Preventive services/screenings

Medicare pays for a full range of preventive services and screenings.

CMS recognizes the crucial role that health care professionals play in promoting, providing, and educating Medicare patients about potentially life-saving preventive services and screenings.

CMS developed an interactive [Preventive Services Chart](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html) to assist the health care community as part of a comprehensive provider education program on preventive services and screenings covered by Medicare. This educational tool includes HCPCS/ CPT codes; diagnosis codes; coverage requirements; frequency requirements; and beneficiary liability for each Medicare preventive service.

[Advanced care planning (ACP)](https://www.cms.gov/files/document/mln909289-advance-care-planning.pdf)

ACP is a separate Part B service that enables Medicare patients to make important decisions over the type of care they receive and when they receive it.

ACP services may be billed by physicians and non-physician practitioners (NPPs) whose scope of practice and Medicare benefit category include the services described by the CPT codes.

ACP services may also be billed by hospitals.

There are no place-of-service limitations on the new ACP codes. ACP services can be appropriately furnished in both facility and non-facility settings and are not limited to particular physician specialties.

HCPCS/CPT codes

* 99497 – ACP including explanation and discussion of advance directives (first 30 minutes)
* 99498 – each additional 30 minutes, list separately in addition to code for primary procedure

Note: This is an add-on code; therefore, payment for the service is unconditionally packaged (assigned status indicator ‘‘N’’) under OPPS.

Frequency

* No set frequency guidelines
* When the service is billed multiple times for a patient, we would expect to see a documented change in the patient’s health status and/or wishes regarding end-of-life care.

Deductible and coinsurance

* Waived when billed with annual wellness visit (AWV) (code G0438 or G0439) on the same claim, same day and furnished by the same provider.
* Waived for ACP once per year.

Notes

* Payment for an AWV is limited to once per year.
* Add modifier 33 if billed along with AWV.
* If the AWV billed with ACP is denied for exceeding the once per year limit, the deductible and coinsurance will be applied to the ACP.
* ACP can be an optional element of initial or subsequent AWV upon agreement with the patient.
* Face-to-face by physician or other qualified health care professional with patient, family members(s) and/or surrogate.
* Voluntary ACP means the face-to-face service between a physician (or other qualified health care professional) and the patient discussing advance directives, with or without completing relevant legal forms.
* An advance directive is a document appointing an agent and/or recording the wishes of a patient pertaining to medical treatment at a future time should the patient lack decisional ability at that time.
* Document time for ACP separately.
* Critical access hospitals (CAHs) may also bill for ACP using type of bill 85X with revenue codes 96X, 97X, and 98X.
* CAH Method II payment is based on the lesser of the actual charge or the facility-specific Medicare physician fee schedule.

References

* CMS IOM [Pub. 100-02, Benefit Policy Manual, Chapter 15, section 280.5.1](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf)
* CMS IOM [Pub. 100-04, Claims Processing Manual, Chapter 18, section 140.8](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf)

[Alcohol misuse screening and counseling](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#ALC_MISUSE)

All Medicare beneficiaries are eligible for alcohol screening.

Medicare beneficiaries are eligible for counseling if they:

* Screen positive (those who misuse alcohol but whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence).
* Are competent and alert at the time counseling is provided.
* Get counseling from qualified primary care physicians or other primary care practitioners in a primary care setting.

HCPCS/CPT code

* G0442 – Annual alcohol misuse screening, 5 to 15 minutes.
* G0443 – Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes (4 times per year for those who screen positive).

Frequency

* Annually for G0442 (screening).
* For those who screen positive, 4 times per year for G0443 (counseling).

Deductible and coinsurance are waived.

References

* CMS IOM [Pub. 100-03, National Coverage Determinations Manual, Chapter 1, Part 4, section 210.8](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf)
* CMS IOM [Pub. 100-04, Claims Processing Manual, Chapter 18, section 180](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf)

[Annual wellness visits (AWV](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html%22%20%5Cl%20%22AWV))

AWV is covered for all Medicare beneficiaries who:

* Are not within 12 months after the effective date of their first Medicare Part B coverage period and
* Have not received an Initial Preventive Physical Examination (IPPE) or AWV within the past 12 months.

What's new

Effective for dates of service (DOS) on and after January 1, 2024, social determinants of health (SDOH) risk assessment has been added as an optional element:

* The billing HCPCS code is G0136.
* Add modifier -33 to an SDOH (HCPCS G0136), performed on the same day as the AWV to waive copayment and deductible.
* Note: Per [MM13486 - Annual Wellness Visit: Social Determinants of Health Risk Assessment](https://www.cms.gov/files/document/mm13486-annual-wellness-visit-social-determinants-health-risk-assessment.pdf), the implementation date for modifier 33, to be billed with G0136, is October 7, 2024.
* G0136 is covered once a year with copayment and deductible waived.

Effective for dates of service (DOS) on and after January 1, 2024 added information about [community health integration](https://www.cms.gov/files/document/mln9201074-health-equity-services-2024-physician-fee-schedule-final-rule.pdf-0) (CHI) initiating visit.

* The AWV can be an optional CHI initiating visit when the provider identifies any unmet SDOH needs that prevent the patient from doing the recommended personalized prevention plan.

HCPCS/CPT codes

* G0438 – Initial visit (once in a lifetime).
* G0439 – Subsequent visit (annually).
* 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 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).

Frequency

* Once in a lifetime for G0438 (first AWV).
* Annually for G0439 (subsequent AWV) and G0468 (AWV in FQHC)
* Annually for optional 99497, 99498.

Deductible and coinsurance for Advance Care Planning is only waived when furnished as an optional element of an AWV, which requires:

* Billing with modifier –33 (Preventive Service) on the same claim as an AWV.
* Furnishing on the same day and by the same provider as the AWV.

