Medicare Screening Services 2018

Physicians are often confused about how to document and report preventive services provided to their Medicare patients. This document is designed to assist physicians in documenting, reporting, and receiving reimbursement for these preventive services.

Although Medicare does not cover comprehensive preventive service visits such as those reported with CPT codes 99381-99397, Medicare continues to reimburse for certain screening services that are often performed during preventive service visits, including:

- Abdominal Aortic Aneurysm Screening
- Adult Immunizations
- Annual Wellness Visit (AWV),including Personalized Prevention Plan Services
- Bone Mass Measurements
- Cancer Screenings
- Cardiovascular Screening
- Diabetes Screening
- Diabetes Self-Management Training
- Diabetes Supplies
- Glaucoma Screening
- HIV Screening
- Initial Preventive Physical Exam (IPPE or "Welcome to Medicare" Physical Exam)
- Intensive Behavioral Therapy for Cardiovascular Disease
- Intensive Behavioral Therapy for Obesity
- Medical Nutrition Therapy (for Medicare beneficiaries with diabetes or renal disease)
- Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse
- Screening for Depression in Adults
- Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling to Prevent STI
- Tobacco Use Cessation Counseling Services

Under the Affordable Care Act (ACA), deductibles and coinsurance/copayment for specific preventive services are waived.

The table at the end of this document provides an overview of Medicare screening services. For additional information, please visit Medicare's website at https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html.

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: Waiver of Liability Statement Issued as Required by Payer Policy**
  This modifier is used to report that a mandatory ABN was issued and is on file (there is no need to submit a copy of the ABN, but it must be available on request).

- **GX: Notice of Liability Issued, Voluntary Under Payer Policy**
  This modifier is used to report that a voluntary ABN was issued and is on file for a service Medicare never covers because it is statutorily excluded or is not a Medicare benefit. This modifier may be used in combination with modifier GY.

- **GY: Item of Service Statutorily Excluded, Does not Meet the Definition of Any Medicare Benefit**
  This modifier is used to report that an ABN was not issued as the service is excluded from Medicare coverage or no Medicare benefit exists. May be used in combination with modifier GX.

- **GZ: Item or Service Expected to Be Denied as Not Reasonable and Necessary**
  Report this modifier when you expect Medicare to deny payment of the item or service due to a lack of medical necessity and no ABN was issued.

Using the appropriate modifier ensures 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

CMS reimburse for two annual wellness 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.

The following CPT/HCPCS 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
- 99497 Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional; first 30 minutes, face-to-face with the patient, family member(s) and/or surrogate
- 99498 Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)

Code G0438 should be reported only once in a lifetime (first AWV), and code G0439 (subsequent AWV) may be reported annually after the initial wellness visit. Advance Care Planning (99497-99498) is treated as an optional preventive care service when furnished with an AWV for services provided on or after January, 2016. Advanced Care Plan (ACP) services may be reported in addition to codes G0438 and G0439.

For codes G0438 and G0439, both copayment/coinsurance and deductible are waived. For 99497 and 99498, copayment/coinsurance and deductible waived for Advance Care Planning when performed during AWV as an optional element, which requires billing modifier -33 on the same day as an AWV and performance on the same day and by the same physician as the AWV. However, the deductible and coinsurance does apply when ACP is not performed as a part of a covered AWV.

Per Medicare, practitioners furnishing a preventive medicine E/M service who donot 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. Please note that these codes continue to be non-covered by Medicare.

Reporting, as always, will depend upon the services actually performed. However, it is recommended not to report these multiple services on 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 Health Economics and Coding 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 copay/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 no Pap smears within the last 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.

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:

- Z01.411 Encounter for gynecological examination (general) (routine) with abnormal findings
- Z01.419 Encounter for gynecological examination (general) (routine) without abnormal findings
- Z12.4 Encounter for screening for malignant neoplasm of cervix
- Z12.72 Encounter for screening for malignant neoplasm of vagina
- Z12.79 Encounter for screening for malignant neoplasm of other genitourinary organs
- Z12.89 Encounter for screening for malignant neoplasm of other sites
- Z77.9 Other contact with and (suspected) exposures hazardous to health
- Z91.89 Other specified personal risk factors, not elsewhere classified
- Z77.29 Contact with and (suspected) exposure to other hazardous substances

- Z92.89 Personal history of other medical treatment
- Z72.51 High risk heterosexual behavior
- Z72.52 High risk homosexual behavior
- Z72.53 High risk bisexual behavior

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 CODE	ICD-10-CM CODE(S)	CHARGE
Medicare	G0101-GA	Z01.411, Z01.419, Z12.4, Z12.72, Z12.79, Z12.89, Z77.9, Z91.89, Z77.29, Z92.89, Z72.51, Z72.52, Z72.53	$39.12
	Q0091-GA	Z01.411, Z01.419, Z12.4, Z12.72, Z12.79, Z12.89, Z77.9, Z91.89, Z77.29, Z92.89, Z72.51, Z72.52, Z72.53	$45.58
Patient	N/A	N/A	$0.00
TOTAL AMOUNT BILLED			$84.70

