ACOG
THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS

Medicare Screening Services

Physicians are often confused about how to document and report preventive services provided to their Medicare patients. This document is designed to assist physicians in documenting, reporting and receiving reimbursement for these services.

Medicare does not cover comprehensive preventive visits (99381-99397). However, Medicare does cover certain screening services which are often performed during preventive visits such as:

- Screening pelvic exam
- Collection of screening Pap smear specimen
- Interpretation of the Pap smear test (reported by the laboratory)
- Screening hemoccult
- Screening mammography
- Screening bone mass measurement
- Initial preventive physical examination (Welcome to Medicare examination)
- Diabetes screening
- Cardiovascular blood test
- Tobacco use cessation counseling

The table at the end of this document provides an overview of Medicare screening services. The Centers for Medicare and Medicaid (CMS) have published several educational products that describe covered screening services available to Medicare patients. Physicians can either order these booklets free of charge or download a copy by visiting Medicare's website at the following websites:

- http://www.medicare.gov/publications/pubs/pdf/women.pdf
- http://www.cms.hhs.gov/MLNProducts/Downloads/education_products_prevserv.pdf

ADVANCED BENEFICIARY NOTIFICATION

Medicare screening services are limited to a specific frequency (e.g., once every 2 years, once every year). A physician may not know whether a patient is eligible for this service in a given year. If she is not eligible, the service will be denied. Therefore, the physician should ask the patient to sign an advance beneficiary notice of noncoverage (ABN) using the form provided by Medicare. For more information on Medicare's ABN form, visit http://www.cms.hhs.gov/BNI/02_ABN.asp. Claims for Medicare patients should be submitted with the appropriate HCPCS modifier.

- GA modifier indicates that an ABN form has been signed.
- GZ modifier indicates that an ABN form has not been signed. (Item or service expected to be denied as not reasonable and necessary)
- GY modifier indicates that the service provided is not a covered Medicare benefit. The service is being reported to Medicare in order to receive a denial.

Using the appropriate modifier ensures that the patient will receive the correct information on her Explanation of Benefits (EOB). For example, when a service is reported with a GY modifier, the EOB will state that it is not covered and therefore is the patient's responsibility.

COLLECTION OF SCREENING PAP SMEAR SPECIMEN

Medicare reimburses for collection of a screening Pap smear every two years in most cases. This service is reported using HCPCS code Q0091 (Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory). The patient does not have to meet her Part B deductible, but is responsible for 20% of the Medicare approved amount for the service. For the laboratory's interpretation of the test, the patient does not need to pay a copay nor meet her deductible.

The collection is reimbursed every year if the patient meets Medicare's criteria for high risk. Following are the only criteria that are accepted by Medicare to indicate a high risk patient:

- Woman is of childbearing age **AND**
  - cervical or vaginal cancer is present (or was present) **OR**
  - abnormalities were found within last 3 years **OR**
  - is considered high risk (as described below) for developing cervical or vaginal cancer.

- Woman is not of childbearing age **AND** she has at least one of the following:
  - High risk factors for **cervical cancer**:
    - Onset of sexual activity under 16 years of age
    - Five or more sexual partners in a lifetime
    - History of sexually transmitted disease (including the human papillomavirus and/or HIV infection);
    - Fewer than 3 negative Pap smears within previous 7 years
    - No Pap smears at all within the previous 7 years
  - High risk factor for **vaginal cancer**:
    - She had been exposed to DES in utero

SCREENING PELVIC EXAM

Medicare reimburses for a screening pelvic examination every two years in most cases. This service is reported using HCPCS code G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination). If the patient meets Medicare's criteria for high risk, the examination is reimbursed every year. These criteria are the same as the ones listed above for the collection of screening Pap smear specimen. The diagnosis codes for pap smear collection and screening pelvic exam are listed below.

Effective September 23, 2008, Medicare clarified that the clinical breast check is no longer considered a mandatory element of the screening pelvic exam. It is now one of the eleven elements that may be performed as part of the exam.