Telehealth options: Ways to improve your Medicare patient's access to AWV

* Telehealth has the potential to expand access, reduce costs, and improve patient's health.
* Telehealth (video/audio) can improve access to AWV.
* The CMS [List of Telehealth Services](https://www.cms.gov/medicare/coverage/telehealth/list-services) allows AWV using the telephone only.

Notes

* ACP is treated as an optional preventive service when furnished with an AWV.
* Practitioners may provide advance care planning outside of the AWV multiple times in a year, but the practitioner must document a change in the beneficiary’s health for each additional service in a year. When providing advance care planning outside the AWV, the beneficiary is responsible for the deductible and coinsurance.
* Refer to the [Medicare Wellness Visits booklet](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html) for more information.

References

* CMS IOM [Pub. 100-04, Claims Processing Manual, Chapter 9, section 60.2](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf)
* CMS IOM [Pub. 100-04, Claims Processing Manual, Chapter 18, section 140](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf)
* [MM13486 - Annual Wellness Visits: Social Determinants of Health Risk Assessment](https://www.cms.gov/files/document/mm13486-annual-wellness-visit-social-determinants-health-risk-assessment.pdf)
* [Medicare Wellness Visits booklet](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html)
* [MLN Booklet - Health Equity Services in the 2024 Physician Fee Schedule Final Rule](https://www.cms.gov/files/document/mln9201074-health-equity-services-2024-physician-fee-schedule-final-rule.pdf-0)

[Bone mass measurements](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#BONE_MASS)

Medicare covers bone mass measurements for certain Medicare beneficiaries who fall into at least one of the following categories:

* Women determined by their physician or qualified nonphysician practitioner (NPP) to be estrogen deficient and at clinical risk for osteoporosis.
* Individuals with vertebral abnormalities.
* Individuals getting (or expecting to get) glucocorticoid therapy for more than 3 months.
* Individuals with primary hyperparathyroidism.
* Individuals being monitored to assess response to U.S. Food and Drug Administration (FDA)-approved osteoporosis drug therapy.

HCPCS/CPT codes

* 76977 – Ultrasound bone density measurement and interpretation, peripheral site, any method.
* 77078 – Computed tomography, bone mineral density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine).
* 77080 – Dual-energy X-ray absorptiometry (DEXA), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine).
* 77081 – DEXA, bone density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel).
* G0130 – Single energy X-ray absorptiometry (SEXA) bone density study, 1 or more sites, appendicular skeleton (peripheral) (e.g., radius, wrist, heel).

Frequency

* Every 2 years.
* More frequently if medically necessary.

Notes

* Do not report 77080 with 77085 or 77086. Do not report 77085 with 77080 or 77086. Do not report 77086 with 77080 or 77085. Medicare does not cover 77086 for this service.
* When coding 77085 and 77081 together, attach modifier –XU (Unusual non-overlapping service, the use of a service that is distinct because it does not 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, the use of a service that is distinct because it does not overlap usual components of the main service) to 77080.

Deductible and coinsurance waived.

References

* CMS IOM [Pub. 100-02, Benefit Policy Manual, Chapter 15, section 80.5](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf)
* CMS IOM [Pub. 100-03, National Coverage Determinations Manual, Chapter 1, Part 2, section 150.3](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part2.pdf)
* CMS IOM [Pub. 100-04, Claims Processing Manual, Chapter 13, section 140](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c13.pdf)

[Cardiovascular screening tests](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#CARDIO_DIS)

Medicare covers cardiovascular screening tests for Medicare beneficiaries without apparent signs or symptoms of cardiovascular disease.

References

* CMS IOM [Pub. 100-03, National Coverage Determinations Manual, Chapter 1, Part 4, section 210.11](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf)
* CMS IOM [Pub. 100-04, Claims Processing Manual, Chapter 18, section 100](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf)

[Colorectal cancer screening (CRC)](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html%22%20%5Cl%20%22COLO_CAN)

Effective with dates of service on and after January 1, changes occurred for CRC:

* Reduction in coinsurance when a screening colorectal cancer becomes diagnostic
* Minimum age for colorectal cancer screening tests from 50 to 45
* Colorectal cancer screening tests include a follow-on screening colonoscopy if a non-invasive test returns a positive result.
* Report the KX modifier on colorectal cancer screening tests including a screening colonoscopy (HCPCS codes G0105, G0121) after a non-invasive test (HCPCS codes 82270, G0328 and 81528).
* The KX modifier needs to be reported on the screening colonoscopy claim. Deductible and coinsurance do not apply to the non-invasive tests nor the screening colonoscopy because both tests are specified preventive screening services.

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

* Patients with Medicare Part B who meet these criteria:
* Aged 45–85 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 45 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))

HCPCS/CPT codes

* 00811 - Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified.
* 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 (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided 3 cards or single triple card for consecutive collection).
* 0464U – Oncology (colorectal) screening, quantitative real-time target and signal amplification, methylated DNA markers, including LASS4, LRRC4 and PPP2R5C, a reference marker ZDHHC1, and a protein marker (fecal hemoglobin), utilizing stool, algorithm reported as a positive or negative result (effective October 3, 2024).
* 0537U – Oncology (colorectal cancer), analysis of cell-free DNA for epigenomic patterns, next-generation sequencing, >2500 differentially methylated regions (DMRs), plasma, algorithm reported as positive or negative (effective April 1, 2025).
* 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
* For codes 00812, 81528, 82270, G0104, G0105, G0121, G0327 and G0328, deductible and coinsurance are waived.

For codes G0106 and G0120, deductible is waived, but coinsurance applies.

No deductible applies for all surgical procedures (CPT code range of 10000 to 69999) furnished 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 surgical range of 10000 to 69999 in this scenario.

To indicate a screening colorectal cancer procedure (codes G0104, G0105, or G0121) has become a diagnostic or therapeutic service, add modifier –PT to at least 1 code on the claim, submitted on the line item with codes 10000–69999, G0500, 00811, or 99153 for a diagnostic colonoscopy, diagnostic flexible sigmoidoscopy, or other procedure. The deductible and, for dates of service from January 1, 2023–December 31, 2026, will apply a reduced coinsurance of 15% for all procedure codes identified here that are performed on that date of service and billed on the same claim.

