This educational tool provides information on Medicare preventive services. Information provided includes Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes; International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis codes; coverage requirements; frequency requirements; and beneficiary liability for each Medicare preventive service.

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>HCPCS/CPT CODES</th>
<th>ICD-9-CM CODES</th>
<th>WHO IS COVERED</th>
<th>FREQUENCY</th>
<th>BENEFICIARY PAYS</th>
</tr>
</thead>
</table>
| 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 | No specific diagnosis code  
Contact the local Medicare Contractor for guidance | All Medicare beneficiaries whose first Part B coverage began on or after 01/01/05  
Important – The screening EKG is an optional service that may be performed as a result of a referral from an IPPE | Once in a lifetime  
Must furnish no later than 12 months after the effective date of the first Medicare Part B coverage | G0402:  
• Copayment/coinsurance waived  
• Deductible waived  
G0403, G0404, and G0405:  
• Copayment/coinsurance applies  
• Deductible applies |
| Annual Wellness Visit (AWV) | G0438 – Initial visit  
G0439 – Subsequent visit | No specific diagnosis code  
Contact the local Medicare Contractor for guidance | All Medicare beneficiaries who are no longer within 12 months after the effective date of their first Medicare Part B coverage period and who have not received an IPPE or AWV within the past 12 months | • Once in a lifetime for G0438  
• Annually for G0439 | • Copayment/coinsurance waived  
• Deductible waived |
| Ultrasound Screening for Abdominal Aortic Aneurysm (AAA) | G0389 – Ultrasound exam AAA screening | No specific diagnosis code  
Contact the local Medicare Contractor for guidance | Medicare beneficiaries with certain risk factors for AAA  
Important – Eligible beneficiaries must receive a referral for an ultrasound screening for AAA as a result of an IPPE | Once in a lifetime | • Copayment/coinsurance waived  
• Deductible waived |
| Cardiovascular Screening Blood Tests | 80061 – Lipid panel  
82465 – Cholesterol  
83718 – Lipoprotein  
84478 – Triglycerides | Report one or more of the following codes:  
V81.0, V81.1, V81.2 | All Medicare beneficiaries without apparent signs or symptoms of cardiovascular disease | Every 5 years | • Copayment/coinsurance waived  
• Deductible waived |
| Diabetes Screening Tests | 82947 – Glucose; quantitative, blood (except reagent strip)  
82950 – Glucose; post-glucose dose (includes glucose)  
82951 – Glucose; tolerance test (GT), 3 specimens (includes glucose) | V77.1 | Medicare beneficiaries with certain risk factors for diabetes or diagnosed with pre-diabetes  
Beneficiaries previously diagnosed with diabetes are not eligible for this benefit | • Two screening tests per year for beneficiaries diagnosed with pre-diabetes  
• One screening per year if previously tested, but not diagnosed with pre-diabetes, or if never tested | • Copayment/coinsurance waived  
• Deductible waived |
| Diabetes Self-Management Training (DSMT) | G0108 – DSMT, individual, per 30 minutes  
G0109 – DSMT, group (2 or more), per 30 minutes | No specific diagnosis code  
Contact the local Medicare Contractor for guidance | Medicare beneficiaries diagnosed with diabetes  
Physician or qualified non-physician practitioner treating the beneficiary’s diabetes must order DSMT | • Up to 10 hours of initial training within a continuous 12-month period  
• Subsequent years: Up to 2 hours of follow-up training each year after the initial year | • Copayment/coinsurance applies  
• Deductible applies |
<table>
<thead>
<tr>
<th>SERVICE</th>
<th>HCPCS/CPT CODES</th>
<th>ICD-9-CM CODES</th>
<th>WHO IS COVERED</th>
<th>FREQUENCY</th>
<th>BENEFICIARY PAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Nutrition Therapy (MNT)</td>
<td>97802 – MNT; initial assessment, individual, each 15 minutes 97803 – MNT; re-assessment, individual, each 15 minutes 97804 – MNT; group (2 or more), 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</td>
<td>No specific diagnosis code Contact the local Medicare Contractor for guidance</td>
<td>Certain Medicare beneficiaries diagnosed with diabetes, renal disease, or who have received a kidney transplant within the last 3 years A registered dietitian or nutrition professional must provide the services</td>
<td>• First year: 3 hours of one-on-one counseling • Subsequent years: 2 hours</td>
<td>• Copayment/coinsurance waived • Deductible waived</td>
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<td>Screening Pap Tests</td>
<td>G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148 – Screening cytology, 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</td>
<td>Report one of the following codes: Low Risk – V72.31, V76.2, V76.47, V76.49 High Risk – V15.89</td>
<td>All female Medicare beneficiaries</td>
<td>• Annually if at high risk for developing cervical or vaginal cancer, or childbearing age with abnormal Pap test within past 3 years • Every 24 months for all other women</td>
<td>• Copayment/coinsurance waived • Deductible waived</td>
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<td>Screening Pelvic Examinations</td>
<td>G0101 – Cervical or vaginal cancer screening; pelvic and clinical breast examination</td>
<td>Report one of the following codes: Low Risk – V72.31, V76.2, V76.47, V76.49 High Risk – V15.89</td>
<td>All female Medicare beneficiaries</td>
<td>• Annually if at high risk for developing cervical or vaginal cancer, or childbearing age with abnormal Pap test within past 3 years • Every 24 months for all other women</td>
<td>• Copayment/coinsurance waived • Deductible waived</td>
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<td>Screening Mammography</td>
<td>77052 – Computer-aided detection; screening mammography 77057 – Screening mammography, bilateral G0202 – Screening mammography, digital</td>
<td>Report one of the following codes: V76.11 or V76.12</td>
<td>All female Medicare beneficiaries aged 35 and older</td>
<td>• Aged 35 through 39: One baseline • Aged 40 and older: Annually</td>
<td>• Copayment/coinsurance waived • Deductible waived</td>
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<td>Bone Mass Measurements</td>
<td>76977 – Ultrasound bone density measurement and interpretation; peripheral site(s), any method</td>
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<td>Certain Medicare beneficiaries that fall into at least one of the following categories:</td>
<td>Every 24 months</td>
<td>• Copayment/coinsurance waived</td>
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<td>77078 – Computed tomography, bone mineral density study, 1 or more sites; axial skeleton</td>
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<td>• Women determined by their physician or qualified non-physician practitioner to be estrogen deficient and at clinical risk for osteoporosis;</td>
<td>More frequently if medically necessary</td>
<td>• Deductible waived</td>
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<td>77079 – Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)</td>
