Provider Education Webinars

Course 7:

Course 7: Proper Coding For Preventive And Problem-Oriented Sick Visits
Housekeeping Items

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Welcome

Welcome to this presentation of Community Health Plan’s Provider Education Webinar, Course 7: Proper Coding For Preventative And Problem-Oriented Sick Visits

This webinar series is designed specifically for Community Health Plan’s Physicians, Healthcare Professionals, and Administrative Staff who want to broaden their understanding and use of documentation and coding skills.

This webinar series consists of 10 one-hour courses.

Attendees may earn

• Continuing Medical Education (CME) through the AAFP*, and/or
• Continuing Education Units (CEU) through AAPC** and AHIMA***

Courses and Self-Assessments must be completed to earn the CME/CEU credit.

* American Academy of Family Physicians
** American Academy of Professional Coders
*** American Health Information Management Association
A Comprehensive Approach to Optimizing Documentation & Coding

Documentation → Coding → Revenue Capture → Billing → Team Members

Clinics
Clinicians
Coders
Billers
CHP
Our Role – Clinical Components

- Deliver timely comprehensive care....
- Document the care you deliver....
- Code the care you document....
- Capture the codes you document...
Community Health Plan - Medicare Advantage
Member HCC Report

HEALTH CENTER - Clinic Name

Run Date: 10/27/2008

Patient Name: Doe, John
Address: 1234 Main Street, Anytown, US 98785
(555) 666-6666

Member ID: HP1000000000

How To Use This Report

Step 1: Please review the diagnoses (ICD9 codes) and conditions (Hierarchical Condition Categories (HCC Codes)) listed in Sections 1 and 2. If you believe that a diagnosis/condition listed here is not relevant to this patient, please circle the diagnosis/condition.

Step 2: After reviewing, please sign below and fax this form to our confidential fax: 206-652-7024. Attn: Member HCC Report.

Step 3: At your next visit with this patient, please check for the presence of these diagnoses/conditions and document each currently present diagnosis/condition accordingly in your visit note.

Section 1 - Conditions (HCCs) Reported in Current Year
(Reported diagnoses may come from multiple care settings, including primary care, specialty care and hospital providers. Only one HCC per patient is shown, with highest documented ICD9 code.)

<table>
<thead>
<tr>
<th>ICD9 Code</th>
<th>ICD9 Description</th>
<th>HCC Code</th>
<th>HCC Description</th>
<th>Risk Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>250.00</td>
<td>Dmi/Wp Crep Nl St Unconr</td>
<td>19</td>
<td>Diabetes without Complication</td>
<td>0.2</td>
</tr>
</tbody>
</table>

Section 2 - Additional Conditions (HCCs) Reported in Prior Years

<table>
<thead>
<tr>
<th>ICD9 Code</th>
<th>ICD9 Description</th>
<th>HCC Code</th>
<th>HCC Description</th>
<th>Risk Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>291.51</td>
<td>Alcohol Withdraw</td>
<td>51</td>
<td>Drug/Alcohol Psychosis</td>
<td>0.353</td>
</tr>
<tr>
<td>303.90</td>
<td>Aloch Dep Nec/Nos-Unspec</td>
<td>52</td>
<td>Drug/Alcohol Dependence</td>
<td>0.265</td>
</tr>
<tr>
<td>780.39</td>
<td>Convulsions Nec</td>
<td>74</td>
<td>Seizure Disorders and Convulsions</td>
<td>0.269</td>
</tr>
<tr>
<td>428.0</td>
<td>Chf Nos.</td>
<td>80</td>
<td>Congestive Heart Failure</td>
<td>0.417</td>
</tr>
<tr>
<td></td>
<td></td>
<td>16</td>
<td>Diabetes with Neurologic or Other</td>
<td>0.262</td>
</tr>
<tr>
<td></td>
<td></td>
<td>71</td>
<td>Specified Manifestation</td>
<td>0.260</td>
</tr>
</tbody>
</table>

I have reviewed the diagnoses/conditions listed on this page, along with the medical history of this patient. With the exception of those codes that are circled, I attest that these diagnoses/conditions are present in this patient’s medical history as available to me beginning __________ (mm/yyyy).

