MEDICARE PREVENTIVE SERVICES

ICN 006559 October 2016

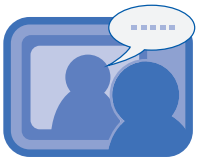
This educational tool provides the following information on Medicare preventive services: Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes; International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10) diagnosis codes; coverage requirements; frequency requirements; and Medicare beneficiary liability for each Medicare preventive service.

Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare). For additional guidance on the use of diagnosis codes, go to the Claims Processing Manual, Publication 100-04, Chapter 18 on the Centers for Medicare & Medicaid Services (CMS) website.

Watch the "CMS Provider Minute: Preventive Services" video for pointers to help you submit sufficient documentation when billing for certain preventive services.

Table 2. Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

You may provide some preventive services via telehealth; this symbol designates these services:



NOTE: We return preventive services next eligible dates for many of these services when you request Medicare eligibility. If you do not currently get this data, contact your eligibility service provider to determine availability. Refer to the Frequently Asked Questions section of this document for information on how to request the next eligible date.

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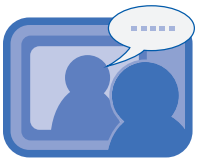
Alcohol Misuse Screening and Counseling



Also referred to as the Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse

HCPCS/CPT Codes

G0442 – Annual alcohol misuse screening, 15 minutes

G0443 – Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes

ICD-10 Codes

See the CMS ICD-10 webpage for individual Change Requests (CRs) and coding translations for ICD-10 and contact your Medicare Administrative Contractor (MAC) for guidance

Who Is Covered

All Medicare beneficiaries are eligible for alcohol screening.

Medicare beneficiaries who screen positive (those who misuse alcohol but whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence) are eligible for counseling if:

- They are competent and alert at the time counseling is provided and
- Counseling is furnished by qualified primary care physicians or other primary care practitioners in a primary care setting

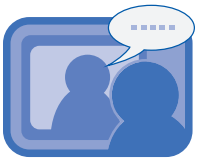
Frequency

- Annually for G0442
- For those who screen positive, 4 times per year for G0443

Medicare Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

Annual Wellness Visit (AWV)



HCPCS/CPT Codes

G0438 – Initial visit

G0439 – Subsequent visit

ICD-10 Codes

See the CMS ICD-10 webpage for individual CRs and coding translations for ICD-10 and contact your MAC for guidance

Who Is Covered

All Medicare beneficiaries who are both:

- Not within 12 months after the effective date of their first Medicare Part B coverage period
- Have not received an Initial Preventive Physical Examination (IPPE) or AWV within the past 12 months

Frequency

- Once in a lifetime for G0438 (first AWV)
- Annually for G0439 (subsequent AWV)

Medicare Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

Bone Mass Measurements

HCPCS/CPT Codes

76977 – Ultrasound bone density measurement and interpretation, peripheral site(s), any method

77078 – Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)

77080 – Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)

77081 – DXA, bone density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)

G0130 – Single energy X-ray absorptiometry (SEXA) bone density study, 1 or more sites, appendicular skeleton (peripheral) (e.g., radius, wrist, heel)

ICD-10 Codes

See the CMS ICD-10 webpage for individual CRs and coding translations for ICD-10 and contact your MAC for guidance

Who Is Covered

Certain Medicare beneficiaries who fall into at least one of the following categories:

- Women determined by their physician or qualified non-physician practitioner (NPP) to be estrogen deficient and at clinical risk for osteoporosis
- Individuals with vertebral abnormalities
- Individuals getting (or expecting to get) glucocorticoid therapy for more than 3 months
- Individuals with primary hyperparathyroidism
- Individuals being monitored to assess response to U.S. Food and Drug Administration (FDA)-approved osteoporosis drug therapy

Frequency

- Every 2 years
- More frequently if medically necessary

Medicare Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

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Cardiovascular Disease Screening Tests

HCPCS/CPT Codes

80061 – Lipid panel, this panel must include the following:

- **82465** – Cholesterol, serum, total
- **83718** – Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol)
- **84478** – Triglycerides

ICD-10 Codes

Z13.6

Who Is Covered

All Medicare beneficiaries without apparent signs or symptoms of cardiovascular disease

Frequency

Once every 5 years

Medicare Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

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Colorectal Cancer Screening

Effective January 1, 2016, use CPT code 81528 when billing for the Cologuard™ test (note that your MAC will accept HCPCS code G0464 for claims with dates of service on or before December 31, 2015).