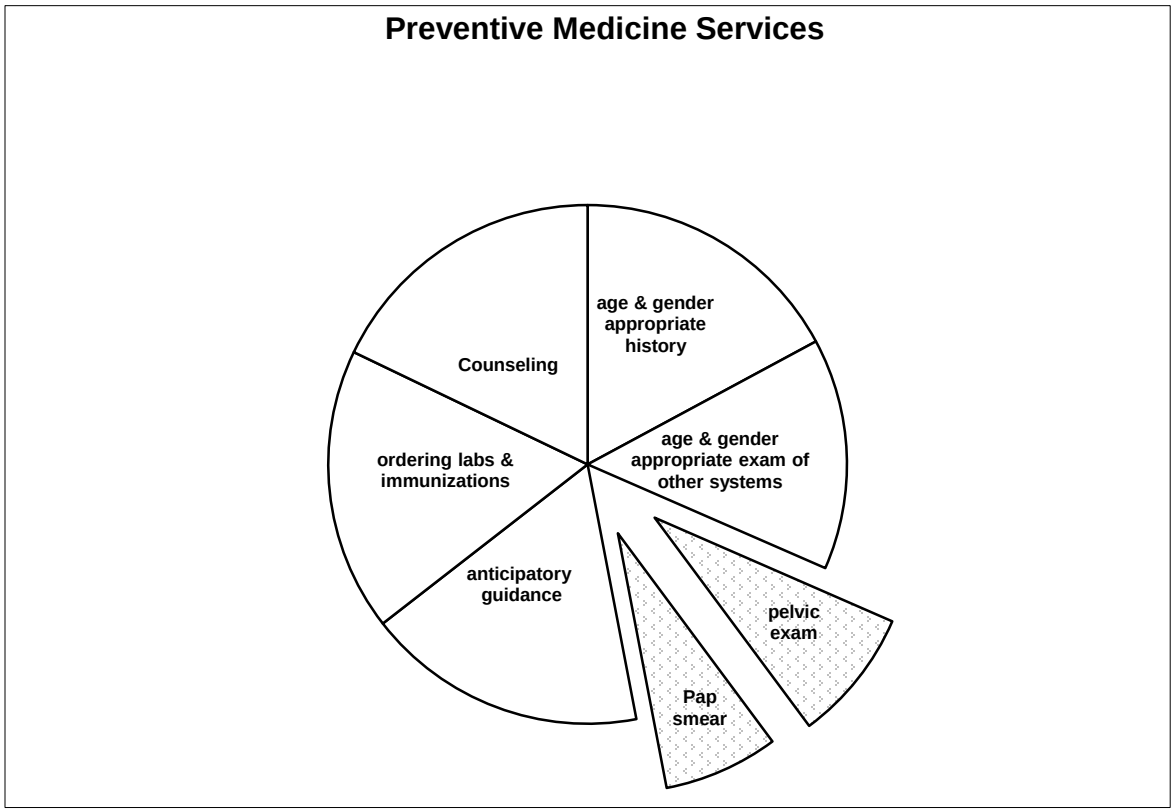
The assumption is that the physician in this example provided only Medicare covered services with no additional preventive care.

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 copay/coinsurance are waived.

Preventive Medicine Service Provided at the Time of Covered Screening Service

A preventive medicine exam, as described by CPT 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:

Non-Covered Preventive Service with G0101

BILL TO	CPT/HCPCS CODE	ICD-10-CM CODE(S)	ESTABLISHED HYPOTHETICAL CHARGE	CHARGE TO PATIENT/MEDICARE ALLOWABLE
Patient	99397-GY	Z01.419	$100.00	$60.88
Medicare	G0101-GA	Z01.411, Z01.419, Z12.4, Z12.72, Z12.79, Z12.89, Z77.9, Z91.89, Z77.29, Z92.89, Z72.51, Z72.52, Z72.53		$39.12
TOTAL ALLOWABLE CHARGES				$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):

Non-Covered Preventive Service with G0101 and Q0091

BILL TO	CPT/HCPCS CODE	ICD-10-CM CODE(S)	ESTABLISHED HYPOTHETICAL CHARGE	CHARGE TO PATIENT/MEDICARE ALLOWABLE
Patient	99397-GY	Z01.419	$100.00	$15.30
Medicare	G0101-GA	Z01.411, Z01.419, Z12.4, Z12.72, Z12.79, Z12.89, Z77.9, Z91.89, Z77.29, Z92.89, Z72.51, Z72.52, Z72.53	N/A	$39.12
Medicare	Q0091-GA	Z01.411, Z01.419, Z12.4, Z12.72, Z12.79, Z12.89, Z77.9, Z91.89, Z77.29, Z92.89, Z72.51, Z72.52, Z72.53	N/A	$45.58
TOTAL ALLOWABLE CHARGES				$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):

BILL TO	HCPCS CODE	ICD-10-CM CODE(S)	CHARGE
Medicare	99213-25	N95.2, N94.1	$44.14
	G0101-GA	Z12.4 or Z77.9	$39.12
TOTAL ALLOWABLE CHARGES			$83.26

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 copay 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 (99212). 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.

