Talking points

Patients may have questions when receiving preventive services. Clearly communicating with them from the onset can help mitigate problems later. Below are some helpful tips:

- To prepare patients for the costs of the initial preventive physical examination (IPPE), physicians and/or office staff should inform patients about the following:
  - Clinical lab tests are not covered by Medicare as part of the IPPE. During the IPPE the physician may refer for clinical lab tests, some of which may or may not be covered by Medicare and may necessitate separate billing.
  - Other services that are recognized for payment under local coverage determinations would be paid by their insurance, but they may be responsible for a deductible and 20 percent coinsurance.
- Consider using an advanced beneficiary notice (ABN) when letting patients know about their out-of-pocket expenses.
- Let patients know what to expect when receiving preventive services. For example, if you are not performing the service, let them know that you will be reviewing the information.

Visit www.ama-assn.org/go/cptmedicareps for more information.

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Essential terms

Following is a useful guide to some commonly used terms as they pertain to Medicare coverage.

Eligible patient—an individual who is no longer within the first 12 months of his or her effective date of Medicare Part B coverage, and who has not received either an initial preventive physical examination or an annual wellness visit that provided a personalized prevention plan within the past 12 months.

Establishment of, or an update to, the individual's medical and family history—at minimum, the collection and documentation of the following: (1) past medical and surgical history; (2) use or exposure to medications and supplements; (3) medical events in the patient's parents and any siblings and children.

Review of the individual's functional ability and level of safety—at minimum, assessment of the following topics: hearing impairment, fall risk, activities of daily living, home safety.

In addition to essential terms, it's equally important to understand the USPSTF rating system. In May 2007, the USPSTF changed its grade definitions based on a change in methods. The following chart serves as a quick reference to USPSTF grades and their meaning.

Grade	Definition*	Suggestions for practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service.
C	The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service to an individual. There is moderate certainty that the net benefit is small.	Offer this service only if other considerations support providing of this service in an individual patient.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service.	Read the clinical considerations section of the USPSTF Recommendation Statement. Patients should understand the uncertainty involved.

* U.S. Preventive Services Task Force grade definitions after May 2007, May 2008. www.uspreventiveserviestaskforce.org/uspstf/gradespost.htm

Medicare preventive services with cost-sharing waived*

U.S. Preventive Service Task Force (USPSTF) recommendations and their corresponding codes and grades.

CPT or HCPCS Code	USPSTF rating
Initial preventive physical examination (IPPE)	
G0402	Not rated**
G0403^	Not rated**
G0404^	Not rated**
G0405^	Not rated**
Annual wellness visit (AWV)	
G0438	Not rated**
G0439	Not rated**
Bone mass measurement	
G0130	B
77078	B
77079	B
77080	B
77081	B
77083	B
76977	B
Cardiovascular disease screening	
80061∞	A
82465∞	A
83718∞	A
84478∞	A
Colorectal cancer screening	
G0104	A
G0105	A
G0106†	Not rated**
G0120†	Not rated**
G0121	A
82270∞	A
G0328∞	A
Diabetes screening tests	
82947∞	B
82950∞	B
82951∞	Not rated**

CPT or HCPCS Code	USPSTF rating
Diabetes self-management training services (DSMT)	
G0108^	Not rated**
G0109^	Not rated**
Glaucoma screening	
G0117^	I
G0118^	I
Hepatitis B vaccine	
90740√	A
90743√	A
90744√	A
90746√	A
90747√	A
G0010	A
HIV screening	
G0432√	A
G0433√	A
G0435√	A
Influenza virus vaccine	
90655√	B
90656√	B
90657√	B
90660√	B
90662√	B
Q2035√	B
Q2036√	B
Q2037√	B
Q2038√	B
Q2039√	B
G0008	B
G9141	B
G9142√	B

CPT or HCPCS Code	USPSTF rating
Medical nutrition therapy (MNT) services	
97802	B
97803	B
97804	B
G0270	B
G0271	B
Pneumococcal vaccine	
90669√	B
90670√	B
90732√	B
G0009	B
Prostate cancer screening	
G0102^	D
G0103∞	D
Screening mammography	
77052	B
77057	B
G0202	B