Effective for claims with dates of service on or after January 1, 2023, colorectal cancer screening tests include a screening colonoscopy (HCPCS codes G0105, G0121) after a non-invasive test (HCPCS codes 82270, G0328 and 81528). This scenario shall be identified by including the KX modifier on the screening colonoscopy claim. Deductible and coinsurance do not apply to the non-invasive tests nor the screening colonoscopy because both tests are specified preventive screening services.

Effective January 1, 2023, if the patient initially has a non-invasive screening test (FOBT or MT-sDNA test) and receives a positive result, Medicare also covers a follow-up colonoscopy as a screening test. The patient pays nothing for the screening test(s) if their doctor or other qualified health care provider accepts assignment. The frequency limitations described for screening colonoscopy in the charts below do not apply in this scenario.

Frequency

For beneficiaries not meeting criteria for high risk:

|  |  |
| --- | --- |
| Service | Timeframe |
| MT s-DNA and blood-based biomarker tests | Once every 3 years |
| Screening FOBT | Once every 12 months |
| Screening flexible sigmoidoscopy | Once every 48 months (unless the beneficiary does not meet high-risk colorectal cancer criteria and had a screening colonoscopy within the preceding 10 years, in which case Medicare may cover a screening flexible sigmoidoscopy only after at least 119 months have passed following the month that the beneficiary received 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 |

For beneficiaries at high risk:

|  |  |
| --- | --- |
| Service | Timeframe |
| Screening FOBT | Once every 12 months |
| Screening flexible colonoscopy | Once every 48 months |
| Screening colonoscopy | Once every 24 months (unless a screening flexible sigmoidoscopy has been performed and then Medicare 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 |

Notes

* Anesthesia services furnished in conjunction with and in support of a screening colonoscopy are reported with CPT code 00812 and coinsurance and deductible are waived.
* When a screening colonoscopy becomes a diagnostic colonoscopy, anesthesia services are reported with CPT code 00811 and with the PT modifier; only the deductible is waived.
* Coinsurance and deductible are waived for moderate sedation services (reported with G0500 or 99153) when furnished in conjunction with and in support of a screening colonoscopy service and when reported with modifier 33.
* When a screening colonoscopy becomes a diagnostic colonoscopy, moderate sedation services (G0500 or 99153) are reported with only the PT modifier; only the deductible is waived.

References

* CMS IOM [Pub. 100-03, National Coverage Determination Manual, Chapter 1, Part 4, section 210.3](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf)
* CMS IOM [Pub. 100-04, Claims Processing Manual, Chapter 18, section 60](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf)
* [MM13017 - Removal of a National Coverage Determination & Expansion of Coverage of Colorectal Cancer Screening](https://www.cms.gov/files/document/mm13017-removal-national-coverage-determination-expansion-coverage-colorectal-cancer-screening.pdf)

[Counseling to prevent tobacco use](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#TOBACCO)

Medicare covers counseling to prevent tobacco use for outpatient and hospitalized Medicare beneficiaries for whom all of the following are true:

* Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease.
* Competent and alert at the time of counseling.
* Counseling furnished by a qualified physician or other Medicare-recognized practitioner.

HCPCS/CPT codes

* 99406 - Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes.
* 99407 - Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes.

Frequency

* Two cessation attempts per year, each attempt may include a maximum of 4 intermediate or intensive sessions.
* Total annual benefit covering up to 8 sessions per year.

Deductible and coinsurance waived.

Reference

* CMS IOM [Pub. 100-03, National Coverage Determinations Manual, Chapter 1, Part 4, section 210.4.1](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf)

[Depression screening](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#DEPRESSION)

All Medicare beneficiaries are eligible for depression screening.

HCPCS/CPT code

* G0444 – Annual depression screening, 5 to 15 minutes

Frequency

* Annually

Note: Screening must be furnished in primary care settings with staff-assisted depression care supports in place to ensure accurate diagnosis, effective treatment, and follow-up.

Deductible and coinsurance are waived.

References

* CMS IOM [Pub. 100-03, National Coverage Determinations Manual, Chapter 1, Part 4, section 210.9](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf)
* CMS IOM [Pub. 100-04, Claims Processing Manual, Chapter 18, section 190](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf)

[Diabetes screening tests](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#DIABETES)

Medicare covers diabetes screening tests for Medicare beneficiaries with certain risk factors for diabetes or diagnosed with pre-diabetes.

Note: Medicare beneficiaries previously diagnosed with diabetes are not eligible for this benefit.

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)

Frequency

* One screening every 6 months for Medicare beneficiaries diagnosed with pre-diabetes.
* One screening every 12 months if previously tested but not diagnosed with pre-diabetes or if never tested.

Deductible and coinsurance waived.

Note: Append modifier TS when submitting claims for Medicare beneficiaries with pre-diabetes.

[Diabetes Screening & Definitions Update, MM13487](https://www.cms.gov/files/document/mm13487-diabetes-screening-definitions-update-cy-2024-physician-fee-schedule-final-rule.pdf), CMS clarified claims processing requirements for ICD-10 diagnosis code Z13.1.

Reference

* CMS IOM [Pub. 100-04, Claims Processing Manual, Chapter 18, section 90](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf)
* [CDC Diabetes](https://www.cdc.gov/diabetes/index.html) webpage
* [Diabetes Prevalence Among Medicare Beneficiaries in the Community (PDF)](https://www.cms.gov/files/document/cms-diabetes-infographic-6-2023.pdf) infographic
* Information for your patients:
* [Diabetes screenings](https://www.medicare.gov/coverage/diabetes-screenings)
* [Diabetes self-management training](https://www.medicare.gov/coverage/diabetes-self-management-training)
* [Medical nutrition therapy services](https://www.medicare.gov/coverage/nutrition-therapy-services)
* [Medicare Diabetes Prevention Program](https://www.medicare.gov/coverage/medicare-diabetes-prevention-program)

[Diabetes self-management training (DSMT)](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#DIABETES_SELF)

Certain Medicare beneficiaries when all of the following are true:

* Diagnosed with diabetes
* Received an order for DSMT from the physician or qualified NPP treating the Medicare beneficiary's diabetes

HCPCS/CPT codes

* G0108 - DSMT, individual, per 30 minutes
* G0109 - DSMT, group (2 or more), per 30 minutes

Frequency

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

Deductible and coinsurance apply.