Printed Name & Credentials

Signature

Date

Confidential patient information. Not to be filed in chart.
Community Health Plan of Washington Provider Education Webinar

Course 7: Proper Coding For Preventive And Problem-Oriented Sick Visits

Marvel Gray, CPC, CCS-P, MCS-P, PCS, CCP, CCO, CMPM
Cost Reimbursement and Research Analyst

Kate Parman, CPC, CCS, CCS-P, MCS-P
Cost Recovery Analyst
Learning Objectives

Webinar Learning Objective:
The goal of Community Health Plan is that our Providers will apply this career training and best practices information across their care spectrum, regardless of their Patients’ ability to pay or insurance type.

Course 7:
Proper Coding For Preventive and Problem Visits

Learning Objective:
To focus on proper use of CPT & HCPCS codes to meet various coding and descriptive requirements.

Participants’ learning objectives for Course 7:
• Understand the purpose of coding wellness and illness visits separately and in combination
• Learn how proper coding of preventive visits with problem visits optimizes reimbursement and enhances compliance
• Recognize how to improve documentation quality, coding accuracy, and revenue when coding preventive visits and/or problem visits.
Preventive (Wellness) Visit Defined

If a Patient presents for:

- Annual Physical
- Well Child Physical
- Women’s Physical
- Men’s Physical
- Partial Physical (not including the male/female reproductive system/s)
- Sports Physical
- Immunizations
- Tests scheduled for a certain age/risk group

And receives only Preventive services, then report ONLY the Preventive codes (CPT 99381-99397).
Preventive Medicine Services
CPT Code Range 99381 - 99397

• Preventive codes describe New and Established Patients
• Extent and focus of preventive services is defined by the Patient’s age
• Include counseling, risk factors reduction, interventions, and counseling
• Appropriate immunizations and/or diagnostic procedures are reported separately
• Management of insignificant or trivial problem or abnormality that is encountered should not be reported separately.
Problem Oriented “Sick” Visit Defined

If the Patient presents with:

- Signs of a condition
- Symptoms of a condition
- Exposure to a condition or hazard
- Follow-up to Emergency Department visit
- Follow-up to previous office visit for a condition

And receives only Problem services,
then report ONLY the a Problem service code (CPT 99201-99215).
Preventive Visit without Problem Visit

For example, a 9-month old established Patient is seen for and receives a well-baby physical. During the exam, the Provider notes a small area of mild diaper rash, and advises the Parent of the Patient to obtain over-the-counter (OTC) diaper rash ointment to treat it. There is no additional work involved in recommending OTC ointment (no testing, prescription medication prescribed, no appreciable medical decision making, no additional history).

This scenario doesn’t warrant the use of a problem visit in addition to the preventive visit. For further instruction, CPT defines when to charge both types of visits in the beginning of the Preventive Medicine Section.

Proper coding:
99391: Established Patient Preventive Medicine Service, age < 1 year
V20.2 : Routine Infant or Child Health Check
Preventive Visit with Problem Visit

For example, a 9-month old established Patient is seen for and receives a well-baby physical. During the exam, the Provider notes left acute otitis media, and prescribes antibiotics to treat it. This is not an insignificant/trivial finding, and requires extra work in the performance and documentation of the problem-focused history and straightforward medical decision-making for the problem portion of this visit.

This scenario warrants the use of a problem visit in addition to the preventive visit. For further instruction, CPT defines when to charge both types of visits in the beginning of the Preventive Medicine Section.

Proper coding:
- 99391: Established pt. preventive med. service, age < 1 year
- V20.2: Routine infant or child health check
- 99212-25: Established office or other outpatient visit
- 381.00: Acute non-suppurative otitis media, unspecified
“Significant” versus “Insignificant”

If the problem addressed during the preventive visit is significant:

• Requires documented additional work and performance of the key components of a problem-oriented E/M service: history, exam, and medical decision making.
• Report E/M code range 99201-99215 in addition to 99381-99397
• To charge both the preventive and problem services together, modifier 25 must be appended to the problem visit code.
• Chart documentation must support the service as a significant, separately identifiable service in order to append modifier 25.

If the problem addressed during the preventive visit is insignificant or trivial:

• Doesn’t require additional work and performance of the key components of a problem-oriented E/M service.
• Don’t report E/M code range 99201-99215 in addition to 99381-99397
• Don’t report Modifier 25
Insignificant vs. Significant Problem Scenario #1

**Significant Problem during a Preventive Visit**

An established 52-year old Patient presented for and received her annual physical exam. She also complained of flushing, sleeplessness, headache, concentration problems, and light, irregular menses. After treatment options, risks and benefits were discussed, estrogen replacement was prescribed. The Patient was symptomatic, so additional history was taken, and medical decision making performed.

