Medicare Learning Network
MLN Matters
CMS CENTERS for MEDICARE & MEDICAID SERVICES
Information for Medicare Fee-for-Service Health Care Professionals

MLN Matters Number: MM6223 Revised
Related CR Release Date: October 24, 2008
Related CR Transmittal #: R1615CP
Related Change Request (CR) #: 6223
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

Update to the Initial Preventive Physical Examination (IPPE) Benefit

Note: This article was revised on April 11, 2018, to update Web addresses. All other information remains the same.

Provider Types Affected

Physicians and providers who submit claims to Medicare Fiscal Intermediaries (FIs), Carriers and/or Part A/B Medicare Administrative Contractors (A/B MACs) for the IPPE provided to Medicare beneficiaries

What You Need to Know

This article is based on Change Request (CR) 6223, which announces that, effective January 1, 2009, the Centers for Medicare & Medicaid Services (CMS) is expanding coverage for the IPPE benefit.

This expanded coverage is subject to certain eligibility and other limitations that allow payment for an IPPE, no later than 12 months (rather than 6 months as previously required) after the date the individual's first coverage period begins under Medicare Part B. However, this expanded coverage only applies if the IPPE is performed on or after January 1, 2009.

The IPPE has been expanded to include measurement of an individual's body mass index, and end-of-life planning as mandatory services (upon an individual's consent). The screening electrocardiogram (EKG) is no longer a mandatory part of the IPPE, but it may be performed as an optional one-time service as a result of a referral arising out of the IPPE. Be sure your billing staff is aware of these changes.

Background

Pursuant to Section 101 (b) of the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA), CMS is amending section 410.16 and related regulation provisions of the Code of Federal Regulations. Effective January 1, 2009, this expanded coverage is subject to certain eligibility and other limitations that allow payment for an IPPE, also

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known as the "Welcome to Medicare Visit", not later than 12 months after the date the individual's first coverage period begins under Medicare Part B.

Changes to IPPE

The Initial Preventive Physical Examination

- Effective for services performed on or after January 1, 2009, MIPPA changes the IPPE as follows:
  - Waives the deductible for the IPPE.
  - Adds the measurement of body mass index as part of the IPPE,
  - Adds end-of-life planning to the IPPE (upon an individual's consent), and
  - Removes the mandatory requirement of the screening electrocardiogram (EKG). The screening EKG is optional and is permitted as a one-time screening service as a result of a referral arising out of the IPPE.

Eligibility

- Effective January 1, 2009, the MIPPA of 2008 extends the eligibility period from 6 months after Part B enrollment to 12 months after enrollment.
- Effective for IPPEs performed on or after January 1, 2009, a beneficiary is eligible for the extended IPPE benefits of MIPPA when he/she first enrolls in Medicare Part B and receives the IPPE benefit within the first 12 months of the effective date of the initial Part B coverage period.
- For IPPEs performed on or after January 1, 2009, the Medicare deductible does not apply to the IPPE.
- The waived deductible is applicable to the IPPE (code G0402) only, but the coinsurance still applies. Prior to January 1, 2009, the deductible was not waived.

Billing Requirements

Codes Used to Bill the IPPE

- Effective January 1, 2005, the physician or qualified non-physician practitioner will bill for IPPEs performed on or before December 31, 2008, using HCPCS code G0344 with one of the following HCPCS codes for the mandatory EKG: G0366, G0367, or G0368.
- Effective January 1, 2009, the screening EKG is billable with HCPCS code(s) G0403, G0404, or G0405, when it is a result of a referral from an IPPE.
- For an IPPE performed during the global period of surgery refer to Section 30.6.6, Chapter 12 of the Medicare Claims Processing Manual for reporting instructions at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf**.

The following HCPCS codes have been developed for the IPPE benefit effective January 1, 2009:

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HCPCS Code	Short Descriptor
G0402: Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment	Initial Preventive Exam
G0403: Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report	EKG for initial prevent exam
G0404: Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination	EKG tracing for initial prev
G0405: Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination	EKG interpret & report preve

Professional Claims Processed by Carriers/MACs

- The type of service (TOS) for each of the new codes is as follows:
  - G0402: TOS = 1
  - G0403: TOS = 5
  - G0404: TOS = 5
  - G0405: TOS = 5
- The HCPCS codes for an IPPE and screening EKG are paid under the Medicare Physician Fee Schedule (MPFS). The appropriate deductible and coinsurance applies to codes G0344, G0366, G0367, G0368, G0403, G0404, and G0405.
- The deductible is waived for code G0402 after January 1, 2009, but the coinsurance still applies.

