimbursed every year if the patient meets Medicare's criteria for high risk. Following are the only criteria that are accepted by Medicare to indicate a high risk patient:

- Woman is of childbearing age **AND**
  - Cervical or vaginal cancer is present (or was present) **OR**
  - Abnormalities were found within last 3 years **OR**
  - Is considered high risk (as described below) for developing cervical or vaginal cancer
- Woman is not of childbearing age **AND** she has at least one of the following:
  High risk factors for **cervical and vaginal cancer**
  - Onset of sexual activity under 16 years of age
  - Five or more sexual partners in a lifetime
  - History of sexually transmitted diseases (including human papilloma virus and/or HIV infection)
  - Fewer than 3 negative or any Pap smears within previous 7 years
  - DES (diethylstilbestrol)-exposed daughters of women who took DES during pregnancy

Screening Pelvic Exam

Medicare reimburses for a screening pelvic examination every two years in most cases.

This service is reported using HCPCS code G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination). If the patient meets Medicare's criteria for high risk, the examination is reimbursed every year. These criteria are the same as the ones listed above for the collection of screening Pap smear specimen. The diagnosis codes for Pap smear collection and screening pelvic exam are listed below.

Effective September 23, 2008, Medicare clarified that the clinical breast exam is no longer considered a mandatory element of the screening pelvic exam. It is now one of the eleven elements that may be performed as part of the exam.

A screening pelvic examination (HCPCS code G0101) should include documentation of at least **seven** of the following **eleven** elements:

1. Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge
2. Digital rectal examination including sphincter tone, presence of hemorrhoids, and rectal masses
3. External genitalia (for example, general appearance, hair distribution, or lesions)
4. Urethral meatus (for example, size, location, lesions, or prolapse)
5. Urethra (for example, masses, tenderness, or scarring)
6. Bladder (for example, fullness, masses, or tenderness)
7. Vagina (for example, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, or rectocele)
8. Cervix (for example, general appearance, lesions or discharge)

9. Uterus (for example, size, contour, position, mobility, tenderness, consistency, descent, or support)
10. Adnexa/parametria (for example, masses, tenderness, organomegaly, or nodularity) and/or
11. Anus and perineum

HCPCS code G0101 includes only the above examination elements. It does not include the many other services normally included in a comprehensive preventive visit.

Diagnostic Coding for the Collection of a Pap Smear Specimen and the Screening Pelvic Exam

Both the collection of the screening Pap smear specimen (Q0091) and screening pelvic exam (G0101) are reported with one of the following diagnosis codes:

- V72.31 - Routine gynecological exam (reported when provider performs a full gyn examination)
- V76.2 - Special screening for malignant neoplasms, cervix (patient has a cervix)
- V76.47 - Special screening for malignant neoplasms, vagina (patient does not have a cervix)
- V76.49 - Special screening for malignant neoplasms, other sites
- V15.89 - Other specified personal history presenting hazards to health. (patient is considered high risk according to Medicare's criteria)

Collection of a diagnostic Pap smear (performed due to illness, disease, or symptoms indicating a medically necessary reason) is included in the physical examination portion of a problem-oriented E/M service and is not reported or reimbursed separately.

Often, both the G0101 and Q0091 are provided during the same visit. An example follows.

Example 1: Collection of a screening Pap smear (Q0091) reported with the screening pelvic examination (G0101):

Bill to:	HCPCS Codes	ICD-9 Codes	Charge
Medicare	G0101-GA	V76.2, V76.47, V76.49, or V15.89	$34.60
	Q0091-GA	V76.2, V76.47, V76.49, or V15.89	$40.00
Patient	N/A	N/A	$ 0.00
Total amount billed			$74.60

