CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1615	**Date: October 17, 2008**
	Change Request 6223

NOTE: This Transmittal is no longer sensitive and is being re-communicated October 31, 2008. The Transmittal Number, date of Transmittal and all other information remain the same.

SUBJECT: Update to the Initial Preventive Physical Examination (IPPE) Benefit

I. SUMMARY OF CHANGES: Effective January 1, 2009, coverage for the Initial Preventive Physical Examination (IPPE) has been expanded. This expanded coverage is subject to certain eligibility and other limitations that allow payment for an IPPE, not later than 12 months after the date the individual`s first coverage period begins under Medicare Part B. The IPPE has been expanded to include measurement of an individual`s body mass index, and end-of-life planning. The screening electrocardiogram is no longer a mandatory part of the IPPE, but it may be performed as an optional one-time service as a result of a referral from an IPPE.

NEW / REVISED MATERIAL
EFFECTIVE DATE: *January 1, 2009
IMPLEMENTATION DATE: January 5, 2009(unless otherwise specified by the individual business requirement).

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-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	12/Table of Contents
R	12/30.6.1.1/Initial Preventive Physical Examination
R	18/80/Initial Preventive Physical Examination (IPPE)
R	18/80.1/HCPCS Coding for the IPPE
R	18/80.2/Carrier Billing Requirements
R	18/80.3/Fiscal Intermediary Billing Requirements
R	18/80.3.1/RHC/FQHCs Special Billing Instructions
R	18/80.3.2/Indian Health Services (IHS) Hospitals Special Billing Instructions
R	18/80.3.3/OPPS Hospital Billing

R	18/80.4/Coinsurance and Deductible
R	18/80.5/Medicare Summary Notices (MSNs)
R	18/80.6/Remittance Advice Remark Codes
R	18/80.7/Claims Adjustment Reason Codes
R	18/80.8/Advanced Beneficiary Notice (ABN) as Applied to the IPPE

III. FUNDING:
SECTION A: For Fiscal Intermediaries and 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.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1615	Date: October 17, 2008	Change Request: 6223

NOTE: This Transmittal is no longer sensitive and is being re-communicated October 31, 2008. The Transmittal Number, date of Transmittal and all other information remain the same.

SUBJECT: Update to the Initial Preventive Physical Examination (IPPE) Benefit.

Effective Date: January 1, 2009.

Implementation Date: January 5, 2009 (unless otherwise specified by the individual business requirement).

I. GENERAL INFORMATION

A. Background: Over the past 25 years, Congress has added specific preventive and screening services to the voluntary Medicare Part B Program, and one of those services is the initial preventive physical examination (IPPE). Pursuant to section 101(b) of the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA), we are amending §§410.16 and related regulation provisions to conform the Medicare law to the Code of Federal Regulations effective January 1, 2009, subject to certain eligibility and other limitations that allow a one-time only payment for an IPPE not later than 12 months after the date the individual's first coverage period begins under Medicare Part B. (Prior to the enactment of MIPPA, the IPPE had to be performed not later than 6 months after the date the individual's first coverage period began.)

B. Policy: Effective for dates of service on or after January 1, 2009, the IPPE has been expanded to include measurement of an individual's body mass index, and, upon the individual's consent, end-of-life planning, as mandatory services. End-of-life planning is defined as verbal or written information regarding: (1) an individual's ability to prepare an advance directive (AD) in the case that an injury or illness causes the individual to be unable to make health care decisions, and (2) whether or not the physician is willing to follow the individual's wishes as expressed in the AD. The annual Part B deductible is waived for the IPPE (code G0402) for dates of service January 1, 2009, and after (coinsurance still applies). Last, the eligibility period for receiving an IPPE has been extended from 6 months to 12 months following an individual's enrollment in Medicare Part B. Therefore, any beneficiaries who have not yet had an IPPE and whose initial enrollment in Medicare began in 2008 will be able to have an IPPE in 2009, as long as it is done within 12 months of their initial enrollment.