Only laboratories authorized by the manufacturer to perform the Cologuard test may bill for this test.

HCPCS/CPT Codes

00810 – Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum

81528 – Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result

82270 – Blood, occult, by peroxidase activity (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)

G0104 – Flexible Sigmoidoscopy

G0105 – Colonoscopy (high risk)

G0106 – Barium Enema (alternative to G0104)

G0120 – Barium Enema (alternative to G0105)

G0121 – Colonoscopy (not high risk)

G0328 – Fecal Occult Blood Test (FOBT), immunoassay, 1–3 simultaneous

G0464 – Colorectal cancer screening; stool-based DNA and fecal occult hemoglobin (e.g., KRAS, NDRG4 and BMP3)

ICD-10 Codes

See the CMS ICD-10 webpage for individual CRs and coding translations for ICD-10 and contact your MAC for guidance

For Cologuard Multitarget Stool DNA (sDNA) Test, use Z12.11 and Z12.12

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Who Is Covered

For colorectal cancer screening using Cologuard—a Multitarget Stool DNA (sDNA) Test:

All Medicare beneficiaries who fall into all of the following categories:

- Aged 50 to 85 years
- Asymptomatic
- At average risk of developing colorectal cancer

For screening colonoscopies, FOBTs, flexible sigmoidoscopies, and barium enemas:

All Medicare beneficiaries who fall into at least one of the following categories:

- Aged 50 and older who are at normal risk of developing colorectal cancer
- At high risk of developing colorectal cancer

"High risk for developing colorectal cancer" is defined in the Code of Federal Regulations (CFR) at 42 CFR 410.37(a)(3)

NOTE: For coverage of screening colonoscopies, there is no age limitation

Frequency

Normal Risk:

- Cologuard Multitarget Stool DNA (sDNA) Test: once every 3 years
- Screening FOBT: every year
- Screening flexible sigmoidoscopy: once every 4 years (unless a screening colonoscopy has been performed and then Medicare may cover a screening flexible sigmoidoscopy only after at least 119 months)
- Screening colonoscopy: every 10 years (unless a screening flexible sigmoidoscopy has been performed and then Medicare may cover a screening colonoscopy only after 47 months)
- Screening barium enema (as an alternative to covered screening flexible sigmoidoscopy)

High Risk:

- Screening FOBT: every year
- Screening flexible sigmoidoscopy: once every 4 years
- Screening colonoscopy: every 2 years (unless a screening flexible sigmoidoscopy has been performed and then Medicare may cover a screening colonoscopy only after at least 47 months)
- Screening barium enema (as an alternative to covered screening flexible sigmoidoscopy or colonoscopy)

Medicare Beneficiary Pays

81528, 82270, G0104, G0105, G0121, G0328, and G0464:

- Copayment/coinsurance waived
- Deductible waived

Append modifier -33 to the anesthesia CPT code 00810 when you furnish a separately payable anesthesia service in conjunction with a screening colonoscopy (G0105 and G0121) to waive Medicare beneficiary copayment/coinsurance and deductible.

G0106 and G0120:

- Copayment/coinsurance applies
- Deductible waived

No deductible for all surgical procedures (CPT code range of 10000 to 69999) furnished on the same date and in the same encounter as a screening colonoscopy, flexible sigmoidoscopy, or barium enema initiated as colorectal cancer screening services.

Append modifier -PT to CPT code in the surgical range of 10000 to 69999 in this scenario.

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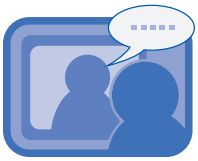
Counseling to Prevent Tobacco Use



Effective September 30, 2016, HCPCS codes G0436 and G0437 are deleted. Use existing CPT codes 99406 and 99407 for smoking and tobacco-use cessation counseling visits.