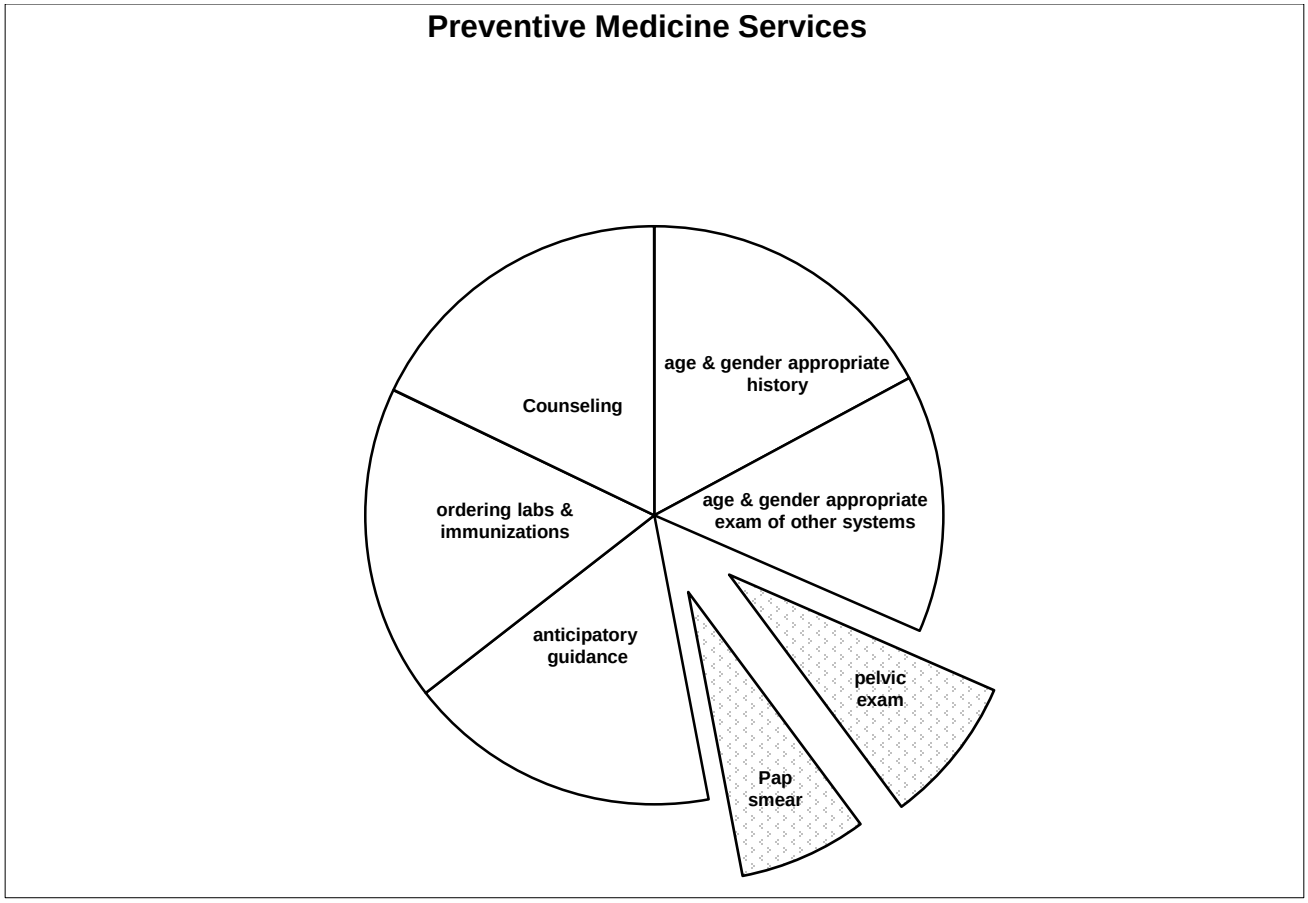
The assumption is that the physician in this example provided only Medicare covered services with no additional preventive care.

The GA modifier indicates that an ABN has been signed and is on file. Note that the charges listed in the example above are Medicare allowable amounts but do not include the geographical adjustment factor.

The patient is not initially billed for either of these services since Medicare covers them. Both the deductible and co-pay/coinsurance are waived.

Preventive Medicine Service Provided at the Time of Covered Screening Service

A preventive medicine exam, as described by CPT-4 codes 99384 – 99397, includes a comprehensive age and gender appropriate history, examination, counseling/anticipatory guidance/risk-factor reduction interventions, and the ordering of appropriate immunization(s) and laboratory/diagnostic procedures. Sometimes these other elements are performed during the same visit as the Medicare covered services, particularly G0101 and Q0091. The following pie chart illustrates this circumstance.



Medicare will reimburse for the shaded parts of the pie (the collection of the Pap smear and the pelvic exam). The remaining portions of the preventive service are billed to the patient. The amount paid by Medicare is subtracted from the physician's usual fee for a preventive service. The remaining amount is the patient's responsibility. This is referred to as a "carve out," meaning that Medicare's covered portion of the preventive service is carved out of the total preventive service. The amount reimbursed by Medicare and the amount reimbursed by the patient will equal the physician's usual fee.

Example 2: The "carve out" method for reporting the screening pelvic examination (G0101) with other preventive medicine care:

Bill to:	CPT/HCPCS Code(s)	ICD-9 Code(s)	Charge
Patient	99397-GY	V72.31	$65.40
Medicare	G0101-GA	V72.31 or V15.89	$34.60
Total amount billed			$100.00

The physician's usual charge for the preventive visit (99397) is $100. The total billed to the patient and to Medicare equals the physician's usual charge for the preventive service.

The GA modifier indicates that a required ABN has been signed and is on file. Modifier GY is reported for a service that is not a Medicare covered benefit. The service is being reported to Medicare to receive a denial. The patient is responsible for the preventive service less the Medicare carve out amount.

Example 3: Preventive visit reported with screening pelvic examination (G0101) and collection of a screening Pap smear specimen (Q0091):

Bill to:	CPT/HCPCS Code(s)	ICD-9 Code(s)	Charge
Patient	99397-GY	V72.31	$25.40
Medicare	G0101-GA	V72.31 or V15.89	$34.60
	Q0091-GA	V72.31 or V15.89	$40.00
Total amount billed			$100.00

The physician's usual charge for the preventive visit (99397) is $100. The total billed to the patient and to Medicare equals the physician's usual charge.

The GA modifier indicates that a required ABN has been signed and is on file. Modifier GY is reported for a service that is not a Medicare covered benefit. The service is being reported to Medicare to receive a denial. The patient is responsible for the preventive service less the Medicare carve out amount and can be billed at the time of service for the portion not covered by Medicare.

Medicare Screening Service at the Time of Covered E/M Services

Medicare will reimburse separately for covered screening services (e.g., G0101, Q0091) when performed at the same encounter as a covered E/M service, such as a problem-oriented visit (codes 99201-99215). The level of E/M service reported is based solely on the evaluation of the problem.

Example 4: Covered problem-oriented visit reported with a screening pelvic examination (G0101) and collection of a screening Pap smear specimen (Q0091).

