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Screening and Preventive Services

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Part B

IMPORTANT

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IMPORTANT

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Screening and Preventive Services

GENERAL INFORMATION

Title XVIII of the Social Security Act (the Act), Section 1862(a)(7) excludes routine physical checkups (including tests that are performed in the absence of signs or symptoms) from the Medicare program.

The Social Security Act, Title XVIII Section 1862(a)(1)(A) reads:

"Notwithstanding any other provision of this title, no payment can be made under Part A or Part B for any expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

Definition

Screening is defined as examinations and/or diagnostic procedures performed in the absence of signs or symptoms.

Screening is often performed based on patient age and/or family history. Most screening and preventive services are considered statutory exclusions from the Medicare program.

Exceptions

The following preventive services may be covered:

- Bone mass measurements.
- Cardiovascular screening blood tests (effective January 1, 2005).
- Colorectal cancer screening.
- Diabetes outpatient self-management training services.
- Diabetes screening tests (effective January 1, 2005).
- Glaucoma screening.
- Hepatitis B vaccine.
- Influenza vaccine.
- Mammography screening.
- Medical nutrition therapy for individuals with diabetes or renal disease.
- Pneumococcal Pneumonia Vaccine (PPV).
- Screening Pap smears.
- Screening pelvic and clinical breast examinations.
- Prostate cancer screening.
- Initial Preventive Physical Examination (IPPE)/“Welcome to Medicare Exam” (effective January 1, 2005).

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- Ultrasound screening for Abdominal Aortic Aneurysms (AAA) (effective January 1, 2007).

CPT and HCPCS Coding

The same services and tests provided for screening and preventive care purposes are also performed to diagnose an illness or injury. In most cases, specific procedure codes have been developed to indicate whether the test is a screening test or a diagnostic test. Many of the tests or services performed for screening purposes have been assigned an HCPCS level II procedure code. When the same test or service is performed for a diagnostic or treatment purpose (i.e., to evaluate a sign, symptom, illness or injury), a CPT code is used. The procedure code reported on the claim depends on the purpose of the test. This manual will only address Medicare guidelines regarding screening and preventive services. If the same tests are being performed for diagnostic purposes, please refer to the appropriate policy regarding the diagnostic service.

Although Medicare covers some screening and preventive care services, Medicare does not cover the evaluation and management services needed to determine the need for a preventive test or service. Except for some limited examinations described later in this manual, these services are not covered by Medicare and may be billed to the patient. The appropriate CPT code to report should be selected from the preventive medicine services CPT codes range 99381–99397.

Non-Covered/Excluded Services

Physicians are not required by law to submit claims to Medicare for non-covered services unless the patient requests that one be submitted. Patients sometimes do request that a claim for the services be filed with Medicare to receive a Medicare denial to submit to their supplemental insurance company.

These services submitted to Medicare for the purpose of receiving a denial may be submitted with the GY modifier.

GY Modifier	Item or service statutorily excluded or does not meet the definition of any Medicare benefit

Please refer to the *Advance Beneficiary Notice of Noncoverage (ABN)* training manual for information concerning services that deny due to medical necessity and how to determine which services fall under Medicare program exclusions.

Diagnosis Codes

When reporting a screening test, the diagnosis code(s) indicated on the claim should reflect the reason for performing the service. For example: When a screening laboratory test results in an abnormal finding, the test should be coded to the diagnosis for "why" the test was ordered, not to the diagnosis found as a result of performing the test. If the

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intent of performing the test was for routine screening purposes (regardless of the diagnostic findings as a result), the service is non-covered by Medicare as screening. Use the appropriate ICD-9-CM "V" code to designate the screening as the primary diagnosis. Any condition discovered during the screening should be reported as a secondary diagnosis.

The following diagnosis codes (not an all-inclusive list) may be used to indicate the service performed was for screening:

V160–V162	V1640–V1643	V1649	V165	V1651
V1659	V166–V169	V170–V178	V180–V185	V1861
V1869	V187–V188	V190–V198	V280–V286	V288–V289
V700–V707	V709	V720–V722	V7231–V7232	V7240–V7241
V727	V729	V730–V736	V7388–V7389	V7398–V7399
V740–V743	V745–V746	V748–V749	V750–V759	V760
V763	V7641–V7643	V7649	V7681	V7689
V769	V770–V778	V7791	V7799	V780–V783
V788–V789	V790–V793	V798–V799	V800–V803	V810–V816
V820–V826	V8281	V8289	V829	

Routine Physical Exam in Conjunction With Medically Necessary Visit

When a medically necessary Evaluation and Management (E/M) service is provided as part of what would otherwise be a non-covered routine physical examination, the physician may bill the beneficiary for the non-covered portion of the visit. However, the physician may bill no more than the amount by which the physician's current established charge for the routine physical exam exceeds his established charge for the covered service.

For example, the patient is scheduled for a routine physical examination and the physician is also following the patient's diabetes for possible changes. The physician's established charge for a routine physical (99397) is $100; the established charge for a covered E/M service (99212) is $30. The physician may bill code 99397 for $70 and code 99212 for $30 ($100 - $30 = $70). If the physician accepts assignment, the beneficiary would be responsible for the full $70 and the 20 percent coinsurance and any unmet deductible for the code 99212 charge.

Note: If a patient is being seen for a routine physical exam, a screening pelvic exam (G0101) and screening Pap smear (Q0091) in conjunction with a medically necessary visit, the medically necessary visit can be billed if it meets the criteria of a significant, separately identifiable service being provided. Bill the medically necessary visit with the 25 modifier to identify a significant, separately identifiable service occurred.

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25 Modifier	Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service

The patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting the E/M services on the same date.

Use the preventive service codes (99381–99397) to report the routine portion of the encounter with the patient. Report the covered portion of the service with the appropriate E/M code.

Medicare payment is made for the covered visit based on the lesser of the fee schedule amount or the physician's actual charge for the visit. The physician is not required to provide advance notice of non-coverage to the beneficiary because Medicare coverage of routine physical examinations is denied based on the specific Section 1862(a)(7) statutory exclusion rather than on medical necessity, per Section 1862(a)(1) of the Social Security Act. Many providers/physicians have found that advising their patients of a non-covered service is a good business practice that results in fewer problems for their staff and patients.

Frequency Requirements

When determining when the next covered Medicare screening service may be performed, start counting the month following the last covered screening service.

For example, if the patient is eligible to receive a certain screening test once every 12 months, then 11 months must elapse between services. Start counting the 11 months from the month following the last covered service:

- Last covered screening service provided May 25, 2007.
- Next screening service may be provided on or after May 1, 2008.

Determining a Medicare Beneficiary's Eligibility for Preventive Services

Providers who access the preventive services data via Common Working File (CWF) provider inquiry screens now have access to preventive services next eligible date data.

The CMS Educational Guide *Determining a Medicare Beneficiary's Eligibility for Medicare Preventive Services* is available on the CMS Web site on the MedLearn Network's Preventive Services Education Resource Web Guide page under the Provider Education header. This guide can be viewed at:

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http://www.cms.hhs.gov/MLNProducts/downloads/Preventive_Services_Eligibility.pdf

This guide provides information to providers on interpreting the Medicare beneficiary preventive services next eligible date data. It is intended to supplement the educational materials already available for the HIQA, HIQH, HUQA, ELGA, ELGB and ELGH eligibility inquiry screens used to access CWF records.

INITIAL PREVENTIVE PHYSICAL EXAMINATION (IPPE)/'WELCOME TO MEDICARE EXAM'

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA Section 611) provides for coverage under Medicare Part B of an Initial Preventive Physical Examination (IPPE)/"Welcome to Medicare Exam," including a screening EKG for new beneficiaries (subject to certain eligibility and other limitations), effective for services furnished on or after January 1, 2005.

This provision provides for payment for an IPPE examination to be performed in various provider settings by:

- Physicians (a doctor of medicine or osteopathy).
- Qualified Non-Physician Practitioners (NPPs) (physician assistant, nurse practitioner or clinical nurse specialist).

Services Included in the Initial Examination (For Dates of Service January 1, 2005, through December 31, 2008)

- This physical examination is a once-a-lifetime benefit for a beneficiary.
- It must be performed within six months after the effective date of the beneficiary's first Part B coverage.
- Part B coverage must begin on or after January 1, 2005.