CPT or HCPCS Code	USPSTF rating
Screening pap test	
G0123∞	A
G0124	A
G0141	A
G0143∞	A
G0144∞	A
G0145∞	A
G0147∞	A
G0148∞	A
P3000∞	A
P3001	A
Q0091	A
Screening pelvic exam	
G0101	A
Smoking and tobacco cessation	
G0436	A
G0437	A
Ultrasound screening for abdominal aortic aneurysm	
G0389	B

Quick guide of the symbols:
* Per Section 1861 (ddd)(3)(A) of the Affordable Care Act
** Preventive service is not rated by the USPSTF
^ Coinsurance/deductible is not waived for calendar year 2011
† Coinsurance applies and deductible is waived for calendar year 2011
∞ Payment method is based on the clinical laboratory fee schedule
√ Payment method is based on the drug pricing file

Non-covered preventive services

Preventive medicine service codes* not covered by Medicare.

New patient

Code	Descriptor
99381	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; Infant (age younger than 1 year)
99382	Early childhood (age 1–4 years)
99383	Late childhood (age 5–11 years)
99384	Adolescent (age 12–17 years)
99385	18–39 years
99386	40–64 years
99387	65 years and older

Established patient

Code	Descriptor
99391	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; Infant (age younger than 1 year)
99392	Early childhood (age 1–4 years)
99393	Late childhood (age 5–11 years)
99394	Adolescent (age 12–17 years)
99395	18–39 years
99396	40–64 years
99397	65 years and older

* Please note these services are not covered by Medicare. For covered Medicare preventive service codes review the initial preventive physical examination (IPPE) and annual wellness visit (AWV) charts on the reverse side.

Preventive services means all of the following:

1. The specific services listed in section 1861(ww)(2) of the Affordable Care Act (ACA), with the explicit exclusion of electrocardiograms
2. The initial preventive physical examination, as specified by section 1861(ww)(1) of the ACA
3. Annual wellness visit, providing personalized prevention plan services, as specified by section 1861(hhh)(1) of the ACA

Putting prevention into practice

Medicare preventive services

A new benefit for patients and physicians

AMA AMERICAN MEDICAL ASSOCIATION

With the passage of the Affordable Care Act (ACA), physicians now have more opportunities to ensure their Medicare patients receive preventive services, particularly after the initial "Welcome to Medicare" visit or the initial preventive physical examination (IPPE) is completed.

The ACA waives the deductible and coinsurance for selected preventive services. For physicians and patients, this means that the patient's deductible and coinsurance will be paid by Centers for Medicare & Medicaid Services (CMS). Thus, physicians can offer preventive services at a more affordable cost to the patient and, in doing so, enhance the physician-patient relationship.

The American Medical Association created this brochure to help physicians and their team members help patients navigate their Medicare coverage. It can be used as a reference to:

1. Understand when and which preventive services will be covered when providing specified preventive physical exams/ wellness visits for patients
2. Identify the recommended U.S. Preventive Service Task Force (USPSTF) recommendations for preventive services quickly
3. Ensure that patients are informed and prepared to potentially pay additional costs for certain preventive services
4. Clarify essential terms regarding the delivery of preventive services

Personalize your prevention plan

What's now covered for each patient wellness visit?

Foremost, cost-sharing is now waived for most services. The following information outlines the services that are covered during your patients' initial preventive physical examination (IPPE) and their annual wellness visit (AWV) covered under Medicare Part B only.

Note that patients are eligible for an IPPE visit **within one year** of the effective date of their Medicare Part B coverage. Patients are eligible for an AWV 12 months after eligibility of the IPPE (no IPPE or subsequent AWV may occur within 12 months of this visit). The secretary of Health and Human Services has the potential under the ACA to add other elements to the AWV, as determined to be appropriate.