Bill to:	CPT/HCPCS Code(s)	ICD-9 Code(s)	Charge
Medicare	99213-25	Problem diagnosis	$61.20
	G0101-GA	V76.2, V76.47, V76.49, or V15.89	$34.60
	Q0091-GA	V76.2, V76.47, V76.49, or V15.89	$40.00
Patient	N/A	N/A	$135.80

The GA modifier indicates that a required ABN has been signed and is on file. Modifier 25 indicates that the E/M service was significant and separately identifiable and not part of the pelvic examination or collection of the Pap smear.

The patient is not billed for her portion (i.e., deductible and co-pay for the problem visit) until Medicare has processed the claim. The diagnosis code for the patient's problem, signs or symptoms should be linked to the E/M service (99213). The level of service for the E/M visit will depend on what was performed and documented.

Other Medicare Preventive Services

Following are brief descriptions of other preventive services covered by Medicare and sometimes provided by obstetrician/gynecologists.

Seasonal Influenza Vaccine and Administration

For Medicare beneficiaries, the seasonal influenza vaccine is usually administered once a year during the fall or winter months. Additional influenza vaccines (i.e., the number of doses of a vaccine and/or the type of influenza vaccine) are covered by Medicare when medically necessary. Influenza vaccine plus its administration is a covered Part B benefit. Influenza vaccine is NOT a Part D covered drug.

For the administration of the vaccine report the following HCPCS code:

- G0008 - Administration of influenza virus vaccine

For the Influenza Virus Vaccine the following codes are reported for this service:

- 90654 - Influenza virus vaccine, split virus, preservative-free, for intradermal use
- 90656 - Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
- 90660 - Influenza virus vaccine, live, for intranasal use
- 90662 - Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use
- Q2034 - Influenza virus vaccine, split virus, for intramuscular use (Agriflu) **(Effective for dates of service on or after 07/01/12, and claims processed on or after 10/01/12)**
- Q2035 - Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (AFLURIA)
- Q2036 - Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (FLULAVAL)
- Q2037 - Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (FLUVIRIN)
- Q2038 - Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluzone)
- Q2039 - Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (not otherwise specified)

Diagnosis code(s) V04.81 (Influenza) or V06.6 (Streptococcus pneumoniae [pneumococcus] and influenza) are appropriate when reporting these services. Both the deductible and copay/coinsurance are waived.

Bone Mass Measurements

Medicare covers bone mass measurements every two years for qualified individuals. Both the deductible and co-pay/coinsurance are waived.

A "qualified individual" must meet at least **one** of these medical indications:

- Estrogen-deficient and at clinical risk for osteoporosis
- Vertebral abnormalities as demonstrated by an x-ray
- Receiving (or expecting to receive) glucocorticoid (steroid) therapy equivalent to 5.0 mg of prednisone or greater, per day, for more than 3 months
- Has a diagnosis of primary hyperparathyroidism
- Being monitored to assess the response to or efficacy of an FDA – approved osteoporosis drug therapy

Medicare may pay for more frequent screenings when medically necessary. Examples include, but are not limited to, the following medical circumstances:

- Monitoring beneficiaries on long-term (more than 3 months) glucocorticoid (steroid) therapy
- Confirming baseline BMMs to permit monitoring of beneficiaries in the future.

Procedure Codes

Medicare allows the physician to choose the screening test. The CPT/HCPCS coding options are:

- 77078 - Computed tomography, bone mineral density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)

- 77079 - **(HAS BEEN DELETED)** To report, please refer to code(s): 77078, 77080-77081
- 77080 - Dual energy x-ray absorptiometry (DXA), bone density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)
    - 77081 - appendicular skeleton (peripheral) (e.g., radius, wrist, heel)
- 77083 - **(HAS BEEN DELETED)** To report, please refer to code(s): 77080-7708277083
- 76977 - Ultrasound bone density measurement and interpretation, peripheral site(s), any method
- G0130 - Single energy x-ray absorptiometry (SEXA) bone density study, one or more sites, appendicular skeleton (peripheral) (e.g., radius, wrist, heel)

Diagnosis Codes
Local carriers determine the ICD-9-CM diagnostic codes that they will accept as supporting these indications. The test must be ordered by a physician or a qualified non-physician practitioner who is treating the patient. Qualified non-physician practitioners include physician assistants, nurse practitioners, clinical nurse specialists, and nurse-midwives. The test results must be required as part of the patient's evaluation and/or formulation of a treatment plan.

Mammography Screening
Medicare covers one screening mammogram for women aged 40 years or older once every 12 months. CPT code 77057 (screening mammography, bilateral [two view film study of each breast]) is reported if a standard screening mammogram is performed. Medicare also covers computer aided detection (CAD) technology services when it is performed in addition to standard mammography. This service is reported using CPT add-on code +77052 (computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography) in addition to code 77057. Both the deductible and co-pay/coinsurance are waived for this service.

In April 2001, Medicare began to cover and provide additional payment for the use of digital technology for screening and diagnostic mammography studies. HCPCS code G0202 (Screening mammography, producing direct digital image, bilateral, all views) was developed to be reported for a screening full-field digital (FFDM) mammogram. Diagnosis code(s) V76.11 (screening mammogram for high-risk patient) or V76.12 (other screening mammogram) should be linked to the appropriate CPT-4 mammography code reported. Both the Medicare deductible and co-pay/coinsurance is waived for this service.

A diagnostic mammogram (when the patient has an illness, disease or symptoms indicating the need for a mammogram) is covered whenever it is medically necessary.

Colorectal Cancer Screening
Medicare covers one screening fecal-occult blood test for women 50 years and older once every 12 months. The attending physician must submit a written order for the test. The deductible and coinsurance do not apply to this test.