Note: You cannot bill DSMT and Medical Nutrition Therapy (MNT) on the same date of service for the same beneficiary.

Accreditation

In order for an individual or entity to furnish diabetes self-management training (DSMT) for Medicare beneficiaries, a provider must be accredited by a national accreditation organization that has been approved by the Centers for Medicare & Medicaid Services (CMS):

* American Diabetes Association (ADA)
* American Association of Diabetes Educators
* Indian Health Service

Note: DSMT is not a separately recognized provider type, and a person or entity cannot enroll in Medicare for the sole purpose of performing DSMT.

For additional information on accreditation please visit the [Diabetic Self-Management Training (DSMT) Accreditation Program](file:///C%3A/Users/d9mu/AppData/Local/Microsoft/Windows/Temporary%20Internet%20Files/Content.IE5/RTXGMIXX/Diabetic%20Self-Management%20Training%20%28DSMT%29%20Accreditation%20Program)

References

* CMS IOM [Pub. 100-03, National Coverage Determinations Manual, Chapter 1, Part 1, section 40.1](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part1.pdf)
* CMS IOM [Pub. 100-04, Claims Processing Manual, Chapter 18, section 120](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf)

[Glaucoma screening](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#GLAUCOMA)

Glaucoma screening is covered for all Medicare beneficiaries who fall into at least one of the following high-risk categories:

* Individuals with diabetes mellitus
* Individuals with a family history of glaucoma
* African-Americans aged 50 and older
* Hispanic-Americans aged 65 and older

HCPCS codes

* G0117 – By an optometrist or ophthalmologist.
* G0118 – Under the direct supervision of an optometrist or ophthalmologist.

Frequency

* Annually

Deductible and coinsurance apply.

Reference

* CMS IOM [Pub. 100-04, Claims Processing Manual, Chapter 18, section 70](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf)

[Hepatitis b vaccination](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#HEP_B)

Payment for the hepatitis B vaccine and its administration is only available to Medicare beneficiaries who are at high or intermediate risk of contracting hepatitis B, which includes patients who haven't previously gotten a completed hepatitis B shot series or whose shot history is unknown

High risk individuals include:

* ESRD patients
* Hemophiliacs who receive Factor VIII or IX concentrates
* Clients of institutions for the mentally retarded
* Persons who live in the same household as a Hepatitis B Virus carrier
* Homosexual men
* Illicit injectable drug abusers
* Persons diagnosed with diabetes mellitus

Individuals at intermediate risk include:

* Staff in institutions for the mentally retarded
* Workers in health care professions who have frequent contact with blood or blood-derived body fluids during routine work

Medicare beneficiaries who are currently positive for antibodies for hepatitis B are not eligible for this benefit.

Deductible and coinsurance waived.

Medicare pays an additional payment for [in-home hepatitis B](https://www.cms.gov/medicare/coverage/preventive-services/home-vaccine-administration-additional-payment) shot administration under certain circumstances

A physician's order is no longer required for the administration of a hepatitis B shot

Hepatitis B vaccines can be roster billed. For additional information, refer to Roster billing for Part B providers

References

* CMS IOM [Pub. 100-02, Benefit Policy Manual, Chapter 15, section 50.4.4.2B](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf)
* CMS IOM [Pub. 100-04, Claims Processing Manual, Chapter 18, sections 10.1.3 & 230](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf)
* [Medicare Learning Network (MLN) Article: MM13937 – Roster Billing for Hepatitis B: July 2025 Release](https://www.cms.gov/files/document/mm13937-roster-billing-hepatitis-b-july-2025-release.pdf)

[Hepatitis c virus (HCV)](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#HEP_C)

Medicare covers hepatitis C virus for certain adult Medicare beneficiaries who fall into at least one of the following categories:

* High risk for HCV infection
* Born between 1945 and 1965
* Had a blood transfusion before 1992

HCPCS/CPT code

* G0472 - Hepatitis C antibody screening, for individual at high risk and other covered indication(s)

Frequency

* Once for Medicare beneficiaries born from 1945 through 1965 who are not considered high risk (use ICD-10 Z11.59; effective October 1, 2017)
* An initial screening for Medicare beneficiaries, regardless of birth year, for adults at high risk, that is, beneficiaries who had a blood transfusion before 1992 and beneficiaries with a current or past history of illicit injection drug use
* Annually only for high-risk Medicare beneficiaries with continued illicit injection drug use since the prior negative (HCV) screening test
* There is no coinsurance and deductible.

Deductible and coinsurance waived.

References

* CMS IOM [Pub. 100-03, National Coverage Determinations Manual, Chapter 1, Part 4, section 210.13](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf)
* CMS IOM [Pub. 100-04, Claims Processing Manual, Chapter 18, section 210](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf)
* [Screening for Hepatitis C Virus (HCV) in Adults](https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=N&NCAId=272)

[Human immunodeficiency virus (HIV) screening](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#HIV)

Certain Medicare beneficiaries without regard to perceived risk or who are at increased risk for HIV infection, including anyone who asks for the test, or pregnant women.

HCPCS/CPT codes

* 80081 – Obstetric panel (includes HIV testing).
* G0432 - Infectious agent antibody detection by Enzyme Immunoassay (EI) technique.
* G0433 - Infectious agent antibody detection by Enzyme-Linked Immunosorbent Assay (ELIA) technique.
* G0435 - Infectious agent antibody detection by rapid antibody test.
* G0475 – HIV antigen/antibody, combination assay, screening.

