Kent J. Moore

YOUR PRACTICE AND YOUR PATIENTS WILL HAPPILY RING IN THESE THREE CHANGES.

New Year, New Medicare Preventive Coverage

Last July, Congress overrode a presidential veto to pass the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). This immediately averted a statutory 10.6-percent reduction in Medicare physician payments. As a side benefit, this law put three improvements in Medicare preventive services coverage into effect on Jan. 1. Here is how these improvements will affect you and your patients. (For a summary of all preventive services covered under Medicare Part B, see page 20.)

Changes to the "Welcome to Medicare" covered services

The list of services covered under the initial preventive physical exam, known as the "Welcome to Medicare" visit, has been modified. Two services were added to the list: measurement of body mass index and end-of-life planning with agreement from the patient. Medicare defines end-of-life planning as verbal or written information regarding the patient's ability to prepare an advance directive and the physician's willingness to follow the individual's wishes as expressed in the advance directive.

Also, the electrocardiogram (ECG) is no longer a required component of the Welcome to Medicare exam. The ECG component is now an educational, counseling and referral service that should be discussed with the patient and ordered by the physician, if necessary.

The *FPM* encounter form for Welcome to Medicare physicals has been updated accordingly; it is available online in the *FPM* Toolbox at http://www.aafp.org/fpm/20060900/medicarepreventiveexam.pdf.

To reflect these changes, the Centers for Medicare & Medicaid Services (CMS) implemented new G codes that replaced codes G0344, G0366, G0367 and G0368, which were used in 2008. Effective Jan. 1, physicians should report the Welcome to Medicare physical and associated ECGs with the following new G codes:

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

You should be aware that some Medicare Advantage plans may not reimburse for these codes because Advantage plans already offer extra benefits, including preventive exams. Be sure to note whether the patient has traditional Medicare or a Medicare Advantage plan before submitting a claim for the Welcome to Medicare visit to prevent your claim from being denied.

You may continue to report a medically necessary evaluation and management (E/M) service furnished at the same encounter as the Welcome to Medicare visit. In this circumstance, modifier 25 should be appended to the E/M service to indicate that it was significant and separately identifiable from the Welcome to Medicare visit. CMS has stated that it does not believe this scenario will be typical and that it will monitor utilization patterns, particularly involving level-IV and level-V services with the Welcome to Medicare visit, so be careful when exercising this opportunity.

Increased accessibility to the "Welcome to Medicare" exam

Under MIPPA, the Welcome to Medicare exam is now more accessible to Medicare patients. The eligibility period for the Welcome to Medicare exam has been extended to the first year of Medicare Part-B enrollment, and although coinsurance continues to apply, the deductible does not. Previously, eligibility for the Welcome to Medicare visit was limited to the first six months of Medicare Part-B enrollment and was subject to both the annual deductible and coinsurance.

This means that Medicare patients have an additional six months to take advantage of this benefit, and they may incur fewer out-of-pocket expenses. ➤

Easier coverage of additional preventive services

MIPPA also has the potential to expand the list of Medicare-covered preventive services without legislative approval. The law states that coverage of "additional preventive services" can be added through existing Medicare coverage rules. This change should make preventive-service coverage easier to obtain and could potentially grow the list of covered services. Previously, gaining Medicare coverage of a particular preventive service required a change in the law.

For the purpose of this provision, "additional preventive services" are services not otherwise described in Medicare law that identify medical conditions or risk factors and that the U.S. Department of Health and Human Services determines meet these conditions:

1. They are reasonable and necessary for the prevention or early detection of an illness or disability;
2. They are recommended with a grade of A (strongly recommended) or B (recommended) by the U.S. Preventive Services Task Force (USPSTF);
3. They are appropriate for individuals entitled to