Since January 1, 2007, guaiac based screening has been reported to Medicare using CPT code 82270 rather than deleted HCPCS code G0107. The descriptor for CPT code 82270 reads "Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided three cards or single triple card for consecutive collection)." Therefore the patient must complete the test by taking samples from consecutive stools.

As an alternative to the guaiac-based fecal occult blood test, (FOBT), reported with CPT-4 code 82270**,** Medicare also covers screening performed by immunoassay. It is reported to Medicare using HCPCS code G0328 (colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous determinations). The number of specimens required depends on the individual manufacturer's instructions. However, Medicare will pay for only one covered FOBT per year, either 82270 or G0328, but not both.

The diagnosis code reported is either V76.41 (special screening for malignant neoplasms, rectum) or V76.51 (special screening for malignant neoplasms, colon).

Initial Preventive Physical Examination

This examination (referred to as the IPPE or "Welcome to Medicare Exam") covers specific services for new Medicare beneficiaries. The exam is payable once in a lifetime, and only if provided within the first twelve months of the beneficiary's first Part B coverage period. Both the deductible and co-pay/coinsurance are waived.

The service may be provided by a physician or qualified non-physician provider (e.g., physician assistants (PA), nurse practitioners (NP), and clinical nurse specialists (CNS).

The IPPE includes the following:

- **Medical and Social History**: Review of patient's history with particular attention to modifiable risk factors for disease.
- **Depression Risk Assessment**: Review of the patient's risk factors for depression, including current or past experience with depression or other mood disorders. Patients cannot have a current diagnosis of depression. The provider may use one of the standardized screening tests designed for this purpose and recognized by national medical professional organizations.
- **Functional Ability and Level of Safety**: The provider may select from screening questions or standardized questionnaires designed for the purpose of reviewing, at a minimum; hearing impairment, daily living, fall risk, and home safety. The screening tools provided for the IPPE should be recognized by national medical professional organizations.
- **Examination**: Measurements and tests including measurement of the patient's height, weight, body mass index, blood pressure, a visual acuity screen, and other factors as deemed appropriate, based on her medical and social history and current clinical standards.
- **End of Life Planning (Upon an Individual's Consent):** End-of-life planning is defined as verbal or written information regarding: (1) an individual's ability to prepare an advance directive (AD) in the case that an injury or illness causes the individual to be unable to make health care decisions, and (2) whether or not the physician is willing to follow the individual's wishes as expressed in the AD.
- **Education, Counseling, and Referral Based on Previous 5 Components**: Provided as appropriate, based on the results of the first five elements of the IPPE.
- **Education, Counseling, and Referral Based on Other Preventive Services:** Brief written plan such as a checklist should be provided to the patient for obtaining appropriate screening and other preventive services which are separately covered under Medicare Part B benefits (e.g., screening services described above, vaccinations, diabetes self-management, glaucoma screening, medical nutrition therapy).
    - **Optional Electrocardiogram**: Performance and interpretation by provider or by referral provider.

NOTE: Although the EKG is an optional service, if the physician or NPP cannot perform the EKG in the office suite, alternative arrangements can be made with an outside entity. However, if performed, the primary care provider must incorporate the results of the EKG into the beneficiary's medical record.

For the purposes of the IPPE benefit, "medical history" is defined as:

- Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries, and treatment
- Current medications and supplements, including calcium and vitamins
- Family history, including a review of medical events in the patient's family, including diseases that may be hereditary or place the individual at risk

For the purposes of this benefit, "social history" is defined as:

- History of alcohol, tobacco, and illicit drug use
- Diet
- Physical activities

The following HCPCS codes are used to report these services:

- G0402 – Initial preventive physical examination; face-to-face visit, services limited to new beneficiaries during the first (12) months of Medicare enrollment.
- G0403 - Electrocardiogram, routine ECG with at least 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report. G0404 - Tracing only, without interpretation and report, performed as a component of the initial preventive physical examination
- G0405 - Interpretation and report only, performed as a component of the initial preventive physical examination

The diagnosis code reported is V70.0 (Routine general medical examination at a health care facility).

Other covered preventive, screening or problem-oriented services may be performed at the same encounter as the IPPE. These are reported using the appropriate codes. If reporting an E/M service, add a modifier 25. The documentation for the problem-oriented portion of the encounter must support the level of service reported.

Diabetes Screening

The diabetes screening tests include a fasting blood glucose test, post-glucose challenge tests, and either an oral glucose tolerance test with a glucose challenge of 75 grams of glucose for non-pregnant adults or a 2-hour post-glucose challenge test alone.

Individuals are eligible for the benefit if they have the following risk factors:

- Hypertension (High blood pressure)
- Dyslipidemia (History of abnormal cholesterol and triglyceride levels)
- Obesity (body mass index 30 kg/m2 or more)
- Previous identification of an elevated impaired fasting glucose or glucose tolerance **OR**
  - Have at least two of the following risk factors: Overweight (body mass index greater than 25 kg/m2, but less than 30)
  - A family history of diabetes
  - A history of gestational diabetes mellitus or delivery of a baby weighing greater than 9 pounds 65 years of age or older

Two screening tests per year are covered for individuals who have been diagnosed with pre-diabetes. Pre-diabetes is defined as a fasting glucose level of 100-125 mg/dL, or a 2 hour post-glucose challenge of 140-199 mg/dL.

One screening per year is covered for individuals previously tested who have not been diagnosed with pre-diabetes, or who have never been tested.

Patients previously diagnosed as diabetic are not covered for this screening service.

