CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12546	**Date: March 14, 2024**
	Change Request 13548

SUBJECT: Update Pub. 100-04, Medicare Claims Processing Manual, Chapter 12, Section 30.6.1.1 Concerning Healthcare Common Procedure Coding System (HCPCS) Billing Codes and Chapter 12, Section 30.6.2 Concerning Advance Beneficiary Notice of Non-coverage (ABN) Requirements

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the HCPCS code billing section 30.6.1.1 and the Advance Beneficiary Notice of Non-coverage (ABN) section 30.6.2 in Chapter 12 of Pub. 100-04, Medicare Claims Processing Manual concerning the Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV) services. These updates clarify the billing code requirements for the IPPE and the AWV and provide additional ABN guidance.

EFFECTIVE DATE: May 15, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 15, 2024

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	12/30/30.6.1.1 - Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV)
R	12/30/30.6.2 - Billing for Medically Necessary Visit on Same Occasion as Preventive Medicine Service

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

IV. ATTACHMENTS:
Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	**Transmittal: 12546**	**Date: March 14, 2024**	**Change Request: 13548**

SUBJECT: Update Pub. 100-04, Medicare Claims Processing Manual, Chapter 12, Section 30.6.1.1 Concerning Healthcare Common Procedure Coding System (HCPCS) Billing Codes and Chapter 12, Section 30.6.2 Concerning Advance Beneficiary Notice of Non-coverage (ABN) Requirements

EFFECTIVE DATE: May 15, 2024
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IMPLEMENTATION DATE: May 15, 2024

I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to update the HCPCS code billing section 30.6.1.1 and the Advance Beneficiary Notice of Non-coverage (ABN) section 30.6.2 in Chapter 12 of Pub. 100-04, Medicare Claims Processing Manual concerning the Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV) services. These updates clarify the billing code requirements for the IPPE and the AWV and provide additional ABN guidance.

Medicare established preventive service billing HCPCS codes G0402 - Initial Preventive Physical Examination (IPPE); face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment, G0438 - Annual Wellness Visit; includes a personalized prevention plan of service (PPS), initial visit, and G0439 - Annual Wellness Visit; includes a personalized prevention plan of service (PPS), subsequent visit. These codes must be used for these services for Medicare beneficiaries. CPT codes 99381-99397 for comprehensive preventive medicine evaluation and management services should not be used to bill for Medicare services covered by HCPCS codes G0402, G0438 and G0439.

A physician is not required to give a Medicare beneficiary written advance notice of noncoverage of the part of the visit that constitutes a routine preventive visit not covered by Medicare such as comprehensive preventive Medicine evaluation and management services in the CPT code range 99381-99397. However, in accordance with Pub.100-04, Chapter 50, section 50.2.1, physicians are strongly encouraged to provide an ABN to beneficiaries when providing and billing for a preventive medicine service (CPT codes 99381-99397). The physician is responsible for notifying the patient in advance of his/her liability for the charges for services that are not medically necessary to treat an illness or injury.

B. Policy: No new policy is established by this Change Request.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13548.1	Contractors shall be aware of the updates to Pub. 100-04, Medicare Claims Processing Manual, Chapter 12,	X	X	X						

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	section 30.6.1.1									
13548.2	Contractors shall be aware of the updates to Pub. 100-04, Medicare Claims Processing Manual, Chapter 12, section 30.6.2	X	X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13548.3	Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.	X	X	X		

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

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

ATTACHMENTS: 0

30.6.1.1 - Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV)

(Rev. 12546; Issued: 03-14-24; Effective: 05-15-24; Implementation: 05-15-24)

F. HCPCS Codes Used to Bill the IPPE or AWV

1. HCPCS Codes Used to Bill the IPPE

For IPPE and EKG services provided prior to January 1, 2009, the physician or qualified NPP shall bill HCPCS code G0344 for the IPPE performed face-to-face, and HCPCS code G0366 for performing a screening EKG that includes both the interpretation and report. If the primary physician or qualified NPP performs only the IPPE, he/she shall bill HCPCS code G0344 only. The physician or entity that performs the screening EKG that includes both the interpretation and report shall bill HCPCS code G0366. The physician or entity that performs the screening EKG tracing only (without interpretation and report) shall bill HCPCS code G0367. The physician or entity that performs the interpretation and report only (without the EKG tracing) shall bill HCPCS code G0368. Medicare will pay for a screening EKG only as part of the IPPE. HCPCS codes G0344, G0366, G0367 and G0368 will not be billable codes effective on or after January 1, 2009.

Effective for a beneficiary who has the IPPE on or after January 1, 2009, and within his/her 12-month enrollment period of Medicare Part B, the IPPE and screening EKG services are billable with the appropriate HCPCS G code(s).

The physician or qualified NPP shall bill HCPCS code G0402 for the IPPE performed face-to-face with the patient.

The physician or entity shall bill HCPCS code G0403 for performing the complete screening EKG that includes the tracing, interpretation and report.

The physician or entity that performs the screening EKG tracing only (without interpretation and report) shall bill HCPCS code G0404.

The physician or entity that performs the screening EKG interpretation and report only, (without the EKG tracing) shall bill HCPCS code G0405.

2. HCPCS Codes Used to Bill the AWV

For the first AWV provided on or after January 1, 2011, the health professional shall bill HCPCS G0438 (Annual wellness visit, including PPPS, first visit). This is a once per beneficiary per lifetime allowable Medicare Part B benefit. *Do not bill for AWV services using CPT codes 99381-99397.*

All subsequent AWVs shall be billed with HCPCS G0439 (Annual Wellness Visit, including PPPS, subsequent visit). In the event that a beneficiary selects a new health professional to complete a subsequent AWV, the new health professional will continue to bill the subsequent AWV with HCPCS G0439. *Do not bill for AWV services using CPT codes 99381-99397.*

NOTE: For an IPPE or AWV performed during the global period of surgery, refer to chapter 12, §30.6.6 of this chapter for reporting instructions.

30.6.2 - Billing for Medically Necessary Visit on Same Occasion as Preventive Medicine Service

(Rev. 12546; Issued: 03-14-24; Effective: 05-15-24; Implementation: 05-15-24)

See Chapter 18 for payment for covered preventive services.

When a physician furnishes a Medicare beneficiary a covered visit at the same place and on the same occasion as a noncovered preventive medicine service (CPT codes 99381-99397), consider the covered visit to be provided in lieu of a part of the preventive medicine service of equal value to the visit. A preventive medicine service (CPT codes 99381-99397) is a noncovered service. The physician may charge the beneficiary, as a charge for the noncovered remainder of the service, the amount by which the physician's current established charge for the preventive medicine service exceeds his/her current established charge for the covered visit. Pay for the covered visit based on the lesser of the fee schedule amount or the physician's actual charge for the visit. The physician is not required to give the beneficiary written advance notice of noncoverage *(ABN)* of the part of the visit that constitutes a routine preventive visit. *However, in accordance with Pub.100-04, Chapter 50, section 50.2.1, physicians are strongly encouraged to provide an ABN to beneficiaries when providing and billing for a preventive medicine service (CPT codes 99381-99397). Also, the* physician is responsible for notifying the patient in advance of his/her liability for the charges for services that are not medically necessary to treat the illness or injury.

There could be covered and noncovered procedures performed during this encounter (e.g., screening x-ray, EKG, lab tests.). These are considered individually. Those procedures which are for screening for asymptomatic conditions are considered noncovered and, therefore, no payment is made. Those procedures ordered to diagnose or monitor a symptom, medical condition, or treatment are evaluated for medical necessity and, if covered, are paid.