CENTERS FOR MEDICARE AND MEDICAID SERVICES

Medicare Contractor Training Conference Call:

Initial Preventive Physical Examination (CR 3638), Cardiovascular Screening Blood Test (CR 3411), and Diabetes Screening Test (CR 3637)

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Thursday

February 10, 2005

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PROCEEDINGS

[1:09 p.m.]

THE OPERATOR: Thank you for holding.

The parties will be in a listen-only mode until the question-and-answer session of today's conference.

This call is being recorded. If you have any objections, you may disconnect.

I would like to introduce your first speaker, Ms. Robin Phillips.

Opening Remarks

Robin Phillips

MS. PHILLIPS: Thank you, Julie.

Hi. This is Robin Phillips. I'm with the Provider Communications Group, Division of Provider Information, Planning, and Development at CMS in Baltimore. I would like to welcome everyone to the second contractor educational conference call that will focus on the new preventive services covered under MMA, the initial preventive physical examination, CR 3638, Cardiovascular Screening Blood Test, CR 3411, and Diabetes Screening Test, CR 3637.

Today, we will start by addressing questions that we were not able to answer on the January 12th call and questions received in the Contractor Training e-mail box. We will also take a little time to see how the beneficiaries are being educated about the new services. Then the call will be opened up for questions.

We have made some revisions to the January 12th PowerPoint slide presentation. If you want to, you can have this in front of you to refer to for this call. The presentation can be found at www.cms.hhs.gov/medlearn/cmsinit.asp.

Before we begin, I would like to remind everyone that this call is for Medicare contractors, Central Office, and Regional Office staff and is not for providers. The call is being recorded and transcribed, so please identify yourself before you speak.

At this time, I would like to have each person in the room here at CMS in Baltimore introduce themselves and say what component organization they are with.

MS. ROULAC: Hazeline Roulac, Provider Communications Group.

MS. WILKERSON: Jeannie Wilkerson, Division of Beneficiary Publication Development.

MR. KESSLER: Tom Kessler, Division of Consumer Protection.

MS. GILL: Pat Gill, the Division of Practitioner Claims Processing.

MS. SCALLY: Kit Scally, Division of Practitioner Services and Physician Payment Policy.

MS. RIVERA: Taneka Rivera, Division of Institutional Claims Processing.

MS. ENG: Joyce Eng, Coverage and Analysis Group.

DR. SANDERS: Tiffany Sanders, Coverage and Analysis Group.

MS. GREENBERG: Anita Greenberg, Division of Ambulatory Services.

MS. MURPHY: Cindy Murphy, Institutional Claims Processing.

MS. CARMONDY: Elizabeth Carmondy, Division of Consumer Protection.

MS. BOYD: Shelly Boyd, Division of Consumer

Protection.

MS. PARDUE: Karen Pardue, Provider Communications Group.

MS. PHILLIPS: At this time, the subject-matter experts will respond to the unanswered questions from the January 12th call and those sent to the Contractor Training e-mail box. We appreciate you sending in your questions.

We will begin with Kit Scally, who will answer the first question.

CMS Presentation

Cathleen (Kit) Scally

MS. SCALLY: Hello, everyone. The question was, "Change Request 3638, Initial Preventive Physical Examination, instructs the carrier to tell providers to use a modifier -25 with a 99201 through 99215 code series if a separately identifiable service is performed beyond the IPPE. CMS has instructed that a modifier -25 is not required on initial visit codes. Please clarify this apparent contradiction."

I am not aware of any instruction about saying

a modifier -25 cannot be on an initial visit code. Our instructions say that when you are doing a service and you do a separately identifiable, medically necessary E & M service, you always append the -25 modifier to the E & M service.

I hope that answers that portion of the question.

Taneka, do you have something to add?

MS. RIVERA: Yes. This is Taneka Rivera. I have an addition to the modifier -25. For hospital outpatient departments subject to OPPS, which is 13X or 12X, a modifier -25 must be on the G0344 if G0367 is billed on the same claim.

MS. PHILLIPS: Let's go on to the next question.

MS. GILL: This is Pat Gill. The second question is, "Since the IPPE benefit, which is basically G0344 or G0366 through G0368, does not allow for a specific diagnosis, would it be an error if carriers used a repeat diagnosis 70.0 for billing purposes, or would this diagnosis fall under the statutory denial under

Section 1861(O)? We look forward to your response to these inquiries."