Medicare covers these tests when reported with diagnosis code V77.1 (Screening for diabetes mellitus) and one of the following CPT codes:

- 82947 - Glucose; quantitative, blood (except reagent strip)
- 82950 - Glucose; post glucose dose (includes glucose)
- 82951 - Glucose; tolerance test (GTT), three specimens (includes glucose)

Cardiovascular Screening Blood Tests

This benefit provides a blood test for the early detection of cardiovascular disease or abnormalities associated with an elevated risk of this disease. Three clinical laboratory tests are covered—total cholesterol, high density lipoprotein (HDL), and triglycerides. These tests are covered once every five years and can be ordered as one of each individual test or combination as a panel.

The tests must be ordered by a treating physician and used in the management of the patient. Laboratories must offer physicians the ability to order a lipid panel without the direct low density lipoprotein (LDL)

measurement. However, if the screening lipid panel results illustrate a triglycerides level that indicates the need for a direct LDL measurement, the physician may order this test.

Report procedure codes for lipid panel (80061) or the individual codes for the tests included in the panel (82465, 83718, or 84478). Report a diagnosis code from the series V81.0-V81.2 (Special screening for cardiovascular diseases).

Behavioral Interventions Counseling

Tobacco Use Counseling

Cessation Counseling

Medicare covers counseling for tobacco cessation for outpatients and for inpatients. Inpatients are covered only if counseling for tobacco use is not the primary reason for the patient's hospital stay. Medicare covers 2 cessation attempts per year. Cessation counseling benefits are for individuals who:

- Use tobacco and have been diagnosed with a recognized tobacco-related disease **OR**
- Use tobacco and exhibit symptoms consistent with a tobacco-related disease

The counseling during an E/M service must be either intermediate or intensive. Intermediate counseling is 2 to 3 sessions of 3 to 10 minutes each. Intensive counseling is 4 sessions of more than 10 minutes each. Minimal counseling involving sessions lasting less than 3 minutes is considered part of an E/M service and is not reimbursed separately. Each attempt may include a maximum of four intermediate or intensive counseling sessions. The total annual benefit is for 8 sessions in a 12 month period.

Services may be provided by a physician, physician assistant, nurse practitioner, clinical nurse specialist, qualified psychologist or clinical social worker. CMS does not currently have specific training requirements, but may in the future. The counseling must be provided face-to-face with the patient.

These services are reported using CPT-4 code 99406 (intermediate, E/M counseling service) or code 99407 (intensive, E/M counseling service). Documentation must include sufficient information to adequately demonstrate that Medicare coverage conditions were met for providing the service.

The diagnosis code should reflect the condition the patient has that is adversely affected by tobacco use or the condition the patient is being treated for with a therapeutic agent whose metabolism or dosing is affected by tobacco use.

Preventive Counseling

Effective Jan 1, 2011, CMS provides a benefit for counseling to prevent tobacco use for outpatient and hospitalized Medicare beneficiaries. These counseling benefits are for individuals who:

- Use tobacco but have no tobacco-related disease
- Are competent and alert at the time that the counseling is provided
- Whose counseling is provided by a qualified physician or other Medicare-recognized practitioner

The following codes are reported for this service:

- 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; intermediate, greater than 10 minutes

Diagnosis codes that should be reported for this service are ICD-9-CM codes 305.1 (Tobacco use disorder) and V15.82 (History of tobacco use). Both the deductible and co-pay/coinsurance are waived for this service.

For more information on tobacco cessation counseling, view the MLN Matters article at:
http://www.cms.gov/MLNMattersArticles/downloads/MM7133.pdf

Alcohol Reductions and Misuse

Medicare beneficiaries, who test positive during the initial screening, will be covered for up to four brief face-to-face behavioral counseling interventions in a 12 month period. Medicare beneficiaries who misuse alcohol, but whose levels of alcohol consumption do not meet the requirements for alcohol dependence are eligible for counseling if coherent during the counseling visit. Both the deductible and copay/coinsurance are waived for this type of counseling.

The initial screening may be reported using code:

- G0442 - Annual alcohol misuse screening, 15 minutes

Alcohol dependence is defined as at least **three** of the following:

- Tolerance
- Withdrawal symptoms
- Impaired control
- Preoccupations with acquisition and/or use
- Persistent desire or unsuccessful efforts to quit
- Sustains social, occupational, or recreational disability **OR**
- Use continues despite adverse consequences **AND**
- Who are competent and alert at the time that counseling is provided **AND**
- Whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting

Medical records must document all coverage requirements and may be reported using code:

- G0443 - Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes. (Four times per year)

Screening for Depression

Medicare covers screening for depression annually; therefore 11 full months must elapse following the month in which the last annual depression screening took place. If counseling is provided, it must be provided by a qualified primary physician or other primary care practitioner that has staff-assisted depression care support who can facilitate and coordinate referrals to mental health treatment. There are several screening tools available for depression. CMS does not specify which depression screening tools should be used, since that decision is at the discretion of the clinician in the primary care setting. Both the deductible and copay/coinsurance are waived if conditions of coverage are met.

This type of screening is only covered in the following places of service:

- Office
- Outpatient Hospital
- Independent clinic
- A state or local public health clinic

The following HCPCS code is used to report this service:

- G0444 - Annual depression screening, 15 minutes

Intensive Behavioral Therapy for Obesity

Certain screening services are considered reasonable and necessary for the prevention or early detection of an illness or disability. Obesity is directly or indirectly associated with many chronic diseases, such as cardiovascular disease, musculoskeletal conditions, and diabetes. Due to those risk factors, Medicare covers beneficiaries diagnosed with obesity; defined as a body mass index (BMI) ≥ 30 kg/m^2.

