Initial Preventive Physical Examination

Overview

Through legislation passed over the past 25 years, Congress has expanded the number of preventive and screening services available to beneficiaries under the Medicare Part B Program. Section 611 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 added coverage of a one-time Initial Preventive Physical Examination (IPPE), also referred to as the "Welcome to Medicare" physical exam or visit. The goals of this benefit are health promotion and disease detection and include education, counseling, and referral for other screening and preventive services also covered under Medicare Part B.

NEW for 2009

Section 101(b) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) provided for improvements to the IPPE benefit, including:

- The addition of measurement of body mass index
- End-of-life-planning (upon an individual's consent)
- Extension of the coverage period from 6 months to 12 months
- Waiver of the Medicare Part B deductible for an IPPE visit performed on or after January 1, 2009
- Removal of the mandatory requirement of the screening electrocardiogram (EKG). The screening EKG is optional and is permitted as a one-time screening service as a result of a referral resulting from the IPPE visit.

Important Reminders About the IPPE:

1. The IPPE is a unique benefit available only for beneficiaries new to the Medicare Program and must be received within the first 12 months of the effective date of their Medicare Part B coverage.
2. This exam is a preventive physical exam and not a "routine physical checkup" that some seniors may receive every year or two from their physician or other qualified non-physician practitioner. Medicare Part B does not provide coverage for routine physical exams.

The IPPE is a preventive evaluation and management (E/M) service that includes all of the following components:

1. A review of an individual's medical and social history with attention to modifiable risk factors for disease detection.
2. A review of an individual's potential (risk factors) for depression or other mood disorders.
3. A review of the individual's functional ability and level of safety.
4. An examination to include an individual's height, weight, blood pressure measurement, visual acuity screen, measurement of body mass index (required service effective January 1, 2009), and other factors as deemed appropriate by the examining physician or qualified non-physician practitioner.
5. End-of-life planning, effective for dates of service on or after January 1, 2009 (upon an individual's consent).
6. Education, counseling, and referral based on the results of the review and evaluation services described in the previous five components.

7. Education, counseling, and referral for other preventive services (including a brief written plan such as a checklist provided to the individual for obtaining a screening EKG, as appropriate, and the appropriate screenings and other preventive services that are covered as separate Medicare Part B benefits).

Each of these components is further defined on the following pages.

Important 2009 Changes

Effective for dates of service on or after January 1, 2009, the screening EKG is no longer a required part of the IPPE. It is optional and may be performed as a result of a referral from an IPPE (as part of the educational, counseling, and referral services the beneficiary is entitled to during the beneficiary's IPPE visit). (See component # 7.) The screening EKG will be allowed only once in a beneficiary's lifetime.

The MIPPA legislation added a provision of "additional preventive services" under education, counseling, and referral services to allow for future covered preventive services. These preventive services may be added in the future through the National Coverage Determination (NCD) process.

NOTE: The IPPE does not include any clinical laboratory tests. The physician, qualified non-physician practitioner, or hospital may also provide and bill separately for the screening and other preventive services that are currently covered and paid for by Medicare Part B.

Components of the Initial Preventive Physical Examination

These seven components enable the Medicare provider to identify risk factors that may be associated with various diseases and to detect diseases early when outcomes are best. The provider is then able to educate and counsel the beneficiary about the identified risk factors and possible lifestyle changes that could have a positive impact on the beneficiary's health. The IPPE includes all of the following services furnished to a beneficiary by a physician or other qualified non-physician practitioner:

Component 1 -- Review of the beneficiary's medical and social history with attention to modifiable risk factors for disease detection

- Medical history includes, at a minimum, past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments; current medications and supplements, including calcium and vitamins; and family history, including a review of medical events in the beneficiary's family, including diseases that may be hereditary or place the individual at risk.
- Social history includes, at a minimum, history of alcohol, tobacco, and illicit drug use, diet, and physical activities.