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<td>• Individuals with vertebral abnormalities; • Individuals receiving (or expecting to receive) glucocorticoid therapy for more than 3 months; • Individuals with primary hyperparathyroidism; or • Individuals being monitored to assess response to FDA-approved osteoporosis drug therapy</td>
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<td>77080 – Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton</td>
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<td>77081 – DXA, bone density study, 1 or more sites; appendicular skeleton</td>
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<td>77083 – Radiographic absorptiometry (e.g., photodensitometry, radiogrammetry), 1 or more sites</td>
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<td>G0130 – Single energy X-ray study</td>
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<td>Colorectal Cancer Screening</td>
<td>G0104 – Flexible Sigmoidoscopy</td>
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<td>All Medicare beneficiaries aged 50 and older who are:</td>
<td>FOBT every year</td>
<td>• Copayment/coinsurance waived</td>
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<td>G0105 – Colonoscopy (high risk)</td>
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<td>• At normal risk of developing colorectal cancer; or • At high risk of developing colorectal cancer</td>
<td>Flexible Sigmodoscopy once every 4 years, or 120 months after a previous Screening Colonoscopy for people not at high risk</td>
<td>• Deductible waived</td>
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<td>G0106 – Barium Enema (alternative to G0104)</td>
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<td>High risk for developing colorectal cancer is defined in 42 CFR 410.37(a)(3)</td>
<td>Screening Colonoscopy every 10 years (every 24 months for high risk), or 48 months after a previous Flexible Sigmodoscopy</td>
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<td>G0121 – Colonoscopy (not high risk)</td>
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<td>G0328 – Fecal Occult Blood Test (FOBT), immunoassay, 1-3 simultaneous</td>
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<td>82270 – FOBT (blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided 3 cards or single triple card for consecutive collection)</td>
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<td>G0104, G0105, G0121, G0328, and 82270:</td>
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<td>• Copayment/coinsurance waived</td>
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<td>G0106 and G0120:</td>
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<td>Deductible waived</td>
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<td>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 Colonoscopy, Flexible Sigmodoscopy, or Barium Enema that were initiated as colorectal cancer screening services</td>
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<td>Modifier -PT should be appended</td>
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<td>at least one CPT code in the surgical range of 10000 to 69999 on a claim for services furnished in this scenario</td>
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<td>SERVICE</td>
<td>HCPCS/CPT CODES</td>
<td>ICD-9-CM CODES</td>
<td>WHO IS COVERED</td>
<td>FREQUENCY</td>
<td>BENEFICIARY PAYS</td>
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| **Prostate Cancer Screening** | G0102 – Digital Rectal Exam (DRE)  
G0103 – Prostate Specific Antigen Test (PSA) | V76.44 | All male Medicare beneficiaries aged 50 and older (coverage begins the day after 50th birthday) | Annually for covered beneficiaries | **G0102:**  
- Copayment/coinsurance applies  
- Deductible applies  
**G0103:**  
- Copayment/coinsurance waived  
- Deductible waived |
| **Glaucoma Screening** | G0117 – By an optometrist or ophthalmologist  
G0118 – Under the direct supervision of an optometrist or ophthalmologist | V80.1 | Medicare beneficiaries with diabetes mellitus, family history of glaucoma, African-Americans aged 50 and older, or Hispanic-Americans aged 65 and older | Annually for covered beneficiaries |  
- Copayment/coinsurance applies  
- Deductible applies |
| **Seasonal Influenza Virus Vaccine and Administration** | 90654, 90655, 90656, 90657, 90660, 90662, Q2034 (effective for dates of service on or after 07/01/12, and claims processed on or after 10/01/12), Q2035, Q2036, Q2037, Q2038, Q2039 – Influenza Virus Vaccine  
G0008 – Administration | Report one of the following codes:  
V04.81 – Influenza  
V06.6 – Pneumococcus and Influenza | All Medicare beneficiaries | Once per influenza season  
Medicare may provide additional flu shots if medically necessary |  
- Copayment/coinsurance waived  
- Deductible waived |
| **Pneumococcal Vaccine and Administration** | 90669, 90670 – Pneumococcal Conjugate Vaccine  
90732 – Pneumococcal Polysaccharide Vaccine  
G0009 – Administration | Report one of the following codes:  
V03.82 – Pneumococcus  
V06.6 – Pneumococcus and Influenza | All Medicare beneficiaries | Once in a lifetime  
Medicare may provide additional vaccinations based on risk and provided that at least 5 years have passed since receipt of a previous dose |  
- Copayment/coinsurance waived  
- Deductible waived |
| **Hepatitis B (HBV) Vaccine and Administration** | 90740 – Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule)  
90743 – Hepatitis B vaccine, adolescent dosage (2 dose schedule)  
90744 – Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule)  
90746 – Hepatitis B vaccine, adult dosage  
90747 – Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule)  
G0010 – Administration | V05.3 | Certain Medicare beneficiaries at intermediate or high risk for contracting hepatitis B  
Medicare beneficiaries that are currently positive for antibodies for hepatitis B are not eligible for this benefit | Scheduled dosages required |  
- Copayment/coinsurance waived  
- Deductible waived |
<table>
<thead>
<tr>
<th>SERVICE</th>
<th>HCPCS/CPT CODES</th>
<th>ICD-9-CM CODES</th>
<th>WHO IS COVERED</th>
<th>FREQUENCY</th>
<th>BENEFICIARY PAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling to Prevent Tobacco Use for Asymptomatic Beneficiaries</td>
<td>G0436 – Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes</td>
<td>Report one of the following codes: 305.1 or V15.82</td>
<td>Outpatient and hospitalized beneficiaries who use tobacco, regardless of whether they have signs or symptoms of tobacco-related disease; who are competent and alert at the time that counseling is provided; and whose counseling is furnished by a qualified physician or other Medicare-recognized practitioner</td>
<td>Two cessation attempts per year; each attempt includes a maximum of four intermediate or intensive sessions, up to eight sessions in a 12-month period</td>
<td>• Copayment/coinsurance waived  • Deductible waived</td>
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<td>G0437 – Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes</td>
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<td>Human Immunodeficiency Virus (HIV) Screening</td>
<td>G0432 – Infectious agent antibody detection by enzyme immunoassay (EIA) technique</td>
<td>Report one of the following codes: V73.89 – Primary V22.0, V22.1, V69.8, or V23.9 – Secondary, as appropriate</td>