No, it would not be an error if the provider billed for the IPPE benefit using the 70.0. Most likely, what is driving this question is, in the carrier system anyway, there is probably an edit or some type of audit set up that would normally deny CPT codes for a routine physical using the 70.0, since we don't cover routine physicals.

If the provider would bill use the 70.0 with one of these G codes, you should exclude that from that edit and let it go through and pay. We did not specifically put any diagnosis codes in the instruction because we didn't really necessarily want this denied because the providers didn't use the 70 or didn't use another code. This is a one-time benefit, and we wanted it to be able to pay for the beneficiary as long as they meet all the criteria.

I'm not sure if that is helpful. Are we taking questions at the end? Okay.

MS. SCALLY: Question No. 3: "If a practice

performs the IPPE on a new patient and the patient returns at a later date for an illness, is it appropriate to bill for a new patient code at that later visit?"

No, the patient would be an established patient because, in our E & M rule, our criteria states that when you provide a face-to-face service with the patient within a three-year period, subsequent services or visits would be an established patient. It would not be a new patient.

MS. RIVERA: Question No. 4: "The slide indicates that the initial IPPE cannot bill with a 23X bill type. Why would the IPPE visit not be allowed on a 23X bill type?"

They initially did not put the 23X bill type in there because we couldn't see why a SNF would bill a physician visit for an outpatient.

MS. PHILLIPS: Our next question is going to be with Kit Scally.

MS. SCALLY: "During the conference call the other day, it was stated that an E & M service could be billed in addition to the IPPE. This raises several

concerns regarding the beneficiary community. The beneficiary in this instance will be made to pay a copay and/or deductible for both services. The beneficiary community is under the impression that this is an all-inclusive service and should not be billed any additional charges for the same visit. How should call centers handle these types of complaints, and how will the beneficiary community be educated?"

Well, the stipulation in the legislation is that the copayment and the deductible were not waived, so we have no authority then to go ahead and do that. We have to administer the program the way the legislation is written.

I am going to turn it over to Jeannie.

CMS PARTICIPANT: Actually, Jeannie is going to answer that question a little bit later in our presentation, the rest of that for the beneficiaries.

MS. SCALLY: All right. So you will be hearing more about that later.

Now we have Cindy Murphy.

Oh, I'm sorry. Taneka. I'm sorry.

MS. RIVERA: Question No. 6: "Should the actual date of the technical component and the actual date of the interpretation be submitted, or should the dates reflect the date of the IPPE?"

Yes, it should reflect the actual date of the technical component and the actual date of the interpretation.

MS. PHILLIPS: The next question is going to be addressed by Pat Gill.

MS. GILL: "If the patient is sent out for the EKG after the performance of the IPPE and the patient does not obtain the screening EKG, will the service for the IPPE be denied since the EKG was not performed?"

When the claim is sent in, if the IPPE is sent in before the EKG or --

[Interruption.]

MS. GILL: I'm sorry. Should I stop?

CMS PARTICIPANT: I don't think they will be able to hear you over it.

MS. PHILLIPS: I'm sorry. We are having a message here at CMS.

MS. GILL: Let me know if you can't hear me or if I am breaking up.

"If the patient is sent out for the EKG after the performance of the IPPE and the patient does not obtain the screening EKG, will the service for the IPPE be denied since the EKG was not performed?"

No. If the IPPE was submitted first, the claim will pay. If the EKG comes in first, the claim will pay. It could be a possibility on any post-pay review that you might do and you come across the IPPE benefit and the EKG was not ever performed in that time period that the beneficiary was able to get it but the IPPE was actually paid, that money could possibly be recouped at that time.

But that would be, you know, if you find it on a post-pay review. Initially, there is no edit set up in the system. The IPPE comes in first, we pay it, or if the EKG, we pay it.

MS. PHILLIPS: Thank you, Pat.

Pat, I believe you have the next question, also, you and Kit.

MS. GILL: "Does a normal EKG billed under

G0366 through G0368 stand alone or become part of frequency limits of subsequent EKGs billed in the beneficiary's history?"

The G codes, the G0366 through G0368, are stand-alone. They are a one-time benefit. So as long as it is billed in that first six months, the beneficiary is coming onto Part B, and we only pay it one time.

MS. SCALLY: I would also add that this is a screening benefit, and it is a one-time service. Diagnostic EKGs, I don't believe that there is any limit on them if they are medically necessary.

MS. PHILLIPS: Our next question, please?