Preparing Beneficiaries For the IPPE Visit

Providers can help beneficiaries get ready for the IPPE visit by suggesting they come prepared with the following information:

- Medical records, including immunization records.
- Family health history, in as much detail as possible.
- A full list of medications and supplements, including calcium and vitamins – how often and how much of each is taken.

Component 2 -- Review of the beneficiary's potential (risk factors) for depression and other mood disorders

This includes current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression. The physician or other qualified non-physician practitioner may select from various available standardized screening tests that are designed for this purpose and recognized by national professional medical organizations.

Component 3 -- Review of the beneficiary's functional ability and level of safety

This is based on the use of appropriate screening questions or methods. The physician or other qualified non-physician practitioner may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations. This review must include, at a minimum, the following areas:

- Hearing impairment
- Activities of daily living
- Falls risk
- Home safety

Component 4 -- A physical examination

This examination includes measurement of the beneficiary's height, weight, and blood pressure; measurement of body mass index (required service effective January 1, 2009); a visual acuity screen; and other factors as deemed appropriate by the physician or qualified non-physician practitioner, based on the beneficiary's medical and social history and current clinical standards.

Component 5 -- End-of-life planning

Effective for dates of service on or after January 1, 2009, the IPPE includes end-of-life planning as a required service, upon the beneficiary's consent. End-of-life planning is verbal or written information provided to the beneficiary regarding:

- The beneficiary's ability to prepare an advance directive in the case that an injury or illness causes the beneficiary to be unable to make health care decisions, and
- Whether or not the physician is willing to follow the beneficiary's wishes as expressed in the advance directive.

Component 6 -- Education, counseling, and referral based on the previous five components

Education, counseling, and referral, as determined appropriate by the physician or qualified non-physician practitioner, based on the results of the review and evaluation services described in the previous five components. Examples include the following:

- Counseling on diet if the beneficiary is overweight
- Education on prevention of chronic diseases
- Referral for smoking and tobacco-use cessation counseling

Component 7 -- Education, counseling, and referral for other preventive services

Education, counseling, and referral, including a brief written plan, such as a checklist, provided to the individual for obtaining a screening EKG, if appropriate, and the appropriate screenings and other preventive services that are covered as separate Medicare Part B benefits, as listed below:

- Bone mass measurements
- Cardiovascular screening blood tests
- Colorectal cancer screening tests
- Diabetes screening tests
- Diabetes outpatient self-management training services
- Medical nutrition therapy for individuals with diabetes or renal disease
- Pneumococcal, influenza, and hepatitis B vaccines and their administration
- Prostate cancer screening tests
- Screening for glaucoma
- Screening mammography
- Screening Pap test and screening pelvic examinations
- Ultrasound screening for abdominal aortic aneurysms

Each of the preventive services and screenings listed above are discussed in detail in this Guide.

Coverage Information

Medicare provides coverage of the IPPE for beneficiaries new to the Medicare Program. The IPPE is a preventive physical examination and is not a "routine physical checkup" that some seniors may receive every year or two from their physician or other qualified non-physician practitioner. **Medicare Part B does not provide coverage for routine physical examinations.**

Medicare provides coverage of the IPPE for all newly enrolled beneficiaries who receive the IPPE within the first 12 months after the effective date of their Medicare Part B coverage. However, only beneficiaries whose first Part B coverage period began on or after January 1, 2005 are eligible for the IPPE. The IPPE is covered only as a **one-time** benefit per Medicare Part B enrollee.

Who May Perform the IPPE?

Physician

A physician is defined as a doctor of medicine or osteopathy.

Qualified Non-Physician Practitioner

For the purpose of the IPPE, a qualified non-physician practitioner is a physician assistant, nurse practitioner, or clinical nurse specialist.

NOTE: Medicare beneficiaries who cancel their Medicare Part B coverage but later re-enroll in Medicare Part B are not eligible for the IPPE benefit.

The IPPE must be furnished by either a physician or a qualified non-physician practitioner.