A screening pelvic examination (HCPCS code G0101) should include documentation of at least **seven** of the following **eleven** elements:

- Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge;
- Digital rectal examination including sphincter tone, presence of hemorrhoids, and rectal masses;
- External genitalia (for example, general appearance, hair distribution, or lesions);
- Urethral meatus (for example, size, location, lesions, or prolapse);
- Urethra (for example, masses, tenderness, or scarring);
- Bladder (for example, fullness, masses, or tenderness);
- Vagina (for example, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, or rectocele);
- Cervix (for example, general appearance, lesions or discharge)

- Uterus (for example, size, contour, position, mobility, tenderness, consistency, descent, or support);
- Adnexa/parametria (for example, masses, tenderness, organomegaly, or nodularity);and
- Anus and perineum.

HCPCS code G0101 includes only the above examination elements. It does not include many other services normally included in a comprehensive preventive visit.

DIAGNOSTIC CODING FOR THE COLLECTION OF PAP SMEAR AND SCREENING PELVIC EXAM

Both the collection of the screening Pap smear specimen (Q0091) and screening pelvic exam (G0101) are reported with one of the following diagnosis codes:

- V72.31 – routine gynecological exam (reported when provider performs a full gyn examination)
- V76.2 - Special screening for malignant neoplasms, cervix (patient has a cervix)
- V76.47 - Special screening for malignant neoplasms, vagina (patient does not have a cervix)
- V76.49 - Special screening for malignant neoplasms, other sites
- V15.89 - Other specified personal history presenting hazards to health. (patient is considered high risk according to Medicare's criteria)

Collection of a diagnostic Pap smear (performed due to illness, disease, or symptoms indicating a medically necessary reason) is included in the physical examination portion of a problem-oriented E/M service and is not reported or reimbursed separately.

Often, both the G0101 and Q0091 are provided during the same visit. An example follows.

Example 1: Collection of a screening Pap smear (Q0091) reported with the screening pelvic examination (G0101):

Bill to:	HCPCS Codes	ICD-9 Codes	Charge
Medicare	G0101-GA	V76.2, V76.47, V76.49, or V15.89	$34.60
	Q0091-GA	V76.2, V76.47, V76.49, or V15.89	$40.00
Patient	N/A	N/A	$ 0.00
Total amount billed			$74.60

