CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3096	**Date: October 17, 2014**
	Change Request 8881

SUBJECT: Medicare Coverage of Ultrasound Screening for Abdominal Aortic Aneurysms (AAA) and Screening Fecal-Occult Blood Tests (FOBT)

I. SUMMARY OF CHANGES: Effective for dates of service on and after January 27, 2014, contractors shall pay claims for Ultrasound screening for AAA and screening FOBTs, per the modified requirements in 42 CFR 410.19 and 410.37.

EFFECTIVE DATE: January 27, 2014
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: November 18, 2014

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	12/30.6.1.1/Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV)
R	18/60.2/HCPCS Codes, Frequency Requirements, and Age Requirements (If Applicable)
R	18/80/Initial Preventive Physical Examination (IPPE)
R	18/110/Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)
R	18/110.1/Definitions
R	18/110.2/Coverage

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3096	Date: October 17, 2014	Change Request: 8881

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I. GENERAL INFORMATION

A. Background: As part of the CY 2014 Physician Fee Schedule rule, CMS revised the Medicare Part B coverage requirements for Ultrasound Screening for AAA (42 CFR 410.19) and Screening FOBT (42 CFR 410.37). Pub. 100-04, chapter 12, section 30.6.1.1 and Pub.100-04, chapter 18, sections 80, 110, 110.1, and 110.2 have been updated to align these manual sections with the modified regulations due to policy changes, and by removing outdated information for purposes of clarity. Except as described in the Policy section below, all other coverage requirements for these services remain unchanged.

B. Policy: Effective for dates of service on and after January 27, 2014:

- Ultrasound Screening for AAA: Per Section 42 CFR 410.19, coverage of AAA screening is modified by eliminating the one year time limit with respect to the referral for this service. This modification allows coverage of AAA screening for eligible beneficiaries without requiring them to receive a referral as part of the Initial Preventive Physical Examination (IPPE, also commonly known as the "Welcome to Medicare Preventive Visit"). The beneficiary need only obtain a referral from their physician, physician assistant, nurse practitioner, or clinical nurse specialist, and meet other coverage requirements per 42 CFR 410.19.

- Screening FOBTs: In addition to the beneficiary's attending physician, section 42 CFR 410.37(b) is modified to allow the beneficiary's attending physician assistant, nurse practitioner, or clinical nurse specialist, to furnish written orders for screening FOBTs.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8881 - 04.1	Effective for dates of service on and after January 27, 2014, contractors shall pay claims for Ultrasound screening for AAA and screening FOBTs, per the modified requirements in 42 CFR 410.19 and 410.37. See Pub. 100-04, chapter 12,	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	section 30.6.1.1, and Pub. 100-04, chapter 18, sections 60.2, 80, 110, 110.1, and 110.2.									
8881 - 04.2	For claims with dates of service on or after January 27, 2014, Medicare contractors shall not search their files. However, contractors shall adjust claims brought to their attention.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
8881 - 04.3	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X			

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Wanda Belle, 410-786-7491 or wanda.belle@cms.hhs.gov (Coverage), Jamie Hermansen, 410-786-2064 or jamie.hermansen@cms.hhs.gov (Coverage)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR)

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 12 - Physicians/Nonphysician Practitioners

30.6.1.1 – Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV)
(Rev. 3096, Issued: 10-17-14, Effective: 01-27-14, Implementation: 11-18-14)

A. Definitions

1. Initial Preventive Physical Examination (IPPE)

The initial preventive physical examination (IPPE), or "Welcome to Medicare *Preventive* Visit" is a *preventive visit authorized by sections 1861(s)(2)(w) and 1861(ww) of the Social Security Act (and implementing regulations at 42 CFR 410.16, 411.15(a)(1), and 411.15(k)(11)).*

As described in the implementing regulations, the IPPE includes the following:

(1) review of the individual's medical and social history with attention to modifiable risk factors for disease detection,

(2) review of the individual's potential (risk factors) for depression or other mood disorders,