Screening for Cervical Cancer with Human Papillomavirus (HPV) Tests

HPV screening is recommended for all female Medicare beneficiaries who are asymptomatic and aged 30 to 65. Medicare reimburses for HPV screening once every 5 years.

The following HCPCS code is used to report this service:

- G0476 Infectious agent detection by nucleic acid (DNA or RNA); human papillomavirus (HPV), high-risk types (e.g., 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68) for cervical cancer screening, must be performed in addition to pap test

Diagnosis codes reported for this service are Z11.51 and either Z01.411 or Z01.419.

- Z11.51 Encounter for screening for human papillomavirus (HPV)
- Z01.411 Encounter for gynecological examination (general) (routine) with abnormal findings
- Z01.419 Encounter for gynecological examination (general) (routine) without abnormal findings

Both deductible and copayment/coinsurance are waived for this type of service.

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:

- 90630 Influenza virus vaccine, quadrivalent (IIV4), for intradermal use
- 90653 Influenza vaccine, inactivated, subunit, adjuvanted, for intramuscular use
- 90654 Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, for intradermal use
- 90655 Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.25 mL dosage, for intramuscular use
- 90656 Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.5 mL dosage, for intramuscular use
- 90657 Influenza virus vaccine, trivalent (IIV3), split virus, 0.25 mL dosage, for intramuscular use
- 90658 Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 ml dosage, for intramuscular use
- 90660 Influenza virus vaccine, trivalent, live (LAIV3), for intranasal use
- 90661 Influenza virus vaccine, trivalent (ccIIV3), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use
- 90662 Influenza virus vaccine (IIV), split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use
- 90672 Influenza virus vaccine, quadrivalent, live (LAIV4), for intranasal use
- 90673 Influenza virus vaccine, trivalent (RIV3), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use
- 90674 Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use
- 90682 Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use
- 90685 Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.25 mL dosage, for intramuscular use
- 90686 Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use
- 90687 Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.25 mL dosage, for intramuscular use
- 90688 Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.25 mL dosage, for intramuscular use
- 90756 Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5 mL dosage, for intramuscular use
- Q2034 Influenza virus vaccine, split virus, for intramuscular use (agriflu)
- 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)

Per Medicare, Until CPT code 90756 is implemented on 1/1/2018, Q2039 will be used for products described by the following language: influenza virus vaccine, quadrivalent (ccllV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use.

Providers should use HCPCS code Q2039 (Influenza virus vaccine, not otherwise specified) for dates of service 8/1/2017-12/31/2017. The payment allowance will be determined by the local claims processing contractor with effective dates of 8/1/2017-7/31/2018.

Diagnosis code Z23 (Encounter for immunization**)** is 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 copay/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
- Receiving (or expecting to receive) glucocorticoid (steroid) therapy 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:

- 76977 Ultrasound bone density measurement and interpretation, peripheral site(s), any method
- 77078 Computed tomography, bone mineral density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)
- 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)
- 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-10-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.

The following diagnosis codes may be appropriate when reporting these services:

- M81.0 Age-related osteoporosis without current pathological fracture
- M81.6 Localized osteoporosis [Lequesne]
- M81.8 Other osteoporosis without current pathological fracture
- M85.811 Other specified disorders of bone density and structure, right shoulder
- M85.812 Other specified disorders of bone density and structure, left shoulder
- M85.821 Other specified disorders of bone density and structure, right upper arm
- M85.822 Other specified disorders of bone density and structure, left upper arm
- M85.831 Other specified disorders of bone density and structure, right forearm
- M85.832 Other specified disorders of bone density and structure, left forearm
- M85.841 Other specified disorders of bone density and structure, right hand
- M85.842 Other specified disorders of bone density and structure, left hand
- M85.851 Other specified disorders of bone density and structure, right thigh

- M85.852 Other specified disorders of bone density and structure, left thigh
- M85.861 Other specified disorders of bone density and structure, right lower leg
- M85.862 Other specified disorders of bone density and structure, left lower leg
- M85.871 Other specified disorders of bone density and structure, right ankle and foot
- M85.872 Other specified disorders of bone density and structure, left ankle and foot
- M85.88 Other specified disorders of bone density and structure, other site
- M85.89 Other specified disorders of bone density and structure, multiple sites
- M94.9 Disorder of cartilage, unspecified

Mammography Screening

Medicare covers one baseline screening mammogram for women aged 35-39 and annual mammograms for women 40 years or older.