If appropriately documented, this would be considered a significant problem, and would be reported with a menopause ICD-9 diagnosis code linked to the problem visit CPT code.

Proper coding:

99397 Established pt. preventive med. service, age 40-64 years  
V70.0 Routine general medical exam  
99213-25 Established office or other outpatient visit  
627.2 Symptomatic menopause
Insignificant vs. Significant Problem Scenario #2

**Insignificant Problem during a Preventive Visit**

An established 42-year old female Patient* presents for her annual well-woman exam. A reproductive system-only exam was performed (including pap smear collection) and Patient was counseled on diet and exercise. Appropriate labs were ordered.

During the encounter the Patient complained of occasional vaginal dryness and was advised to try OTC lubricant. Her prescriptions for oral contraception medications were renewed.

This work is considered part of the preventive service and the prescription renewal would **NOT** be considered significant.

Proper coding:

- **G0101** Cervical or vaginal cancer screening; pelvic and clinical breast examination
- **V72.31** Routine gynecological examination
- **Q0091** Screening papanicolaou [pap] smear, obtaining, preparing and conveyance of cervical or vaginal smear to laboratory
- **V76.2** Screening for malignant neoplasms of the cervix

*Non-Medicare
Preventive Services with CPT Modifier 52

Modifier 52 – Partially reduced or eliminated services is used when the service is reduced: the Physician didn’t perform the service to the complete description as listed in the CPT manual.

Example
An established 41-yr old female patient presented for a preventive exam. Medical, family, and social history was reviewed, and a complete review of systems was documented. A detail physical exam was performed, and the patient deferred the pelvic and breast examination and pap smear. Counseling was provided regarding diet and exercise, substance abuse, sexual safety, and dental health. Risk factors were identified and interventions were discussed. Appropriate lab test were ordered.

Report 99396-52 because the service didn’t include a portion of the CPT 99396 description: age and gender appropriate exam.
New vs. Established Patient

The answers to these three questions determine whether a Patient is New or Established:

- Was this Patient seen by this Provider in the last 3 years?
- Was this Patient seen by any Provider in this same group for the last 3 years?
- Was this Patient seen by a Provider in this group of the same subspecialty in the last 3 years?

If the answer to any of these questions is Yes, the Patient is Established.

If the answer to all of these questions is No, the Patient is New.
Counseling and/or Risk Factor Reduction Interventions
CPT Codes 99401 - 99429

• Purpose: promoting health and preventing illness or injury and/or behavior change intervention
• No Exam is necessary to charge these codes, but documentation must support their use by detailing the counseling’s specifics
• No distinction between new and established Patients
• Extent and focus of preventive service is defined by the Patient's age
• Code range is based on individual or group counseling
• Assign these codes based on time spent counseling an individual or in a group setting.
• Any additional E/M services reported on the same day as these counseling codes must be distinctly separate, and time spent providing these services may not be used as a basis for the E/M code selection.
NEW 2009 CPT Codes: Newborn Care Codes 99460-99464

- Report codes 99460-99464 for Newborns in the hospital and birthing room setting
- To use these codes, the baby must be a “normal” Newborn: Newborns with an illness are not covered in this code range
- Apply the New vs. Established criteria to the Newborn when seen subsequently for the first time in the office - the setting doesn’t matter. If the Newborn was seen in the hospital, the New vs. Established criteria still applies to the first visit in the office.
G0101 Requires 7 of 11 Areas Documented

To report the HCPCS code G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination) the Provider is required to examine and document seven of the following eleven areas.

- Breasts
- External genitalia
- Urethral meatus
- Urethra
- Bladder
- Vagina
- Cervix
- Uterus
- Adnexa
- Anus/perineum
- Digital rectal exam

- Digital rectal exam only (when no other services are performed): use G0102.
New Rules and Codes For Medicare’s One-Time “Welcome to Medicare” Physical Exam G0402

“Welcome to Medicare” preventive services
Physical must be done within 12 months of Part B coverage

The New HCPCS code is G0402

Medicare has waived the deductible for the G0402 (IPPE), but coinsurance still applies.