Also effective for dates of service on and after January 1, 2009, the electrocardiogram (EKG) is no longer a mandatory part of the IPPE, but it may be performed as an optional once-in-a-lifetime screening service as a result of a referral from an IPPE (as part of the educational, counseling, and referral service an individual is entitled to during his/her IPPE visit). In addition, "additional preventive services" has been added to the list of educational, counseling, and referral services to allow for future covered services that may be added through the national coverage determination (NCD) process.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

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	
6223.1	Effective for dates of service on and after January 1, 2009, contractors shall pay providers that bill an IPPE with code G0402, performed not later than 12 months after the date the individual's first coverage period begins under Medicare Part B. **NOTE:** An IPPE is only allowed one time. Payment for new IPPE code G0402 will not be allowed if old IPPE code G0344 is paid in history.	X		X	X		X	X		X	NGD/ MBD
6223.1.1	Contractors and Medicare system maintainers shall accept HCPCS code G0402 for claims billed for an IPPE visit. **NOTE:** This new IPPE code will be part of the 2009 HCPCS update, will be type of service 1, and payment will be under the Medicare Physician Fee Schedule (MPFS) or Outpatient Prospective Payment System (OPPS) for claims submitted to the carrier, fiscal intermediary, or A/B MAC. The finalized code description will be added to this change request before it is released. Codes G0344, G0366, G0367, and G0368 will no longer be valid for dates of service on or after January 1, 2009. This change will be part of the 2009 HCPCS update.	X		X	X		X	X		X	OCE
6223.2	Effective January 1, 2009, the screening EKG is not a required part of the IPPE. It is optional and may be performed as a result of a referral from an IPPE. Contractors shall allow codes G0403, G0404, and G0405 to be allowed only once in a beneficiary's lifetime. **NOTE:** The descriptions of the new screening EKG codes G0403, G0404, and G0405 are similar to codes G0366, G0367, and G0368, with the exception that the EKG is no longer "performed as a component of the initial preventive physical examination", but it is performed as an optional one-time only screening as a result of a referral from an IPPE. These new screening EKG codes will be part of the 2009 HCPCS update, will all be type of service 5, and payment will be under the MPFS for claims submitted to the carrier or A/B MAC. Payment will be made under the OPPS for claims submitted to the fiscal intermediary or A/B MAC for G0404 (code for the	X		X	X		X	X		X	OCE/ NGD/ MBD