HCPCS/CPT Codes

99406 – Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes

99407 – Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes

ICD-10 Codes

F17.200, F17.201, F17.210, F17.211, F17.220, F17.221, F17.290, F17.291, T65.211A, T65.212A, T65.213A, T65.214A, T65.221A, T65.222A, T65.223A, T65.224A, T65.291A, T65.292A, T65.293A, T65.294A, and Z87.891

NOTE: Additional ICD-10 codes may apply

Who Is Covered

Outpatient and hospitalized Medicare beneficiaries for whom all of the following are true:

- Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease
- Competent and alert at the time of counseling
- Counseling furnished by a qualified physician or other Medicare-recognized practitioner

Frequency

Two cessation attempts per year. Each attempt may include a maximum of 4 intermediate or intensive sessions, with the total annual benefit covering up to 8 sessions per year

Medicare Beneficiary Pays

99406 and 99407:

- Copayment/coinsurance waived
- Deductible waived

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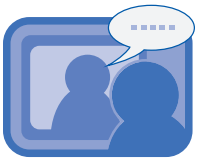
Depression Screening



HCPCS/CPT Codes

G0444 – Annual depression screening, 15 minutes

ICD-10 Codes

See the CMS ICD-10 webpage for individual CRs and coding translations for ICD-10 and contact your MAC for guidance

Who Is Covered

All Medicare beneficiaries

Must be furnished in a primary care setting that has staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up

Frequency

Annually

Medicare Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

Diabetes Screening

Medicare only pays claims for Durable Medicare Equipment (DME) if the ordering provider and DME supplier are actively enrolled in Medicare on the date of service. Tell the Medicare beneficiary if you are not participating in Medicare before you order DME. Refer to "Medicare Enrollment Guidelines for Ordering/Referring Providers" for information on how to enroll as an ordering/referring provider.

HCPCS/CPT Codes

82947 – Glucose; quantitative, blood (except reagent strip)

82950 – Glucose; post glucose dose (includes glucose)

82951 – Glucose; tolerance test (GTT), 3 specimens (includes glucose)

ICD-10 Codes

Z13.1

Who Is Covered

Medicare beneficiaries with certain risk factors for diabetes or diagnosed with pre-diabetes

NOTE: Medicare beneficiaries previously diagnosed with diabetes are not eligible for this benefit

Frequency

- Two screening tests per year for Medicare beneficiaries diagnosed with pre-diabetes
- One screening per year if previously tested but not diagnosed with pre-diabetes or if never tested

Medicare Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

Append modifier -TS when submitting claims for Medicare beneficiaries with pre-diabetes

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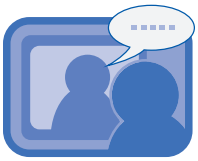
Diabetes Self-Management Training (DSMT)



HCPCS/CPT Codes

G0108 – DSMT, individual, per 30 minutes

G0109 – DSMT, group (2 or more), per 30 minutes

ICD-10 Codes

See the CMS ICD-10 webpage for individual CRs and coding translations for ICD-10 and contact your MAC for guidance

Who Is Covered

Certain Medicare beneficiaries when all of the following are true:

- Diagnosed with diabetes
- Receive an order for DSMT from the physician or qualified NPP treating the Medicare beneficiary's diabetes

Frequency

- Initial year: 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

Medicare Beneficiary Pays

- Copayment/coinsurance applies
- Deductible applies

Glaucoma Screening

HCPCS/CPT Codes

G0117 – By an optometrist or ophthalmologist

G0118 – Under the direct supervision of an optometrist or ophthalmologist

ICD-10 Codes

Z13.5

Who Is Covered

Medicare beneficiaries who fall into at least one of the following categories:

- Have diabetes mellitus
- Have a family history of glaucoma
- Are African-Americans aged 50 and older
- Are Hispanic-Americans aged 65 and older

Frequency

Annually for covered Medicare beneficiaries

Medicare Beneficiary Pays

- Copayment/coinsurance applies
- Deductible applies

Hepatitis B Virus (HBV) Vaccine and Administration

Refer to "Medicare Part B Immunization Billing" for more information.