Patients are responsible for the deductible and the 20% coinsurance for G0403 (EKG referral resulting from the IPPE).
Medicare Preventive Services Quick Reference Information:
The ABCs of Providing the Initial Preventive Physical Examination

The Initial Preventive Physical Examination (IPPE), also known as the “Welcome to Medicare Physical Exam” or the “Welcome to Medicare Visit,” is a preventive evaluation and management (E/M) service. The goals of the IPPE are health promotion and disease detection. All components of the IPPE must be provided, or provided and referred, prior to submitting claims for the IPPE visit.

Components of the IPPE (as of January 1, 2009)

<table>
<thead>
<tr>
<th>Acquire Patient History</th>
<th>Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Review of Individual’s Medical and Social History</td>
<td>At a minimum, obtain the following:</td>
</tr>
<tr>
<td></td>
<td>• Past medical/surgical history (experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments)</td>
</tr>
<tr>
<td></td>
<td>• Current medications and supplements (including calcium and vitamins)</td>
</tr>
<tr>
<td></td>
<td>• Family history (review of medical events in the family, including diseases that may be hereditary or place the individual at risk)</td>
</tr>
<tr>
<td></td>
<td>• History of alcohol, tobacco, and illicit drug use</td>
</tr>
<tr>
<td></td>
<td>• Diet</td>
</tr>
<tr>
<td></td>
<td>• Physical activities</td>
</tr>
<tr>
<td>2. Review of Individual’s Potential (Risk Factors) for Depression and Other Mood Disorders</td>
<td>Use any appropriate screening instrument recognized by national professional medical organizations to obtain current or past experiences with depression or other mood disorders.</td>
</tr>
<tr>
<td>3. Review of Individual’s Functional Ability and Level of Safety</td>
<td>Use any appropriate screening questions or standardized questionnaires recognized by national professional medical organizations to review, at a minimum, the following areas:</td>
</tr>
<tr>
<td></td>
<td>• Hearing impairment</td>
</tr>
<tr>
<td></td>
<td>• Activities of daily living</td>
</tr>
<tr>
<td></td>
<td>• Falls risk</td>
</tr>
<tr>
<td></td>
<td>• Home safety</td>
</tr>
</tbody>
</table>

Begin Physical Examination | Elements |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4. A Physical Examination</td>
<td>Obtain the following:</td>
</tr>
<tr>
<td></td>
<td>• Weight, weight, and blood pressure</td>
</tr>
<tr>
<td></td>
<td>• Visual acuity screen</td>
</tr>
<tr>
<td></td>
<td>• Measurement of body mass index (required effective January 1, 2009)</td>
</tr>
<tr>
<td></td>
<td>• Other factors deemed appropriate based on the individual’s medical and social history and current clinical standards.</td>
</tr>
</tbody>
</table>

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 beneficiary’s consent. End-of-life planning is verbal or written information provided to the beneficiary regarding: |
| | • The beneficiary’s ability to prepare an advance directive in the case that an injury or illness causes the beneficiary to be unable to make health care decisions, and |
| | • Whether or not the physician is willing to follow the beneficiary’s wishes as expressed in the advance directive. |

Counsel Patient | Elements |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Education, Counseling, and Referral Based on the Previous Five Components</td>
<td>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:</td>
</tr>
<tr>
<td></td>
<td>• Counseling on diet if the individual is overweight</td>
</tr>
<tr>
<td></td>
<td>• Education on prevention of chronic diseases</td>
</tr>
<tr>
<td></td>
<td>• Smoking and tobacco-use cessation counseling</td>
</tr>
</tbody>
</table>

7. Education, Counseling, and Referral for Other Preventive Services | Complete a brief written plan, such as a checklist, to be given to the beneficiary for obtaining an electrocardiogram, as appropriate, and the appropriate screenings and other preventive services that are covered as separate Medicare Part B benefits. (Refer to back page for a list of Medicare-covered preventive services.)
Medicare Preventive Services Quick Reference Information: The ABCs of Providing the Initial Preventive Physical Examination

**Who is Eligible to Receive the IPPE?**
Effective for dates of service on or after January 1, 2009, Medicare provides coverage of the IPPE for all newly enrolled beneficiaries who receive the IPPE within the first 12 months after the effective date of their Medicare Part B coverage. However, only beneficiaries whose first Part B coverage began on or after January 1, 2009, are eligible for the IPPE. This is a one-time benefit per Medicare Part B enrollee.

