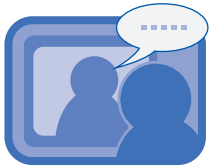
PREVENTIVE SERVICES CHART

ICN 006559 October 2015

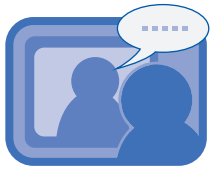
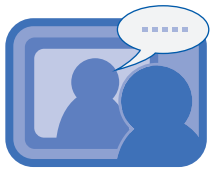
This educational tool provides the following information on Medicare preventive services: Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes; coverage requirements; frequency requirements; and beneficiary liability for each Medicare preventive service.

Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare). For additional guidance on the use of diagnoses codes, go to Pub. 100-04 Claims Processing Manual, Chapter 18.

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



Medicare Preventive Services

Service	HCPCS/CPT Codes	ICD-10-CM Codes	Who Is Covered	Frequency	Beneficiary Pays
Alcohol Misuse Screening and Counseling Also referred to as the Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse 	**G0442** – Annual alcohol misuse screening, 15 minutes **G0443** – Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	See https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html for individual Change Requests (CRs) and coding translations for ICD-10	All Medicare beneficiaries are eligible for alcohol screening. Medicare beneficiaries who screen positive (those who misuse alcohol but whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence) are eligible for counseling if: • They are competent and alert at the time that counseling is provided; **and** • Counseling is furnished by qualified primary care physicians or other primary care practitioners in a primary care setting.	• Annually for G0442; **or** • For those who screen positive, 4 times per year for G0443	• Copayment/ coinsurance waived • Deductible waived
Annual Wellness Visit (AWV) 	**G0438** – Initial visit **G0439** – Subsequent visit	See https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html for individual Change Requests (CRs) and coding translations for ICD-10	All Medicare beneficiaries: • Who are not within 12 months after the effective date of their first Medicare Part B coverage period; **and** • Who have not received an Initial Preventive Physical Examination (IPPE) or AWV within the past 12 months	• Once in a lifetime for G0438 (first AWV); **or** • Annually for G0439 (subsequent AWV)	• Copayment/ coinsurance waived • Deductible waived

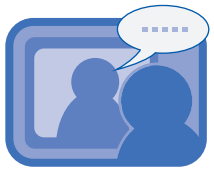
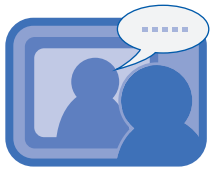
Medicare Preventive Services (cont.)

Service	HCPCS/CPT Codes	ICD-10-CM Codes	Who Is Covered	Frequency	Beneficiary Pays
Bone Mass Measurements	**76977** – Ultrasound bone density measurement and interpretation, peripheral site(s), any method **77078** – Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine) **77080** – Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine) **77081** – DXA, bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel) **G0130** – Single energy X-ray absorptiometry (SEXA) bone density study, 1 or more sites, appendicular skeleton (peripheral) (eg, radius, wrist, heel)	See https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html for individual Change Requests (CRs) and coding translations for ICD-10	Certain Medicare beneficiaries who fall into at least one of the following categories: • Women determined by their physician or qualified non-physician practitioner (NPP) to be estrogen deficient and at clinical risk for osteoporosis; • Individuals with vertebral abnormalities; • Individuals getting (or expecting to get) glucocorticoid therapy for more than 3 months; • Individuals with primary hyperparathyroidism; **or** • Individuals being monitored to assess response to U.S. Food and Drug Administration (FDA)-approved osteoporosis drug therapy	• Every 2 years; **or** • More frequently if medically necessary	• Copayment/ coinsurance waived • Deductible waived
Cardiovascular Disease Screening Tests	**80061** – Lipid panel, this panel must include the following: **82465** – Cholesterol, serum, total **83718** – Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) **84478** – Triglycerides	Z13.6	All Medicare beneficiaries without apparent signs or symptoms of cardiovascular disease	Once every 5 years	• Copayment/ coinsurance waived • Deductible waived

Medicare Preventive Services (cont.)