Frequency

* Annually for Medicare beneficiaries between the ages of 15 and 65 without regard to perceived risk.
* Annually for Medicare beneficiaries younger than 15 and adults older than 65 who are at increased risk for HIV infection.
* For Medicare beneficiaries who are pregnant, 3 times per pregnancy.
* First, when a woman is diagnosed with pregnancy.
* Second, during the third trimester.
* Third, at labor, if ordered by the woman’s clinician.

Deductible and coinsurance are waived.

References

* CMS IOM [Pub. 100-03, National Coverage Determinations Manual, Chapter 1, Part 4, section 210.7](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf)
* CMS IOM [Pub. 100-04, Claims Processing Manual, Chapter 18, section 130](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf)
* [Screening for the Human Immunodeficiency Virus (HIV) Infection](https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2016-Transmittals-Items/R190NCD)

[Intensive behavioral therapy (IBT) for cardiovascular disease](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#CARDIO_IBT)

Medicare covers IBT for all beneficiaries who are:

* Competent and alert at the time counseling is provided.
* Furnished counseling by a qualified primary care physician or other primary care practitioner and in a primary care setting.

HCPCS/CPT code

* G0446 – Intensive behavioral therapy to reduce cardiovascular disease risk, individual, face-to-face, bi-annual, 15 minutes.

Frequency

* Annually

Deductible and coinsurance waived.

References

* CMS IOM [Pub. 100-03, National Coverage Determinations Manual, Chapter 1, Part 4, section 210.11](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf)
* CMS IOM [Pub. 100-04, Claims Processing Manual, Chapter 18, section 160](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf)

[Intensive behavioral therapy (IBT) for obesity](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#OBESITY_IBT)

Medicare covers IBT for obesity for beneficiaries when all of the following are true:

* Obesity (Body Mass Index [BMI] ≥ 30 kilograms [kg] per meter squared).
* Competent and alert at the time counseling is provided.
* Counseling furnished by a qualified primary care physician or other primary care practitioner in a primary care setting.

HCPCS/CPT codes

* G0447 – Face-to-face behavioral counseling for obesity, 15 minutes.
* G0473 – Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes.

Frequency

* Medicare will pay for up to 22 visits billed with the codes G0447 and G0473, combined, in a 12-month period:
* First month: one face-to-face visit every week.
* Months 2–6: one face-to-face visit every other week.
* Months 7–12: one face-to-face visit every month if certain requirements are met.

Deductible and coinsurance waived.

Notes

* At the 6-month visit, a [reassessment of obesity](https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=353) and a determination of the amount of weight loss must be performed.
* To be eligible for additional face-to-face visits occurring once a month for months 7–12, Medicare beneficiaries must have lost at least 3 kg.
* For Medicare beneficiaries who do not achieve a weight loss of at least 3 kg during the first 6 months, a reassessment of their readiness to change and BMI is appropriate after an additional 6-month period.

References

* CMS IOM [Pub. 100-03, National Coverage Determinations Manual, Chapter 1, Part 4, section 210.12](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf)
* CMS IOM [Pub. 100-04, Claims Processing Manual, Chapter 18, section 200](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf)

[Influenza virus vaccination](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#FLU)

Medicare covers flu shots once per influenza season. Additional flu shots may be covered if medically necessary.

Deductible and coinsurance waived.

For the Medicare-covered codes for the influenza vaccines approved by FDA for current influenza vaccine season, please go to the CMS [Seasonal Influenza Vaccines Pricing](https://www.cms.gov/medicare/payment/all-fee-service-providers/medicare-part-b-drug-average-sales-price/vaccine-pricing) page.

References

* CMS IOM [Pub. 100-02, Benefit Policy Manual, Chapter 15, section 50.4.4.2C](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf)
* CMS IOM [Pub. 100-04, Claims Processing Manual, Chapter 18, section 10.1.2](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf)

[Initial preventive physical exam (IPPE)](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#IPPE)

IPPE is covered new Medicare beneficiaries who are within the first 12 months of their first Medicare Part B coverage period.

HCPCS/CPT codes

* G0402 – IPPE (Deductible and coinsurance waived).
* G0403 – EKG for IPPE (Deducible and coinsurance applies).
* G0404 – EKG tracing for IPPE (Deducible and coinsurance applies).
* G0405 – EKG interpret & report (Deducible and coinsurance applies).
* G0468 – Federally qualified health center (FQHC) visit (Deductible and coinsurance waived).
* AWV or IPPE must be provided with a standard bundle of services available to all beneficiaries to use this code; refer to pages 2, 5, and 6 of the [Frequently Asked Questions on the Medicare FQHC PPS](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-PPS-FAQs.pdf) fact sheet for more information.

Frequency

* Once in a lifetime
* Must furnish no later than 12 months after the effective date of the first Medicare Part B coverage period

References

* CMS IOM [Pub. 100-04, Claims Processing Manual, Chapter 18, section 80](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf)
* [IPPE Booklet](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html)

[Lung cancer screening](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#LUNG_CAN)

Medicare covers lung cancer screening counseling for Medicare beneficiaries who meet all of the following categories:

* Aged 50 through 77.
* Asymptomatic (no signs or symptoms of lung cancer).
* Tobacco smoking history of at least 20 pack-years (one pack-year = smoking one pack per day for one year; 1 pack = 20 cigarettes).
* Current smoker or one who has quit smoking within the last 15 years.
* Receive a written order for lung cancer screening with low dose CT (LDCT).

HCPCS/CPT codes

* G0296 - Counseling visit to discuss need for lung cancer screening with LDCT (service is for eligibility determination and shared decision making).

G0297 - LDCT for lung cancer screening.