Coverage of the IPPE visit is provided as a Medicare Part B benefit. For dates of service on or after January 1, 2009, the yearly Medicare Part B deductible is waived for the IPPE only. The deductible is not waived for the screening EKG. The coinsurance or copayment still applies to both the IPPE and the screening EKG.

Documentation

The physician or qualified non-physician practitioner must document that they provided, or provided and referred, all seven required components of the IPPE. The physician and/or qualified non-physician practitioner should use the appropriate screening tools normally used in a routine physician's practice.

If a separately identifiable, medically necessary E/M service is also performed, the physician and/or qualified non-physician practitioner must document this in the medical record. Follow the 1995 and 1997 E/M documentation guidelines, available at http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp on the CMS website, for recording the appropriate clinical information in the beneficiary's medical record. Include all referrals and a written medical plan in this documentation.

Coding and Diagnosis Information

Procedure Codes and Descriptors

Effective January 1, 2009, use the following Healthcare Common Procedure Coding System (HCPCS) codes listed in Table 1 to report the IPPE and screening EKG services:

Table 1 – HCPCS Codes for the IPPE and Screening EKG

HCPCS Code	Code Descriptor
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 preventative 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 preventative physical examination
G0405	Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventative physical examination

NOTE: Effective January 1, 2009, the screening EKG is billable with HCPCS code(s) G0403, G0404, or G0405, when it is a result of a referral from an IPPE.

For IPPEs performed on or before December 31, 2008, report HCPCS code G0344 with one of the following HCPCS codes for the mandatory EKG: G0366, G0367, or G0368.

The HCPCS codes for the IPPE do not include other preventive services that are currently paid separately under Medicare Part B screening benefits. When Medicare providers perform these other preventive services, they must identify the services using the appropriate existing codes. The HCPCS/Current Procedural Terminology (CPT) codes for other preventive services will be provided later in this Guide.

Diagnosis Requirements

Although Medicare providers must report a diagnosis code on the claim, there are no specific International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis codes that are required for the IPPE and screening EKG. Medicare providers should choose an appropriate ICD-9-CM diagnosis code. Contact the local Medicare Contractor for further guidance.

Billing Requirements

Billing and Coding Requirements When Submitting Claims to Carriers/AB Medicare Administrative Contractors (AB MACs)

When physicians and qualified non-physician practitioners are submitting claims to carriers/AB MACs, they must report the appropriate HCPCS G code for the IPPE and screening EKG in the HIPAA 837 Professional electronic claim format.

NOTE: In those cases where a Medicare provider qualifies for an exception to the ASCA requirement, Form CMS-1500 may be used to submit these claims on paper. Form CMS-1500 has been revised to accommodate the reporting of the National Provider Identifier (NPI). All Medicare providers must use Form CMS-1500 (08-05) when submitting paper claims. Additional information on Form CMS-1500 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp on the CMS website.

Administrative Simplification Compliance Act Claims Requirements

The Administrative Simplification Compliance Act (ASCA) requires that claims be submitted to Medicare electronically to be considered for payment with limited exceptions. Claims are to be submitted electronically using the X12 837-P (professional) or 837-I (institutional) format as appropriate, using the version adopted as a national standard under the Health Insurance Portability and Accountability Act (HIPAA). Additional information on these formats can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp on the CMS website.

Medicare will reimburse physicians or qualified non-physician practitioners for only **one** IPPE performed no later than 6 months after the date the beneficiary's first Medicare Part B coverage begins, but only if that coverage begins January 1, 2005 or after. Effective January 1, 2009, the eligibility period for receiving an IPPE has been extended from 6 months to 12 months following an individual's enrollment in Medicare Part B. Therefore, any beneficiaries who have not yet had an IPPE and whose initial enrollment in Medicare began in 2008 will be able to have an IPPE in 2009, as long as it is performed within 12 months of their initial enrollment.

When a physician or qualified non-physician practitioner provides a separately identifiable, medically necessary E/M service in addition to the IPPE, they may use CPT codes 99201 - 99215 depending on the clinical appropriateness of the encounter. The E/M code should be reported with modifier -25, identifying the service as a significant, separately identifiable, E/M service from the reported IPPE code.

