Medicare Part B Covered Preventive Services

Prior to providing the following PREVENTATIVE services:

F5 for ONLINE ELIG via **Patient Insurance Maintenance** screen for Ins Code 'MC' to determine if the patient is eligible, i.e., not exceeding the maximum frequency for a service and/or obtain an ABN and add mod GA. If no ABN is obtained, i.e., claim filed without a GA modifier and the patient has exceeded the Preventative Frequency Limits, the charge will be denied as not medically necessary related to Frequency Limits and will not be billable to the patient.

Service Description	HCPCS/CPT Codes	ICD-9 Medical Necessity	Who is covered…	What the patient pays…
Abdominal Aortic Aneurysms (AAA) Ultrasound Screening: Effective Date of Service (DOS): 01/01/2007 Frequency: Once per lifetime	G0389 Further information included in Medlearn Matters 5235 and 12/2006 Providers' News	No specific Dx Required	All Medicare beneficiaries: • Referred during IPPE • Receives ultrasound by authorized provider • Is in one of the following categories: - family history of AAA - man 65-75 who smoked at least 100 cigarettes in a lifetime - manifests risk factors as defined by Health and Human Services	Deductible is waived 20% of the Medicare approved amount or a set co-payment amount
Bone Mass Measurements: Frequency: Once every 24 months for qualified individuals; once every 6-12 months if medically necessary	77078, 77079, 77080, 77081, 77083, 76977, 78350*, 78351*, G0130, 76499* Further information included in the 2/1998, 2/1999, 8/1999, & 11/1999 Providers' News *Investigational & Not Covered by Medicare	See Local Coverage Determinations Payment for 77080 with 733.00, 733.01, 733.02, 733.03, 733.09, 733.90, or 255.0 or any of the other valid Dx No payment will be made for codes 77078, 77079, 77081, 77083, 76977, and G0130 when billed with Dx codes: 733.00, 733.01, 733.02, 733.03, 733.09, 733.90, or 255.0	Medicare beneficiaries at risk for developing Osteoporosis	20% of the Medicare approved amount or a set co-payment amount after the yearly Part B deductible
Cardiovascular Screening: Effective DOS: 01/01/2005 Frequency: Once every 5 years	80061 – Lipid Panel; or the components: 82465 – Cholesterol 83718 – Lipoprotein 84478 – Triglycerides Further information included in the 1/2005 Providers' News	V81.0, V81.1, V81.2	All asymptomatic Medicare beneficiaries following a 12 hour fast; no age limit	No coinsurance and no Part B deductible

Medicare Part B Covered Preventive Services

Service Description	HCPCS/CPT Codes	ICD-9 Medical Necessity	Who is covered…	What the patient pays…
Colorectal Cancer Screening: • G0104 Flexible Sigmoidoscopy – once every 4 years or once every 10 years following a screening colonoscopy • G0105 Colonoscopy – High risk, once every 2 years or once every 10 years but not within 47 months of a G0104 • G0121 Colonoscopy – Low risk, once every 10 years but not within 4 years of a G0104 • 0066T & 0067T – CTC (virtual colonoscopy) - ** Not covered by Medicare* • G0106 Barium Enema – once every 4 years if patient is at low risk (alternative to G0104); once every 2 years if patient is at high risk • G0120 Barium Enema – once every 2 years if patient is at high risk (alternative to G0105) • G0122 Barium Enema (screening) – ** Not covered by Medicare* • 82270 Fecal Occult Blood Test – once every year – no specific diagnosis, for screening only • G0328 Fecal Occult Blood Test – once every year (alternative to 82270)	<u>For screening:</u> G0104, G0105, G0106, G0120, G0121, G0122*, G0328, 82270, 0066T*, 0067T* <u>For diagnostic:</u> *patients already diagnosed with malignancy* 82272, (collection of single sample) 82271, 82274 Further information included in the 2/1998, 5/1998, 4/2001, & 7/2003 Providers' News NOTE: If during colon screening a biopsy or removal of a growth is performed, do not bill the G code, instead, bill the appropriate diagnostic procedure, with the initial V diagnosis code as the primary Dx. Any discovered conditions should be listed as *additional diagnoses*. ** G0122, 0066T and 0067T Not covered by Medicare*	V76.51	Medicare beneficiaries age 50 and older For screening Colonoscopy; any age 50 or older and others at risk without regard to age No minimum age for Barium Enema as an alternative to a high risk screening Colonoscopy if the beneficiary is at high risk	No coinsurance and no Part B deductible for 82270 and G0328. All other tests, 20% of the Medicare approved amount or a set co-payment amount; no deductible 25% of the Medicare approved amount if the flexible sigmoidoscopy (G0104) or colonoscopy (G0105 or G0121) are done in a hospital outpatient department or colonoscopies (G0105 or G0121) done in ambulatory surgery centers
Diabetes Monitoring - Self Management Training (DSMT): Includes coverage for up to 10 hours of initial training within a continuous 12 month period and 2 hours of training every follow-up year of self-management training Physician or NPP must certify that DSMT is needed	G0108 individual session, per 30 mins G0109 group session (2 or more) per 30 mins Further information included in the 9/1998, 11/1998, 10/2001 & 12/2002 Providers News and CMS website Medlearn Matters MM3185	Diabetes	Medicare beneficiaries diagnosed with diabetes (insulin users and non-users) A plan of care must be written to include: number and type of sessions, frequency and duration	20% of the Medicare approved amount after the yearly Part B deductible
Diabetes Monitoring - Testing Supplies: Limited coverage available for glucose self-testing equipment & supplies including: • Monitors • Test strips • Lancets • Insulin pumps • Insulin used in the pumps – does not cover under Part B unless used with an insulin pump; insulin not used with an external pump is covered under Medicare prescription drug coverage • Therapeutic shoes – one pair of depth-inlay shoes & 3 pairs of inserts or one pair of custom-molded shoes including inserts	A4258, A4259 - Lancet A4253 - Test strips E2100, E2101- (DME) monitor S1030 - Device Purchase S1031 - Device Rental E0784 - Insulin pumps	Diabetes	All insulin dependent Medicare beneficiaries	20% of the MC approved amount after yearly Part B deductible Patient pays 100% for insulin unless used in an external insulin pump – unless covered under Medicare prescription drug coverage