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	
	screening EKG tracing only). The finalized code descriptions will be added to this change request before it is released.										
6223.2.1	Contractors and Medicare system maintainers shall accept HCPCS code G0403 when interpretation and report are done with the EKG tracing.	X		X	X		X	X		X	
6223.2.2	Contractors and Medicare system maintainers shall accept HCPCS code G0404 when the EKG tracing only, is performed.	X		X	X		X	X		X	
6223.2.3	Contractors and Medicare system maintainers shall accept HCPCS code G0405 when the EKG interpretation and report, alone, are performed. **NOTE**: Included in the RHC/FQHC encounter rate.	X		X	X		X	X		X	
6223.3	Contractors shall allow payment for a medically necessary E/M service (CPT code 99201 – 99215) at the same visit as the IPPE (G0344 or G0402, whichever applies based on the beneficiary's enrollment date) when billed with modifier-25. That portion of the visit must be medically necessary to treat the patient's illness or injury or to improve the functioning of a malformed body member. **NOTE:** This does not apply to RHCs/FQHCs. TOBs 71X, and 73X.	X		X	X		X	X		X	OCE
6223.4	Contractors shall waive the deductible for the IPPE code G0402 effective January 1, 2009, and after.	X		X	X		X	X			OPPS/ OCE
6223.5	Contractors shall apply the deductible to optional screening EKG codes G0403, G0404, or G0405.	X		X	X		X	X		X	OPPS/ OCE
6223.6	Contractors shall pay for G0402, G0403, G0404, or G0405 only when the services are submitted on one of the following type bills: 12X, 13X, 22X, 71X, 73X and 85X.	X		X			X			X	OCE
6223.7	Contractors shall pay for new IPPE code G0402 and G0404 for the screening EKG tracing only for hospitals subject to OPPS.(TOB 12X, and 13X) **NOTE:** Hospitals not subject to OPPS shall be paid under their current payment methodologies.	X		X			X			X	OCE
6223.8	For claims with dates of service on or after January 1, 2009, CWF shall create edits to allow new IPPE code G0402 only once in a beneficiary's lifetime not later than 12 months after the date the individual's coverage first begins under Medicare Part B.									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	
	NOTE: Hospitals shall be allowed to bill for the facility payment of these new codes. There will be no Part A/Part B crossover edit.										
6223.8.1	CWF shall not allow payment for new IPPE code G0402 if old IPPE code G0344 is paid in history. **NOTE:** Although the new IPPE code is effective for dates of service on and after January 1, 2009, the history must be checked for the old IPPE code. Any beneficiary whose initial enrollment in Medicare began in 2008 will be able to have an IPPE in 2009, as long as it is done within 12 months of his/her initial enrollment.									X	
6223.8.2	CWF shall not apply the frequency edit based on receipt of a claim containing new IPPE code G0402 from institutions (FIs), other than CAHs that have elected method 2 payment for outpatient claims. Only if an 85X is received in CWF with charges in revenue codes 096X or 098X and new IPPE code G0402 should CWF indicate that the professional component of the IPPE has been provided to the beneficiary based on the receipt of a bill from an FI or Part A MAC.									X	
6223.8.3	CWF shall not allow payment for G0403 (global) if G0366, technical component codes G0404 or G0367, or professional component codes G0405 or G0368 are paid in history.									X	
6223.8.4	CWF shall not allow payment for G0404 (technical component) if G0366, G0367, or G0403 (global), is paid in history.									X	
6223.8.5	CWF shall not allow payment for G0405 (professional component) if G0366, G0368, or G0403 (global), is paid in history.									X	
6223.8.6	For claims with dates of service on or after January 1, 2009, CWF shall create new edits to allow payment for only one global screening EKG in a lifetime (code G0403).									X	
6223.8.7	For claims with dates of service on or after January 1, 2009, CWF shall create new edits to allow payment for only one technical component screening EKG in a lifetime (code G0404).									X	
6223.8.8	For claims with dates of service on or after January 1, 2009, CWF shall create new edits to allow payment for only one professional component screening EKG in a lifetime (code G0405).									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	
6223.8.9	Contractors shall accept the new CWF reject(s).	X		X	X		X	X		X	
6223.9	When denying additional claims (or claims with dates of service beyond the 12 month period) for new IPPE code G0402, contractors shall use the following new Medicare Summary Notice (MSN) with group code PR (patient responsibility): 20.91 - This service was denied. Medicare covers a one-time initial preventive physical exam (Welcome to Medicare physical exam) if you get it within the first 12 months of the effective date of your Medicare Part B coverage. The Spanish version is: Este servicio fue negado. Medicare cubre un examen físico de "Bienvenido a Medicare" ofrecido una sola vez si se obtiene dentro de los primeros 12 meses de la fecha efectiva de su inscripción a la Parte B de Medicare. **NOTE:** If a second preventive physical and/or screening electrocardiogram is billed for the same beneficiary, it would be denied as a statutory (technical) denial under Section 1862(a)(1)(K) of the Social Security Act--not a medical necessity denial. Such a denial would be similar to the noncovered routine services denial. An Advanced Beneficiary Notice is not required.	X		X	X		X	X			
6223.10	When denying additional claims for frequency purposes for screening EKG codes G0403, G0404, or G0405, contractors shall use existing MSN message 20.12 – This service was denied because Medicare only covers this service once in a lifetime.	X		X	X		X	X			
6223.11	Contractors shall use claim adjustment reason code 149 (Lifetime benefit maximum has been reached for this service/benefit category.) when denying additional claims for G0402, G0403, G0404, and G0405.	X		X	X		X	X			
6223.12	Contractors shall use remittance advice remark code N117 (This service is paid only once in a patient's lifetime.) when denying additional claims for G0402, G0403, G0404, and G0405.	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	
6223.13	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 one 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	X					

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s):

Physician Payment Policy issues: Kit Scally (Cathleen.Scally@cms.hhs.gov), 410-786-5714;
OPPS Policy issues: Carrie Bullock (Carrie.bullock@cms.hhs.gov), 410-786-1947;
Coverage Issues: Bill Larson (William.Larson@cms.hhs.gov), 410-786-4639;
Part A Claims Processing: Antoinette Johnson (Antoinette.Johnson@cms.hhs.gov), 410-786-9326;
Part B Claims Processing: Kathy Kersell (Kathleen.Kersell@cms.hhs.gov), 410-786-2033, or Bridgitte Davis (Bridgitte.davis@cms.hhs.gov) 410-786-4573

Post-Implementation Contact(s): Appropriate Regional Office Staff

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (RHHIs)* use only one of the following statements:

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)*, use the following statement:

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.