Intensive behavioral therapy for obesity consists of the following:

- Screening for obesity in adults using measurement of BMI calculated by dividing weight in kilograms by the square of height in meters (expressed in kg/m^2).
- Dietary (nutritional) assessment **AND**
- Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on diet and exercise.

The intensive behavioral intervention for obesity should be consistent with the 5-A framework that has been highlighted by the USPSTF:

1. **Assess**: Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/methods.
2. **Advise**: Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.
3. **Agree**: Collaboratively select appropriate treatment goals and methods based on the patient's interest in and willingness to change the behavior.
4. **Assist**: Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.
5. **Arrange**: Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

Medicare beneficiaries with obesity, who are competent and alert at the time that 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, are allowed:

- One face-to-face visit every week for the first month
- One face-to-face visit every other week for months 2-6
- One face-to-face visit every month for months 7-12, if the beneficiary meets the 3kg weight loss requirement as discussed below

A reassessment of obesity and a determination of the amount of weight loss must be provided at the six month visit. This reassessment is required to determine eligibility for any additional face-to-face visits occurring once a month for an additional six months. All Medicare beneficiaries must have achieved a reduction in weight of at least 3kg over the course of the first six months of intensive therapy to qualify. Beneficiaries who do not achieve a weight loss of at least 3kg during the first six months of intensive therapy, a reassessment of their readiness to change and BMI is appropriate after an additional six month period.

The following HCPCS code is used to report this service:

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

Diagnosis code(s) V85.3X (Body Mass Index between 30-39, adult) or V85.4X (Body Mass Index 40 and over, adult) are appropriate when reporting these services. Both the deductible and copay/coinsurance are waived for this type of intense therapy if conditions of coverage are met.

High Intensity Behavioral Counseling (HIBC) and Sexually Transmitted Infections (STI) Screening

High Intensity Behavioral Counseling (HIBC)

Medicare will cover High Intensity Behavioral Counseling (HIBC) to prevent STIs in addition to screening for Sexually Transmitted Infections (STIs) - specifically chlamydia, gonorrhea, syphilis, and hepatitis B.

Coverage for HIBC consist of up to two individual, 20- to 30-minute, face-to-face counseling sessions annually for Medicare beneficiaries to prevent STIs for all sexually active adolescents and for adults at increased risk for STIs. This service is covered only if referred by a primary care provider and provided by a Medicare eligible primary care provider in a primary care setting.

The high/increased risk individual sexual behaviors, based on the USPSTF guidelines, include any of the following:

- Multiple sex partners
- Using barrier protection inconsistently
- Having sex under the influence of alcohol or drugs

- Having sex in exchange for money or drugs
- Age (24 years of age or younger and sexually active for women for chlamydia and gonorrhea)
- Having an STI within the past year
- IV drug use (hepatitis B only) **AND**
- In addition, for men – men having sex with men (MSM) and engaged in high-risk sexual behavior, but no regard to age.

The following HCPCS code is used to report this service:

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

STI

Social factors within the community that contribute to STIs should also be considered when determining high/increased risk for chlamydia, gonorrhea, syphilis, and in recommending HIBC. High/increased risk sexual behavior for STIs is determined by how the primary care provider assesses the patient's sexual history, which is normally part of any complete medical history. This screening requires the appropriate Food and Drug Administration (FDA) approved/cleared laboratory tests when ordered by the primary care provider. The tests must be used consistent with FDA approved labeling and in compliance with the Clinical Laboratory Improvement Act (CLIA) regulations and performed by an eligible Medicare provider for these services.

The following link provides additional information on the increased risk for STIs found in Publication 100-03, Section 210.10:
http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R141NCD.pdf

The following CPT/HCPCS codes are used to report these services:

- 86631 - Antibody; Chlamydia
- 86632 - Antibody; Chlamydia, IgM
- 87110 - Culture, chlamydia, any source
- 87270 - Infectious agent antigen detection by immunofluorescent technique; Chlamydia trachomatis
- 87320 - Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Chlamydia trachomatis
- 87490 - Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, direct probe technique
- 87491 - Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique
- 87810 - Infectious agent antigen detection by immunoassay with direct optical observation; Chlamydia trachomatis
- 87590 - Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, direct probe technique
- 87591 - Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, amplified probe technique
- 87850 - Infectious agent antigen detection by immunoassay with direct optical observation; Neisseria gonorrhoeae
- 87800 - Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique **(Combined chlamydia and gonorrhea testing)**
- 86592 - Syphilis test, non-treponemal antibody; qualitative (eg, VDRL, RPR, ART)
- 86593 - Syphilis test, non-treponemal antibody; quantitative
- 86780 - Antibody; Treponema pallidum
- 87340 - Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; hepatitis B surface antigen (HBsAg)
- 87341 - Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; hepatitis B surface antigen (HBsAg) neutralization

Diagnosis codes V74.5 (Venereal disease) AND V69.8 (Other problems related to lifestyle) should be reported for chlamydia, gonorrhea, and syphilis screening in women at increased risk for STIs who are **not** currently pregnant.