(3) review of the individual's functional ability and level of safety,

(4) *an* examination to include measurement of the individual's height, weight, *body mass index,* blood pressure, a visual acuity screen, and other factors as deemed appropriate*, based on the beneficiary's medical and social history*,

(5) *end-of-life planning, upon agreement of the individual*,

(6) education, counseling, and referral, as deemed appropriate, based on the results of the review and evaluation services described in the previous 5 elements, and

(7) education, counseling, and referral including a brief written plan (e.g., a checklist or alternative) provided to the individual for obtaining the appropriate screening and other preventive services, *which are separately covered under Medicare Part B (that is, pneumococcal, influenza and hepatitis B vaccines and their administration, screening mammography, screening pap smear and screening pelvic examinations, prostate cancer screening tests, colorectal cancer screening tests, diabetes outpatient self-management training services, bone mass measurements, glaucoma screening, medical nutrition therapy for individuals with diabetes or renal disease, cardiovascular screening blood tests, diabetes screening tests, screening ultrasound for abdominal aortic aneurysms, an electrocardiogram, and additional preventive services covered under Medicare Part B through the Medicare national coverage determinations process).*

2. Annual Wellness Visit (AWV)

Effective January 1, 2011, *Sections 1861(s)(2)(FF) and 1861(hhh) of the Social Security Act and implementing regulations at 42 CFR 410.15, authorize* for an AWV *providing personalized* prevention plan services (PPPS). The AWV is *a preventive visit* available *to* eligible beneficiaries, and identified by HCPCS codes G0438 (Annual wellness visit, including PPPS, first visit) and G0439 (Annual wellness visit, including PPPS,

subsequent visit). *Information, including definitions of relevant terms and coverage requirements for the* AWV are included *in* Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 280.5.

The first AWV providing PPPS (HCPCS G0438) *is* a 'one time' allowed Medicare benefit and *includes* the following elements furnished to an eligible beneficiary by a health professional:

Review (and administration if needed) of a health risk assessment,

- Establishment of the individual's medical/family history,
- Establishment of a list of current providers and suppliers that are regularly involved in providing medical care to the individual,
- Measurement of the individual's height, weight, body mass index (or waist circumference, if appropriate), blood pressure (BP), and other routine measurements as deemed appropriate, based on the individual's medical and family history,
- Detection of any cognitive impairment that the individual may have,
- Review of an individual's potential risk factors for depression, including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the health professional may select from various available standardized screening tests designed for this purpose and recognized by national professional medical organizations,
- Review of the individual's functional ability and level of safety, based on direct observation of the individual, or the use of appropriate screening questions or a screening questionnaire, which the health professional may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations,
- Establishment of a written screening schedule for the individual, such as a checklist for the next 5 to 10 years, as appropriate, based on recommendations of the *United States Preventive Services Task Force (*USPSTF*)* and Advisory Committee of Immunizations Practices (ACIP), *and the individual's health risk assessment,* health status, screening history, and age-appropriate preventive services covered by Medicare,
- Establishment of a list of risk factors and conditions of which primary, secondary, or tertiary interventions are recommended or underway for the individual, including any mental health conditions or any such risk factors or conditions that have been identified through an IPPE, and a list of treatment options and their associated risks and benefits,
- *Furnishing* of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management 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, and,
- Any other element(s) determined appropriate by the Secretary through the *national coverage determinations* process.

Subsequent AWV*s providing* PPPS (HCPCS G0439) include the following key elements furnished to an eligible beneficiary by a health professional:

Review (and administration, if needed) of an updated health risk assessment,

- Update *of* the individual's medical/family history,
- Update to the list of current providers and suppliers that are regularly involved in providing medical care to the individual as that list was developed for the first AWV providing PPPS, *or the previous subsequent AWV providing PPPS,*
- Measurement of an individual's weight (or waist circumference), *blood pressure,* and other routine measurements as deemed appropriate, based on the individual's medical and family history,
- Detection of any cognitive impairment that the individual may have,
- Update to the individual's written screening schedule as developed at the first AWV providing PPPS,
- Update to the individual's list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are underway for the individual, as that list was developed at the first AWV providing PPPS*, or the previous subsequent AWV providing PPPS,*
- *Furnishing of* personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs, and,
- Any other element determined appropriate by the Secretary through the *national coverage determinations* process.