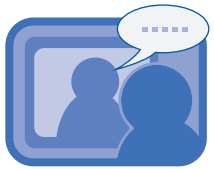
Service	HCPCS/CPT Codes	ICD-10-CM Codes	Who Is Covered	Frequency	Beneficiary Pays
Colorectal Cancer Screening Effective January 1, 2016, use CPT code 81528* when billing for the Cologuard test (note that your MAC will continue to accept HCPCS code G0464 for claims with dates of service prior to December 31, 2015). * Only laboratories that are authorized by the manufacturer to perform the Cologuard™ test may bill for this test.	**00810** – Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum **81528** – Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result **82270** – Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided 3 cards or single triple card for consecutive collection) **G0104** – Flexible Sigmoidoscopy **G0105** – Colonoscopy (high risk) **G0106** – Barium Enema (alternative to G0104) **G0120** – Barium Enema (alternative to G0105) **G0121** – Colonoscopy (not high risk) **G0328** – Fecal Occult Blood Test (FOBT), immunoassay, 1-3 simultaneous **G0464** – Colorectal cancer screening; stool-based DNA and fecal occult hemoglobin (e.g., KRAS, NDRG4 and BMP3)	See https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html for individual Change Requests (CRs) and coding translations for ICD-10 For Cologuard™ Multitarget Stool DNA (sDNA) Test, use Z12.11 and Z12.12	**For colorectal cancer screening using Cologuard™—a Multitarget Stool DNA (sDNA) Test:** All Medicare beneficiaries: • Aged 50 to 85 years; • Asymptomatic; **and** • At average risk of developing colorectal cancer **For screening colonoscopies, FOBTs, flexible sigmoidoscopies, and barium enemas:** All Medicare beneficiaries: • Aged 50 and older who are at normal risk of developing colorectal cancer; **or** • At high risk of developing colorectal cancer "High risk for developing colorectal cancer" is defined in the Code of Federal Regulations (CFR) at 42 CFR 410.37(a)(3). **NOTE:** For coverage of screening colonoscopies, there is no age limitation.	**Normal Risk:** • Cologuard™ Multitarget Stool DNA (sDNA) Test: once every 3 years; • Screening FOBT: every year; • Screening flexible sigmoidoscopy: once every 4 years (unless a screening colonoscopy has been performed and then Medicare may cover a screening flexible sigmoidoscopy only after at least 119 months); • Screening colonoscopy: every 10 years (unless a screening flexible sigmoidoscopy has been performed and then Medicare may cover a screening colonoscopy only after 47 months); **and** • Screening barium enema (as an alternative to covered screening flexible sigmoidoscopy) **High Risk:** • Screening FOBT: every year; • Screening flexible sigmoidoscopy: once every 4 years; • Screening colonoscopy: every 2 years (unless a screening flexible sigmoidoscopy has been performed and then Medicare may cover a screening colonoscopy only after at least 47 months); **and** • Screening barium enema (as an alternative to covered screening flexible sigmoidoscopy or colonoscopy)	**81528, 82270, G0104, G0105, G0121, and G0328:** • Copayment/ coinsurance waived • Deductible waived Append modifier -33 to the anesthesia CPT code 00810 when you furnish a separately payable anesthesia service in conjunction with a screening colonoscopy (G0105 and G0121) to waive beneficiary copayment/coinsurance and deductible. **G0106 and G0120:** • Copayment/ coinsurance applies • Deductible waived No deductible for all surgical procedures (CPT code range of 10000 to 69999) furnished on the same date and in the same encounter as a screening colonoscopy, flexible sigmoidoscopy, or barium enema initiated as colorectal cancer screening services. Append modifier -PT to CPT code in the surgical range of 10000 to 69999 in this scenario.

Medicare Preventive Services (cont.)