The initial examination means all of the following services:

- Review of an individual's medical and social history, with attention to modifiable risk factors for disease detection, including past medical and surgical history, such as experiences with illnesses, hospital stays, operations, allergies, injuries and treatments; current medication and supplements; family history (including diseases that may be hereditary or place the individual at risk); history of alcohol, tobacco and illicit drug use; diet; and physical activities.
- Review of an individual's potential (risk factors) for depression, including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the physician or other qualified NPP may select from various available standardized screening tests designed for this purpose and recognized by national professional medical organizations.
- Review of the individual's functional ability and level of safety based on the use of appropriate screening questions or a screening questionnaire, which the physician or other qualified NPP may select from various available screening questions or standardized questionnaires designed for this purpose and

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recognized by national professional medical organizations, including, at a minimum, a review of hearing impairment, activities of daily living, falls risk and home safety.

- An examination to include measurement of the individual's height, weight and blood pressure; a visual acuity screen; and other factors as deemed appropriate by the physician or qualified NPP, based on the individual's medical and social history (refer to service element 1) and current clinical standards.
- Performance and interpretation of an EKG.
- Education, counseling and referral as deemed appropriate by the physician or qualified NPP, based on the results of the review and evaluation services described in the previous five elements.
- Education, counseling and referral, including a brief written plan (e.g., a checklist or alternative) provided to the individual for obtaining the appropriate screening and other preventive services, which are covered separately under Medicare Part B. These include: (1) pneumococcal, influenza and hepatitis B vaccines and their administration; (2) screening mammography; (3) screening Pap smear and screening pelvic examinations; (4) prostate cancer screening tests; (5) colorectal cancer screening tests; (6) diabetes outpatient self-management training services; (7) bone mass measurements; (8) screening for glaucoma; (9) medical nutrition therapy for individuals with diabetes or renal disease; (10) cardiovascular screening blood tests; and (11) diabetes screening tests.

Coding (Dates of Service January 1, 2005, through December 31, 2008)

G0344 Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first six months of Medicare enrollment

G0366 Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report, performed as a component of the initial preventive physical examination

G0367 Tracing only, without interpretation and report, performed as a component of the initial preventive physical examination

G0368 Interpretation and report only, performed as a component of the initial preventive physical examination

As required by statute, this benefit always includes a screening EKG, which should always be billed separately. When the total component screening EKG is performed, report code G0366 in addition to G0344. Use codes G0367 and G0368 when the technical and professional components of the screening EKG are billed separately.

Screening and Preventive Services

Changes That Apply to the IPPE for Dates of Service on or After January 1, 2009

Effective January 1, 2009, Section 101(b) of the Medicare Improvement for Patients and Providers Act (MIPPA) of 2008 updates the IPPE benefit. The changes are explained as follows:

- The IPPE may be performed no later than 12 months after the date the individual's coverage period begins under Medicare Part B. Therefore, any beneficiaries who have not yet had an IPPE and whose initial enrollment in Medicare began in 2008 will be able to have an IPPE in 2009, as long as it is done within 12 months of their initial enrollment.
- A required measurement of the patient's body mass index.
- The addition of an end-of-life planning (upon the patient's consent).
- Changed the EKG from a required element of the IPPE to an optional element. This EKG is permitted as a once-in-a-lifetime screening service as a result of a referral from an IPPE.
- Waiving of the Part B deductible for the IPPE.

Coding (Dates of Service on or After January 1, 2009)

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

Screening EKG

If the primary physician or qualified NPP does not perform the EKG during the IPPE visit, another physician or entity may perform and/or interpret the EKG. However, the referring provider must ensure that the performing provider bills the appropriate G code for the screening EKG and **not a CPT code** in the 93000 series. Both the IPPE and the EKG should be billed in order for the beneficiary to receive the complete IPPE service. The primary physician or qualified NPP shall document the results of the screening EKG into the beneficiary's medical record to complete and bill for the IPPE benefit.

Note: Both components of the IPPE (the examination and the screening EKG) must be performed before the claims are submitted by the physician, qualified NPP and/or entity.

Screening and Preventive Services

Physicians and qualified NPPs should bill G0366 for the full EKG service (tracing, interpretation and report), or G0367 when only the tracing is performed, or G0368 when only the interpretation or reporting is performed.

Should the same physician or NPP need to perform an additional medically necessary EKG in the 93000 series on the same day as the IPPE, the provider should report the appropriate EKG CPT code(s) with the modifier 59, indicating the EKG is a distinct procedural service.

Medically Necessary E/M Service

While some components for a medically necessary Evaluation and Management (E/M) service will be reflected in the new HCPCS code of G0344, Medicare will, when it is clinically appropriate, allow payment for a medically necessary E/M service (CPT codes 99201–99215) at the same visit as the IPPE. That portion of the visit must be medically necessary to treat the patient's illness or injury or to improve the function of a malformed body member and will be reported with modifier 25.

A physician or qualified NPP, in various provider settings, may bill for the screening and other preventive services currently covered and paid by Medicare Part B under separate provisions of Section 1861 of the Act, if provided during this IPPE.

Advance Beneficiary Notice of Noncoverage (ABN)

If a second IPPE is billed for the same beneficiary, it would be denied as a statutory denial under Section 1861(s)(2) of the Act, since the IPPE is a one-time benefit, and an ABN would not be required in order to hold the beneficiary liable for the cost of the IPPE. However, an ABN should be issued for all IPPEs conducted after the beneficiary's statutory six-month/12-month period (based on the date the IPPE was performed) has lapsed since, based on Section 1862(a)(1)(K), Medicare is statutorily prohibited from paying for an IPPE outside the six-month period.

An ABN also should be issued for an IPPE that is conducted within the first six months/12 months (based on the date the IPPE was performed) but which is "not reasonable and necessary" for the beneficiary on the occasion in question, e.g., if the beneficiary has a terminal illness, conducting an IPPE may not be appropriate.

ULTRASOUND SCREENING FOR ABDOMINAL AORTIC ANEURYSMS (AAA)

Background

Section 5112 of the Deficit Reduction Act (DRA) of 2005 allows for one ultrasound screening Abdominal Aortic Aneurysms (AAA) under Medicare Part B, effective for services furnished on or after January 1, 2007, as a result of a referral from an Initial Preventive Physical Examination (IPPE) and subject to certain eligibility and other limitations. This provision waives the annual Part B deductible for the AAA screening test.

Key Points

Effective for dates of service on and after January 1, 2007, Medicare will pay for a one-time ultrasound screening for AAA for beneficiaries who meet the following criteria:

- Receives a referral for such an ultrasound screening as a result of an IPPE.
- Receives such ultrasound screening from a provider or supplier who is authorized to provide covered ultrasound diagnostic services.
- Has not been previously furnished such an ultrasound screening under the Medicare Program.
- Is included in at least one of the following risk categories:
  - Has a family history of abdominal aortic aneurysm.
  - Is a man aged 65 to 75 who has smoked at least 100 cigarettes in his lifetime.
  - Is a beneficiary who manifests other risk factors in a beneficiary category recommended for screening by the United States Preventive Services Task Force regarding AAA, as specified by the Secretary of Health and Human Services, through the national coverage determinations process.

Payment

The Part B deductible for screening AAA is waived effective January 1, 2007, but coinsurance is applicable.

HCPCS Code

G0389 Ultrasound, B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) screening

Advance Beneficiary Notice of Noncoverage (ABN)

An AAA screening service will be denied if it is billed more than once in a beneficiary's lifetime.

If a second G0389 is billed for AAA for the same beneficiary or if any of the other statutory criteria for coverage are not met, the service will be denied as a statutory exclusion.

If a provider cannot determine whether or not the beneficiary has previously had an AAA screening, but all of the other statutory requirements for coverage have been met, the provider should issue the ABN. Likewise, if all of the statutory requirements for coverage have been met, but a question of medical necessity still exists, the provider should issue the ABN.

CARDIOVASCULAR SCREENING BLOOD TESTS

Background

In accordance with Section 612 of the Medicare Modernization Act (MMA), Medicare coverage is provided for cardiovascular screening blood tests (tests for the early detection of cardiovascular disease or abnormalities associated with an elevated risk for that disease), effective for services performed on or after January 1, 2005.

The MMA permits coverage of tests for cholesterol and other lipid or triglycerides levels for this purpose. Therefore, effective January 1, 2005, coverage is provided for the following:

- Total cholesterol test.
- Cholesterol test for high-density lipoproteins.
- Triglycerides test.

