From the desk of CMS

Preventive Services and Medicare

William Rogers, MD, FACEP

The gray-haired physicians reading this article will recall that when it began, Medicare did not pay for any preventive services. I used to wonder about the wisdom of that policy, but it makes some sense if we think about how we practiced medicine in the '60s.

When Congress and President Johnson were laboring over the law that created the Medicare program, health care in America was very different than it is today. In 1965 physicians had little interest in preventive services. We physicians intervened when patients became ill. That was the focus of our training; we were justly proud of our ability to save the lives of patients using new medications and treatments just being developed. We recognized the value of healthy lifestyles to some extent, but the value of lipid screening, regular pap smears, and colonoscopy was not generally appreciated.

These new treatments were increasingly expensive. Driven by concern for elderly Americans who had lost their health insurance when they retired, Congress designed a program that would help senior citizens pay for hospitalization. The original bill, called the King-Anderson Act, would have created a Medicare program that only paid for inpatient care. At the last moment, Congressman Wilbur Mills,

Table 1: Quick Reference Information: Medicare Preventive Services

SERVICE	HCPCS/CPT CODES		ICD-9-CM CODES	WHO IS COVERED	FREQUENCY	BENEFICIARY PAYS
Initial Preventive Physical Examination (IPPE) *Also known as the "Welcome to Medicare Physical Exam" or "Welcome to Medicare Visit"*	**Effective January 1, 2009** **G0402** – IPPE **G0403** – EKG for IPPE **G0404** – EKG tracing for IPPE **G0405** – EKG interpret & report *Important – Effective for dates of service on or after January 1, 2009, the screening EKG is an optional service that may be performed as a result of a referral from an IPPE*		**No specific diagnosis code required for IPPE**	**All Medicare beneficiaries whose first Part B coverage began on or after January 1, 2005**	**Once in a lifetime benefit per beneficiary** *Must be furnished no later than 12 months after the effective date of the first Medicare Part B coverage begins*	**Copayment/coinsurance** **Deductible applies prior to January 1, 2009** **No deductible applies for code G0402, effective for dates of service on or after January 1, 2009** **Deductible still applies for G0403, G0404, and G0405**
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)	**G0389** – Ultrasound exam AAA screen		**No specific code** *Contact local Medicare Contractor for guidance*	**Medicare beneficiaries with certain risk factors for abdominal aortic aneurysm** *Important – Eligible beneficiaries must receive a referral for an AAA ultrasound screening as a result of an IPPE*	**Once in a lifetime benefit per eligible beneficiary, effective January 1, 2007**	**Copayment/coinsurance** **No deductible**
Cardiovascular Disease Screenings	**80061** – Lipid Panel **82465** – Cholesterol **83718** – Lipoprotein **84478** – Triglycerides		Report one or more of the following codes: **V81.0, V81.1, V81.2**	**All asymptomatic Medicare beneficiaries** *12-hour fast is required prior to testing*	**Every 5 years**	**No copayment/coinsurance** **No deductible**
Diabetes Screening Tests	**82947** – Glucose, quantitative, blood (except reagent strip) **82950** – Glucose, post-glucose dose (includes glucose) **82951** – Glucose Tolerance Test (GTT), three specimens (includes glucose)		**V77.1** *Report modifier "TS" (follow-up service) for diabetes screening where the beneficiary meets the definition of pre-diabetes*	**Medicare beneficiaries with certain risk factors for diabetes or diagnosed with pre-diabetes** *Beneficiaries previously diagnosed with diabetes are not eligible for this benefit*	• **2screening tests per year for beneficiaries diagnosed with pre-diabetes** • **1 screening per year if previously tested but not diagnosed with pre-diabetes, or if never tested**	**No copayment/coinsurance** **No deductible**
Diabetes Self-Management Training (DSMT)	**G0108** – DSMT, individual session, per 30 minutes **G0109** – DSMT, group session (2 or more), per 30 minutes		**No specific code** *Contact local Medicare Contractor for guidance*	**Medicare beneficiaries at risk for complications from diabetes, recently diagnosed with diabetes, or previously diagnosed with diabetes** *Physician must certify that DSMT is needed*	• **Up to 10 hours of initial training within a continuous 12-month period** • **Subsequent years: Up to 2 hours of follow-up training each year**	**Copayment/coinsurance** **Deductible**
Medical Nutrition Therapy (MNT)	**97802, 97803, 97804, G0270, G0271** *Services must be provided by registered dietitian or nutrition professional*		*Contact local Medicare Contractor for guidance*	**Medicare beneficiaries diagnosed with diabetes or a renal disease**	• **1st year: 3 hours of one-on-one counseling** • **Subsequent years: 2 hours**	**Copayment/coinsurance** **Deductible**
Screening Pap Tests	**G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091**		**V76.2, V76.47, V76.49, V15.89, V72.31**	**All female Medicare beneficiaries**	• **Annually if high-risk, or childbearing age with abnormal Pap test within past 3 years** • **Every 24 months for all other women**	**Copayment/coinsurance for Pap test collection** *(No copayment/coinsurance for Pap lab test)* **No deductible**
Screening Pelvic Exam	**G0101** – Cervical or vaginal cancer screening; pelvic and clinical breast examination		**V76.2, V76.47, V76.49, V15.89, V72.31**	**All female Medicare beneficiaries**	• **Annually if high-risk, or childbearing age with abnormal Pap test within past 3 years** • **Every 24 months for all other women**	**Copayment/coinsurance** **No deductible**
Screening Mammography	**77052, 77057, G0202**		**V76.11 or V76.12**	**All female Medicare beneficiaries age 40 or older**	**Annually**	**Copayment/coinsurance** **No deductible**
Screening Mammography	**77052, 77057, G0202**		**V76.11 or V76.12**	**Female Medicare beneficiaries ages 35 - 39**	**One baseline**	**Copayment/coinsurance** **No deductible**