If the primary physician or qualified non-physician practitioner does not perform a screening EKG as a result of the IPPE visit, another physician or entity may perform and/or interpret the EKG. The referring provider should ensure that the performing provider bills the appropriate HCPCS G code listed in Table 1 for the screening EKG, and not a CPT code in the 93000 series. When the primary physician or qualified non-physician practitioner performs the screening EKG, they shall document the results in the beneficiary's medical record to complete and bill for the IPPE benefit.

Should an additional medically necessary EKG in the 93000 series need to be performed on the same day as the IPPE, report the appropriate EKG CPT code(s) with modifier -59. This will indicate that the additional EKG is a distinct procedural service.

Other covered preventive services that are performed may be billed in addition to HCPCS code G0402 and the appropriate EKG HCPCS G code.

Billing and Coding Requirements When Submitting Claims to Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

When submitting claims to FIs/AB MACs, Medicare providers must report the appropriate HCPCS G code for the IPPE benefit and screening EKG service in the HIPAA 837 Institutional electronic claim format. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) must report the HCPCS code for the IPPE to avoid application of the deductible (on RHC claims), assure payment for this service in addition to another encounter on the same day if they are both separate, unrelated and appropriate, and to update the Common Working File (CWF) record to track this once in a lifetime benefit.

NOTE: In those cases where an institution qualifies for an exception to the ASCA requirement, Form CMS-1450 may be used to submit these claims on paper. As of May 23, 2007, all Medicare providers must use Form CMS-1450 (UB-04) when submitting paper claims. Additional information on Form CMS-1450 can be found at http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

When a physician or qualified non-physician practitioner provides a separately identifiable, medically necessary E/M service in addition to the IPPE, they may use CPT code(s) 99201 - 99215 depending on the clinical appropriateness of the encounter. The E/M code should be reported with modifier -25. Hospitals subject to the Outpatient Prospective Payment System (OPPS) that bill for both the technical component of the screening EKG (G0404) and the IPPE itself (G0402) must report modifier -25 with HCPCS code G0402.

Types of Bills for FIs/AB MACs

The FI/AB MAC will reimburse for the IPPE and screening EKG (HCPCS code G0404, tracing only), when submitted on the following Types of Bills (TOBs) listed in Table 2:

Table 2 – Facility Types and Types of Bills for IPPE and Screening EKG

Facility Type	Type of Bill
Hospital Inpatient Part B including Critical Access Hospital (CAH)	12X
Hospital Outpatient	13X
Skilled Nursing Facility (SNF) Inpatient Part B	22X
Rural Health Clinic (RHC)	71X
Federally Qualified Health Center (FQHC)	73X
CAH Outpatient*	85X

***NOTE:** Medicare pays all CAHs for the technical or facility component of the IPPE itself. Medicare also pays CAHs for the technical component of the EKG (the tracing only) if the screening EKG is performed.

Medicare pays only Method II CAHs for the professional component of the IPPE (HCPCS code G0402) itself (in addition to the facility payment) in revenue code 0960. If a Method II CAH performs the screening EKG, Medicare may also pay for the interpretation of the EKG (in addition to the payment for the tracing) when billed on 71X, 73X, and 85X (CAH Method II) TOBs in revenue codes 0985 or 0986.

