Preventive Services
Payment Policy

Applicability

This Policy applies to the following Fallon Health products:
☒ Fallon Medicare Plus
☒ MassHealth ACO
☒ NaviCare HMO SNP
☒ Summit Eldercare PACE
☒ Fallon Health Weinberg PACE
☒ Community Care (Commercial/Exchange)

Policy

Plan members have no member cost-sharing for preventive services rendered by in-network providers. Members may be required to pay a copayment, deductible, or coinsurance for non-preventive services received in conjunction with a preventive service visit.

Definitions

Preventive care: Services, tests, and immunizations that are intended to screen for diseases or conditions and to improve early detection of disease when there is no diagnosis or symptoms present. This includes immunizations, health maintenance visits (routine physical exams) for adults and children, as well as mammograms, Pap tests and other tests associated with the health maintenance visit, prenatal maternity care, well child care (including vision and auditory screening), voluntary family planning, nutrition counseling, and health education.

Reimbursement

Claims for preventive services must be submitted with service and diagnosis codes indicating that the service is preventive. Preventive ICD-10 codes must be in the primary diagnosis position. If another diagnosis is in the primary position on the claims, the service may be subject to member cost-sharing.

Reimbursement will be made for a preventive code with a problem focused code when modifier 25 is applied to the problem-focused code. Reimbursement for the preventive service will be made at 100% of the contracted rate, and reimbursement for the problem focused service will be made at 50% of the contracted rate. This should only occur when a significant abnormality or pre-existing condition is addressed and additional work is required to perform the key components of a problem focused E&M service, and services should be submitted on the same claim. Members have no copayment and/or deductible for routine physical exams. Medicare Advantage plan members will be responsible for a copayment and/or deductible when a problem-focused code with modifier 25 is included on the claim. The provider is responsible for disclosing to the member when a problem-focused E&M service is being billed so the member knows there will be cost-sharing. Therefore, the appropriate use of modifier 25 is critical since it will be transparent to members.

The Plan will not calculate a copayment and/or deductible for E&M codes submitted with modifier 25 when billed with annual preventive services for members enrolled in a commercial plan. Those services coded with modifier 25 will be regularly reviewed for coding accuracy.

Billing/coding guidelines

In order for a service to be considered preventive care, a preventive diagnosis must be the primary diagnosis on the claim. In addition, each claim line should indicate the applicable diagnosis. In cases where the diagnosis is not preventive in nature, cost-sharing will apply. The

below coding represents services and diagnosis codes that the Plan considers preventive, while the below listed are considered preventive there may be other preventive benefits available based upon the member's plan type. As some CPT/HCPCS codes can be both preventive and diagnostic the appropriate preventive diagnostic code should be billed.

Abdominal Aortic Aneurysm (AAA): Screening

Code	Description	Guidance/Instructions
76706	Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)	For commercial and MassHealth members, AAA screening is covered in accordance with the United States Preventive Service Task Force (USPSTF) A and B recommendations in effect at the time the service is rendered (Date of current recommendation: December 10, 2019). For commercial and MassHealth members, the Plan covers one-time ultrasound screening for AAA for men aged 65 to 75 years who have ever smoked. Effective for dates of service on or after January 1, 2007, a one-time ultrasound screening for AAA is covered for eligible Medicare members.* No specific diagnosis code requirements.

* An eligible Medicare member is one who meets all of the following criteria:

- Receives a referral for such an ultrasound screening as a result of an initial preventive physical examination (IPPE), also known as the Welcome to Medicare visit, from a physician or qualified non-physician practitioner (physician assistant, nurse practitioner or clinical nurse specialist);
- Receives such ultrasound screening from a provider or supplier who is authorized to provide covered ultrasound diagnostic services for plan members;
- Has not been previously furnished such an ultrasound screening under the Medicare Program; and
- Is included in at least one of the following risk categories:
  - Has a family history of abdominal aortic aneurysm;
  - Is a man age 65 to 75 who has smoked at least 100 cigarettes in his lifetime;
  - Is a beneficiary, who manifests other risk factors in a beneficiary category recommended for screening by the United States Preventive Services Task Force regarding AAA, as specified by the Secretary of Health and Human Services, through the national coverage determinations process.

(Source: Medicare Claims Processing Manual, Chapter 18, Section 110 - Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)

Unhealthy Alcohol Use in Adults: Screening and Behavioral Counseling Interventions

The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or

hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use (Date of current recommendation: November 2018).

Structured screening for unhealthy alcohol use and brief intervention services (CPT 99408-99409) may be reported for commercial plan members age 18 years of age and older when performed as part of the treatment of condition(s) related to or potentially exacerbated by the behavior or when performed to change the harmful behavior that has not yet resulted in illness.

CPT codes 99408 and 99409 cannot be billed when screening results are negative because there is no required intervention.

Any Evaluation and Management Service reported on the same day must be distinct and reported with modifier 25. Time spent providing structured screening and brief intervention services may not be used as a basis for the Evaluation and Management code selection. Structured screening and brief intervention services involve specific validated interventions of assessing readiness for change and barriers to change (for example, Alcohol Use Disorders Identification Test), advising a change in behavior, assisting by providing suggested actions and motivational counseling, and arranging for services and follow-up.

Effective March 1, 2023, CPT codes 99408 and 99409 are not covered for MassHealth ACO plan members in accordance with MassHealth program regulations (MassHealth Transmittal Letter PHY-166 March 2023, MassHealth Transmittal Letter PHY-164 June 2022).

Effective March 1, 2023, CPT codes 99408 and 99409 are not covered for Medicare plan members (Fallon Medicare Plus, NaviCare and PACE). CPT codes 99408 and 99409 describe which are not covered under the Medicare program. See Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse below.

Effective July 1, 2023, CPT codes 99408 and 99408 are covered for MassHealth ACO, NaviCare and Summit ElderCare PACE plan members in accordance with MassHealth program regulations (MassHealth Transmittal Letter PHY-168 September 2023).