G0402: Initial preventive physical examination (IPPE) services

1. **Review of individual's medical and social history**
   At a minimum, obtain the following:
   - Past medical/surgical history (experiences with illnesses, hospital stays, operations, allergies, injuries and treatments)
   - Current medications and supplements (including calcium and vitamins)
   - Family history (review of medical events in the family, including diseases that may be hereditary or place the individual at risk)
   - History of alcohol, tobacco and illicit drug use
   - Diet
   - Physical activities
2. **Review of individual's risk factors for depression and other mood disorders**
   Use any appropriate screening instrument recognized by national professional medical organizations to obtain current or past experiences with depression or other mood disorders.
3. **Review of individual's functional ability and level of safety**
   Use any appropriate screening questions or standardized questionnaires recognized by national professional medical organizations to review, at a minimum, the following areas:
   - Hearing impairment
   - Activities of daily living
   - Fall risk
   - Home safety
4. **A physical examination**
   Obtain the following:
   - Height, weight and blood pressure
   - Visual acuity screen
   - Measurement of body mass index
   - Other factors deemed appropriate based on the individual's medical and social history and current clinical standards
5. **End-of-life planning**
   Effective for dates of service on or after January 1, 2009, the IPPE includes end-of-life planning as a required service, upon the patient's consent. End-of-life planning is verbal or written information provided to the patient regarding:
   - The patient's ability to prepare an advance directive in the case that an injury or illness causes the patient to be unable to make health care decisions, and
   - Whether or not the physician is willing to follow the patient's wishes as expressed in the advance directive.
6. **Education, counseling and referral based on the previous five components**
   Based on the results of the review and evaluation services provided in the previous five components, provide education, counseling and referral. Examples include the following:
   - Counseling on diet if the individual is overweight
   - Education on prevention of chronic diseases
   - Smoking and tobacco-use cessation counseling
7. **Education, counseling and referral for other preventive services**
   Complete a brief written plan, such as a checklist, to be given to the patient for obtaining an electrocardiogram, as appropriate, and the appropriate screenings and additional preventive services that are covered as separate Medicare Part B benefits.

G0438: First annual wellness visit (AWV) services

1. **Establish the patient's medical and family history.**
2. **Establish a list of current providers and suppliers** who are regularly involved in providing medical care to the individual.
3. **Measure height, weight, body mass index** (or waist circumference, if appropriate), blood pressure and other routine measurements as deemed appropriate, based on the individual's medical and family history.
4. **Detect any cognitive impairments.**
5. **Review patient's risk factors for depression,** including current or past experiences with depression or other mood disorders, based on direct observation or use of appropriate screening questions or questionnaires.
6. **Review patient's functional ability and level of safety.**
7. **Establish the following:**
   - A written screening schedule, such as a checklist, for the next five to 10 years as appropriate, based on USPSTF recommendations, the Advisory Committee on Immunization Practices and the individual's health status, screening history and age-appropriate preventive services covered by Medicare.
   - A list of risk factors and conditions for which primary, secondary or tertiary interventions are recommended or are underway, including any mental health conditions or any risk factors or conditions that have been identified through an initial preventive physical examination. Provide a list of treatment options and their associated risks and benefits.
8. **Furnish personalized health advice to the individual and a referral,** where appropriate, for health education, preventive counseling services or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention and nutrition.
9. **Through the CMS regulatory process,** CMS may make changes to the Medicare preventive services coverage policy. Visit **www.cms.gov/mcd** and click on "Indexes" for more information about the National Coverage Determination (NCD) process.

G0439: Annual wellness visit (AWV) services, subsequent to the first AWV

1. **Update the individual's medical and family history.**
2. **Update the list of current providers and suppliers** who are regularly involved in providing medical care to the individual.
3. **Measure weight, body mass index** (or waist circumference, if appropriate), blood pressure and other routine measurements as deemed appropriate, based on the individual's medical and family history.
4. **Detect any cognitive impairments.**
5. **Update both of the following:**
   - The written screening schedule developed at the first AWV
   - The list of risk factors and conditions for which primary, secondary or tertiary interventions are recommended or are underway for the individual
6. **Furnish personalized health advice to the individual and refer,** as appropriate, to health education or preventive counseling services.
7. **Any other element determined through the NCD process.**

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