Additional Billing Instructions for Rural Health Clinics/Federally Qualified Health Centers (RHCs/FQHCs)

- RHCs and FQHCs should follow normal billing procedures for RHC/FQHC services.
- Encounters with more than one health professional and multiple encounters with the same health professionals that take place on the same day and at the same location constitute a single visit. In rare circumstances, an RHC/FQHC can receive a separate payment for an encounter in addition to the payment for the IPPE when they are performed on the same day, when the encounters are separate, unrelated, and appropriate.
- The technical component of the EKG performed at an independent RHC/FQHC is billed to the carrier/AB MAC. For RHCs and FQHCs, there is no separate payment for the professional component of the EKG and no separate billing of it.
- The technical component of the EKG performed at a provider-based RHC/FQHC is billed on the applicable TOB, as listed in Table 3, and submitted to the FI/AB MAC using the base provider number and billing instructions.
- RHCs and FQHCs use revenue code 052X. RHCs and FQHCs will use revenue codes 0521, 0522, 0524, 0525, 0527, and 0528 in lieu of revenue code 0520.
- The professional portion of the service billed to the FI or Part A MAC on TOBs 71X or 73X should be made using the appropriate site of service revenue code in the 052X series and must include the HCPCS code.

Table 3 – Facility Types and Types of Bills for RHCs and FQHCs

Facility Type	Type of Bill	Basis of Payment
Rural Health Clinic (RHC)	71X	All-inclusive Rate **(for professional services)**
Federally Qualified Health Center (FQHC)	73X	All-inclusive Rate **(for professional services)**

NOTE: For RHCs and FQHCs, there is no separate payment for the screening EKG.

Reimbursement Information

General Information

Medicare provides coverage of the IPPE visit as a Part B benefit. Medicare pays for the HCPCS codes for the IPPE and screening EKG under the Medicare Physician Fee Schedule (MPFS). **For dates of service on or after January 1, 2009, the annual Part B deductible is waived for the IPPE (HCPCS code G0402). However, the deductible and coinsurance still apply to HCPCS codes G0344, G0366, G0367, G0368, G0403, G0404, and G0405.**

Additional information about MPFS can be found at http://www.cms.hhs.gov/PhysicianFeeSched on the CMS website.

Additional information about OPPS can be found at http://www.cms.hhs.gov/HospitalOutpatientPPS on the CMS website.

Hospital Outpatient Department: Ambulatory Payment Classification (APC) Group, effective January 1, 2009:

G0402 will be assigned to APC 0605; and

G0404 will be assigned to APC 0099.

Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the APC group to which the service is assigned.

Reimbursement of Claims by Carriers/AB Medicare Administrative Contractors (AB MACs)

Reimbursement for the IPPE is paid under the Medicare Physician Fee Schedule (MPFS) when billed to the carrier/AB MAC.

Reimbursement of Claims by Fiscal Intermediaries/AB Medicare Administrative Contractors (FIs/AB MACs)

Reimbursement for the IPPE depends on the type of facility providing the service. Table 4 lists the type of payment that facilities receive for the IPPE:

Table 4 – Facility Types and Types of Payments Received by Facilities for the IPPE

Facility Type	Basis of Payment
Hospital Outpatient	Outpatient Prospective Payment System (OPPS), for hospitals subject to the OPPS. Hospitals not subject to OPPS are paid under current methodologies.
Critical Access Hospital (CAH)	Reasonable Cost Basis (Paid at 101% of their reasonable cost)
Skilled Nursing Facility (SNF)	Payment for the technical component of the EKG based on the Medicare Physician Fee Schedule (MPFS)
Rural Health Clinic (RHC)	All-inclusive Rate
Federally Qualified Health Center (FQHC)	All-inclusive Rate

NOTE: Maryland hospitals will be reimbursed for inpatient or outpatient services according to the Maryland State Cost Containment Plan.

NOTE: For RHCs and FQHCs, there is no separate payment for the screening EKG and no separate billing of it. The IPPE is the only HCPCS for which the deductible is waived under this benefit and for which HCPCS codes are separately reported.

Reasons for Claim Denial

The following are examples of situations when Medicare may deny coverage of the IPPE:

- The beneficiary's Medicare Part B coverage did not begin on or after January 1, 2005.
- A second IPPE is billed for the same beneficiary.
- The IPPE was performed outside of the first 12 months of Medicare Part B coverage.

Medicare providers may find specific payment decision information on the remittance advice (RA). The RA will include Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide additional information on payment adjustments. The most current listing of these codes can be found at http://www.wpc-edi.com/Codes on the Web. Additional information about claims can be obtained from the carrier/AB MAC or FI/AB MAC.