Code	Description	Guidance/Instructions
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes	No specific diagnosis code requirements.
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes	

Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse

For Medicare plan members (Fallon Medicare Plus, Medicare Plus Central, NaviCare and PACE), alcohol misuse screening and counseling is covered once per year for members who use alcohol but don't meet criteria for alcohol dependence. For those who screen positive, up to 4 brief face-to-face counseling sessions per year are covered (NCD 210.8 Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse).

Nationally Covered Indications

- Who misuse alcohol, but whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence (defined as at least three of the following: tolerance, withdrawal symptoms, impaired control, preoccupation with acquisition and/or use, persistent desire or unsuccessful efforts to quit, sustains social, occupational, or recreational disability, use continues despite adverse consequences); and
- Who are competent and alert at the time that counseling is provided; and,

- Whose counseling is furnished by qualified primary care physicians or other primary care practitioners in a primary care setting.

Services covered under this NCD must be provided by a primary care provider or by a provider in a primary care setting. Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities and hospices are not considered primary care settings for the purposes of alcohol misuse screening and counseling.

G0442 and G0443 are payable on the same date of service (exception: FQHCs and RHCs). Only one unit of G0443 is payable per date of service.

A separately identifiable Evaluation and Management service can be billed (with modifier 25) on the same date of service. It must be documented that the reason for the visit was unrelated to the alcohol misuse screening.

Code	Description	Guidance/Instructions
G0442	Annual alcohol misuse screening, 15 minutes	No specific diagnosis code requirements.
G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	

Asymptomatic Bacteriuria in Adults: Screening

The USPSTF recommends screening for asymptomatic bacteriuria using urine culture in pregnant persons**.** The USPSTF recommends against screening for asymptomatic bacteriuria in nonpregnanct adults. Screening of pregnant persons for asymptomatic bacteriuria using a midstream, clean-catch urine culture should occur at the first prenatal visit or at 12 to 16 weeks of gestation, whichever is earlier.

Code	Description	Guidance/Instructions
87081	Culture, presumptive, pathogenic organisms, screening only	For commercial and MassHealth members, screening for asymptomatic bacteriuria is covered in accordance with the USPSTF A and B recommendations in effect at the time the service is rendered (Date of current recommendation: September 24, 2019). ICD-10-CM diagnosis code requirements: Z34.00-Z34.93 - Encounter for supervision of normal pregnancy O09.00-O09.93 – Supervision of high-risk pregnancy O36.80x0-O36.80x9 – Pregnancy with inconclusive fetal viability
87084	Culture, presumptive, pathogenic organisms, screening only; with colony estimation from density chart	
87086	Culture, bacterial; quantitative colony count, urine	
87088	Culture, bacterial; with isolation and presumptive identification of each isolate, urine	

MassHealth Postpartum and Caregiver Depression, Developmental, or Autism Spectrum Disorder Screening

Effective November 21, 2024, and in accordance with Appendix W: EPSDT Services Medical and Dental Protocols and Periodicity Schedules and Appendix Z: EPSDT/PPHSD Screening Services

Codes of the MassHealth Provider Manuals , Pediatricians and pediatric providers must use CPT 96110 and modifiers U1, U2, U3, U4 and UG, as applicable, for Parent and Caregiver Depression, Developmental, or Autism Spectrum Disorder Screening.

Note: Parent and Caregiver Depression Screening is billed using the child's member ID.

Modifier/Modifier Description
U1 - No developmental health or behavioral health need identified
U2 - Developmental health or behavioral health need identified.
U3 - No follow-up needed
U4 - Follow-up needed
UD - Administration and scoring of a standardized screening tool for parent and caregiver postpartum depression (used in combination with U1 or U2)

CPT Code	Description
96110	Developmental screening, with scoring and documentation, per standardized instrument Use for Postpartum or Caregiver Depression Screening,. Screening the child's parent(s) or caregiver(s), including paternal, adoptive, and non-birthing caregivers, should occur at every preventive pediatric health care visit from the one month visit to the 12-month visit, may be billed up to the 12-month preventive pediatric visit for the administration and scoring of a recommended postpartum depression screening tool, and must be billed using the infant's MassHealth ID number and with the UD modifier used together with either modifier U1 or U2based on the screening result.
96110	Developmental screening, with scoring and documentation, per standardized instrument Use for Developmental Screening,. Developmental Screening should occur at the 9-, 18-, and 30-month preventive pediatric visits and at any visit in which developmental surveillance elicits a concern, up to the age 8 preventive pediatric visit for administration and scoring of an age-appropriate standardized developmental screening tool per Appendix W and must be billed with modifier U1 or U2.) MassHealth only pays for one developmental screening per member per date of service and one autism spectrum disorder screening per member per date of service, as clinically appropriate.
96110	Developmental screening, with scoring and documentation, per standardized instrument Usse for Autism Spectrum Disorder Screening. Autism Spectrum Disorder Screening should occur at the 18- and 24-month preventive pediatric visits, may be billed up to the age 3 preventive pediatric visit for administration and scoring of a standardized autism screening tool per Appendix W and must be billed with modifier U3 or U4.) MassHealth only pays for one developmental screening per member per date of service and one autism spectrum disorder screening per member per date of service, as clinically appropriate.

If multiple screenings are performed during a single visit, it is permitted to list 96110 along with the appropriate modifier multiple times on the claim so long as different screenings are performed for each listing of 96110 and the exact modifiers do not repeat.

Claims for CPT 96110 submitted for MassHealth ACO members 21 years of age and older will deny. Claims for CPT 96110 submitted without a U modifier will deny.

“Developmental health need identified” means the provider administering the screening tool, in their professional judgment, identified a child with a potential developmental health services need.

“Behavioral health need identified” means the provider administering the screening tool, in their professional judgment, identified a child with a potential behavioral health services need.

MassHealth Behavioral Health Assessment and Depression Screening

Providers must use CPT 96127 and modifier U1 or U2, as applicable for Behavioral Health Assessment and Depression Screening.

Modifier/Modifier Description
U1 - No developmental health or behavioral health need identified
U2 - Developmental health or behavioral health need identified.

