North Carolina HFMA Medicare Workshop

Novant Health Conference Center
January 22, 2025

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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Part B Preventive Services

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Disclaimer

The content in this presentation is intended for JJ/JM Part B providers and is current as of December 1, 2024. Any changes or new information superseding this information is provided in articles with publication dates after December 1, 2024, at www.PalmettoGBA.com.

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Agenda

- Medicare Preventive Services Overview
- Initial Preventive Physical Exam (IPPE)
- Annual Wellness Visit (AWV)
  - **Subsequent AWV**
- Summary
- Resources

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Medicare Preventive Services Overview

Medicare Preventive Services

- Helps keep patients healthy
- Discover problems early, when treatment works best
- Includes exams, shots, lab tests and screenings
  - Plus, programs for health monitoring, and counseling and education
- What preventive services does Medicare cover?
  - **MLN006559 — Medicare Preventive Services**
  - This is often referred to as the Preventive Services Tool or Chart

Medicare Preventive Services Chart

- Each listed service is a hyperlink to additional information
  - **HCPCS and CPT® codes**
  - **ICD-10 diagnosis codes**
  - **Coverage**
  - **Frequency**
  - **Patient payment responsibility**
  - **Changes**
  - **Other information, including a National Coverage Determination when applicable**

Medicare Preventive Services Chart

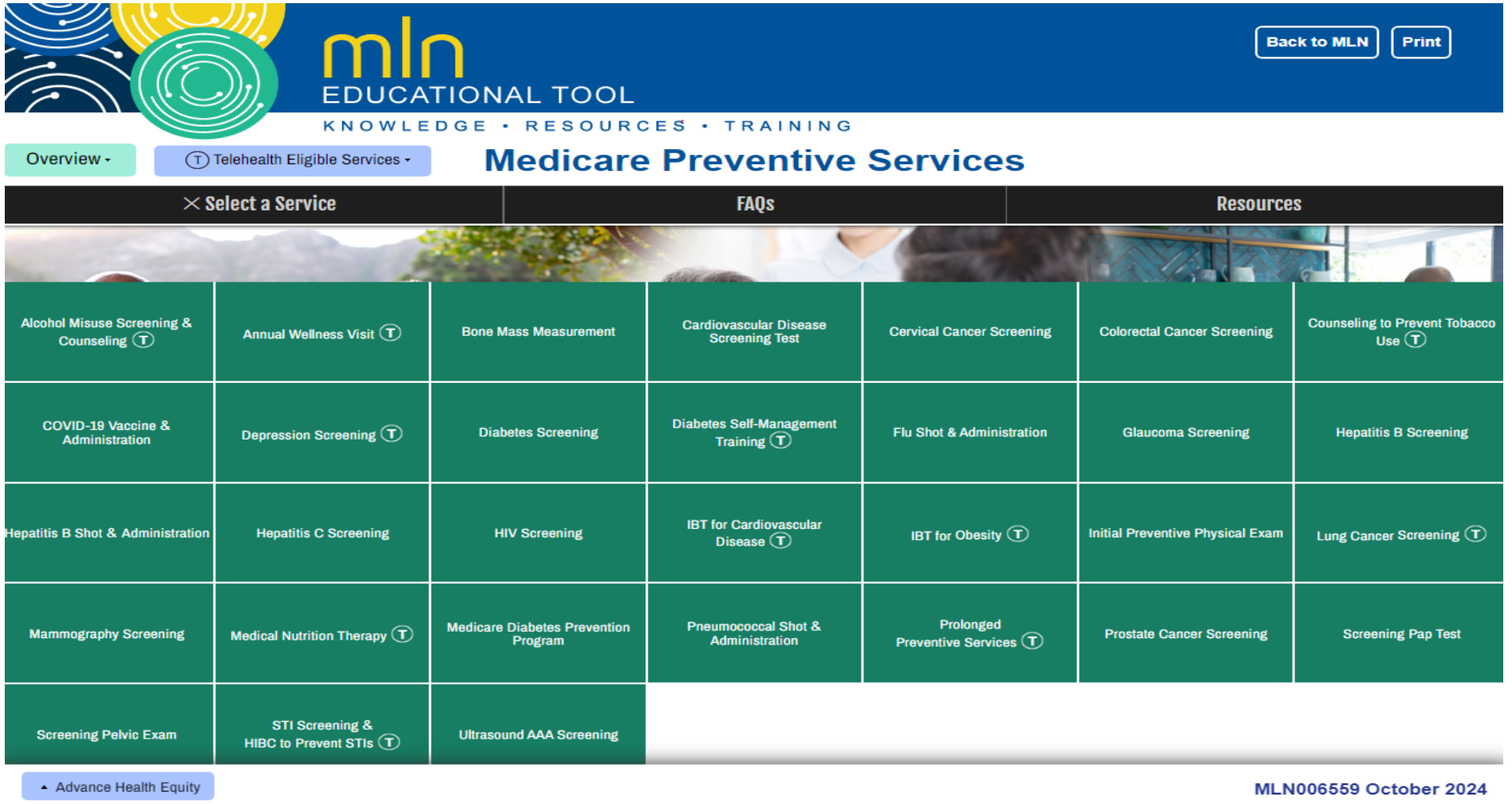

Chart Overview

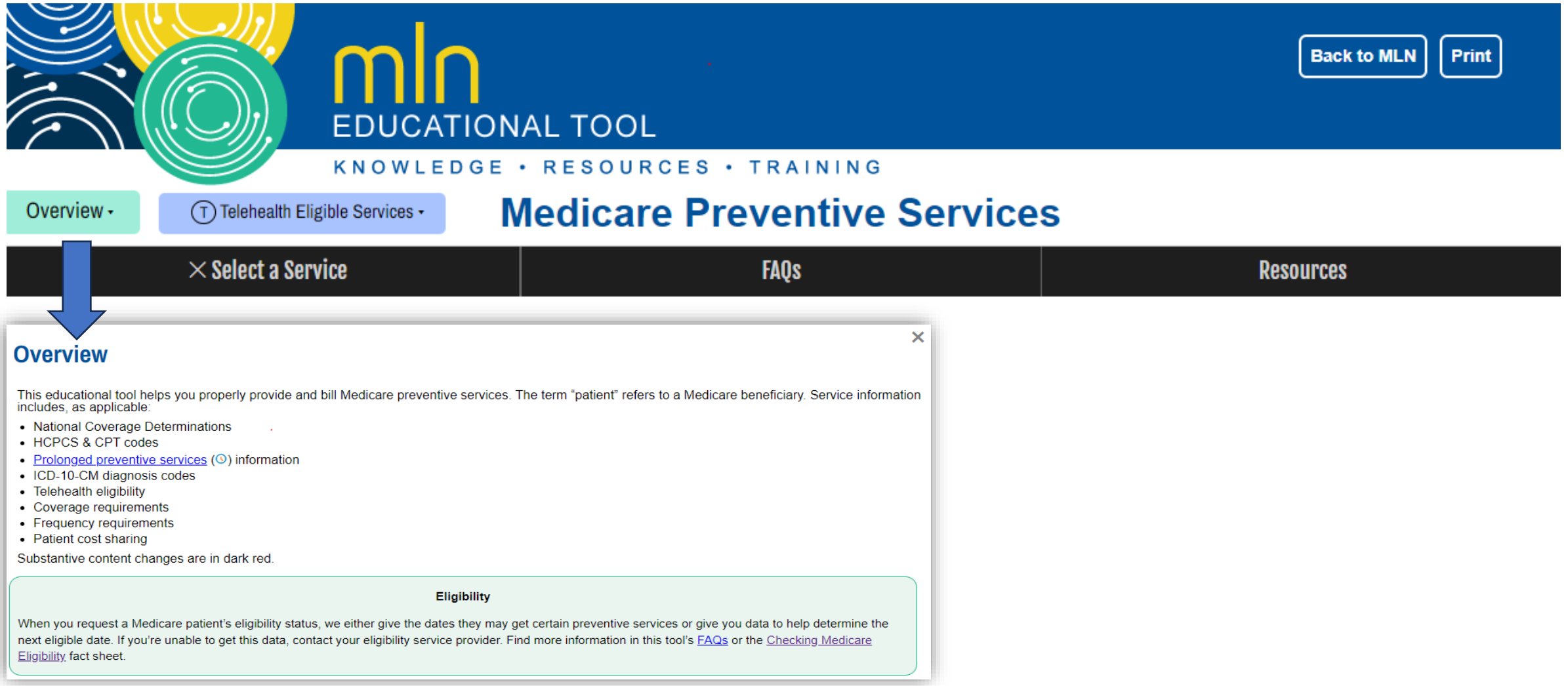

Chart Telehealth Eligible Services

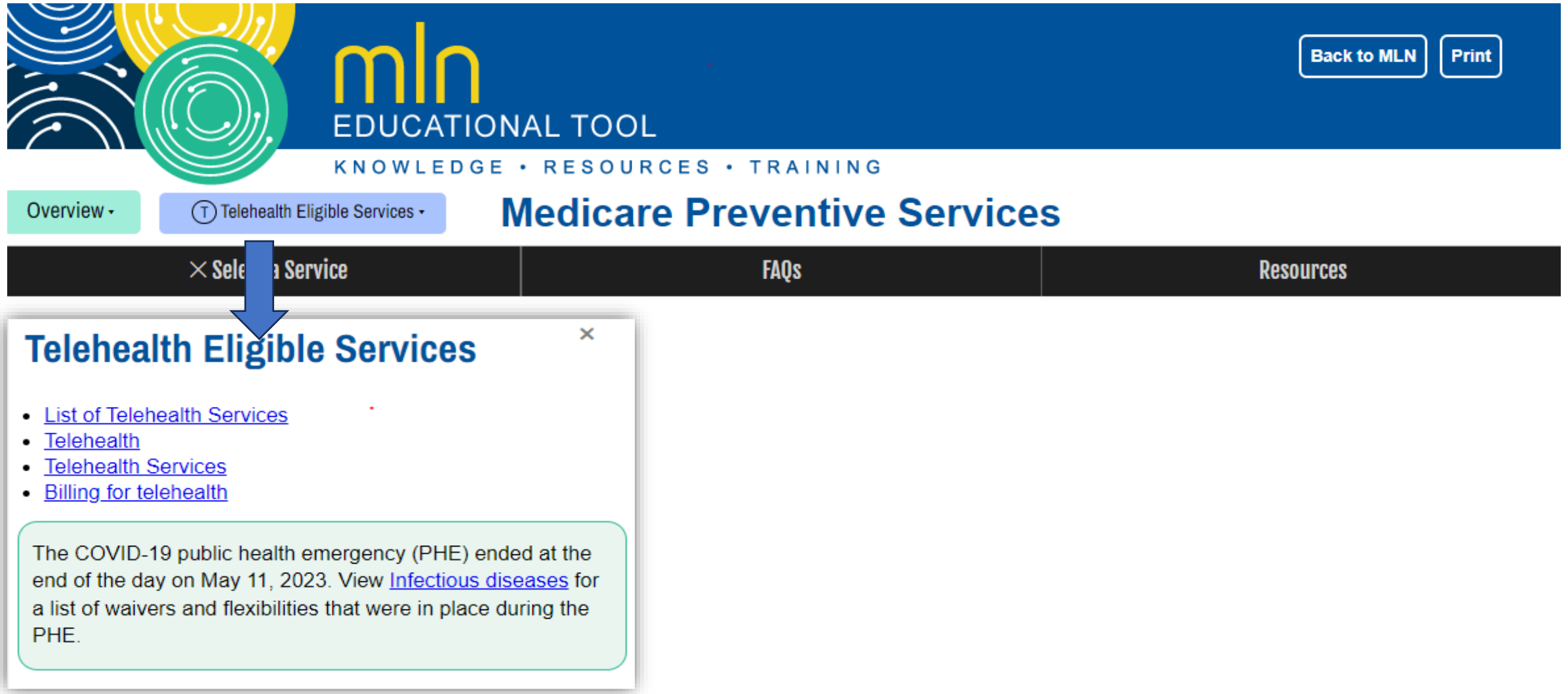

Chart FAQ


mln
EDUCATIONAL TOOL
KNOWLEDGE • RESOURCES • TRAINING
Back to MLN
Print
Overview
Telehealth Eligible Services
Medicare Preventive Services
Select a Service
FAQs
Resources
FAQs
How do I determine the last date a patient got a preventive service so I know if they're eligible to get the next service and it won't deny due to frequency edits?
Learn how to check eligibility. You may access eligibility information through the CMS HIPAA Eligibility Transaction System (HETS) either directly or through your:
Eligibility services vendor
Medicare Administrative Contractor (MAC) provider call center interactive voice response (IVR) unit
MAC provider web portal
Contact your eligibility service vendor or find your MAC's website.
My patients don't follow up on routine preventive care. How can I help them remember when they're due for their next preventive service?
We offer a Preventive Services Checklist so they can track their preventive services.
When can CMS add new Medicare preventive services?
Select another service
We may add preventive services coverage through the National Coverage Determination (NCD) process if the service is:
Reasonable and necessary for prevention or early detection of illness or disability
U.S. Preventive Services Task Force (USPSTF)-recommended with grade A or B
Appropriate for people entitled to Part A benefits or enrolled under Medicare Part B
We may also add preventive services through statutory and regulatory authority.
USPSTF Published Recommendations has more preventive services information.
What's a primary care setting?
We define a primary care setting as a place where clinicians deliver integrated, accessible health care services and are responsible for addressing most patient health care needs, developing a sustained patient partnership, and practicing in the context of family and community. Under this direction, we don't consider emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities, and hospices as primary care settings.