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

- V74.5 - Venereal disease **AND**
- V69.8 - Other problems related to lifestyle **AND**
- V22.0 - Supervision of normal first pregnancy **OR**
- V22.1 - Supervision of other normal pregnancy **OR**
- V23.9 - Unspecified high-risk pregnancy

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

- V74.5 - Venereal disease **AND**
- V69.8 - Other problems related to lifestyle **AND**
- V22.0 - Supervision of normal first pregnancy **OR**
- V22.1 - Supervision of other normal pregnancy **OR**
- V23.9 - Unspecified high-risk pregnancy

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

- V73.89 - Other specified viral diseases **AND**
- V69.8 - Other problems related to lifestyle **AND**
- V22.0 - Supervision of normal first pregnancy **OR**
- V22.1 - Supervision of other normal pregnancy **OR**
- V23.9 - Unspecified high-risk pregnancy

For screening for syphilis in pregnant women who are **not** at increased risk for STIs report:

- V74.5 - Venereal disease **AND**
- V22.0 - Supervision of normal first pregnancy **OR**
- V22.1 - Supervision of other normal pregnancy **OR**
- V23.9 - Unspecified high-risk pregnancy

For screening for hepatitis B in pregnant women **not** at increased risk for STIs report:

- V73.89 - Other specified viral diseases **AND**
- V22.0 - Supervision of normal first pregnancy **OR**
- V22.1 - Supervision of other normal pregnancy **OR**
- V23.9 - Unspecified high-risk pregnancy

Both the deductible and copay/coinsurance are waived for this type of screening if conditions of coverage are met.

NOTE: The use of the correct diagnosis code(s) on the claims is imperative to identify these services as preventive services and to show that the services were provided within the guidelines for coverage as preventive services. The patient's medical record must clearly support the diagnosis of high/increased risk for STIs and clearly reflect the components of the HIBC service provided – education, skills training, and guidance on how to change sexual behavior - as required for coverage.

Screening for Human Immunodeficiency Virus

HIV screening is recommended for all adolescents and adults at risk for HIV infection, as well as all pregnant women. CMS covers both standard and Food and Drug Administration (FDA)-approved HIV rapid screening tests for Medicare beneficiaries at increased risk for HIV infection per USPSTF guidelines.

USPSTF guidelines for what constitutes an individual at "high risk" for HIV infection may be found in CMS publication 100-03, National Coverage Determinations Manual (NCD) Sections 190.14 (diagnostic) and 210.7 (screening), at URL: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part3.pdf **AND** http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf

Medicare covers beneficiaries for HIV screening as follows:

- An annual voluntary HIV screening for beneficiaries at increased risk for HIV infection per USPSTF guidelines

NOTE: Eleven full months must elapse following the month in which the previous test was performed in order for a subsequent test to be covered.

- Three voluntary HIV screenings of pregnant Medicare beneficiaries;
  (1) When the diagnosis of pregnancy is known,
  (2) During the third trimester, and
  (3) At labor, if ordered by the woman's physician

NOTE: A maximum of three tests will be covered for each pregnancy beginning with the date of the 1st test.

Diagnosis codes V73.89 (Other specified viral and chlamydial diseases; other specified viral diseases) and V69.8 (Other problems related to lifestyle) may be reported for this screening. Pregnant patients would also have a pregnancy status code reported (such as V22.X or V23.9), in addition to the appropriate V73.89 and/or V69.8 code(s).

Patients with any known prior diagnosis of HIV-related illness are not eligible for this screening test.

The following three HCPCS codes are reported for this service:

1. G0432 - Infectious agent antibody detection by enzyme immunoassay (EIA) technique, HIV-1 and/or HIV-2, screening
2. G0433 - Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 **AND/OR** HIV-2, screening, **AND/OR**
3. G0435 - Infectious agent antibody detection by rapid antibody test, HIV-1 and/or HIV-2 screening.

More information on HIV screening may be found in the MLN Matters article at: http://www.cms.gov/MLNMattersArticles/downloads/MM6786.pdf

Modifier 33

Modifier 33 was created to allow providers to identify preventive services that are not subject to cost-sharing.

Only specific screening services require modifier 33 and those services only require the modifier when they are provided during a visit whose primary purpose is not preventative. If the primary purpose of the visit is preventative, and screening services are provided, no cost sharing is required for the services provided during the visit. In this case, the modifier is not required.

For separately reported services specifically identified as preventive, the modifier should not be used.

However, if the patient comes in for a problem visit and during the visit you provide an A or B rated screening service or immunization from the US Preventive Services Task Force, that service would have modifier 33 appended to indicate to the payer that no cost-sharing is applicable to the screening service.

Modifier 33 is applicable for the following services:

- Services rated A or B by the US Preventive Services Task Force. These are posted annually on the Agency for Healthcare Research and Quality website at URL: www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm
- Routine immunizations as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention

- Preventive care and screenings for children and newborn testing as supported by the Health Resources and Services Administration
- Preventive care and screenings for women as supported by the Health Resources and Services Administration

Additional information on this modifier may be found in CPT Assistant, December 2010, *New CPT Modifier for Preventive Services*