Frequency

* Annually for covered Medicare beneficiaries.
* First year: Before the first lung cancer LDCT screening, Medicare beneficiaries must receive a counseling and shared decision-making visit.
* Subsequent years: The Medicare beneficiary must receive a written order furnished during any appropriate visit with a physician or NPP.

Deductible and coinsurance waived.

References

* CMS IOM [Pub. 100-03, National Coverage Determinations Manual, Chapter 1, Part 4, section 210.14](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf)
* CMS IOM [Pub. 100-04, Claims Processing Manual, Chapter 18, section 220](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf)
* [Medicare Coverage of Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)](https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=N&NCAId=274)

[Medical nutrition therapy (MNT)](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#MNT)

Certain Medicare beneficiaries when all of the following are true:

* Receive a referral from their treating physician.
* Diagnosed with diabetes or renal disease or received a kidney transplant within the last 36 months.
* Service provided by a registered dietitian or nutrition professional.

HCPCS/CPT codes

* 97802 – MNT; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes.
* 97803 – MNT; re-assessment and intervention, individual, face-to-face with the patient each 15 minutes.
* 97804 – MNT; group (2 or more individual), each 30 minutes.
* G0270 – MNT reassessment and subsequent intervention for change in diagnosis, individual, each 15 minutes.
* G0271 – MNT reassessment and subsequent intervention for change in diagnosis, group (2 or more), each 30 minutes.

Frequency

* During the initial calendar year, three hours of one-on-one MNT counseling are covered.
* Two hours each calendar year are covered during subsequent years.

Deductible and coinsurance waived.

Note: You cannot bill DSMT and MNT on the same date of service for the same beneficiary.

Reference

* CMS IOM [Pub. 100-03, National Coverage Determinations Manual, Chapter 1, Part 3, section 180.1](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part3.pdf)

[Medicare diabetes prevention program (MDPP) expanded model](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#MDPP)

Medicare covers MDPP for Medicare beneficiaries:

* Enrolled in Medicare Part B (or getting Medicare benefits through a Medicare Advantage [Part C] plan).
* Body mass index of at least 25 (23 if the beneficiary self-identifies as Asian) on the date of the first core session.
* Meet one of the three following blood test requirements within the 12 months before attending the first core session:
* hemoglobin A1c test with a value between 5.7 percent and 6.4 percent.
* fasting plasma glucose test of 110–125 mg/dL.
* 2-hour plasma glucose test (oral glucose tolerance test) of 140–199 mg/dL.
* No previous diagnosis of diabetes prior to the date of the first core session (except for gestational diabetes).
* Do not have ESRD.
* Has not previously received MDPP services.

HCPCS/CPT codes

* G9873 – First MDPP core session.
* G9874 – Four total MDPP core sessions.
* G9875 – Nine total MDPP.
* G9876 – Two MDPP core maintenance sessions (MS) attended by beneficiary in months 7–9.
* G9877 – Two MDPP core MS attended by beneficiary in months 10–12.
* G9878 – Two MDPP core MS attended by beneficiary in months 7–9.
* G9879 – Two MDPP core MS attended by beneficiary in months 10–12.
* G9880 – The MDPP beneficiary achieved at least 5% weight loss (WL) from baseline weight in months 1–12.
* G9881 – The MDPP beneficiary achieved at least 9% WL from baseline weight in months 1–24.
* G9882 – Two MDPP ongoing MS attended by beneficiary in months 13–15.
* G9883 – Two MDPP ongoing MS attended by beneficiary in months 16–18.
* G9884 – Two MDPP ongoing MS attended by beneficiary in months 19–21.
* G9885 – Two MDPP ongoing MS attended by beneficiary in months 22–24.
* G9890 – Bridge Payment: A one-time payment for the first MDPP core session, core maintenance session, or ongoing maintenance session furnished by an MDPP supplier to an MDPP beneficiary during months 1–24.
* G9891 – MDPP session reported as a line-item on a claim for a payable MDPP Expanded Model HCPCS code for a session furnished by the billing supplier and counting toward achievement of the attendance performance goal for the payable MDPP Expanded Model HCPCS code. (This code is for reporting purposes only).

For detailed HCPCS codes descriptions, please refer to the CMS [Preventive Services Chart](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html).

Frequency

* Each G-code may be paid only once in a beneficiary’s lifetime, with the exception of the bridge payment (may only be paid once per beneficiary per supplier) and session reporting code.
* Up to 24 sessions within 2 years.

Deductible and coinsurance waived.

Notes

* Billing for MDPP services must begin with core session 1, unless the beneficiary is switching after receiving the first core session from another supplier.
* Any MDPP service can be delivered as a virtual make-up session except for the first core session (baseline weight must be measured at this core session).
* MDPP suppliers must maintain all books, contracts, records, documents, and other evidence for 10 years from the last day the beneficiary received MDPP services from the supplier or from the date of completion of any audit, evaluation, inspection, or investigation, whichever is later.

Reference

* [Medicare Diabetes Prevention Program Expanded Model booklet](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN34893002.html)

Monkeypox vaccine and laboratory codes

Medicare covers the administration for Monkeypox & Smallpox vaccines effective July 26, 2022. The vaccines are provided by the government without charge, only bill for the vaccine administration. Don't include the vaccine codes on the claim when the vaccines are free.

AMA created new code 87593 for the detection of monkeypox effective July 26, 2022.

Reference

* Monkeypox vaccine and laboratory codes

[Pneumococcal pneumonia vaccination (PPV)](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#PNEUMO)

Medicare covers an initial pneumococcal vaccine to Medicare beneficiaries who never received the vaccine under Medicare Part B. A different, second pneumococcal vaccine 1 year after the first vaccine was administered.