HCPCS/CPT Codes

90739 – Hepatitis B vaccine, adult dosage (2 dose schedule), for intramuscular use

90740 – Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use

90743 – Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use

90744 – Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use

90746 – Hepatitis B vaccine, adult dosage (3 dose schedule), for intramuscular use

90747 – Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use

G0010 – Administration of Hepatitis B vaccine

ICD-10 Codes

Z23

Who Is Covered

Certain Medicare beneficiaries at intermediate or high risk for contracting hepatitis B

NOTE: Medicare beneficiaries who are currently positive for antibodies for hepatitis B are **not** eligible for this benefit

Frequency

Scheduled dosages required

Medicare Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

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Hepatitis C Virus (HCV) Screening

HCPCS/CPT Codes

G0472 – Hepatitis C antibody screening, for individual at high risk and other covered indication(s)

ICD-10 Codes

Z72.89 and F19.20

Who Is Covered

Certain adult Medicare beneficiaries who fall into at least one of the following categories:

- High risk for HCV infection
- Born between 1945 and 1965

Frequency

- Annually only for high risk Medicare beneficiaries with continued illicit injection drug use since the prior negative screening test
- Once in a lifetime for Medicare beneficiaries born between 1945 and 1965 who are not considered high risk

Medicare Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

Human Immunodeficiency Virus (HIV) Screening

Effective April 13, 2015, procedure code G0475 may be billed for HIV screening.

Refer to "Screening for the Human Immunodeficiency Virus (HIV) Infection" for more information.

HCPCS/CPT Codes

80081 – Obstetric panel (includes HIV testing)

G0432 – Infectious agent antibody detection by enzyme immunoassay (EIA) technique

G0433 – Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique

G0435 – Infectious agent antibody detection by rapid antibody test

G0475 – HIV antigen/antibody, combination assay, screening

ICD-10 Codes

Increased risk factors **not** reported – Z11.4

Increased risk factors reported – Z11.4 and Z72.89, Z72.51, Z72.52, or Z72.53

Pregnant Medicare beneficiaries – Z11.4 and Z34.00, Z34.01, Z34.02, Z34.03, Z34.80, Z34.81, Z34.82, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93, O09.90, O09.91, O09.92, or O09.93

Who Is Covered

Certain Medicare beneficiaries who are at increased risk for HIV infection, including anyone who asks for the test, or pregnant women

NOTE: "Increased risk for HIV infection" is defined in the Medicare National Coverage Determinations Manual, Publication 100-03, Chapter 1, Section 210.7

Frequency

- Annually for Medicare beneficiaries between the ages of 15 and 65 without regard to perceived risk
- Annually for Medicare beneficiaries younger than 15 and adults older than 65 who are at increased risk for HIV infection
- For Medicare beneficiaries who are pregnant, 3 times per pregnancy:
  - First, when a woman is diagnosed with pregnancy
  - Second, during the third trimester
  - Third, at labor, if ordered by the woman's clinician

Medicare Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

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Influenza Virus Vaccine and Administration

Refer to "Medicare Part B Immunization Billing" for more information.

HCPCS/CPT Codes

90630, 90653, 90654, 90655, 90656, 90657, 90661, 90662, 90672, 90673, 90674, 90685, 90686, 90687, 90688, Q2035, Q2036, Q2037, Q2038, Q2039 – Influenza Virus Vaccine

G0008 – Administration of influenza virus vaccine

ICD-10 Codes

Z23

Who Is Covered

All Medicare beneficiaries

Frequency

Once per influenza season

Medicare covers additional flu shots if medically necessary

Medicare Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

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Initial Preventive Physical Examination (IPPE)

Also known as the “Welcome to Medicare Preventive Visit”

HCPCS/CPT Codes

G0402 – IPPE

G0403 – EKG for IPPE

G0404 – EKG tracing for IPPE

G0405 – EKG interpret & report for IPPE

ICD-10 Codes

See the CMS ICD-10 webpage for individual CRs and coding translations for ICD-10 and contact your MAC for guidance