Summary of Medicare Screening Services

Possible Procedure/ HCPCS Codes	Coverage	Patient Criteria	Patient Financial Responsibility	Provider Criteria	Possible Diagnosis Codes
Screening Pelvic Examination					
G0101	Every 2 years	Not high risk	No Co-pay No Part B deductible	None stated	V76.2, V76.47, V76.49, V72.31
	Annually	High risk			V15.89
Collection of Pap Smear Specimen					
Q0091	Every 2 years	Not high risk	No Co-pay No Part B deductible	None stated	V76.2, V76.47, V76.49, V72.31
	Annually	High risk			V15.89
Screening Hemoccult					
82270, G0328	Annually	>50 years old	None	None stated	V76.51, V76.41
Screening Mammography					
77057, +77052 G0202	Annually	>40 years old	No Co-pay No Part B deductible	None stated	V76.12, V76.11
Screening Bone Mass Measurement					
77078, 77080, 77081, 76977, G0130	Once every 24 months	Patients at risk	No Co-pay No Part B deductible	Test ordered by physician or qualified nonphysician practitioner who is treating the patient.	Determined by Local Carriers*
Initial Preventive Physical Examination (Welcome to Medicare Examination)					
G0402, G0403 G0404,G0405	Once	Within first 12 months of Medicare coverage	No Co-pay No Part B deductible	Test ordered by physician or qualified nonphysician practitioner who is treating the patient.	V70.0
Annual Well Visit					
G0438, G0439	Once for G0438, Annually for G0439	All Medicare beneficiaries, At least 12 months after IPPE	No Co-pay No Part B deductible	Test ordered by physician or qualified nonphysician practitioner who is treating the patient.	V70.0
Diabetes Screening					
82947, 82950 82951	Twice in 12 month period	Patients at risk	None	None stated	V77.1
Cardiovascular Screening Blood Test					
82465, 84478 83718, 80061	Every 5 years	All Medicare beneficiaries	None	Test must be ordered by physician and used in management of patient	V81.0, V81.1, V81.2
Tobacco Use Counseling					
99406, 99407	2 cessation attempts in 12 month period (1 attempt = up to 4 sessions)	Patient has condition or is receiving treatment that is being adversely affected by tobacco use	No Co-pay No Part B deductible	Provided by a physician, physician assistant, nurse practitioner, clinical nurse specialist, qualified psychologist or clinical social worker	Use code indicating patient's condition or treatment affected by tobacco use
G0436, G0437	2 cessation attempts in 12 month period (1 attempt = up to 4 sessions)	Patient uses tobacco (asymptomatic)	No Co-pay No Part B deductible	Provided by a physician, or other Medicare recognized practitioner	305.1, V15.82
HIV Screening Blood Test					
G0432, G0433, G0435	Annually, 3 times per pregnancy	All adolescents and adults at risk, All Pregnant women	No Co-pay No Part B deductible	Test must be ordered by physician at labor	V73.89, V69.8 V22.X or V23.9 for pregnant women

Possible Procedure/ HCPCS Codes	Coverage	Patient Criteria	Patient Financial Responsibility	Provider Criteria	Possible Diagnosis Codes
Seasonal Influenza Virus Vaccine and Administration					
90654, 90655, 90656, 90657, 90660, 90662, Q2034-Q2039, G0008	Once per influenza season Additional flu shots if medically necessary	All Medicare beneficiaries	No Co-pay No Part B deductible	None stated	V04.81, V06.6
Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse					
G0442	Annually for G0442	All Medicare beneficiaries	No Co-pay No Part B deductible	None stated	Determined by Local Carriers*
G0443	Four times per year for G0443	Medicare beneficiaries who misuse alcohol but whose levels of consumption do not meet the criteria for dependence are eligible for counseling		Qualified primary care physicians or other primary care practitioners in a primary care setting	
Screening for Depression					
G0444	Annually	All Medicare beneficiaries	No Co-pay No Part B deductible	Qualified primary care physicians or other primary care practitioners in a primary care setting that has staff-assisted depression care supports in place	Determined by Local Carriers*
High Intensity Behavioral Counseling (HIBC) to Prevent STIs and Screening for Sexually Transmitted Infections (STIs)					
G0445 86631, 86632, 87110, 87270, 87320, 87490, 87491, 87810, 87590, 87591, 87850, 87800, 86592, 86593, 86780, 87340, 87341	Annually	Sexually active adolescents and adults at increased risk for STIs: HIBC consisting of individual, 20 to 30 minute, face-to-face counseling sessions	No Co-pay No Part B deductible	Referred by a primary care provider and provided by a Medicare eligible primary care provider in a primary care setting	V74.5, V69.8, V22.0, V22.1, V23.9, V73.89
Intensive Behavioral Therapy (IBT) for Obesity					
G0447	One visit every week for the first month; one visit every other week for 2-6 months; and one visit every month for 7-12 months	Medicare beneficiaries with obesity BMI ≥ 30 kg/m^2 who are competent and alert at the time of counseling	No Co-pay No Part B deductible	Qualified primary care physicians or other primary care practitioners in a primary care setting	V85.30-V85.39, V85.41-V85.45

Explaining Medicare Annual Wellness Visits
To Patients

Date

Dear Medicare Patient:

Medicare began paying for special Annual Wellness Visits on January 1, 2011. These services are intended to help you develop a plan for addressing ongoing medical problems. In general, these services should be performed by your primary care provider. The services you normally receive in our office are not included in this Annual Wellness Visit. Specifically, the new Annual Wellness Visit does **not** include pelvic and breast examinations or the collection of Pap smears. The Medicare Annual Wellness Visit is geared to address your ongoing general medical needs and not specific gynecologic problems or concerns.

The Medicare Annual Wellness Visit should be available to you through your primary care provider. (OPTIONAL: This office will no longer perform annual well-woman exams for Medicare recipients.) As always, we are happy to see you for any gynecologic problems you may have, including the ongoing management of menopausal symptoms, bladder problems, and issues with pelvic pain, prolapse, osteoporosis, breast concerns, or other gynecologically related conditions. Your normal deductible and co-insurance will apply to these problem-oriented services.

If you have any questions please feel free to call our office and speak with _____, our insurance coordinator or _____, Office Manager at _____.

Thank you

_____, M.D.