<td>Beneficiaries who are at increased risk for HIV infection or pregnant  • Increased risk for HIV infection is defined in Publication 100-03, Sections 190.14 (diagnostic) and 210.7 (screening)</td>
<td>Annually for beneficiaries at increased risk  • Three times per pregnancy for beneficiaries who are pregnant:  • First, when a woman is diagnosed with pregnancy;  • Second, during the third trimester; and  • Third, at labor, if ordered by the woman’s clinician</td>
<td>• Copayment/coinsurance waived  • Deductible waived</td>
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<td>G0433 – Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique</td>
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<td>G0435 – Infectious agent antibody detection by rapid antibody test</td>
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<tr>
<td>Intensive Behavioral Therapy (IBT) for Cardiovascular Disease</td>
<td>This is a new benefit beginning for dates of service on or after 11/08/11</td>
<td>G0446 – Intensive behavioral therapy to reduce cardiovascular disease risk, individual, face-to-face, bi-annual, 15 minutes</td>
<td>No specific diagnosis code</td>
<td>Annually for covered beneficiaries</td>
<td>• Copayment/coinsurance waived  • Deductible waived</td>
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<td>Contact the local Medicare Contractor for guidance</td>
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<td>• Men aged 45 through 79 and women aged 55 through 79: Encouraging aspirin use for the primary prevention of cardiovascular disease when the benefits outweigh the risks  • Adults aged 18 and older: Screening for high blood pressure  • Adults with hyperlipidemia, hypertension, advancing age, and other known risk factors for cardiovascular- and diet-related chronic disease: Intensive behavioral counseling to promote a healthy diet Must be furnished by a qualified primary care physician or other primary care practitioner in a primary care setting</td>
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<td>Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse</td>
<td>This is a new benefit beginning for dates of service on or after 10/14/11</td>
<td>G0442 – Annual alcohol misuse screening, 15 minutes</td>
<td>No specific diagnosis code</td>
<td>• Annually for G0442  • Four times per year for G0443</td>
<td>• Copayment/coinsurance waived  • Deductible waived</td>
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<td>G0443 – Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes</td>
<td>Contact the local Medicare Contractor for guidance</td>
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<td>• All Medicare beneficiaries are eligible for alcohol screening  • Medicare beneficiaries 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</td>
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<tr>
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<td>HCPCS/CPT CODES</td>
<td>ICD-9-CM CODES</td>
<td>WHO IS COVERED</td>
<td>FREQUENCY</td>
<td>BENEFICIARY PAYS</td>
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<td><strong>Screening for Depression</strong>&lt;br&gt;This is a new benefit beginning for dates of service on or after 10/14/11</td>
<td>G0444 – Annual depression screening, 15 minutes</td>
<td>No specific diagnosis code</td>
<td>All Medicare beneficiaries&lt;br&gt;Must be furnished by a qualified primary care physician or other primary care practitioner in a primary care setting that has staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up</td>
<td>Annually</td>
<td>• Copayment/coinsurance waived&lt;br&gt;• Deductible waived</td>
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<td><strong>Sexually Transmitted Infections (STIs)</strong>&lt;br&gt;Screening and High Intensity Behavioral Counseling (HIBC) to Prevent STIs&lt;br&gt;This is a new benefit beginning for dates of service on or after 11/08/11</td>
<td>86631, 86632, 87110, 87270, 87320, 87490, 87491, 87810 – Chlamydia&lt;br&gt;87590, 87591, 87850 – Gonorrhea&lt;br&gt;87800 – Combined chlamydia and gonorrhea testing&lt;br&gt;86592, 86593, 86780 – Syphilis&lt;br&gt;87340, 87341 – Hepatitis B (hepatitis B surface antigen)&lt;br&gt;G0445 – High intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes</td>
<td>For screening for chlamydia, gonorrhea, and syphilis in women at increased risk who are not pregnant report V74.5 and V69.8&lt;br&gt;For screening for syphilis in men at increased risk report V74.5 and V69.8&lt;br&gt;For screening for chlamydia and gonorrhea in pregnant women at increased risk for STIs report:&lt;br&gt;• V74.5 and V69.8, and V22.0, V22.1, or V23.9&lt;br&gt;For screening for syphilis in pregnant women report V74.5 and V22.0, V22.1, or V23.9&lt;br&gt;For screening for syphilis in pregnant women at increased risk for STIs report:&lt;br&gt;• V74.5 and V69.8, and V22.0, V22.1, or V23.9&lt;br&gt;Sexually active adolescents and adults at increased risk for STIs: HIBC consisting of individual, 20 to 30 minute, face-to-face counseling sessions, if referred for this service by a primary care provider and provided by a Medicare eligible primary care provider in a primary care setting&lt;br&gt;Increased risk for STIs is defined in Publication 100-03, Section 210.10&lt;br&gt;Refer to <a href="http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R141NCD.pdf">http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R141NCD.pdf</a> on the CMS website</td>
<td>• One annual occurrence of screening for chlamydia, gonorrhea, and syphilis in women at increased risk who are not pregnant&lt;br&gt;• One annual occurrence of screening for syphilis in men at increased risk&lt;br&gt;• 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&lt;br&gt;• One occurrence per pregnancy of screening for syphilis in pregnant women; up to two additional occurrences per pregnancy if at continued increased risk for STIs&lt;br&gt;• One occurrence per pregnancy of screening for syphilis in pregnant women at increased risk for STIs&lt;br&gt;• One occurrence per pregnancy of screening for hepatitis B in pregnant women; one additional occurrence per pregnancy if at continued increased risk for STIs&lt;br&gt;• Up to two HIBC counseling sessions annually</td>
<td>• Copayment/coinsurance waived&lt;br&gt;• Deductible waived</td>
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<td>Intensive Behavioral Therapy (IBT) for Obesity</td>
<td>G0447 – Face-to-face behavioral counseling for obesity, 15 minutes</td>
<td>Report one of the following codes: V85.30 – V85.39, V85.41 – V85.45</td>
<td>Medicare beneficiaries with obesity (BMI ≥ 30 kg/m²) who are competent and alert at the time that counseling is provided and whose counseling is furnished by a qualified primary care physician or other primary care practitioner in a primary care setting</td>
<td>• One visit every week for the first month; • One visit every other week for months 2 – 6; and • One visit every month for months 7 – 12 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 3kg during the first 6 months, a reassessment of their readiness to change and BMI is appropriate after an additional 6-month period</td>
<td>• Copayment/coinsurance waived • Deductible waived</td>
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Frequently Asked Questions

