

# A Comprehensive Guide to Medicare Covered Preventive Services: Coding, Billing, and Payment Information

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## **Introduction**

Federal law prohibits the Medicare Program from covering items and services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. However, Medicare covers preventive/screening services specifically authorized by the law. This guide contains information on Medicare covered screening services most relevant to internists: bone mass measurements, diabetes monitoring and supplies, medical nutrition therapy, colorectal cancer screening, prostate cancer screening, pap smear and pelvic examination (including clinical breast examination), and vaccinations.

This guide contains the following information for each covered screening service relevant to internists: Medicare's definition of the service (when applicable); coverage criteria; frequency; procedure code; required diagnosis code (when applicable); special payment rules (when applicable); 2003 payment rate (representing the national average unless otherwise noted); and beneficiary co-payment information. A list of helpful resources related to the Medicare covered services discussed in this guide appears as an addendum to this document.

This is not an all-inclusive list of Medicare-covered screening services. A complete list of Medicare covered screening services is available at:

<http://www.medicare.gov/publications/pubs/pdf/prevent.pdf>.

## **I. Bone Mass Measurements**

Medicare Definition of Covered Service: Medicare defines bone mass measurement as radiologic, radioscopy, or other procedure approved by the Food and Drug Administration (FDA); for the purpose of identifying bone mass, detecting bone loss, or interpreting bone quality. The documentation should include the physician's interpretation of the results of the bone mass measurement procedure.

Coverage Criteria: Beneficiaries who may be covered include:

- A woman who has been determined by a physician or qualified non-physician practitioner to be estrogen-deficient and at clinical risk for osteoporosis, based on her medical history and other findings;
- An individual with vertebral abnormalities as demonstrated by an x-ray to be indicative of osteoporosis, osteopenia, or vertebral fracture;
- An individual receiving (or expecting to receive) glucocorticoid (steroid) therapy equivalent to 7.5 mg of Prednisone, or greater; per day, for more than 3 months;
- An individual with primary hyperparathyroidism; and/or
- An individual being monitored to assess the response to or efficacy of an FDA-approved osteoporosis drug therapy.

Frequency: Once every two years. Medicare will cover bone mass measurements more frequently when medically necessary. Medicare cites monitoring long-term glucocorticoid (steroid) therapy of more than three months as an example of when more frequent bone mass measurements may be medically necessary.

Procedure Code: Select from the following Current Procedure Terminology (CPT) codes and/or Healthcare Financing Administration Common Procedure Coding System (HCPCS):

CPT 76070; Computed tomography, bone mineral density study, one or more sites, axial skeleton (e.g. hips, pelvis, spine).

CPT 76071; Computed tomography, bone mineral density study, one or more sites appendicular skeleton (peripheral) (e.g. radius, wrist, heel).

CPT 76075; Dual energy x-ray absorptiometry (DEXA), bone density study, one or more sites; axial skeleton (e.g. hips, pelvis, spine).

CPT 76076; Dual energy x-ray absorptiometry (DEXA), bone density study, one or more sites; appendicular skeleton (peripheral) (e.g. radius, wrist, heel).

CPT 76078; Radiographic absorptiometry (photo densitometry), one or more sites;

CPT 78350; Bone density (bone mineral content) study, one or more sites; single photon absorptiometry;

HCPCS G0130; Single energy x-ray (SEXA) absorptiometry bone density study, one or more sites; appendicular skeleton (peripheral) (e.g. radius, wrist, heel).

2003 Payment Rate:

CPT 76070; \$125.44

CPT 76071; \$120.66

CPT 76075; \$133.90

CPT 76076; \$ 40.46

CPT 76078; \$ 39.36

CPT 78350; \$ 40.46

HCPCS G0130; \$ 43.04

Beneficiary Co-payment: Beneficiary pays 20% of the Medicare approved amount, after the yearly Part B deductible.

## **II. Diabetes Monitoring and Supplies**

### **A. Outpatient Self-Management Training Services**

Medicare Definition of Covered Service: Diabetes outpatient self-management and training service programs designed to educate beneficiaries in the successful self-management of diabetes. A program includes instructions in the self-monitoring of blood glucose; education about diet and exercise; an insulin treatment plan developed specifically for the patient who is insulin dependent; and motivation for patients to use the skills for self-management of their diabetes.

Beneficiaries are eligible to receive follow-up training each calendar year following the year in which they were certified as requiring initial training.