Medicare Part B Covered Preventive Services

Service Description	HCPCS/CPT Codes	ICD-9 Medical Necessity	Who is covered…	What the patient pays…
Diabetes Screening: Effective DOS: 01/01/2005 Frequency: One screening annually for patients previously tested but not diagnosed with pre-diabetes, or those who have never been tested before; Two screenings annually for pre-diabetics: • No more than one every 6 months • Must use modifier TS (if 2 screenings) Not allowed for beneficiaries already diagnosed with diabetes Requires physician or NPP referral	82947, 82950, 82951 Further information included in the 1/2005 & 9/2006 Providers' News and CMS website Medlearn Matters MM3637	V77.1	<u>Annual Screening:</u> Medicare beneficiaries at risk for having pre-diabetes, but has never been diagnosed with pre-diabetes; any of the following risk factors: • High blood pressure • Dyslipidemia • Obesity • History of high blood sugar <u>Two Screenings per Year:</u> Medicare beneficiaries diagnosed with pre-diabetics; 2 or more of the following risk factors: • Age 65 or over • Overweight • Family history of diabetes • A history of gestational diabetes or delivery of a baby weighting more than 9 pounds	No coinsurance and no Part B deductible
Diabetic Services - Foot Exam: Frequency: Once every six months	G0245-G0247	250.60-250.63, 357.2	Medicare patients with diabetic peripheral neuropathy and loss of protective sensation (LOPS), with some exceptions	20% of the Medicare approved amount after the yearly Part B deductible
Glaucoma Screening: Effective DOS: 01/01/2002 Frequency: Annually	G0117, G0118 Further information included in 10/2001, 12/2001 & 2/2002 Providers' News and CMS website Medlearn Matters MM4365	V80.1	Medicare beneficiaries with diabetes mellitus, family history of Glaucoma, or African Americans age 50 and older Effective 01/01/2006, Hispanic Americans age 65 and older	20% of the Medicare approved amount after the yearly Part B deductible