See chapter 18 of this manual for additional information regarding preventive services *that* are separately covered under Medicare Part B.

B. Who May Perform *an IPPE or AWV*

The contractor pays the appropriate physician fee schedule amount based on the rendering National Provider Identification (NPI) number.

The IPPE may be performed by:

- a doctor of medicine or osteopathy as defined in Section 1861(r) (1) of the *Social Security* Act, *or*
- a qualified nonphysician practitioner (nurse practitioner, physician assistant or clinical nurse specialist).

The AWV *may be performed* by a health professional, which is defined as:

- a doctor of medicine or osteopathy as defined in Section 1861(r)(1) of the Social Security Act,

  a physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5) of the Social Security Act), or

- a medical professional (including a health educator, registered dietitian, nutrition professional, or other licensed practitioner) or a team of such medical professionals, working under the direct supervision of a physician *(doctor of medicine or osteopathy)*.

C. Eligibility

1. IPPE

Medicare *pays* for one IPPE per beneficiary per lifetime *for beneficiaries within the* first 12 months *of the effective date of the beneficiary's first* Part B coverage *period*.

2. AWV

Medicare *pays* for an AWV for a beneficiary who is no longer within 12 months after the effective date of his/her first Medicare Part B coverage period, and *who* has not received either an IPPE or an AWV providing PPPS within the past 12 months. Medicare pays for only one first AWV (HCPCS G0438), per beneficiary per lifetime. All subsequent *AWVs* must be billed *using* HCPCS G0439.

D. Deductible and Coinsurance

1. IPPE

The Medicare deductible and coinsurance apply for the IPPE provided before January 1, 2009.

The Medicare deductible is waived effective for the IPPE provided on or after January 1, 2009. However, the applicable coinsurance continues to apply for the IPPE provided on or after January 1, 2009.

As a result of the *Affordable Care Act* (ACA), effective for the IPPE provided on or after January 1, 2011, the Medicare deductible and coinsurance (for HCPCS code G0402 only) are waived.

2. AWV

As a result of the ACA, effective January 1, 2011, the Medicare deductible and coinsurance for the AWV (HCPCS G0438 and G0439) are waived.

E. The EKG Component of the IPPE

The once-in-a-lifetime screening EKG may be performed, as appropriate, with a referral from an IPPE.

F. HCPCS Codes Used to Bill the IPPE or AWV

1. HCPCS Codes Used to Bill the IPPE

For IPPE and EKG services provided prior to January 1, 2009, the physician or qualified NPP shall bill HCPCS code G0344 for the *IPPE* performed face-to-face, and HCPCS code G0366 for performing a screening EKG that includes both the interpretation and report. If the primary physician or qualified NPP performs only the *IPPE*, he/she shall bill HCPCS code G0344 only. The physician or entity that performs the screening EKG that includes both the interpretation and report shall bill HCPCS code G0366. The physician or entity that performs the screening EKG tracing only (without interpretation and report) shall bill HCPCS code G0367. The physician or entity that performs the interpretation and report only (without the EKG tracing) shall bill HCPCS code G0368. Medicare will pay for a screening EKG only as part of the IPPE. HCPCS codes G0344, G0366, G0367 and G0368 will not be billable codes effective on or after January 1, 2009.

Effective for a beneficiary who has the IPPE on or after January 1, 2009, and within his/her 12-month enrollment period of Medicare Part B, the IPPE and screening EKG services are billable with the appropriate HCPCS G code(s).

The physician or qualified NPP shall bill HCPCS code G0402 for the *IPPE* performed face-to-face with the patient.

The physician or entity shall bill HCPCS code G0403 for performing the complete screening EKG that includes the tracing, interpretation and report.

