

How to Bill for the ‘Welcome to Medicare’ Visit

Since its introduction in 2005, the Welcome to Medicare visit has continued to confuse physicians with its requirements and limitations. Medicare will cover one initial preventive exam within the first six months of the effective date of a beneficiary's Part B coverage. The Welcome to Medicare visit is likely different from any other service that a physician would typically perform, so it is important to review the requirements for the service, which are:

- **Comprehensive medical and social history review.** This review should pay particular attention to modifiable disease risk factors. At a minimum, the medical history must include:
 - Past medical and surgical history, including illnesses, hospital stays, operations, allergies, injuries and treatments.
 - Current medications and supplements, including calcium and vitamins.
 - Family history, with a review of medical events in the patient's family, including diseases that may be hereditary or place the individual at risk.
 - The CMS defines social history to minimally include a history of alcohol, tobacco and illicit drug use; diet; and social and physical activities.
- **Limited Physical exam.** This must include measuring the patient's height, weight and blood pressure, as well as a visual acuity screen and other factors based on the patient's medical and social history.
- **Potential risk for depression review.** This review must include a patient's past experience with depression or other mood disorders, based on the use of an appropriate screening instrument, for patients without a current diagnosis.
- **Functional ability and level of safety assessment.** This should be based on the use of an appropriate screening instrument.
- **Electrocardiogram (ECG).** The exam covers performance and interpretation of an ECG.
- **Education, counseling and referral.** The exam covers these services as deemed appropriate based on review results and evaluation services.

- The exam also covers education, counseling and referral—including a written plan, such as a checklist—to help patients get appropriate screening and other preventive services covered separately under Medicare Part B.

The exam is billed using CMS-specific G codes. A physician will always bill G0344 for the exam itself and an additional code for the component of the ECG completed by the physician. CMS recognizes that not all physicians can perform an ECG in their office. Physicians can make alternative arrangements to make sure an ECG is performed, then include ECG results in the patient's record to complete—and bill for—the initial preventive exam.

The following are the HCPCS codes to be used:

- G0344: Initial, face-to-face visit service 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 exam. (You must report G0344 and G0366 if you furnish the complete initial exam.)
- G0367: Tracing only, without interpretation and report, performed as an initial exam component.
- G0368: Interpretation and report only, performed as an initial exam component.