CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2122	**Date: December 21, 2010**
	Change Request 7208

NOTE: Transmittal 2093, dated November 12, 2010 is being rescinded and replaced by Transmittal 2122, dated December 21, 2010 to include the new HCPCS Codes (G0438 and G0439) for the annual wellness visit listed in Attachment A. All other information remains the same.

SUBJECT: Waiver of Coinsurance and Deductible for Preventive Services in Rural Health Clinics (RHCs), Section 4104 of Affordable Care Act (ACA).

I. SUMMARY OF CHANGES: This instruction waives coinsurance and deductible for preventive services with a USPSTF grade of A or B when provided in RHCs.

EFFECTIVE DATE: January 1, 2011
IMPLEMENTATION DATE: April 4, 2011

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	9/120/General Billing Requirements for Preventive Services
R	9/160/Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question

and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2122	Date: December 21, 2010	Change Request: 7208

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SUBJECT: Waiver of Coinsurance and Deductible for Preventive Services for Rural Health Clinics (RHCs), Section 4104 of the Affordable Care Act (ACA)

Effective Date: January 1, 2011

Implementation Date: April 4, 2011

I. GENERAL INFORMATION

A. Background:

Provisions of the Affordable Care Act waive coinsurance and deductible for the initial preventive physical examination (IPPE), the annual wellness visit, and other Medicare covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B. Detailed HCPCS coding is required to ensure that coinsurance and deductible are not applied to these preventive services when submitted by RHCs on a 71X type of bill with dates of service on or after 01/01/2011.

B. Policy:

Payment for the professional component of allowable preventive services is made under the all-inclusive rate when all of the program requirements are met. HCPCS coding is required to allow for the coinsurance and deductible to be waived for IPPE, the annual wellness visit, and those Medicare covered preventive services recommended by the USPSTF with a grade of A or B for any indication or population and that are appropriate for the individual. The Affordable Care Act also waives the deductible for planned colorectal cancer screening tests that become diagnostic.

When one or more preventive service that meets the specified criteria is provided as part of an RHC visit, charges for these services must be deducted from the total charge for purposes of calculating beneficiary copayments and deductibles. For example, if the total charge for the visit is $150, and $50 of that is for a qualified preventive service, the beneficiary copayment and deductible is based on $100 of the total charge. If no other RHC service took place along with the preventive service, there would be no copayment or deductible applied.

Please refer to attachment A for a list of HCPCS codes that are defined as preventive services under Medicare and the HCPCS codes for IPPE and the annual wellness visit.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)

		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7208.1	Effective for DOS 01/01/11 and after, Contractors shall allow additional revenue lines containing preventive services HCPCS codes on 71X types of bills. Note: As outlined in CR7012, coinsurance and deductible are not applicable.	X		X			X				
7208.2	Contractors shall not make an additional payment for service lines containing preventive services HCPCS codes on 71X types of bills (excluding IPPE).						X				
7208.2.1	Medicare systems shall use group code CO and reason code 97 –"The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present".	X		X			X				

III. PROVIDER EDUCATION TABLE

Number	**Requirement**	**Responsibility (place an "X" in each applicable column)**									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7208.3	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the Contractors next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X							

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Tracey Mackey (claims processing) 410-786-5736 or Corinne Axelrod (policy) 410-786-5620

Post-Implementation Contact(s): Appropriate RO

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

120 – General Billing Requirements for Preventive Services

(Rev. 2122, Issued: 12--21-10 Effective: 01-01-11, Implementation: 04-04-11)

Professional components of preventive services are part of the overall encounter, and for TOBs 71x or 73x/*77x*, have always been billed on lines with the appropriate site of service revenue code in the 052x series. In addition to previous requirements for independent FQHCs exclusively, all RHCs/FQHCs had been required to report HCPCS codes for certain preventive services subject to frequency limits.

For dates of service on or after April 1, 2005 through *December 31, 2010*, RHCs and FQHCs do not have to report HCPCS codes associated with preventive services subject to frequency limits on any line items billed on TOBs 71x *or* 73x/*77x* absent a few exceptions.

Effective for dates of service on or after January 1, 2011, coinsurance and deductible are not applicable for preventive services. RHCs and FQHCs must provide detailed HCPCS coding for preventives services to ensure coinsurance and deductible are not applied.

An additional line with the appropriate site of service revenue code in the 052X series should be submitted with the approved preventive service HCPCS code and the associated charges. For example, if the total charge for the visit is $150.00, and $50.00 of that is a qualified preventive service, the service lines should be coded as follows:

Line	*Revenue Code*	*HCPCS code*	*Date of Service*	*Charges*
1	*052X*		*01/01/2011*	*100.00*
2	*052X*	*preventive service code*	*01/01/2011*	*50.00*

The services reported under the first revenue line will receive an encounter/visit. Payment will be based on the all-inclusive rate, coinsurance and deductible will be applied. The qualified preventive service reported on the second revenue line will not receive payment, as payment is made under the all-inclusive rate for the services reported on the first revenue line. Coinsurance and deductible are not applicable.