CPT Code	Description
96127	Brief emotional/behavioral assessments, with scoring and documentation, per standardized instrument (4 to 21 years of age. From 4 to 11 years of age, to be billed for the administration of a standardized behavioral health screening tool per Appendix W. From 12 to 21 years of age, to be billed for the administration of a standardized depression screening tool per Appendix W. Must be billed with either modifier U1 or U2. Code 96127 is not payable when code 90791 is billed for the same date of service for the same member. For such dates of service, the provider must bill only code 90791).

MassHealth Perinatal Depression Screening

In accordance with Chapter 186 of the Acts of 2024, MassHealth requires primary care providers, obstetricians, gynecologists, and certified nurse midwives to offer postpartum depression screening to members during the 12 months following the end of pregnancy and take certain actions for positive screens.

Consistent with guidelines from the American College of Obstetricians and Gynecologists, MassHealth recommends that obstetricians and gynecologists screen for perinatal depression at the initial prenatal visit, later in pregnancy, and at postpartum visits at a minimum.

Effective for dates of service beginning August 19, 2025, MassHealth covers all perinatal depression screenings that occur during pregnancy through 12 months following the end of the pregnancy, inclusive of all pregnancy outcomes, as clinically appropriate. MassHealth covers one perinatal depression screening per member per date of service. Such depression screenings must be billed using the perinatal member’s MassHealth ID number and modifier U1 or U2 as applicable (MassHealth All Provider Bulletin 405 August 2025).

For those patients who have a positive screen for depression, providers should discuss available treatments for perinatal depression or major depressive disorder, including pharmacological options, and a referral to a mental health clinician, when clinically appropriate.

CPT Code	Description
S3005	Performance measurement, evaluation of patient self-assessment, depression Use for perinatal depression screening provided by primary care providers, obstetricians, gynecologists, and certified nurse midwives; must be billed with modifier U1 or U2 as described below, to indicate whether a behavioral health need was identified.

U1 Providers Serving Perinatal Members – Positive Screen: completed prenatal or postpartum depression screening and behavioral health need identified.

U2 Providers Serving Perinatal Members – Negative Screen: completed prenatal or postpartum depression screening with no behavioral health need identified

Birth Control

Note: Contraceptive drugs and devices are not covered for Medicare Advantage plan members per Medicare statute 1862(a)(1) (Medicare Benefit Policy Manual, Chapter 16 – General Exclusions From Coverage, Section 20 – Services Not Reasonable and Necessary). Under Medicare Part B, IUDs may be covered for the treatment of medical conditions, such as endometrial hyperplasia. When IUDs are covered under Part B, Medicare would cover the costs for insertion and removal by a physician. For additional information, see Obstetrics and Gynecology Payment Policy.

Code	Description	Guidance/ Instructions
00851	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transection	The Plan covers Birth Control as preventive based upon the FDA Approved Categories Please bill with the appropriate encounter code range encounters for contraceptive management Z30.0- Z30.9
00952	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); hysteroscopy and/or hysterosalpingography	
11976	Removal, implantable contraceptive capsules	
11981	Insertion, non-biodegradable drug delivery implant	
11982	Removal, non-biodegradable drug delivery implant	
11983	Removal with reinsertion, non-biodegradable drug delivery implant	
57170	Diaphragm or cervical cap fitting with instructions	
58300	Insertion of intrauterine device (IUD)	
58301	Removal of intrauterine device (IUD)	
58565	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants	
58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral	
58615	Occlusion of fallopian tube(s) by device (eg, band, clip, Falope ring) vaginal or suprapubic approach	
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)	
58671	Laparoscopy, surgical; with occlusion of oviducts by device (eg, band, clip, or Falope ring)	
A4261	Cervical cap for contraceptive use	
A4266	Diaphragm for contraceptive use	
J7296	Levonorgestrel-releasing intrauterine contraceptive system, (Kyleena), 19.5 mg	
J7297	Levonorgestrel-releasing intrauterine contraceptive system (Liletta), 52 mg	
J7298	Levonorgestrel-releasing intrauterine contraceptive system (Mirena), 52 mg	
J7300	Intrauterine copper contraceptive	
J7301	Levonorgestrel-releasing intrauterine contraceptive system (Skyla), 13.5 mg	
J7303	Contraceptive supply, hormone containing vaginal ring, each	
J7307	Etonogestrel (contraceptive) implant system, including implant and supplies	

BRCA

Code	Description	Guidance/Instructions
81212	BRCA1, BRCA2 (breast cancer 1 and 2) (eg, hereditary breast and ovarian cancer) gene analysis; 185delAG, 5385insC, 6174delT variants	Prior Authorization is required Considered preventive only when meeting the USPSTF B level recommendation here: Recommendation Use a below diagnoses code to indicate preventative Z80.0: Family history of malignant neoplasm of digestive organs Z80.3: Family history of malignant neoplasm of breast Z80.41: Family history of malignant neoplasm of ovary Z80.49: Family history of malignant neoplasm of other genital organs
81215	BRCA1 (breast cancer 1) (eg, hereditary breast and ovarian cancer) gene analysis; known familial variant	
81216	BRCA2 (breast cancer 2) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis	
81217	BRCA2 (breast cancer 2) (eg, hereditary breast and ovarian cancer) gene analysis; known familial variant	

Breast Cancer Screening

For Fallon Medicare Plus, NaviCare and PACE members:

- Baseline screening mammography with or without screening digital breast tomosynthesis is covered for women age 35-39.
- Annual screening mammography with or without screening digital breast tomosynthesis is covered for women 40 and older.

For Community Care members:

- Baseline screening mammography with or without screening digital breast tomosynthesis is covered for women age 35 to 40.
- Yearly screening mammography with or without screening digital breast tomosynthesis is covered for women age 40 and older.
- Effective for dates of service on or after January 1, 2026, medically necessary and appropriate screening breast magnetic resonance imaging (MRI) or screening breast ultrasound will be covered as an alternative to screening mammography. Note: Prior authorization is required for high-tech radiology, including screening breast MRI.