The physician or entity that performs the screening EKG tracing only (without interpretation and report) shall bill HCPCS code G0404.

The physician or entity that performs the screening EKG interpretation and report only, (without the EKG tracing) shall bill HCPCS code G0405.

2. HCPCS Codes Used to Bill the AWV

For the first AWV provided on or after January 1, 2011, the health professional shall bill HCPCS G0438 (Annual wellness visit, including PPPS, first visit). This is a once per beneficiary per lifetime allowable Medicare *Part B* benefit.

All subsequent AWVs shall be billed with HCPCS G0439 (Annual Wellness Visit, including PPPS, subsequent visit). In the event that a beneficiary selects a new health professional to complete a subsequent AWV, the new health professional will continue to bill the subsequent AWV with HCPCS G0439.

NOTE: For an IPPE or AWV performed during the global period of surgery, refer to chapter 12, §30.6.6 of this *chapter* for reporting instructions.

G. Documentation for the IPPE or AWV

Practitioners eligible to furnish an IPPE or an AWV are required to use the 1995 and 1997 E/M documentation guidelines to document the medical record with the appropriate clinical information. *(http://xmarks.com/site/www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp)*. All referrals and a written medical plan must be included in this documentation.

H. Reporting a Medically Necessary E/M Service Furnished During the Same Encounter as an IPPE or AWV

When the physician or qualified NPP, or for AWV the health professional, provides a significant, separately identifiable medically necessary E/M service in addition to the IPPE or an AWV, CPT codes 99201 – 99215 may be reported depending on the clinical appropriateness of the circumstances. CPT Modifier –25 shall be appended to the medically necessary E/M service identifying this service as a significant, separately identifiable service from the IPPE or AWV code reported (HCPCS code G0344 or G0402, whichever applies based on the date the IPPE is performed, or HCPCS code G0438 or G0439 whichever AWV code applies).

NOTE: Some of the components of a medically necessary E/M service (e.g., a portion of history or physical exam portion) may have been part of the IPPE or AWV and should not be included when determining the most appropriate level of E/M service to be billed for the medically necessary, separately identifiable, E/M service.

Medicare Claims Processing Manual
Chapter 18 - Preventive and Screening Services

60.2 - HCPCS Codes, Frequency Requirements, and Age Requirements (If Applicable)
(Rev. 3096, Issued: 10-17-14, Effective: 01-27-14, Implementation: 11-18-14)

Effective for services furnished on or after January 1, 1998, the following codes are used for colorectal cancer screening services:

- 82270* (G0107*) - Colorectal cancer screening; fecal-occult blood tests, 1-3 simultaneous determinations;
- G0104 - Colorectal cancer screening; flexible sigmoidoscopy;
- G0105 - Colorectal cancer screening; colonoscopy on individual at high risk;
- G0106 - Colorectal cancer screening; barium enema; as an alternative to G0104, screening sigmoidoscopy;
- G0120 - Colorectal cancer screening; barium enema; as an alternative to G0105, screening colonoscopy.

Effective for services furnished on or after July 1, 2001, the following codes are used for colorectal cancer screening services:

- G0121 - Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk. Note that the description for this code has been revised to remove the term “noncovered.”
- G0122 - Colorectal cancer screening; barium enema (noncovered).

Effective for services furnished on or after January 1, 2004, the following code is used for colorectal cancer screening services as an alternative to 82270* (G0107*):

- G0328 - Colorectal cancer screening; immunoassay, fecal-occult blood test, 1-3 simultaneous determinations.

*__NOTE__: For claims with dates of service prior to January 1, 2007, physicians, suppliers, and providers report HCPCS code G0107. Effective January 1, 2007, code G0107 is discontinued and replaced with CPT code 82270.

G0104 - Colorectal Cancer Screening; Flexible Sigmoidoscopy

Screening flexible sigmoidoscopies (code G0104) may be paid for beneficiaries who have attained age 50, when performed by a doctor of medicine or osteopathy at the frequencies noted below.