Effective January 1, 2005, Medicare provides coverage for the cardiovascular screening blood test for beneficiaries every five years (i.e., 59 months after the last covered screening tests). Medicare has determined that it is not necessary to test more frequently since lipid and cholesterol levels for people often stay fairly consistent beyond age 65.

Medicare Part B covers cardiovascular screening blood tests when ordered by the physician who is treating the beneficiary for the purpose of early detection of cardiovascular disease in individuals without apparent signs or symptoms.

The implementation of this new benefit permits Medicare beneficiaries who have not been previously diagnosed with cardiovascular disease to receive cardiovascular screening blood tests for risk factors associated with cardiovascular disease. This includes individuals who have no prior knowledge of heart problems, but recognize that their behavior or lifestyle may be at risk because of diet or lack of exercise.

Payment is provided under the Medicare Clinical Laboratory Fee Schedule. There is no deductible or copayment for this benefit.

HCPCS/CPT Codes/Diagnosis Codes

The following HCPCS/ CPT codes should be billed for the cardiovascular screening blood tests:

80061© Lipid panel

82465© Cholesterol, serum, or whole blood, total

83718© Lipoprotein, direct measurement; high-density cholesterol

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84478© Triglycerides

The tests should be performed as a panel; however, they are also available as individual tests.

The following diagnosis codes must be submitted on the claim form when billing for cardiovascular screening blood test:

V81.0 Special screening for ischemic heart disease

V81.1 Special screening for hypertension

V81.2 Special screening for other and unspecified cardiovascular conditions

Medicare will pay for cardiovascular disease screening under the Medicare Clinical Laboratory Fee Schedule. Providers and suppliers that bill for the cardiovascular disease screening benefit must point the screening diagnosis (V81.0, V81.1, V81.2) to the line-item service.

Other cardiovascular screening blood tests (for which CMS has not specifically indicated approval for national coverage) continue to be non-covered.

How Carriers and Intermediaries Will Treat Claims

Medicare carriers and intermediaries will treat claims as follows:

- Carriers/intermediaries will accept claims with HCPCS 80061 (lipid panel), 82465 (cholesterol, serum or whole blood, total), 83718 (lipoprotein, direct measurement; high-density cholesterol, HDL cholesterol), or 84478 (triglycerides) when there is a reported diagnosis of V81.0 (special screening for ischemic heart disease), V81.1 (special screening for hypertension) or V81.2 (special screening for other and unspecified cardiovascular conditions).
- Carriers/intermediaries will deny claims with code 80061 when there is already evidence of a paid claim within the prior 60 months that was billed with a diagnosis code of V81.0, V81.1 or V81.2, and with a procedure code of 80061, 82465, 83718 or 84478.
- Carriers/intermediaries will deny claims with procedure codes of 82465, 83718 or 84478 when billed within 60 months of a previous paid claim with a diagnosis code of V81.0, V81.1 or V81.2, and a procedure code of 80061.

Separate Venipuncture Not Allowed

The MMA did not include a provision for coverage of the venipuncture for the cardiovascular screening blood tests. Therefore, the service would be denied as a routine screening service, and the patient may be billed.

DIABETES SCREENING TESTS

Medicare will permit coverage for the following diabetes screening tests for services performed on or after January 1, 2005, for individuals who satisfy the eligibility requirements of being at risk for diabetes:

- Fasting blood glucose test.
- Post-glucose challenge test (an oral glucose tolerance test with a glucose challenge of 75 grams of glucose for non-pregnant adults or a two-hour post-glucose challenge test alone).

Coverage will be provided for two screening tests per year for individuals diagnosed with pre-diabetes, and one screening test per year for individuals previously tested who were not diagnosed with pre-diabetes or who have never been tested. This coverage does not apply to individuals previously diagnosed as diabetic.

Definitions

Diabetes – Diabetes mellitus, a condition of abnormal glucose metabolism diagnosed from a fasting blood sugar > 126 mg/dL on two different occasions; a two-hour post-glucose challenge > 200 mg/dL on two different occasions; or, a random glucose test > 200 mg/dL for an individual with symptoms of uncontrolled diabetes.

Pre-Diabetes – Abnormal glucose metabolism diagnosed from a previous fasting glucose level of 100 to 125 mg/dL, or a two-hour post-glucose challenge of 140 to 199 mg/dL. The term “pre-diabetes” includes impaired fasting glucose and impaired glucose tolerance.

An individual with **one of the following individual risk factors for diabetes is eligible** for this new benefit:

- Hypertension.
- Dyslipidemia.
- Obesity (with a body mass index greater than or equal to 30 kg/m2).
- Previous identification of elevated impaired fasting glucose or glucose intolerance.

Or an individual with any **two of the following risk factors for diabetes is also eligible** for this new benefit:

- Overweight (a body mass index greater than 25 but less than 30 kg/m2).
- A family history of diabetes.
- Age 65 years or older.
- A history of gestational diabetes mellitus or giving birth to a baby weighing more than nine pounds.

Screening and Preventive Services

Effective for services performed on or after January 1, 2005, Medicare will pay for diabetes screening tests under the Medicare Clinical Laboratory Fee Schedule. To indicate that the purpose of the test(s) is for diabetes screening, a screening diagnosis code is required in the diagnosis section of the claim:

- Two screening tests per calendar year are covered for individuals diagnosed with pre-diabetes. Effective April 1, 2005, modifier TS should be reported when the patient has been diagnosed with pre-diabetes.
- One screening test per year is covered for individuals previously tested who were not diagnosed with pre-diabetes or who have never been tested.

Nationally Non-Covered Indications

- No coverage is permitted under the Medicare Modernization Act (MMA) benefit for individuals previously diagnosed as diabetic.
- Other diabetes screening blood tests for which Medicare has not specifically indicated national coverage continue to be non-covered.

HCPCS/CPT Codes

82947©	Assay, glucose, blood quant
82950©	Glucose test
82951©	Glucose tolerance test (gtt)

ICD-9-CM Diagnosis Codes

V77.1	Diabetes screening

Billing for Individuals Diagnosed With Pre-Diabetes

Effective April 1, 2005

When the test is performed on individuals diagnosed with pre-diabetes, both the screening diagnosis code V77.1 and modifier TS, follow-up service, are required.

Separate Venipuncture Not Allowed

The MMA did not include a provision for coverage of the venipuncture for the diabetes screening blood test. Therefore, the service would be denied as a routine screening service, and the patient may be billed.

COLORECTAL CANCER SCREENING

Medicare covers colorectal cancer screening for the early detection of cancer. Section 4104 of the Balanced Budget Act of 1997 (PL 10533) provides for Part B coverage of various colorectal cancer screening examinations, subject to certain frequency and payment limitations, performed on or after January 1, 1998. Coverage of these colorectal cancer screening examinations was published in regulations at 62 FR 59079 on October 31, 1997, effective January 1, 1998. The following services are considered colorectal cancer screening services:

- Fecal Occult Blood Tests (FOBTs).
- Flexible sigmoidoscopy.
- Colonoscopy.
- Barium enema.

Advance Beneficiary Notice of Noncoverage (ABN)

An ABN should only be obtained for colorectal cancer screening services when notifying the patient of Medicare's frequency limitations. Refer to the ABN section for additional information.

Evaluation and Management Services for Colon Cancer Screening Benefits

National policy stipulates that Medicare does not cover an evaluation and management service for an asymptomatic patient prior to a screening colonoscopy.

Deductible and Coinsurance for Colorectal Screening Services

Prior to January 1, 2007, deductible and coinsurance apply to HCPCS codes G0104, G0105, G0106, G0120 and G0121. **On or after January 1, 2007**, the annual Part B deductible is waived for the listed HCPCS coded **screening services. Coinsurance still applies.**

Coinsurance and deductible applies to the diagnostic colorectal service codes 45330, 45378 and 74280.

Effective for services on or after January 1, 2007, Medicare requires a 25 percent beneficiary coinsurance for colorectal cancer screening colonoscopies performed in Ambulatory Surgery Centers (ASCs). This only applies to ASC bills, not the physician bill.