Institutional Claims Processed by FIs/MACs

- FIs/MACs will pay for code G0402 for the IPPE and code G0404 for the screening EKG, tracing only when those services are submitted on a TOB 12X or 13X for hospitals subject to the outpatient prospective payment system (OPPS). Codes G0403 and G0405 are not payable under the OPPS. Hospitals not subject to OPPS will be paid under current methodologies.
- For inpatient or outpatient services in hospitals in Maryland, payment is made according to the State Cost Containment System.
- For services performed on a 12X, Indian Health Services (IHS) hospitals, payment is made based on an all-inclusive ancillary per diem rate.

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- For services performed on a 13X, IHS hospitals, payment is made based on the all-inclusive rate (AIR).
- For services performed on an 85X, IHS critical access hospitals (CAHs), payment is made based on an all inclusive facility specific per visit rate. For other CAHs billing on the 85X, payment is based on reasonable cost.
- For services billed by Skilled Nursing Facilities (SNFs) on the 22X, payment for the technical component of the EKG is based on the MPFS.

NOTE: HCPC code G0405 is a professional component and is only allowable on 71x, 73x and 85x (**CAH Method II**) TOBs. In addition, G0404 is a Technical component HCPCS code that can only be submitted on 12x, 13x, 22x, OR 85x(Method I and II) TOBs.

Rural Health Clinics/Federally Qualified Heath Centers (RHCs/FQHCs) Special Billing Instructions

- Payment for the professional services will be made under the all-inclusive rate. Encounters with more than one health professional and multiple encounters with the same health professionals that take place on the same day and at a single location constitute a single visit.

OPPS Hospital Billing

- Hospitals subject to OPPS (TOBs 12X and 13X) must use modifier 25 when billing the IPPE G0344 along with technical component of the EKG, G0367, on the same claim. **The same is true when billing IPPE code G0402 along with the technical component of the screening EKG, code G0404.**

Reporting a Medically Necessary Evaluation and Management (E/M) at Same IPPE Visit

- When the physician or qualified NPP provides a medically necessary E/M service in the same visit as the IPPE, CPT codes 99201 – 99215 may be used depending on the clinical appropriateness of the circumstances. CPT modifier –25 will be appended to the medically necessary E/M service identifying this service as a significant, separately identifiable service from the IPPE code **reported (G0344 or G0402, whichever applies based on the date of service).**

Documentation

Physicians and qualified NPPs are required to use the 1995 and 1997 E/M documentation guidelines to document the medical record with the appropriate clinical information. The guidelines may be reviewed at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html**.

Medicare Notices and Messages

Remittance Advice Remark Codes and Claim Adjustment Reason Codes

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- Your Medicare contractors will use the appropriate Remittance Advice Remark Code, i.e., N117 (This service is paid only once in a patient's lifetime) when denying additional claims for an IPPE and/or a screening EKG.
- Your Medicare contractors will use the appropriate Claim Adjustment Reason Code, such as, 149 (Lifetime benefit maximum has been reached for this service/benefit category) when denying additional claims for an IPPE and/or a screening EKG.

Advance Beneficiary Notice (ABN) as Applied to the IPPE

- Effective for beneficiaries whose IPPE is provided on January 1, 2005, through December 31, 2008, an ABN will be issued for all IPPEs conducted after the beneficiary's statutory 6-month period has lapsed.
- Effective for IPPEs performed **on or after January 1, 2009,** an ABN will be issued for all IPPEs conducted after the beneficiary's statutory 12-month period has lapsed since based on Social Security Act Section 1862(a)(1)(K), Medicare is statutorily prohibited from paying for an IPPE outside the initial 12-month period under the MIPPA of 2008.

Medicare Summary Notices (MSNs)

- When denying additional claims for G0402, Medicare contractors will use MSN message 20.91 - This service was denied. Medicare covers a one-time initial preventive physical exam (Welcome to Medicare physical exam) if you get it within the first 12 months of the effective date of your Medicare Part B coverage.
- When denying additional claims for screening EKG codes G0403, G0404 and G0405, contractors will use MSN message 20.12 - This service was denied because Medicare only covers this service once a lifetime.

Additional Information

The official instruction (CR6223) issued to Medicare Carriers, FIs and A/B MACs regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1615CP.pdf**. If you have any questions, please contact your Medicare contractor (carrier, FI, or MAC) at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** .

Document History

- November 7, 2008 – Initial article released.
- March 11, 2011 – The article was revised to add a reference to MLN Matters® article MM7079, which is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7079.pdf**, for information on additional wellness benefits enacted in the Affordable Care Act. All other information is unchanged.

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