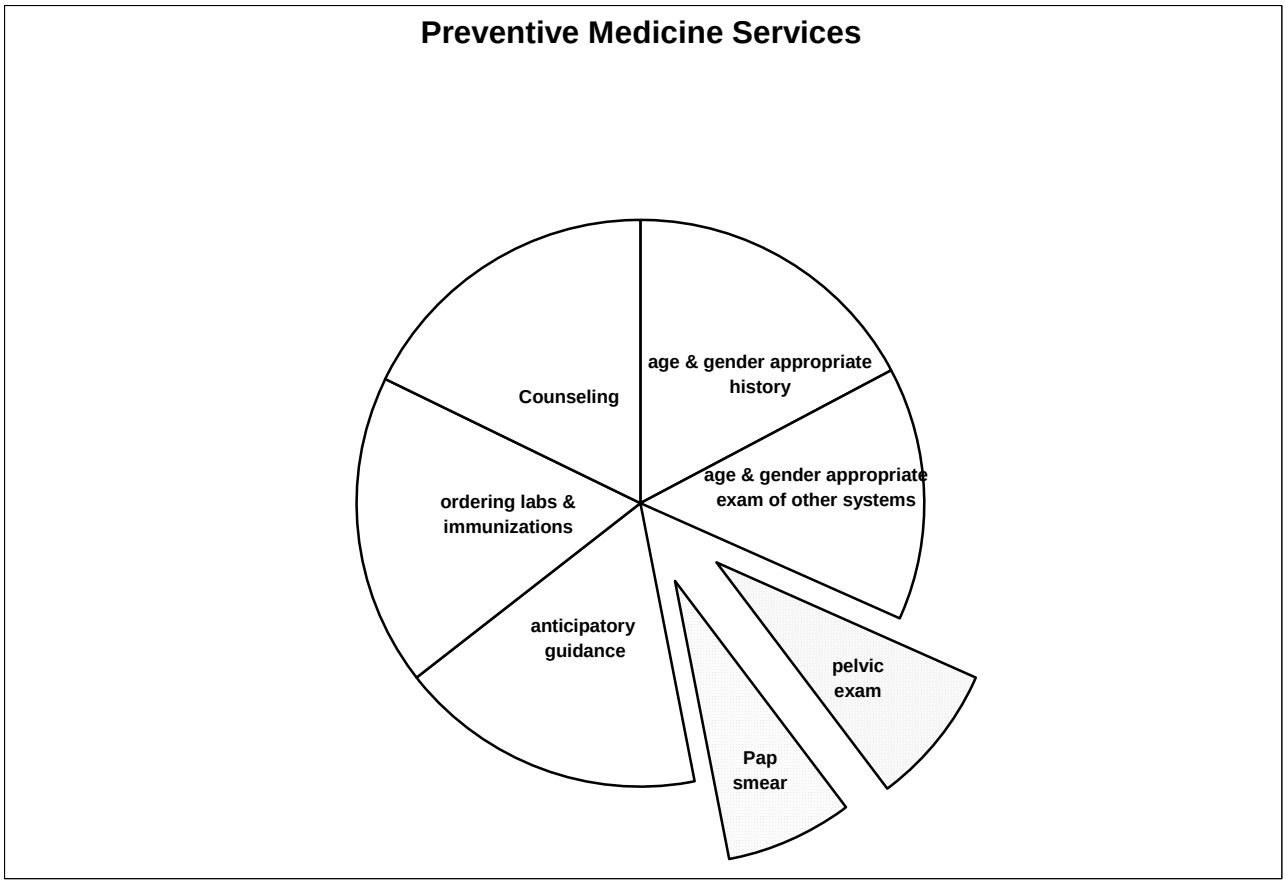
The assumption is that the physician in this example provided only Medicare covered services with no additional preventive care.

The GA modifier indicates that an ABN has been signed. Note that the charges listed in the example above are Medicare allowable amounts but do not include the geographical adjustment factor.

The patient is not initially billed for either of these services since Medicare covers them. Once Medicare has processed the claim, the physician bills the patient for her portion (20% of the Medicare approved amount).

PREVENTIVE MEDICINE SERVICE PROVIDED AT THE TIME OF COVERED SCREENING SERVICE

A preventive medicine exam includes a comprehensive age and gender appropriate history, examination, counseling/anticipatory guidance/risk-factor reduction interventions, and the ordering of appropriate immunization(s) and laboratory/diagnostic procedures. Sometimes these other elements are performed during the same visit as the Medicare covered services, particularly G0101 and Q0091. The following pie chart illustrates this circumstance.



Medicare will reimburse for the shaded parts of the pie (the collection of the Pap smear and the pelvic exam). The remaining portions of the preventive service are billed to the patient. The amount paid by Medicare is subtracted from the physician's usual fee for a preventive service. The remaining amount is the patient's fee. This is referred to as a "carve out," meaning that Medicare's covered portion of the preventive service is carved out of the total preventive service. The amount reimbursed by Medicare and the amount reimbursed by the patient will equal the physician's usual fee.

Example 2: The "carve out" method for reporting the screening pelvic examination (G0101) with other preventive medicine care:

Bill to:	CPT/HCPCS Code(s)	ICD-9 Code(s)	Charge
Patient	99397-GY	V72.31	$65.40
Medicare	G0101-GA	V72.31 or V15.89	$34.60
Total amount billed			$100.00

The physician's usual charge for the preventive visit (99397) is $100. The total billed to the patient and to Medicare equals the physician's usual charge for the preventive service.

