Dear Physicians and Practitioners,

Effective January 1, 2011, due to new provisions mandated by passage of the Affordable Care Act, Medicare will provide 100 percent payment for the Initial Preventive Physical Examination (IPPE), the Annual Wellness Visit (AWV), and preventive services that:

1. Are identified with a grade of A or B by the United States Preventive Services Task Force (USPSTF) for any indication or population
2. Are appropriate for the individual.

Please see the list of Medicare covered preventive services on the PDF link attached.

Thank you,

Senior Provider Outreach
News Flash – As a result of The Affordable Care Act, claims with dates of service on or after January 1, 2010, received later than one calendar year beyond the date of service will be denied by Medicare. For full details, see the MLN Matters® article, MM6960, at http://www.cms.gov/MLNMattersArticles/downloads/MM6960.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

MLN Matters® Number: MM7012 Revised
Related CR Release Date: March 2, 2011
Related CR Transmittal #: R864OTN
Related Change Request (CR) #: 7012
Effective Date: January 1, 2011
Implementation Date: January 3, 2011

Waiver of Coinsurance and Deductible for Preventive Services, Section 4104 of The Affordable Care Act, Removal of Barriers to Preventive Services in Medicare

Note: This article was revised on March 3, 2011, as a result of revisions to CR 7012 made on March 2, 2011. In the article, the CR release date, transmittal number, and the internet address for accessing CR 7012 were revised. All other information remains the same.

Provider Types Affected

This article is for physicians, hospitals, and other providers who submit claims to Medicare Fiscal Intermediaries (FI), carriers, or Medicare Administrative Contractors (A/B MAC) for providing preventive services to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 7012, from which this article is taken, implements the changes in Section 4104 of The Affordable Care Act. The CR announces that (effective for dates of service on or after January 1, 2011) Medicare will provide 100 percent payment (in other words, will waive any coinsurance or copayment) for the Initial Preventive Physical Examination (IPPE), the Annual Wellness Visit (AWV), and for those preventive services that: 1) Are identified with a grade of A or B by the United States Preventive Services Task Force (USPSTF) for any indication or population; and 2) Are appropriate for the individual.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2009 American Medical Association.
**Background**

Sections of The Affordable Care Act amend sections of The Social Security Act to require changes in payment (with respect to deductible and coinsurance/copayment) for identified preventive services. In addition, The Affordable Care Act waives the deductible and coinsurance/copayment for the IPPE and the AWV. The changes apply in all settings in which the services are furnished.

The following preventive services are covered by Medicare:

- Pneumococcal, influenza, and hepatitis B vaccine and administration;
- Screening mammography;
- Screening pap smear and screening pelvic examination;
- Prostate cancer screening tests;
- Colorectal cancer screening tests;
- Diabetes Outpatient Self-Management Training (DSMT);
- Bone mass measurement;
- Screening for glaucoma;
- Medical Nutrition Therapy (MNT) services;
- Cardiovascular screening blood test;
- Diabetes screening tests;
- Ultrasound screening for Abdominal Aortic Aneurysm (AAA); and
- Additional preventive services (identified for coverage through the National Coverage Determination (NCD) process. Currently, these are limited to Human Immunodeficiency Virus (HIV) testing).

**Preventive Services That Do Not Have a USPSTF Grade A or B**

The Affordable Care Act waives the deductible and coinsurance/copayment for many of the preventive services listed above because those services have a recommendation grade of A or B by the USPSTF. In other cases, the deductible and coinsurance are waived because the preventive services are clinical laboratory tests to which the deductible and coinsurance do not apply according to another section of the statute.

Several preventive services covered by Medicare do not have a USPSTF recommendation grade of A or B. These include digital rectal examinations provided as prostate screening tests; glaucoma screening; DSMT services; and barium enemas provided as colorectal cancer screening tests. In the case of a screening barium enema, the deductible is waived under another section of the
statute. The deductible continues to apply to the other services and coinsurance/copayment also continue to apply to all of them.

The table in CR7012 provides a complete list of the Healthcare Common Procedure Coding System (HCPCS) codes that are defined as preventive services under Medicare and also identifies the HCPCS codes for the IPPE and the AWV. CR7012 is available at [http://www.cms.gov/Transmittals/downloads/R864OTN.pdf](http://www.cms.gov/Transmittals/downloads/R864OTN.pdf) Centers for Medicare & Medicaid Services (CMS) website.

**Extension of Waiver of Deductible to Services Furnished in Connection with or in Relation to a Colorectal Screening Test that Becomes Diagnostic or Therapeutic**

The Affordable Care Act waives the Part B deductible for colorectal cancer screening tests that become diagnostic. The Medicare policy is that the deductible is waived for all surgical procedures (Current Procedural Terminology (CPT) code range of 10000 to 69999) furnished on the same date and in the same encounter as a colonoscopy, flexible sigmoidoscopy, or barium enema that were initiated as colorectal cancer screening services. Modifier “PT” has been created effective January 1, 2011 and providers and practitioners should append the modifier “PT” to a least one CPT code in the surgical range of 10000 to 69999 on a claim for services furnished in this scenario.

**Additional Information**


If you have any questions, please contact your FI, carrier, or A/B MAC at their toll-free number, which may be found at [http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip](http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip) on the CMS website.

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