Medicare Claims Processing Manual

Chapter 12 - Physicians/Nonphysician Practitioners

Table of Contents

(Rev.1615, 10-17-08)

30.6.1.1 – *Initial Preventive Physical Examination*

(Rev.1615, Issued: 10-17-08, Effective: 01-01-09, Implementation: 01-05-09)

A. Definition

The initial preventive physical examination (IPPE), or "Welcome to Medicare Visit" *(WMV)* is a preventive evaluation and management service (E/M)*, allowed by Section 611 of the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003,* that 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) a physical examination to include measurement of the individual's height, weight, blood pressure, a visual acuity screen, and other factors as deemed appropriate by the examining physician or qualified nonphysician practitioner (NPP), (5) performance and interpretation of an electrocardiogram (EKG), (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.

Effective January 1, 2007, Section 5112 of the Deficit Reduction Act of 2005 allows for one ultrasound screening for Abdominal Aortic Aneurysm (AAA), HCPCS code G0389, as a result of a referral from an IPPE. This service is not subject to the Part B annual deductible. For AAA physician/practitioner billing, correct coding, and payment policy, refer to Chapter 18, § 110, of this manual.

Effective January 1, 2009, Section 101 (b) of the Medicare Improvement for Patients and Providers Act (MIPPA) of 2008 requires the addition of the measurement of an individual's body mass index and, upon an individual's consent, end-of-life planning, to the IPPE. Also, effective January 1, 2009, MIPPA removes the screening electrocardiogram (EKG) as a mandatory service of the IPPE. MIPPA requires that

there be education, counseling, and referral for an EKG, as appropriate. This is a once-in-a-lifetime screening EKG as a result of a referral from an IPPE.

The MIPPA of 2008 allows for possible future payment for additional preventive services not otherwise described in Title XVIII of the Social Security Act (the Act) that identify medical conditions or risk factors for eligible individuals if the Secretary determines through the national coverage determination (NCD) process (as defined in Section 1869(f)(1)(B) of the Act) that they are: (1) reasonable and necessary for the prevention or early detection of illness or disability, (2) recommended with a grade of A or B by the United States Preventive Services Task Force, and, (3) appropriate for individuals entitled to benefits under Part A or enrolled under Part B, or both. MIPPA requires that there be education, counseling, referral for additional preventive services, as appropriate, under the IPPE, if the Secretary determines in the future that such services are covered.

Preventive services are separately covered under Medicare Part B benefits.

(For billing requirements, refer to Chapter 18, § 80, of this manual.)

B. Who May Perform

The IPPE may be performed by a doctor of medicine or osteopathy as defined in *S*ection 1861*(r)(1)* of the *Act* or by a qualified NPP (nurse practitioner, physician assistant and clinical nurse specialist). The *contractor* will pay the appropriate physician fee schedule amount based on the rendering *National Provider Identification (NPI) number*.

C. Eligibility

As a result of the MMA 2003, Medicare will pay for one IPPE per beneficiary per lifetime. A beneficiary is eligible when he first enrolls in Medicare Part B on or after January 1, 2005, and receives the IPPE benefit within the first 6 months of the effective date of the initial Part B coverage period.

The Medicare deductible for the IPPE performed before January 1, 2009, (HCPCS code G0344) applies.

The MIPPA of 2008 extends the eligibility period for an IPPE from 6 months to 12 months after an individual's Medicare Part B enrollment. A beneficiary is eligible for IPPE benefits identified in MIPPA if the IPPE is performed on or after January 1, 2009 and within the 12-month period of his/her effective date of the initial enrollment in Medicare Part B.

For a Medicare beneficiary who has the IPPE performed on or after January 1, 2009, and it occurs within the 12-month period of his/her effective date of the initial enrollment in Medicare Part B, the Medicare deductible for the IPPE (HCPCS code G0402) is waived and no longer applies.

Medicare continues to pay for only one IPPE per beneficiary per lifetime. Co-insurance for these services applies both prior to and after January 1, 2009.