The GA modifier indicates that an ABN has been signed. Modifier GY is reported for a service that is not a Medicare covered benefit. The service is being reported to Medicare to receive a denial. The patient is responsible for the preventive service less the Medicare carve out amount.

Example 3: Preventive visit reported with screening pelvic examination (G0101) and collection of a screening Pap smear specimen (Q0091):

Bill to:	CPT/HCPCS Code(s)	ICD-9 Code(s)	Charge
Patient	99397-GY	V72.31	$25.40
Medicare	G0101-GA	V72.31 or V15.89	$34.60
	Q0091-GA	V72.31 or V15.89	$40.00
Total amount billed			$100.00

The physician's usual charge for the preventive visit (99397) is $100. The total billed to the patient and to Medicare equal the physician's usual charge.

The GA modifier indicates that an ABN has been signed. Modifier GY is reported for a service that is not a Medicare covered benefit. The service is being reported to Medicare to receive a denial. The patient is responsible for the preventive service less the Medicare carve out amount.

Once Medicare has processed the claim, the patient is billed for her portion of G0101 and Q0091. However, the patient can be billed at the time of service for the portion not covered by Medicare.

MEDICARE SCREENING SERVICE AT THE TIME OF COVERED E/M SERVICES

Medicare will reimburse separately for covered screening services (e.g., G0101, Q0091) when performed at the same encounter as a covered E/M service, such as a problem-oriented visit (codes 99201-99215). The level of E/M service reported is based solely on the evaluation of the problem.

Example 4: Covered problem-oriented visit reported with a screening pelvic examination (G0101) and collection of a screening Pap smear specimen (Q0091).

Bill to:	CPT/HCPCS Code(s)	ICD-9 Code(s)	Charge
Medicare	99213-25	Problem diagnosis	$61.20
	G0101-GA	V76.2, V76.47, V76.49, or V15.89	$34.60
	Q0091-GA	V76.2, V76.47, V76.49, or V15.89	$40.00
Patient	N/A	N/A	$135.80

The GA modifier indicates that an ABN has been signed. Modifier 25 indicates that the E/M service was significant and separately identifiable and not part of the pelvic examination or collection of the Pap smear.

The patient is not billed for her portion until Medicare has processed the claim. The diagnosis code for the patient's problem, signs or symptoms should be linked to the E/M service (99213). The level of service for the E/M visit will depend on what was performed and documented.

OTHER MEDICARE PREVENTIVE SERVICES

Following are brief descriptions of other preventive services covered by Medicare and sometimes provided by obstetrician/gynecologists.

Bone Mass Measurements

Medicare covers bone mass measurements every two years for qualified individuals. The patient is responsible for meeting her Medicare Part B deductible and for her 20% co-payment.

A "qualified individual" meets at least **one** of these medical indications:

- Estrogen-deficient and at clinical risk for osteoporosis
- Vertebral abnormalities as demonstrated by an x-ray
- Receiving (or expecting to receive) glucocorticoid (steroid) therapy equivalent to 5.0 mg of prednisone or greater, per day, for more than 3 months
- Has a diagnosis of primary hyperparathyroidism
- Being monitored to assess the response to or efficacy of an FDA – approved osteoporosis drug therapy

Medicare may pay for more frequent screenings when medically necessary. Examples include, but are not limited to, the following medical circumstances:

- Monitoring beneficiaries on long-term (more than 3 months) glucocorticoid (steroid) therapy
- Confirming baseline BMMs to permit monitoring of beneficiaries in the future

Procedure Codes

Medicare allows the physician to choose the screening test. As of January 1, 2007, the CPT/HCPCS coding options are:

77078	Computed tomography, bone mineral density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)
77079	appendicular skeleton (peripheral) (e.g., radius, wrist, heel)
77080	Dual energy x-ray absorptiometry (DXA), bone density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)
77081	appendicular skeleton (peripheral) (e.g., radius, wrist, heel)
77083	Radiographic absorptiometry (photodensitometry, radiogrammetry), one or more sites
76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method
G0130	Single energy x-ray absorptiometry (SEXA) bone density study, one or more sites, appendicular skeleton (peripheral; e.g., radius, wrist, heel)

Diagnosis Codes

Local carriers determine the ICD-9-CM diagnostic codes that they will accept as supporting these indications. The test must be ordered by a physician or a qualified nonphysician practitioner who is treating the patient. Qualified nonphysician practitioners include physician assistants, nurse practitioners, clinical nurse specialists, and nurse-midwives. The test results must be required as part of the patient's evaluation and/or formulation of a treatment plan.

