Telehealth Eligable

(https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf)

Alcohol Misuse Screening & Counseling (NCD 210.8 (https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=347&ncdver=1&bc=AgAAgAAAAAAA&))

Also known as **Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse**

HCPCS & CPT Codes

G0442 — Annual alcohol misuse screening, 15 minutes

G0443 — Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes

What's Changed?

- No changes from the last quarter

ICD-10 Codes

Note: Additional ICD-10 codes may apply. Find individual Change Requests (CRs) and specific ICD-10-CM service codes that we cover on the CMS ICD-10 (https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10) webpage. Find your MAC's website (https://www.cms.gov/MAC-info) for more information.

Medicare Covers

Patients with Medicare Part B who:

- Screen positive (misuse alcohol but levels or alcohol consumption patterns don't meet alcohol dependence criteria)
- Are competent and alert when counseling is delivered
- Get qualified primary care physician or other primary care practitioner counseling in a primary care setting

Frequency

- Annually (G0442 screening)
- If they screen positive for misuse, 4 times per year (G0443 counseling)

Note: See FAQ on how to check eligibility (#FAQ).

Patient Pays

- No copayment, coinsurance, or deductible

Telehealth Eligable

(https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf)

Annual Wellness Visit (AWV)

HCPCS & CPT Codes

G0438 — Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit

G0439 — Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit

What's Changed?

- No changes from the last quarter

G0468 — Federally qualified health center (fqhc) visit, ippe or awv; a fqhc visit that includes an initial preventive physical examination (ippe) or annual wellness visit (awv) and includes a typical bundle of medicare-covered services that would be furnished per diem to a patient receiving an ippe or awv

99497 — Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

99498 — Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)

ICD-10 Codes

Note: Additional ICD-10 codes may apply. Find individual Change Requests (CRs) and specific ICD-10-CM service codes that we cover on the CMS ICD-10 (https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10) webpage. Find your MAC's website (https://www.cms.gov/MAC-info) for more information.

Medicare Covers

Patients with Medicare Part B who:

- Aren't within 12 months after effective date of their first Medicare Part B coverage period
- Haven't had an Initial Preventive Physical Exam (IPPE) or AWV within the past 12 months

Frequency

- Once per lifetime G0438 (first AWV)
- Annually G0439 (subsequent AWV) and G0468 (AWV in FQHC)
- Annually optional 99497, 99498

Note: See FAQ on how to check eligibility (#FAQ).

Patient Pays

G0438 and G0439:

- No copayment, coinsurance, or deductible

G0468:

- You must provide AWV or IPPE with a standard bundle of services available to all patients; get more information at section 60.2 of Medicare Claims Processing Manual, Chapter 9 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf#page=15)
- No copayment, coinsurance, or deductible

99497 and 99498:

- No copayment, coinsurance, or deductible for Advance Care Planning when provided as optional AWV element
  - Bill using modifier –33 (Preventive Service) on same AWV claim
  - Must deliver on same day by same AWV provider

Other Notes

- Advance Care Planning (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf) is an optional preventive service when provided with an AWV.
  - You may deliver Advance Care Planning (ACP) outside the AWV multiple times in a year. You must document a patient's health change for each additional ACP service in a year.
  - Deductible and coinsurance (https://www.medicare.gov/your-medicare-costs/medicare-costs-at-a-glance) apply when delivering ACP outside an AWV.
- Medicare Wellness Visits (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html) educational tool has more information.

Bone Mass Measurements (NCD 150.3 (https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=256))

Also known as **Bone (Mineral) Density Studies**

HCPCS & CPT Codes

76977 — Ultrasound bone density measurement and interpretation, peripheral site(s), any method

77078 — Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)

What's Changed?