**Why is CMS adding new preventive services as Medicare benefits?**
Under Section 4105 of the Affordable Care Act, CMS may add coverage of “additional preventive services” through the National Coverage Determination (NCD) process if the service meets all of the following criteria. They 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/recommendations.htm](http://www.uspreventiveservicestaskforce.org/recommendations.htm) on the Internet. Watch for announcements of additional new preventive benefits and educational materials at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html) on the CMS website, or refer to [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNProducts_listserv.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNProducts_listserv.pdf) to sign up to receive news of new Medicare Learning Network® (MLN) products by e-mail. For the latest information on Medicare preventive services, visit [http://www.cms.gov/Medicare/Prevention/PreventionGenInfo/News_and_Announcements.html](http://www.cms.gov/Medicare/Prevention/PreventionGenInfo/News_and_Announcements.html) on the CMS website.

**Some services must be performed in a primary care setting. What is that?**
A primary care setting is one in which there is 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. We do not consider Ambulatory Surgical Centers (ASCs), emergency departments, hospices, independent diagnostic testing facilities, inpatient hospital settings, Inpatient Rehabilitation Facilities (IRFs), and Skilled Nursing Facilities (SNFs) to be primary care settings under this definition.

**How do I determine the last date a beneficiary received a preventive service, so that I know the beneficiary is eligible to receive the next service and the service will not be denied due to frequency edits?**
Your options for accessing eligibility information depend on the Medicare Administrative Contractor (MAC) jurisdiction in which your practice or facility is located. For example, MACs who have Internet portals provide the information through the eligibility screens of the portals. You may also be able to access the information through the HIPAA Eligibility Transaction System (HETS), as well as HETS User Interface, 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 eligibility.

**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.gov](http://www.medicare.gov) provides a “Preventive Screening Checklist” that you can give to your patients. They can use the checklist to track their preventive services. For the checklist, visit [http://www.medicare.gov/navigation/manage-your-health/preventive-services/preventive-service-checklist.aspx](http://www.medicare.gov/navigation/manage-your-health/preventive-services/preventive-service-checklist.aspx) on the Internet.
## Resources

<table>
<thead>
<tr>
<th>RESOURCE</th>
<th>WEBSITE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Preventive Services General Information</td>
<td><a href="http://www.cms.gov/Medicare/Prevention/PreventionGenInfo">http://www.cms.gov/Medicare/Prevention/PreventionGenInfo</a></td>
</tr>
</tbody>
</table>

This educational tool was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This educational tool was prepared as a service to the public and is not intended to grant rights or impose obligations. This educational tool may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) is published by the United States Government. A CD-ROM, which may be purchased through the Government Printing Office, is the only official Federal government version of the ICD-9-CM. ICD-9-CM is an official Health Insurance Portability and Accountability Act standard.

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Your feedback is important to us and we use your suggestions to help us improve our educational products, services and activities and to develop products, services and activities that better meet your educational needs. To evaluate Medicare Learning Network® (MLN) products, services and activities you have participated in, received, or downloaded, please go to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts and click on the link called ‘MLN Opinion Page’ in the left-hand menu and follow the instructions.

Please send your suggestions related to MLN product topics or formats to MLN@cms.hhs.gov.
Frequently Asked Questions about Billing Medicare for Transitional Care Management Services

Effective January 1, 2013, Medicare pays for two CPT codes (99495 and 99496) that are used to report physician or qualifying nonphysician practitioner care management services for a patient following a discharge from a hospital, SNF, or CMHC stay, outpatient observation, or partial hospitalization. This policy is discussed in the CY 2013 Physician Fee Schedule final rule published on November 16, 2012 (77 FR 68978 through 68994). The following are some frequently asked questions that we have received about billing Medicare for transitional care management services.

- **What date of service should be used on the claim?**

  The 30-day period for the TCM service begins on the day of discharge and continues for the next 29 days. The reported date of service should be the 30th day.

- **What place of service should be used on the claim?**

  The place of service reported on the claim should correspond to the place of service of the required face-to-face visit.

- **If the codes became effective on Jan. 1 and, in general, cannot be billed until 29 days past discharge, will claims submitted before Jan. 29 with the TCM codes be denied?**

  Because the TCM codes describe 30 days of services and because the TCM codes are new codes beginning on January 1, 2013, only 30-day periods beginning on or after January 1, 2013 are payable. Thus, the first payable date of service for TCM services is January 30, 2013.

- **The CPT book describes services by the physician's staff as "and/or licensed clinical staff under his or her direction." Does this mean only RNs and LPNs or may medical assistants also provide some parts of the TCM services?**

  Medicare encourages practitioners to follow CPT guidance in reporting TCM services. Medicare requires that when a practitioner bills Medicare for services and supplies commonly furnished in physician offices, the practitioner must meet the “incident to” requirements described in Chapter 15 Section 60 of the Benefit Policy Manual 100-02.

- **Can the services be provided in an FQHC or RHC?**

  While FQHCs and RHCs are not paid separately by Medicare under the PFS, the face-to-face visit component of TCM services could qualify as a billable visit in an FQHC or RHC. Additionally, physicians or other qualified providers who have a separate fee-for-service practice when not working at the RHC or FQHC may bill the CPT TCM codes, subject to the other existing requirements for billing under the MPFS.
• **If the patient is readmitted in the 30-day period, can TCM still be reported?**

Yes, TCM services can still be reported as long as the services described by the code are furnished by the practitioner during the 30-day period, including the time following the second discharge. Alternatively, the practitioner can bill for TCM services following the second discharge for a full 30-day period as long as no other provider bills the service for the first discharge. CPT guidance for TCM services states that only one individual may report TCM services and only once per patient within 30 days of discharge. Another TCM may not be reported by the same individual or group for any subsequent discharge(s) within 30 days.