Who Is Covered

All new Medicare beneficiaries who are within the first 12 months of their first Medicare Part B coverage period

Frequency

Once in a lifetime

Must furnish no later than 12 months after the effective date of the first Medicare Part B coverage period

Medicare Beneficiary Pays

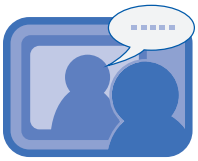
G0402:

- Copayment/coinsurance waived
- Deductible waived

G0403, G0404, and G0405:

- Copayment/coinsurance applies
- Deductible applies

Intensive Behavioral Therapy (IBT) for Cardiovascular Disease (CVD)



Also known as a CVD risk reduction visit

HCPCS/CPT Codes

G0446 – Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes

ICD-10 Codes

See the CMS ICD-10 webpage for individual CRs and coding translations for ICD-10 and contact your MAC for guidance

Who Is Covered

All Medicare beneficiaries who are:

- Competent and alert at the time counseling is provided
- Furnished counseling by a qualified primary care physician or other primary care practitioner and in a primary care setting

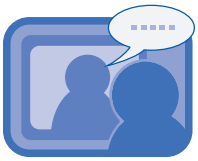
Frequency

Annually for covered Medicare beneficiaries

Medicare Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

Intensive Behavioral Therapy (IBT) for Obesity



HCPCS/CPT Codes

G0447 – Face-to-face behavioral counseling for obesity, 15 minutes

G0473 – Face-to-face behavioral counseling for obesity, group (2–10), 30 minutes

ICD-10 Codes

Z68.30, Z68.31, Z68.32, Z68.33, Z68.34, Z68.35, Z68.36, Z68.37, Z68.38, Z68.39, Z68.41, Z68.42, Z68.43, Z68.44, or Z68.45

Who Is Covered

Medicare beneficiaries when all of the following are true:

- Obesity (Body Mass Index [BMI] ≥ 30 kilograms [kg] per meter squared)
- Competent and alert at the time counseling is provided
- Counseling furnished by a qualified primary care physician or other primary care practitioner in a primary care setting

Frequency

- First month: one face-to-face visit every week
- Months 2–6: one face-to-face visit every other week
- Months 7–12: one face-to-face visit every month if certain requirements are met

At the 6-month visit, a reassessment of obesity and a determination of the amount of weight loss must be performed.

To be eligible for additional face-to-face visits occurring once a month for an additional 6 months, Medicare beneficiaries must have lost at least 3 kg.

For Medicare beneficiaries who do not achieve a weight loss of at least 3 kg during the first 6 months, a reassessment of their readiness to change and BMI is appropriate after an additional 6-month period.

Medicare Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

Lung Cancer Screening Counseling and Annual Screening for Lung Cancer With Low Dose Computed Tomography (LDCT)

Refer to "Medicare Coverage of Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)" for more information.

HCPCS/CPT Codes

G0296 – Counseling visit to discuss need for lung cancer screening (LDCT) using low dose CT scan (service is for eligibility determination and shared decision making)

G0297 – Low dose CT scan (LDCT) for lung cancer screening

ICD-10 Codes

Z87.891

Who Is Covered

Medicare beneficiaries who fall into all of the following categories:

- Age 55–77 years
- Asymptomatic
- Tobacco smoking history of at least 30 pack-years (one pack-year = smoking one pack per day for one year; 1 pack = 20 cigarettes)
- Current smoker or one who has quit smoking within the last 15 years
- Receive a written order for lung cancer screening with LDCT

Frequency

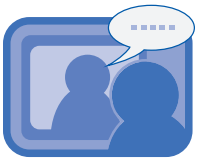
Annually for covered Medicare beneficiaries

- First year: Before the first lung cancer LDCT screening, Medicare beneficiaries must receive a counseling and shared decision making visit
- Subsequent years: The Medicare beneficiary must receive a written order furnished during an appropriate visit with a physician or NPP