If the only services provided were preventives, report the appropriate site of service revenue code (052X) with the preventive service HCPCS code(s). The services reported under the first revenue line will receive an encounter/visit. Coinsurance and deductible are not applicable.

***NOTE:** This example does not apply to the initial preventive physical examination (IPPE), individual Diabetes Self Management (DSMT), and individual Medical Nutrition Therapy (MNT) as these preventives services are eligible to receive an additional encounter payment at the all-inclusive rate, coinsurance and deductible are not applicable. DSMT and MNT apply to FQHCs only. Coinsurance is applicable for DSMT.*

For vaccines, RHCs/FQHCs do not report charges for influenza virus or pneumococcal pneumonia vaccines on the 71x *or* 73x/*77x* claims. Costs for the influenza virus or

pneumococcal pneumonia vaccines are included in the cost report and no line items are billed. Neither co-insurance nor deductible apply to either of these vaccines.

Hepatitis B vaccine is included in the encounter rate. The charges of the vaccine and its administration can be included in the line item for the otherwise qualifying encounter. An encounter can not be billed if vaccine administration is the only service the RHC/FQHC provides.

RHCs/FQHCs do not receive any reimbursement on TOBs 71x *or* 73x/*77x* for technical components of services provided by clinics/centers. This is because the technical components of services are not within the scope of Medicare-covered RHC/FQHC services. The associated technical components of services furnished by the clinic/center are billed on other types of claims that are subject to strict editing to enforce statutory frequency limits.

Though most preventive services have HCPCS codes that allow separate billing of professional and technical components, mammography and prostate PSA do not. However, RHCs/FQHCs still may provide the professional component of these services since they are in the scope of the RHC/FQHC benefit. Such encounters are billed on line items using the appropriate site of service revenue code in the 052x series.

Additional information on vaccines can be found in Chapter 1, section 10 of this manual. Additional coverage requirements for pneumococcal vaccine, hepatitis B vaccine, and influenza virus vaccine can be found in Publication 100-02, the Medicare Benefit Policy Manual, Chapter 15.

160 – Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)

(Rev. 2122, Issued: 12--21-10 Effective: 01-01-11, Implementation: 04-04-11)

Section 5112 of the Deficit Reduction Act of 2005 amended the Social Security Act to provide coverage under Part B of the Medicare program for a one-time ultrasound screening for abdominal aortic aneurysms (AAA). Payment for the professional services that meet all of the program requirements will be made under the all-inclusive rate. For RHCs the Part B deductible for screening AAA is waived for dates of service on or after January 1, 2007. FQHC services are always exempt from the Part B deductible. Coinsurance is applicable. *For RHCs and FQHCs, coinsurance for screening AAA is waived for dates of service on or after January 1, 2011*. Additional information on AAA can be found in Chapter 18, section 110 of this manual.

If the screening is provided in an RHC or FQHC, the professional portion of the service is billed to the FI or Part A MAC using TOBs 71X and 73X/*77X*, respectively, and the appropriate site of service revenue code in the 052X revenue code series and must include HCPCS *code* G0389.

If the AAA screening is provided in an independent RHC or freestanding FQHC, the technical component of the service can be billed by the practitioner to the carrier or Part B MAC under the practitioner's ID following instructions for submitting practitioner claims.

If the screening is provided in a provider-based RHC/FQHC, the technical component of the service can be billed by the base provider to the FI or Part A MAC under the base provider's ID, following instructions for submitting claims to the FI/Part A MAC from the base provider.

Attachment A

Deductible and Coinsurance for Preventive Services
(Includes the IPPE and the Annual Wellness Visit)