For claims with dates of service January 1, 2017-December 31, 2017, the CPT/HCPCS options are:

- G0202 Screening mammography, bilateral (2-view study of each breast), including computer-assisted detection (CAD) when performed
- +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)

Mammography codes 77052 (Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further review for interpretation; screening mammography) and 77057 (Screening mammography, bilateral (2-view film study of each breast) were deleted for 2017 and replaced by new code 77067 (Screening mammography, bilateral (20view study of each breast), including computer-aided detection (CAD) when performed. However, for 2017, CMS was not able to process claims using CPT code 77067 due to the reasons related to claims processing systems. CMS approves the use of code 77067 for claims with dates of service on or after January 1, 2018. For claims with dates of service on or after January 1, 2018, HCPCS code G0202 will be replaced by CPT code 77067.

For claims with dates of service January 1, 2018 or later, the CPT/HCPCS options are:

- 77067 Screening mammography, bilateral (20view study of each breast), including computer-aided detection (CAD) when performed
- +77063 Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure) (Use this as an add-on code when tomosynthesis is used in addition to 2-D mammography)

For additional details please visit NLM Matters article MM10181 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10181.pdf.

Diagnosis code Z12.31 (Encounter for screening mammogram for malignant neoplasm of breast) should be linked to the appropriate CPT mammography code reported.

Both the Medicare deductible and copay/coinsurance are 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. When it is appropriate to report a screening and a diagnostic diagram on the same day, use modifier GG to show a screening mammography turned into a diagnostic mammography.

Colorectal Cancer Screening

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

- 81528 Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result
- 82270 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 3 cards or single triple card for consecutive collection)
- G0104 Colorectal cancer screening; flexible sigmoidoscopy
- G0105 Colorectal cancer screening; colonoscopy on individual at high risk
- G0106 Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema
- G0120 Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema
- G0121 Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk
- G0328 Colorectal cancer screening; fecal occult blood test, immunoassay, 1–3 simultaneous
- G0464 Colorectal cancer screening; stool-based DNA and fecal occult hemoglobin (e.g., KRAS, NDRG4 and BMP3)

For **colorectal cancer screening using multitarget sDNA test**, Medicare covers the beneficiaries who fall into ALL of the following three categories:

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

For **screening colonoscopies, fecal occult blood tests (FOBTs), flexible sigmoidoscopies, and barium enemas,** Medicare covers all the beneficiaries who are:

- 50 years and older and at normal risk of developing colorectal cancer, **AND/OR**
- At high risk of developing colorectal cancer

There is no age limitation for coverage of screening colonoscopies.

For the definition of high risk for developing colorectal cancer, please visit https://www.govinfo.gov/content/pkg/CFR-2015-title42-vol2/pdf/CFR-2015-title42-vol2-sec410-37.pdf.

Frequency
The following table shows the frequency of covered screening services for Medicare beneficiaries:

TYPE OF SCREENING	BENEFICIARIES	
	Not Meeting High-Risk Criteria	**At High Risk**
FOBT	Once every 12 months	Once every 12 months
Flexible Sigmoidoscopy	Once every 48 months*	Once every 48 months
Colonoscopy	Once every 120 months (10 years), or 48 months after a previous sigmoidoscopy	Once every 24 months (unless a screening flexible sigmoidoscopy has been performed, after what Medicare may cover a screening colonoscopy only after at least 47 months)
Barium Enema	Once every 48 months (when used instead of flexible sigmoidoscopy or colonoscopy)	Once every 24 months (when used instead of flexible sigmoidoscopy or colonoscopy)
Multitarget sDNA Test	Once every 3 years	

*Note: Unless the beneficiary does not meet the criteria for high risk of developing colorectal cancer and has had a screening colonoscopy within the last 10 years, in which case a screening flexible sigmoidoscopy may be covered only after at least 119 months have passed since the month the beneficiary received the screening colonoscopy.
For all surgical procedures (CPT 10000-69999) provided on the same date and during the same encounter with a screening colonoscopy initiated as flexible sigmoidoscopy or barium enema for colorectal cancer screening purposes, no deductible is paid.
In this scenario, modifier -PT **(**Colorectal cancer screening test; converted to diagnostic test or other procedure) should be applied to the surgical procedure code in CPT range of 10000 to 69999.
To waive Medicare beneficiary copayment/coinsurance and deductible when providing a separately payable anesthesia in conjunction with a screening colonoscopy (G0105 and G0121), the anesthesia code 00810 should be used with modifier 33 (preventive services).
Append modifier PT(Colorectal cancer screening test; converted to diagnostic test or other procedure) to anesthesia code 00810 when a screening colonoscopy becomes a diagnostic colonoscopy.

Both the deductible and copay/coinsurance are waived for this service except for codes G0106 and G0120. For G0106 and G0120, only the deductible is waived, but copayment/coinsurance still applies.

For diagnoses codes, please see the CMS ICD-10 webpage at https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html and contact your MAC https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/ for guidance.

For multitarget sDNA test, report either Z12.12 (Encounter for screening for malignant neoplasm of rectum) or Z12.11 (Encounter for screening for malignant neoplasm of colon).