Chart Advance Health Equity

- Advance Health Equity

Advance Health Equity

Together we can advance health equity and help eliminate health disparities for all minority and underserved groups. Find resources and more from the CMS Office of Minority Health:

- Health Equity Technical Assistance Program
- Disparities Impact Statement

Determining Eligibility

- You may access eligibility information through the CMS HIPAA Eligibility Transaction System (HETS) either directly or through your:
  - **Eligibility services vendor**
  - **Medicare Administrative Contractor (MAC) provider call center Interactive Voice Response (IVR) unit**
  - **MAC provider web portal**
- CMS requires providers, billing companies, and outsourced agencies to obtain eligibility information from one of our self-service tools

Determining Eligibility: HETS

- HIPAA Eligibility Transaction System (HETS) for 270/271
- CMS offers real-time Internet-based eligibility transactions as an alternative to the IVR. These 270/271 transactions are processed through the CMS data center. Providers and clearinghouses must be authenticated by CMS before conducting these transactions. Telecommunications software is also required in order to access the CMS network. For more information, visit the HIPAA Eligibility Transaction System (HETS) overview page.

Determining Eligibility: IVR

- Call 855–696–0705 for Jurisdiction M
  - Select option **3** when prompted to get assistance
  - Select **Part B**
  - Select **Eligibility**
- To safeguard beneficiaries from Medicare fraud, the Centers for Medicare & Medicaid Services (CMS) has issued Change Request (CR) 13754, instructing Medicare Administrative Contractors (MACs) to disable beneficiary eligibility information from their Interactive Voice Response (IVR) systems by March 31, 2025.

Determining Eligibility: eServices

- The eServices eligibility functions are based on CMS' HIPAA Eligibility Transaction System (HETS)
- When you choose the Eligibility tab from within eServices, you will see a new set of tabs to display information related to your inquiry. In this instance, the Eligibility and Preventive tabs are applicable.
- Jurisdiction M Part B — eServices: Preventive Services Eligibility

Preventive Services Eligibility

- The Preventive tab provides information regarding the beneficiary's smoking cessation and preventive services. The information on the screen is organized into the Healthcare Common Procedure Coding System (HCPCS) categories (e.g., Cardiovascular, Colorectal and Diabetes).
- Only HCPCS codes for which a particular beneficiary is eligible will be displayed and grouped together under their appropriate categories. If a service has been rendered, it is removed from the list until closer to the time the beneficiary is eligible to receive the service again.

Eligibility Resources

- MLN 8816413: Checking Medicare Eligibility.pdf
- Updated: Jurisdiction M Part B — eServices: Eligibility Options Module
- Jurisdiction M Part B — Disable Beneficiary Eligibility Information from Medicare Administrative Contractor (MAC) Interactive Voice Response (IVR) Systems
- Jurisdiction M Part B — Beneficiary Eligibility to Be Removed from Interactive Voice Response System

Routine Physical Exam

Medicare Physical Exam Coverage

Initial Preventive Physical Exam (IPPE)

Review of medical and social health history and preventive services education.

✓ New Medicare patients within 12 months of starting Part B coverage

✓ Patients pay nothing (if provider accepts assignment)

Annual Wellness Visit (AWV)

Visit to develop or update a personalized prevention plan and perform a health risk assessment.

✓ Covered once every 12 months

✓ Patients pay nothing (if provider accepts assignment)

Routine Physical Exam

Exam performed without relationship to treatment or diagnosis of a specific illness, symptom, complaint, or injury.