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	CY 2011 Coins. / Deductible
Initial Preventive Physical Examination, IPPE	G0402	Initial preventive physical examination; face to face visits, services limited to new beneficiary during the first 12 months of Medicare enrollment	***Not Rated**	WAIVED
	G0403	Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report		Not Waived
	G0404	Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination		Not Waived
	G0405	Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination		Not Waived
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)	G0389	Ultrasound, B-scan and /or real time with image documentation; for abdominal aortic aneurysm (AAA) ultrasound screening	B	WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	CY 2011 Coins. / Deductible
Cardio-vascular Disease Screening	80061	Lipid panel	A	WAIVED
	82465	Cholesterol, serum or whole blood, total		WAIVED
	83718	Lipoprotein, direct measurement; high density cholesterol (hdl cholesterol)		WAIVED
	84478	Triglycerides		WAIVED
Diabetes Screening Tests	82947	Glucose; quantitative, blood (except reagent strip)	B	WAIVED
	82950	Glucose; post glucose dose (includes glucose)		WAIVED
	82951	Glucose; tolerance test (gtt), three specimens (includes glucose)	***Not Rated**	WAIVED
Diabetes Self-Management Training Services (DSMT)	G0108	Diabetes outpatient self-management training services, individual, per 30 minutes	***Not Rated**	Not Waived
	G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes		Not Waived
Medical Nutrition Therapy (MNT) Services	97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	B	WAIVED
	97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes		WAIVED
	97804	Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes		WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	CY 2011 Coins. / Deductible
	G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes	B	WAIVED
	G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes		WAIVED
Screening Pap Test	G0123	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision	A	WAIVED
	G0124	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician		WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	CY 2011 Coins. / Deductible
	G0141	Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician	A	WAIVED
	G0143	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision	A	WAIVED
	G0144	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision	A	WAIVED
	G0145	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision	A	WAIVED
	G0147	Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision	A	WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	CY 2011 Coins. / Deductible
	G0148	Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening	A	WAIVED
	P3000	Screening papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision		WAIVED
	P3001	Screening papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician		WAIVED
	Q0091	Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory		WAIVED
Screening Pelvic Exam	G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	A	WAIVED
Screening Mammo-graphy	77052	Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography (list separately in addition to code for primary procedure)	B	WAIVED
	77057	Screening mammography, bilateral (2-view film study of each breast)	B	WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	CY 2011 Coins. / Deductible
	G0202	Screening mammography, producing direct digital image, bilateral, all views		WAIVED
Bone Mass Measurement	G0130	Single energy x-ray absorptiometry (sexa) bone density study, one or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)	B	WAIVED
	77078	Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)		WAIVED
	77079	Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)		WAIVED
	77080	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)		WAIVED
	77081	Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)		WAIVED
	77083	Radiographic absorptiometry (eg, photodensitometry, radiogrammetry), 1 or more sites		WAIVED
	76977	Ultrasound bone density measurement and interpretation, peripheral site(s), any method		WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	CY 2011 Coins. / Deductible
Colorectal Cancer Screening	G0104	Colorectal cancer screening; flexible sigmoidoscopy	A	WAIVED
	G0105	Colorectal cancer screening; colonoscopy on individual at high risk		WAIVED
	G0106	Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema	***Not Rated**	Coins. Applies & Ded. is waived
	G0120	Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema.		Coins. Applies & Ded. is waived
	G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk	A	WAIVED
	82270	Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, consecutive		WAIVED
	G0328	Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous		WAIVED
Prostate Cancer Screening	G0102	Prostate cancer screening; digital rectal examination	D	Not Waived
	G0103	Prostate cancer screening; prostate specific antigen test (PSA)		WAIVED
Glaucoma Screening	G0117	Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist	I	Not Waived

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	CY 2011 Coins. / Deductible
	G0118	Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or ophthalmologist		Not Waived
Influenza Virus Vaccine	90655	Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use	B	WAIVED
	90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use		WAIVED
	90657	Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use		WAIVED
	90658	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use		WAIVED
	90660	Influenza virus vaccine, live, for intranasal use		WAIVED
	90662	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use		WAIVED
	G0008	Administration of influenza virus vaccine		WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	CY 2011 Coins. / Deductible
	G9141	Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family)		WAIVED
	G9142	Influenza A (H1N1) Vaccine, any route of administration		WAIVED
Pneumo-coccal Vaccine	90669	Pneumococcal conjugate vaccine, polyvalent, when administered to children younger than 5 years, for intramuscular use	B	WAIVED
	90670	Pneumococcal conjugate vaccine, 13 valent, for intramuscular use.		WAIVED
	90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use		WAIVED
	G0009	Administration of pneumococcal vaccine		WAIVED
Hepatitis B Vaccine	90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use	A	WAIVED
	90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use		WAIVED
	90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use		WAIVED

Service	CPT/ HCPCS Code	Long Descriptor	USPSTF Rating[1]	CY 2011 Coins. / Deductible
	90746	Hepatitis B vaccine, adult dosage, for intramuscular use		WAIVED
	90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use		WAIVED
	G0010	Administration of hepatitis B vaccine	A	WAIVED
HIV Screening	86689	HTLV or HIV antibody, confirmatory test (eg, Western Blot)	A	WAIVED
	G0432	Infectious agent antigen detection by enzyme immunoassay (EIA) technique, qualitative or semi-qualitative, multiple-step method, HIV-1 or HIV-2, screening		WAIVED
	G0433	Infectious agent antigen detection by enzyme-linked immunosorbent assay (ELISA) technique, antibody, HIV-1 or HIV-2, screening		WAIVED
	G0435	Infectious agent antigen detection by rapid antibody test of oral mucosa transudate, HIV-1 or HIV-2 , screening		WAIVED
Annual Wellness Visit	G0438	Annual wellness visit, including PPPS, first visit	***Not Rated**	WAIVED
	G0439	Annual wellness visit, including PPPS, subsequent visit		WAIVED