The training must be ordered by the physician or non-physician practitioner treating the beneficiary's diabetes. The physician managing the beneficiary's care must certify the need for training services by sending an original referral form to the diabetes education program. Medicare will only pay for training services furnished by a certified provider who meets certain quality standards. Programs must be recognized by the American Diabetes Association (ADA) Education Recognition Program (ERP) to be a certified provider. A training program entity must submit a copy of its ADA ERP certificate with its first claim to affirm that it is a recognized provider.

The order must be part of a comprehensive plan of care established by the physician or non-physician practitioner and describe the training that the referring physician or qualified non-physician practitioner is ordering and/or any special concerns such as the need for general training, or insulin-dependence. The referring physician or qualified non-physician practitioner must maintain the plan of care in the beneficiary's medical record and documentation substantiating the need for training on an individual basis when group training is typically covered, if so ordered. The order must also include a statement signed by the physician that the service is needed. The provider of the service must maintain documentation in the file that includes the original order from the physician and any special conditions noted by the physician.

When the training under the order is changed, the change must be signed by the physician or qualified non-physician practitioner treating the beneficiary and maintained in the beneficiary's file with the provider of the training.

Outpatient diabetes self-management training is classified as initial or follow-up training. When a beneficiary has not yet received initial training meeting the quality standards of this section, they are eligible to receive 10 hours of initial training within a continuous 12-month period. The 12-month period does not need to be on a calendar-year basis. Nine hours of initial training must be provided in a group setting consisting of 2 to 20 individuals. (trainees in the group need not all be Medicare beneficiaries) unless the ordering physician or non-physician practitioner certifies that a special condition exists that makes it impossible for the beneficiary to attend a group training session.

Those conditions include but are not limited to:

- No group session is available within two months of the date training is ordered; and
- The beneficiary has special needs resulting from problems with hearing, vision or language limitations.

For all beneficiaries, one hour of initial training may be provided on an individual basis for the purpose of conducting an individual assessment and providing specialized training. The 10 hours of initial training may be provided in any combination of half-hour increments within the 12-month period if, for example, the beneficiary does not attend all of the sessions or the physician does not order the full training program.

Medicare also covers 2 hours of follow-up training each year starting with the calendar year, following the year in which the beneficiary completes the initial training. The 2 hours of training may be given in any combination of half-hour increments on either an individual or group basis without the certification of the ordering physician or non-physician practitioner that special conditions exist.

Coverage Criteria: Medicare covers self-management training services furnished to all diabetic beneficiaries who:

- Have new onset diabetes;
- Have inadequate glycemic control as evidenced by a glycosylated hemoglobin (HbA1c) level of 8.5 percent or more on two consecutive HbA1c determinations 3 or more months apart in the year before the beneficiary begins receiving the training;
- Have a change in treatment regimen from diet control to oral diabetes medication, or from oral diabetes medication to insulin;
- Are at high risk for complications based on inadequate glycemic control (documented acute have episodes of sever hypoglycemia or acute severe hyperglycemia occurring in the past year during which the beneficiary needed emergency room visits or hospitalization); and/or
- Have high risk diabetes based on at least one of the following:
  - Lack of feeling in the foot or other foot complications such as foot ulcers, deformities, or amputation;
  - Pre-proliferative or proliferative retinopathy or prior laser treatment of the eye; and/or
  - Kidney complications related to diabetes, when manifested by albinuria, without other cause, or elevated creatine.

Procedure Code: Select from the following:

G0108; Diabetes outpatient self-management training services, individual session, per 60 minutes of training; and

G0109; Diabetes outpatient self-management training services, group session, per individual, per 60 minutes of training.

Payment Rules:

When billing for initial diabetes training, the beneficiary must not have already received initial training from an ADA recognized program.

For initial or follow-up diabetes training, the beneficiary must not be receiving services as an inpatient in a hospital, skilled nursing facility, under a hospice or home health benefit, or be a resident of a nursing home.

For initial or follow-up diabetes training, the beneficiary must not be receiving services as an outpatient in a rural health clinic or a federally qualified health center.

2003 Payment Rate:

G0108; \$30.53

G0109; 18.02

Beneficiary Co-payment: Beneficiary pays 20% of the Medicare approved amount after the yearly Part B deductible.

## **B. Blood Glucose Monitors and Supplies**

Coverage Criteria: Medicare covers blood glucose monitors and test strips and lancets for all diabetic beneficiaries (i.e. insulin and non-insulin treated). The beneficiary or the beneficiary's caregiver must be trained to use the monitor and supplies and must be able to use the results to assure appropriate glycemic control.