For MassHealth ACO members:

- Screening mammography with or without screening digital breast tomosynthesis is covered annually starting at age 40.
- Effective for dates of service on or after January 1, 2026, medically necessary and appropriate screening breast magnetic resonance imaging (MRI) or screening breast ultrasound will be covered as an alternative to screening mammography. Note: Prior authorization is required for high-tech radiology, including screening breast MRI.

Providers should report ICD-10-CM diagnosis code Z12.31, “Encounter for screening mammogram for malignant neoplasm of breast,” when billing for a screening mammogram.

Providers should report ICD-10-CM diagnosis code Z12.39, “Encounter for other screening for malignant neoplasm of breast,” for non-mammography imaging techniques, such as a screening breast magnetic resonance imaging (MRI) or a screening breast ultrasound.

Service Provided	Medicare (Fallon Medicare Plus, NaviCare, SEC/FHW PACE)	Community Care	MassHealth ACO
Screening mammography	CPT 77067	CPT 77067	CPT 77067
Screening digital breast tomosynthesis, bilateral	CPT 77063 (add-on code; cannot be reported as a stand-alone service)	CPT 77063 (add-on code; cannot be reported as a stand-alone service)	CPT 77063 (add-on code; cannot be reported as a stand-alone service)
Screening mammography with screening digital breast tomosynthesis	CPT 77067 + CPT 77063	CPT 77067 + CPT 77063	CPT 77067 + CPT 77063
Screening breast magnetic resonance imaging (MRI) Requires prior authorization	Not covered	CPT 77046, 77047, 77048 or 77049	CPT 77046, 77047, 77048 or 77049
Screening breast ultrasound	Not covered	CPT 76641 or 76642 Both codes are unilateral; append modifier 50 to report bilateral procedure	CPT 76641 or 76642 Both codes are unilateral: If medical necessity requires bilateral imaging, you may append modifier 50 Bilateral procedure

Cervical Cancer Screening

Code	Description	Guidance/Instructions
88141-88175	Cytopath codes	Cervical Cancer Screening should be performed in accordance with the USPSTF recommendation ICD-10 Codes Z01.411: Encounter for gynecological examination (general) (routine) with abnormal findings Z01.419: Encounter for gynecological examination (general) (routine) without abnormal findings Z12.4: Encounter for screening for malignant neoplasm of cervix

Chlamydia and Gonorrhea Screening for Women

Code	Description	Guidance/Instructions

87491	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique	Chlamydia and Gonorrhea screenings are appropriate for woman as outlined by USPSTF Recommendation
87591	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, amplified probe technique	

Colorectal Cancer Screening

Commercial and MassHealth members

Effective May 18, 2021, the USPSTF has expanded the recommended ages for colorectal cancer screening to 45 to 75 years of age (previously it was 50 to 75 years). Recommended screening strategies include:

- High-sensitivity guaiac fecal occult blood test (HSgFOBT) or fecal immunochemical test (FIT) every year
- Stool DNA-FIT every 1 to 3 years
- Computed tomography colonography every 5 years
- Flexible sigmoidoscopy every 5 years
- Flexible sigmoidoscopy every 10 years + annual FIT
- Colonoscopy screening every 10 years

Code	Description	Guidance/Instructions
00811	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified	For commercial and MassHealth members, colorectal cancer screening is covered in accordance with the USPSTF A and B Recommendations in effect at the time the service is rendered (Colorectal Cancer: Screening, updated May 18, 2021). ICD-10 Codes Z12.11: Encounter for screening for malignant neoplasm of colon Z80.0: Family history of malignant neoplasm of digestive organs The ICD-10 definition of a screening is Screening is the testing for disease or disease precursors in seemingly well individuals so that early detection and treatment can be provided for those who test positive for the disease. Note: Computed tomographic (CT) colonography, diagnostic, including image postprocessing, with or without contrast (74261/74262) requires prior authorization
00812	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy	
45330	Sigmoidoscopy, flexible; diagnostic, with or without collection of specimen(s) by brushing or washing	
45331	Sigmoidoscopy, flexible; with biopsy, single or multiple	
45332	Sigmoidoscopy, flexible; with removal of foreign body(s)	
45333	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	
45334	Sigmoidoscopy, flexible; with control of bleeding, any method	
45335	Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance	
45337	Sigmoidoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed	
45338	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	
45340	Sigmoidoscopy, flexible; with transendoscopic balloon dilation	
45341	Sigmoidoscopy, flexible; with endoscopic ultrasound examination	
45342	Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)	

45346	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)	
45378	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	
45379	Colonoscopy, flexible; with removal of foreign body(s)	
45380	Colonoscopy, flexible; with biopsy, single or multiple	
45381	Colonoscopy, flexible; with directed submucosal injection(s), any substance	
45382	Colonoscopy, flexible; with control of bleeding, any method	
45384	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	
45385	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	
45386	Colonoscopy, flexible; with transendoscopic balloon dilation	
45388	Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)	
45391	Colonoscopy, flexible; with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures	
45392	Colonoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures	
74261	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material	
74262	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast Images, if performed	
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 Use for Cologuard™ multitarget stool DNA (sDNA) test	
82270	Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was	

	provided 3 cards or single triple card for consecutive collection) Use for HSgFOBT	
82274	Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations Use for Fecal Immunochemical Test (FIT), such as InSure®	
99151	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient younger than 5 years of age	
99152	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older	
99153	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intraservice time (List separately in addition to code for primary service)	
99155	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient younger than 5 years of age	
99156	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient age 5 years or older	
99157	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other	

	qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intraservice time (List separately in addition to code for primary service)	

Colorectal Cancer Screening for Fallon Medicare Plus, NaviCare and PACE member

Effective January 1, 2025, CMS is removing coverage of barium enema as a method of colorectal cancer (CRC) screening because this service is rarely used in Medicare and is no longer recommended as an evidence-based screening method (Transmittal R13295CP).

Effective January 1, 2025, CMS is expanding coverage for CRC screening to include computed tomography colonography (CTC). Refer to conditions and limitations of coverage in § 410.37(h) and (i) (Transmittal R13295CP).