Medicare Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

Medical Nutrition Therapy (MNT)



HCPCS/CPT Codes

97802 – MNT; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes

97803 – MNT; re-assessment and intervention, individual, face-to-face with the patient each 15 minutes

97804 – MNT; group (2 or more individual(s)), each 30 minutes

G0270 – MNT reassessment and subsequent intervention(s) for change in diagnosis, medical condition or treatment regimen, individual, each 15 minutes

G0271 – MNT reassessment and subsequent intervention(s) for change in diagnosis, medical condition or treatment regimen, group (2 or more), each 30 minutes

ICD-10 Codes

See the CMS ICD-10 webpage for individual CRs and coding translations for ICD-10 and contact your MAC for guidance

Who Is Covered

Certain Medicare beneficiaries when all of the following are true:

- Receive a referral from their treating physician
- Diagnosed with diabetes or renal disease, or who have received a kidney transplant within the last 3 years
- Service provided by a registered dietitian or nutrition professional

Frequency

- First year: 3 hours of one-on-one counseling
- Subsequent years: 2 hours

Medicare Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

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Pneumococcal Vaccine and Administration

Refer to "Medicare Part B Immunization Billing" for more information.

HCPCS/CPT Codes

90670 – Pneumococcal Conjugate Vaccine

90732 – Pneumococcal polysaccharide vaccine

G0009 – Administration

ICD-10 Codes

Z23

Who Is Covered

All Medicare beneficiaries

Frequency

- An initial pneumococcal vaccine to Medicare beneficiaries who never received the vaccine under Medicare Part B
- A different, second pneumococcal vaccine 1 year after the first vaccine was administered

Medicare Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

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Prostate Cancer Screening

HCPCS/CPT Codes

G0102 – Digital Rectal Exam (DRE)

G0103 – Prostate Specific Antigen Test (PSA)

ICD-10 Codes

Z12.5

Who Is Covered

All male Medicare beneficiaries aged 50 and older (coverage begins the day after their 50th birthday)

Frequency

Annually for covered Medicare beneficiaries

Medicare Beneficiary Pays

G0102:

- Copayment/coinsurance applies
- Deductible applies

G0103:

- Copayment/coinsurance waived
- Deductible waived

Screening for Cervical Cancer with Human Papillomavirus (HPV) Tests

Effective July 9, 2015!

Refer to "Screening for Cervical Cancer with Human Papillomavirus (HPV) Testing – National Coverage Determination (NCD) 210.2.1" for more information.

From July 9, 2015, through December 31, 2016, code G0476 is only paid when billed by a laboratory entity.

HCPCS/CPT Codes

G0476 – Cervical cancer screening, all-inclusive HPV co-test with cytology (Pap smear) to detect HPV DNA or RNA sequences

ICD-10 Codes

Use either of the following:

- Encounter for screening for HPV – Z11.51 and Encounter for gynecological exam (general) (routine) with abnormal findings – Z01.411
- Encounter for gynecological exam (general) (routine) without abnormal findings – Z01.419

Who Is Covered

All asymptomatic female Medicare beneficiaries aged 30 to 65 years

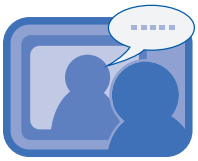
Frequency

Once every 5 years

Medicare Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling (HIBC) to Prevent STIs



HCPCS/CPT Codes

86631, 86632, 87110, 87270, 87320, 87490, 87491, 87810 – Chlamydia

87590, 87591, 87850 – Neisseria gonorrhoeae

87800 – Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique

86592 – Syphilis test, non-treponemal antibody; qualitative (e.g., VDRL, RPR, ART)

86593 – Syphilis test, non-treponemal, quantitative

86780 – Treponema pallidum

87340, 87341 – Hepatitis B (hepatitis B surface antigen)

G0445 – Semiannual high intensity behavioral counseling to prevent STIs, individual, face-to-face, includes education skills training & guidance on how to change sexual behavior, 30 minutes