Payment Rules: The physician must include the following on a prescription to the supplier:

- The item(s) to be dispensed
- The quantity of items to be dispensed;
- For a publication that explains the process of ordering Durable Medical Equipment (DME) please refer to our ACP website, [www.acponline.org/pmc](http://www.acponline.org/pmc), select Index of Publication and Resources, then scroll down to publication - Ordering Durable Medical Equipment Under Medicare.
- The frequency of testing (“as needed” is not acceptable);
- Whether the patient has insulin-treated or non-insulin treated diabetes; and
- A start date of the order – only required if the start date is different than the signature date.

Renewal orders must contain the same information as the initial prescription. A prescription is valid for 12 months unless an earlier date is indicated. The physician must sign and date each prescription.

CMS expects that the medical record maintained by the physician will contain evidence of the medical necessity of the testing frequency. CMS states that DME suppliers are not to request that physicians fill out additional forms unless the DMERC specifically requests information from the supplier.

A DME supplier may not dispense more than a three-month supply of diabetic testing supplies at one time.

Suppliers should not dispense a quantity of supplies exceeding the beneficiary's expected utilization (e.g. testing once a day would require approximately 100 strips for a three month period). The supplier could “refill” the order four times over a 12-month prescription period without the physician needing to complete paperwork beyond the initial order. The physician does not need to complete the paperwork for a prescription “renewal”. A renewal is an order for an additional period of time beyond the initial time ordered by the physician. A renewal order can also be up to 12 months.

This new CMS policy represents an improvement. CMS extended the re-certification time frame from 6 to 12 months and streamlined the physician documentation requirements. CMS implemented this less onerous policy because of complaints from ACP and other organizations.

Medicare will cover blood glucose monitors with special features and specifically designed supplies for the visually impaired under certain circumstances.

Beneficiary Co-payment: Beneficiary pays 20% of the Medicare approved amount after the yearly Part B deductible.

### **C. Therapeutic Shoes**

Medicare Definition of Covered Service: Medicare covers therapeutic shoes as durable medical equipment for people with diabetes. Medicare covers depth in-lay shoes, custom molded shoes and shoe inserts for people with diabetes who qualify under Medicare part B. The physician providing the medical care for the diabetic condition must sign a statement certifying the conditions stated above are met. The durable medical equipment regional carrier (DMERC) in your area may make a model “certifying statement” available on its website. Beneficiaries are generally limited to one pair of shoes per year.

Coverage Criteria: Beneficiaries who qualify:

- Have diabetes mellitus: (ICD-9 codes 250.00 to 250.91);
- Have one or more of the following conditions in one or both feet:
  - History of partial or complete amputation,
  - History of previous foot ulcers,
  - History of callous that could lead to ulcers,
  - Peripheral neuropathy with signs that you have problems with calluses,
  - Poor circulation,
  - Foot deformity,
  - Are being treated under a comprehensive diabetes care plan and need therapeutic shoes and or inserts because of diabetes.

The certifying physician who is managing the patient’s systemic diabetes condition has certified that indications 1 and 2 are met and that he/she is treating the patient under a comprehensive plan of care for his/her diabetes and the patient needs diabetic shoes.

Beneficiary Co-Payment: Beneficiary pays 20% of the Medicare approved amount after the yearly Part B deductible.

### **III. Medical Nutrition Therapy Services**

Medicare Definition of Covered Services: Medicare covers medical nutrition therapy (MNT) services for beneficiaries with diabetes or renal disease. Medicare will pay registered dietitians or nutrition professionals (that meet certain qualification criteria) for MNT services.

Coverage Criteria: Beneficiaries are eligible for MNT if they:

- Have Type I, type II, or gestational diabetes;
- Suffer from chronic renal insufficiency, defined as: a reduction in renal function not severe enough to require dialysis or a transplant—glomerular filtration rate (GFR) 13-50mL/min 1.73m<sup>2</sup> ;
- Have end stage renal disease (ESRD) and are not receiving dialysis; and/or
- Have been discharged from the hospital after successful renal transplant within the past six months.

Procedure Code: Select from the following:

CPT 97802 Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with patient, each 15 minutes;

CPT 97803 re-assessment and intervention, individual, face-to-face with patient, each 15 minutes; or

CPT 97804 group (two or more individuals), each 30 minutes.

Payment Rules: Registered dietitians and nutrition professionals who enroll in Medicare are paid 85% of the amount payable under the physician fee schedule. Registered dietitians and nutrition professionals employed by a physician or practice can reassign their right to Medicare payment for MNT services to their employer. However, physicians are unable to bill for MNT services under the Medicare “incident-to” rules. The incident-to rules permit physicians to bill for services performed by auxiliary personnel that are performed as integral yet incident to the physician’s service. For example, under the incident-to rules, a physician can bill an established patient a follow-up office visit, performed by a nurse practitioner under physician supervision, as if the physician personally performed the service.. For medical nutrition therapy assessment and/or intervention performed by a physician, use Evaluation and Management or Preventive Medicine service codes.