✗ Medicare doesn't cover a routine physical

✗ Patients pay 100% out-of-pocket

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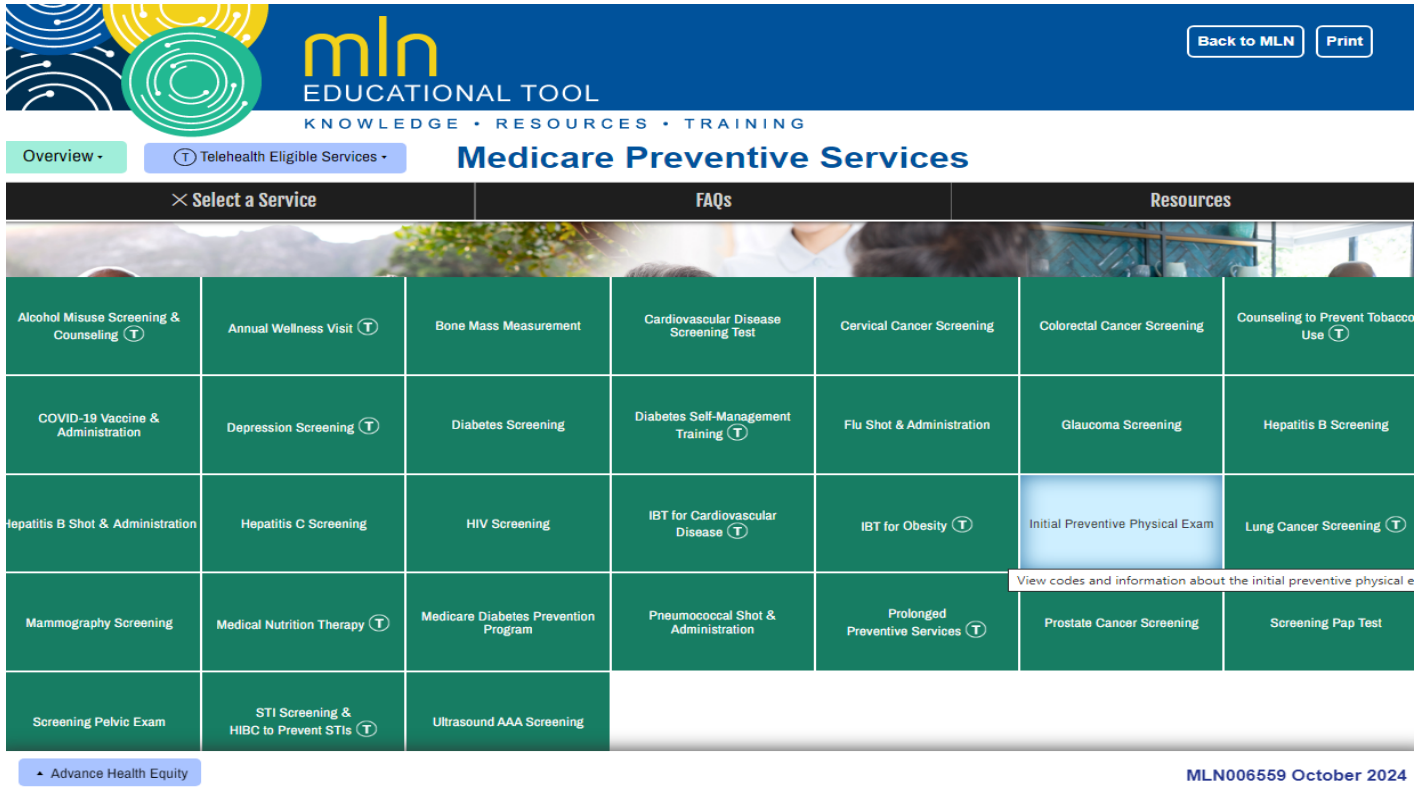
IPPE: Initial Preventive Physical Exam



Initial Preventive Physical Exam (IPPE)

IPPE

Welcome to Medicare visit

All new Medicare beneficiaries who are within the first 12 months of their first Part B coverage period are eligible for an IPPE.

IPPE

- HCPCS G0402: Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment
  - **Important: The screening EKG is an optional service that may be performed as a result of a referral from an IPPE**

- HCPCS G0468: Federally Qualified Health Center (FQHC) visit, IPPE or AWV; a FQHC visit that includes an IPPE or AWV and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV

IPPE: Electrocardiogram

- HCPCS G0402: IPPE
  - **HCPCS G0403 — Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report**
  - **HCPCS G0404 — Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination**
  - **HCPCS G0405 — Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination**

IPPE Billing

- Part B covers an IPPE when performed by a:
  - **Physician (doctor of medicine or osteopathy)**
  - **Qualified nonphysician practitioner (physician assistant, nurse practitioner, or certified clinical nurse specialist)**
- Report a diagnosis code when submitting IPPE claims. We don't require you to use a specific IPPE diagnosis code, so you may choose any diagnosis code consistent with the patient's exam.
- While there is no copayment, coinsurance, or deductible for HCPCS G0402, they do apply for the screening electrocardiograms

IPPE Billing

- When you provide an IPPE and a significant, separately identifiable, medically necessary evaluation and management (E/M) service, we may pay for the additional service
  - **Report the additional CPT® code (99202–99205, 99211–99215) with modifier 25. That portion of the visit must be medically necessary and reasonable to treat the patient's illness or injury or to improve the functioning of a malformed body part.**

IPPE Required Elements

- Review the patient’s medical and social history
- Review potential risk factors for depression and other mood disorder
- Review functional ability and level of safety
- Exam — Measurement of height, weight, body mass index, visual acuity screening, etc.

