Capture Billing
Medical Billing Services

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"Welcome to Medicare Visit" aka IPPE aka G0402

Initial Preventative Physical Exam (IPPE) G0402 is Known as the "Welcome to Medicare Visit" to Most Medical Billers

What is a Welcome to Medicare visit, and how do you bill for it? Let's see if I can help to explain and to point you in the right direction for more information.

A patient who has just qualified for Medicare Part B is allowed this once-in-a-lifetime benefit within the first 12 months of Medicare eligibility. Medicare calls this exam the Initial Preventative Physical Exam, or IPPE, but it is more widely known as the "Welcome to Medicare Visit." This is a great benefit that also includes several exams that are normally not covered. A properly trained front desk staff who can schedule appropriate appointments is essential for both your office and for your newly Medicare-eligible patient to properly utilize these once-in-a-lifetime benefits.

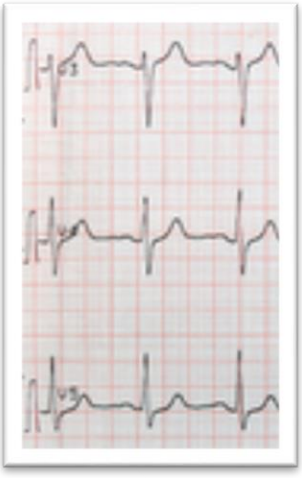
The IPPE is designed for "health promotion and disease detection," per Medicare. The following requirements of the IPPE can found at the CMS website at:
http://www.cms.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf

What are the requirements of the IPPE?

The following requirements must be met in order to bill for the IPPE:

1. Review of medical and social history to include past medical/surgical history; current medications and supplements; family history; history of alcohol; tobacco and illicit drug use; diet; and physical activities
2. Review of potential risk factors for depression and other mood disorders
3. Review of functional ability and level of safety for hearing impairment; activities of daily living; falls risk; and home safety
4. Examination to obtain height, weight, and blood pressure; visual acuity screen; measurement of body mass index; and other factors deemed appropriate based on the beneficiary's medical/social history and current clinical standards
5. End of life planning is a required service with the patient's consent to discuss an advance directive and whether or not the physician is willing to follow the beneficiary's wishes as expressed in the advance directive
6. Education, counseling, and referral based on the previous five components, as appropriate
7. Education, counseling, and referral for other preventive services in the form of a brief written plan for the beneficiary to obtain a screening electrocardiogram and any other preventive services/screenings covered by Medicare Part B benefits

The IPPE is billed out using HCPCS Code **G0402**.



Additional once-in-a-lifetime benefits in conjunction with the IPPE:

Screening Electrocardiogram (EKG) – Medicare no longer deems the screening EKG as a mandatory service component of the IPPE. However, there is a once-in-a-lifetime screening EKG that is allowed as a result of a referral from an IPPE and must be performed at the time of the IPPE. The screening EKG and IPPE must both be completed before

they can be billed to Medicare, and the beneficiary will be responsible for any copayment, coinsurance, or deductible that is assessed by Medicare.

G0403 Complete screening EKG with 12 leads; for IPPE that includes the tracing, interpretation and report (copayment/coinsurance/deductible applies)
G0404 Screening EKG with 12 leads; tracing only without interpretation and report (copayment/coinsurance/deductible applies)
G0405 Screening EKG with 12 leads; interpretation and report only, without tracing
See the rules for the IPPE screening EKG provided in the Medicare Claims Processing Manual at: http://www.cms.gov/manuals/downloads/clm104c12.pdf

Ultrasound Screening for Abdominal Aortic Aneurysm (AAA) – patient must receive a referral for an AAA ultrasound screening as a result of an IPPE and must meet the criteria to have this screening ordered. Medicare will pay for this once-in-a-lifetime benefit as long as your patient meets the following requirements:

1. Beneficiaries at risk that have a family history of AAA
2. Men age 65 to 75 who have smoked at least 100 cigarettes in their lifetime

The HCPCS code for the AAA is G0389 and the beneficiary's copayment/coinsurance deductible is waived.

Pneumococcal Vaccine – This vaccine is also considered a once-in-a-lifetime benefit, but additional vaccinations may also be allowed only once every five years, based on patient risk. Beneficiary's copayment/coinsurance, deductible is waived. This does not need to be billed out with the IPPE, but it is highlighted here because of the once-in-a-lifetime benefit stipulation.

Who should be immunized?

If a beneficiary is uncertain about his vaccination history in the past five years, then it is recommended that the vaccine be given. It is also

recommended that persons 65 years of age or older and anyone considered high risk be immunized.

Who else is considered to be at increased risk?

According to the Advisory Committee on Immunization Practices (ACIP) that advises the Department of Health and Human Services, the following groups are considered high risk and should receive the initial pneumococcal vaccine or revaccination every five years:

1. Persons 2 years of age and older with a normal immune system who have a chronic illness such as: cardiovascular or pulmonary disease, diabetes, alcoholism, chronic liver disease, cerebrospinal fluid leak, cochlear implant
2. Immuno-compromised persons 2 years of age and older who have: splenic dysfunction, Hodgkin disease, lymphoma, multiple myeloma, chronic renal failure, nephritic syndrome, organ transplantation, immunosuppressed from chemotherapy or high dose corticosteroid therapy, asymptomatic/symptomatic HIV infection

See additional information at www.CMS.com.

Bill for the Pneumococcal Vaccine with the following applicable codes plus the administration of the vaccine G0009:

1. 90669 Pneumococcal Conjugate Vaccine, polyvalent, when administered to children younger than 5 years, for intramuscular use
2. 90670 Pneumococcal Conjugate Vaccine, 13 valent, for intramuscular use
3. 90732 Pneumococcal Polysaccharide Vaccine, 23 valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use
    a. Use diagnosis code V03.82 for just the Pneumococcal vaccination visit
    o Otherwise use diagnosis code V06.6 when the purpose of visit was to receive both pneumococcal and seasonal influenza virus vaccines.

Additional information regarding immunization can be found at www.CMS.com.

About the Author

Manny Oliverez

Manny Oliverez, CPC, is a 20-year healthcare veteran and the CEO and co-founder of Capture Billing, a medical billing services company located outside of Washington, D.C. He teaches the nation's physicians, administrators, and medical practices how to maximize billing and revenue cycle management processes. Manny also frequently posts articles and videos on his award-winning healthcare blog. For more information on Manny and his company, please visit his website, or call (703)327-1800. And if you're on LinkedIn, please look for him there too. **READ MORE**

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