CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 417 **Date: DECEMBER 22, 2004**

CHANGE REQUEST 3638

SUBJECT: Initial Preventive Physical Examination (IPPE)-(Note: This is a full replacement of CR 3413, transmittal 294, dated September 3, 2004. CR 3413 is rescinded.)

SUMMARY OF CHANGES: Section 611 of the Medicare Prescription Drug Improvement and Modernization Act (MMA) provides for coverage under Part B of an initial preventative physical examination (IPPE), including a screening electrocardiogram (EKG), for new Medicare beneficiaries, effective for services furnished on or after January 1, 2005, subject to certain eligibility and other limitations.

The Medicare Claims Processing Manual, Publication 100-04, Chapters 12 and 18, have been updated to include the requirements to implement section 611 of the MMA as described in the Physician Fee Schedule Final Rule published November 15, 2004. New sections in these chapters address the payment for an IPPE performed not later than 6 months after the date the individual's first coverage period begins under Medicare Part B, but only if that coverage period begins on or after January 1, 2005. The IPPE includes a measurement of height, weight, and blood pressure, a screening EKG, a review of the individual's medical and social history, and a review of the individual's potential (risk factors) for depression, functional ability and level of safety with the goal of health promotion and disease detection. It also includes education, counseling, and referral with respect to screening and preventive services currently covered under Medicare Part B.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: January 1, 2005
IMPLEMENTATION DATE: January 3, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N	12/Table of Contents
N	12/30.6.1.1 Initial Preventive Physical Examination (HCPCS Codes G0344, G0366, G0367 and G0368)
N	18/Table of Contents

N	18/80 Initial Preventive Physical Examination (IPPE)
N	18/80.1 HCPCS Coding for the IPPE
N	18/80.2 Carrier Billing Requirements
N	18/80.3 Fiscal Intermediary Billing Requirements
N	18/80.3.1 RHCs/FQHCs Special Billing Requirements
N	18/80.3.2 Indian Health Services (IHS) Hospitals Special Billing Requirements
N	18/80.4 Coinsurance and Deductible
N	18/80.5 Medicare Summary Notices
N	18/80.6 Remittance Advice Remark Codes
N	18/80.7 Claims Adjustment Reason Codes
N	18/80.8 Advanced Beneficiary Notice (ABN) as Applied to the IPPE

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

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

Attachment – Business Requirements

Pub. 100-04	Transmittal: 417	Date: December 22, 2004	Change Request 3638

SUBJECT: Initial Preventive Physical Examination (IPPE)-(NOTE: Transmittal 294, CR 3413, Dated September 3, 2004, is Rescinded and Replaced with CR 3638.)

I. GENERAL INFORMATION

A. Background: Pursuant to section 611 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), we amended §§411.15 (a)(1) and 411.15 (k)(11) (list of examples of routine physical examinations excluded from coverage) effective for services furnished on or after January 1, 2005. This expanded coverage is subject to certain eligibility and other limitations that allow payment for an initial preventive physical examination (IPPE) including a screening electrocardiogram (EKG), not later than 6 months after the date the individual's first coverage period begins under Medicare Part B.

B. Policy: This examination will include measurement of height, weight, and blood pressure and a screening EKG with the goal of health promotion and disease detection and includes education, counseling, and referral with respect to screening and preventive services currently covered and paid under Medicare Part B. Pursuant to final regulations published on November 15, 2004, we amended 42 CFR §§411.15 (a)(1) and 411.15 (k)(11) of the Code of Federal Regulations to allow payment for an IPPE (as established at 42 CFR 410.16) when performed by physicians and qualified nonphysician practitioners (NPPs). In addition, we amended section 419.21 of the Outpatient Prospective Payment System (OPPS) regulations to specify payment for an IPPE as a Medicare Part B covered service.

Coverage is available for an initial preventive physical examination (as defined below) that meets the following requirements:

1. It is performed by either a physician or by a qualified NPP (as defined below); and

2. It is furnished to an eligible beneficiary who receives the IPPE within 6 months after the effective date of his/her first Part B coverage, but only if such Part B coverage begins on or after January 1, 2005. (This is a 1-time benefit only per Part B enrollee.)