Screening Mammography

Medicare covers one screening mammogram for women aged 40 years or older once every 12 months. CPT code 77057 (screening mammography, bilateral [two view film study of each breast]) is reported if a standard screening mammogram is performed. Medicare also covers computer aided detection (CAD) technology when performed in addition to the standard mammography. This service is reported using CPT add-on code +77052 (computer-aided detection (computer algorithm analysis of digital image data for lesion detection); screening mammography) in addition to code 77057. The Medicare deductible is waived for this service but the patient is responsible for 20% of the Medicare approved amount.

In April 2001, Medicare began to cover and provide additional payment for the use of digital technology for screening and diagnostic mammography studies. HCPCS code G0202 (Screening mammography, producing direct digital image, bilateral, all views) was developed to be reported for a screening full-field digital (FFDM) mammogram. Diagnosis code(s) V76.11 (screening mammogram for high-risk patient) or V76.12 (other screening mammogram) should be linked to the appropriate CPT-4 mammography code reported. The Medicare deductible is waived for this service but the patient is responsible for 20% of the Medicare approved amount.

A diagnostic mammogram (when the patient has an illness, disease or symptoms indicating the need for a mammogram) is covered whenever it is medically necessary.

Colorectal Cancer Screening

Medicare covers one screening fecal-occult blood test for women 50 years and older once every 12 months. The attending physician must submit a written order for the test.

Beginning January 1, 2007, the guaiac based screening should be reported to Medicare using CPT code 82270 rather than HCPCS code G0107. The descriptor for CPT code 82270 reads "Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided three cards or single triple card for consecutive collection)." Therefore the patient must complete the test by taking samples from consecutive stools.

As an alternative to the guaiac-based fecal occult blood test, (FOBT), reported with CPT-4 code 82270**,** Medicare also covers screening performed by immunoassay. It is reported to Medicare using HCPCS code G0328 (colorectal cancer screening; fecal occult blood test immunoassay, 1-3 simultaneous). The number of specimens required depends on the individual manufacturer's instructions. However, Medicare will pay for only one covered FOBT per year, either 82270 or G0328, but not both.

The diagnosis code reported is either V76.41 (special screening for malignant neoplasms, rectum) or V76.51 (special screening for malignant neoplasms, colon). The patient is not responsible for any copay or deductible.

Initial Preventive Physical Examination

This examination (referred to as the IPPE or "Welcome to Medicare Exam") covers specific services for new Medicare beneficiaries. The exam is payable once and only if provided within the first twelve months of the beneficiary's first Part B coverage period. The usual deductible is waived, but co-insurance provisions apply.

The service may be provided by a physician or qualified non-physician provider (e.g., physician assistants (PA), nurse practitioners (NP), and clinical nurse specialists (CNS).

The IPPE includes the following:

- **Medical and social history**: Review of patient's history with particular attention to modifiable risk factors for disease.
- **Depression Risk Assessment**: Review of the patient's risk factors for depression, including current or past experience with depression or other mood disorders. She cannot have a current diagnosis of depression. The provider may use one of the standardized screening tests designed for this purpose and recognized by national medical professional organizations.
- **Functional ability and level of safety**: Review based on the use of appropriate screening questions or a screening questionnaire. The provider may select from screening questions or standardized questionnaires designed for this purpose and recognized by national medical professional organizations.
- **Examination**: Measurements and tests including measurement of the patient's height, weight, blood pressure, a visual acuity screen, and other factors as deemed appropriate, based on her medical and social history and current clinical standards.
    - Effective January 1, 2009, the examination element of the IPPE now requires measurement of body mass index
      to identify those at risk for weight-related health problems.