(continued)

then the powerful chair of the House Ways and Means Committee, introduced a bill that added voluntary outpatient coverage, the program we now call Part B. This was the bill that was passed by Congress and signed by President Lyndon Johnson in the Truman library on June 30, 1965.

The statute creating the Medicare program was very prescriptive about what the program could pay for. My copy of Title XVIII of the Social Security Act is over 2000 pages long and filled with lyrical prose worthy of memorization. No passage is more important than the one we know as 1862(a)(1)(A), which says that "payments are only allowed for those services which are reasonable and necessary for the diagnosis or treatment of an illness or injury." Note that the words "prevention of disease" are absent.

In fact, from 1965 until 1981 Medicare was prohibited from paying for any preventive services. The first exception to that prohibition occurred in 1981, when Congress added language to Title XVIII allowing Medicare to pay for the pneumococcal vaccine. Over the next 10 years, Medicare added hepatitis B vaccine, pap smears, mammography, and the flu vaccine. Medicare now pays for 17 preventive services, each of them because Congress created a specific benefit category (Table 1).

I receive a card every year from my dog's vet reminding me that she needs a rabies shot. My dentist's office gives me an appointment for my next cleaning at the end of every visit. Why don't we do the same thing to encourage Medicare patients to get their covered preventive services? It may not be as exciting as intubating a patient with congestive heart failure or as interesting as working up an icteric 24-year-old patient from Somalia, but it is just as important. *MPM*

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Table 1: Quick Reference Information: Medicare Preventive Services *(continued)*