D. The EKG Component

Under the MMA of 2003, if the physician or qualified NPP is not able to perform both the examination and the screening EKG, an arrangement may be made to ensure that another physician or entity performs the screening EKG and reports the EKG separately using the appropriate HCPCS G code*(s) identified in E*. *When the screening EKG is performed, the* primary physician or qualified NPP shall document the results of the screening EKG into the beneficiary's medical record to complete and bill for the IPPE benefit. **NOTE**: Both components of the IPPE (the examination and the screening EKG) must be performed before the claims can be submitted by the physician, qualified NPP, and/or entity.

MIPPA 2008 changes the once-in-a-lifetime screening EKG from a mandated service to a service that may be performed, as appropriate, with a referral from an IPPE. The waived deductible for the IPPE, effective January 1, 2009, does not apply to the screening EKG service irrespective of the codes used or date of service.

E. 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 physical examination 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 examination, 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 physical examination 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.

For an IPPE performed during the global period of surgery refer to Chapter 12, § 30.6.6, of this manual for reporting instructions.

F. Documentation

The physician and qualified NPP shall use the appropriate screening tools typically used in routine physician practice. Physicians and qualified NPPs are required to use the 1995 and 1997 E/M documentation guidelines *to document the medical record with the appropriate clinical information.*
(http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp)
All referrals and a written medical plan must be included in this documentation.

G. Reporting *a* Medically Necessary E/M *Service* at *the* Same IPPE Visit

When the physician or qualified NPP provide*s* a medically necessary E/M service in addition to the IPPE, CPT codes 99201 – 99215 may be used 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 code *reported (G0344 or G0402, whichever applies based on the date the IPPE is performed).* **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 and should not be included when determining the most appropriate level of E/M service to be billed for the medically necessary E/M service.

80 – Initial Preventive Physical Examination (IPPE)

(Rev.1615, Issued: 10-17-08, Effective: 01-01-09, Implementation: 01-05-09)

Background: Effective for services furnished on or after January 1, 2005, Section 611 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) provides for coverage under Part B of one initial preventive physical examination (IPPE) for new beneficiaries only, subject to certain eligibility and other limitations. We amended §§411.15 (a)(1) and 411.15 (k)(11) of the Code of Federal Regulations (CFR) to permit payment for an IPPE as described at 42 CFR §410.16, added by 69 FR 66236, 66420 (November 15, 2004) not later than 6 months after the date the individual's first coverage period begins under Medicare Part B.

Under the MMA of 2003, 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 mid-level nonphysician practitioner (NPP) (nurse practitioner, physician assistant or clinical nurse specialist), not later than 6 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 fiscal intermediaries (FIs) for this service.) This examination will include: (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) a physical examination to include measurement of the individual's height, weight, blood pressure, a visual acuity screen, and other factors as deemed appropriate by the examining physician or qualified nonphysician practitioner (NPP), (5) performance and interpretation of an electrocardiogram (EKG); (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 benefits. The EKG performed as a component of the IPPE will be billed separately. Medicare will pay for only one IPPE per beneficiary per lifetime. The Common Working File (CWF) will edit for this benefit.

As required by statute *under the MMA of 2003*, the total IPPE service includes an EKG, but the EKG is billed with its own unique HCPCS code(s). The IPPE does not include other preventive services that are currently separately covered and paid under Section 1861 of the Act under Medicare Part B screening benefits. (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, and diabetes screening tests.)

Section 5112 of the Deficit Reduction Act of 2005 allows for one ultrasound screening for Abdominal Aortic Aneurysm (AAA) as a result of a referral from an IPPE effective January 1, 2007. For AAA physician/practitioner billing, correct coding, and payment policy information, refer to Section 110 of this chapter.

Effective January 1, 2009, Section 101 (b) of the Medicare Improvement for Patients and Providers Act (MIPPA) of 2008 updates the IPPE benefit described under the MMA of 2003. The MIPPA allows the IPPE to be performed not later than 12 months after the date the individual's first coverage period begins under Medicare Part B, requires the addition of the measurement of an individual's body mass index to the IPPE, adds end-of-life planning (upon an individual's consent) to the IPPE, and removes the screening electrocardiogram (EKG) as a mandatory service of the IPPE. The screening EKG is optional effective January 1, 2009, and is permitted as a once-in-a-lifetime screening service as a result of a referral from an IPPE.