MS. SCALLY: "CMS indicates the physician performing the IPPE can make arrangements to send the patient out for the EKG. Is the IPPE physician to bill the professional and the technical component even though provided by an outside entity, or does the actual physician rendering the interpretation and the entity providing the technical component bill for each component?"

We actually created four distinct codes. They

are in the regulation, and they are also in our instructions. There is a G code for the physical exam. There is a G code for the screening EKG that includes performance of the EKG and the interpretation and the report.

If it must be done by someone else because the physician or the qualified NPP is not able to do the EKG, then someone else will be asked to do that and that individual, if they do the tracing only, there is a G code to bill the tracing. If they do the entire EKG with tracing and interpretation, there is a G code for that. If they only do the interpretation and report, there is a separate G code for that.

So in response to whether the primary physician who is doing the physical exam portion of the IPPE benefit or Welcome to Medicare physical, if they only do that portion, then someone else is asked to go ahead, the beneficiary is asked to go to someone else who can do that, the instructions will have, probably, arrangements with a clinic or somewhere to have the EKG done. Whoever does those components of the EKG will be billing it.

It is not expected that the primary physician would be billing for those services done by someone else. We unbundled the service, and that is why we created the four codes for that.

I hope that helps.

The next one, "What are oversight rules pertinent to patients who receive the IPPE benefit in a residency program; is any modifier required?"

Since the regulation, we have actually discussed that at Central Office. Residents are permitted to perform the IPPE, both exam and screening EKG if they are in an approved GME program, because there is an exclusion to the services provided by residents.

Residents are permitted to actually bill the first three codes of the new office/clinic visit or the first three codes of the established office/clinic and without the attendance of the teaching physician. Since the IPPE is based on a level 99203, new patients, it has been determined that then residents in an approved program could actually do the IPPE because that is similar to the exclusionary codes that are in the

Teaching Physician Benefit.

I actually do not handle the Teaching Physician Policy. If folks have specific questions about the Teaching Physician Policy, they need to contact Ken Marsalek, and that is kmarsalek@cms.hhs.gov.

Again, I am not an expert on the Teaching Physician Policy, but it is my understanding that the -GC modifier is used. So I hope that qualifies.

MS. PHILLIPS: Dr. Sanders?

DR. SANDERS: The next question states that "There are only four required exam elements: height, weight, blood pressure, and visual acuity. Is it correct to interpret that there is no requirement for any 'hands-on' examination?"

Based on the regulation, that is correct. Those four elements, the height, weight, blood pressure, and visual acuity are the required elements. Other physical exams we just said "as deemed appropriate by the physician or provider." So there is no actual other hands-on examination requirement.

The next question was in reference to Slide No.

12. It says, "As you can see, there are five elements, and the fifth one states, 'Other factors as deemed appropriate.' If during the IPPE some abnormality is detected -- for example, if a patient happens to have high blood pressure -- and the provider decides to pursue this further during the very same encounter, does this become an E & M code with a modifier -25, or is there another service or another factor as deemed appropriate and the next visit becomes, for lack of a better word, the medically necessary visit?"

My understanding is, it sort of would depend on how much examination or how much further the physician went in-depth with that one individual issue. If, for example, the person had high blood pressure and the physician just listened to the heart as part of that, I believe that would still be part of the IPPE. If the physician performed some extensive examination based on what was discussed with the patient, then they could use one of the appropriate E & M codes for the level of visit that they performed.

The ending of the question says, "Along the

same line comes question regarding the EKG and any further evaluations that might be triggered by the visit." Basically, there would be the same answer. If findings were found on the EKG and the provider felt the patient needed to be referred, then that would become a diagnostic issue.

Or, if the provider felt they needed to do more in-depth evaluation, then they could go on to use the other E & M codes with the appropriate modifier at that time.

MS. PHILLIPS: Thank you.

Taneka, next question, please?

MS. RIVERA: Question No. 13: "According to the slides, IPPE services may be billed on an RHC claim. Can a cardiovascular screening blood test and diabetes screen test be billed by the RHC? If not, may they be billed by the hospitals when the RHC is hospital-based?"

The first answer is "no" to the first question. No, they cannot bill the cardiovascular or the diabetes screening test.

The answer to the second question is "yes." If

the RHC is hospital-based, they can bill for these services.

MS. PHILLIPS: Thank you.

Taneka, could you verify information from Slide 27 and 28, please?

MS. RIVERA: Yes. After looking over these, Slides 27 and 28 are correct.

MS. PHILLIPS: Thank you.

Now we have Tom Kessler, who is going to present our next question.