The physician who is treating the beneficiary must order MNT services. Medicare defines the treating physician as the “primary care physician or specialist coordinating care for the beneficiary with diabetes or renal disease.” The treating physician must document the order for MNT services in the patient record.

2003 Payment Rate:

97802; \$17.66

97803; \$17.66

97804; \$6.99.

Beneficiary Co-payment: Beneficiary pays 20% of the Medicare approved amount after the yearly Part B deductible.

#### **IV. Colorectal Cancer Screening**

##### **A. Fecal Occult Blood Test**

Coverage Criteria: Beneficiaries age 50 and older.

Frequency: Once a year

Procedure Code: HCPCS G0107 – Colorectal cancer screening; fecal-occult blood test, 1-3 simultaneous determinations.

Payment Rate: Same as CPT 82270 – Blood, occult,(e.g.guaiac) 1-3 simultaneous determinations which is paid according to the laboratory fee schedule.

Beneficiary Co-payment: There is no beneficiary co-payment or yearly Part B deductible applied.

##### **B. Flexible Sigmoidoscopy**

Coverage Criteria: Beneficiaries ages 50 and older.

Frequency: Once every four years.

Procedure Code: HCPCS G0104 colorectal cancer screening, flexible sigmoidoscopy.

Payment Rules: If a growth is detected that results in a biopsy or removal, bill for a flexible sigmoidoscopy with biopsy or removal instead of G0104.

2003 Payment Rate: \$104.10, same as CPT 45330, sigmoidoscopy, flexible; diagnostic with or without collection of specimen(s) by brushing or washing.

Beneficiary Co-payment: Beneficiary pays 20% of the Medicare approved amount after the yearly Part B deductible, in an office setting. Beneficiary pays 25% in an ambulatory surgical center or hospital outpatient department.

##### **C. Colonoscopy**

###### **High Risk**

Coverage: All beneficiaries who have: a family history of colorectal cancer; prior experience with cancer or precursor neoplastic polyps; a history of chronic digestive disease conditions (including inflammatory bowel disease; Crohn's disease, or ulcerative colitis); the presence of any appropriate recognized gene markers for colorectal cancer; or other predisposing factors.

Frequency: Once every two years.

Procedure Code: HCPCS G0105 Colorectal cancer screening; colonoscopy of individual at high risk

Required Diagnosis Code: The appropriate "high risk" diagnosis code should be submitted. Listed below are some examples of diagnoses that meet high risk criteria for colon cancer, excerpted from the CMS website, "Carriers' Manual, Part 3 Chapter IV, Section 4180.3. This is not an all inclusive list. There may be more instances of conditions that may be coded and could be at the medical directors' discretion.

Personal history

- V10.05 Personal history of malignant neoplasm of large intestine
- V10.06 Personal history of malignant neoplasm of rectum, rectosigmoid junction, and anus

Chronic Digestive Disease Condition

- 555.0 Regional enteritis of small intestine
- 555.1 Regional enteritis of large intestine

Payment Rules: If you perform a biopsy or remove a lesion, bill for a colonoscopy with biopsy or removal instead of G0105.

Payment Rate: \$438.85 when performed in a hospital or other facility, the same as the payment for CPT 45378, colonoscopy, flexible; proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression.

Beneficiary Co-payment: Beneficiary pays 20% of the Medicare approved amount after the yearly Part B deductible. Beneficiary pays 25% in an ambulatory surgical center or hospital outpatient department.

## **Non-High Risk**

Coverage Criteria: All beneficiaries.

Frequency: Once every ten years, as long as the beneficiary has not undergone a screening flexible sigmoidoscopy within the past 48 months.

Procedure Code: HCPCS G0121; Colon cancer screening; colonoscopy on individuals not meeting criteria for high risk

Payment Rate: \$438.85 when performed in a hospital or other facility, same as the payment for CPT 45378 and HCPCS G0105.

Payment Rules: If you perform a biopsy or remove a lesion, bill for a colonoscopy with biopsy or removal instead of G0121.

Beneficiary Co-payment: Beneficiary pays 20% of the Medicare approved amount after the yearly Part B deductible. Beneficiary pays 25% in an ambulatory surgical center or hospital outpatient department.