The MIPPA of 2008 allows for possible future payment for additional preventive services not otherwise described in Title XVIII of the Social Security Act (the Act) that identify medical conditions or risk factors for eligible individuals if the Secretary determines through the national coverage determination (NCD) process (as defined in section 1869(f)(1)(B) of the Act) that they are: (1) reasonable and necessary for the prevention or early detection of illness or disability, (2) recommended with a grade of A or B by the United States Preventive Services Task Force, and, (3) appropriate for individuals entitled to benefits under Part A or enrolled under Part B, or both. MIPPA requires that there be education, counseling, referral for additional preventive services, as appropriate, under the IPPE, if the Secretary determines in the future that such services are covered.

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

80.1 – HCPCS Coding for the IPPE

(Rev.1615, Issued: 10-17-08, Effective: 01-01-09, Implementation: 01-05-09)

The *HCPCS* codes *listed below were* developed for the IPPE benefit *effective January 1, 2005, for individual's whose initial enrollment is on or after January 1, 2005.*

G0344: Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 6 months of Medicare enrollment

Short Descriptor: Initial Preventive Exam

G0366: Electrocardiogram, routine ECG with 12 leads; performed as a component of the initial preventive examination with interpretation and report

Short Descriptor: EKG for initial prevent exam

G0367: tracing only, without interpretation and report, performed as a component of the initial preventive examination

Short Descriptor: EKG tracing for initial prev

G0368: interpretation and report only, performed as a component of the initial preventive examination

Short Descriptor: EKG interpret & report preve

The following new HCPCS codes have been developed for the IPPE benefit effective January 1, 2009, and replace codes G0344, G0366, G0367, and G0368 shown above beginning with dates of service on or after January 1, 2009:

G0402: *Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment*

Short Descriptor: *Initial Preventive exam*

G0403: *Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report*

Short Descriptor: *EKG for initial prevent exam*

G0404: *Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination*

Short Descriptor: *EKG tracing for initial prev*

G0405: *Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination*

Short Descriptor: *EKG interpret & report preve*

80.2 – Carrier Billing Requirements:

(Rev.1615, Issued: 10-17-08, Effective: 01-01-09, Implementation: 01-05-09)

Effective for dates of service on and after January 1, 2005, *through December 31, 2008, contractors* shall recognize the *HCPCS codes G0344, G0366, G0367, and G0368 shown above in § 80.1 for an* IPPE. The type of service (TOS) for each of the new codes is as follows:

G0344: TOS = 1
G0366: TOS = 5

G0367: TOS = 5
G0368: TOS = 5

Contractors shall pay physicians or qualified nonphysician practitioners for only one IPPE performed not later than 6 months after the date the individual's first coverage begins under Medicare Part B, but only if that coverage period begins on or after January 1, 2005.

Effective for dates of service on and after January 1, 2009, contractors shall recognize the HCPCS codes G0402, G0403, G0404, and G0405 shown above in § 80.1 for an IPPE. The type of service (TOS) for each of the new codes is as follows:

G0402: TOS = 1
G0403: TOS = 5
G0404: TOS = 5
G0405: TOS = 5

Under the MIPPA of 2008, contractors shall pay physicians or qualified nonphysician practitioners for only one IPPE performed not later than 12 months after the date the individual's first coverage begins under Medicare Part B.

Contractors shall allow payment for a medically necessary Evaluation and Management (E/M) service at the same visit as the IPPE when it is clinically appropriate. Physicians and qualified nonphysician practitioners shall use CPT codes 99201 - 99215 to report an E/M with CPT modifier 25 to indicate that the E/M is a significant, separately identifiable service from the *IPPE code reported (G0344 or G0402, whichever applies based on the date the IPPE is performed).* Refer *to Chapter* 12, *§* 30.6.1.1, *of this manual* for the physician/practitioner billing correct coding *and payment* policy regarding E/M services.

If the EKG performed as a component of the IPPE is not performed by the primary physician or qualified NPP during the IPPE visit, another physician or entity may perform and/or interpret the EKG. The referring *physician or qualified NPP* needs to make sure that the performing *physician or entity* bills the appropriate G code for the screening EKG, and **not** a CPT code in the 93000 series. **Both the IPPE and the EKG should be billed in order for the beneficiary to receive the complete IPPE service**. *Effective for dates of service on and after January 1, 2009, the screening EKG is optional and is no longer a mandated service of an IPPE if performed as a result of a referral from an IPPE.*

Should the same physician or NPP need to perform an additional medically necessary EKG in the 93000 series on the same day as the IPPE, *report* the appropriate EKG CPT code(s) with modifier 59, indicating that the EKG is a distinct procedural service.