Service	HCPCS/CPT Codes	ICD-10-CM Codes	Who Is Covered	Frequency	Beneficiary Pays
Counseling to Prevent Tobacco Use (for Asymptomatic Beneficiaries) 	**G0436** – Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes **G0437** – Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes	F17.200, F17.201, F17.210, F17.211, F17.220, F17.221, F17.290, F17.291, and Z87.891	Outpatient and hospitalized Medicare beneficiaries: • Who use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease; • Who are competent and alert at the time of counseling; **and** • Who get counseling furnished by a qualified physician or other Medicare-recognized practitioner	Two cessation attempts per year. Each attempt may include a maximum of 4 intermediate or intensive sessions, with the total annual benefit covering up to 8 sessions per year	• Copayment/ coinsurance waived • Deductible waived
Depression Screening 	**G0444** – Annual depression screening, 15 minutes	See https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html for individual Change Requests (CRs) and coding translations for ICD-10	All Medicare beneficiaries Must be furnished in a primary care setting that has staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up	Annually	• Copayment/ coinsurance waived • Deductible waived
Diabetes Screening*	**82947** – Glucose; quantitative, blood (except reagent strip) **82950** – Glucose; post glucose dose (includes glucose) **82951** – Glucose; tolerance test (GTT), 3 specimens (includes glucose)	Z13.1	Medicare beneficiaries with certain risk factors for diabetes or diagnosed with pre-diabetes **NOTE:** Beneficiaries previously diagnosed with diabetes are **not** eligible for this benefit	• Two screening tests per year for beneficiaries diagnosed with pre-diabetes; **or** • One screening per year if previously tested but not diagnosed with pre-diabetes or if never tested	• Copayment/ coinsurance waived • Deductible waived

* Medicare will only pay claims for DME if the ordering physician and DME supplier are actively enrolled in Medicare on the date of service. Physicians and suppliers have to meet strict standards to enroll and stay enrolled in Medicare. If you are not enrolled on the date the prescription is filled or re-filled, Medicare will not pay the submitted claims. It is also important to tell the Medicare beneficiary if you are not participating in Medicare before you order DME. If you do not have an active record, please see the following fact sheet containing information on how to enroll, revalidate your enrollment, and/or make a change: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243432.html on the CMS website.

Medicare Preventive Services (cont.)

Service	HCPCS/CPT Codes	ICD-10-CM Codes	Who Is Covered	Frequency	Beneficiary Pays
Diabetes Self-Management Training (DSMT) 	**G0108** – DSMT, individual, per 30 minutes **G0109** – DSMT, group (2 or more), per 30 minutes	See https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html for individual Change Requests (CRs) and coding translations for ICD-10	Certain Medicare beneficiaries who: • Are diagnosed with diabetes; **and** • Who receive an order for DSMT from the physician or qualified non-physician practitioner (NPP) treating the beneficiary's diabetes	• Initial year: Up to 10 hours of initial training within a continuous 12-month period; **or** • Subsequent years: Up to 2 hours of follow-up training each year after the initial year	• Copayment/ coinsurance applies • Deductible applies
Glaucoma Screening	**G0117** – By an optometrist or ophthalmologist **G0118** – Under the direct supervision of an optometrist or ophthalmologist	Z13.5	Medicare beneficiaries who: • Have diabetes mellitus; • Have a family history of glaucoma; • Are African-Americans aged 50 and older; **or** • Are Hispanic-Americans aged 65 and older	Annually for covered beneficiaries	• Copayment/ coinsurance applies • Deductible applies

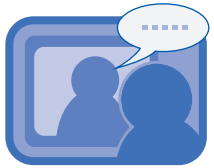
Medicare Preventive Services (cont.)