    - **Optional Electrocardiogram**: Performance and interpretation by provider or by referral provider.
- **Education, counseling, and referral**: Provided as appropriate, based on the results of the first five elements of the IPPE.
- **End of Life Planning (Upon an individual's consent):** 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.
- **Brief written plan such as a checklist**: Provided to the patient for obtaining appropriate screening and other preventive services which are separately covered under Medicare Part B benefits (e.g., screening services described above, vaccinations, diabetes self-management, glaucoma screening, medical nutrition therapy)

For the purposes of the IPPE benefit, medical history is defined as:

- Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries, and treatment.
- Current medications and supplements, including calcium and vitamins.
- Family history, including a review of medical events in the patient's family, including diseases that may be hereditary or place the individual at risk.

For the purposes of this benefit, social history is defined as:

- History of alcohol, tobacco, and illicit drug use.
- Diet.
- Physical activities.

If the physician or NPP cannot perform the EKG in the office suite, then alternative arrangements may be made with an outside entity. The primary care provider must incorporate the results of the EKG into the beneficiary's medical record.

The following HCPCPS codes are used to report these services:

- G0402 - Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during first six months of Medicare enrollment
- G0403 - Electrocardiogram, routine ECG with at least 12 leads: with interpretation and report, performed as a component of the initial preventive physical examination
- G0404 - Tracing only, without interpretation and report, performed as a component of the initial preventive physical examination
- G0405 - Interpretation and report only, performed as a component of the initial preventive physical examination

The diagnosis code reported is V70.0 (routine general medical examination at a health care facility).

Other covered preventive, screening or problem-oriented services may be performed at the same encounter as the IPPE. These are reported using the appropriate codes. If reporting an E/M service, add a modifier 25. The documentation for the problem-oriented portion of the encounter must support the level of service reported.

Diabetes Screening

The diabetes screening tests include a fasting blood glucose test, post-glucose challenge tests, and either an oral glucose tolerance test with a glucose challenge of 75 grams of glucose for non-pregnant adults or a 2-hour post-glucose challenge test alone. This screening is covered twice within a 12-month period.

Individuals are eligible for the benefit if they have the following risk factors:

- Hypertension.
- Dyslipidemia.
- Obesity (body mass index 30 kg/m2 or more).

- Previous identification of an elevated impaired fasting glucose or glucose tolerance.
- At least two of the following:
  - Overweight (body mass index greater than 25 kg/m2, but less than 30).
  - A family history of diabetes.
  - A history of gestational diabetes mellitus or delivery of a baby weighing greater than 9 pounds.
  - 65 years of age or older.

Patients previously diagnosed as diabetic are not covered. Individuals diagnosed as pre-diabetic are eligible for this benefit. Pre-diabetes is defined as a fasting glucose level of 100-125 mg/dL, or a 2 hour post-glucose challenge of 140-199 mg/dL. Individuals not meeting the pre-diabetes criteria are eligible for one screening test per year.

Medicare covers these tests when reported with diagnosis code V77.1 (screening for diabetes mellitus) and one of the following CPT codes:

- 82947 - Glucose; quantitative, blood (except reagent strip)
- 82950 - Glucose; post glucose dose (includes glucose)
- 82951 - Glucose; tolerance test (GTT), three specimens (includes glucose)

Cardiovascular Screening Blood Tests

This benefit provides a blood test for the early detection of cardiovascular disease or abnormalities associated with an elevated risk of this disease. Three clinical laboratory tests are covered—total cholesterol, high density lipoprotein (HDL), and triglycerides. These tests are covered once every five years and can be ordered as one of each individual test or combination as a panel.