Definitions:

- Initial Preventive Physical Examination, as defined in 42 CFR 410.16 (a), means all of the following services furnished to an individual by a physician or other qualified NPP with the goal of health promotion and disease detection:

    a. Review of an individual's medical and social history, with attention to modifiable risk factors for disease detection, as those terms are defined below;

b. 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 physician or other qualified NPP may select from various available standardized screening tests designed for this purpose and recognized by national professional medical organizations;

c. Review of the individual's functional ability and level of safety, as described below, based on the use of appropriate screening questions or a screening questionnaire, which the physician or other qualified NPP may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations;

d. An examination to include measurement of the individual's height, weight, blood pressure, a visual acuity screen, and other factors as deemed appropriate by the physician or qualified NPP, based on the individual's medical and social history and current clinical standards;

e. Performance and interpretation of an EKG;

f. Education, counseling, and referral, as deemed appropriate by the physician or qualified NPP, based on the results of the review and evaluation services described in the previous 5 elements; and

g. Education, counseling, and referral, including a brief written plan such as a checklist, provided to the individual for obtaining the appropriate screening and other preventive services that are covered as separate Medicare Part B benefits as described individually in section 1861 of the Act. That is: (1) pneumococcal, influenza, and hepatitis B vaccines and their administration, (2) screening mammography, (3) screening pap smear and screening pelvic examinations, (4) prostate cancer screening tests, (5) colorectal cancer screening tests, (6) diabetes outpatient self-management training services, (7) bone mass measurements, (8) screening for glaucoma, (9) medical nutrition therapy for individuals with diabetes or renal disease, (10) cardiovascular screening blood tests, and (11) diabetes screening tests.

- Medical history, as defined in 42 CFR 410.16 (a), includes at a minimum, the following:

  a. Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries and treatments;

  b. Current medications and supplements, including calcium and vitamins; and

  c. Family history, including a review of medical events in the beneficiary's family, including diseases that may be hereditary or place the individual at risk.

- Social history, as defined in 42 CFR 410.16 (a), includes, at a minimum, the following:

  a. History of alcohol, tobacco, and illicit drug use;
  b. Diet; and

c. Physical activities.

- Review of the individual's functional ability and level of safety, as defined in 42 CFR 410.16 (a), must include, at a minimum, a review of the following areas:

  a. Hearing impairment;
  b. Activities of daily living;
  c. Falls risk; and
  d. Home safety.

- Eligible Beneficiary, as defined in 42 CFR 410.16 (a), means an individual who receives their IPPE within 6 months after the effective date of his/her first Medicare Part B coverage period, but only if the first Part B coverage period begins on or after January 1, 2005.

- Physician, as defined in 42 CFR 410.16 (a), means a doctor of medicine or osteopathy (as defined in section 1861 (r)(1) of the Act.

- Qualified non-physician practitioner, as defined in 42 CFR 410.16 (a), means a physician assistant, nurse practitioner, or clinical nurse specialist (as authorized under sections 1861 (s)(2)(K)(i) and 1861 (s)(2)(K)(ii) of the Act and defined in section 1861 (aa)(5) of the Act, or in regulations at 42 CFR 410.74, 410.75, and 410.76).

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, which is $110 for calendar year 2005, if the deductible has not been met, with the exception of Federally Qualified Health Centers (FQHCs). The usual coinsurance provisions would apply.

A new HCPCS code, G0344 will be used by physicians, qualified NPPs, and hospitals for billing the physical examination component of the IPPE. As required by statute, the IPPE benefit always includes a screening EKG, which should be billed using new HCPCS codes G0366, G0367, and G0368. These 3 codes represent the global, technical, and professional components of the screening EKG respectively. Therefore, if the primary physician or qualified NPP does not perform the EKG during the IPPE visit, another physician or entity may perform and/or interpret the EKG. The referring provider needs to ensure that the performing provider bills the appropriate G code for the screening EKG, and **not** a CPT code in the 93000 series. Physicians and NPPs should bill G0366 for the full EKG service (tracing, interpretation and report), or G0367 when only the tracing is performed, or G0368 when only the interpretation and report are performed. Hospitals can only perform the EKG tracing, so they should bill G0367 when they perform the tracing component of the EKG.

Rural Health Clinics (RHCs) and FQHCs should follow normal procedures for billing for RHC/FQHC services. 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. Payment for the technical component of the EKG that is included in the IPPE is not billed by the RHC/FQHC itself, but by either the base provider or the individual practitioner.

While some components of a medically necessary evaluation and management (E/M) service will be reflected in new HCPCS code G0344, Medicare will, when it is clinically appropriate, allow payment for a medically necessary E/M service at the same visit as the IPPE. 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 and shall be reported with modifier 25.

The physician, qualified NPP, or hospital may also bill for the screening and other preventive services currently covered and paid by Medicare Part B under separate provisions of section 1861 of the Act, if provided during the IPPE.