- No changes from the last quarter

77080 — Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)

77081 — Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)

77085 — Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine), including vertebral fracture assessment

G0130 — Single energy x-ray absorptiometry (sexa) bone density study, 1 or more sites, appendicular skeleton (peripheral) (e.g., radius, wrist, heel)

ICD-10 Codes

- E21.0, E21.3, E23.0, E34.2, E89.40, E89.41, M80.08xA, M80.88xA, M84.58xA, M84.68xA, N95.8, N95.9, Q78.0, S34.3xxA, Z78.0, Z79.3, Z79.51, Z79.52, Z79.811, Z79.818, Z79.83, Z87.310

Notes:

- Additionally, you may use the specific ICD-10 codes listed above or more specific codes from these ICD-10 categories or subcategories: E24, E28.3, M48, M81, M85.8 (codes for unspecified body parts excluded), Q96, S12, S14, S22, S24, S32.0, S32.1, S32.2, S34.1.
- Additional ICD-10 codes may apply. Find individual Change Requests (CRs) and specific ICD-10-CM service codes that we cover on the CMS ICD-10 (https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10) webpage. Find your MAC's website (https://www.cms.gov/MAC-info) for more information.

Medicare Covers

Patients with Medicare Part B who meet at least 1 of these criteria:

- Women whose physician or qualified practitioner determines them estrogen-deficient and at clinical osteoporosis risk
- Individuals with vertebral abnormalities
- Individuals getting (or expecting to get) glucocorticoid therapy for more than 3 months
- Individuals with primary hyperparathyroidism
- Individuals monitored to assess FDA-approved osteoporosis drug therapy response

Frequency

- Every 2 years
- More frequently if medically necessary

Note: See FAQ on how to check eligibility (#FAQ).

Patient Pays

- No copayment, coinsurance, or deductible

Other Notes

- Don't report 77080 with 77085 or 77086. We don’t cover 77086 for this service.
- When coding 77085 and 77081 together, attach modifier –XU (Unusual non-overlapping service, a distinct service because it doesn’t overlap usual components of the main service) to 77081 to bypass Correct Coding Initiative edit.
- When coding 77080 and 77081 together, attach modifier –XU (Unusual non-overlapping service, a distinct service because it doesn’t overlap usual components of the main service) to 77080.

Cardiovascular Disease Screening Tests

HCPCS & CPT Codes

80061 — Lipid panel: this panel must include:

- **82465 —** Cholesterol, serum, total
- **83718 —** Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol)
- **84478 —** Triglycerides

What's Changed?

- No changes from the last quarter

ICD-10 Codes

- Z13.6

Note: Additional ICD-10 codes may apply. Find individual Change Requests (CRs) and specific ICD-10-CM service codes that we cover on the CMS ICD-10 (https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10) webpage. Find your MAC's website (https://www.cms.gov/MAC-info) for more information.

Medicare Covers

- Patients with Medicare Part B without apparent cardiovascular disease signs or symptoms

Frequency

- Once every 5 years

Note: See FAQ on how to check eligibility (#FAQ).

Patient Pays

- No copayment, coinsurance, or deductible

Colorectal Cancer Screening Tests (NCD 210.3

(https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?

NCDId=281&ncdver=3&CoverageSelection=National&bc=gAAAACAAAAAA&)

HCPCS & CPT Codes

What's Changed?

- No changes from the last quarter

00812 — Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy

81528 — Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result

82270 — Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided 3 cards or single triple card for consecutive collection)

G0104 — Colorectal cancer screening; flexible sigmoidoscopy

G0105 — Colorectal cancer screening; colonoscopy on individual at high risk

G0106 — Colorectal cancer screening; alternative to g0104, screening sigmoidoscopy, barium enema

G0120 — Colorectal cancer screening; alternative to g0105, screening colonoscopy, barium enema

G0121 — Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk

G0327 — Colorectal cancer screening; blood-based biomarker

G0328 — Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous

ICD-10 Codes

- Z86.004
  - For multitarget stool DNA (MT-sDNA) and blood-based biomarker tests, use Z12.11 and Z12.12

Note: Additional ICD-10 codes may apply. Find individual Change Requests (CRs) and specific ICD-10-CM service codes that we cover on the CMS ICD-10 (https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10) webpage. Find your MAC's website (https://www.cms.gov/MAC-info) for more information.