MR. KESSLER: There were actually multiple questions with regard to the appropriate form to use for the denial of the IPPE and the actual basis on which the denial is made, specifically whether or not you should be using the Notice of Exclusion from Medicare Benefits or the Advance Beneficiary Notice Form.

A couple of things that may be causing confusion in this area are that, previously, we have issued guidance which actually describes an item or service that fails to meet the definition of a benefit as an item or service that is statutorily excluded under the

law. We are now taking the position that that is not the case.

Merely because an item or service does not meet the definition of the benefit, for instance the IPPE, does not mean that is the same thing as a statutory exclusion. The only statutory exclusions are those statutory exclusions that are listed in 1862(a)(1).

The result is that when you are dealing with an item or service that fails to meet the definition of the benefit such as an IPPE, an ABN is not the appropriate form to use. The Notice of Exclusion from Medicare Benefits is the actual form that should be used when an item or service does not meet the definition of the benefit.

For instance, with the initial preventive physical exam, the actual definition of the benefit incorporates that the IPPE is only given once. As such, a second IPPE will always be outside the definition of the benefit. Because a second IPPE is always outside the definition of the benefit, the ABN would not be the appropriate form to use for a second IPPE.

Instead, a provider could voluntarily issue the Notice of Exclusion from Medicare Benefits and tell the beneficiary that because this is a second IPPE that Medicare will not cover it. It does not meet the definition of the benefit.

Alternatively, in 1862 the law establishes that an IPPE that is given outside the initial first six months of coverage will never be paid for by Medicare, i.e., we only pay for the IPPE if you receive it during the first six months. After the first six months, the IPPE is statutorily excluded from being covered.

Because the liability protection afforded by Section 1879 of the Act provides liability protection for those items and services that are statutorily excluded in 1862(a)(1) and the IPPE is listed in 1862(a)(1)(k), an ABN would be the appropriate form to use if providers wanted to protect themselves from being liable for the cost of an IPPE that was given after the six-month period had elapsed and is thereby excluded under 1862(a)(1)(k).

Again, the basis for the exclusion and which of the forms applies will be based on whether or not the

item or service fails to meet the definition of the benefit or whether the item or service in a particular instance is statutorily excluded under 1862(a).

There are multiple items and services that are actually statutorily excluded in 1862(a)(1). Many of those refer to frequency, such as a colorectal screening exam that is performed more frequently than is normally allowed.

The IPPE is actually one of the only ones that is a little different than that. As opposed to being a true frequency limit, it is a time frame limit, but it is still located within the same section where all the other frequency-limiting items and service exclusions are listed, and because of that, an ABN will be the appropriate form to use.

Now, there was one other question about information that was provided in a MedLearn Matters article. At this point, in answering that question, I can only say that we are going to review information that is out there with regard to the IPPE and we will make adjustments as necessary.

MS. PHILLIPS: Thank you, Tom.

Taneka, the next question is yours, please.

CMS PARTICIPANT: Before we do that, I'm sorry, let me interrupt.

MS. PHILLIPS: I'm sorry.

CMS PARTICIPANT: There is another question here that I think we might be able to answer. It is No. 17. It has to do with, "If a provider is currently seeing a patient and now they turn 65, is it mandatory that they do the IPPE if a patient wants it?"

The only thing we can say to that is, you know, this is a new screening benefit. Certainly, if the patient is eligible and requests their physician to perform the IPPE, we would hope that the physician would honor that request and do that.

I'm sorry. I just wanted to get that out of the way.

MS. PHILLIPS: Thank you.

MS. RIVERA: Question No. 22: "Slide 54 provides the applicable bill type for diabetes screening and includes 22X and 23X. However, Slide 55 indicates

when furnished to a beneficiary in a skilled nursing facility, bill type 22X should be used. I'm very confused. Does this really mean when furnished to a beneficiary in a Part A stay in a SNF bill type 22X should be used? What if the beneficiary is in a bed not certified for Medicare; wouldn't the bill type be 23X?"

Yes, we are stating that if a beneficiary is in a Part A stay in a SNF, 22X should be used. If a beneficiary is in a non-certified bed for Medicare, you should use 23X.

The next question: "I just need a little clarification on Slides 38 and 54 of the Cardiovascular Screening and the Diabetes Screening. This relates to the RHC. These are not with RHC clinics as being those providers that can bill. Is it correct that RHCs can perform these services but hospitals bill them; is that correct because of the diagnosis?"