IPPE Required Elements

- End-of-life planning (upon agreement of the individual)
- Review opioid prescriptions and screen for substance abuse disorders
- Education, counseling and referral based on the review of previous components
- Education, counseling and referral for other preventive services, including a brief written plan such as a checklist

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Annual Wellness Visit (AWV)

Annual Wellness Visit (AWV)

AWV

Medicare covers an annual AWV for patients who:

- Aren’t within 12 months of the effective date of their first Part B coverage period
- Haven’t had an IPPE or AWV within the previous 12 months

There is no copayment, coinsurance or deductible.

AWV

- AWV
  - **HCPCS G0438: Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit. Covered once in a lifetime.**
  - **HCPCS G0439: Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit. Covered annually.**
  - **HCPCS G0468: Federally Qualified Health Center (FQHC) visit, IPPE or AWV; a FQHC visit that includes an IPPE or AWV and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV. Covered annually.**

AWV Billing

- Part B covers an AWV if performed by a:
  - **Physician (doctor of medicine or osteopathy)**
  - **Qualified nonphysician practitioner (physician assistant, nurse practitioner, or certified clinical nurse specialist)**
  - **Medical professional (including health educator, registered dietitian, nutrition professional, or other licensed practitioner) or a team of medical professionals directly supervised by a physician**
- Report a diagnosis code when submitting AWV claims. We don't require you to use a specific AWV diagnosis code, so you may choose any diagnosis code consistent with the patient's exam

AWV Billing

- When you provide an AWV and a significant, separately identifiable, medically necessary evaluation and management (E/M) service, we may pay for the additional service
  - **Report the additional CPT® code (99202–99205, 99211–99215) with modifier 25. That portion of the visit must be medically necessary and reasonable to treat the patient's illness or injury or to improve the functioning of a malformed body part.**
- Medicare telehealth includes HCPCS codes G0438 and G0439

Initial AWV Required Elements

- Health Risk Assessment
- Establishment of a current list of healthcare providers and suppliers
- Review of medical and family history
- Measurement of height, weight, BMI and blood pressure
- Review of potential risk factors for depression and other mood disorders

Initial AWV Required Elements

- Review of functional ability and level of safety
- Detection of any cognitive impairment the patient may have
- Establishment of a written screening schedule
- Establishment of a list of risk factors
- Provision of personalized health advice and referral to appropriate health education or other preventive services

Initial AWV

- Provide Advance Care Planning (ACP) services (at patient's discretion)
- Review current opioid prescriptions
- Screen for potential substance use disorders (SUDs), as appropriate
- You can find additional details for the elements of the initial AWV here: **MLN6775421 — Medicare Wellness Visits**

Social Determinants of Health (SDOH) Risk Assessment

- In 2024, Medicare began including an optional SDOH Risk Assessment as part of the AWV
- SDOH risk assessment refers to a review of the individual's SDOH needs or identified social risk factors influencing the diagnosis and treatment of medical conditions
- **MLN9201074 — Health Equity Services in the 2024 Physician Fee Schedule Final Rule**

SDOH Risk Assessment

- This assessment must follow standardized, evidence-based practices and ensure communication aligns with the patient's educational, developmental, and health literacy level, as well as being culturally and linguistically appropriate
- HCPCS G0136: Administration of a standardized, evidence-based social determinants of health risk assessment tool, five to 15 minutes, not more often than every six months
- **MM13486 — Annual Wellness Visit: Social Determinants of Health Risk Assessment**

Subsequent AWV

- Subsequent AWV
  - **HCPCS G0439 Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit**

Subsequent AWV Required Elements

- **Review** of **updated** health risk assessment
- **Update** medical and family history
- **Update** list of current healthcare providers and suppliers
- Measurement of weight and blood pressure
- Assessment/Detection of any cognitive impairment the patient may have
- **Update** written screening schedule
- **Update** list of risk factors
- Provision of personalized health advice and referral for appropriate health education or other preventive services

Subsequent AWV Requirements

- Provide Advance Care Planning (ACP) services at patient's discretion
- Review current opioid prescriptions
- Screen for potential substance use disorders (SUDs), if appropriate

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2025 Medicare Physician Fee Schedule (PFS) Final Rule

Services Addressing Health-Related Social Needs

- Services Addressing Health-Related Social Needs (Community Health Integration Services, Social Determinants of Health Risk Assessment, and Principal Illness Navigation Services)
  - **In the CY 2025 PFS proposed rule, CMS issued a broad request for information (RFI) on the newly implemented Community Health Integration (CHI) services, Principal Illness Navigation (PIN) services, and Social Determinants of Health (SDOH) Risk Assessment to engage interested parties on additional policy refinements for CMS to consider in future rulemaking**