Medicare Covers

Colorectal cancer screening using MT-sDNA and blood-based biomarker tests:

Patients with Medicare Part B who meet these criteria:

- Aged 50–85 years
- Asymptomatic
- At average colorectal cancer risk

Screening colonoscopies, Fecal Occult Blood Tests (FOBTs), flexible sigmoidoscopies, and barium enemas:

Patients with Medicare Part B who meet at least 1 criteria:

- Aged 50 and older at normal colorectal cancer risk (there's no minimum age requirement for screening colonoscopies)
- At high colorectal cancer risk (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-410/subpart-B/section-410.37#p-410.37(a)(3))

Frequency

Table 1. Patients Not Meeting High-Risk Criteria

Service	Timeframe
MT-sDNA and blood-based biomarker tests	Once every 3 years
Screening FOBT	Once every 12 months
Screening flexible sigmoidoscopy	Once every 48 months (unless the patient doesn't meet high-risk colorectal cancer criteria and had a screening colonoscopy within the preceding 10 years. If so, we may cover a screening flexible sigmoidoscopy only after at least 119 months passed following the month the patient got the screening colonoscopy).
Screening colonoscopy	Once every 120 months (10 years) or 48 months after a previous sigmoidoscopy
Screening barium enema (when used instead of a flexible sigmoidoscopy or colonoscopy)	Once every 48 months

Table 2. High-Risk Patients

Service	Timeframe
Screening FOBT	Once every 12 months
Screening flexible sigmoidoscopy	Once every 48 months
Screening colonoscopy	Once every 24 months (unless patient got a screening flexible sigmoidoscopy and then we may cover a screening colonoscopy only after at least 47 months)
Screening barium enema (when used instead of a flexible sigmoidoscopy or colonoscopy)	Once every 24 months

Note: See FAQ on how to check eligibility (#FAQ).

Patient Pays

00812, 81528, 82270, G0104, G0105, G0121, G0327, and G0328:

- No copayment, coinsurance, or deductible

G0106 and G0120:

- Copayment or coinsurance apply (https://www.medicare.gov/your-medicare-costs/medicare-costs-at-a-glance)
- No deductible

No deductible applies for all surgical procedures (CPT code range 10000–69999) provided on the same date and in the same encounter as a screening colonoscopy, flexible sigmoidoscopy, or barium enema initiated as colorectal cancer screening services.

Append modifier –PT to CPT code in the 10000–69999 surgical range in this scenario.

Other Notes

- Append modifier –33 (Preventive Service) to anesthesia CPT code 00812 when you supply a separately payable anesthesia service with a screening colonoscopy (G0105 and G0121) to eliminate patient copayment, coinsurance, and deductible.
- When a screening colonoscopy becomes a diagnostic colonoscopy, report anesthesia services with CPT code 00811 (Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified) with only the –PT modifier; we don't charge the deductible. Report this with 00812.
- We waive coinsurance and deductible for moderate sedation services (reported with G0500 or 99153) when provided with and in support of a screening colonoscopy service and when reported with modifier –33. When a screening colonoscopy becomes a diagnostic colonoscopy, report moderate sedation services (G0500 or 99153) with only the –PT modifier; we don't charge the deductible.

Telehealth Eligable

(https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf)

Counseling to Prevent Tobacco Use (NCD 210.4.1 (https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=342&ncdver=2&bc=AgAAQAAAAAAA&))

HCPCS & CPT Codes

99406 — Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes

99407 — Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

What's Changed?

- No changes from the last quarter

ICD-10 Codes

- F17.210, F17.211, F17.213, F17.218, F17.219, F17.220, F17.221, F17.223, F17.228, F17.229, F17.290, F17.291, F17.293, F17.298, F17.299, T65.211A, T65.212A, T65.213A, T65.214A, T65.221A, T65.222A, T65.223A, T65.224A, T65.291A, T65.292A, T65.293A, T65.294A, Z87.891

Note: Additional ICD-10 codes may apply. Find individual Change Requests (CRs) and specific ICD-10-CM service codes that we cover on the CMS ICD-10 (https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10) webpage. Find your MAC's website (https://www.cms.gov/MAC-info) for more information.

Medicare Covers

Outpatient and hospitalized patients with Medicare Part B who meet these criteria:

- Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease
- Competent and alert when counseling is delivered
- Counseling is provided by qualified physician or other Medicare-recognized practitioner

Frequency

- 2 cessation attempts per year
  - Each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year

Note: See FAQ on how to check eligibility (#FAQ).