**Preparing Eligible Medicare Patients for the IPPE Visit**
Providers can help eligible Medicare patients get ready for their IPPE visit 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 list of medications and supplements, including calcium and vitamin D, how often and how much of each is taken

**Resources**
The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals
Medicare Claims Processing Manual – Pub. 120-04, Chapter 12, Section 30.6.1.1
Medicare Claims Processing Manual – Pub. 120-04, Chapter 18, Section 59
Change Request 4523/Transmittal 1616 – Update to the Initial Preventive Physical Examination (IPPE) Benefit

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**Frequently Asked Questions**

Is the IPPE the same as a beneficiary’s yearly physical exam? Yes, an annual physical exam provided to a Medicare beneficiary

Who can perform the IPPE? The IPPE must be furnished by either a physician (a doctor of medicine or osteopathy) or a qualified non-physician practitioner (physician assistant, nurse practitioner, or clinical nurse specialist).

Are clinical laboratory tests part of the IPPE? No, the IPPE does not include any clinical laboratory tests. However, the provider may want to make referrals for such tests as part of the IPPE.

Is there a deductible or coinsurance/copayment for the IPPE? There is no deductible or coinsurance/copayment for the IPPE.

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**Medicare Part B Preventive Services**

| Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)* | Bone Mass Measurements |
| Cardiovascular Screening Blood Tests | Colorectal Cancer Screening |
| Diabetes Screening Tests | Prostate Cancer Screening |
| Diabetes Self-Management Training and Medical Nutrition Therapy | Influenza, Pneumococcal, and Hepatitis B Vaccinations |
| Screening Pap Tests and Pelvic Examination | Glaucoma Screening |
| Screening EKG** | Screening Mammography |

* Effective January 1, 2007, a Medicare beneficiary, who is at risk for abdominal aortic aneurysm (AAA), may receive a referral for a one-time preventive ultrasound screening for the early detection of AAA as part of their IPPE.

**NEW: Effective for dates of service on or after January 1, 2009, the screening EKG is no longer a required part of the IPPE. It is optional and may be performed as a result of a referral from an IPPE (as part of the educational, counseling, and referral service the beneficiary is entitled to during the beneficiary’s IPPE visit). (See component D7.) The screening EKG will be allowed only once if a beneficiary’s lifetime.

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## CMS Preventive Services Quick References

