CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 864	**Date: March 2, 2011**
	Change Request 7012

Transmittal 739, dated July 30, 2010, is being rescinded and replaced by Transmittal 864 to remove Hepatitis B Vaccine Administration codes 90471 and 90472 from the Preventive Services Table. All other information remains the same.

SUBJECT: Waiver of Coinsurance and Deductible for Preventive Services, Section 4104 of the Patient Protection and Affordable Health Care Act (the Affordable Care Act), Removal of Barriers to Preventive Services in Medicare

I. SUMMARY OF CHANGES: This Change Request implements the changes in Section 4104 of the Patient Protection and Affordable Care Act (the Affordable Care Act), Removal of Barriers to Preventive Services in Medicare.

EFFECTIVE DATE: January 1, 2011
IMPLEMENTATION DATE: January 3, 2011

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
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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.

IV. ATTACHMENTS:

One-Time Notification

Unless otherwise specified, the effective date is the date of service.

Attachment – One Time Notification

Pub. 100-20	Transmittal: 864	Date: March 2, 2011	Change Request: 7012

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SUBJECT: Waiver of Coinsurance and Deductible for Preventive Services, Section 4104 of the Patient Protection and Affordable Health Care Act (ACA), Removal of Barriers to Preventive Services in Medicare

EFFECTIVE DATE: JANUARY 1, 2011
IMPLEMENTATION DATE: JANUARY 3, 2011

I. GENERAL INFORMATION

A. Background: Provisions of the ACA waive the coinsurance/copayment and deductible for the initial preventive physical examination (IPPE), the annual wellness visit, and those Medicare covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B for any indication or population and that are appropriate for the individual. The ACA also waives the deductible for planned colorectal cancer screening tests that become diagnostic.

NOTE: This CR applies to all preventive services, the IPPE, and the annual wellness visit furnished by any provider or supplier that is eligible to bill and be paid by Medicare for the service.

B. Policy:

1. Definition of "Preventive Services"

The specific preventive services covered by Medicare include the following:

- Pneumococcal, influenza, and hepatitis B vaccine and administration;
- Screening mammography;
- Screening pap smear and screening pelvic exam;
- Prostate cancer screening tests;
- Colorectal cancer screening tests;
- Diabetes outpatient self-management training (DSMT);
- Bone mass measurement;
- Screening for glaucoma;
- Medical nutrition therapy (MNT) services;
- Cardiovascular screening blood tests;
- Diabetes screening tests;
- Ultrasound screening for abdominal aortic aneurysm (AAA); and
- Additional preventive services (identified for coverage through the national coverage determination (NCD), currently this is limited to HIV testing).

2. Deductible and Coinsurance for Preventive Services

The ACA waives the deductible and coinsurance/copayment for the preventive services listed above with a recommendation grade of A or B by the USPSTF. In addition, the ACA waives the deductible and coinsurance/copayment for the IPPE and annual wellness visit.

All preventive services recommended by the USPSTF do not have a grade of A or B. In some cases where they do not have this grade, the deductible and coinsurance may be waived on another basis, such as the waiver of deductible and coinsurance that currently applies to all diagnostic clinical laboratory tests.

The following Medicare covered preventive services do not comply with the USPSTF recommendation requirement (that is, the USPSTF does not recommend them with a grade of A or B): digital rectal examination provided as a prostate screening service; glaucoma screening; DSMT services; and barium enema provided as a colorectal cancer screening service. However, the deductible does not apply to barium enemas provided as colorectal cancer screening tests because colorectal cancer screening tests are explicitly excluded from the deductible under another section of the statute.

The table below provides the HCPCS codes that are defined as preventive services under Medicare and also identifies the HCPCS codes for the IPPE and the annual wellness visit.