Service	HCPCS/CPT Codes	ICD-10-CM Codes	Who Is Covered	Frequency	Beneficiary Pays
Hepatitis B Virus (HBV) Vaccine and Administration For more information, refer to https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243321.html on the Centers for Medicare & Medicaid Services (CMS) website.	**90739** – Hepatitis B vaccine, adult dosage (2 dose schedule), for intramuscular use **90740** – Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use **90743** – Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use **90744** – Hepatitis B vaccine, pediatric/ adolescent dosage (3 dose schedule), for intramuscular use **90746** – Hepatitis B vaccine, adult dosage (3 dose schedule), for intramuscular use **90747** – Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use **G0010** – Administration	Z23	Certain Medicare beneficiaries at intermediate or high risk for contracting hepatitis B **NOTE:** Medicare beneficiaries who are currently positive for antibodies for hepatitis B are **not** eligible for this benefit	Scheduled dosages required	• Copayment/ coinsurance waived • Deductible waived
Hepatitis C Virus (HCV) Screening New Service! Medicare began covering HCV screening effective June 2, 2014.	**G0472** – Hepatitis C antibody screening, for individual at high risk and other covered indication(s)	Z72.89 and F19.20	Certain adult Medicare beneficiaries who: • Are at high risk for HCV infection; **or** • Were born between 1945 and 1965	• Annually only for high risk beneficiaries with continued illicit injection drug use since the prior negative screening test; **or** • Once in a lifetime for beneficiaries born between 1945 and 1965 who are not considered high risk	• Copayment/ coinsurance waived • Deductible waived

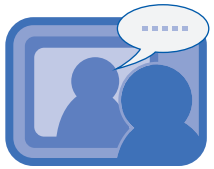
Medicare Preventive Services (cont.)

Service	HCPCS/CPT Codes	ICD-10-CM Codes	Who Is Covered	Frequency	Beneficiary Pays
Human Immunodeficiency Virus (HIV) Screening	**G0432** – Infectious agent antibody detection by enzyme immunoassay (EIA) technique **G0433** – Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique **G0435** – Infectious agent antibody detection by rapid antibody test	High risk – Z11.4 and Z72.89 Not high risk – Z11.4 Pregnant beneficiaries – Z11.4 and Z34.00, Z34.01, Z34.02, Z34.03, Z34.80, Z34.81, Z34.82, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93, O09.90, O09.91, O09.92, OR O09.93	Certain Medicare beneficiaries who are at increased risk for HIV infection, including anyone who asks for the test, or pregnant women **NOTE:** "Increased risk for HIV infection" is defined in the Medicare National Coverage Determinations Manual, Publication 100-03, Chapter 1, Section 210.7.	Annually for beneficiaries at increased risk, including anyone who asks for the test For beneficiaries who are pregnant, 3 times per pregnancy: • First, when a woman is diagnosed with pregnancy; • Second, during the third trimester; **and** • Third, at labor, if ordered by the woman's clinician	• Copayment/ coinsurance waived • Deductible waived
Influenza Virus Vaccine and Administration For more information, refer to https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243321.html on the Centers for Medicare & Medicaid Services (CMS) website.	**90630, 90653, 90654, 90655, 90656, 90657, 90660, 90661, 90662, 90672, 90673, 90685, 90686, 90687, 90688, Q2035, Q2036, Q2037, Q2038, Q2039** – Influenza Virus Vaccine **G0008** – Administration	Z23	All Medicare beneficiaries	Once per influenza season Medicare covers additional flu shots if medically necessary	• Copayment/ coinsurance waived • Deductible waived

Medicare Preventive Services (cont.)