**Quick Reference Information: Medicare Preventive Services**

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<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>Initial Preventive Physical Examination (IPPE)</td>
<td>Effective January 1, 2009 G0402 - IPPE G0403 - EXG for IPPE G0404 - EXG testing for IPPE G0405 - EXG interpret &amp; report</td>
<td>No specific diagnostic code required for IPPE</td>
<td>All Medicare beneficiaries whose first Part B coverage began on or after January 1, 2005</td>
<td>Once in a lifetime benefit per beneficiary Must be furnished no later than 12 months after the effective date of the first Medicare Part B coverage begins</td>
<td>Copayment/coinsurance Deductible applies prior to January 1, 2009 No deductible applies for code G0402, effective for dates of service on or after January 1, 2008 Deductible still applies for G0403, G0404, and G0405</td>
</tr>
<tr>
<td>Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)</td>
<td>GE069 - Ultrasound exam AAA screen</td>
<td>No specific code</td>
<td>Contact local Medicare Contractor for guidance</td>
<td>Once in a lifetime benefit per eligible beneficiary, effective January 1, 2007</td>
<td>Copayment/coinsurance No deductible</td>
</tr>
<tr>
<td>Cardiovascular Disease Screenings</td>
<td>82261 – Lipid Panel 82455 – Cholesterol 83716 – Lipoprotein 84578 – Triglycerides</td>
<td>Report one or more of the following codes V01.1, V01.1, V61.2</td>
<td>All asymptomatic Medicare beneficiaries 12-month test is required prior to testing</td>
<td>Every 5 years</td>
<td>No copayment/coinsurance No deductible</td>
</tr>
<tr>
<td>Diabetes Screening Tests</td>
<td>82347 – Glucose, quantitave, blood (except morning) 82555 – Glucose, post-glucose dose (includes glucose) 82551 – Glucose Tolerance Test (GTT), three specimens (includes glucose)</td>
<td>V03.1 Report modifier “S1” (follow-up service)</td>
<td>Medicare beneficiaries with certain risk factors for diabetes or diagnosed with pre-diabetes Beneficiaries previously diagnosed with diabetes who are not eligible for this benefit</td>
<td>2 screening tests per year for beneficiaries diagnosed with pre-diabetes 1 screening per year if previously tested but not diagnosed with pre-diabetes, or if never tested</td>
<td>No copayment/coinsurance No deductible</td>
</tr>
<tr>
<td>Diabetes Self-Management Training (DSMT)</td>
<td>G0460 – DSMT, individual session, per 30 minutes G0465 – DSMT, group session (2 or more), per 30 minutes</td>
<td>No specific code</td>
<td>Contact local Medicare Contractor for guidance</td>
<td>Medicare beneficiaries at risk for complications from diabetes, recently diagnosed with diabetes, or previously diagnosed with diabetes Physician must certify that DSMT is needed</td>
<td>Copayment/coinsurance Deductible</td>
</tr>
<tr>
<td>Medical Nutrition Therapy (MNT)</td>
<td>S7802, S7803, S7804, S7810, S7817, S7818</td>
<td>Services must be provided by registered dietitian or nutrition professional</td>
<td>Contact local Medicare Contractor for guidance</td>
<td>Medicare beneficiaries diagnosed with diabetes or a renal disease</td>
<td>Copayment/coinsurance Deductible</td>
</tr>
<tr>
<td>Screening Pap Tests</td>
<td>G0132, G0134, G0141, G0143, G0144, G0145, G0147, G0148, P0050, P0061, G0281</td>
<td>V76.2, V76.47, V76.48, V15.09, V72.31</td>
<td>All female Medicare beneficiaries</td>
<td>1st year: 3 hours of one-on-one counseling Subsequent years: 2 hours</td>
<td>Copayment/coinsurance Deductible</td>
</tr>
<tr>
<td>Screening Mammography</td>
<td>G0301 – Central or vaginal cancer screening: pelvic and clinical breast examination</td>
<td>V76.2, V76.47, V76.48, V15.09, V72.31</td>
<td>All female Medicare beneficiaries</td>
<td>If eligible, annual Pap test or every 3 years if Pap test is normal</td>
<td>Copayment/coinsurance Deductible</td>
</tr>
<tr>
<td>Screening Mammography</td>
<td>77552, 77557, G0222</td>
<td>V76.11 or V76.12</td>
<td>Female Medicare beneficiaries ages 40 – 74</td>
<td>One baseline</td>
<td>Copayment/coinsurance Deductible</td>
</tr>
<tr>
<td>Screening Mammography</td>
<td>77552, 77557, G0222</td>
<td>V76.11 or V76.12</td>
<td>Female Medicare beneficiaries ages 35 – 39</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# CMS Preventive Services Quick References

## General Information

- **Service**: Preventive services for Medicare beneficiaries.
- **HCPCS/CPT Codes**: Codes used for billing.
- **ICD-9-CM Codes**: Codes used for diagnostic purposes.
- **Who is Covered**: Eligibility criteria for each service.
- **Frequency**: Recommended frequency of service.
- **Beneficiary Pays**: Cost-sharing requirements.

## Services

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<th>SERVICE</th>
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<th>FREQUENCY</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure Measurements</td>
<td>G0315, G0321, G0327</td>
<td></td>
<td>Medicare beneficiaries at risk for developing hypertension</td>
<td>Every 2 years if medically necessary</td>
<td>Copayment/coinsurance Deductible</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>G0304, G0305</td>
<td></td>
<td>Use appropriate code Contact local Medicare Contractor for guidance</td>
<td>Annual</td>
<td>Copayment/coinsurance Deductible</td>
</tr>
<tr>
<td>Prostate Cancer Screening</td>
<td>G0315, G0316, G0317</td>
<td></td>
<td>Medicare beneficiaries age 50 and older</td>
<td>Annually</td>
<td>Copayment/coinsurance Deductible</td>
</tr>
<tr>
<td>Glaucoma Screening</td>
<td>G0317, G0318</td>
<td></td>
<td>Medicare beneficiaries with diabetes mellitus, family history of glaucoma, African-American, Hispanic-American age 65 and over</td>
<td>Annually</td>
<td>Copayment/coinsurance Deductible</td>
</tr>
<tr>
<td>Influenza Vaccine</td>
<td>G0355, G0356</td>
<td></td>
<td>Medicare beneficiaries</td>
<td>Annually</td>
<td>Copayment/coinsurance Deductible</td>
</tr>
<tr>
<td>Pneumococcal Vaccine</td>
<td>G0369, G0370</td>
<td></td>
<td>Medicare beneficiaries</td>
<td>Annually</td>
<td>Copayment/coinsurance Deductible</td>
</tr>
<tr>
<td>Hepatitis B (HepB) Vaccine</td>
<td>G0369, G0370</td>
<td></td>
<td>Medicare beneficiaries</td>
<td>Annually</td>
<td>Copayment/coinsurance Deductible</td>
</tr>
<tr>
<td>Smoking and Tobacco-Use Cessation Counseling</td>
<td>G0369</td>
<td></td>
<td>Medicare beneficiaries who use tobacco and have a disease or adverse health effect linked to tobacco use or take certain therapeutic agents whose mentalization or dosage is affected by tobacco use</td>
<td>3 cessation attempts per year; Each attempt includes maximum of 4 intermediate or intensive sessions, up to 8 sessions in a 12-month period</td>
<td>Copayment/coinsurance Deductible</td>
</tr>
</tbody>
</table>