Yes, if the RHC is a provider-based, the base provider may bill under its own provider number.

The next question, No. 24: "I believe today RHCs aren't required to HCPCS code. Do they need to at

least HCPCS code these until April, or can we tell them, don't have HCPCS codes at all?"

No, do not tell them to discontinue using HCPCS codes because we didn't say that in the FISS requirements. So they are required to report these HCPCS codes.

The next question, No. 25: "On Slide 38, it states that they will be covered when performed on an outpatient or inpatient basis in a hospital, critical access, SNF, et cetera. Then it lists the type of bills that are submitted. Now, I guess my question is that if the patient is an inpatient, this is paid outside the DRG or RUG code?" Then it goes into a brief discussion.

Yes; the answer to the question is "yes." It is part of the Part B-only service.

MS. PHILLIPS: Thank you, Taneka.

MS. MURPHY: [Inaudible] for a minute, Robin, and clarify something on Question Nos. 24 and 25. That is that we did not instruct RHCs and FQHCs to use HCPCS codes for the IPPE. So technically, we don't believe anybody will be looking for those HCPCS codes. However,

the instructions telling RHCs next week that they can stop HCPCS coding are not effective until April.

So while I don't believe those codes would be required by anybody, you might have a little trouble getting an FI to say they weren't required.

MS. PHILLIPS: Thank you. That was Cindy Murphy. Thank you, Cindy.

Before we open our call up for questions and answers, I would like to ask Jeannie Wilkerson from the Centers for Beneficiary Choices to tell us what they are doing to educate beneficiaries.

MS. WILKERSON: Sure. I'm actually from the Beneficiary Publication Division. I can give you a little -- no, pardon me, CBC. I can give you an overview of what we are doing as far as publications go.

The Medicare New 2005 Handbook included information about the new benefits. We also did something a little different. Starting in November, we modified the new enrollee handbook that is mailed to all new beneficiaries to include a Welcome to Medicare introduction letter, giving them information on the

physical exam, encouraging them to schedule that right away. There will also be information in the Medicare and You 2006 Handbook.

We have the Guide to Medicare's Preventive Services Publication that is currently available on Medicare.gov and by calling 1-800-MEDICARE. It is available in English and Spanish.

We had to revise this publication before the final rule came out, so we will be revising that in the next couple of months. Hopefully, it will be available by this coming summer.

We have also created a Staying Healthy: Medicare's Preventive Services publication. It is a brief overview of all of Medicare's preventive services, and was created in collaboration with American Diabetes Association, American Cancer Society, and the American Heart Association. That is available, also, by calling 1-800-MEDICARE and on Medicare.gov, and it is available in English and Spanish.

There is also The Facts About Medicare's New Preventive Benefits that is currently at the printer. It

will be available very shortly, in English and Spanish. It is currently on Medicare.gov and 1-800-MEDICARE. That highlights the Welcome to Medicare physical exam, the diabetes screening, and the cardiovascular screening.

We are also currently revising the IEP package, which will be mailed out beginning September of 2005. It will include information on Medicare's preventive services and also, again, encouraging people to schedule their Welcome to Medicare physical exam.

We are also working with 1-800-MEDICARE to make sure all the scripts are updated with all the current information, and the call center operations staff has also added tips to any relevant script that cues CSRs to inform new enrollees of the physical exam. Then, periodically, we are posting new questions on Medicare.gov, as things come up.

If any questions come up after the call, any beneficiary education questions come up, please feel free to contact me. My name is Jeannie Wilkerson, and my e-mail address is jwilkerson@cms.hhs.gov.

MS. PHILLIPS: Thank you, Jeannie.

MS. WILKERSON: Thanks.

MS. PHILLIPS: Before we start the question-and-answer session, I just want to let you know that the transcript will be posted on www.cms.hhs.gov/medlearn/cmsinit.asp. We are also going to have Hazeline Roulac talk about the preventive services guide and the brochures that we have out.

MS. ROULAC: Thank you, Robin.

Jeannie just gave a brief overview of some of the products that are out to educate the beneficiaries. We currently have posted to MedLearn to educate the providers about Medicare's new preventive services as well as the other preventive services that are available The Guide to Medicare Preventive Services for Providers, Physicians, Suppliers, and Other Healthcare Professionals. This is a comprehensive guide. It gives a brief overview of the services, coverage information, billing information, risk factors, et cetera.

In addition to the guide, we also have five new preventive service brochures that are posted to MedLearn. One brochure is entitled Expanded Benefits, and this

brochure gives a brief overview of the IPPE cardiovascular screening and the diabetes blood test.