• **Can TCM services be reported if the beneficiary dies prior to the 30th day following discharge?**

Because the TCM codes describe 30 days of care, in cases when the beneficiary dies prior to the 30th day, practitioners should not report TCM services but may report any face-to-face visits that occurred under the appropriate evaluation and management (E/M) code.

• **Medicare will only pay one physician or qualified practitioner for TCM services per beneficiary per 30 day period following a discharge. If more than one practitioner reports TCM services for a beneficiary, how will Medicare determine which practitioner to pay?**

Medicare will only pay the first eligible claim submitted during the 30 day period that commences with the day of discharge. Other practitioners may continue to report other reasonable and necessary services, including other E/M services, to beneficiaries during those 30 days.

• **Can TCM services be reported under the primary care exception? Can the services be reported with the –GC modifier?**

TCM services are not on the primary care exception list, so the general teaching physician policy applies as it would for E/M services not on the list. When a physician (or other appropriate billing provider) places the -GC modifier on the claim, he/she is certifying that the teaching physician has complied with the requirements in the Medicare Claims Processing Manual, Chapter 12, sections 100.1 through 100.1.6.

• **Can practitioners under contract to the physician billing for the TCM service furnish the non-face to face component of the TCM?**

Physician offices should follow “incident to” requirements for Medicare billing. “Incident to” recognizes numerous employment arrangements, including contractual arrangements, when there is direct physician supervision of auxiliary personnel.


• **During the 30 day period of TCM, can other medically necessary billable services be reported?**
Yes, other reasonable and necessary Medicare services may be reported during the 30 day period, with the exception of those services that cannot be reported according to CPT guidance and Medicare HCPCS codes G0181 and G0182.

- **If a patient is discharged on Monday at 4:30, does Monday count as the first business day and then Tuesday as the second business day, meaning that the communication must occur by close of business on Tuesday? Or, would the provider have until the end of the day on Wednesday?**

  In the scenario described, the practitioner must communicate with the patient by the end of the day on Wednesday, the second business day following the day of discharge.

- **Can TCM services be reported when furnished in the outpatient setting?**

  Yes. CMS has established both a facility and non-facility payment for this service. Practitioners should report TCM services with the place of service appropriate for the face-to-face visit.
MEDICARE WELLNESS CHECKUP

Please complete this checklist before seeing your doctor or nurse. Your responses will help you receive the best health and health care possible.

1. What is your age?
   □ 65-69.  □ 70-79.  □ 80 or older.

2. Are you a female or a male?
   □ Male.  □ Female.

3. During the past four weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue?

4. During the past four weeks, has your physical and emotional health limited your social activities with family, friends, neighbors, or groups?

5. During the past four weeks, how much bodily pain have you generally had?

6. During the past four weeks, was someone available to help you if you needed and wanted help?
   (For example, if you felt very nervous, lonely or blue; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help just taking care of yourself.)
   □ Yes, as much as I wanted.  □ Yes, quite a bit.  □ Yes, some.  □ Yes, a little.  □ No, not at all.

7. During the past four weeks, what was the hardest physical activity you could do for at least two minutes?

8. Can you get to places out of walking distance without help? (For example, can you travel alone on buses, taxis, or drive your own car?)
   □ Yes.  □ No.

9. Can you go shopping for groceries or clothes without someone's help?
   □ Yes.  □ No.

10. Can you prepare your own meals?
    □ Yes.  □ No.

11. Can you do your housework without help?
    □ Yes.  □ No.

12. Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around the house?
    □ Yes.  □ No.

13. Can you handle your own money without help?
    □ Yes.  □ No.

14. During the past four weeks, how would you rate your health in general?

continued ➤
15. How have things been going for you during the past four weeks?
   □ Very well; could hardly be better.
   □ Pretty well.
   □ Good and bad parts about equal.
   □ Pretty bad.
   □ Very bad; could hardly be worse.

16. Are you having difficulties driving your car?
   □ Yes, often.
   □ Sometimes.
   □ No.
   □ Not applicable, I do not use a car.

17. Do you always fasten your seat belt when you are in a car?
   □ Yes, usually.
   □ Yes, sometimes.
   □ No.

18. How often during the past four weeks have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Never</th>
<th>Seldom</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falling or dizzy when standing up.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Sexual problems.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Trouble eating well.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Teeth or denture problems.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Problems using the telephone.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Tiredness or fatigue.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

19. Have you fallen two or more times in the past year?
   □ Yes. □ No.

20. Are you afraid of falling?
   □ Yes. □ No.

21. Are you a smoker?
   □ No.
   □ Yes, and I might quit.
   □ Yes, but I'm not ready to quit.

22. During the past four weeks, how many drinks of wine, beer, or other alcoholic beverages did you have?
   □ 10 or more drinks per week.
   □ 6-9 drinks per week.
   □ 2-5 drinks per week.
   □ One drink or less per week.
   □ No alcohol at all.

23. Do you exercise for about 20 minutes three or more days a week?
   □ Yes, most of the time.
   □ Yes, some of the time.
   □ No, I usually do not exercise this much.

24. Have you been given any information to help you with the following:
   - Hazards in your house that might hurt you?
     □ Yes. □ No.
   - Keeping track of your medications?
     □ Yes. □ No.

25. How often do you have trouble taking medicines the way you have been told to take them?
   □ I do not have to take medicine.
   □ I always take them as prescribed.
   □ Sometimes I take them as prescribed.
   □ I seldom take them as prescribed.

26. How confident are you that you can control and manage most of your health problems?
   □ Very confident.
   □ Somewhat confident.
   □ Not very confident.
   □ I do not have any health problems.

27. What is your race? (Check all that apply.)
   □ White.
   □ Black or African American.
   □ Asian.
   □ Native Hawaiian or Other Pacific Islander.
   □ American Indian or Alaskan Native.
   □ Hispanic or Latino origin or descent.
   □ Other.

Thank you very much for completing your Medicare Wellness Checkup. Please give the completed checkup to your doctor or nurse.
COVERAGE INFORMATION

Effective for dates of service on or after January 1, 2011, Medicare provides coverage of an AWV for a beneficiary who is no longer within 12 months after the effective date of his or her first Medicare Part B coverage and who has not received either an IPPE or an AWV within the past 12 months.

Medicare pays for only one first AWV per beneficiary per lifetime. However, a beneficiary may receive subsequent AWVs if at least 12 months have passed since the last AWV.