ICD-10 Codes

Z11.3, Z72.89, Z72.51, Z72.52, Z72.53, Z34.00, Z34.01, Z34.02, Z34.03, Z34.80, Z34.81, Z34.82, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93, O09.90, O09.91, O09.92, and O09.93

Who Is Covered

Certain Medicare beneficiaries when all of the following are true:

- Sexually active adolescents and adults at increased risk for STIs
- Referred for this service by a primary care provider and provided by a Medicare-eligible primary care provider in a primary care setting

NOTE: For more information about increased risk for STIs and covered Medicare beneficiaries, refer to the Medicare National Coverage Determinations Manual, Publication 100-03, Chapter 1, Section 210.10

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Frequency

- One annual occurrence of screening for chlamydia, gonorrhea, and syphilis in women at increased risk who are not pregnant
- One annual occurrence of screening for syphilis in men at increased risk
- Up to two occurrences per pregnancy of screening for chlamydia and gonorrhea in pregnant women who are at increased risk for STIs and continued increased risk for the second screening
- One occurrence per pregnancy of screening for syphilis in pregnant women; up to two additional occurrences in the third trimester and at delivery if at continued increased risk for STIs
- One occurrence per pregnancy of screening for hepatitis B in pregnant women; one additional occurrence at delivery if at continued increased risk for STIs
- Up to two 20–30 minute, face-to-face HIBC sessions annually

Medicare Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

Screening Mammography

HCPCS/CPT Codes

77052 – Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further review for interpretation; screening mammography (List separately in addition to code for primary procedure)

77057 – Screening mammography, bilateral (2-view film study of each breast)

77063 – Screening digital breast tomosynthesis; bilateral (List separately in addition to code for primary procedure) (Use this as an add-on code to G0202 when tomosynthesis is used in addition to 2-D mammography)

G0202 – Screening mammography, producing direct 2-D digital image, bilateral, all views

ICD-10 Codes

Z12.31

Who Is Covered

All female Medicare beneficiaries aged 35 and older

Frequency

- Aged 35 through 39: One baseline
- Aged 40 and older: Annually

Medicare Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

NOTE: If billing a screening mammogram and a diagnostic mammogram on the same day, use modifier -GG to show a screening mammogram turned into a diagnostic mammogram

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Screening Pap Tests

HCPCS/CPT Codes

G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148 – Screening cytopathology, cervical or vaginal

P3000 – Screening Pap smear by technician under physician supervision

P3001 – Screening Pap smear requiring interpretation by physician

Q0091 – Screening Pap smear; obtaining, preparing and conveyance to lab

ICD-10 Codes

High risk – Z77.21, Z77.22, Z77.9, Z91.89, Z92.89, Z72.51, Z72.52, and Z72.53

Low risk – Z01.411, Z01.419, Z12.4, Z12.72, Z12.79, and Z12.89

Who Is Covered

All female Medicare beneficiaries

Frequency

- Annually if at high risk for developing cervical or vaginal cancer or childbearing age with abnormal Pap test within past 3 years
- Every 2 years for women at normal risk

Medicare Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

Screening Pelvic Examinations (includes a clinical breast examination)

HCPCS/CPT Codes

G0101 – Cervical or vaginal cancer screening; pelvic and clinical breast examination

ICD-10 Codes

High risk – Z77.22, Z77.9, Z91.89, Z72.89, Z72.51, Z72.52, and Z72.53

Low risk – Z01.411, Z01.419, Z12.4, Z12.72, Z12.79, and Z12.89

Who Is Covered

All female Medicare beneficiaries

Frequency

- Annually if at high risk for developing cervical or vaginal cancer or childbearing age with abnormal Pap test within past 3 years
- Every 2 years for women at normal risk

Medicare Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)

HCPCS/CPT Codes

G0389 – Ultrasound exam for AAA screening

ICD-10 Codes

See the CMS ICD-10 webpage for individual CRs and coding translations for ICD-10 and contact your MAC for guidance

Who Is Covered

Medicare beneficiaries when all of the following are true:

- Certain risk factors for AAA
- Receive a referral from their physician, physician assistant, nurse practitioner, or clinical nurse specialist

Frequency

Once in a lifetime

Medicare Beneficiary Pays

- Copayment/coinsurance waived
- Deductible waived

Frequently Asked Questions (FAQs)

May CMS add new preventive services as Medicare benefits?