Physicians or qualified nonphysician practitioners shall bill the *contractor* the appropriate HCPCS codes for IPPE on the Form CMS-1500 claim or an approved electronic format. The *HCPCS* codes *for an IPPE and screening EKG* are paid under the Medicare

Physician Fee Schedule (MPFS). The appropriate deductible and coinsurance applies *to codes G0344, G0366, G0367, G0368, G0403, G0404, and G0405. The deductible is waived for code G0402 (insert new IPPE code), but the coinsurance still applies.*

80.3 – Fiscal Intermediary Billing Requirements:

(Rev.1615, Issued: 10-17-08, Effective: 01-01-09, Implementation: 01-05-09)

The FI will pay for IPPE or EKG only when the services are submitted on one of the following type bills (TOB): 12X, 13X, 22X, 71X, 73X and 85X.

Type of facility and setting determines the basis of payment:

- For *the IPPE or the screening EKG tracing only* performed on a 12X and 13X, for hospitals subject to the outpatient prospective payment system (OPPS), under the OPPS. Hospitals not subject to OPPS shall be paid under current methodologies.

- For services performed on an 85X TOB, Critical Access Hospitals, pay on reasonable cost.

- For services performed in a SNF, TOB 22x, make payment for the technical component of the EKG based on the MPFS.

- *For inpatient or outpatient services in hospitals in Maryland, make payment according to the State Cost Containment System.*

- *For services performed on a 12X, Indian Health Services (IHS) hospitals, payment is made based on an all inclusive ancillary per diem rate.*

- *For services performed on a 13X, IHS hospitals, payment is made based on the all inclusive rate (AIR).*

- *For services performed on an 85X, IHS CAHs, payment is made based on an all inclusive facility specific per visit rate.*

All CAHs are paid for the technical or facility component of the IPPE itself. They are also paid for the technical component of the EKG, the tracing only, if the EKG is performed.

Only Method II CAHs are paid for the professional component of the IPPE itself (in addition to the facility payment) in rev code 0960. If the EKG is performed, Method II CAHs may also be paid for the interpretation of the EKG (in addition to the payment for the tracing) when billed in revenue codes 0985 or 0986.

80.3.1 – RHC/FQHCs Special Billing Instructions

(Rev.1615, Issued: 10-17-08, Effective: 01-01-09, Implementation: 01-05-09)

Payment for the professional services will be made under the all-inclusive rate. Encounters with more than one health professional and multiple encounters with the same health professionals that take place on the same day and at a single location constitute a single visit. Beneficiary CWF records will not be updated to reflect the *G* code when the IPPE is provided in an RHC/FQHC.

The technical component of the EKG performed at independent RHC/FQHC is billed to Medicare carriers on professional claims (Form CMS 1500 or 837P). The technical component of the EKG performed at a provider-based RHC\FQHC is billed on the applicable TOB and submitted to the FI using the base provider number.

80.3.2 – Indian Health Services (IHS) Hospitals Special Billing Instructions

(Rev.1615, Issued: 10-17-08, Effective: 01-01-09, Implementation: 01-05-09)

For the period January 1, 2005 through December 31, 2008, the designated FI pays IHS hospitals when G0344 is submitted; this includes the IPPE whether or not the *screening* EKG is performed at the same time. The designated FI will also pay IHS hospitals for the *screening* EKG if HCPCS code G0367 is present. For the professional component of the EKG, the designated carrier shall pay the billing physician or other practitioner the established amount.

Effective January 1, 2009 the following new HCPCS codes have been developed for the IPPE benefit and replace the codes in the paragraph above: G0402 for the IPPE itself, and G0404 for the technical component (tracing only) of the EKG.

80.3.3 - OPPS Hospital Billing

(Rev.1615, Issued: 10-17-08, Effective: 01-01-09, Implementation: 01-05-09)

Hospitals subject to OPPS (TOBs 12X and 13X) must use modifier 25 when billing the IPPE G0344 along with technical component of the EKG, G0367, on the same claim. *The same is true when billing IPPE code G0402 along with the technical component of the screening EKG, code G0404.* This is due to an Outpatient Prospective Payment System (OPPS) Outpatient Code Editor (OCE) which contains an edit that requires a modifier 25 on any evaluation and management (E/M) HCPCS code if there is also a status “S” or “T” HCPCS procedure code on the claim.