Note: The AWV is a preventive wellness visit and is not a "routine physical checkup" that some seniors may receive every year or two from their physician or other qualified non-physician practitioner.

Medicare Part B does not provide coverage for routine physical examinations.

The AWV must be furnished by a health professional, meaning a physician (a doctor of medicine or osteopathy), a qualified non-physician practitioner (a physician assistant, nurse practitioner, or clinical nurse specialist), or by a medical professional (including a health educator, registered dietitian, nutrition professional, or other licensed practitioner), or a team of such medical professionals who are working under the direct supervision of a physician.

Medicare provides coverage for the AWV as a Medicare Part B benefit. The beneficiary will pay nothing for the AWV (there is no coinsurance or copayment and no Medicare Part B deductible for this benefit).

DOCUMENTATION

Medical record documentation must show that the health professionals provided, or provided and referred, all required components of the AWV.

RESOURCES

The Centers for Medicare & Medicaid Services (CMS) has developed a variety of educational resources as part of a broad outreach campaign to promote awareness and increase utilization of preventive services covered by Medicare.

For more information about coverage, coding, billing, and reimbursement of Medicare-covered preventive services and screenings, visit http://www.cms.gov/MLNProducts/35_PreventiveServices.asp on the CMS website.

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BENEFICIARY-RELATED INFORMATION

The official U.S. Government website for people with Medicare is located on the web at http://www.medicare.gov, or more information can be obtained by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-485-2048.

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Annual Wellness Visit
The summary of information presented in this brochure is intended for Medicare Fee-For-Service physicians, providers, suppliers, and other health care professionals who furnish or provide referrals for and/or file claims for the Medicare-covered preventive benefit discussed in this brochure.

As a result of the Affordable Care Act, Medicare can now cover an Annual Wellness Visit (AWV), providing Personalized Prevention Plan Services (PPPS) at no cost to the beneficiary, so beneficiaries can work with their physicians to develop and update a personalized prevention plan. This new benefit will provide an ongoing focus on prevention that can be adapted as a beneficiary’s health needs change over time.

AWV, PROVIDING PPPS

The first AWV providing PPPS is a one-time Medicare benefit and includes the following key elements furnished to an eligible beneficiary by a health professional:

- Establishment of the beneficiary’s medical/family history;
- Measurement of the beneficiary’s height, weight, body mass index, blood pressure, and other routine measurements as deemed appropriate, based on the beneficiary’s medical and family history;
- Establishment of a list of current providers and suppliers that are regularly involved in providing medical care to the beneficiary;
- Detection of any cognitive impairment that the beneficiary may have;
- Review of a beneficiary’s potential risk factors for depression;
- Review of the beneficiary’s functional ability and level of safety, based on direct observation of the beneficiary;
- Establishment of a written screening schedule for the beneficiary, such as a checklist for the next 5 to 10 years;
- Establishment of a list of risk factors and conditions of which primary, secondary, or tertiary interventions are recommended or underway for the beneficiary, including any mental health conditions or any such risk factors or conditions that have been identified through an initial preventive physical examination (IPPE), and a list of treatment options and their associated risks and benefits; and
- Provision of personalized health advice to the beneficiary and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management or community-based lifestyle interventions to reduce health risks, and promote self-management and wellness.

Subsequent AWV services proving PPPS include the following key elements furnished to an eligible beneficiary by a health professional:

- Update to the beneficiary’s medical/family history;
- Measurements to a beneficiary’s weight, blood pressure, and other routine measurements as deemed appropriate, based on the beneficiary’s medical and family history;
- Update to the list of the beneficiary’s current medical providers and suppliers that are regularly involved in providing medical care to the beneficiary, as was developed at the first AWV providing PPPS;
- Detection of any cognitive impairment that the beneficiary may have;

Update to the beneficiary’s written screening schedule as developed at the first AWV providing PPPS;

Update to the beneficiary’s list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are underway for the beneficiary, as was developed at the first AWV providing PPPS; and

Furnish appropriate personalized health advice to the beneficiary and a referral, as appropriate, to health education or preventive counseling service or programs.

PREPARING ELIGIBLE MEDICARE BENEFICIARIES FOR THE AWV

Providers can help eligible Medicare beneficiaries get ready for their AWV by encouraging them to come prepared with the following information:

- Medical records, including immunization records;
- Family health history, in as much detail as possible;
- A full list of medications and supplements including calcium and vitamins – how often and how much of each is taken; and
- A full list of current providers and suppliers involved in providing care.
**Medicare Wellness Visits**  
**1-10 Step by Step Guide**  
**Document Requirements for all 3 Visits and meet all Guidelines!**

<table>
<thead>
<tr>
<th>Year</th>
<th>dx code</th>
<th>dx description</th>
<th>dx allowed</th>
<th>dx allowed amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>G0402</td>
<td>$162 (Noridian) Only allowed during the first year patient is on Medicare (7 components)</td>
<td>DX</td>
<td>Any DX! Up to 4 for IDX</td>
</tr>
<tr>
<td></td>
<td>G0438</td>
<td>$168 (Noridian) Allowed the first time - anytime after 1st year of enrollment on Medicare</td>
<td>DX</td>
<td>Any DX! Up to 4 for IDX</td>
</tr>
<tr>
<td></td>
<td>G0439</td>
<td>$111 (Noridian) Allowed every year after the G0438 (1st Visit) is performed.</td>
<td>DX</td>
<td>Any DX! Up to 4 for IDX</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Required Components (Document all 10 points!)</strong></th>
</tr>
</thead>
</table>
| 1 Patient completes the **Health Risk Assessment (HRA)** and it is scanned into the EMR for that Date of Service **(New in 2012)**  
   **G0402, G0438 and G0439** |
| 2 Document **Height, Weight, Blood Pressure, BMI and [Visual Acuity (G0402)]**  
   **G0438 and G0439** |
| 3 Review the patient’s **Medical History** and **Social History - Attention to modifiable risk factors**  
   **(G0402)**  
   Special attention to past illnesses, surgeries, allergies, injuries, hospital stays, operations and treatments  
   **(G0438)**  
   List **current medications** including vitamin supplements  
   **(G0438 and G0439)**  
   Query **Family History** pertinent in lowering risk in certain health areas  
   **(G0438 and G0439)** |
| 4 Did the patient ever **smoke** (or still does) or drink **alcohol**? If so discuss counseling /cessation classes if needed.  
   ******* See Below** |
| 5 List all **current Providers and Suppliers** (i.e. Diabetic Supplies, ect.)  
   **G0438 and G0439** |
   **G0402, G0438 and G0439** |
| 7 **Cognitive Impairment Assessment / Observation. Info from family or care givers is permissible.**  
   **G0438 and G0439** |
| 8 Risk of **Depression or Mood Disorder.** Particular **method used?** DX currently or in past?  
   **G0402, G0438 and G0439** |
| 9 **End of Life Planning.** Does the patient have Advance Directives? Does the provider agree with the wishes?  
   **G0402** |
| 10 Give patient a **Written Plan for the next 1-10 years** that **addresses Preventative Services** available  
   **(G0402, G0438 and G0439)**  
   Risk Factors that includes Education, Counseling and Referrals based upon the findings of 1 - 9 above!  
   **G0402, G0438, G0439** |
| 11 **HCC / RAF Reminder !!! List all the chronic diagnosis (s) that that patient has! Is the DX.Controlled? Uncontrolled?**  
   Manifestations? Treatment Plan?  
   The Wellness Visit is a good way to catch these HCC DX’s at least once a year/every year! |