Service	HCPCS/CPT Codes	ICD-10-CM Codes	Who Is Covered	Frequency	Beneficiary Pays
Initial Preventive Physical Examination (IPPE) Also known as the "Welcome to Medicare Preventive Visit"	**G0402** – IPPE **G0403** – EKG for IPPE **G0404** – EKG tracing for IPPE **G0405** – EKG interpret & report for IPPE	See https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html for individual Change Requests (CRs) and coding translations for ICD-10	All new Medicare beneficiaries who are within the first 12 months of their first Medicare Part B coverage period	Once in a lifetime Must furnish no later than 12 months after the effective date of the first Medicare Part B coverage period	**G0402:** • Copayment/ coinsurance waived • Deductible waived **G0403, G0404, and G0405:** • Copayment/ coinsurance applies • Deductible applies
Intensive Behavioral Therapy (IBT) for Cardiovascular Disease (CVD) Also known as a CVD risk reduction visit 	**G0446** – Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes	See https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html for individual Change Requests (CRs) and coding translations for ICD-10	All Medicare beneficiaries: • Who are competent and alert at the time counseling is provided; **and** • Whose counseling is furnished by a qualified primary care physician or other primary care practitioner and in a primary care setting	One CVD risk reduction visit annually	• Copayment/ coinsurance waived • Deductible waived

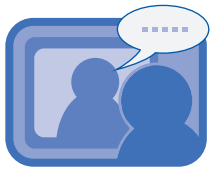
Medicare Preventive Services (cont.)

Service	HCPCS/CPT Codes	ICD-10-CM Codes	Who Is Covered	Frequency	Beneficiary Pays
Intensive Behavioral Therapy (IBT) for Obesity 	**G0447** – Face-to-face behavioral counseling for obesity, 15 minutes **G0473** – Face-to-face behavioral counseling for obesity, group (2–10), 30 minutes	Z68.30, Z68.31, Z68.32, Z68.33, Z68.34, Z68.35, Z68.36, Z68.37, Z68.38, Z68.39, Z68.41, Z68.42, Z68.43, Z68.44, or Z68.45	Medicare beneficiaries: • With obesity (Body Mass Index [BMI] ≥ 30 kilograms [kg] per meter squared); • Who are competent and alert at the time counseling is provided; **and** • Whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting	• First month: one visit every week; • Months 2 – 6: one visit every other week; **and** • Months 7 – 12: one visit every month if certain requirements are met At the 6-month visit, a reassessment of obesity and a determination of the amount of weight loss must be performed. To be eligible for additional face-to-face visits occurring once a month for an additional 6 months, beneficiaries must have lost at least 3kg. For beneficiaries who do not achieve a weight loss of at least 3 kg during the first 6 months, a reassessment of their readiness to change and BMI is appropriate after an additional 6-month period.	• Copayment/ coinsurance waived • Deductible waived

Medicare Preventive Services (cont.)

Service	HCPCS/CPT Codes	ICD-10-CM Codes	Who Is Covered	Frequency	Beneficiary Pays
Lung Cancer Screening Counseling and Annual Screening for Lung Cancer with Low Dose Computed Tomography	This product will be updated with more information as it becomes available.	Z87.891	Effective February 5, 2015, Medicare began covering lung cancer screening counseling and a shared decision making visit, and for appropriate beneficiaries, annual screening for lung cancer with low dose computed tomography (LDCT). For more information, refer to https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=274 on the Centers for Medicare & Medicaid Services (CMS) website. This product will be updated with more information as it becomes available.	This product will be updated with more information as it becomes available.	This product will be updated with more information as it becomes available.

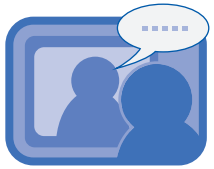
Medicare Preventive Services (cont.)

Service	HCPCS/CPT Codes	ICD-10-CM Codes	Who Is Covered	Frequency	Beneficiary Pays
Medical Nutrition Therapy (MNT) 	**97802** – MNT; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes **97803** – MNT; re-assessment and intervention, individual, face-to-face with the patient each 15 minutes **97804** – MNT; group (2 or more individual(s)), each 30 minutes **G0270** – MNT reassessment and subsequent intervention(s) for change in diagnosis, individual, each 15 minutes **G0271** – MNT reassessment and subsequent intervention(s) for change in diagnosis, group (2 or more), each 30 minutes	See https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html for individual Change Requests (CRs) and coding translations for ICD-10	Certain Medicare beneficiaries: • Who receive a referral from their treating physician; **and** • Are diagnosed with diabetes, renal disease, or who have received a kidney transplant within the last 3 years; **and** • A registered dietitian or nutrition professional must provide the services	• First year: 3 hours of one-on-one counseling; **or** • Subsequent years: 2 hours	• Copayment/ coinsurance waived • Deductible waived

Medicare Preventive Services (cont.)