References

* CMS IOM [Pub. 100-02, Benefit Policy Manual, Chapter 15, section 50.4.4.2A](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf)
* CMS IOM [Pub. 100-04, Claims Processing Manual, Chapter 18, section 10.1.1](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf)
* [Revision to Coverage of Pneumococcal Vaccinations Policy](https://www.cms.gov/files/document/mm13750-revisions-medicare-part-b-coverage-pneumococcal-vaccinations-policy.pdf)

[Pre-exposure Prophylaxis (PrEP) Using Antiretroviral Drugs to Prevent Human Immunodeficiency Virus (HIV) infection](https://www.cms.gov/medicare-coverage-database/view/ncacal-tracking-sheet.aspx?NCAId=310)

Starting September 30, Medicare covers PrEP to prevent HIV in individuals at increased risk of getting HIV, without cost-sharing (for example, deductibles or co-pays for people with Medicare Part B. Physician or health care practitioner who assesses the patient's history determines whether they are at increased risk for HIV.

If assessing your patients for PrEP to prevent HIV, or they're using it, we cover the following as an additional preventive service:

* Up to 8 individual counseling visit every 12 months
* Up to 8 HIV screening tests every 12 months
* Single screening for hepatitis B virus

Notes

* If a physician or health care practitioner buys an injectable PrEP drug, submit claims to Novitas (A/B MAC)
* Pharmacies can bill for PrEP for HIV drugs if they are enrolled as one of the following:
	+ DMEPOS supplier, submit claims to DME MAC
	+ Part B pharmacy supplier, submit claims to Novitas (A/B MAC)
* If physician or health care practitioner prescribes PrEP drug, at least one valid ICD-10 diagnosis code should be included to help pharmacies submit their claims. There are multiple diagnosis codes that may be appropriate, including codes for:
* Encounter for HIV pre-exposure prophylaxis
* Encounter for screening for human immunodeficiency virus
* Increased risk factors

References

* [Fact Sheet](https://www.cms.gov/files/document/fact-sheet-potential-medicare-part-b-coverage-preexposure-prophylaxis-prep-using-antiretroviral.pdf)
* [Technical FAQs for pharmacies](https://www.cms.gov/files/document/faq-prep-hiv-06242024.pdf)
* [Information for your patients](https://www.cms.gov/files/document/prep-hiv-prevention.pdf)
* [PrEP for HIV & Related Preventive Services](https://www.cms.gov/medicare/coverage/prep)

[Prolonged preventive services](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#PROLONGED)

Medicare coverage varies according to individual Medicare preventive service.

HCPCS/CPT codes

* G0513 - Preventive service (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (list separately in addition to code for preventive service).
* G0514 - Preventive service (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (list separately in addition to G0513).

Frequency

* Varies according to individual Medicare preventive service.

Deductible and coinsurance waived.

References

* CMS IOM [Pub. 100-04, Claims Processing Manual, Chapter 18, section 240](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf)
* [MLN Matters, MM10181 - Replacement of Mammography HCPCS Codes, Waiver of Coinsurance and Deductible for Preventive and Other Services, and Addition of Anesthesia and Prolonged Preventive Services](https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/mm101811.pdf)

[Prostate cancer screening](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#PROSTATE_CAN)

Medicare will cover prostate cancer screening for all male Medicare beneficiaries aged 50 and older (coverage begins the day after 50th birthday).

HCPCS/CPT codes

* G0102 – Digital Rectal Exam (DRE) (Coinsurance and deductible apply).
* G0103 – Prostate Specific Antigen (PSA) Test (Coinsurance and deductible waived).

Frequency

* Annually

References

* [Prostate cancer: talk to your patients about screening](https://www.cms.gov/training-education/medicare-learning-network/newsletter/2024-09-12-mlnc#_Toc176869503)
* CMS IOM [Pub. 100-03, National Coverage Determinations Manual, Chapter 1, Part 4, section 210.1](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf)
* CMS IOM [Pub. 100-04, Claims Processing Manual, Chapter 18, section 50](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf)

[Screening for cervical cancer with human papillomavirus (HPV) tests](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#CERV_CAN)

Medicare covers screening for cervical cancer with HPV tests for all asymptomatic female Medicare beneficiaries aged 30 to 65 years.

HCPCS/CPT code

* G0476 – Infectious agent detection by nucleic acid (DNA or RNA); human papillomavirus (HPV), high-risk types (e.g., 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68) for cervical cancer screening, must be performed in addition to pap test.

Frequency

* Once every 5 years.

Deductible and coinsurance waived.

References

* CMS IOM [Pub. 100-03, National Coverage Determinations Manual, Chapter 1, Part 4, section 210.2.1](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf)
* [Screening for Cervical Cancer with Human Papillomavirus (HPV) Testing](https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=Y&NCAId=278)

[Sexually transmitted infections (STIs) screening and high intensity behavioral counseling (HIBC) to prevent STIs](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#STI)

Medicare covers STI screening and HIBC for certain Medicare beneficiaries when all of the following are true:

* Sexually active adolescents and adults at increased risk for STIs.
* Referred for this service by a primary care provider and provided by a Medicare-eligible primary care provider in a primary care setting.

HCPCS/CPT codes

* Chlamydia
* 86631 – Antibody; Chlamydia.
* 86632 – Antibody; Chlamydia, IgM.
* 87110 – Culture, chlamydia, any source.
* 87270 – Infectious agent antigen detection by immunofluorescent technique; Chlamydia trachomatis.
* 87320 – 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; Chlamydia trachomatis.
* 87490 – Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, direct probe technique.
* 87491 – Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique.
* 87810 – Infectious agent antigen detection by immunoassay with direct optical observation; Chlamydia trachomatis.
* 87800 – Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique.
* Use 87800 when performing combined chlamydia and gonorrhea testing.
* Gonorrhea
* 87590 – Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoea, direct probe technique.
* 87591 – Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoea, amplified probe technique.
* 87850 – Infectious agent antigen detection by immunoassay with direct optical observation; Neisseria gonorrhoea.
* 87800 – Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique.
* Use 87800 when performing combined chlamydia and gonorrhea testing.
* Syphilis
* 86592 – Syphilis test, non-treponemal antibody; qualitative (eg, VDRL, RPR, ART).
* 86593 – Syphilis test, non-treponemal antibody, quantitative.
* 86780 – Antibody; Treponema pallidum.
* Hepatitis B (Hepatitis B Surface Antigen)
* 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.
* HIBC
* G0445 – High intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes education, skills training, and guidance on how to change sexual behavior; performed semi-annually, 30 minutes.