#### **D. Barium Enemas**

Coverage Criteria: All Medicare beneficiaries over age 50 can have a barium enema substituted for a screening flexible sigmoidoscopy or a screening colonoscopy if the ordering physician documents that a barium enema is more appropriate and has equal or greater screening potential.

Procedure Code: Please select from the following:

HCPCS G0106; colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema; or

HCPCS G0120; colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema

2003 Payment Rate:

G0106; \$136.11, non-facility same as the CPT code equivalent, 74280  
\$ 50.40, facility

G0120; \$136.11, non-facility same as the CPT code equivalent, 74280  
\$ 50.40, facility

Beneficiary Co-payment: Beneficiary pays 20% of the Medicare approved amount after the yearly Part B deductible.

#### **V. Prostate Cancer Screening**

##### **A. Digital Rectal Examination**

Coverage Criteria: Male beneficiaries age 50 and older.

Frequency: Once a year

Procedure Code: HCPCS G0102; prostate cancer screening; digital rectal examination

Payment Rules: Medicare requires that a digital rectal examination (DRE) be performed by a physician who is “knowledgeable about the patient and responsible for explaining the results.”

Medicare will pay separately for a screening DRE if it is the only service provided during an encounter or if it is furnished as part of a service that is otherwise not covered (i.e. a comprehensive preventive examination, CPT 99397 periodic comprehensive re-evaluation and management of an individual age 65 and over, including history, examination, counseling/guidance/risk factor reduction interventions and the ordering of appropriate immunizations, laboratory/diagnostic procedures, established patient).

Medicare will not pay separately for a screening DRE provided during a medically necessary visit. Medicare considers the screening DRE to be a component of the medically necessary visit.

CMS maintains this policy despite the ACP’s effort to persuade the agency to pay separately for a screening DRE when it is provided on the same date as a medically necessary office visit (or other E/M service).

2003 Payment Rate: \$20.60.

Beneficiary Co-payment: Beneficiary pays 20% of the Medicare approved amount after the yearly Part B deductible.

## **B. Prostate-Specific Antigen Testing (PSA)**

Coverage Criteria: Male beneficiaries age 50 and older

Frequency: Once a year

Procedure Code: HCPCS G0103 prostate cancer screening; prostate specific antigen test

Payment Rules: Medicare requires that a PSA test be ordered by a physician who is “knowledgeable about the patient and responsible for explaining the results.”

2003 Payment Rate: Same as CPT 84153, which is paid according to the laboratory fee schedule. Payment may vary by geographic area.

Beneficiary Co-payment: None

## **VI Pap Smear and Pelvic Examination (Includes Clinical Breast Examination)**

### **A. Pap Smear**

#### **High Risk**

Coverage Criteria: All female beneficiaries at high risk for cervical cancer. Medicare considers a woman at high risk if she:

- Is of childbearing age;
- Has a prior history of cancer or sexually transmitted disease;
- Has been infected with human papilloma viruses (HPVs).
- Had an abnormal Pap smear within the past three years;
- Began having sexual intercourse before age 16;
- Has had more than five sexual partners;
- Has not had a Pap smear within seven years; and/or
- Has a mother who used diethylstilbestrol (DES) during pregnancy.

Frequency: Once per year.

Procedure Code: The following should be used when the physician obtains, prepares, conveys the tests and sends the specimen to a laboratory:

HCPCS Q0091 Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory

Required Diagnosis Code: Use V15.89, other specified personal history presenting hazards to health.

Payment Rules: Medicare will pay you separately for obtaining a specimen for a screening Pap smear during a patient office visit or other evaluation and management service. You must append CPT modifier –25 to the E/M service to indicate that it is a significant, separately identifiable service performed on the same date as a specimen collection service. For example, if a beneficiary visits your office for ongoing treatment of her chronic hypertension—a service consistent with a mid-level established patient office visit, CPT 99213—and you obtain a specimen for a screening Pap smear, bill 99213-25 in addition to HCPCS Q0091.

2003 Payment Rate: \$38.99 when the specimen is obtained in your office or other outpatient setting.

Beneficiary Co-payment: Beneficiary has no co-payment for the Pap smear lab test. For Pap smear collection and pelvic and breast exams the co-payment is 20% of the Medicare-approved amount with no Part B deductible.

### **Non High Risk**

Coverage Criteria: All female beneficiaries who do not meet the Medicare definition of high risk for cervical cancer.

Frequency: Once every two years.