Patient Pays

- No copayment, coinsurance, or deductible

Telehealth Eligable

(https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf)

Depression Screening (NCD 210.9 (https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=346&ncdver=1&bc=AAAAQAAAAAAA&))

Also known as **Screening for Depression in Adults**

HCPCS & CPT Codes

G0444 — Annual depression screening, 15 minutes

What's Changed?

- No changes from the last quarter

ICD-10 Codes

Note: Additional ICD-10 codes may apply. Find individual Change Requests (CRs) and specific ICD-10-CM service codes that we cover on the CMS ICD-10 (https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10) webpage. Find your MAC's website (https://www.cms.gov/MAC-info) for more information.

Medicare Covers

- Patients with Medicare Part B

Frequency

- Annually

Note: See FAQ on how to check eligibility (#FAQ).

Patient Pays

- No copayment, coinsurance, or deductible

Other Notes

- You must deliver the screening in primary care settings with staff-assisted depression care supports in place to ensure accurate diagnosis, effective treatment, and follow-up

Diabetes Screening

HCPCS & CPT Codes

82947 — Glucose; quantitative, blood (except reagent strip)

82950 — Glucose; post glucose dose (includes glucose)

82951 — Glucose; tolerance test (GTT), 3 specimens (includes glucose)

What's Changed?

- No changes from the last quarter

ICD-10 Codes

- Z13.1

Note: Additional ICD-10 codes may apply. Find individual Change Requests (CRs) and specific ICD-10-CM service codes that we cover on the CMS ICD-10 (https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10) webpage. Find your MAC's website (https://www.cms.gov/MAC-info) for more information.

Medicare Covers

- Patients with Medicare Part B with certain diabetes risk factors or diagnosed with pre-diabetes

Note: Patients previously diagnosed with diabetes aren't eligible for this benefit.

Frequency

- 1 screening every 6 months for patients diagnosed with pre-diabetes
- 1 screening every 12 months if previously tested but not diagnosed with pre-diabetes or if never tested

Note: See FAQ on how to check eligibility (#FAQ).

Patient Pays

- No copayment, coinsurance, or deductible

Other Notes

- Append modifier –TS (Follow-up service) when patients meet the pre-diabetes definition.
- We pay ordering providers' and Durable Medical Equipment (DME) suppliers' DME claims when they're actively enrolled in Medicare on the service date or, in the case of the provider, has a valid opt-out affidavit on file. If you don't participate in Medicare, tell your patients before you order DME.

Telehealth Eligable

(https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf)

Diabetes Self-Management Training (DSMT) (NCD 40.1 (https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=251&ncdver=1&bc=AAAAQAAAAAAA&))

HCPCS & CPT Codes

G0108 — Diabetes outpatient self-management training services, individual, per 30 minutes

G0109 — Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes

What's Changed?

- No changes from the last quarter

ICD-10 Codes

Note: Additional ICD-10 codes may apply. Find individual Change Requests (CRs) and specific ICD-10-CM service codes that we cover on the CMS ICD-10 (https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10) webpage. Find your MAC's website (https://www.cms.gov/MAC-info) for more information.

Medicare Covers

Certain patients with Medicare Part B who meet these criteria:

- Diagnosed with diabetes
- Got treating physician's or qualified practitioner's DSMT patient order

Frequency

- **Initial year:** Up to 10 hours initial training within a continuous 12-month period
- **Subsequent years:** Up to 2 hours follow-up training each calendar year after completing the initial 10 hours

Note: See FAQ on how to check eligibility (#FAQ).

Patient Pays

- Copayment or coinsurance, and deductible apply (https://www.medicare.gov/your-medicare-costs/medicare-costs-at-a-glance)

Other Notes

- Provider Compliance Tips: Glucose Monitors and Diabetic Accessories & Supplies (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/medicare-provider-compliance-tips/medicare-provider-compliance-tips.html#DiabeticAccessories) educational tool has more information
- You can't bill DSMT and Medical Nutrition Therapy (MNT) for the same patient on the same service date, or incident to a physician's or NPP's professional services
- DSMT Accreditation Program (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/DSMT-Accreditation-Program) webpage has information on accreditation
- Get information at Diabetes Disparities in Medicare Fee-for-Service Beneficiaries (https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Data-Snapshots-Diabetes.pdf)

Flu Shot & Administration

HCPCS & CPT Codes

Find the most current flu season list of billing codes, payment allowances, and effective dates on the Seasonal Influenza Vaccines Pricing (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing) webpage.