Service	HCPCS/CPT Codes	ICD-10-CM Codes	Who Is Covered	Frequency	Beneficiary Pays
Pneumococcal Vaccine and Administration For more information, refer to https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243321.html on the Centers for Medicare & Medicaid Services (CMS) website.	**90670** – Pneumococcal Conjugate Vaccine **90732** – Pneumococcal polysaccharide vaccine **G0009** – Administration	Z23	All Medicare beneficiaries	• An initial pneumococcal vaccine to Medicare beneficiaries who never received the vaccine under Medicare Part B; **and** • A different, second pneumococcal vaccine 1 year after the first vaccine was administered	• Copayment/ coinsurance waived • Deductible waived
Prostate Cancer Screening	**G0102** – Digital Rectal Exam (DRE) **G0103** – Prostate Specific Antigen Test (PSA)	Z12.5	All male Medicare beneficiaries aged 50 and older (coverage begins the day after their 50th birthday)	Annually for covered beneficiaries	**G0102:** • Copayment/ coinsurance applies • Deductible applies **G0103:** • Copayment/ coinsurance waived • Deductible waived

Medicare Preventive Services (cont.)

Service	HCPCS/CPT Codes	ICD-10-CM Codes	Who Is Covered	Frequency	Beneficiary Pays
Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling (HIBC) to Prevent STIs 	**86631, 86632, 87110, 87270, 87320, 87490, 87491, 87810** – Chlamydia **87590, 87591, 87850** – Neisseria gonorrhoeae **87800** – Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique **86592** – Syphilis test, non-treponemal antibody; qualitative (eg, VDRL, RPR, ART) **86593** – Syphilis test, non-treponemal, quantitative **86780** – Treponema pallidum **87340, 87341** – Hepatitis B (hepatitis B surface antigen) **G0445** – Semiannual high intensity behavioral counseling to prevent STIs, individual, face-to-face, includes education skills training & guidance on how to change sexual behavior, 30 minutes	Z11.3, Z72.89, Z72.51, Z72.52, Z72.53, Z34.00, Z34.01, Z34.02, Z34.03, Z34.80, Z34.81, Z34.82, Z37.83, Z34.90, Z34.91, Z34.92, Z34.93, O09.90, O09.91, O09.92, and O09.93	Certain Medicare beneficiaries who are: • Sexually active adolescents and adults at increased risk for STIs; **and** • Referred for this service by a primary care provider and provided by a Medicare-eligible primary care provider in a primary care setting **NOTE:** More information on covered beneficiaries and a definition of "increased risk for STIs" can be found in the Medicare National Coverage Determinations Manual, Publication 100-03, Chapter 1, Section 210.10.	• One annual occurrence of screening for chlamydia, gonorrhea, and syphilis in women at increased risk who are not pregnant • One annual occurrence of screening for syphilis in men at increased risk • Up to two occurrences per pregnancy of screening for chlamydia and gonorrhea in pregnant women who are at increased risk for STIs and continued increased risk for the second screening • One occurrence per pregnancy of screening for syphilis in pregnant women; up to two additional occurrences in the third trimester and at delivery if at continued increased risk for STIs • One occurrence per pregnancy of screening for hepatitis B in pregnant women; one additional occurrence at delivery if at continued increased risk for STIs • Up to two 20-30 minute, face-to-face HIBC counseling sessions annually	• Copayment/ coinsurance waived • Deductible waived

Medicare Preventive Services (cont.)