Effective January 1, 2025, CMS is adding Medicare covered blood-based biomarker CRC screening tests as part of the continuum of screening. Like stool-based CRC screening tests, which are already in the definition of a complete CRC screening, a blood-based biomarker test with a positive result will lead to a follow-on screening colonoscopy (with no member cost-sharing) and is also revising the regulation text to clarify that CRC screening frequency limitations do not apply to the follow-on screening colonoscopy in the context of complete CRC screening (Transmittal R13295CP).

Effective for dates of service on or after January 1, 2023, coverage for the following colorectal cancer screening tests will begin at age 45 (reduced from 50 to 45): fecal occult blood tests (FOBT), multi-target stool DNA tests, blood-based biomarker tests, and flexible sigmoidoscopy.

Screening colonoscopy does not have a minimum age requirement under Medicare coverage.

Code	Description	Guidance/Instructions
00811	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified	For Medicare members, colorectal cancer screening for is covered in accordance with the Medicare Benefit Policy Manual, Chapter 15, Section 60, and the National Coverage Determination (NCD) for Colorectal Cancer Screening Tests (210.3) Find the current list of ICD-10 codes in the 210.3 Colorectal Cancer Screening coding file. For multitarget sDNA testing (0464U, 81528) and blood-based testing (0537U, G0327), use ICD-10 codes Z12.11 and Z12.12 For additional information on coverage for colorectal cancer screening services, refer to
00812	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy	
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 for dates of service on or after October 3, 2024. Use for Cologuard Plus™ (Exact Sciences Corporation) multitarget stool DNA (MT sDNA) test.	
0537U	Oncology (colorectal cancer), analysis of cell-free DNA for epigenomic patterns, nextgeneration sequencing, >2500 differentially methylated regions (DMRs), plasma, algorithm reported as positive or negative	

	Effective for dates of service on or after April 1, 2025. Use for Shield™ (Guardant Health, Inc.) FDA approval July 26, 2024.	Medicare Preventive Services Chart[1]
74263	Computed tomographic (CT) colonography, screening, including image postprocessing Effective for dates of service on or after January 1, 2025	
81528[2]	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 Use for Cologuard™ (Exact Sciences Corporation) multitarget stool DNA (MT sDNA) test. Cologuard (MT sDNA) is covered once every three years for Medicare members who meet all of the following criteria: • Age 45-85 years, and • Asymptomatic, and • At average risk of developing colorectal cancer.	
82270	Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided 3 cards or single triple card for consecutive collection) Use for HSgFOBT	
G0104	Colorectal cancer screening; flexible sigmoidoscopy NOTE: If during the course of a screening flexible sigmoidoscopy a lesion or growth is detected which results in a biopsy or removal of the growth; the appropriate diagnostic procedure classified as a flexible sigmoidoscopy with biopsy or removal along with modifier –PT should be billed rather than HCPCS G0104.	
G0105	Colorectal cancer screening; colonoscopy on individual at high risk NOTE: If during the course of the screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the growth, the	

[1] Medicare Preventive Services Chart available at: https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html.

[2] HCPCS code G0464 expired on December 31, 2015, and has been replaced with CPT code 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, effective January 1, 2016.

	appropriate diagnostic procedure classified as a colonoscopy with biopsy or removal along with modifier –PT should be billed and paid rather than HCPCS G0105. When a covered colonoscopy is attempted but cannot be completed because of extenuating circumstances, the Plan will pay for the interrupted colonoscopy as long as the coverage conditions are met for the incomplete procedure. When submitting a claim for the interrupted colonoscopy, professional providers are to suffix the colonoscopy code with a modifier of -53 to indicate that the procedure was interrupted. When submitting a facility claim for an interrupted colonoscopy, use modifier -73 or -74 as appropriate.	
G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk	
G0327	Colorectal cancer screening; blood-based biomarker The currently available FDA-approved ColoHealth (previously Epi proColon® (New Day Diagnostics) does not meet Medicare coverage criteria. At this time, ColoHealth is not covered.	
G0328	Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous Use for Fecal Immunochemical Test (FIT), such as InSure®	
G0500	Moderate sedation services provided by the same physician or other qualified health-care professional performing a gastrointestinal endoscopic service that sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intra-service time, patient age 5 years or older. Report G0500 for all endoscopic procedures where moderate sedation is inherent to the procedure. Additional time may be reported with 99153, as appropriate.	
99153	Moderate sedation services provided by the same physician or other qualified health-care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes of intra- service time (List separately in addition to code for primary service).	

Annual Depression Screening for Medicare Members

Annual depression screening, up to 15 minutes (G0444) is covered for Medicare Advantage (Fallon Medicare Plus/Plus Central), NaviCare, Summit ElderCare PACE and Fallon Health Weinberg PACE) plan members when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up. At a minimum level, staff-assisted supports consist of clinical staff (e.g., nurse, physician assistant) in the primary care setting who can advise the physician of screening results and who can facilitate and coordinate referrals to mental health treatment (NCD 210.9 Screening for Depression in Adults). Depression screening is a required component of a Medicare Initial Preventive Physical Examination (IPPE, "Welcome to Medicare" exam) and an initial Medicare annual wellness visit (AWV), therefore G0444 should not be reported with G0438 or G0402.

Effective January 1, 2025, annual depression screening may be provided via telehealth and billed with Place of Service (POS) 02 or 10 (CMS Transmittal R12763CP).

HCPCS G0444 is not covered for MassHealth ACO members (not listed as payable in MassHealth Physician Manual Subchapter 6, PHY-168, eff 07/01/2023, PHY-169 eff 01/01/2024).

Initial and periodic comprehensive preventive medicine visits (CPT 99381-99386, 99391-99396) include age- and gender-appropriate history; physical examination; counseling, anticipatory guidance, or risk factor reduction interventions; and the ordering of laboratory or diagnostic procedures. HCPCS G0444 (Annual depression screening, up to 15 minutes) should not be reported with an initial or periodic comprehensive preventive medicine visit (CPT 99381-99386, 99391-99396).