What's Changed?

- No changes from the last quarter

G0008 — Administration of influenza virus vaccine

90662 — Influenza virus vaccine (IIV), split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use

90672 — Influenza virus vaccine, quadrivalent, live (LAIV4), for intranasal use

90674 — Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use

90682 — Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use

90685 — Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.25 mL dosage, for intramuscular use

90686 — Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use

90687 — Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.25 mL dosage, for intramuscular use

90688 — Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.5 mL dosage, for intramuscular use

90694 — Influenza virus vaccine, quadrivalent (aIIV4), inactivated, adjuvanted, preservative free, 0.5 mL dosage, for intramuscular use

90756 — Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5 mL dosage, for intramuscular use

Q2039 — Influenza virus vaccine, not otherwise specified

ICD-10 Codes

- Z23

Note: Additional ICD-10 codes may apply. Find individual Change Requests (CRs) and specific ICD-10-CM service codes that we cover on the CMS ICD-10 (https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10) webpage. Find your MAC's website (https://www.cms.gov/MAC-info) for more information.

Medicare Covers

- Patients with Medicare Part B

Frequency

- Once per flu season
- We cover additional flu shots if medically necessary

Note: See FAQ on how to check eligibility (#FAQ).

Patient Pays

- No copayment, coinsurance, or deductible

Other Notes

- Medicare hospice providers may bill flu shot services on institutional claims
- CMS Flu Shot (https://www.cms.gov/flu-provider) and CDC Seasonal Influenza Vaccination Resources for Health Professionals (https://www.cdc.gov/flu/professionals/vaccination/index.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fflu%2Fseason%2Fhealth-care-professionals.htm) webpages have more information

Glaucoma Screening

HCPCS & CPT Codes

G0117 — Glaucoma screening for high risk patients furnished by an optometrist or ophthalmologist

G0118 — Glaucoma screening for high risk patient furnished under the direct supervision of an optometrist or ophthalmologist

What's Changed?

- No changes from the last quarter

ICD-10 Codes

- Z13.5

Note: Additional ICD-10 codes may apply. Find individual Change Requests (CRs) and specific ICD-10-CM service codes that we cover on the CMS ICD-10 (https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10) webpage. Find your MAC's website (https://www.cms.gov/MAC-info) for more information.

Medicare Covers

Patients with Medicare Part B who meet at least 1 high-risk criteria:

- Individuals with diabetes mellitus
- Individuals with glaucoma in family history
- Black or African-Americans aged 50 and older
- Hispanics or Latinos aged 65 and older

Frequency

- Annually

Note: See FAQ on how to check eligibility (#FAQ).

Patient Pays

- Copayment or coinsurance, and deductible apply (https://www.medicare.gov/your-medicare-costs/medicare-costs-at-a-glance)

Hepatitis B Screening (NCD 210.6 (https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=369&ncdver=1&bc=AAAAgAAAAAAAAA))

Also known as **Screening for Hepatitis B Virus (HBV) Infection**

HCPCS & CPT Codes

Asymptomatic, Non-Pregnant Adolescents and High-Risk Adults

G0499 — Hepatitis b screening in non-pregnant, high risk individual includes hepatitis b surface antigen (hbsag) followed by a neutralizing confirmatory test for initially reactive results, and antibodies to hbsag (anti-hbs) and hepatitis b core antigen (anti-hbc)

What's Changed?