*** 12 months must have passed **prior to the next Wellness Visit!**

**Use other DX in lieu of V70.0 if you have them!**
Transitional Care Management Services

This publication provides the following information:

- Transitional Care Management (TCM) services;
- Health care professionals who may furnish TCM services;
- TCM services settings;
- Components included in TCM;
- Billing TCM services;
- Frequently Asked Questions; and
- Resources.

The requirements for TCM services include:

- The services are required during the beneficiary’s transition to the community setting following particular kinds of discharges;
- The health care professional accepts care of the beneficiary post-discharge from the facility setting without a gap;
- The health care professional takes responsibility for the beneficiary’s care; and
- The beneficiary has medical and/or psychosocial problems that require moderate or high complexity medical decision making.

The 30-day TCM period begins on the date the beneficiary is discharged from the inpatient hospital setting and continues for the next 29 days.
HEALTH CARE PROFESSIONALS WHO MAY FURNISH TCM SERVICES

The following health care professionals may furnish TCM services:

■ Physicians (any specialty); and
■ The following non-physician practitioners (NPP) who are legally authorized and qualified to provide the services in the State in which they are furnished:
  • Certified nurse-midwives;
  • Clinical nurse specialists;
  • Nurse practitioners; and
  • Physician assistants.

When "you" is used in this publication, we are referring to these health care professionals.

TCM SERVICES SETTINGS

TCM services are furnished following the beneficiary’s discharge from one of the following inpatient hospital settings:

■ Inpatient Acute Care Hospital;
■ Inpatient Psychiatric Hospital;
■ Long Term Care Hospital;
■ Skilled Nursing Facility;
■ Inpatient Rehabilitation Facility;
■ Hospital outpatient observation or partial hospitalization; and
■ Partial hospitalization at a Community Mental Health Center.

Following discharge from one of the above settings, the beneficiary must be returned to his or her community setting, such as:

■ His or her home;
■ His or her domiciliary;
■ A rest home; or
■ Assisted living.

COMPONENTS INCLUDED IN TCM

During the 30 days beginning on the date the beneficiary is discharged from a hospital inpatient setting, the following three TCM components must be furnished:

■ An interactive contact;
■ Certain non-face-to-face services; and
■ A face-to-face visit.

Each component is discussed in more detail on pages 3 and 4.
AN INTERACTIVE CONTACT
You must make an interactive contact with the beneficiary and/or caregiver, as appropriate, within 2 business days following the beneficiary’s discharge to the community setting. The contact may be via telephone, e-mail, or face-to-face.

For Medicare purposes, attempts to communicate should continue after the first two attempts in the required 2 business days until they are successful. A successful attempt requires a direct exchange of information and appropriate medical direction by clinical staff with the beneficiary and/or caregiver and not merely receipt of a voicemail or e-mail without response from the beneficiary and/or caregiver. You may not bill the TCM if there was no successful communication within the 30-day period between the facility discharge and the date of service for the post-discharge TCM code.

CERTAIN NON-FACE-TO-FACE SERVICES
You must furnish non-face-to-face services to the beneficiary, unless you determine that they are not medically indicated or needed. Certain non-face-to-face services may be furnished by licensed clinical staff under your direction.

Services Furnished by Physicians or NPPs
You may furnish the following non-face-to-face services:

■ Obtain and review discharge information (for example, discharge summary or continuity of care documents);
■ Review need for or follow-up on pending diagnostic tests and treatments;
■ Interact with other health care professionals who will assume or reassume care of the beneficiary’s system-specific problems;
■ Provide education to the beneficiary, family, guardian, and/or caregiver;
■ Establish or re-establish referrals and arrange for needed community resources; and
■ Assist in scheduling required follow-up with community providers and services.

Services Furnished by Licensed Clinical Staff Under the Direction of a Physician or NPP
Licensed clinical staff under your direction may furnish the following face-to-face services:

■ Communicate with agencies and community services used by the beneficiary;
■ Provide education to the beneficiary, family, guardian, and/or caretaker to support self-management, independent living, and activities of daily living;
■ Assess and support treatment regimen adherence and medication management;
■ Identify available community and health resources; and
■ Assist the beneficiary and/or family in accessing needed care and services.

A FACE-TO-FACE VISIT
One face-to-face visit must be furnished within certain timeframes as described by the following two new Current Procedural Terminology (CPT) codes (effective for services furnished on or after January 1, 2013):

■ CPT Code 99495 – Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge); or

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CPT Code 99496 – Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge).

The face-to-face visit is part of the TCM service and is not reported separately.

**Medical Decision Making**

Medical decision making is determined by considering the following factors:

- The number of possible diagnoses and/or the number of management options that must be considered;
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and
- The risk of significant complications, morbidity, and/or mortality as well as comorbidities associated with the patient’s presenting problem(s), selecting the diagnostic procedure(s), and/or selecting the possible management options.

The table below shows the elements for each level of medical decision making. Note that to qualify for a given type of medical decision making, two of the three elements must be either met or exceeded.