Screening and Preventive Services

Screening Fecal-Occult Blood Tests (FOBTs) (Codes G0107 and G0328)

G0107 Colorectal cancer screening; fecal-occult blood test, 1–3 simultaneous determinations (code discontinued effective for dates of service on or after January 1, 2007)

82270© Occult blood, other sources (report this code for screening purposes for dates of service on or after January 1, 2007)

G0328 Colorectal cancer screening; fecal-occult blood test, immunoassay, 1–3 simultaneous determinations

Coverage

One guaiac-based or one immunoassay-based screening FOBT (code G0107 or G0328) is covered for beneficiaries who have attained age 50, at a frequency of once every 12 months (i.e., at least 11 months have passed following the month in which the last covered screening FOBT was done).

Report test codes only once. The reimbursement for these codes includes three determinations. The date of service reported on the claim should be the date the final card is received in the office.

This screening requires a written order from the beneficiary's attending physician.

Payment is based on the clinical laboratory fee schedule and is made at 100 percent of the allowed amount. Coinsurance and deductible do not apply.

Flexible Sigmoidoscopy

G0104 Colorectal cancer screening; flexible sigmoidoscopy

Coverage

A screening flexible sigmoidoscopy is covered once every four years for beneficiaries age 50 or older.

This code will be paid at the same amount as code 45330, diagnostic sigmoidoscopy, under the physician fee schedule in the provider's area. Prior to January 1, 2007, deductible and coinsurance apply. Beginning with services provided on or after January 1, 2007, deductible does not apply. Coinsurance still applies.

If, in the course of a screening flexible sigmoidoscopy, a lesion or growth is detected that results in a biopsy or removal of the growth, report the appropriate diagnostic procedure classified as a flexible sigmoidoscopy with biopsy or removal rather than code G0104.

Colonoscopy – High-Risk Individual

G0105 Colorectal cancer screening; colonoscopy on individual at high risk

In determining whether the beneficiary is at high risk for developing colorectal cancer, consider the following characteristics of the high-risk individual:

- A close relative (sibling, parent or child) has had colorectal cancer or an adenomatous polyp.
- A family history of familial adenomatous polyposis.
- A family history of hereditary non-polyposis colorectal cancer.
- A personal history of adenomatous polyps.
- A personal history of colorectal cancer.
  Or,
- A personal history of inflammatory bowel disease, including Crohn's disease and ulcerative colitis.

Coverage

A screening colonoscopy is covered every two years for individuals at high risk for colorectal cancer.

Covered diagnosis codes:

5550	5562	V1005
5551	5563	V1006
5552	5568	V1272
5559	5569	V160
5560	5582	V185
5561	5589	

Code G0105 will be paid at the same amount as code 45378, diagnostic colonoscopy, under the physician fee schedule in your area. Prior to January 1, 2007, deductible and coinsurance apply. Beginning with services provided on or after January 1, 2007, deductible does not apply. Coinsurance still applies.

If during the screening colonoscopy a lesion or growth is detected that results in a biopsy or removal of the growth, report the procedure code for a colonoscopy with biopsy or removal of lesion rather than procedure code G0105.

Screening Colonoscopy – Individual Not Meeting Criteria for High Risk

G0121 Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk

Payment for screening colonoscopy on an individual not meeting criteria for high risk (G0121) may be made if performed under the following conditions:

- On individuals not meeting the criteria for being at high risk for developing colorectal cancer.
- At a frequency of once every 10 years (at least 119 months have passed following the month in which the last covered G0121 screening colonoscopy was performed).
- If the individual would otherwise qualify to have a covered G0121 screening colonoscopy based on the above but has had a covered screening flexible sigmoidoscopy (G0104), he may have a covered G0121 screening colonoscopy only after 47 months have passed following the month in which the last covered G0104 flexible sigmoidoscopy was performed.

If during the screening colonoscopy a lesion or growth is detected that results in a biopsy or removal of the growth, report the procedure code for a colonoscopy with biopsy or removal of lesion, rather than procedure code G0121.

Code G0121 is paid based on the Medicare Physician Fee Schedule. Prior to January 1, 2007, deductible and coinsurance apply. Beginning with services provided on or after January 1, 2007, deductible does not apply. Coinsurance still applies.

Incomplete Screening Colonoscopies

Effective for dates of services on or after January 1, 2004, when a covered colonoscopy is attempted but cannot be completed because of extenuating circumstances, Medicare will pay for the interrupted colonoscopy at a rate consistent with that of a flexible sigmoidoscopy as long as coverage conditions are met for the incomplete procedure. When a covered colonoscopy is next attempted and completed, Medicare will pay for that colonoscopy according to its payment methodology for this procedure as long as coverage conditions are met. This policy is applied to both screening and diagnostic colonoscopies. When submitting a claim for the interrupted colonoscopy, professional providers should suffix the colonoscopy code with a modifier 53 to indicate the procedure was interrupted. When submitting a claim for the facility fee associated with this procedure, ASCs should suffix the colonoscopy code with 73 or 74, as appropriate. Payment for covered screening colonoscopies, including that for the associated ASC facility fee when applicable, will be consistent with payment for diagnostic colonoscopies, whether the procedure is complete or incomplete.

Screening and Preventive Services

Note that Medicare would expect the provider to maintain adequate information in the patient's medical record, in case it is needed by the contractor to document the incomplete procedure.

Screening Barium Enemas

Screening barium enema examinations (G0106 and G0120) are covered as an alternative to either a screening sigmoidoscopy (code G0104) or a screening colonoscopy (code G0105) if the beneficiary's physician has determined that the screening barium enema will be as effective as the screening flexible sigmoidoscopy or screening colonoscopy for that individual. Substitution of the barium enema for either the screening sigmoidoscopy or the screening colonoscopy must be ordered in writing by the beneficiary's attending physician.

Both G0106 and G0120 will be paid at the same amount as code 74280, contrast X-ray exam of colon, under the physician fee schedule for the provider's area.

G0106 Colorectal cancer screening; barium enema; as an alternative to G0104, screening sigmoidoscopy

Coverage

- Patient must be at least 50 years old.
- At least 47 months have passed following the month in which the last screening barium enema or screening flexible sigmoidoscopy was performed.

Payment will not be made for both a screening barium enema and a screening flexible sigmoidoscopy for the beneficiary who is not at high risk for colorectal cancer during the same 48-month period.

There are no specific diagnosis code requirements for code G0106 at this time. The appropriate screening (V) ICD-9-CM code must be chosen when filing the claim.

Prior to January 1, 2007, deductible and coinsurance apply. Beginning with services provided on or after January 1, 2007, deductible does not apply. Coinsurance still applies.

G0120 Colorectal cancer screening; barium enema; as an alternative to G0105, screening colonoscopy

Coverage

- Patient must be at least 50 years old.
- At least 23 months have passed following the month in which the last screening

barium enema or screening colonoscopy was performed.

- Refer to list of covered diagnosis codes for code G0105.

Payment will not be made for both a screening barium enema and a screening colonoscopy for an individual who is at high risk for colorectal cancer during the same 24-month period.

Prior to January 1, 2007, deductible and coinsurance apply. Beginning with services provided on or after January 1, 2007, deductible does not apply. Coinsurance still applies.

G0122 Colorectal cancer screening; barium enema (non-covered)

Code G0122 should be used when a screening barium enema is performed, not as an alternative to either a screening colonoscopy (code G0105) or a screening flexible sigmoidoscopy (code G0104). This service is denied as non-covered because it fails to meet the requirement of the benefit, and the patient may be billed for the service.

SCREENING MAMMOGRAMS

Medicare provides Part B coverage of screening mammographies for women. Screening mammographies are radiological procedures for early detection of breast cancer and include a physician's interpretation of the results.

A doctor's prescription or referral is not required for payment. Payment is determined by the patient's age and the amount of time that has elapsed since her last screening mammography.

After May 23, 2008, in cases where the screening mammography services are self-referred, the facility's National Provider Identifier (NPI) number should be used in place of the attending/referring physician NPI number (Item 17b on the CMS-1500 claim form or electronic equivalent).

Note: When a mammogram is billed as a purchased service and the service is purchased from a provider in another jurisdiction, the provider must submit his own NPI with the name, address and ZIP code of the performing provider.

Screening mammographies are paid based on the Medicare Physician Fee Schedule (MPFS) and coinsurance does apply. However, Medicare Part B deductible does not apply.