For claims with dates of service on or after January 1, 2002, contractors pay for screening flexible sigmoidoscopies (code G0104) for beneficiaries who have attained age 50 when these services were performed by a doctor of medicine or osteopathy, or by a physician assistant, nurse practitioner, or clinical nurse specialist (as defined in §1861(aa)(5) of the Act and in the Code of Federal Regulations at 42 CFR 410.74, 410.75, and 410.76) at the frequencies noted above. For claims with dates of service prior to January 1, 2002, contractors pay for these services under the conditions noted only when a doctor of medicine or osteopathy performs them.

For services furnished from January 1, 1998, through June 30, 2001, inclusive:

- Once every 48 months (i.e., at least 47 months have passed following the month in which the last covered screening flexible sigmoidoscopy was done).

For services furnished on or after July 1, 2001:

- Once every 48 months as calculated above **unless** the beneficiary does not meet the criteria for high risk of developing colorectal cancer (refer to §60.3 of this chapter) **and** he/she has had a screening colonoscopy (code G0121) within the preceding 10 years. If such a beneficiary has had a screening colonoscopy within the preceding 10 years, then he or she can have covered a screening flexible sigmoidoscopy only after at least 119 months have passed following the month that he/she received the screening colonoscopy (code G0121).

NOTE: If during the course of a screening flexible sigmoidoscopy a lesion or growth is detected which results in a biopsy or removal of the growth; the appropriate diagnostic procedure classified as a flexible sigmoidoscopy with biopsy or removal should be billed and paid rather than code G0104.

G0105 - Colorectal Cancer Screening; Colonoscopy on Individual at High Risk

Screening colonoscopies (code G0105) may be paid when performed by a doctor of medicine or osteopathy at a frequency of once every 24 months for beneficiaries at high risk for developing colorectal cancer (i.e., at least 23 months have passed following the month in which the last covered G0105 screening colonoscopy was performed). Refer to §60.3 of this chapter for the criteria to use in determining whether or not an individual is at high risk for developing colorectal cancer.

NOTE: If during the course of the screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a colonoscopy with biopsy or removal should be billed and paid rather than code G0105.

A. Colonoscopy Cannot be Completed Because of Extenuating Circumstances

1. ***A/B MACs (A)***

When a covered colonoscopy is attempted but cannot be completed because of extenuating circumstances, Medicare will pay for the interrupted colonoscopy as long as the coverage conditions are met for the incomplete procedure. However, the frequency standards associated with screening colonoscopies will not be applied by CWF. When a covered colonoscopy is next attempted and completed, Medicare will pay for that colonoscopy according to its payment methodology for this procedure as long as coverage conditions are met, and the frequency standards will be applied by CWF. This policy is applied to both screening and diagnostic colonoscopies. When submitting a facility claim for the interrupted colonoscopy, providers are to suffix the colonoscopy

HCPCS codes with a modifier of "–73" or" –74" as appropriate to indicate that the procedure was interrupted. Payment for covered incomplete screening colonoscopies shall be consistent with payment methodologies currently in place for complete screening colonoscopies, including those contained in 42 CFR 419.44(b). In situations where a critical access hospital (CAH) has elected payment Method II for CAH patients, payment shall be consistent with payment methodologies currently in place as outlined in *c*hapter 3 *of this manual*. As such, instruct CAHs that elect Method II payment to use modifier "–53" to identify an incomplete screening colonoscopy (physician professional service(s) billed in revenue code 096X, 097X, and/or 098X). Such CAHs

will also bill the technical or facility component of the interrupted colonoscopy in revenue code 075X (or other appropriate revenue code) using the "-73" or "-74" modifier as appropriate.

Note that Medicare would expect the provider to maintain adequate information in the patient's medical record in case it is needed by the contractor to document the incomplete procedure.

