



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/MLN MattersArticles/downloads/MM6960.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

MLN Matters® Number: MM7012

Related Change Request (CR) #: 7012

Related CR Release Date: July 30, 2010

Effective Date: January 1, 2011

Related CR Transmittal #: R7390TN

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

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.

Background

Sections of The Affordable Care Act amend sections of The Social Security Act to require changes in payment (with respect to deductible and

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coinsurance/copayment) for identified preventive services: In addition, The Affordable Care Act waives the deductible and coinsurance/copayment for the IPPE and the AWW. 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.

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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 AWW. CR7012 is available at

<http://www.cms.gov/Transmittals/downloads/R7390TN.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

You can find more information about the waiver of coinsurance and deductible for preventive services by going to CR7012, located at

<http://www.cms.gov/Transmittals/downloads/R7390TN.pdf> on the CMS website.

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> on the CMS website.

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