Service	HCPCS/CPT Codes	ICD-10-CM Codes	Who Is Covered	Frequency	Beneficiary Pays
Screening Mammography Update: Medicare now requires an add-on code when you furnish a mammography using 3-D mammography in conjunction with a 2-D digital mammography, effective January 1, 2015.	**77052** – Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further review for interpretation; screening mammography (List separately in addition to code for primary procedure) **77057** – Screening mammography, bilateral (2-view film study of each breast) **77063** – Screening digital breast tomosynthesis; bilateral (List separately in addition to code for primary procedure) (Use this as an add-on code to G0202 when tomosynthesis is used in addition to 2-D mammography) **G0202** – Screening mammography, producing direct 2-D digital image, bilateral, all views **NOTE:** If billing a screening mammogram and a diagnostic mammogram on the same day, use modifier –GG to show a screening mammogram turned into a diagnostic mammogram.	Z12.31	All female Medicare beneficiaries aged 35 and older	• Aged 35 through 39: One baseline; **or** • Aged 40 and older: Annually	• Copayment/ coinsurance waived • Deductible waived

Medicare Preventive Services (cont.)

Service	HCPCS/CPT Codes	ICD-10-CM Codes	Who Is Covered	Frequency	Beneficiary Pays
Screening Pap Tests	**G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148** – Screening cytopathology, cervical or vaginal **P3000** – Screening Pap smear by technician under physician supervision **P3001** – Screening Pap smear requiring interpretation by physician **Q0091** – Screening Pap smear; obtaining, preparing and conveyance to lab	High risk – Z77.22, Z77.9, Z91.89, Z72.89, Z72.51, Z72.52, AND Z72.53 Low risk – Z01.411, Z01.419, Z12.4, Z12.72, Z12.79, and Z12.89	All female Medicare beneficiaries	• Annually if at high risk for developing cervical or vaginal cancer or childbearing age with abnormal Pap test within past 3 years; **or** • Every 2 years for women at normal risk	• Copayment/ coinsurance waived • Deductible waived
Screening Pelvic Examinations (includes a clinical breast examination)	**G0101** – Cervical or vaginal cancer screening; pelvic and clinical breast examination	High risk – Z77.22, Z77.9, Z91.89, Z72.89, Z72.51, Z72.52, AND Z72.53 Low risk – Z01.411, Z01.419, Z12.4, Z12.72, Z12.79, and Z12.89	All female Medicare beneficiaries	• Annually if at high risk for developing cervical or vaginal cancer, or childbearing age with abnormal Pap test within past 3 years; **or** • Every 2 years for women at normal risk	• Copayment/ coinsurance waived • Deductible waived
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)	**G0389** – Ultrasound exam for AAA screening	See https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html for individual Change Requests (CRs) and coding translations for ICD-10	Medicare beneficiaries: • With certain risk factors for AAA; **and** • Who receive a referral from their physician, physician assistant, nurse practitioner, or clinical nurse specialist	• Once in a lifetime	• Copayment/ coinsurance waived • Deductible waived

Frequently Asked Questions (FAQs)

May CMS add new preventive services as Medicare benefits?

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

What is a primary care setting?

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

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

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

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

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

Resources

Resource	Website
Preventive Services	CMS Web Page https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo FAQs https://questions.cms.gov/faq.php?id=5005&rtopic=1991 Preventive Services Medicare Learning Network® (MLN) Web Page https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html MLN Matters® Articles Related to Medicare-Covered Preventive Benefits https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNPrevArticles.pdf
Regulations	Code of Federal Regulations https://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR Internet-Only Manuals (IOMs) https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html
Related MLN Products	Guided Pathways (GPs) https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Guided_Pathways.html “Resources for Medicare Beneficiaries” Fact Sheet https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN905183.html “Telehealth Services” Fact Sheet https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243327.html