C. Provider Education: A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "Medlearn 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 must be included in your next regularly scheduled bulletin following availability of the article. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3638.1	Effective for dates of service on and after January 1, 2005, contractors shall pay providers for an IPPE, including a screening EKG, performed not later than 6 months after the date the individual's first coverage period begins under Medicare Part B, but only if that coverage begins January 1, 2005, or later. **NOTE:** Contractors should refer to CR3498 for instructions on Common Working File editing requirements and the monitoring of the 6-month eligibility period. Contractors are not required to edit for January, February, or March 2005.	X		X						

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3638.2	Contractors and Medicare system maintainers shall accept HCPCS code G0344 (Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 6 months of Medicare enrollment) for claims billed for the IPPE visit.	X		X		X	X	X		
3638.3	Contractors and Medicare system maintainers shall accept HCPCS code G0366 (Electrocardiogram, routine ECG with 12 leads; performed as a component of the initial preventive examination with interpretation and report) when the interpretation and report are done with the EKG tracing.	X		X		X	X	X		
3638.4	Contractors and Medicare system maintainers shall accept HCPCS code G0367 (tracing only, without interpretation and report, performed as a component of the initial preventive examination) when the EKG tracing only, is performed.	X		X		X	X	X		
3638.4.1	Contactors shall accept HCPCS code G0367 when the EKG tracing only is performed by an RHC/FQHC base provider or independent practitioner.	X				X				
3638.5	Contractors and Medicare system maintainers shall accept HCPCS code G0368 (interpretation and report only, performed as a component of the initial preventive examination) when the EKG interpretation and report, alone, are performed. **NOTE**: Included in the RHC/FQHC encounter rate.	X		X		X	X	X		
3638.6	Contractors shall pay for other preventive services that are currently separately covered and paid under the Medicare Part B screening and preventive benefits.	X		X		X	X	X		

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3638.7	Contractors shall allow payment for a medically necessary E/M service (CPT codes 99201 – 99215) at the same visit as the IPPE 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		
3638.8	Contractors shall apply coinsurance and deductible to payments for the IPPE except for payments by the FI to FQHCs where only co-insurance applies.	X		X		X	X	X		
3638.8.1	The designated FI shall waive the coinsurance for IHS facilities.	X				X				
3638.9	Contractors shall pay for the IPPE or EKG only when the services are submitted on one of the following type bills: 12X, 13X, 22X, 71X, 73X, 85X. NOTE: Contractors shall pay SNFs, TOB 22X, and make payment for the technical component of the EKG based on the Medicare Physician Fee Schedule.	X				X				
3638.10	Contractors shall pay for G0344 and G0367 on TOB 12X and 13X under the OPPS for hospitals subject to OPPS. **NOTE**: Hospitals not subject to OPPS shall be paid under current payment methodologies.	X				X				
3638.11	Contractors shall pay for IPPE in Maryland Hospitals, on an inpatient or outpatient basis according to the Maryland State Cost Containment Plan.	X				X				

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3638.12	Contractors shall pay for Critical Access Hospitals, TOB 85X, on reasonable cost.	X				X				
3638.13	Contractors shall pay for all professional services related to the EKG and on the IPPE under the all-inclusive rate (AIR) when billed by independent and provider-based RHCs/FQHCs on TOBs 71X and 73X, respectively, with revenue code 052X. **NOTE:** FIs shall not make a separate payment to an RHC/FQHC for the professional component of any IPPE service in addition to the AIR.	X				X				
3638.14	Contractors shall pay for the technical component of the IPPE EKG performed in provider-based RHCs/FQHCs when billed under the base provider's number using the above requirements for that particular base provider type.	X				X				
3638.15	Contractors shall pay for the technical component of the IPPE EKG performed in independent RHCs/FQHCs when billed under the practitioner number using the above requirements for billing the carrier.			X			X	X		
3638.16	The contractors shall pay IHS hospitals TOB 13X, revenue code 051X under the AIR for the IPPE and/or the EKG. **NOTE**: The designated FI shall pay IHS hospitals when G0344 is submitted; this includes the IPPE whether or not the EKG is performed at the same time. The designated FI shall pay IHS hospitals for the EKG if HCPCS code G0367 is present. For the professional component of the EKG the designated contractor shall pay the billing physician or other practitioner the established amount.	X		X		X	X	X		

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2005 **Implementation Date:** January 3, 2005 **Pre-Implementation Contact(s):** Kit Scally (410) 786-5714, Cscally@cms.hhs.gov (payment) Bill Larson (410) 786-4639, WLarson@cms.hhs.gov (coverage) Kathy Kersell (410) 786-2033, Kkersell@cms.hhs.gov (Part B claims processing) Taneka Rivera (410) 786-9502, Trivera@cms.hhs.gov (Part A claims processing) **Post-Implementation Contact(s):** The appropriate regional office.	**Medicare Contractors shall implement these instructions within their current operating budgets.**

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

Medicare Claims Processing Manual

Chapter 12 - Physicians/Nonphysician Practitioners

Table of Contents
(Rev. 417, 12-22-04)

30.6.1.1 – Initial Preventive Physical Examination (HCPCS Codes G0344, G0366, G0367 and G0368)

(Rev. 417, Issued: 12-22-04, Effective: 01-01-05, Implementation: 01-03-05)

A – Definition

The initial preventive physical examination (IPPE), or "Welcome to Medicare Visit", is a preventive evaluation and management service (E/M) 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, which are separately covered under Medicare Part B benefits. (For billing requirements, refer to Pub. 100-04, Chapter 18, Section 80.)