Per MLN Matters article MM10181(https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10181.pdf): In the Calendar Year (CY) 2018 Physician Fee Schedule (PFS) Final Rule, the Centers for Medicare & Medicaid Services (CMS) modified reporting and payment for anesthesia services furnished in conjunction with and in support of colorectal cancer screening services.

Effective for claims with dates of service on or after January 1, 2018, prolonged preventive services will be payable by Medicare when billed as an add-on to an applicable preventive service that is payable from the Medicare Physician Fee Schedule, and both deductible and coinsurance do not

apply. G0513 and G0514 for prolonged preventive services will be added as part of January 1, 2018 HCPCS update and the coinsurance and deductible will be waived.

Anesthesia Services
Anesthesia services furnished in conjunction with and in support of a screening colonoscopy are reported with CPT code 00812 (Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy). CPT Code 00812 will be added as part of January 1, 2018 HCPCS update. Effective for claims with dates of service on or after January 1, 2018, Medicare will pay claim lines with new CPT code 00812 and waive the deductible and coinsurance.

When a screening colonoscopy becomes a diagnostic colonoscopy, anesthesia services are reported with CPT code 00811 (Anesthesia for lower intestinal endoscopic procedures, endoscopy introduced distal to duodenum; not otherwise specified) and with the PT modifier. CPT code 00811 will be added as part of the January 1, 2018 HCPCS update. Effective for claims with dates of service on or after January 1, 2018, Medicare will pay claim lines with new CPT code 00811 and waive only the deductible when submitted with the PT modifier.

ADDITIONAL INFORMATION: The official instruction, CR10181, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3844CP.pdf.

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. The deductible and copay/coinsurance are waived for this service.

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 the 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, and 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 beneficiary during the first 12 months of Medicare enrollment
- G0403 Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report
- G0404 Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination
- G0405 Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination

Both the deductible and copay/coinsurance are waived for G0402. For codes G0403, G0404, and G0405 both the deductible and copayment/coinsurance apply.

**For ICD-10 codes, please visit the CMS ICD-10 webpage at https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html for individual CRs and coding translations and contact your MAC for guidance (https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).

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 modifier 25. The documentation for the problem-oriented portion of the encounter must support the level of service reported.

The following link provides additional information on the Initial Preventive Physical Examination: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243320.html.

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, or one screening per year if previously tested but not diagnosed with pre-diabetes or if never tested. 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.

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

Medicare covers these tests when reported with diagnosis code Z13.1 (Encounter for 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), 3 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. Medicare covers cardiovascular disease screening for all beneficiaries without apparent signs and symptoms of the disease.

Both the deductible and copay/coinsurance are waived.

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 diagnosis code Z13.6 (*Encounter for screening for cardiovascular disorders*).

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, regardless of whether they exhibit signs or symptoms of tobacco-related disease
- Competent and alert at the time of counseling, **AND**
- Receives counseling furnished by a qualified or other Medicare-recognized practitioner

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 4 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 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

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

Effective September 30, 2016, HCPCS codes G0436 and G0437, previously used to report smoking and tobacco cessation counseling, were deleted. To report smoking and tobacco cessation counseling visits, use CPT codes 99406 and 99407:

- 99406 Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
- 99407 Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

Diagnosis codes that should be reported for this service are ICD-10-CM codes F17.200, F17.201, F17.210, F17.211, F17.220, F17.221, F17.290, F17.291, T65.211A, T65.212A, T65.213A, T65.214A, T65.221A, T65.222A, T65.223A, T65.224A, T65.291A, T65.292A, T65.293A, T65.294A, or Z87.891.

Both the deductible and copay/coinsurance are waived for this service.

Alcohol Reductions and Misuse

All Medicare beneficiaries are eligible for alcohol screening. Medicare beneficiaries who test positive (those who misuse alcohol but whose levels of 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 practitioner in a primary care setting

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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

The initial screening may be reported using code:

- G0442 Annual alcohol misuse screening, 15 minutes

Medical records must document all coverage requirements. For those who screen positive 4 times per year, counseling may be reported using code:

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

For correct diagnosis codes, please contact your Medicare Administrative Contractor (MAC) for guidance: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

Both the deductible and copay/coinsurance are waived for this type of counseling.

Screening for Depression

Medicare covers screening for depression annually. If counseling is provided, it must be performed in a primary care setting with staff-assisted depression care support for effective treatment and coordination of referrals, if needed.

The following HCPCS code is used to report this service:

- G0444 Annual depression screening, 15 minutes

For ICD-10 codes, please visit the CMS ICD-10 webpage at https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html for individual CRs and coding translations and contact your MAC for guidance https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

Both the deductible and copay/coinsurance are waiv
ed if conditions of coverage are met.

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.

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 certain requirements are met

In total, up to 22 visits billed with the codes G0447 and G0473, combined, may be covered by Medicare annually.

A reassessment of obesity and a determination of the amount of weight loss must be provided at the six-month visit. 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.