SERVICE	HCPCS/CPT CODES		ICD-9-CM CODES	WHO IS COVERED	FREQUENCY	BENEFICIARY PAYS
Bone Mass Measurements	**G0130, 77078, 77079, 77080, 77081, 77083, 76977**		*Contact local Medicare Contractor for guidance*	**Medicare beneficiaries at risk for developing Osteoporosis**	**Every 24 months** *More frequently if medically necessary*	**Copayment/coinsurance** **Deductible**
Colorectal Cancer Screening	**G0104** – Flexible Sigmoidoscopy **G0105** – Colonoscopy (high risk) **G0106** – Barium Enema *(alternative to G0104)* **G0120** – Barium Enema *(alternative to G0105)* **G0121** – Colonoscopy (not high risk) **G0122** – Barium Enema (non-covered) **G0328** – Fecal Occult Blood Test *(alternative to 82270)* **82270** – Fecal Occult Blood Test		**Use appropriate code** *Contact local Medicare Contractor for guidance*	• **Medicare beneficiaries age 50 and older** • **Screening colonoscopy: Individuals at high risk; no minimum age requirement** • **Nominimum age for having a barium enema as an alternative to a high risk screening colonoscopy if the beneficiary is at high risk**	• **Fecal Occult: Annually** • **Flexible Sigmoidoscopy: Every 4 years or once every 10 years after having a screening colonoscopy** • **Screening Colonoscopy: Every 24 months at high risk; every 10 years not at high risk** • **Barium Enema: Every 24 months at high risk; every 4 years not at high risk**	**No copayment/coinsurance or deductible for Fecal Occult Blood Tests** **For all other tests copayment/coinsurance apply** **No deductible**
Prostate Cancer Screening	**G0102** – Digital Rectal Exam (DRE)		**V76.44**	**All male Medicare beneficiaries 50 or older (coverage begins the day after 50th birthday)**	**Annually**	**Copayment/coinsurance** **Deductible**
Prostate Cancer Screening	**G0103** – Prostate Specific Antigen Test (PSA)		**V76.44**	**All male Medicare beneficiaries 50 or older (coverage begins the day after 50th birthday)**	**Annually**	**No copayment/coinsurance** **No deductible**
Glaucoma Screening	**G0117** – By an optometrist or ophthalmologist **G0118** – Under the direct supervision of an optometrist or ophthalmologist		**V80.1**	**Medicare beneficiaries with diabetes mellitus, family history of glaucoma, African-Americans age 50 and over, or Hispanic-Americans age 65 and over**	**Annually for beneficiaries in one of the high risk groups**	**Copayment/coinsurance** **Deductible**
Influenza Virus Vaccine	**90655, 90656, 90657, 90658, 90660** – Influenza Virus Vaccine **G0008** – Administration		**V04.81** **V06.6** – *When purpose of visit was to receive both influenza virus and pneumococcal vaccines*	**All Medicare beneficiaries**	**Once per influenza season in the fall or winter** *Medicare may provide additional flu shots if medically necessary*	**No copayment/coinsurance** **No deductible**
Pneumococcal Vaccine	**90669** – Pneumococcal Conjugate Vaccine **90732** – Pneumococcal Polysaccharide Vaccine **G0009** – Administration		**V03.82** **V06.6** – *When purpose of visit was to receive both pneumococcal and influenza virus vaccines*	**All Medicare beneficiaries**	**Once in a lifetime** *Medicare may provide additional vaccinations based on risk and provided that at least 5 years have passed since receipt of a previous dose*	**No copayment/coinsurance** **No deductible**
Hepatitis B (HBV) Vaccine	**90740, 90743, 90744, 90746, 90747** – Hepatitis B Vaccine **G0010** – Administration **90471** or **90472** – Administration (OPPS hospitals only)		**V05.3**	**Medicare beneficiaries at medium to high risk**	**Scheduled dosages required**	**Copayment/coinsurance** **Deductible**
Smoking and Tobacco-Use Cessation Counseling	**99406** – counseling visit; intermediate, greater than 3 minutes up to 10 minutes **99407** – counseling visit; intensive, greater than 10 minutes		**Use appropriate code** *Contact local Medicare Contractor for guidance*	**Medicare beneficiaries who use tobacco and have a disease or adverse health effect linked to tobacco use or take certain therapeutic agents whose metabolism or dosage is affected by tobacco use**	**2 cessation attempts per year;** **Each attempt includes maximum of 4 intermediate or intensive sessions, up to 8 sessions in a 12-month period**	**Copayment/coinsurance** **Deductible**

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