- No changes from the last quarter

For Pregnant Women

86704 — Hepatitis B core antibody (HBcAb); total

86706 — Hepatitis B surface antibody (HBsAb)

87340 — Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; hepatitis B surface antigen (HBsAg)

87341 — Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; hepatitis B surface antigen (HBsAg) neutralization

ICD-10 Codes

Table 3. ICD-10 Codes by Patient Condition

Condition	ICD-10 Codes
Persons With ESRD	Z11.59 **and** N18.6
Asymptomatic, Non-Pregnant Adolescents and High-Risk Adults	Z11.59 **and** Z72.89
Asymptomatic, Non-Pregnant Adolescents and Adults, Subsequent Visits	Z11.59 **and 1 of these**: F11.10, F11.11, F11.13, F13.10, F13.11, F13.130, F13.131, F13.132, F14.10, F14.11, F14.13, F14.93, F15.10, F15.11, F15.13, Z20.2, Z20.5, Z72.52, Z72.53
Pregnant Women	Z11.59 **and 1 of these**: Z34.00, Z34.80, Z34.90, O09.90
High-Risk Pregnant Women	Z11.59 **and** Z72.89 **and 1 of these**: Z34.00, Z34.01, Z34.02, Z34.03, Z34.80, Z34.81, Z34.82, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93, O09.90, O09.91, O09.92, O09.93

Note: Additional ICD-10 codes may apply. Find individual Change Requests (CRs) and specific ICD-10-CM service codes that we cover on the CMS ICD-10 (https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10) webpage. Find your MAC's website (https://www.cms.gov/MAC-info) for more information.

Medicare Covers

Certain patients with Medicare Part B who meet any criteria:

- High-risk (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf#page=16), asymptomatic, non-pregnant adolescents and adults
- Pregnant women

Frequency

- 1 asymptomatic screening for non-pregnant adolescents and adults who meet high-risk definition
- Annually for those with continued high risk who don't get HBV
- 1 screening for pregnant women at first prenatal visit for each pregnancy, and rescreening at delivery for those with new or continued risk factors

Notes:

- This includes screening during the first prenatal visit for future pregnancies, even if the patient previously got the HBV shot or had a negative hepatitis B surface antigen screening result
- See FAQ on how to check eligibility (#FAQ)

Patients Pays

- No copayment, coinsurance, or deductible

Hepatitis B Shot & Administration

HCPCS & CPT Codes

G0010 — Administration of hepatitis b vaccine

90739 — Hepatitis B vaccine (HepB), adult dosage, 2 dose schedule, for intramuscular use

90740 — Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 3 dose schedule, for intramuscular use

What's Changed?

- Added CPT code 90759, effective January 11, 2022

90743 — Hepatitis B vaccine (HepB), adolescent, 2 dose schedule, for intramuscular use

90744 — Hepatitis B vaccine (HepB), pediatric/adolescent dosage, 3 dose schedule, for intramuscular use

90746 — Hepatitis B vaccine (HepB), adult dosage, 3 dose schedule, for intramuscular use

90747 — Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 4 dose schedule, for intramuscular use

90759 — Hepatitis B vaccine (HepB), 3-antigen (S, Pre-S1, Pre-S2), 10 mcg dosage, 3-dose schedule, for intramuscular use

ICD-10 Codes

- Z23

Note: Additional ICD-10 codes may apply. Find individual Change Requests (CRs) and specific ICD-10-CM service codes that we cover on the CMS ICD-10 (https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10) webpage. Find your MAC's website (https://www.cms.gov/MAC-info) for more information.

Medicare Covers

- Certain patients with Medicare Part B at intermediate or high risk (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf#page=63) for contracting hepatitis B

Note: Patients currently positive for hepatitis B antibodies aren't eligible for this benefit.

Frequency

- 2, 3, or 4 doses depending on vaccine or condition

Note: See FAQ on how to check eligibility (#FAQ).

Patient Pays

- No copayment, coinsurance, or deductible

Hepatitis C Screening (NCD 210.13 (https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=361&ncdver=1&bc=AAAAgAAAAAAA&))

Also known as **Screening for Hepatitis C Virus (HCV) in Adults**

HCPCS & CPT Codes

G0472 — Hepatitis c antibody screening, for individual at high risk and other covered indication(s)

What's Changed?

- No changes from the last quarter

ICD-10 Codes

- Z72.89, F19.20

Note: Additional ICD-10 codes may apply. Find individual Change Requests (CRs) and specific ICD-10-CM service codes that we cover on the CMS ICD-10 (https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10) webpage. Find your MAC's website (https://www.cms.gov/MAC-info) for more information.