Services Addressing Health-Related Social Needs

- Services Addressing Health-Related Social Needs (Community Health Integration Services, Social Determinants of Health Risk Assessment, and Principal Illness Navigation Services)
  - **CMS requested information on other factors for us to consider, such as other types of auxiliary personnel (including clinical social workers) and other certification and training requirements that are not adequately captured in current coding and payment for these services, and how to improve utilization in rural areas. CMS also sought comment about how these codes are being furnished in conjunction with community-based organizations. CMS received many detailed comments in response to this RFI, which we summarize in the final rule and may consider for future rulemaking.**

Telehealth Services Background

- During the COVID-19 Public Health Emergency (PHE), CMS offered certain flexibilities to help ease the burden and help providers care for Americans during the PHE
- The PHE ended at midnight on May 11, 2023
- Some telehealth flexibilities (but no all) were extended through the end of 2024
- The 2025 Physician Fee Schedule Final Rule provides updates to the Medicare telehealth coverage and guidelines

Telehealth Services under the PFS

- Absent congressional action, beginning January 1, 2025, the statutory limitations that were in place for Medicare telehealth services prior to the COVID-19 PHE will retake effect for most telehealth services
  - **Geographic and location restrictions on where services are provided**
  - **Limitation on the scope of practitioners who can provide telehealth**

- Palmetto GBA must wait for the formal publication of the Final Rule in the Federal Register (anticipated December 9, 2024), and then specific directives from CMS on how to implement the Final Rule changes

Behavioral Health Services

- Behavioral Health Services
  - **In this rule, CMS is finalizing several additional actions to help support access to behavioral health, in line with the CMS Behavioral Health Strategy**
  - **These are not preventive services, but behavioral and depression risk factors are part of the IPPE, AWV and subsequent AWV**

Opioid Treatment Programs (OTPs)

- Opioid Treatment Programs (OTPs)
  - **CMS is finalizing several telecommunication technology flexibilities for opioid use disorder (OUD) treatment services furnished by OTPs, so long as all requirements are met, and the use of these technologies are permitted under the applicable Substance Abuse and Mental Health Services (SAMHSA) and the Drug Enforcement Administration (DEA) requirements at the time the services are furnished**

Opioid Treatment Programs (OTPs)

- Opioid Treatment Programs (OTPs), page 2
  - **CMS is updating payment for SDOH risk assessments as part of intake activities within OUD treatment services furnished by OTPs, if medically reasonable and necessary to adequately reflect additional effort for OTPs, to identify a patient's unmet health-related social needs (HRSNs) or the need and interest for harm reduction interventions and recovery support services that are critical to the treatment of an OUD. After consideration of public comments, CMS is also updating payment for periodic assessments to include payment for SDOH risk assessments to reflect additional reassessments that OTPs may conduct throughout treatment, to monitor potential changes in a patient's HRSNs or support services.**

Opioid Treatment Programs (OTPs)

- Opioid Treatment Programs (OTPs), page 3
  - **CMS is also updating payment for periodic assessments to include payment for SDOH risk assessments to reflect additional reassessments that OTPs may conduct throughout treatment, to monitor potential changes in a patient's HRSNs or support services**
  - **CMS is finalizing new add-on codes to account for coordinated care and referral services, patient navigational services, and peer recovery support services. Establishing payment for these services can support OTPs in coordinating with community-based organizations to address various patient needs across the continuum of care, and directly provide or refer patients to navigational and/or peer recovery support services to assist patients in navigating multiple care settings and meeting MOUD treatment and recovery goals.**

Telecommunication Services in RHCs and FQHCs

- Telecommunication Services in RHCs and FQHCs
  - **CMS is finalizing a policy clarification to continue to allow direct supervision via interactive audio and video telecommunications and to extend the definition of "immediate availability" as including real-time audio and visual interactive telecommunications (excluding audio-only) through December 31, 2025**
  - **CMS is also finalizing a policy to allow payment, on a temporary basis, for non-behavioral health visits furnished via telecommunication technology under the methodology that has been in place for these services during and after the COVID-19 PHE through December 31, 2024**

Telecommunication Services in RHCs and FQHCs

- Telecommunication Services in RHCs and FQHCs, page 2
  - **CMS is finalizing a continued policy to delay the in-person visit requirement for mental health services furnished via communication technology by RHCs and FQHCs to beneficiaries in their homes until January 1, 2026**