Procedure Code: The following should be used when the physician obtains, prepares, conveys the tests and sends the specimen to a laboratory:

HCPCS Q0091 Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory

Required Diagnosis Code: Select from:

- V76.2; special screening for malignant neoplasms, cervix; routine cervical Papanicolaou smear
- V76.47; special screening for malignant neoplasms, vagina
- V76.49; special screening for malignant neoplasms, other sites

Payment Rules: Medicare will pay you separately for obtaining a specimen for a screening Pap smear during a patient office visit or other evaluation and management (E/M) service. You must append CPT modifier –25 to the E/M service to indicate that it is a significant, separately identifiable service performed on the same date as a specimen collection service. For example, if a beneficiary visits your office for ongoing treatment of her chronic hypertension—a service consistent with a mid-level established patient office visit, CPT 99213—and you obtain a specimen for a screening Pap smear, bill 99213-25 in addition to HCPCS Q0091.

2003 Payment Rate: \$38.99 when the specimen is obtained in your office or other outpatient setting.

Beneficiary Co-payment: Beneficiary has no co-payment for the Pap smear lab test. For Pap smear collection and pelvic and breast exams the co-payment is 20% of the Medicare-approved amount with no Part B deductible.

## **B. Pelvic and Clinical Breast Exam.**

### **High Risk**

Coverage Criteria: All female beneficiaries considered at high risk for cervical cancer. Medicare considers a woman at high risk if she:

- Is of childbearing age;
- Has a prior history of cancer or sexually transmitted disease;
- Has been infected with human papilloma viruses (HPVs).
- Had an abnormal Pap smear within the past three years;
- Began having sexual intercourse before age 16;
- Has had more than five sexual partners;
- Has not had a Pap smear within seven years; and/or
- Has a mother who used diethylstilbestrol (DES) during pregnancy.

Frequency: Once per year.

Procedure Code · HCPCS G0101 Cervical or vaginal cancer screening; pelvic and clinical breast exam

Required Diagnosis Code: Use V15.89, other specified personal history presenting hazards to health.

Payment Rules: Medicare will pay separately for a screening pelvic and clinical breast exam, G0101, and for obtaining a specimen for a Pap smear, Q0091, when the two services are billed together for the same patient on the same date.

Medicare will pay for G0101 when it is billed with a medically necessary E/M service and modifier –25.

Medicare will pay for both G0101 and Q0091 when they are billed with an E/M service, as long as the E/M service is appended with modifier –25.

Medicare will pay separately for a pelvic and clinical breast exam performed during a medically necessary office visit even if you do not obtain a specimen for a screening Pap smear. Append the E/M service with modifier –25 and also bill G0101 for the pelvic and clinical breast exam.

Append the modifier –25 to an E/M service to report a separately identifiable patient visit provided on the same date as the specimen collection.

2003 Payment Rate: \$35.68.

Beneficiary Co-Payment: For pelvic and breast exams the co-payment is 20% of the Medicare-approved amount with no Part B deductible.

### **Non High Risk**

Coverage Criteria: All female beneficiaries who do not meet the Medicare definition of high risk for cervical cancer.

Frequency: Once every two years.

Procedure Code · HCPCS G0101 Cervical or vaginal cancer screening; pelvic and clinical breast exam

Required Diagnosis Code: Select from:

V76.2; routine cervical Papanicolaou smear

V76.47; special screening for malignant neoplasms vagina

V76.49; special screening for malignant neoplasms other sites

Payment Rules: Medicare will pay separately for a screening pelvic and clinical breast exam, G0101, and for obtaining a specimen for a Pap smear, Q0091, when the two services are billed together for the same patient on the same date.

Medicare will pay for G0101 when it is billed with a medically necessary E/M service and modifier –25.

Medicare will pay for both G0101 and Q0091 when they are billed with an E/M service, as long as the E/M service is appended with modifier –25.

Medicare will pay separately for a pelvic and clinical breast exam performed during a medically necessary office visit even if you do not obtain a specimen for a screening Pap smear. Append the E/M service with modifier –25 and also bill G0101 for the pelvic and clinical breast exam.

Append the modifier –25 to an E/M service to report a separately identifiable patient visit provided on the same date as the specimen collection.

2003 Payment Rate: \$35.68.

Beneficiary Co-Payment: For pelvic and breast exams the co-payment is 20% of the Medicare-approved amount with no Part B deductible.

## **VII Vaccinations**

### **A. Influenza**

Coverage Criteria: All beneficiaries

Frequency: Once per flu season. Medicare does not limit coverage to one influenza vaccination per 12-month period. It will pay for additional vaccinations that are medically necessary.