2. ***A/B MACs (B)***

When a covered colonoscopy is attempted but cannot be completed because of extenuating circumstances (see chapter 12), Medicare will pay for the interrupted colonoscopy at a rate consistent with that of a flexible sigmoidoscopy as long as coverage conditions are met for the incomplete procedure. When a covered colonoscopy is next attempted and completed, Medicare will pay for that colonoscopy according to its payment methodology for this procedure as long as coverage conditions are met. This policy is applied to both screening and diagnostic colonoscopies. When submitting a claim for the interrupted colonoscopy, professional providers are to suffix the colonoscopy code with a modifier of "–53" to indicate that the procedure was interrupted. When submitting a claim for the facility fee associated with this procedure, Ambulatory Surgical Centers (ASCs) are to suffix the colonoscopy code with "–73" or "–74" as appropriate. Payment for covered screening colonoscopies, including that for the associated ASC facility fee when applicable, shall be consistent with payment for diagnostic colonoscopies, whether the procedure is complete or incomplete.

Note that Medicare would expect the provider to maintain adequate information in the patient's medical record in case it is needed by the contractor to document the incomplete procedure.

G0106 - Colorectal Cancer Screening; Barium Enema; as an Alternative to G0104, Screening Sigmoidoscopy

Screening barium enema examinations may be paid as an alternative to a screening sigmoidoscopy (code G0104). The same frequency parameters for screening sigmoidoscopies (see those codes above) apply.

In the case of an individual aged 50 or over, payment may be made for a screening barium enema examination (code G0106) performed after at least 47 months have passed following the month in which the last screening barium enema or screening flexible sigmoidoscopy was performed. For example, the beneficiary received a screening barium enema examination as an alternative to a screening flexible sigmoidoscopy in January 1999. Start counts beginning February 1999. The beneficiary is eligible for another screening barium enema in January 2003.

The screening barium enema must be ordered in writing after a determination that the test is the appropriate screening test. Generally, it is expected that this will be a screening double contrast enema unless the individual is unable to withstand such an exam. This means that in the case of a particular individual, the attending physician must determine that the estimated screening potential for the barium enema is equal to or greater than the screening potential that has been estimated for a screening flexible sigmoidoscopy for the same individual. The screening single contrast barium enema also requires a written order from the beneficiary's attending physician in the same manner as described above for the screening double contrast barium enema examination.

82270* (G0107*) **- Colorectal Cancer Screening; Fecal-Occult Blood Test, 1-3 Simultaneous Determinations**

Effective for services furnished on or after January 1, 1998, screening FOBT (code 82270* (G0107*) may be paid for beneficiaries who have attained age 50, and at a frequency of once every 12 months (i.e., at least 11 months have passed following the month in which the last covered screening FOBT was performed). This screening FOBT means a guaiac-based test for peroxidase activity, in which the beneficiary completes it by taking samples from two different sites of three consecutive stools. This screening requires a written order from

the beneficiary's attending physician*, or effective for dates of service on or after January 27, 2014, the beneficiary's attending physician assistant, nurse practitioner, or clinical nurse specialist*. (The term "attending physician" is defined to mean a doctor of medicine or osteopathy (as defined in §1861(r)(1) of the Act) who is fully knowledgeable about the beneficiary's medical condition, and who would be responsible for using the results of any examination performed in the overall management of the beneficiary's specific medical problem.)

Effective for services furnished on or after January 1, 2004, payment may be made for an immunoassay-based FOBT (G0328, described below) as an alternative to the guaiac-based FOBT, 82270* (G0107*). Medicare will pay for only one covered FOBT per year, either 82270* (G0107*) or G0328, but not both.

***NOTE**: For claims with dates of service prior to January 1, 2007, physicians, suppliers, and providers report HCPCS code G0107. Effective January 1, 2007, code G0107 is discontinued and replaced with CPT code 82270.

G0328 - Colorectal Cancer Screening; Immunoassay, Fecal-Occult Blood Test, 1-3 Simultaneous Determinations

Effective for services furnished on or after January 1, 2004, screening FOBT, (code G0328) may be paid as an alternative to 82270* (G0107*) for beneficiaries who have attained age 50. Medicare will pay for a covered FOBT (either 82270* (G0107*) or G0328, but not both) at a frequency of once every 12 months (i.e., at least 11 months have passed following the month in which the last covered screening FOBT was performed).