MEDICARE PREVENTIVE SERVICES: A SUMMARY OF THE PART B COVERED SERVICES FOR 2009

Service	Who and what is eligible?
Bone mass measurement	People with Medicare who are at risk for osteoporosis.
Cardiovascular disease screening	All people with Medicare Part B.
Colorectal cancer screening	People with Medicare who are age 50 or older, with two exceptions: 1) there is no minimum age for screening colonoscopy, and 2) those with a high risk of developing colorectal cancer are eligible for barium enema screening, regardless of age.
Diabetes screening	People with Medicare who have high blood pressure, dyslipidemia, obesity, history of high blood sugar or two of the following characteristics: age 65 or older, overweight, family history of diabetes, or a history of gestational diabetes or delivery of a baby weighing more than 9 pounds. A fasting blood glucose test and a glucose challenge test or a two-hour glucose challenge test alone may be given.
Diabetes self-management training (DSMT)	Medicare beneficiaries at risk for complications from diabetes, recently diagnosed with diabetes or previously diagnosed with diabetes. Physician must certify that DSMT is needed.
Flu shot	All people with Medicare.
Glaucoma test	People with Medicare who have diabetes, have a family history of glaucoma, are African-American age 50 or older, or are Hispanic-American age 65 or over.
Hepatitis-B shot	People with Medicare who are at medium to high risk.
Initial preventive physical examination (IPPE, also known as the "Welcome to Medicare" physical exam)	All new enrollees in Medicare Part B.
Mammogram	Women with Medicare who are age 40 or older. Women with Medicare who are age 35 to 39.
Medical nutrition therapy (MNT)	People with Medicare who have been diagnosed with diabetes or a renal disease.
Pap test and pelvic screening exam	All women with Medicare.
Pneumococcal shot	All people with Medicare.
Prostate cancer screening	All men with Medicare who are age 50 or older.
Smoking and tobacco-use cessation counseling	People with Medicare 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.
Ultrasound screening for abdominal aortic aneurysm (AAA)	Medicare beneficiaries with certain risk factors for AAA. Note: Eligible beneficiaries must receive a referral for an ultrasound screening for AAA as a result of their IPPE.

Medicare Part A or enrolled in Medicare Part B.

For a list of preventive services recommended by the USPSTF, see http://www.ahrq.gov/clinic/pocketgd.htm. CMS began accepting requests for preventive service coverage determinations on Jan. 1. For an overview of the Medicare coverage determination process, including how to request a coverage determination, see http://www.cms.hhs.gov/determinationprocess/.

Medicare coverage of preventive services has not yet reached its potential, but thanks to MIPPA it will make a few positive strides in 2009. FPM

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	How often can a Medicare beneficiary get this service?	Is it subject to coinsurance or deductible?
	Every 24 months (more often if medically necessary).	Coinsurance and deductible apply.
	Every 60 months.	No coinsurance or deductible.
	Fecal occult blood test – every 12 months; Flexible sigmoidoscopy – every 48 months (or 10 years following a screening colonoscopy); Screening colonoscopy – every 24 months if the patient is at high risk; every 10 years if the patient is not at high risk and it has been at least 48 months since a flexible sigmoidoscopy was performed; Barium enema (as an alternative to flexible sigmoidoscopy or colonoscopy) – every 24 months if the patient is at high risk; every 48 months if the patient is not at high risk.	No coinsurance or deductible for fecal occult blood tests. Coinsurance applies for flexible sigmoidoscopy, colonoscopy and barium enema screening; no deductible.
	• One screening per year if the patient has never been tested or if the patient was previously tested but not diagnosed with pre-diabetes. • Two screenings per year, at least six months apart, if the patient is diagnosed with pre-diabetes.	No coinsurance or deductible.
	• Up to 10 hours of initial training within a continuous 12-month period. • Subsequent years: up to two hours of follow-up training each subsequent year.	Coinsurance and deductible apply.
	Once a flu season, or more frequently if medically necessary.	No coinsurance or deductible.
	Every 12 months.	Coinsurance and deductible apply.
	One series if ordered by a doctor.	Coinsurance and deductible apply.
	One time only, within the first year the patient has Medicare Part B. (Before 2009, patients had six months to use this service.) Note: Do not duplicate this service for patients who have previously completed an IPPE.	Coinsurance applies; no deductible. (Before 2009, this service was subject to a deductible and coinsurance.)
	Every 12 months. One baseline mammogram.	Coinsurance applies; no deductible.
	• First year: three hours of one-on-one counseling. • Subsequent years: two hours.	Coinsurance and deductible apply.
	• Every 24 months. • Every 12 months if the patient is high-risk or if she is of childbearing age and has had an abnormal Pap test in the past 36 months.	Coinsurance applies, but there is no deductible for the pelvic exam. Beneficiary pays nothing for the lab analysis.
	Once in a lifetime.	No coinsurance or deductible.
	Every 12 months for digital rectal exam (DRE) and prostate-specific antigen (PSA) test.	Coinsurance and deductible apply for DRE. The DRE is reimbursable when provided with a noncovered service, such as an annual physical. No coinsurance or deductible for PSA test.
	Two cessation attempts per year; each attempt includes a maximum of four intermediate or intensive sessions, up to eight sessions in a 12-month period.	Coinsurance and deductible apply.
	Once in a lifetime.	Coinsurance applies; no deductible.