Procedure Code: To identify the adult vaccine product, use:

CPT 90658 influenza virus vaccine, split virus, 3 years and above dosage, for intramuscular or jet injection use

To report the administration of the vaccine, use:

HCPCS G0008 administration of influenza virus vaccine when no physician fee schedule service on same day

Required Diagnosis Code: Use V04.8 need for prophylactic vaccination against viral influenza, if the sole purpose of the beneficiary's visit is to receive the influenza vaccine.

Payment Rules: You must accept Medicare assignment for the influenza vaccine. If you do not accept Medicare assignment, you can charge the beneficiary for the vaccine administration only (the amount you would charge a non-Medicare patient). However, you must submit an unassigned claim to Medicare on the beneficiary's behalf. Physicians still have to submit a non assigned claim on behalf of the beneficiary for the administration of the immunization.

2003 Payment Rate:

CPT 90658; 95% of average wholesale price  
HCPCS G0008; Medicare makes state-specific payment rates available at  
<http://cms.hhs.gov/medlearn/2003adminrates.pdf>

Beneficiary Co-payment: None. Medicare pays 100% of its approved amount. Neither the deductible nor the co-payment applies.

## **B. Pneumococcal**

Coverage Criteria: All beneficiaries

Frequency: Once per lifetime. However, beneficiaries at high risk of pneumococcal disease who have not received a vaccination in five years; or are unsure of their vaccination status may be re-vaccinated.

Procedure Code: To identify the adult vaccine product, use:

CPT 90732; pneumococcal polysaccharide vaccine (any group(s)), for subcutaneous or jet injection use

To report the administration of the vaccine, use:

HCPCS G0009; administration of pneumococcal vaccine when no physician fee schedule service on the same day.

Required Diagnosis Code: Use ICD-9 code V03.82 need for prophylactic vaccination and inoculation against bacterial streptococcus pneumoniae (pneumococcus) if the sole purpose of the beneficiary's visit is to receive the pneumococcal vaccine.

Payment Rules: You must accept assignment for the pneumococcal vaccine. If you do not accept Medicare assignment, you can charge the beneficiary for the vaccine administration only (the

amount you would charge a non-Medicare patient). However, you must submit an unassigned claim to Medicare on the beneficiary's behalf for the administration of the immunization.

2003 Payment Rate:

CPT 90732; 95% of average wholesale price  
HCPCS G0009; Medicare makes state-specific payment rate available at  
<http://cms.hhs.gov/medlearn/2003adminrates.pdf>

Beneficiary Co-payment: None. Medicare pays 100% of its approved amount. Neither the deductible nor the co-payment applies.

**C. Hepatitis B**

Coverage Criteria: Beneficiaries at medium or high risk for Hepatitis

Procedure Code: To identify the adult vaccine product, select from:

CPT 90746; hepatitis B vaccine, adult dosage, for intramuscular use  
CPT 90740; hepatitis B vaccine, dialysis or immunosuppressed patient dosage  
(3 dose schedule), for intramuscular use  
CPT 90747; hepatitis B vaccine, dialysis or immunosuppressed patient dosage  
(4 dose schedule), for intramuscular use

To report the administration of the vaccine, use:

HCPCS G0010 administration of hepatitis B vaccine when no physician fee schedule service on the same day

Required Diagnosis Code: Use ICD-9 code V05.3 –need for other prophylactic vaccination and inoculation against viral hepatitis, if the sole purpose of the beneficiary's visit is to receive the hepatitis vaccine.

2003 Payment Rate:

CPT 90746; 95% of average wholesale price  
CPT 90740; 95% of average wholesale price  
CPT 90747; 95% of average wholesale price  
HCPCS G0010; Medicare makes state-specific payment rate available at  
<http://cms.hhs.gov/medlearn/2003adminrates.pdf>

Beneficiary Co-payment: Beneficiary pays 20% of the Medicare-approved amount after the yearly Part B deductible.

## ADDENDUM

### Helpful Resources Referenced In This Guide And Other Publications, Websites

#### 1. General Reference Information.

- The CMS website for general information: [www.cms.gov](http://www.cms.gov)
- Advanced Beneficiary Notices for use with non-covered preventive services - GA, GY modifiers: <http://cms.gov/medlearn/> home page. [http://cms.gov/medlearn/abn\\_readers.pdf](http://cms.gov/medlearn/abn_readers.pdf)
- A print version of the CMS 1500 claim form: <http://cms.hhs.gov/providers/edi/cms1500.pdf>
- Medicare Fee Schedule for preventive services using CPT or HCPCS codes : <http://cms.hhs.gov/physicians/mpfsapp>
- Medicare & You 2002 Physician's Guide: <http://cms.hhs.gov/medlearn/phycompl.pdf>
- The Medicare Education home page at: <http://cms.hhs.gov/medlearn/> provides a comprehensive index for reviewing specific topics of interest.
- A pocket guide to Preventive Services for Adults: <http://www.acponline.org/pmc/psc.htm>
- For a discussion of services provided at the same time as preventive services see our article "How to Bill Medicare for Prevention-related Care" at our website: <http://www.acponline.org/journals/news/may00/prevention.htm>
- Medicare Immunization Quick Reference Guide: <http://cms.hhs.gov/medlearn/refimmu.asp>