B – Who May Perform

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 by a qualified NPP (nurse practitioner, physician assistant and clinical nurse specialist). The carrier will pay the appropriate physician fee schedule amount based on the rendering UPIN/PIN.

C – Eligibility

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.

D – The EKG Component

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. 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.*

E – Codes Used to Bill the IPPE

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. **NOTE***: For an IPPE performed during the global period of surgery refer to section 30.6.6, chapter 12, Pub 100-04 for reporting instructions.*

F – Documentation

The physician and qualified NPP shall use the appropriate screening tools typically used in routine physician practice. As for all E/M services, the 1995 and 1997 E/M documentation guidelines (http://www.cms.hhs.gov/medlearn/emdoc.asp) should be followed for recording the appropriate clinical information in the beneficiary's medical record. All referrals and a written medical plan must be included in this documentation.

G – Reporting A Medically Necessary E/M at Same IPPE Visit

When the physician or qualified NPP provide 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 separately identifiable service from the IPPE code G0344 reported. **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.*

Medicare Claims Processing Manual

Chapter 18 - Preventive and Screening Services

Table of Contents
(Rev. 417, 12-22-04)

80 – Initial Preventive Physical Examination (IPPE)

(Rev. 417, Issued: 12-22-04, Effective: 01-01-05, Implementation: 01-03-05)

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.

For the physician/practitioner billing correct coding policy, refer to Publication 100-04, Chapter 12, section 30.6.1.1.

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, 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.)

80.1 – HCPCS Coding for the IPPE
(Rev. 417, Issued: 12-22-04, Effective: 01-01-05, Implementation: 01-03-05)

The following new HCPCS codes have been developed for the IPPE benefit:

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*

80.2 – Carrier Billing Requirements:
(Rev. 417, Issued: 12-22-04, Effective: 01-01-05, Implementation: 01-03-05)

Effective for dates of service on and after January 1, 2005, carriers shall recognize the above new HCPCS codes for 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

Carriers 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.

Carriers 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 separately identifiable service from the G0344. Refer to Publication 100-04, Chapter 12, Section 30.6.1.1, for the physician/practitioner billing correct coding 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 provider needs to make sure that the performing provider 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.***

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, the provider should 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 carrier the appropriate HCPCS codes for IPPE on the Form CMS-1500 claim or an approved electronic format. The new HCPCS codes are paid under the Medicare Physician Fee Schedule (MPFS). The appropriate deductible and coinsurance applies.

80.3 – Fiscal Intermediary Billing Requirements:
(Rev. 417, Issued: 12-22-04, Effective: 01-01-05, Implementation: 01-03-05)

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 services 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.*

80.3.1 – RHC/FQHCs Special Billing Instructions
(Rev. 417, Issued: 12-22-04, Effective: 01-01-05, Implementation: 01-03-05)

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 new 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. 417, Issued: 12-22-04, Effective: 01-01-05, Implementation: 01-03-05)

The designated FI pays IHS hospitals when G0344 is submitted; this includes the IPPE whether or not the EKG is performed at the same time. The designated FI will also pay IHS hospitals for the 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.

80.4 – Coinsurance and Deductible
(Rev. 417, Issued: 12-22-04, Effective: 01-01-05, Implementation: 01-03-05)

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.

80.5 – Medicare Summary Notices (MSNs)
(Rev. 417, Issued: 12-22-04, Effective: 01-01-05, Implementation: 01-03-05)

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.

80.6 – Remittance Advice Remark Codes
(Rev. 417, Issued: 12-22-04, Effective: 01-01-05, Implementation: 01-03-05)

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 G0344, G0366, G0367 and G0368.

80.7 – Claims Adjustment Reason Codes
(Rev. 417, Issued: 12-22-04, Effective: 01-01-05, Implementation: 01-03-05)

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 G0344, G0366, G0367 and G0368.

80.8 – Advanced Beneficiary Notice (ABN) as Applied to the IPPE
(Rev. 417, Issued: 12-22-04, Effective: 01-01-05, Implementation: 01-03-05)

If a second IPPE is billed for the same beneficiary, it would be denied as a statutory denial under section 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 IPPE. However, an ABN should be issued for all IPPEs conducted after the beneficiary's statutory 6-month period has lapsed since based on 1862(a)(1)(K), Medicare is statutorily prohibited from paying for an IPPE outside the 6-month period.

An ABN also should be issued for an IPPE that is conducted within the first 6 months but which is 'not reasonable and necessary" for the beneficiary on the occasion in question, e.g., if the beneficiary has a terminal illness, conducting an IPPE may not be appropriate.