Frequency

* One annual occurrence of screening for chlamydia, gonorrhea, and syphilis in women at increased risk who are not pregnant.
* One annual occurrence of screening for syphilis in men at increased risk.
* Up to two occurrences per pregnancy of screening for chlamydia and gonorrhea in pregnant women who are at increased risk for STIs and continued increased risk for the second screening.
* One occurrence per pregnancy of screening for syphilis in pregnant women.
* Up to two additional occurrences in the third trimester and at delivery if at continued increased risk for STIs.
* One occurrence per pregnancy of screening for hepatitis B in pregnant women.
* One additional occurrence at delivery if at continued increased risk for STIs.
* Up to two 30-minute, face-to-face HIBC sessions annually.

References

* CMS IOM [Pub. 100-03, National Coverage Determinations Manual (NCD), Chapter 1, Part 4, section 210.10](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf)
* CMS IOM [Pub. 100-04, Claims Processing Manual, Chapter 18, section 180](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf)

[Screening mammography](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#MAMMO)

Medicare covers screening mammography for all female Medicare beneficiaries aged 35 and older.

HCPCS/CPT Codes

* 77063 – Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure) (use as add-on code to 77067 when tomosynthesis is used in addition to 2-D mammography).
* 77067 – Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed.

Frequency

* Aged 35 through 39: One baseline
* Aged 40 and older: Annually

Deductible and coinsurance waived.

Notes

* If billing a screening mammogram and a diagnostic mammogram on the same day, use modifier GG (Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day) to show a screening mammography turned into a diagnostic mammography.
* Procedure codes G0202, G0204, and G0206 have an end date of December 31, 2017.

References

* CMS IOM [Pub. 100-03, National Coverage Determinations Manual, Chapter 1, Part 4, section 220.4](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf)
* CMS IOM [Pub. 100-04, Claims Processing Manual, Chapter 18, section 20](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf)
* [MM10181 - Replacement of Mammography HCPCS Codes, Waiver of Coinsurance and Deductible for Preventive and Other Services, and Addition of Anesthesia and Prolonged Preventive Services](https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/mm101811.pdf)

[Screening pap tests](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#PAP)

Medicare covers screening pap tests for all female Medicare beneficiaries.

HCPCS/CPT codes

* G0123 – Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision.
* G0124 – Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician.
* G0141 – Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician.
* 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.
* 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.
* 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.
* G0147 – Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision.
* G0148 – Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening.
* P3000 – Screening papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision.
* P3001 – Screening papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician.
* Q0091 – Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory.
* Covered annually if at high risk for developing cervical or vaginal cancer, or childbearing age with abnormal Pap test within past 3 years; or, every 2 years for women at normal risk.

Frequency

* Annually (or 11 months have passed following the month of the last covered exam) for women at high risk for developing cervical or vaginal cancer or childbearing age with abnormal Pap test within past 3 years.
* Every 2 years (or 23 months have passed following the month of the last covered exam) for women at low risk.

Deductible and coinsurance waived.

References

* CMS IOM [Pub. 100-03, National Coverage Determinations Manual, Chapter 1, Part 4, section 210.2](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf)
* CMS IOM [Pub. 100-04, Claims Processing Manual, Chapter 18, section 30](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf)
* [Screening Pap Tests and Pelvic Examinations Booklet](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Screening-PapPelvic-Examinations.pdf)

[Screening pelvic examination](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#PELVIC)

The screening pelvic examination is covered for all female Medicare beneficiaries.

HCPCS code

* G0101 – Cervical or vaginal cancer screening; pelvic and clinical breast examination.

Frequency

* Annually (or 11 months have passed following the month of the last covered exam) for women at high risk for developing cervical or vaginal cancer or childbearing age with abnormal Pap test within past 3 years.
* Every 2 years (or 23 months have passed following the month of the last covered exam) for women at low risk

Deductible and coinsurance waived.

References

* CMS IOM [Pub. 100-03, National Coverage Determinations Manual, Chapter 1, Part 4, section 210.2](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf)
* CMS IOM [Pub. 100-04, Claims Processing Manual, Chapter 18, section 40](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf)
* [Screening Pap Tests and Pelvic Examinations Booklet](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Screening-PapPelvic-Examinations.pdf)

[Ultrasound screening for abdominal aortic aneurysm (AAA)](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#ULTRASOUND)

Medicare covers ultrasound screening for AAA for Medicare beneficiaries when the following criteria is met:

ICD-10-CM Codes

Z13.6 and either Z87.891, F17.210, F17.211, F17.213, F17.218 and F17.219 or Z84.89

Patients with Medicare Part B who meet these criteria:

* AAA risk factors:
	+ Family history of AAAs
	+ Men aged 65-75 who smoked at least 100 cigarettes in their lifetime
* Receive by a physician, physician assistant, nurse practitioner, or clinical nurse specialist.
* Haven't had a previous AAA screening under Medicare

HCPCS/CPT code

* 76706 - Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA).

Frequency

* Once in a lifetime.

Deductible and coinsurance waived.

Note: For claims for this service furnished prior to January 1, 2017, use G0389 – Ultrasound b-scan and/or real time with image documentation; for AAA screening.

Reference

* CMS IOM [Pub. 100-04, Claims Processing Manual, Chapter 18, section 110](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf)

Preventive services chart & educational tool

The [CMS Preventive Services educational tool](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html) is available online and provides applicable diagnosis codes for most preventive services and screenings.

For further information, please visit the [CMS IOM Pub. 100-04, Claims Processing Manual, Chapter 18](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf) and the [Preventive Services](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/index.html) page on the CMS website.