CMS may add coverage of "additional preventive services" through the National Coverage Determination (NCD) process if the service meets all of the following criteria:

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)
3. Appropriate for individuals entitled to benefits under Part A or enrolled under Part B of the Medicare Program

Visit the USPSTF Published Recommendations webpage for the latest preventive service recommendation and the Medicare Preventive Services Announcements webpage for information from CMS on preventive services.

What is a primary care setting?

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

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

You have different options for accessing eligibility information. You may be able to access the information through the CMS HIPAA Eligibility Transaction System (HETS) either directly or through your eligibility services vendor, through your Medicare Administrative Contractor (MAC) provider call center Interactive Voice Response (IVR) unit and/or MAC provider internet portal. CMS suggests you contact your eligibility service vendor or check your MAC's eligibility services for more information. Find MAC contact information on the Medicare Review Contractor Directory – Interactive Map webpage.

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

Medicare provides a "Preventive Services Checklist" you can give to your patients. They can use the checklist to track their preventive services.

Resources

Table 1. Resources

Resource	Website
ICD-10 Information	CMS.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html
MAC Contact Information	Review Contractor Directory – Interactive Map CMS.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map
Preventive Services	CMS Webpage CMS.gov/Medicare/Prevention/PrevntionGenInfo FAQs Questions.cms.gov/faq.php?id=5005&rtopic=1991 Medicare Preventive Services National Educational Products CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedicarePreventiveServicesNationalEducationProducts.pdf Medicare Preventive Services Announcements CMS.gov/Medicare/Prevention/PrevntionGenInfo/Health-Observance-Messages.html MLN Matters® Articles on Medicare-Covered Preventive Services CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNPrevArticles.pdf Preventive Services Checklist Medicare.gov/Pubs/pdf/11420.pdf USPSTF Published Recommendations USPreventiveServicesTaskForce.org/BrowseRec/Index

Table 1. Resources (cont.)

Resource	Website
Regulations	Code of Federal Regulations GPO.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR Internet-Only Manuals (IOMs) CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html
Related MLN Products	"MLN Guided Pathway: Provider Specific Medicare Resources" Guide CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf "Medicare Enrollment Guidelines for Ordering/Referring Providers" Publication CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1247538.html "Resources for Medicare Beneficiaries" Publication CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN905183.html "Telehealth Services" Publication CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243327.html

Table 2. Hyperlink Table

Embedded Hyperlink	Complete URL
42 CFR 410.37(a)(3)	https://www.govinfo.gov/content/pkg/CFR-2015-title42-vol2/pdf/CFR-2015-title42-vol2-sec410-37.pdf
Claims Processing Manual, Publication 100-04, Chapter 18	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf

Table 2. Hyperlink Table (cont.)

Embedded Hyperlink	Complete URL
Contact your Medicare Administrative Contractor (MAC)	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map
ICD-10	https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html
"Medicare Coverage of Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)"	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm9246.pdf
"Medicare Enrollment Guidelines for Ordering/Referring Providers"	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1247538.html
Medicare National Coverage Determinations Manual, Publication 100-03, Chapter 1	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf
"Medicare Part B Immunization Billing"	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243321.html
Medicare Preventive Services Announcements	https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Health-Observance-Messages.html
Medicare Review Contractor Directory – Interactive Map	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map
Preventive Services Checklist	https://www.medicare.gov/Pubs/pdf/11420.pdf

Table 2. Hyperlink Table (cont.)

Embedded Hyperlink	Complete URL
"Screening for Cervical Cancer with Human Papillomavirus (HPV) Testing – National Coverage Determination (NCD) 210.2.1"	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9434.pdf
"Screening for the Human Immunodeficiency Virus (HIV) Infection"	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9403.pdf
USPSTF Published Recommendations	http://www.uspreventiveservicestaskforce.org/BrowseRec/Index

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