#### 2. Covered Services –Specific Information

##### Bone Mass Measurements

- For a 2002 Medicare guide on covered preventive services related to osteoporosis, diabetes and prostate cancer: <http://www.medicare.gov/publications/pubs/pdf/prevent.pdf> and [http://cms.hhs.gov/medlearn/evolving\\_issues.pdf](http://cms.hhs.gov/medlearn/evolving_issues.pdf)
- An article authored by CMS staff entitled, "Screening for Osteoporosis and Colon Cancer under Medicare" is accessible at: [www.cms.hhs.gov/review/02summer/mcbs.pdf](http://www.cms.hhs.gov/review/02summer/mcbs.pdf)

##### Diabetes Monitoring and Supplies

- For a 2002 Medicare guide on covered preventive services related to osteoporosis, diabetes and prostate cancer: <http://www.medicare.gov/publications/pubs/pdf/prevent.pdf> and [http://cms.hhs.gov/medlearn/evolving\\_issues.pdf](http://cms.hhs.gov/medlearn/evolving_issues.pdf)
- Non-physician Practitioners as providers of Medical Nutrition Therapy and Diabetic Training: [http://cms.hhs.gov/manuals/pm\\_trans/R1764B3.pdf](http://cms.hhs.gov/manuals/pm_trans/R1764B3.pdf)

##### Medical Nutrition Therapy

- Non-physician Practitioners as providers of Medical Nutrition Therapy and Diabetic Training: [http://cms.hhs.gov/manuals/pm\\_trans/R1764B3.pdf](http://cms.hhs.gov/manuals/pm_trans/R1764B3.pdf)

### Colorectal Cancer Screening

- An article authored by CMS staff entitled, “Screening for Osteoporosis and Colon Cancer under Medicare”: [www.cms.hhs.gov/review/02summer/mcbs.pdf](http://www.cms.hhs.gov/review/02summer/mcbs.pdf)
- CMS website Colorectal Cancer Screening –Information and materials: <http://cms.hhs.gov/medlearn/refcolcn.asp>

### Prostate Cancer Screening

- For a 2002 Medicare guide on covered preventive services related to osteoporosis, diabetes and prostate cancer: <http://www.medicare.gov/publications/pubs/pdf/prevent.pdf> and [http://cms.hhs.gov/medlearn/evolving\\_issues.pdf](http://cms.hhs.gov/medlearn/evolving_issues.pdf)

### Pap Smear, Pelvic and Clinical Breast Exam

- **Women with Medicare** - *Visiting Your Doctor for a Pap Test, Pelvic Exam, and Clinical Breast Exam* published by CMS, is a booklet for Medicare beneficiaries and physicians that describes Part B coverage for a screening: the Pap test and pelvic exam, which includes a clinical breast exam. It also explains what beneficiaries are required to pay. This booklet is intended to clarify beneficiary confusion regarding financial liability they incur when receiving these Medicare covered screening services. The booklet was developed in response to physician concern that explaining financial responsibility to beneficiaries can be overly time consuming. Physicians may want to review the information included in this booklet and have it available to their staff. Also, they may want to have copies for beneficiaries to review in their office. This booklet is available by dialing 1-800-MEDICARE. The publication is currently available at the CMS website [www.medicare.gov](http://www.medicare.gov). In order to find the publication select from the left hand column: **Publications**, then select topic **Medicare Basics**, and the contents will appear and you can simply scroll to the title **Women with Medicare** and/or publication number **CMS – 02248**

### Vaccinations

- Additional information on improving immunization rates in your practice is included in our article, “Adult Immunization Initiative” at our website: [www.acponline.org/aii](http://www.acponline.org/aii), scroll down the left side and double-click on Vaccine Information. This publication summarizes Medicare regulations in plain English and provides charts to help you properly code immunizations. It also explains how innovative billing techniques, such as roster billing, when combined with chart reminders, standing orders and other methods of standardizing your office operations, can substantially reduce the costs of administering immunizations in your office.
- Medicare Immunization Quick Reference Guide: <http://cms.hhs.gov/medlearn/refimmu.asp>