Payment for Preventive Vaccine Costs in RHCs and FQHCs

- Payment for Preventive Vaccine Costs in RHCs and FQHCs
  - **CMS is allowing RHCs and FQHCs to bill and be paid for Part B preventive vaccines and their administration at the time of service. CMS is finalizing that payments for these claims will be made according to Part B preventive vaccine payment rates in other settings, to be annually reconciled with the facilities' actual vaccine costs on their cost reports. Due to the operational systems changes needed to facilitate payment through claims, we are finalizing that RHCs and FQHCs begin billing for preventive vaccines and their administration at the time of service, effective for dates of service beginning on or after July 1, 2025. The intent of this policy is to improve the timeliness of payment for critical preventive vaccine administration in RHCs and FQHCs.**

Office/Outpatient Evaluation and Management Visits

- Office/Outpatient (O/O) Evaluation and Management (E/M) Visits
  - **For CY 2025, CMS is finalizing the proposal to allow payment of the O/O E/M visit complexity add-on code, Healthcare Common Procedure Coding System (HCPCS) code G2211, when the O/O E/M base code — Current Procedural Terminology (CPT) codes 99202-99205, 99211-99215 — is reported by the same practitioner on the same day as an annual wellness visit (AWV), vaccine administration, or any Medicare Part B preventive service, including the Initial Preventive Physical Examination (IPPE), furnished in the office or outpatient setting**

Medicare Part B Payment for Preventive Services

- Medicare Part B Payment for Preventive Services
  - **CMS is expanding coverage of hepatitis B vaccinations to include individuals who have not previously received a completed hepatitis B vaccination series or whose vaccination history is unknown**
  - **CMS clarified that a physician's order will no longer be required for the administration of a hepatitis B vaccine under Part B**
  - **CMS finalized a fee schedule for Drugs Covered as Additional Preventive Services (DCAPS drugs), per section 1833(a)(1)(W)(ii) of the Act**
    - Established coverage of HIV PrEP drugs under Part B as additional preventive services
    - PrEP for HIV drugs will therefore be paid under the DCAPS fee schedule effective January 1, 2025

Expand Colorectal Cancer Screening

- Expand Colorectal Cancer Screening
  - **CMS removed coverage of barium enema as a method of screening because this service is rarely used in Medicare and is no longer recommended as an evidence-based screening method**
  - **CMS expanded coverage for CRC screening to include computed tomography colonography (CTC)**
  - **CMS added Medicare covered blood-based biomarker CRC screening tests as part of the continuum of screening**
  - **CMS revised the regulation text to clarify that CRC screening frequency limitations do not apply to the follow-on screening colonoscopy in the context of "complete CRC screening"**

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Summary

Help Prepare Patients for AWV

- Request patients bring certain information to their appointment:
- Medical records, including immunization records
- Detailed family health history
- Full list of medications and supplements, including calcium and vitamins, and how often and how much of each they take
- Full list of current providers and suppliers involved in their care, including community-based providers (for example, personal care, adult day care, and home-delivered meals), and behavioral health specialists

Resources

- MLN6775421 — Medicare Wellness Visits
- MLN006559 — Medicare Preventive Services
- Jurisdiction M Part B — Preventive Services

Contacting Palmetto GBA

Questions such as claim status and general inquiries should be directed to our Provider Contact Center:

- **Phone**: **855–696–0705** (**JM**)
- Need **EDI** or **eServices** assistance?
  - Select **Option 1** for EDI (EDI technical assistance)
  - Select the option for **eServices** (eServices technical questions)
- **Secure eChat**
- **For written correspondence**

  Palmetto GBA

  Part B PCC
  Mail Code: AG-840
  P.O. Box 100238
  Columbia, SC 29202-3238

PECOS

- Supports Medicare Provider and Supplier enrollment process
- Allows registered users to securely and electronically submit and manage Medicare enrollment information

Have you updated PECOS?

Connect With Us

FACEBOOK

Follow us on Facebook to learn about upcoming events and ask us general questions

X (TWITTER)

#StayConnected on X for quick access to news and information

YOUTUBE

Go to YouTube for educational videos, tips and strategies

LINKEDIN

LinkedIn is your source for the latest Palmetto GBA news

Customer Experience Survey

Overall, how satisfied are you with your MAC?

- ☐ **Extremely satisfied**
- ☐ **Somewhat satisfied**
- ☐ **Neither satisfied nor dissatisfied**
- ☐ **Somewhat dissatisfied**
- ☐ **Extremely dissatisfied**

Customer Experience Survey

How likely are you to recommend our education to a colleague or peer?

Customer Experience Survey

FEEDBACK

Don’t forget to complete the feedback survey!