Code	Description	Guidance/Instructions
G0444	Annual depression screening, 15 minutes	Bill with a screening diagnosis code if billed with other preventive services, or with specific diagnosis code Z13.31: Encounter for screening for depression

Fluoride Varnish for MassHealth ACO members

Oral health education, fluoride varnish and fluoride supplementation are three aspects of oral health that are addressed by both primary care providers and dental providers. In accordance with Appendix W: EPSDT Services Medical and Dental Protocols and Periodicity Schedules, the need for fluoride varnish should be assessed at all preventive visits from 6 months to 5 years old. Once teeth are present, fluoride varnish may be applied to the child every 3 to 6 months in the primary care or dental office.

Effective for dates of service on or after August 19, 2025, when billing for fluoride varnish treatment provided to an EPSDT-eligible MassHealth member during a well-child visit (CPT 99381-99385 and 99391-99395) providers must bill the CPT code 99188 and ICD-10 code Z00.129, Routine Child Health Check. When billing for fluoride varnish treatment provided during any other visit, providers must bill CPT code 99188 and ICD-10 code Z41.8, Need for Prophylactic Fluoride Administration (MassHealth Provider Manual Appendix Z. EPSDT/PPHSD Screening Services Codes, page Z-1).

Code	Description
99188	Application of topical fluoride varnish by a physician or other qualified health care professional

Fluoride Varnish for Community Care members

The USPSTF recommends that primary care providers apply fluoride varnish to the primary teeth of all infants and children younger than 5 years, starting at the age of primary tooth eruption (USPSTF Prevention of Dental Caries in Children Younger Than 5 Years: Screening and Interventions).

Primary care providers should bill CPT 99188 with ICD-10-CM code Z29.3, Encounter for prophylactic fluoride administration, for topical application of fluoride varnish.

D1206 may only be used by dentists to bill for topical application of fluoride varnish for Community Care members with preventive dental coverage through Fallon Health.

Code	Description
99188	Application of topical fluoride varnish by a physician or other qualified health care professional
D1206	Topical application of fluoride varnish

Hearing Screening in Children

American Academy of Audiology Childhood Hearing Screening Guidelines[3] recommendations for hearing screening:

1. Screen children age 3 (chronologically and developmentally) and older using pure tone screening.
2. Otoacoustic emissions (OAE) should be used only when screening preschool and school age children for whom pure tone screening is not developmentally appropriate (ability levels < 3 years).
3. Tympanometry should be used as a second-stage screening method following failure of pure tone or otoacoustic emissions screening.

Code	Description	Guidance/Instructions
92551	Screening test, pure tone, air only	ICD-10 Codes Z00.121 Routine child health exam with abnormal findings Z00.129 Routine child health exam without abnormal findings
92558	Evoked otoacoustic emissions, screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis	
92567	Tympanometry (impedance testing)	

Note: ICD-10 codes Z01.10 (encounter for examination of ears and hearing without abnormal findings) and Z01.118 (encounter for examination of ears and hearing with other abnormal findings) are reported only when a child presents for an encounter specific to ears and hearing, not for a routine well-child examination at which a hearing screening is performed.

Hepatitis B Virus Screening

Code	Description	Guidance/Instructions
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)	The USPSTF recommends screening for those at high risk and for pregnant women Please utilize these diagnoses for high risk Z11.3 (Encounter for screening for infections with a predominantly sexual mode of transmission) Z11.59 (Encounter for screening for other viral diseases)
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	

[3] Available at: https://www.cdc.gov/ncbddd/hearingloss/recommendations.html.

	method; hepatitis B surface antigen (HBsAg) neutralization	Please utilize an appropriate encounter code related to pregnancy for pregnant woman
G0499	Hepatitis B screening in non-pregnant, high risk individual includes hepatitis B surface antigen (HBSAG) followed by a neutralizing confirmatory test for initially reactive results, and antibodies to HBSAG (anti-HBS) and hepatitis B core antigen (anti-HBC)	

Hepatitis C Virus Screening for Community Care and MassHealth Members

Effective March 2, 2020, the USPSTF expanded the population that should be screened for Hepatitis C virus to include asymptomatic adults aged 18 to 79 years (including pregnant women) without known liver disease. Previously the USPSTF recommended Hepatitis C virus screening in adults born between 1945 and 1965 and others at high risk.

Most adults should only be screened once per lifetime. Persons with continued risk for HCV infection (e.g., past or current injected drug use) should be screened periodically.

Note: A positive screening Hepatitis C antibody test result may be followed by diagnostic PCR (polymerase chain reaction) testing (e.g., CPT 87522). Diagnostic lab testing for commercial members is subject to member cost-sharing.

Code	Description	Guidance/Instructions
86803	Hepatitis C antibody;	For commercial and MassHealth members, Hepatits C virus screening is covered in accordance with the USPSTF A and B Recommendations in effect at the time the service is rendered: Hepatitis C Virus Infection in Adolescents and Adults: Screening (Updated March 2, 2020). Please utilize these diagnoses for high risk Z11.3 (Encounter for screening for infections with a predominantly sexual mode of transmission) Z11.59 (Encounter for screening for other viral diseases)

Hepatitis C Virus Screening for Fallon Medicare Plus, NaviCare and PACE embers

Hepatitis C screening is covered in accordance with the Medicare NCD for Screening for Hepatitis C Virus (HCV) in Adults (210.13).

1. A single, one-time hepatitis C screening test is covered for adults who do not meet the definition of high risk, but who were born from 1945 through 1965. Persons born before 1945 or after 1965 are not eligible for this benefit. This screening test should be billed with ICD-10 code Z11.59, Other problems related to lifestyle.
2. An initial screening for hepatitis C is covered for adults at high risk for HCV infection regardless of birth year. High risk is defined current or past history of illicit injection drug use and persons who have a history of receiving a blood transfusion prior to 1992. This screening test should be billed with ICD-10 code Z72.90, Other problems related to lifestyle.

3. Repeat screening is covered annually regardless of birth year only for those persons who have had continued illicit injection drug use since the prior negative screening test. This screening test should be billed with ICD-10 codes:
   - Z72.89 - Other problems related to lifestyle; and
   - F19.20 - Other psychoactive substance dependence, uncomplicated.