## Notes

- This quick reference information chart wasprepared as a service to the public and is not intended to grant rights or impose obligations. It may contain references or links to updates, 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.

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- January 2008

- K09693005
HCPCS Modifiers GA, GY & GZ:
Advance Beneficiary Notice (ABN) Modifiers

Modifier GA should be used when Providers of services or supplies want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they have obtained an ABN signed by the Medicare Beneficiary.

Modifier GY should be used when Providers of services or supplies want to indicate that the item or service is statutorily non-covered, and is not ever a covered Medicare benefit.

Modifier GZ should be used when Providers of services or supplies want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they have not obtained an ABN signed by the Medicare Beneficiary.
Building a Bridge, and Using it

Ethical Responsibility

Guessing about where to find rules that apply to documentation and coding questions is not necessary, is unethical, and wastes your valuable time and energy.

CHP is here to help you build a foundation for understanding this valuable career skill, and to assist you with official references when questions about proper documentation and coding arise.

Feedback about the Webinar

Community Health Plan chose this enterprise-wide, long-term approach of online training to serve our Providers, achieve our training objectives, and optimize the delivery of this information (which ultimately benefits the Patients, the Providers, and the Plan).

To that end, CHP has created a dedicated email address for our Providers and their Staff to send questions and comments about this training; please email us at: Providereducation@chpw.org. CHP encourages our Providers to give us feedback about this educational webinar, so that it may be continuously improved.
Continuing Education Credit Requirements

CHP has arranged to award CMEs (through AAFP) and CEUs (through AAPC and AHIMA) for Participants who:

• attend this webinar
• are counted as present
• complete a brief Self-Assessment and Quality Survey at the end of the webinar
• request the continuing, education credit in the manner described in the steps in the next slide.
Obtaining Continuing Education Credits

1. Send an email to Providereducation@chpw.org with “Continuing Education Credit Request” in the subject line.

2. Be sure to let us know which organization/s you’re requesting continuing education credit from, and

3. Include your contact information in the body of the email.

4. A brief Self-Assessment will be emailed to requesters. The brief Self-Assessment is evidence of learning objectives met (and is a requirement of the continuing education granting organizations), and

5. Upon completion of your Self-Assessment, email it back to CHP at the above email address.

6. CHP will process and send the continuing education certificates to the Participants at the contact information provided in Step 3 (above).

7. As always, it’s the responsibility of the Participant to submit and/or make available proof of continuing education credit earned (CME/CEU certificates) to the AAFP, AAPC, and AHIMA on demand. CHP doesn’t submit certificates to these organizations on behalf of webinar Attendees.

Additional Resources: much of the information in the Webinar is available in a more comprehensive form at CMS’s website: http://www.cms.hhs.gov/MLNGenInfo/ and click on the Web-Based Training Modules. There are additional CMS web-based training courses there as well.
Thank You for Participating

Community Health Plan would like to thank you for taking time out of your busy schedule to participate in today’s Provider Education Course 7 Webinar: Proper Coding For Preventive and Problem-Oriented Sick Visits

Community Health Plan has arranged for documentation and coding resources to be made available to you by email for questions about the materials covered in this webinar series. Send an email to Providereducation@chpw.org with “Continuing Education Credit Request” in the subject line.

We cannot address specific, individual claims processing queries. There are other resources available for reimbursement questions, and the usual route for claims questions should be used for them.

The Provider Education Team is looking forward to delivering the next course in this webinar series, and it will reinforce the concepts and complement the content of this course.