Section 4101 of the Balanced Budget Act (BBA) of 1997 provides for annual screening mammographies for women over age 39. Coverage applies as follows:

Age	Screening Period
35-39	Baseline (only one screening allowed for women in this age group)
Over age 39	Annual (11 full months must have elapsed following the month of the last screening)

Note: Count months between mammographies beginning the month after the date of the examination. For example, if Mrs. Smith received a screening mammography examination on January 20, 2007, begin counting the next month (February 2007) until 11 months have elapsed. Payment can be made for another screening mammography beginning January 1, 2008.

Reporting Screening Mammographies

77052© Comp screen mammogram add-on

77057© Mammogram, screening

G0202 Mammogram,screening, bilateral, all views

Screening and Preventive Services

Note: If just the add-on code is billed, the service will be denied. Both the add-on code and the appropriate mammography code should be on the same claim.

Covered For

The Balanced Budget Act (BBA) of 1997 eliminated payment based on high-risk indicators. However, to assure proper coding, one of the following diagnosis codes should be reported on screening mammography claims as appropriate:

V76.11	Special screening for malignant neoplasm, screening mammogram for high-risk patients
V76.12	Special screening for malignant neoplasm, other screening mammography

Diagnostic Mammograms

77051©	Computer dx mammogram add-on
77055©	Mammogram, one breast
77056©	Mammogram, both breasts
G0204	Diagnostic mammography, direct digital image, bilateral, all views
G0206	*Diagnostic mammography, direct digital image, unilateral, all views*

Refer to the "Diagnostic Mammography" Local Coverage Determination (LCD) located on the TrailBlazer Health Enterprises® Web site:

http://www.trailblazerhealth.com/Tools/LCDs.aspx?DomainID=1

Screening Mammogram Turns Into a Diagnostic Mammogram

GG Modifier	Performance and payment of a screening mammography and diagnostic mammography on the same patient same day

Note: Attach the GG modifier to a diagnostic mammography code to show the test changed from a screening test to a diagnostic test.

Medicare allows diagnostic films to be performed without an additional order from the treating physician. When providers submit a claim for a screening mammography and a diagnostic mammography for the same patient on the same day, attach modifier GG to the diagnostic mammography. If diagnosis requirements are met, Medicare will reimburse both the screening mammography and the diagnostic mammography.

Mammography Facility Certification

As required by the Mammography Quality Standards Act (MQSA), all facilities performing screening and diagnostic mammographies must meet national quality standards in order to operate. Facilities providing any mammogram service must be accredited by a designated accreditation body and certified by the Food and Drug Administration (FDA).

The FDA requires that the facility must be accredited through the American College of Radiology (ACR) to become a certified mammography facility. Facilities located in Texas may instead apply for accreditation through the appropriate State Department of Radiation Protection (STX).

Once the facility becomes accredited, it will receive a certificate from the FDA. The FDA will notify CMS, who will then forward the FDA Facility Identification Number and other applicable information to TrailBlazer℠.

When ordering a mammogram for a patient, be sure to refer them to a certified mammography facility. A list of certified facilities in your area may be obtained by accessing the following Web site:

http://www.fda.gov/cdrh/mammography/certified.html

Medicare requires the facility to be certified by the FDA for digital mammograms before coverage can be made for those types of services. Medicare will reject claims for digital services when the facility is certified only to perform film mammograms. Medicare will also reject claims for film services when the facility is certified only to perform digital mammograms.

A facility may be certified by the FDA for both digital and film mammograms. The FDA will notify Medicare of the certification.

For total and technical component billings, the six-digit FDA Facility ID number must be listed in Item 32 of the CMS-1500 claim form or the appropriate field for electronic claims. Failure to provide this information may result in the denial of your claims. If filing electronically, the FDA certification number should be entered in the “mmogrm cert no” field.

Mammography-related Computer-Aided Detection (CAD) equipment does not require FDA certification. Certification from the FDA is needed only for screening and diagnostic mammograms (film and digital).

Screening and Preventive Services

Release of Mammography Interpretations

Mammography facilities that perform screening mammographies should not release screening mammography X-rays for interpretation to physicians who are not approved under the facility's certification number unless:

- The patient has requested a transfer of the films from one facility to another for a second opinion.

  Or,

- The patient has moved to another part of the country where the next screening mammography will be performed.

Only the physicians who are associated with the certified mammography facility should perform interpretations.

Digital and Film Mammographies

Only one screening mammogram, either code 77057 or G0202, may be billed in a calendar year. Therefore, do not submit claims reflecting both a film screening mammography (code 77057) and a digital screening mammography (code G0202) during this time period. The claim will be denied when both a film and a digital screening mammography are reported within the same screening mammography period.

SCREENING PELVIC AND CLINICAL BREAST EXAMINATIONS AND SCREENING PAP SMEARS

Screening Pelvic and Clinical Breast Examinations

Medicare Part B provides coverage of a screening pelvic and clinical breast examination for all female beneficiaries.

A screening pelvic examination (including a clinical breast examination) should include at least seven of the following 11 elements:

- Inspection and palpation of breasts for masses or lumps, tenderness, symmetry or nipple discharge.
- Digital rectal examination, including sphincter tone, presence of hemorrhoids and rectal masses.
- External genitalia (for example, general appearance, hair distribution or lesions).
- Urethral meatus (for example, size, location, lesions or prolapse).
- Urethra (for example, masses, tenderness or scarring).
- Bladder (for example, fullness, masses or tenderness).
- Vagina (for example, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele or rectocele).
- Cervix (for example, general appearance, lesions or discharge).
- Uterus (for example, size, contour, position, mobility, tenderness, consistency, descent or support).
- Adnexa/parametria (for example, masses, tenderness, or organomegaly or nodularity).
- Anus and perineum.

Medicare Part B pays for a screening pelvic examination if it is performed by a doctor of medicine or osteopathy, a certified nurse midwife, a physician assistant, a nurse practitioner, or a clinical nurse specialist who is authorized under state law to perform the examination.

The screening pelvic examination does not have to be ordered by a physician or practitioner.

HCPCS Coding

G0101 Cervical or vaginal cancer screening, pelvic and clinical breast examination

Screening and Preventive Services

Reimbursement

Screening pelvic exams are paid based on the Medicare Physician Fee Schedule. Coinsurance applies; however, Part B deductible does not apply.

Low-Risk Patient

Medicare covers screening pelvic examinations for women who are asymptomatic once every two years.

Report the following ICD-9-CM codes:

V762 Cervix (routine cervical Papanicolaou smear)

V7647 Special screening for malignant neoplasm, vagina

V7649 Special screening for malignant neoplasm, other sites

Note: Providers use this diagnosis for women without a cervix.

Effective July 1, 2005

V72.31 Routine gynecological examination

Note: Only use this diagnosis when the provider performs a full gynecological examination.

Patients at High Risk

Payment may be made for a screening pelvic exam performed once every 12 months if:

- There is evidence that the woman is at high risk (on the basis of her medical history and other findings) of developing cervical or vaginal cancer.

Cervical Cancer High-Risk Factors

- Early onset of sexual activity (under 16 years of age).
- Multiple sexual partners (five or more in a lifetime).
- History of a sexually transmitted disease (including HIV infection).
- Fewer than three negative Pap smears within the previous seven years.

Vaginal Cancer High-Risk Factors

- DES (Diethylstilbestrol) – Exposed daughters of women who took DES during pregnancy.
- The woman is of childbearing age and has had such an examination that indicated the presence of cervical or vaginal cancer or other abnormality during any of the preceding three years. The term “woman of childbearing age” means a woman who is premenopausal and has been determined by a physician or qualified practitioner to be of childbearing age based on her medical history or

other findings.

Report ICD-9-CM code V1589, other specified personal history presenting hazards to health.

Evaluation and Management Services

The same physician may report a covered Evaluation and Management (E/M) visit and code G0101 for the same date of service if the E/M visit is for a separately identifiable service. In this case, the 25 modifier must be reported with the E/M service, and the medical records must clearly document the E/M service reported.

Screening Pap Smears

Screening Pap smears are covered when ordered and collected by a doctor of medicine or osteopathy, or other authorized practitioner (e.g., a certified nurse midwife, physician assistant, nurse practitioner or clinical nurse specialist who is authorized under state law to perform the examination).

Low-Risk Patients

Payment may be made for a screening Pap smear performed on an asymptomatic woman once every 24 months.