Deductible and Coinsurance for Preventive Services
(Includes the IPPE and the Annual Wellness Visit)

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	CY 2011 Coins. / Deductible
Initial Preventive Physical Examination, IPPE	G0402	Initial preventive physical examination; face to face visits, services limited to new beneficiary during the first 12 months of Medicare enrollment	***Not Rated**	WAIVED
	G0403	Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report		Not Waived
	G0404	Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination		Not Waived

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	CY 2011 Coins. / Deductible
	G0405	Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination		Not Waived
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)	G0389	Ultrasound, B-scan and /or real time with image documentation; for abdominal aortic aneurysm (AAA) ultrasound screening	B	WAIVED
Cardio-vascular Disease Screening	80061	Lipid panel	A	WAIVED
	82465	Cholesterol, serum or whole blood, total		WAIVED
	83718	Lipoprotein, direct measurement; high density cholesterol (hdl cholesterol)		WAIVED
	84478	Triglycerides		WAIVED
Diabetes Screening Tests	82947	Glucose; quantitative, blood (except reagent strip)	B	WAIVED
	82950	Glucose; post glucose dose (includes glucose)		WAIVED
	82951	Glucose; tolerance test (gtt), three specimens (includes glucose)	***Not Rated**	WAIVED
Diabetes Self-Management Training Services (DSMT)	G0108	Diabetes outpatient self-management training services, individual, per 30 minutes	***Not Rated**	Not Waived
	G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes		Not Waived
Medical Nutrition Therapy (MNT) Services	97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	B	WAIVED
	97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes		WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	CY 2011 Coins. / Deductible
	97804	Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes		WAIVED
	G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes	B	WAIVED
	G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes		WAIVED
Screening Pap Test	G0123	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision	A	WAIVED
	G0124	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician		WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	CY 2011 Coins. / Deductible
	G0141	Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician		WAIVED
	G0143	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision	A	WAIVED
	G0144	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision		WAIVED
	G0145	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision		WAIVED
	G0147	Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision		WAIVED
	G0148	Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening		WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	CY 2011 Coins. / Deductible
	P3000	Screening papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision		WAIVED
	P3001	Screening papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician		WAIVED
	Q0091	Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory		WAIVED
Screening Pelvic Exam	G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	A	WAIVED
Screening Mammo-graphy	77052	Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography (list separately in addition to code for primary procedure)	B	WAIVED
	77057	Screening mammography, bilateral (2-view film study of each breast)		WAIVED
	G0202	Screening mammography, producing direct digital image, bilateral, all views		WAIVED
Bone Mass Measurement	G0130	Single energy x-ray absorptiometry (sexa) bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)	B	WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	CY 2011 Coins. / Deductible
	77078	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)		WAIVED
	77079	Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)		WAIVED
	77080	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)		WAIVED
	77081	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)		WAIVED
	77083	Radiographic absorptiometry (e.g., photodensitometry, radiogrammetry), 1 or more sites		WAIVED
	76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method		WAIVED
Colorectal Cancer Screening	G0104	Colorectal cancer screening; flexible sigmoidoscopy	A	WAIVED
	G0105	Colorectal cancer screening; colonoscopy on individual at high risk		WAIVED
	G0106	Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema	***Not Rated**	Coins. Applies & Ded. is waived
	G0120	Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema		Coins. Applies & Ded. is waived

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	CY 2011 Coins. / Deductible
	G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk	A	WAIVED
	82270	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive		WAIVED
	G0328	Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous		WAIVED
Prostate Cancer Screening	G0102	Prostate cancer screening; digital rectal examination	D	Not Waived
	G0103	Prostate cancer screening; prostate specific antigen test (PSA)		WAIVED
Glaucoma Screening	G0117	Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist	I	Not Waived
	G0118	Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or ophthalmologist		Not Waived
Influenza Virus Vaccine	90655	Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use	B	WAIVED
	90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use		WAIVED
	90657	Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use		WAIVED
	90660	Influenza virus vaccine, live, for intranasal use		WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	CY 2011 Coins. / Deductible
	90662	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use		WAIVED
	Q2035	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Afluria)		WAIVED
	Q2036	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Flulaval)		WAIVED
	Q2037	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use, (Fluvirin)		WAIVED
	Q2038	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluzone)		WAIVED
	Q2039	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (not otherwise specified)		WAIVED
	G0008	Administration of influenza virus vaccine		WAIVED
	G9141	Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family)		WAIVED
	G9142	Influenza A (H1N1) Vaccine, any route of administration		WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	CY 2011 Coins. / Deductible
Pneumo-coccal Vaccine	90669	Pneumococcal conjugate vaccine, polyvalent, when administered to children younger than 5 years, for intramuscular use	B	WAIVED
	90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use		WAIVED
	90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use		WAIVED
	G0009	Administration of pneumococcal vaccine		WAIVED
Hepatitis B Vaccine	90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use	A	WAIVED
	90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use		WAIVED
	90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use		WAIVED
	90746	Hepatitis B vaccine, adult dosage, for intramuscular use		WAIVED
	90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use		WAIVED
	G0010	Administration of hepatitis B vaccine		WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	CY 2011 Coins. / Deductible
HIV Screening	G0432	Infectious agent antigen detection by enzyme immunoassay (EIA) technique, qualitative or semi-qualitative, multiple-step method, HIV-1 or HIV-2, screening	A	WAIVED
	G0433	Infectious agent antigen detection by enzyme-linked immunosorbent assay (ELISA) technique, antibody, HIV-1 or HIV-2, screening		WAIVED
	G0435	Infectious agent antigen detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV-2 , screening		WAIVED
Smoking and Tobacco Cessation	G0436	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes.	**A**	WAIVED
	G0437	Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes.		WAIVED
Annual Wellness Visit	G0438	Annual wellness visit, including PPPS, first visit	***Not Rated**	WAIVED
	G0439	Annual wellness visit, including PPPS, subsequent visit		WAIVED