Screening FOBT, immunoassay, includes the use of a spatula to collect the appropriate number of samples or the use of a special brush for the collection of samples, as determined by the individual manufacturer's instructions. This screening requires a written order from the beneficiary's attending physician*, or effective for claims with dates of service on or after January 27, 2014, the beneficiary's attending physician assistant, nurse practitioner, or clinical nurse specialist*. (The term "attending physician" is defined to mean a doctor of medicine or osteopathy (as defined in §1861(r)(1) of the Act) who is fully knowledgeable about the beneficiary's medical condition, and who would be responsible for using the results of any examination performed in the overall management of the beneficiary's specific medical problem.)

G0120 - Colorectal Cancer Screening; Barium Enema; as an Alternative to G0105, Screening Colonoscopy

Screening barium enema examinations may be paid as an alternative to a screening colonoscopy (code G0105) examination. The same frequency parameters for screening colonoscopies (see those codes above) apply.

In the case of an individual who is at high risk for colorectal cancer, payment may be made for a screening barium enema examination (code G0120) performed after at least 23 months have passed following the month in which the last screening barium enema or the last screening colonoscopy was performed. For example, a beneficiary at high risk for developing colorectal cancer received a screening barium enema examination (code G0120) as an alternative to a screening colonoscopy (code G0105) in January 2000. Start counts beginning February 2000. The beneficiary is eligible for another screening barium enema examination (code G0120) in January 2002.

The screening barium enema must be ordered in writing after a determination that the test is the appropriate screening test. Generally, it is expected that this will be a screening double contrast enema unless the individual is unable to withstand such an exam. This means that in the case of a particular individual, the attending physician must determine that the estimated screening potential for the barium enema is equal to or greater than the screening potential that has been estimated for a screening colonoscopy, for the same individual. The

screening single contrast barium enema also requires a written order from the beneficiary's attending physician in the same manner as described above for the screening double contrast barium enema examination.

G0121 - Colorectal Screening; Colonoscopy on Individual Not Meeting Criteria for High Risk - Applicable On and After July 1, 2001

Effective for services furnished on or after July 1, 2001, screening colonoscopies (code G0121) performed on individuals not meeting the criteria for being at high risk for developing colorectal cancer (refer to §60.3 of this chapter) may be paid under the following conditions:

- At a frequency of once every 10 years (i.e., at least 119 months have passed following the month in which the last covered G0121 screening colonoscopy was performed.)

- If the individual would otherwise qualify to have covered a G0121 screening colonoscopy based on the above **but** has had a covered screening flexible sigmoidoscopy (code G0104), then he or she may have covered a G0121 screening colonoscopy only after at least 47 months have passed following the month in which the last covered G0104 flexible sigmoidoscopy was performed.

NOTE: If during the course of the screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a colonoscopy with biopsy or removal should be billed and paid rather than code G0121.

G0122 - Colorectal Cancer Screening; Barium Enema

The code is not covered by Medicare.

80 – Initial Preventive Physical Examination (IPPE)

(Rev. 3096, Issued: 10-17-14, Effective: 01-27-14, Implementation: 11-18-14)

(**NOTE:** For billing and payment requirements for the Annual Wellness Visit, see chapter 18, section 140, of this *chapter*.)

Background: *Sections 1861(s)(2)(w) and 1861(ww) of the Social Security Act (and implementing regulations at 42 CFR 410.16, 411.15(a)(1), and 411.15(k)(11)) authorize coverage under Part B for a one-time initial preventive physical examination (IPPE) for new Medicare beneficiaries that meet certain eligibility requirements.*

Coverage: *As described in implementing regulations at 42 CFR 410.16, 411.15(a)(1), and 411.15(k)(11), the* IPPE may be performed by a doctor of medicine or osteopathy as defined in section 1861 (r)(1) of the Social Security Act (the Act) or by a qualified nonphysician practitioner (NPP) (physician assistant, *nurse practitioner,* or clinical nurse specialist), not later than *12* months after the date the individual's first coverage begins under Medicare Part B. (See section 80.3 for a list of bill types of facilities that can bill *A/B MACs* for this service.)