80.4 – Coinsurance and Deductible

(Rev.1615, Issued: 10-17-08, Effective: 01-01-09, Implementation: 01-05-09)

The MMA did not make any provision for the waiver of the Medicare coinsurance and Part B deductible for the IPPE. Payment for this service would be applied to the required deductible if the deductible has not been met, with the exception of FQHCs, and the usual coinsurance provisions would apply to all providers.

The FQHC encounter is exempt from deductible. The contractors shall apply coinsurance and deductible to payments for the IPPE except for payments by the FI to FQHCs where only co-insurance applies.

Effective January 1, 2009, under the MIPPA of 2008, the deductible is waived for IPPE code G0402 only. The coinsurance is still applicable.

80.5 – Medicare Summary Notices (MSNs)

(Rev.1615, Issued: 10-17-08, Effective: 01-01-09, Implementation: 01-05-09)

When denying additional claims for G0344, G0366, G0367 and G0368, contractors shall use MSN 18.22 - This service was denied because Medicare only covers the one-time initial preventive physical exam with an electrocardiogram within the first six months that you have Part B coverage, and only if that coverage begins on or after January 1, 2005.

The Spanish version is: 18.22 - Este servicio fue denegado porque Medicare solamente cubre un examen fisico preventivo con un electrocardiograma dentro de los primeros 6 meses que usted tenga cobertura de la Parte B, y sólo si esta cobertura comienza en o después del 1 de enero de 2005.

When denying additional claims for G0402 (or claims with dates of service beyond the 12 month period) contractors shall use MSN 20.91 - This service was denied. Medicare covers a one-time initial preventive physical exam (Welcome to Medicare physical exam) if you get it within the first 12 months of the effective date of your Medicare Part B coverage.

The Spanish version is: Este servicio fue negado. Medicare cubre un examen físico de "Bienvenido a Medicare" ofrecido una sola vez si se obtiene dentro de los primeros 12 meses de la fecha efectiva de su inscripción a la Parte B de Medicare.

When denying additional claims for screening EKG codes G0403, G0404 and G0405, contractors shall use MSN 20.12 - This service was denied because Medicare only covers this service once a lifetime.

The Spanish version is: Este servicio fue negado porque Medicare sólo cubre este servicio una vez en la vida.

80.6 – Remittance Advice Remark Codes

(Rev.1615, Issued: 10-17-08, Effective: 01-01-09, Implementation: 01-05-09)

Contractors shall use the appropriate claim Remittance Advice Remark code, such as N117 (This service is paid only once in a patient's lifetime) when denying additional claims for *an IPPE and/or a screening EKG.*

80.7 – Claims Adjustment Reason Codes

(Rev.1615, Issued: 10-17-08, Effective: 01-01-09, Implementation: 01-05-09)

Contractors shall use the appropriate Claim Adjustment Reason code, such as 149 (Lifetime benefit maximum has been reached for this service/benefit category) when denying additional claims for *an IPPE and/or a screening EKG.*

80.8 – Advanced Beneficiary Notice (ABN) as Applied to the IPPE

(Rev.1615, Issued: 10-17-08, Effective: 01-01-09, Implementation: 01-05-09)

If a second IPPE is billed for the same beneficiary, it would be denied based on *S*ection 1861(s)(2) of the Act, since the IPPE is a one-time benefit, and an ABN would not be required in order to hold the beneficiary liable for the cost of the second IPPE. However, an ABN should be issued for all IPPEs conducted after the beneficiary's statutory 6-month period has lapsed since based on *Section* 1862(a)(1)(K), Medicare is statutorily prohibited from paying for an IPPE outside the initial 6-month period *under the MMA of 2003. Effective for dates of service on or after January 1, 2009, an ABN should be issued for all IPPEs conducted after the beneficiary's statutory 12-month period has lapsed since based on Section 1862(a)(1)(K), Medicare is statutorily prohibited from paying for an IPPE outside the initial 12-month period under the MIPPA of 2008.*