We have an adult immunization brochure, cancer screening brochure, glaucoma brochure, and a bone mass measurement brochure. Currently, these publications are available as download-only. They will be available in print shortly, and we will put an announcement on the MedLearn website and the provider pages when these publications will be available in print.

Thank you, Robin.

MS. PHILLIPS: Thank you, Hazeline.

Just one reminder. I would like to remind everyone that this call is being recorded and transcribed. So please give your name and tell us what organization you are with.

In an effort to get as many questions as possible, we ask that you limit your questions to one. We hope to have enough time to answer everyone's questions today. If we don't get to your question, please check with the appropriate contact from the CR. The list is on the CR.

Operator, at this time, you may open the call for questions.

Question-and-Answer Session

THE OPERATOR: If you would like to ask a question, press star-1. You will be announced prior to asking your question. To withdraw your question, press star-2. Once again, if you would like to ask a question, it is star-1.

The first question is from Donna Hosani [ph.]

MS. HOSANI: Yes. I didn't quite catch the e-mail address to get that transcript. If you can just repeat that, I would appreciate it.

MS. PHILLIPS: Sure. www.cms.hhs.gov/medlearn/cmsinit.asp.

MS. HOSANI: Thank you so much.

MS. PHILLIPS: You're welcome.

THE OPERATOR: The next question is from Lisa Carly [ph.] Please state your organization.

MR. OLDS: Hi. This is John Olds [ph] with Cahaba in Des Moines. I guess if I have one question, it is, can I make a comment?

MS. PHILLIPS: Yes.

MR. OLDS: Thank you.

The main comment is, I think this benefit is great and is probably going to save Medicare in the long run some money, and it is also going to help a lot of patients who will be better because they have had this exam.

Another comment here is that I think it is a bit of a misnomer to call it a physical exam because there are only four components that are really a physical exam here. That is the blood pressure, the height, the weight, and maybe the vision acuity. The rest of this and the bulk of the time that is going to be spent on this exam is not going to be a physical exam, it is going to be a history.

That is where the physician is going to be quite involved for a long period of time, quite possibly. All these patients are going to be over 65 years of age, and they are likely to have various illnesses and comorbidities.

So they are likely to spill over into things

that are going to take a lot of time and may need that -25 modifier in order to pursue them. Just those three or four items that are on the so-called physical part will probably be done by ancillary personnel and not the physician.

For example now, if we are talking about the blood pressure, and a comment was made if the blood pressure is high, maybe somebody would listen to the heart and that would be included in the exam. I don't think that is accurate because if you listen to the heart, then you assume the accuracy of listening to the heart and the liability of not writing it down correctly or listening to it correctly. That involves a whole new dimension of this physical exam.

So I think the exam is going to have to be limited to the blood pressure, the height, the weight, and the visual acuity, and anything beyond there is probably separately billable.

I just wanted to make that point. Thank you.

MS. PHILLIPS: Thank you very much.

Next question, please.

THE OPERATOR: The next question is from Sonia Armstrong. Please state your organization.

MS. ARMSTRONG: Hi. My question has already been answered. Thank you.

MS. PHILLIPS: I'm sorry. We were going to respond to the comment, please. I'm sorry.

DR. SANDERS: This is Dr. Sanders. In regards to the last comment, any other physical exam maneuvers would not likely be separately billable. They would have to conform to the standards of those E & M codes. You would have to provide those specific services. I just gave the example of listening to the heart, you know, as one example of something that a provider may do as part of the IPPE.

So that is a little bit, I guess, not completely accurate, that all additional services would be separately billable.

THE OPERATOR: Again, if you would like to ask a question, it is star-1.

[Pause.]

THE OPERATOR: I'm not showing any further

questions.

MS. PHILLIPS: Okay. Thank you, Julie.

I would like to make an announcement, if I may. We now have an evaluation form that we would like for you to complete and submit. It can be done very quickly. The form is titled Contractor Training Evaluation Form. It is an online evaluation form that can be found on the Medicare Contractor Training website, and that is the same website that I mentioned earlier that also has the PowerPoint slides. We look forward to hearing your comments for upcoming training conference calls.

If there are no further questions, this ends our call for today. Thank you very much for participating. I also would like to thank our subject-matter experts for participating on the call.

THE OPERATOR: That concludes today's conference. You may disconnect at this time.

[Whereupon, at 1:50 p.m., the conference call was concluded.]

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