For services provided on or after October 1, 2003, use the following diagnosis codes for a low-risk patient:

V762 Cervix (routine cervical Papanicolaou smear)

V7647 Special screening for malignant neoplasm, vagina

V7649 Special screening for malignant neoplasm, other sites

Note: Providers use this diagnosis for women without a cervix.

Effective July 1, 2005

V72.31 Routine gynecological examination

Note: Only use this diagnosis when the provider performs a full gynecological examination.

Frequency for High-Risk Patients

Payment may be made for a screening Pap smear performed once every 12 months if:

- There is evidence that the woman is at high risk (on the basis of her medical history or other findings) of developing cervical or vaginal cancer. Use ICD-9-CM code V1589, other specified personal history presenting hazards to health.

Screening and Preventive Services

Cervical Cancer High-Risk Factors

- Early onset of sexual activity (under 16 years of age).
- Multiple sexual partners (five or more in a lifetime).
- History of a sexually transmitted disease (including HIV infection).
- Fewer than three negative Pap smears within the previous seven years.

Vaginal Cancer High-Risk Factors

- DES (diethylstilbestrol) – exposed daughters of women who took DES during pregnancy.
- The woman is of childbearing age and has had such an examination that indicated the presence of cervical or vaginal cancer or other abnormality during any of the preceding two years. The term “woman of childbearing age” means a woman who is premenopausal and has been determined by a physician or qualified practitioner to be of childbearing age based on her medical history or other findings.

Obtaining/Collecting Screening Pap Smear

Effective July 1, 2005, Medicare established a separate edit for HCPCS code Q0091 to prevent incorrectly paying for claims submitted outside of the frequency for screening Pap smears.

In instances where unsatisfactory screening Pap smear specimens have been collected and sent to the clinical laboratory and the clinical laboratory is unable to interpret the test results, another specimen is needed. Effective July 1, 2005, physicians should use HCPCS code Q0091 with modifier 76 when rebilling.

Effective for services rendered on or after July 1, 2005, when physicians must perform a screening Pap smear that they know Medicare will not cover because the low-risk beneficiary has already received a covered screening Pap smear in the past two years, they can bill Q0091. The claim will be denied appropriately as being not reasonable and necessary.

HCPCS Coding

Services Paid Under the Physician Fee Schedule

These services are paid at 80 percent of the approved amount based on the physician’s fee schedule amount for the service or the submitted charge whichever is lower. Coinsurance does apply. The Medicare Part B deductible does not apply.

Q0091 Screening Pap smear, obtaining, preparing and conveyance of cervical or vaginal smear to laboratory

P3001 Screening Papanicolaou smear, cervical or vaginal, up to three smears requiring interpretation by a physician

Screening and Preventive Services

G0124 Screening cytopathology smears, cervical or vaginal (any reporting system), collected in preservation fluid, automated thin layer preparation, requiring interpretation by a physician

G0141 Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician

Services Paid Under the Clinical Lab Fee Schedule

Services paid under the clinical lab fee schedule are paid at 100 percent of the allowed amount. Coinsurance and deductible do not apply. All clinical lab codes require the ordering physician's name and National Provider Identifier (NPI) number in Items 17 and 17b as well as the Clinical Laboratory Improvement Amendment (CLIA) number in Item 23 of the CMS-1500 claim form (or electronic equivalent).

P3000 Screening Papanicolaou smear, cervical or vaginal, up to three smears by a technician under the physician supervision

G0123 Screening cytopathology, cervical or vaginal (any reporting system), collected in preservation fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision

G0143 Screening cytopathology smears, cervical or vaginal, (any reporting system), collected in preservative fluid, automated thin layer preparation with manual rescreening by cytotechnologist under physician supervision

G0144 Screening cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation, with manual screening and computer-assisted rescreening by cytotechnologist under physician supervision

G0145 Screening cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer

G0147 Screening cytopathology smears, cervical or vaginal; performed by automated system under physician supervision

G0148 Screening cytopathology smears, cervical or vaginal; performed by automated system with a manual rescreening

Billing Requirements

The same physician may report a covered E/M visit and code(s) Q0091 and/or G0101 for the same date of service if the E/M visit is for a separately identifiable service. The 25 modifier must be reported with the E/M service, and the medical records must clearly document the E/M service reported.

PROSTATE CANCER SCREENING

Medicare will cover prostate cancer screening tests/procedures for the early detection of prostate cancer. Coverage of prostate cancer screening tests includes the following procedures furnished to an individual for the early detection of prostate cancer:

- Screening digital rectal examination.
- Screening prostate specific antigen blood test.

HCPCS Coding

G0102 Screening digital rectal examination

G0103 Screening Prostate Specific Antigen (PSA) blood test

Coverage

The screening digital rectal examination and the screening PSA blood test are covered once every 12 months when performed on a male beneficiary age 50 or older. Use ICD-9-CM code V7644, special screening for malignant neoplasm, prostate.

The screening PSA blood test must be ordered by one of the following who is authorized under state law to perform the examination, is fully knowledgeable about the beneficiary, and is responsible for explaining the results of the examination to the beneficiary: A physician (doctor of medicine or osteopathy), qualified physician assistant, qualified nurse practitioner, qualified clinical nurse specialist or qualified nurse midwife.

Claims submitted for code G0103 require the UPIN/National Provider Identifier (NPI) number of the ordering physician as well as the Clinical Laboratory Improvement Amendment (CLIA) number of the performing provider.

Code G0102 in Conjunction With a Covered Evaluation and Management (E/M) Visit

Billing and payment for a Digital Rectal Examination (DRE) (G0102) is bundled into the payment for a covered E/M service (CPT codes 99201–99456 and 99499) when the two services are furnished to a patient on the same day. If the DRE is the only service or is provided as part of an otherwise non-covered service, HCPCS code G0102 would be payable separately if all other coverage requirements are met.

Advance Beneficiary Notice of Noncoverage (ABN)

An ABN should be delivered to the patient notifying him of Medicare’s frequency limitations for the prostate cancer screening services. Refer to the ABN section.

IMMUNIZATIONS/VACCINATIONS

Immunizations are not covered unless the medication is directly related to the treatment of an injury or there is direct exposure to a disease or condition. Preventive immunizations are specifically not covered with the exception of influenza, pneumococcal and hepatitis B vaccines.

No Legal Obligation to Pay

Non-governmental entities that provide immunizations free of charge to all patients, regardless of their ability to pay, must provide the immunizations free of charge to Medicare beneficiaries and may not bill Medicare. For example, Medicare may not pay for flu vaccinations administered to Medicare beneficiaries if a physician provides free vaccinations to all non-Medicare patients or where an employer offers free vaccinations to its employees. Physicians also may not charge Medicare beneficiaries more for a vaccine than they would charge non-Medicare patients. (See Section 1128(b)(6)(A) of the Act.)

Non-governmental entities that do not charge patients who are unable to pay or reduce their charges for patients of limited means, yet expect to be paid if the patient has health insurance coverage for the services provided, may bill Medicare and expect payment.

Governmental entities such as Public Health Clinics (PHCs) may bill Medicare for pneumococcal, hepatitis B and influenza vaccines administered to Medicare beneficiaries when services are rendered free of charge to non-Medicare beneficiaries.

Influenza Virus Vaccine

The Medicare program covers the influenza virus vaccine and its administration. Generally, only one influenza virus vaccination is medically necessary per year. Medicare defines two flu seasons per year (September through December and January through March). It would be possible for a Medicare beneficiary to receive a flu vaccination once per flu season if medically necessary. For coverage purposes, Medicare does not require that a doctor of medicine or osteopathy order the vaccine; therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

Payment

- Paid at 100 percent of the Medicare-allowed amount.
- Part B deductible and coinsurance do not apply.
- Mandatory assignment is required.

Codes

90655© Flu vaccine no preserv 6-35m

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90656© Flu vaccine no preserv 3 > >

90657© Flu vaccine, 6-35 mo, im

90658© Flu vaccine, 3 yrs, im

90660© Influenza virus vaccine, live, for intranasal use

Diagnosis Code

V0481 Influenza

Note: Influenza vaccine claims with no diagnosis code will be rejected as unprocessable.

Effective October 1, 2006

Providers may report diagnosis code V06.6 on claims for PPV and/or influenza virus vaccines when the purpose of the visit was to receive both vaccines.

Continue to report diagnosis code V04.81 on claims that contain only influenza virus vaccine and its administration.