Medicare Part B Covered Preventive Services

Service Description	HCPCS/CPT Codes	ICD-9 Medical Necessity	Who is covered…	What the patient pays…
Initial Preventive Physical Exam (IPPE): *a.k.a., Welcome to Medicare Exam* Effective DOS: 01/01/2005 Frequency: Once per lifetime, must be completed within 6 months of the effective date of a beneficiary's first Medicare Part B coverage period The IPPE & EKG should be billed in order for the beneficiary to receive the complete IPPE service Should the physician or NPP need to perform an additional, medically necessary EKG in the 93000 series on the same day, Modifier 59 should be attached Effective DOS: 01/01/2009 Frequency: Once per lifetime, must be completed within 12 months of the effective date of a beneficiary's first Medicare Part B coverage period. Screening EKG is no longer mandatory, but can be performed as part of an optional one-time service as a result of a referral arising out of the IPPE.	G0344** – IPPE G0366** – Screening EKG (complete procedure) G0367** – Screening EKG (professional component) G0368** – Screening EKG (technical component) Further information included in 1/2005 Providers' News NOTE: If a separately identifiable service is provided on the same DOS, an E&M with modifier 25 can be billed **Effective DOS: 01/01/2009 G0402 – IPPE Includes body mass index measurement and end-of-life planning (replaces G0344) G0403 - Screening EKG (complete procedure) (replaces G0366) G0404 - Screening EKG (technical component) (replaces G0367) G0405 - Screening EKG (professional component) (replaces G0368)	No specific Dx required	Newly enrolled Medicare beneficiaries whose first Part B coverage begins on or after 01/01/2005	20% of the Medicare approved amount after the yearly Part B deductible Effective DOS: 01/01/2009 Deductible waived for G0402 only. Coinsurance still applies.
Mammogram Screening: Frequency: Once every year; regardless of Low or High Dx used; also covers new digital technologies (G codes)	77051+ (w/77055/77056/G0204/G0206) 77052+ (w/77057/G0202) 77055, 77056, 77057 G0202, G0204, G0206 Further information included in the 4/2001, 12/2001, 4/2002 & 2/2003 Providers' News NOTE: If screening and diagnostic performed on same day, add GG mod to the diagnostic mammography; if screening mammography converts to diagnostic, bill 77055 or 77056 with modifier GH '+' denotes add-on code	Low Risk = V76.12 *effective 07/01/2005* High Risk = V76.11 (along with one of the following: V10.3, V16.3, or V15.89)	Medicare beneficiaries (women) age 40 and older; women ages 35-39 can get one baseline mammogram	20% of the Medicare approved amount with no Part B deductible

Medicare Part B Covered Preventive Services

Service Description	HCPCS/CPT Codes	ICD-9 Medical Necessity	Who is covered…	What the patient pays…
Medical Nutrition Therapy: Effective DOS: 01/01/2002 Frequency: 1st year - 3 hours of one-on-one counseling; subsequent years - 2 hours Requires a physician referral; dietician or nutritionist must provide services	97802, 97803, 97804, G0270, G0271 Further information included in the 10/2001, 4/2002, & 6/2002 Providers' News	Diabetes or renal disease	Medicare beneficiaries who have Diabetes or Renal Disease except those receiving dialysis	20% of the Medicare approved amount after the yearly Part B deductible
Pap Smear, Breast Screening, and Pelvic Examination: Frequency: Once every 2 years or Annually if: - the patient is high risk for cervical or vaginal cancer, or - the patient has not had a screening Pap Smear in the preceding 3 years, or - the patient is of childbearing age and has had an abnormal Pap Smear in the preceding 3 years If unsure of previous services or if more often than annually (even for medical reasons), need to complete ABN and use modifier GA to indicate ABN was obtained as patient will be responsible for payment of these services. *(As of 10/20/09, research/testing is being done to see if payable more frequently when submitted/appealed w/notes supporting medical necessity).* NOTE: Online eligibility does provide information regarding prior services received. Refer to User Guide: Online Eligibility Requests.	Screening Pelvic & Breast Exam: G0101 Screening Pap Smear: Q0091 - obtaining, preparing, & conveyance of cervical or vaginal smear to lab *NOTE: If unsatisfactory 'smear' and new 'smear' needs to be done, append mod 76 with Dx V76.2 and either V76.47 or V76.49* Notes: G0101 & Q0091 may be billed together on the same date of service. Further information included in the 2/1998, 5/1998, 2/2003, 4/2001, 7/2003, & 8/2002 Providers' News	Low Risk Patients V76.49 (*to be used for women w/o a cervix)* V76.47 (vaginal) V76.2 (cervical) V72.31 (*Eff 07/01/05-must be full GYN exam)* High Risk Patients V15.89 * More Frequent obtaining/preparing and conveyance of a Pap Smear, because of CA Dx, i.e., 795.0; (i.e., How to bill Q0091 when more frequent use of Q0091 *than Medical Necessity guidelines* is warranted; is pending response from Q&A Medicare.)	All women Medicare beneficiaries	No coinsurance and no Part B deductible for the Pap Smear 20% of the Medicare approved amount with no Part B deductible for the Exam and Collection of the Pap