The tests must be ordered by a treating physician and used in the management of the patient. Laboratories must offer physicians the ability to order a lipid panel without the direct low density lipoprotein (LDL) measurement. However, if the screening lipid panel results illustrate a triglycerides level that indicates the need for a direct LDL measurement, the physician may order this test.

Report procedure codes for lipid panel (80061) or the individual codes for the tests included in the panel (82465, 84478, or 83718). Report a diagnosis code from the series V81.0-V81.2 (special screening for cardiovascular diseases).

Tobacco Use Cessation Counseling

Medicare covers counseling for tobacco cessation for outpatients and for inpatients. Inpatients are covered only if counseling for tobacco use is not the primary reason for the patient's hospital stay. Medicare covers 2 cessation attempts per year.

The counseling during an E/M service must be either intermediate or intensive. Intermediate counseling is 2 to 3 sessions of 3 to 10 minutes each. Intensive counseling is 4 sessions of more than 10 minutes each. Counseling involving only 1 session lasting less than 3 minutes is considered part of an E/M service and is not reimbursed separately. Each attempt may include a maximum of four intermediate or intensive counseling sessions. The total annual benefit is for 8 sessions in a 12 month period.

Services may be provided by a physician, physician assistant, nurse practitioner, clinical nurse specialist, qualified psychologist or clinical social worker. CMS does not currently have specific training requirements, but may in the future. The counseling must be provided face-to-face with the patient.

These services are reported using CPT-4 code 99406 (intermediate, E/M counseling service) or code 99407 (intensive, E/M counseling service). The diagnosis code should reflect the condition the patient has that is adversely affected by tobacco use or the condition the patient is being treated for with a therapeutic agent whose metabolism or dosing is affected by tobacco use.

Summary of Medicare Screening Services

Possible Procedure/ HCPCS Codes	Coverage	Patient Criteria	Patient Financial Responsibility	Provider Criteria	Possible Diagnosis Codes
Screening Pelvic Examination					
G0101	Every 2 years	Not high risk	20 % allowable No Part B deductible	None stated	V76.2, V76.47, V76.49, V72.31
	Annually	High risk			V15.89
Collection of Pap Smear Specimen					
Q0091	Every 2 years	Not high risk	20 % allowable No Part B deductible	None stated	V76.2, V76.47, V76.49, V72.31
	Annually	High risk			V15.89
Screening Hemoccult					
82270, G0328	Annually	>50 years old	None	None stated	V76.51, V76.41
Screening Mammography					
77057, +77052 G0202	Annually	>40 years old	20% allowable No Part B deductible	None stated	V76.12, V76.11
Screening Bone Mass Measurement					
77078, 77079, 77080, 77081, 77083, 76977, G0130	Once every 24 months	Patients at risk	20% allowable Deductible applies	Test ordered by physician or qualified nonphysician practitioner who is treating the patient.	Determined by Local Carriers*
Initial Preventive Physical Examination (Welcome to Medicare Examination)					
G0402, G0403 G0404,G0405	Once	Within first 12 months of Medicare coverage	20% allowable Deductible waived, but co-insurance provisions apply	Test ordered by physician or qualified nonphysician practitioner who is treating the patient.	V70.0
Diabetes Screening					
82947, 82950 82951	Twice in 12 month period	Patients at risk	None	None stated	V77.1
Cardiovascular Screening Blood Test					
82465, 84478 83718, 80061	Every 5 years	All Medicare beneficiaries	None	Test must be ordered by physician and used in management of patient	V81.0, V81.1, V81.2
Tobacco Use Cessation Counseling					
99406, 99407	2 cessation attempts in 12 month period (1 attempt = up to 4 sessions)	Patient has condition or is receiving treatment that is being adversely affected by tobacco use	20% allowable Deductible applies	Provided by a physician, physician assistant, nurse practitioner, clinical nurse specialist, qualified psychologist or clinical social worker	Use code indicating patient's condition or treatment affected by tobacco use

Questions and/or comments may be sent to ACOG's Coding Staff via email at Coding@acog.org