Administration of the Influenza Virus Vaccine

G0008 Administration of influenza virus vaccine

The administration of the influenza virus vaccine may be filed as non-assigned. Limiting charge does not apply.

Code G0008 may be reported when billing for the administration of code 90660.

Reimbursement

Allowed amounts for influenza virus vaccines are based on 95 percent of the Average Wholesale Price (AWP).

The administration (G0008) is reimbursed at the same rate as HCPCS code 90471.

Claims Filing

Providers who do not qualify to use the simplified billing process must complete a standard CMS-1500 claim form or bill electronically for each Medicare beneficiary receiving the influenza vaccine. Refer to the section “Simplified Billing for Influenza and Pneumonia Vaccinations” for additional information about qualifying for the simplified billing process.

Screening and Preventive Services

Influenza A (H1N1) Virus Vaccine

Effective September 1, 2009, the H1N1 virus vaccine will be provided to beneficiaries with Medicare Part B coverage as an additional preventive immunization service. Medicare will pay for the administration for the H1N1 vaccine.

If the H1N1 vaccine is made available to providers free of charge, Medicare will not pay for the H1N1 vaccine itself. Therefore, the HCPCS code for the vaccine need not be included on the bill/claim submitted for payment of the administration of the vaccine.

Coverage and Billing for H1N1 Vaccine and Administration

Coding for vaccine:

G9142 – Influenza A (H1N1) vaccine, any route of administration

Administration:

- *G9141 – Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family).*
- *Administration may be billed and paid multiple times if the H1N1 vaccine requires multiple doses. Medicare claims processing systems will be programmed to pay for both a single dose of the seasonal flu vaccine and its administration and for one or more administrations of H1N1 vaccine.*
- *Administration will be covered and paid at the same rate as G0008 (flu vaccine administration).*

Diagnosis code:

V04.81

Pneumococcal Pneumonia Vaccine

Medicare pays for Pneumococcal Pneumonia Vaccine (PPV) and its administration. Typically, this vaccine is administered once in a lifetime except for persons at highest risk.

Medicare does not require PPV to be ordered by a doctor of medicine or osteopathy. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

An initial vaccine may be administered only to persons at high risk of pneumococcal disease.

Payment

- Paid at 100 percent of the Medicare-allowed amount.
- Part B deductible and coinsurance do not apply.

Screening and Preventive Services

- Mandatory assignment is required.

High-Risk Factors

Beneficiaries considered at high risk are:

- Persons 65 years of age or older.
- Immunocompetent adults who are at increased risk of pneumococcal disease or its complications because of chronic illness.

Code

90669© Pneumococcal conjugate vaccine, polyvalent, when administered to children younger than 5 years, for intramuscular use

90732© Pneumococcal vaccine

Diagnosis Code

V0382 PPV

Effective October 1, 2006

Providers may report diagnosis code V06.6 on claims for PPV and/or influenza virus vaccines when the purpose of the visit was to receive both vaccines.

Continue to report diagnosis code V03.82 on claims that contain only PPV vaccine and its administration.

Administration

The administration of the pneumococcal vaccine may be filed as non-assigned. Limiting charge does not apply.

G0009 Administration of pneumococcal vaccine

Reimbursement

The allowed amount for the pneumococcal vaccine is based on 95 percent of the AWP.

The administration (G0009) is reimbursed at the same rate as HCPCS code 90471.

Frequency and Risk

Provided that at least five years have passed since receipt of a previous dose of PPV, re-vaccination may be administered only to persons at highest risk of serious pneumococcal infection and those likely to have a rapid decline in pneumococcal antibody levels. This group includes persons with:

- Functional or anatomic asplenia (e.g., sickle cell disease, splenectomy).

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- HIV infection.
- Leukemia.
- Lymphoma.
- Hodgkin's disease.
- Multiple myeloma.
- Generalized malignancy.
- Chronic renal failure.
- Nephrotic syndrome.
  Or,
- Other conditions associated with immunosuppression, such as organ or bone marrow transplantation, and those receiving immunosuppressive chemotherapy.

Routine re-vaccinations of people age 65 or older who are not at highest risk are not appropriate.

Those administering the vaccine should not require the patient to present an immunization record prior to administering the PPV, nor should they feel compelled to review the patient's complete medical record if it is not available. Instead, provided that the patient is competent, it is acceptable to rely on the patient's verbal history to determine prior vaccination status. If the patient is uncertain about his vaccination history in the past five years, the vaccine should be given. However, if the patient is certain he was vaccinated in the last five years, the vaccine should not be given. If the patient is certain that the vaccine was given and that more than five years have passed since receipt of the previous dose, re-vaccination is not appropriate unless the patient is at highest risk.

Claims Filing

Providers who do not qualify to use the simplified billing process must complete a standard CMS-1500 claim form or bill electronically for each Medicare beneficiary receiving the PPV. Refer to the section, "Simplified Billing for Influenza and Pneumonia Vaccinations," for additional information about qualifying for the simplified billing process.

Simplified Billing for Influenza and Pneumonia Vaccinations

The Social Security Act requires that providers bill Medicare for covered Part B services rendered to eligible beneficiaries. Public health clinics that have not provided Medicare-covered services to their clients in the past must bill Medicare for the influenza virus vaccine and/or PPV and its administration when provided to Medicare beneficiaries.

Screening and Preventive Services

To alleviate concerns expressed by some public health clinics that have never provided Medicare covered services, CMS initiated a simplified process for certain entities that administer the flu shot and/or PPV to file claims for multiple beneficiaries on a roster bill.

Generally, providers will qualify to use the simplified process if they:

- Bill Medicare for flu and/or pneumonia vaccines for multiple beneficiaries.
- Agree to accept assignment for influenza and/or pneumonia vaccination claims.

Electronic Submission

For providers who qualify for roster billing, Medicare offers free software that will enable them to submit these claims electronically. The I/PRB software is easy to use and will allow providers to take advantage of the 14-day payment floor. Providers qualifying as a roster biller can contact the Technology Support Center at (866) 749-4302 for information regarding the hardware and software requirements, or visit the Web site at:

http://www.trailblazerhealth.com/Electronic%20Data%20Interchange/

Roster billing of vaccinations is an exception to the mandatory electronic Medicare claims provision of the Health Insurance Portability and Accountability Act (HIPAA). Therefore, providers who submit their influenza vaccine and/or pneumococcal vaccine claims using the simplified roster bill may continue to submit the roster bill via paper after October 16, 2003.

The "Roster Billing" job aid includes a sample CMS-1500 claim form, influenza vaccine roster form and a PPV roster form. Providers are only required to complete the blocks that are shaded on the CMS-1500 claim form. Use the record forms or the roster forms as a record of the beneficiary information for those receiving the influenza or pneumonia vaccine. For each beneficiary, include the name and health insurance claim number. Use these forms only to report the influenza or pneumonia vaccine. The job aid can be accessed at:

http://www.trailblazerhealth.com/Publications/Job%20Aid/CentralizedBillingPacketforPPVVaccines.pdf

Claims Filing Requirements

Send the paper simplified billing claims for the influenza virus vaccine to the following special post office box:

Influenza Special Claims
P.O. Box 660157
Dallas, TX 75266-0157

Screening and Preventive Services

Send the paper simplified billing claims for PPV to the following special post office box:

Pneumococcal Special Claims
P.O. Box 660157
Dallas, TX 75266-0157

Put one CMS-1500 claim form with each group of influenza vaccine or PPV record forms (up to 100) and group these together (e.g., rubber band, etc.). Put one CMS-1500 claim form with five influenza or PPV roster forms and group these together. A stamped "signature on file" is acceptable on a simplified claim to qualify as an actual signature, provided that the provider has a signed authorization on file to bill Medicare for services rendered.

Note: *The record* ***must*** *include the following information:*

- *Provider name and National Provider Identifier (NPI).*
- *Date of service.*
- *Patient's health insurance claim number.*
- *Patient's name.*
- *Patient's address.*
- *Patient's date of birth.*
- *Patient's sex.*

Hepatitis B Vaccination

The hepatitis B vaccine and its administration are available to Medicare beneficiaries who are at high or intermediate risk of contracting hepatitis B.

The vaccine may be administered upon the order of a doctor of medicine or osteopathy, or by home health agencies, skilled nursing facilities, End Stage Renal Disease (ESRD) facilities, hospital outpatient departments, and persons recognized under the incident to physicians' services provisions of law.