Medicare Covers

Certain adult patients with Medicare Part B who meet at least 1 of these criteria:

- High risk (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf#page=33) for HCV infection
- Born from 1945–1965
- Had a blood transfusion before 1992

Frequency

- Once for patients born from 1945–1965 not considered high risk (use ICD-10 Z11.59)
- An initial patient screening, regardless of birth year, for high-risk patients (patients who had a blood transfusion before 1992 and patients with current or history of illicit injection drug use)
- Annually only for high-risk patients with continued illicit injection drug use since the prior negative HCV screening test

Note: See FAQ on how to check eligibility (#FAQ).

Patient Pays

- No copayment, coinsurance, or deductible

Human Immunodeficiency Virus (HIV) Screening (NCD 210.7 (https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=335&ncdver=2&bc=AAAAgAAAAAAA&))

HCPCS & CPT Codes

80081 — Obstetric panel (includes HIV testing)

G0432 — Infectious agent antibody detection by enzyme immunoassay (eia) technique, hiv-1 and/or hiv-2, screening

G0433 — Infectious agent antibody detection by enzyme-linked immunosorbent assay (elisa) technique, hiv-1 and/or hiv-2, screening

G0435 — Infectious agent antibody detection by rapid antibody test, hiv-1 and/or hiv-2, screening

G0475 — Hiv antigen/antibody, combination assay, screening

What's Changed?

- No changes from the last quarter

ICD-10 Codes

- **Increased risk factors not reported:** Z11.4
- **Increased risk factors reported:** Z11.4 and Z72.51, Z72.52, Z72.53, or Z72.89
- **Pregnant patients:** Z11.4 and Z34.00, Z34.01, Z34.02, Z34.03, Z34.80, Z34.81, Z34.82, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93, O09.90, O09.91, O09.92, or O09.93

Note: Additional ICD-10 codes may apply. Find individual Change Requests (CRs) and specific ICD-10-CM service codes that we cover on the CMS ICD-10 (https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10) webpage. Find your MAC's website (https://www.cms.gov/MAC-info) for more information.

Medicare Covers

- Certain patients with Medicare Part B without regard to perceived risk or at increased HIV risk (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf#page=19), including anyone who asks for the test or pregnant women

Frequency

- Annually for patients ages 15–65 without regard to perceived risk
- Annually for patients younger than 15 and adults older than 65 at increased HIV risk
- For pregnant patients, 3 times per pregnancy:
  1. When diagnosed as pregnant
  2. During third trimester
  3. At labor, if their clinician orders it

Note: See FAQ on how to check eligibility (#FAQ).

Patient Pays

- No copayment, coinsurance, or deductible

Initial Preventive Physical Exam (IPPE)

Also known as the **"Welcome to Medicare" Preventive Visit**

HCPCS & CPT 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 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination

G0405 — Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination

G0468 — Federally qualified health center (fqhc) visit, ippe or awv; a fqhc visit that includes an initial preventive physical examination (ippe) or annual wellness visit (awv) and includes a typical bundle of medicare-covered services that would be furnished per diem to a patient receiving an ippe or awv

What's Changed?

- No changes from the last quarter

ICD-10 Codes

Note: Additional ICD-10 codes may apply. Find individual Change Requests (CRs) and specific ICD-10-CM service codes that we cover on the CMS ICD-10 (https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10) webpage. Find your MAC's website (https://www.cms.gov/MAC-info) for more information.

Medicare Covers

- Patients with Medicare Part B once within the first 12 months of their Medicare Part B coverage period

Frequency

- Once per lifetime
- Must occur no later than 12 months after effective date of first Medicare Part B coverage period

Note: See FAQ on how to check eligibility (#FAQ).

Patient Pays

- **G0402:** No copayment, coinsurance, or deductible
- **G0403, G0404, and G0405:** Copayment or coinsurance, and deductible apply (https://www.medicare.gov/your-medicare-costs/medicare-costs-at-a-glance)
- **G0468:** No copayment, coinsurance, or deductible
  - You must offer AWV or IPPE with a standard bundle of services to all patients to use this code; FAQs on Medicare FQHC PPS (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-PPS-FAQs.pdf) (pages 2, 5, & 6) fact sheet has more information

Other Notes

- Medicare Wellness Visits (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html) educational tool has more information