[1] U.S. Preventive Services Task Force Recommendations

A -- The USPSTF strongly recommends that clinicians routinely provide [the service] to eligible patients. (The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.)

B -- The USPSTF recommends that clinicians routinely provide [the service] to eligible patients. (The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.)

C -- The USPSTF makes no recommendation for or against routine provision of [the service]. (The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.)

D -- The USPSTF recommends against routinely providing [the service] to asymptomatic patients. (The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.)

I -- The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. (Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.)

3. Extension of Waiver of Deductible to Services Furnished in Connection with or in Relation to a Colorectal Screening Test that Becomes Diagnostic or Therapeutic

The ACA waives the Part B deductible for colorectal cancer screening tests that become diagnostic. Specifically, section 4104(c)(2)of the ACA waives the deductible with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as a screening test. The Medicare policy is that the deductible is waived for all surgical procedures (CPT code range of 10000 to 69999) furnished on the same date and in the same encounter as a colonoscopy, flexible sigmoidoscopy, or barium enema that were initiated as colorectal cancer screening services. Modifier PT has been created and providers and practitioners should append the modifier to the diagnostic procedure code that is reported instead of the screening colonoscopy or screening sigmoidoscopy HCPCS code. The claims processing system would respond to the modifier by waiving the deductible for all surgical services on the same date as the diagnostic test. Coinsurance would continue to apply to the diagnostic test and to other services furnished in connection with, as a result of, and in the same clinical encounter as the screening test.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7012.1	Contractors shall ensure that the CWF record contains the appropriate payment and deductible indicator per the above table.	X		X	X		X	X		X	
7012.1.1	Contractors shall submit a payment indicator of "0" to indicate a copayment of 20% is applicable.	X			X			X		X	
7012.1.2	Contractors shall submit a payment indicator of "1" to indicate 100% payment (no applicable copayment).	X			X			X		X	
7012.1.3	Contractors shall submit a deductible indicator of "0" to indicate the deductible applies.	X			X			X		X	
7012.1.4	Contractors shall submit a deductible indicator of "1" to indicate a zero deductible.	X			X			X		X	
7012.1.5	Contractors shall apply override code of "3" to indicate coinsurance and deductible do not apply.	X		X			X			X	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7012.1.6	Contractors shall apply override code of "1" to indicate deductible does not apply.	X		X			X			X	
7012.1.7	Contractors shall apply override code of "0" to indicate deductible and coinsurance apply.	X		X			X			X	
7012.2	Contractors shall accept new modifier PT for claims with dates of service on or after January 1, 2011.	X		X	X		X	X		X	
7012.3	Contractors shall waive the deductible for all procedures reported by CPT codes within the surgical range of CPT codes (10000 – 69999) when modifier PT is appended to at least one CPT code in the surgical range on the claim for services that were furnished on the same date of service as the procedure with modifier PT appended.	X		X	X		X	X		X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7012.4	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/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 site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your 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	X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): For payment policy questions please contact Stephanie Frilling, Stephanie.Frilling@cms.hhs.gov, (410) 786-4507, or Gaysha Brooks, Gaysha.Brooks@cms.hhs.gov, (410) 786-9649. For claims processing questions please contact William Ruiz, William.Ruiz@cms.hhs.gov, (410) 786-9283 for Part A and Vera Dillard, Vera.Dillard@cms.hhs.gov, (410) 786-6149 for Part B.

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *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.