The IPPE includes:

(1) review of the individual's medical and social history with attention to modifiable risk factors for disease detection,

(2) review of the individual's potential (risk factors) for depression or other mood disorders,

(3) review of the individual's functional ability and level of safety;

(4) *an* examination to include measurement of the individual's height, weight, *body mass index*, blood pressure, a visual acuity screen, and other factors as deemed appropriate, *based on the beneficiary's medical and social history*;

(5) end-of-life planning, upon agreement of the individual.

(6) education, counseling, and referral, as deemed appropriate, based on the results of the review and evaluation services described in the previous 5 elements, and

(7) education, counseling, and referral including a brief written plan (e.g., a checklist or alternative) provided to the individual for obtaining appropriate screening and other preventive services, which are separately covered under Medicare Part B.

Medicare will pay for only one IPPE per beneficiary per lifetime. The Common Working File (CWF) will edit for this benefit.

The IPPE does not include other preventive services that are currently separately covered and paid under Medicare Part B. (That is: pneumococcal, influenza and hepatitis B vaccines and their administration, screening mammography, screening pap smear and screening pelvic examinations, prostate cancer screening tests, colorectal cancer screening tests, diabetes outpatient self-management training services, bone mass measurements, glaucoma screening, medical nutrition therapy for individuals with diabetes or renal disease, cardiovascular screening blood tests, diabetes screening tests*, screening ultrasound for abdominal aortic aneurysms, an electrocardiogram, and additional preventive services covered under Medicare Part B through the Medicare national coverage determination process*.)

For the physician/practitioner billing correct coding and payment policy, refer to chapter 12, section 30.6.1.1, of this manual.

110 - Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)

(Rev. 3096, Issued: 10-17-14, Effective: 01-27-14, Implementation: 11-18-14)

Section *1861(s)(2)(AA) and 1861(bbb) of the Social Security Act and implementing regulations at 42 CFR 410.19 authorize* coverage under *Medicare* Part B for a one-time ultrasound screening for abdominal aortic aneurysm (AAA), *effective January 1, 2007*.

110.1 – Definitions

(Rev. 3096, Issued: 10-17-14, Effective: 01-27-14, Implementation: 11-18-14)

The term "ultrasound screening for abdominal aortic aneurysm" means *the following services furnished to an asymptomatic individual for the early detection of an abdominal aortic aneurysm*—

(1) a procedure using sound waves (or such other procedures using alternative technologies, of commensurate accuracy and cost, as specified by the Secretary of Health and Human Services, through the national coverage determination process) provided for the early detection of abdominal aortic aneurysms; and

(2) includes a physician's interpretation of the results of the procedure.

110.2 – Coverage

(Rev. 3096, Issued: 10-17-14, Effective: 01-27-14, Implementation: 11-18-14)

Payment may be made for a one-time ultrasound screening for AAA for beneficiaries who meet the following criteria:

(i) receives a referral for such an ultrasound screening *from the beneficiary's attending physician, physician assistant, nurse practitioner or clinical nurse specialist;*

(ii) receives such ultrasound screening from a provider or supplier who is authorized to provide covered *ultrasound* diagnostic services;

(iii) has not been previously furnished such an ultrasound screening under the Medicare Program; and

(vi) is included in at least one of the following risk categories--

(I) has a family history of abdominal aortic aneurysm;

(II) is a man age 65 to 75 who has smoked at least 100 cigarettes in his lifetime; or

(III) is a beneficiary who manifests other risk factors in a beneficiary category recommended for screening by the United States Preventive Services Task Force regarding AAA, as specified by the Secretary of Health and Human Services, through the national coverage determination process.