Medicare Contractor Contact Information

To obtain carrier/AB MAC and FI/AB MAC contact information, visit http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

Remittance Advice Information

To obtain more information about the remittance advice (RA), visit http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Written Advance Beneficiary Notice of Noncoverage (ABN) Requirements

Advance Beneficiary Notice of Noncoverage (ABN) as Applied to the IPPE:

If a second IPPE is billed for the same beneficiary, it would be denied based on section 1861(s)(2) of the Act, since the IPPE is a one-time benefit, and an ABN would not be required in order to hold the beneficiary liable for the cost of the second IPPE.

Effective for beneficiaries whose IPPE is provided January 1, 2005 through December 31, 2008, an ABN should be issued for all IPPEs conducted after the beneficiary's statutory 6-month period has lapsed based on section 1862(a)(1)(K) of the Act, since Medicare is statutorily prohibited from paying for an IPPE outside the initial six-month period.

Effective for IPPEs performed on or after January 1, 2009, an ABN should be issued for all IPPEs conducted after the beneficiary's statutory 12-month period has lapsed based on the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 amendment to section 1862(a)(1)(K) of the Act, since Medicare is statutorily prohibited from paying for an IPPE outside the initial 12-month period.

For more information about the Advance Beneficiary Notice of Noncoverage (ABN), please refer to Reference Section G of this publication.

Initial Preventive Physical Examination

Resource Materials

Beneficiary Notices Initiative Website
http://www.cms.hhs.gov/BNI

Carrier/AB MAC and FI/AB MAC Contact Information
http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip

Documentation Guidelines for Evaluation & Management Services
http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp

Electronic Claim Submission Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp

Final Rule, 42 CFR Parts 409, 410, et al: Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008; and the Amendment of the E-Prescribing Exemption for Computer Generated Facsimile Transmissions; Final Rule
http://www.cms.hhs.gov/PhysicianFeeSched/PFSFRN/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=4&sortOrder=ascending&itemID=CMS1204957&intNumPerPage=10

Form CMS-1450 Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp

Form CMS-1500 Information
http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp

Medicare Claims Processing Manual – Pub. 100-04, Chapter 12, Section 30.6.1.1
http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf

Medicare Claims Processing Manual – Pub. 100-04, Chapter 18, Section 80
http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf

Medicare Fee-For-Service Providers Website
This site contains detailed provider-specific information.
http://www.cms.hhs.gov/center/provider.asp

Medicare Learning Network (MLN)
The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at http://www.cms.hhs.gov/MLNGenInfo on the CMS website.

Medicare Physician Fee Schedule Information
http://www.cms.hhs.gov/PhysicianFeeSched

Medicare Preventive Services General Information
http://www.cms.hhs.gov/PrevntionGenInfo

MLN Preventive Services Educational Resource Website
http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp

Beneficiary-related resources can be found in Reference F of this Guide.

National Correct Coding Initiative Edits Website
http://www.cms.hhs.gov/NationalCorrectCodInitEd

Outpatient Prospective Payment System Information
http://www.cms.hhs.gov/HospitalOutpatientPPS

Partnership for Prevention
Partnership for Prevention has developed educational materials to assist health care professionals in delivering the "Welcome to Medicare" visit.
http://www.prevent.org

Physician Information Resource for Medicare Website
This site contains physician-specific information, including updates to policies, regulations, coding and coverage information, program integrity information, and other valuable resources.
http://www.cms.hhs.gov/center/physician.asp

Remittance Advice Information
http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf

U.S. Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services
This website provides the USPSTF written recommendations.
http://www.ahrq.gov/clinic/cps3dix.htm

Washington Publishing Company (WPC) Code Lists
WPC assists in the maintenance and distribution of HIPAA-related code lists that are external to the X12 family of standards.
http://www.wpc-edi.com/Codes

Beneficiary-related resources can be found in Reference F of this Guide.