<table>
<thead>
<tr>
<th>Type of Decision Making</th>
<th>Number of Possible Diagnoses and/or Management Options</th>
<th>Amount and/or Complexity of Data to Be Reviewed</th>
<th>Risk of Significant Complications, Morbidity, and/or Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straightforward</td>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
</tr>
<tr>
<td>Low Complexity</td>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
</tr>
<tr>
<td>Moderate Complexity</td>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>High Complexity</td>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
</tr>
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</table>


**Medication Reconciliation and Management**

Medication reconciliation and management must be furnished no later than the date you furnish the face-to-face visit.

**BILLING TCM SERVICES**

Information about billing TCM services is provided below:

- Only one health care professional may report TCM services;
- Report services once per beneficiary during the TCM period;
The same health care professional may discharge the beneficiary from the hospital, report hospital or observation discharge services, and bill TCM services. However, the required face-to-face visit may not take place on the same day discharge day management services are reported;

- Reasonable and necessary evaluation and management (E/M) services (other than the required face-to-face visit) to manage the beneficiary’s clinical issues should be reported separately;

- You may not bill TCM services and services that are within a post-operative global period (TCM services cannot be paid if any of the 30-day TCM period falls within a global period for a procedure code billed by the same practitioner);

- When you report CPT codes 99495 and 99496 for Medicare payment, you may not also report the following codes during the TCM period:
  - Care plan oversight services: Healthcare Common Procedure Coding System (HCPCS) codes G0181 and G0182; and
  - End-Stage Renal Disease services: CPT codes 90951 – 90970; and

- You must document the following information, at a minimum, in the beneficiary’s medical record:
  - Date the beneficiary was discharged;
  - Date you made an interactive contact with the beneficiary and/or caregiver;
  - Date you furnished the face-to-face visit; and
  - The complexity of medical decision making (moderate or high).

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**FREQUENTLY ASKED QUESTIONS**

What date of service should be used on the claim?
The 30-day period for the TCM service begins on the day of discharge and continues for the next 29 days. The reported date of service should be the 30th day.

What place of service should be used on the claim?
The place of service reported on the claim should correspond to the place of service of the required face-to-face visit.

If the codes became effective on January 1, 2013, and, in general, cannot be billed until 29 days past discharge, will claims submitted before January 29, 2013, with the TCM codes be denied?
Because the TCM codes describe 30 days of services and because the TCM codes are new codes beginning on January 1, 2013, only 30-day periods beginning on or after January 1, 2013, are payable. Thus, the first payable date of service for TCM services is January 30, 2013.

The CPT book describes services by the physician’s staff as “and/or licensed clinical staff under his or her direction.” Does this mean only registered nurses and licensed practical nurses or may medical assistants also provide some parts of the TCM services?
Can the services be provided in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC)?

While FQHCs and RHCs are not paid separately by Medicare under the Medicare Physician Fee Schedule (PFS), the face-to-face visit component of TCM services could qualify as a billable visit in a FQHC or RHC. Additionally, physicians or other qualified providers who have a separate Fee-For-Service practice when not working at the RHC or FQHC may bill the CPT TCM codes, subject to the other existing requirements for billing under the PFS.

If the beneficiary is readmitted within the 30-day period, can TCM still be reported?

Yes, TCM services can still be reported as long as the services described by the code are furnished by the practitioner during the 30-day period, including the time following the second discharge. Alternatively, the practitioner can bill for TCM services following the second discharge for a full 30-day period as long as no other provider bills the service for the first discharge. CPT guidance for TCM services states that only one individual may report TCM services and only once per beneficiary within 30 days of discharge. Another TCM may not be reported by any practitioner for any subsequent discharge(s) within 30 days.

Can TCM services be reported if the beneficiary dies prior to the 30th day following discharge?

Because the TCM codes describe 30 days of care, in cases when the beneficiary dies prior to the 30th day, practitioners should not report TCM services but may report any face-to-face visits that occurred under the appropriate E/M code.

Medicare will only pay one physician or qualified practitioner for TCM services per beneficiary per 30-day period following a discharge. If more than one practitioner reports TCM services for a beneficiary, how will Medicare determine which practitioner to pay?

Medicare will only pay the first eligible claim submitted during the 30-day period that commences with the day of discharge. Other practitioners may continue to report other reasonable and necessary services, including other E/M services, to beneficiaries during those 30 days.

Can TCM services be reported under the primary care exception? Can the services be reported with the -GC modifier?

TCM services are not on the primary care exception list, so the general teaching physician policy applies as it would for E/M services not on the list. When a physician (or other appropriate billing provider) places the -GC modifier on the claim, he or she is certifying that the teaching physician has complied with the requirements in Chapter 12, Sections 100.1 through 100.1.6, of the “Medicare Claims Processing Manual” (Publication 100-04) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf on the CMS website.

Can practitioners under contract to the physician billing for the TCM service furnish the non-face-to-face component of the TCM?

Physician offices should follow “incident to” requirements for Medicare billing. “Incident to” recognizes numerous employment arrangements, including contractual arrangements, when there is direct physician supervision of auxiliary personnel. This issue is addressed in greater detail in Chapter 15, Section 60, of the “Medicare Benefit Policy Manual” (Publication 100-02) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf on the CMS website.

During the 30-day period of TCM, can other medically necessary billable services be reported?

Yes, other reasonable and necessary Medicare services may be reported during the 30-day period, with the exception of those services that cannot be reported according to CPT guidance and Medicare HCPCS codes G0181 and G0182.

If a beneficiary is discharged on Monday at 4:30 p.m., does Monday count as the first business day and then Tuesday as the second business day, meaning that the communication must occur by close of business on Tuesday? Or, would the provider have until the end of the day on Wednesday?

In the scenario described, the practitioner must communicate with the beneficiary by the end of the day on Wednesday, the second business day following the day of discharge.
Can TCM services be reported when furnished in the outpatient setting?
Yes. CMS has established both a facility and non-facility payment for this service. Practitioners should report TCM services with the place of service appropriate for the face-to-face visit.

RESOURCES

The table below provides TCM resource information.

Transitional Care Management Resources

<table>
<thead>
<tr>
<th>For More Information About…</th>
<th>Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Information for Beneficiaries</td>
<td><a href="http://www.medicare.gov">http://www.medicare.gov</a> on the CMS website</td>
</tr>
</tbody>
</table>