High-Risk Groups

- ESRD patients.
- Hemophiliacs who receive Factor VIII or IX concentrates.
- Clients of institutions for the mentally retarded.
- Persons who live in the same household as a Hepatitis B Virus (HBV) carrier.
- Homosexual men.
- Illicit injectable drug users.

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Intermediate Risk Groups

- Staff in institutions for the mentally retarded.
- Workers in health care professions who have frequent contact with blood or blood-derived body fluids during routine work.

Exception

Persons in either of the above listed intermediate and high-risk groups would not be considered at high or intermediate risk for contracting HBV if there is laboratory evidence positive for antibodies to hepatitis B.

Codes

G0010	Administration of hepatitis B vaccine
90740©	Hep b vacc, ill pat 3 dose im
90743©	Hep b vacc, adol, 2 dose, im
90744©	Hep b vacc ped/adol 3 dose im
90746©	Hep b vaccine, adult, im
90747©	Hep b vacc, ill pat, 4 dose im

Diagnosis Code

V053	Hepatitis B vaccine

Note: This diagnosis code must be submitted on the claim.

Claims Filing

The UPIN/NPI of the ordering physician must be entered in Item 17a/17b of the CMS-1500 claim form.

As a reminder, payment for any drug or biological covered under Medicare Part B may be made only on an assignment-related basis. Therefore, assignment must be accepted on your claim.

BONE MASS MEASUREMENT (BMM)

Refer to the “Bone Mass Measurement (BMM)” Local Coverage Determination (LCD) on the TrailBlazer Web site at:

http://www.trailblazerhealth.com/Tools/LCDs.aspx?DomainID=1

GLAUCOMA SCREENING

The Benefits Improvements and Protection Act (BIPA) of 2000, Section 102, provides annual coverage for glaucoma screening for beneficiaries in the following high-risk categories:

- Individuals with diabetes mellitus.
- Individuals with a family history of glaucoma.
- African-Americans age 50 and over.
  Or,
- Hispanic-Americans age 65 and over.

Medicare will pay for glaucoma screening examinations when they are furnished by or under the direct supervision of an ophthalmologist or optometrist who is legally authorized to perform the services under state law.

Screening for glaucoma is defined to include:

- A dilated eye examination with an intraocular pressure measurement.
- A direct ophthalmoscopy examination or a slit-lamp biomicroscopic examination.

Frequency

Payment may be made for a glaucoma screening examination that is performed on an eligible beneficiary once a year (11 full months must have passed between examinations).

Codes

G0117 Glaucoma screening for high-risk patients furnished by a physician

G0118 Glaucoma screening for high-risk patients furnished under the direct supervision of a physician

Covered For

V801 Special screening for neurological, eye and ear diseases, glaucoma

Reimbursement

Glaucoma screening is paid based on the Medicare Physician Fee Schedule (MPFS). Coinsurance and deductible do apply.

Glaucoma Screening Billed in Conjunction With Another Service

Glaucoma screening codes G0117 and G0118 have status code “T” on the Medicare Physician Fee Schedule Database. This means they are not covered if they are

performed on the same day as another service that is payable under the MPFS.

Example: If G0117 is billed on the same day as an eye exam code (e.g., 92012), it will be denied as not separately payable.

Advance Beneficiary Notice of Noncoverage (ABN)

An ABN should be delivered to notify the patient of Medicare's frequency limitation on the glaucoma screening. Also, if the above codes are billed with a diagnosis code other than V801, an ABN should be delivered indicating the service is not covered for the diagnosis on the claim. Refer to the ABN section for additional information.

REVISION HISTORY

Date	Section	Description
November 2005	General Information	• Updated Routine Diagnosis Codes listing – *Medicare Part B Newsletter* No. 05-050, March 1, 2005. • Determining a Medicare Beneficiary's Eligibility for Preventive Services – Change Request (CR) 4011, Transmittal 175.
	Initial Preventive Physical Exam/Welcome to Medicare Exam	Simplified wording and added definitions of physician and Qualified Non-Physician Practitioners for the purposes of this benefit – CR 3638, Transmittal 417.
	Diabetes Screening Tests	• Removed repetitive information. • Added definitions for Diabetes and Pre- Diabetes – CR 3677, Transmittal 457.
	Mammography	• Removed effective date for diagnosis code V76.11 – CR 3562, Transmittal 705. • Updated claim form example to reflect current dates. • Removed reference to obsolete procedure code. • Added new information from Local Coverage Determination (LCD) for diagnostic mammograms.
	Screening Pelvic and Clinical Breast Examinations/Screening Pap Smears	• Updated information for low-risk patient diagnosis code reporting. • Added new information on code Q0091 Obtaining/Collecting Screening Pap Smear. CR 3659, Transmittal 440.
	Immunizations	• Updated reimbursement information for influenza administration and PPV and PPV administration – CR 4109, Transmittal 185. • Removed outdated information about other immunization services.

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Date	Section	Description
	Bone Mass Measurement (BMM)	Removed 76077 from policy. This code was removed from the LCD – *Medicare Part B Newsletter* No. 05-053, June 1, 2005.
	Medical Nutrition Therapy	• Updated definition of diabetes and some wording per CR 3955. • Updated diagnosis codes.
June 2006	Bone Mass Measurements	Removed LCD information.
	Mammograms	Removed information about diagnostic mammograms and added reference to the LCD.
	Immunizations/Vaccinations	• Added CPT code 90660 to list of codes for influenza virus vaccine. • Added diagnosis code V06.6 for influenza virus vaccine and PPV when purpose of the visit is to receive both vaccines (CR 5037).
	Glaucoma Screening	Added expanded coverage for glaucoma screenings due to CR 4365.
January 2007	General Information	AAA added to list of exceptions.
	Ultrasound Screening for AAA	Section added. CR 5235.
	Colorectal Cancer Screening	Updated information about Fecal Occult Blood Tests (FOBTs) (report code 82270 instead of G0107 for dates of service on or after January 1, 2007) from CR 5292.
	Colorectal Cancer Screening	Updated information about deductible for Colorectal Cancer Screening tests. Deductible does not apply to codes G0104, G0105, G0106, G0120 or G0121 for dates of service on or after January 1, 2007. CR 5127.
	Screening Mammograms	• Removed claim form example. • Updated with 2007 CPT codes. CR 5327.
	Screening Pelvic Exams and Pap Smears	Removed claim form examples.

Screening and Preventive Services

Date	Section	Description
	Immunizations/Vaccinations	Condensed information concerning Simplified Billing and referenced yearly special bulletin for pre-printed claims and forms.
	Diabetes Self-Management Training	Section deleted. A separate manual exists.
	Medical Nutrition Therapy	Section deleted. A separate manual exists.
May 2007	General Information	Added medical necessity definition from the Social Security Act.
	Colorectal Cancer Screening	• Added clarification about deductible applying to diagnostic colorectal service codes per CR 5541. • Added Ambulatory Surgery Center (ASC) information concerning coinsurance per CR 5387.
October 2007	Diabetes Screening Tests	Added information about venipuncture.
	Cardiovascular Screening Blood Tests	Added information about venipuncture.
	Applicable Sections	Added references to National Provider Identifier (NPI) number.
January 2008	Screening Mammograms	Codes 76082, 76083, 76090, 76091 and 76092 were replaced with the current procedure codes 77051, 77052, 77055, 77056 and 77057.
March 2008	Immunizations/Vaccinations	Added codes 90660 and 90669.
	Screening Pelvic and Clinical Breast Examinations	Clarified elements of a screening pelvic and clinical breast exam.
July 2008	Immunizations/Vaccinations	Rearranged the codes – no changes to information.
	Screening Pelvic and Breast Exam	Per CR 6085, updated the required elements.
	Screening Mammography	Per CR 6023, added the note about the self-referred service.
January 2009	Initial Preventive Physical Exam/Welcome to Medicare Exam	Per CR 6223, added changes in coverage for dates of service on or after January 1, 2009.

Screening and Preventive Services

Date	Section	Description
	Screening Mammography	Per CR 6023, added information for mammograms purchased out of jurisdiction.
October 2009	*Immunizations*	• *Removed information regarding Special Flu Bulletin and preprinted claim form.* • *Added requirements for the immunization record.* • *Added information regarding H1N1 per MLN Matters SE 0920.*
	Diagnostic Mammograms	*Removed code G0203 and replaced with G0206.*