The following HCPCS code is used to report this service:

- G0447 Face-to-face behavioral counseling for obesity, 15 minutes
- G0473 Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes

Diagnosis code(s) Z68.3- (Body mass index (BMI) 30-39, adult) or Z68.4- (Body mass index (BMI) 40 or greater, 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 individuals, 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 for sexually active adolescents and adults at increased risk for STIs **and** referred by a primary care provider and performed by a Medicare eligible primary care provider in a primary care setting. One annual occurrence of screening for chlamydia, gonorrhea, and syphilis in women at increased risk who are not pregnant. 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.

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 (e.g., 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 Z11.3 (Encounter for screening for infections with a predominantly sexual mode of transmission) **AND** Z72.89 (Other problems related to lifestyle) or Z72.5- (High risk sexual behavior) 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:

- Z11.3 Encounter for screening for infections with a predominantly sexual mode of transmission **AND**
- Z72.89 Other problems related to lifestyle
- Z72.51 Hight risk heterosexual behavior
- Z72.52 High risk homosexual behavior
- Z72.53 High risk bisexual behavior **AND**
- Z34.00 Encounter for supervision of normal first pregnancy, unspecified trimester
- Z34.01 Encounter for supervision of normal first pregnancy, first trimester
- Z34.02 Encounter for supervision of normal first pregnancy, second trimester
- Z34.03 Encounter for supervision of normal first pregnancy, third trimester **OR**
- Z34.80 Encounter for supervision of other normal pregnancy, unspecified trimester
- Z34.81 Encounter for supervision of other normal pregnancy, first trimester
- Z34.82 Encounter for supervision of other normal pregnancy, second trimester
- Z34.83 Encounter for supervision of other normal pregnancy, third trimester **OR**
- Z34.90 Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
- Z34.91 Encounter for supervision of normal pregnancy, unspecified, first trimester
- Z34.92 Encounter for supervision of normal pregnancy, unspecified, second trimester
- Z34.93 Encounter for supervision of normal pregnancy, unspecified, third trimester **OR**
- O09.90 Supervision of high risk pregnancy, unspecified, unspecified trimester
- O09.91 Supervision of high risk pregnancy, unspecified, first trimester
- O09.92 Supervision of high risk pregnancy, unspecified, second trimester
- O09.93 Supervision of high risk pregnancy, unspecified, third trimester

For screening for syphilis in pregnant women, report:

- Z11.3 Encounter for screening for infections with a predominantly sexual mode of transmission
- Z34.00 Encounter for supervision of normal first pregnancy, unspecified trimester
- Z34.01 Encounter for supervision of normal first pregnancy, first trimester
- Z34.02 Encounter for supervision of normal first pregnancy, second trimester
- Z34.03 Encounter for supervision of normal first pregnancy, third trimester **AND**
- Z34.80 Encounter for supervision of other normal pregnancy, unspecified trimester
- Z34.81 Encounter for supervision of other normal pregnancy, first trimester
- Z34.82 Encounter for supervision of other normal pregnancy, second trimester
- Z34.83 Encounter for supervision of other normal pregnancy, third trimester **OR**
- Z34.90 Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
- Z34.91 Encounter for supervision of normal pregnancy, unspecified, first trimester
- Z34.92 Encounter for supervision of normal pregnancy, unspecified, second trimester
- Z34.93 Encounter for supervision of normal pregnancy, unspecified, third trimester **OR**
- O09.90 Supervision of high risk pregnancy, unspecified, unspecified trimester
- O09.91 Supervision of high risk pregnancy, unspecified, first trimester
- O09.92 Supervision of high risk pregnancy, unspecified, second trimester
- O09.93 Supervision of high risk pregnancy, unspecified, third trimester

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

- Z11.3 Encounter for screening for infections with a predominantly sexual mode of transmission
- Z72.89 Other problems related to lifestyle
- Z72.51 Hight risk heterosexual behavior
- Z72.52 High risk homosexual behavior

- Z72.53 High risk bisexual behavior **AND**
- Z34.00 Encounter for supervision of normal first pregnancy, unspecified trimester
- Z34.01 Encounter for supervision of normal first pregnancy, first trimester
- Z34.02 Encounter for supervision of normal first pregnancy, second trimester
- Z34.03 Encounter for supervision of normal first pregnancy, third trimester **OR**
- Z34.80 Encounter for supervision of other normal pregnancy, unspecified trimester
- Z34.81 Encounter for supervision of other normal pregnancy, first trimester
- Z34.82 Encounter for supervision of other normal pregnancy, second trimester
- Z34.83 Encounter for supervision of other normal pregnancy, third trimester **OR**
- Z34.90 Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
- Z34.91 Encounter for supervision of normal pregnancy, unspecified, first trimester
- Z34.92 Encounter for supervision of normal pregnancy, unspecified, second trimester
- Z34.93 Encounter for supervision of normal pregnancy, unspecified, third trimester **OR**
- O09.90 Supervision of high risk pregnancy, unspecified, unspecified trimester
- O09.91 Supervision of high risk pregnancy, unspecified, first trimester
- O09.92 Supervision of high risk pregnancy, unspecified, second trimester
- O09.93 Supervision of high risk pregnancy, unspecified, third trimester