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Service Description	HCPCS/CPT Codes	ICD-9 Medical Necessity	Who is covered…	What the patient pays…
Prostate Cancer Screening: Effective DOS: 01/01/2000 Frequency: • Digital Rectal Examination (DRE) - once every year • Prostate Specific Antigen (PSA) screening test – once every year	G0102 (DRE) G0103 (PSA) Use 84153 for Diagnostic PSA testing only if diagnosed with condition warranting per LA Medicare Medguide, Prostate Cancer Screening section available via: http://www.lamedicare.com/provider/medguide/main.asp Further information included in the 12/1999 & 10/2002 Providers' News	V76.44 *(See Retired Local Coverage Determinations)*	Medicare beneficiaries (men) age 50 and older	20% of the Medicare approved amount after the yearly Part B deductible for DRE No coinsurance and no Part B deductible for the PSA Test
Smoking Cessation: Effective DOS: 03/22/2005 Frequency: Two cessation counseling attempts annually (1 attempt = up to 4 sessions, up to 8 sessions in a 12 month period)	99406 (use G0375–prior to 01/01/2008) counseling 3-10 mins 99407(use G0376–prior to 01/01/2008) counseling > 10 mins Further information included in the 06/2005 Providers' News	Condition that is adversely affected by tobacco use or condition being treated with a therapeutic agent	Individuals who use tobacco and have a disease or adverse health effect linked to tobacco use or taking a therapeutic agent whose metabolism or dosing is affected by tobacco	20% of the Medicare approved amount after the yearly Part B deductible

Medicare Part B Covered Preventive Services

Service Description	HCPCS/CPT Codes	ICD-9 Medical Necessity	Who is covered…	What the patient pays…
Vaccinations: Frequency: • Influenza (Flu) – once per flu season – in the fall or winter (09/01-04/30); more frequently if medically necessary	Influenza (Flu) – 90655, 90656, 90657, 90658, 90660 Administration – G0008	V04.81*	All Medicare beneficiaries	If provider accepts assignment no Coinsurance and no Part B deductible for flu
• Introduced 09/01/09; Effective 10/1/09: Influenza A (H1N1) vaccine *for Swine Flu* – once per flu season, may require 2 administrations (unknown at this time) Can be given in conjunction to Influenza (Flu) vaccine	Influenza A - G9142 Administration - G9141 Vaccine (G9142) will be provided free to providers, *expected availability is 10/15/09*; therefore only the administration will be payable. The vaccine should be billed as a ∅ charge. For more information, see MLM SE0920.Contact information for supplies of H1N1 vaccine can be found at: http://www.cdc.gov/h1n1flu/vaccination/statecontacts.htm?s_cid=ccu083109_VaccinePOC_e	V04.81		
• Pneumonia (PPV) – once in a lifetime; additional shots may be provided based on risk	Pneumonia (PPV) – 90669, 90732 Administration - G0009	V03.82*		If provider accepts assignment no Coinsurance and no Part B deductible for pneumonia
• Hepatitis B (HBV) – for patients at medium to high risk for hepatitis; scheduled dosages required	Hepatitis B (HBV) – 90740, 90743, 90744, 90746, 90747 90748 - non-covered Administration - G0010 Administration – 90471 or 90472+ (OPPS hospitals only) '+' denotes add-on code Further information included in the 10/1999, 12/1999, 2/2003, & 11/2003 Providers' News and Quick Reference Information: Medicare Immunization Billing 10/2006	V05.3 * Effective 10/01/2006: Dx V06.6 should be reported in lieu of V04.81 and V03.82 when purpose of visit was to receive both vaccines and both vaccines were provided on the same DOS		For Hepatitis B shots 20% of the Medicare approved amount after the Part B deductible; mandatory assignment for Vaccine, but not for Administration; must split bill
• All other vaccines – are non-covered unless directly related to injury or exposure to disease or condition (i.e., tetanus for injury, etc.) Refer to User Guide: Vaccines and Administration	Vaccine CPT code as related to service provided	As related to service provided (should indicate injury or direct exposure to disease or condition)	Not covered by Medicare unless directly related to an injury or direct exposure to disease or condition	

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Service Description	HCPCS/CPT Codes	ICD-9 Medical Necessity	Who is covered…	What the patient pays…
Injections: • Therapeutic, prophylactic and diagnostic injections and infusions	90772**, 90773** and 90774** - must be billed with corresponding J code J code must have comment A.B19 linked with dosage information; remove HPSA modifiers if applicable; if diagnosis provided is compatible with J codes, use same diagnosis codes; not billable with NCC procedures 11900, 20600-20610 unless modifier 59 applicable **Effective DOS: 01/01/2009 90772 deleted, use 96372 90773 deleted, use 96373 90774 deleted, use 96374			

****NOTE: This document is distributed with the E&M Service Manual.**