For screening for hepatitis B in pregnant women, report:

- Z11.59 Encounter for screening for other viral diseases **AND**
- Z34.00 Encounter for supervision of normal first pregnancy, unspecified trimester
- Z34.01 Encounter for supervision of normal first pregnancy, first trimester
- Z34.02 Encounter for supervision of normal first pregnancy, second trimester
- Z34.03 Encounter for supervision of normal first pregnancy, third trimester
- Z34.80 Encounter for supervision of other normal pregnancy, unspecified trimester
- Z34.81 Encounter for supervision of other normal pregnancy, first trimester
- Z34.82 Encounter for supervision of other normal pregnancy, second trimester
- Z34.83 Encounter for supervision of other normal pregnancy, third trimester **OR**
- Z34.90 Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
- Z34.91 Encounter for supervision of normal pregnancy, unspecified, first trimester
- Z34.92 Encounter for supervision of normal pregnancy, unspecified, second trimester
- Z34.93 Encounter for supervision of normal pregnancy, unspecified, third trimester **OR**
- O09.90 Supervision of high risk pregnancy, unspecified, unspecified trimester
- O09.91 Supervision of high risk pregnancy, unspecified, first trimester
- O09.92 Supervision of high risk pregnancy, unspecified, second trimester
  O09.93 Supervision of high risk pregnancy, unspecified, third trimester

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

- Z11.59 Encounter for screening for other viral diseases **AND**
- Z72.89 Other problems related to lifestyle
- Z72.51 High risk heterosexual behavior
- Z72.52 High risk homosexual behavior
- Z72.53 High risk bisexual behavior **AND**
- Z34.00 Encounter for supervision of normal first pregnancy, unspecified trimester
- Z34.01 Encounter for supervision of normal first pregnancy, first trimester
- Z34.02 Encounter for supervision of normal first pregnancy, second trimester
- Z34.03 Encounter for supervision of normal first pregnancy, third trimester **OR**
- Z34.80 Encounter for supervision of other normal pregnancy, unspecified trimester
- Z34.81 Encounter for supervision of other normal pregnancy, first trimester
- Z34.82 Encounter for supervision of other normal pregnancy, second trimester
- Z34.83 Encounter for supervision of other normal pregnancy, third trimester **OR**
- Z34.90 Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
- Z34.91 Encounter for supervision of normal pregnancy, unspecified, first trimester
- Z34.92 Encounter for supervision of normal pregnancy, unspecified, second trimester
- Z34.93 Encounter for supervision of normal pregnancy, unspecified, third trimester **OR**
- O09.90 Supervision of high risk pregnancy, unspecified, unspecified trimester
- O09.91 Supervision of high risk pregnancy, unspecified, first trimester
- O09.92 Supervision of high risk pregnancy, unspecified, second trimester
- O09.93 Supervision of high risk pregnancy, unspecified, third trimester

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 National Coverage Determinations Manual (NCD) Section 210.7 (screening) at 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 between the ages of 15 and 65 without regard to perceived risk
- An annual screening for Medicare beneficiaries younger than 15 and adults older than 65 who are at increased risk for HIV infection

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

- Three voluntary HIV screenings of pregnant Medicare beneficiaries:
  - ✓ When the diagnosis of pregnancy is known
  - ✓ During the third trimester, **AND**
  - ✓ 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 Z11.4 (Encounter for screening for human immunodeficiency virus [HIV]) as primary and Z72.89, Z72.51, Z72.52, or Z72.53 as secondary may be reported for this screening. Pregnant patients would also have a pregnancy status code reported (such as Z34.- or O09.9-), in addition to the appropriate Z11.4 as primary and Z34.0-, Z34.8-, or O09.9- as appropriate).

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

Starting April 13, 2015, procedure code G0475 may be billed for HIV screening. For more information, view the Screening for the Human Immunodeficiency Virus (HIV) Infection article at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9403.pdf

The following three HCPCS/CPT codes are reported for this service:

- 80081 Obstetric panel (includes HIV testing)
- G0432 Infectious agent antibody detection by enzyme immunoassay (EIA) technique, HIV-1 and/or HIV-2, screening
- G0433 Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening
- G0435 Infectious agent antibody detection by rapid antibody test, HIV-1 and/or HIV-2, screening
- G0475 HIV agent/antibody, combination assay, screening

More information on HIV screening may be found in the MLN Matters article at: http://www.cms.gov/MLNMattersArticles/downloads/MM6786.pdf. Both the deductible and copay/coinsurance are waived for this type of service.

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 in which the primary purpose is not preventive. If the primary purpose of the visit is preventive 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.

Summary of Medicare Screening Services

POSSIBLE CPT/HCPCS CODES	COVERAGE	PATIENT CRITERIA	PATIENT FINANCIAL RESPONSIBILITY	PROVIDER CRITERIA	POSSIBLE DIAGNOSIS CODES
Screening Pelvic Examination					
G0101	Every 2 years	Low risk	No copay No Part B deductible	None stated	Z12.4, Z12.72, Z12.79, Z12.89, Z01.411, Z01.419
	Annually	High Risk			Z77.29, Z77.9, Z91.89, Z92.89, Z72.5-
Collection of Pap smear Sepecimen					
P3000, P3001, Q0091	Every 2 years	Low risk	No copay No Part B deductible	None stated	Z12.4, Z12.72, Z12.79, Z12.89, Z01.411, Z01.419
	Annually	High risk			Z77.29, Z77.9, Z91.89, Z92.89, Z72.5-
Screening Hemoccult					
82270, G0328	Annually	≥50 years old	No copay No Part B deductible	None stated	Determined by local carriers*
Screening Mammography					
77067, +77063	Aged 35-39: one baseline ≥40: Annually	≥35 years old	No copay No Part B deductible	None stated	Z12.31
Screening Bone Mass Measurement					
77078, 77080, 77081, 76977, G0130	Once every 24 months, more frequently if medically necessary	Patients at risk	No copay No Part B deductible	Test ordered by physician or qualified non-physician practitioner who is treating the patient	M81.0, M81.6, M81.8, M85.8-, M94.9
Initial Preventive Physical Examination (Welcome to Medicare Examination)					
G0402, G0403, G0404, G0405	Once in a lifetime	Within first 12 months of Medicare coverage	No copay No Part B deductible	Test ordered by physician or qualified non-physician practitioner who is treating the patient	Determined by local carriers*
Annual Wellness Visit					
G0438	Once in a lifetime	All Medicare beneficiaries who have not received IPPE or AWV within the past 12 months	No copay No Part B deductible	Test ordered by physician or qualified non-physician practitioner who is treating the patient	Determined by local carriers*
G0439, 99497, 99498	Annually				

Continued

POSSIBLE CPT/HCPCS CODES	COVERAGE	PATIENT CRITERIA	PATIENT FINANCIAL RESPONSIBILITY	PROVIDER CRITERIA	POSSIBLE DIAGNOSIS CODES
Cardiovascular Screening Blood Test					
80061, 82465, 83718, 84478	Every 5 years	All Medicare beneficiaries w/out signs of heart disease	No copay No Part B deductible	Test must be ordered by physician and used in management of patient	Z13.6
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 copay No Part B deductible	Provided by a physician, physician assistant, nurse practitioner, clinical nurse specialist, qualified psychologist, or clinical social worker	F17.2-, T65.2-, and Z87.891 Note: Additional code may apply
HIV Screening Blood Test					
80081, G0432, G0433, G0435, G0475	Annually, 3 times per pregnancy	All adolescents and adults at risk, all pregnant women	No copay No Part B deductible	Test must be ordered by physician at labor	Increased risk factor not reported; if reported, use Z11.4, Z72.89, Z72.5- **OR** for pregnant women Z11.4, Z34.-, O09.9-
Seasonal Influenza Virus Vaccine and Administration					
90630, 90653-90657, 90660-90662, 90672-90674, Q2035-Q2039, G0008	Once per influenza season Additional flu shots if medically necessary	All Medicare beneficiaries	No copay No Part B deductible	None stated	Z23
Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse					
G0442	Annually	All Medicare beneficiaries	No copay No Part B deductible	Qualified primary care physicians or other primary care practitioners in a primary care setting	Determined by local carriers*
G0443	Four times per year	Medicare beneficiaries who misuse alcohol but whose levels of consumption do not meet the criteria for dependence are eligible for counseling			

Continued

POSSIBLE CPT/HCPCS CODES	COVERAGE	PATIENT CRITERIA	PATIENT FINANCIAL RESPONSIBILITY	PROVIDER CRITERIA	POSSIBLE DIAGNOSIS CODES
Screening for Depression					
G0444	Annually	All Medicare beneficiaries	No copay 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 86592, 86593, 86631, 86632, 86780, 87110, 87270, 87320, 87340, 87341, 87490, 87491, 87590, 87591, 87800, 87810, 87850	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 copay No Part B deductible	Referred by a primary care provider and provided by a Medicare eligible primary care provider in a primary care setting	Z11.3, Z72.89, Z72.5- Z34.0-, Z34.8-, O09.9-
Intensive Behavioral Therapy (IBT) for Obesity					
G0447, G0473	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 copay No Part B deductible	Qualified primary care physicians or other primary care practitioners in a primary care setting	Z68.30-Z68.39, Z68.41-Z68.45
Diabetes Screening					
82947, 82950, 82951	Twice in 12-month period for beneficiaries diagnosed with pre-diabetes, once in 12 months if previously tested but not diagnosed with pre-diabetes or if never tested	Patients at risk	No copay No Part B deductible	None stated	Z13.1

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 gynecological 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.