Code	Description	Guidance/Instructions
G0472	Hepatitis C antibody screening, for individual at high risk and other covered indication(s)	
G0567	Infectious agent detection by nucleic acid (DNA or RNA); hepatitis C, screening, amplified probe technique)	

HPV Screening

Code	Description	Guidance/Instructions
87623	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), low-risk types (eg, 6, 11, 42, 43, 44)	Screenings will be covered based upon the USPSTF Recommendation Please utilize these diagnoses for high risk Z11.3 (Encounter for screening for infections with a predominantly sexual mode of transmission) Z11.59 (Encounter for screening for other viral diseases)
87624	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), high-risk types (eg, 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68)	
87625	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), types 16 and 18 only, includes type 45, if performed	

HIV Preexposure Prophylaxis (PrEP) for Community Care and MassHealth ACO members

On June 11, 2019, the USPSTF released a recommendation that clinicians offer preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition. See Clinical Considerations on pages 2205-2206 of the USPSTF Recommendation Statement[4] for information about the identification of persons at high risk of HIV acquisition.

The USPSTF recommendation cites CDC guidelines[5] advise that PrEP is a comprehensive intervention comprised of antiretroviral medication and essential support services (including medication self-management/adherence counseling, risk reduction strategies, and mental health counseling, etc.) that ensure PrEP is administered safely and effectively to plan members who need it.

All persons whose sexual or drug injection history indicates consideration of PrEP and who are interested in taking PrEP must undergo laboratory testing to identify those for whom this intervention would be harmful or for whom it would present specific health risks that would require

[4] The full USPSTF Recommendation Statement is available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-human-immunodeficiency-virus-hiv-infection-pre-exposure-prophylaxis.

[5]. Preexposure Prophylaxis for the Prevention of HIV Infection in the United States – 2021 Update A Clinical Practice Guideline, available at: https://www.cdc.gov/hiv/guidelines/preventing.html. A guide to billing codes for PrEP coverage is available at https://www.nastad.org/resource/bi lling-coding-guide-hiv-prevention.

close monitoring. Tests include HIV testing, Hepatitis B and C testing, pregnancy testing (if applicable), testing for renal insufficiency (creatinine testing and calculated estimated creatinine clearance (eCrCl) or glomerular filtration rate (eGFR)) and screening for sexually transmitted infections (STIs).

Recommended ICD-10-CM codes
ICD-10-CM Z29. 81 – Encounter for HIV pre-exposure prophylaxisis, is a new ICD-10-CM diagnosis code that became effective on October 1, 2023. ICD-10-CM diagnosis code Z29.81 will be the primary diagnosis code for all PrEP claims.

Office visits - Effective October 1, 2023, Z29.81 will be the primary diagnosis code on office visits provided as part of the PrEP protocol. Additional ICD-10-CM diagnosis codes may be added as applicable, such as:

- Contact with and (suspected) exposure to human immunodeficiency virus [HIV] (Z20.6)

Lab tests - Because ICD-10 codes exist for each specific disease or disease category, lab services should be coded with the primary diagnosis code Z29.81 and one of the following additional diagnosis codes as applicable:

- Lab tests prior to initiation use screening codes:
  - Z11.4 - Encounter for screening for HIV
  - Z11.3 - Encounter for screening for infections with a predominantly sexual mode of transmission
  - Z11.59 - Encounter for screening for other viral diseases
- Subsequent lab tests (related to the ongoing risk of HIV, STD or HCV infection while taking PrEP) use contact with codes:
  - Z20.6 - Contact with and (suspected) exposure to HIV
  - Z20.2 - Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission
  - Z20.5 – Contact with and (suspected) exposed to viral hepatitis
- Lab tests ordered to evaluate conditions potentially associated with long-term use of PrEP medication (i.e., creatinine to assess for potential kidney injury) should include Z79.899 (Other long term (current) drug therapy).

Counseling - Effective October 1, 2023, Z29.81 will be the primary diagnosis code on claims for adherence counseling and counseling provided with baseline and periodic HIV and STI screening rendered or ordered as of the PrEP protocol and one of the following additional diagnosis codes as applicable:

- Z71.7 (HIV counseling) for adherence counseling (99401-99404).
- Z11.3, Z11.4, Z20.2 or Z20.6 for preventive counseling and risk factor reduction (99401-99404) provided with baseline and periodic HIV and STI screening.

Injectable PrEP - Z29.81 will be the primary diagnosis code on claims for both the injection and the administration.

Recommended CPT codes

Code	Description	Guidance/Instructions
99202-99205	Office visit or other outpatient visit for the evaluation and management of a new patient	Office visits - Office visits are covered when the primary purpose of the office visit is the delivery of a component of the USPSTF recommendation that is not billed separately,
99211-99215	Office visit or other outpatient visit for the evaluation and management of an established patient	
96572	Therapeutic, Prophylactic, and Diagnostic Injections and Infusions (Excludes Chemotherapy	The FDA has approved one injectable PrEP medication:

	and Other Highly Complex Drug or Highly Complex Biologic Agent Administration)	cabotegravir (CAB) 600 mg (Apretude®). For each injection, encounter the provider administering the Cabotegravir will bill CPT 96372 and J0739.
J0739	Injection, cabotegravir, 1 mg	
86701	HIV-1	HIV testing - Plan members must be tested and confirmed to be uninfected before starting PrEP and tested again for HIV every three months while taking PrEP
86702	HIV-2	
86703	HIV-1 and HIV-2, single result	
87389	HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result	
87535	HIV-1, amplified probe technique, includes reverse transcription when performed	
86704	Hepatitis B core antibody (HBc-Ab); total	Baselline Hepatitis B testing – Hepatitis B virus infection is not a contraindication to PrEP, but plan members being considered for PrEP must be screened so that when the PrEP medication, which suppresses HBV replication in the liver, is stopped, the plan member can be monitored to ensure safety and to rapidly identify any potential injury.
86706	Hepatitis B surface antibody (HBsAb)	
87340	Hepatitis B surface antigen (HBsAG)	
87341	Hepatitis B surface antigen (HBsAG) neutralization	
86803	Hepatitis C antibody	Hepatitis C testing – Plan members should be screened at baseline for hepatitis C virus infection. Plan members with ongoing risk of contracting hepatitis C should be screened periodically consistent with CDC guidelines for hepatitis C screening.
86804	Hepatitis C antibody; confirmatory test (e.g., immunoblot	
82565	Creatinine; blood	Creatinine testing with calculation of estimated creatine clearance (eCrCl) or glomerular filtration rate (eGFR) – The estimated eCrCl or eGFR must be measured and calculated before beginning PrEP to assess if kidney function is in the range for safe prescribing of PrEP medication. Creatinine and eCrCL or eGFR should be checked periodically consistent with CDC guidelines while on PrEP medication to assess for potential kidney injury and to ensure that it is safe to continue PrEP medication.

87491	Chlamydia trachomatis, amplified probe technique	Testing for sexually transmitted infections (STIs) – Persons must be screened for STIs at baseline and should be screened periodically thereafter consistent with CDC guidelines, which may require multiple anatomic site testing (i.e., genital, oropharyngeal, and rectal) for gonorrhea and chlamydia, and testing for syphilis, together with behavioral counseling, which are recommended to reduce the risk of STIs, the presence of which may increase the likelihood of acquiring HIV sexually.
87591	Neisseria gonorrhoeae, amplified probe technique	
87801	Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe technique Use when performing combined chlamydia and gonorrhea testing	
86592	Syphilis test, non-treponemal antibody; qualitative	
86593	Syphilis test, non-treponemal antibody; quantitative	
86780	Treponema pallidum	
84702	Gonadotropin, chorionic (hCG); quantitative	Persons with childbearing potential must be tested for pregnancy at baseline and should be tested again periodically thereafter consistent with CDC guidelines until PrEP is stopped so that pregnant patients, together with their health care providers, can make a fully informed and individualized decision about taking PrEP.
84703	Gonadotropin, chorionic (hCG); qualitative	
84705	Urine pregnancy test, by visual color comparison methods	
99401-99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure)* * Any E&M service reported on the same day must be distinct and reported with modifier 25, and time spent providing these services may not be used as a basis for the E&M selection	Adherence counseling – Persons taking PrEP must be offered regular counseling for assessment of behavior and adherence consistent with CDC guidelines to ensure that PrEP is used as prescribed and to maximize PrEP's effectiveness. Sexually transmitted infection (STI) screening and counseling - Persons taking PrEP must be screened for STIs at baseline and should be screened periodically thereafter consistent with CDC guidelines, together with behavioral counseling, which are recommended to reduce the risk of STIs.

Pre-Exposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) Prevention for Medicare members

Pre-exposure prophylaxis (PrEP) involves the use of antiretroviral drugs to decrease the risk of acquiring human immunodeficiency virus (HIV). The Centers for Medicare and Medicaid Services (CMS) issued a National Coverage Determination (NCD) for Pre-Exposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) Prevention (NCD 210.15) effective for dates of service on or after September 30, 2024. The NCD directs Medicare to cover all forms of PrEP (oral and injectable) under Medicare Part B with no deductibles, copayments, or coinsurance for individuals at increased risk of HIV acquisition. Previously PrEP was only covered under Part D and Medicare beneficiaries without Part D coverage did not have coverage for medications for PrEP.

The determination of whether an individual is at increased risk for HIV is made by a physician or health care practitioner who assessed the individual's history.

For individuals being assessed for or using PrEP to prevent HIV, the NCD includes coverage of the following clinical and laboratory services required for PrEP with no cost-sharing:

a. Up to eight individual counseling visits, every 12 months, that include HIV risk assessment (initial or continued assessment of risk), HIV risk reduction, and medication adherence. Counseling must be furnished by a physician or other health care practitioner. Individuals must be competent and alert at the time that counseling is provided.
b. Up to eight HIV screening tests every 12 months.
c. A single screening for hepatitis B virus (HBV).

These screening tests are covered when the appropriate FDA-approved laboratory tests and point of care tests are used consistent with FDA-approved labeling and in compliance with the Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations.

NOTE: A single (1-time) screening for HBV is available under this NCD. NCD 210.6, Screening for Hepatitis B Virus (HBV) Infection, is a separate benefit and continues to apply to eligible beneficiaries.

Effective January 1, 2025, physicians and health care practitioners can bil the following codes:

Code	Description	Guidance/Instructions
J0739	Injection, cabotegravir, 1mg, FDA approved prescription, only for use as HIV pre-exposure prophylaxis (not for use as treatment for HIV)	ICD-10 Codes Z29.81: Encounter for HIV pre-exposure prophylaxis Z11.4: Encounter for screening for human immunodeficiency virus [HIV] Increased risk factors reported: A51.31, A51.32, A51.39, A51.41, A51.42, A51.43, A51.44, A51.45, A51.46, A51.49, A52.01, A52.02, A52.03, A52.04, A52.05, A52.06, A52.09, A52.11, A52.12, A52.13, A52.14, A52.15, A52.16, A52.17, A52.19, A52.2, A52.71, A52.72, A52.73, A52.74, A52.75, A52.76, A52.77, A52.78, A52.79, A53.0, A54.00, A54.01, A54.02, A54.03, A54.09, A54.1, A54.21, A54.22,
J0799	FDA approved prescription drug, only for use as HIV pre-exposure prophylaxis (not for use as treatment of HIV), not otherwise classified	
G0011	Individual counseling for pre-exposure prophylaxis (PrEP) by physician or QHP to prevent human immunodeficiency virus (HIV), includes: HIV risk assessment (initial or continued assessment of risk), HIV risk reduction and medication adherence, 15-30 minutes	
G0012	Injection of pre-exposure prophylaxis (prep) drug for HIV prevention, under skin or into muscle	
G0013	Individual counseling for pre-exposure prophylaxis (PrEP) by clinical staff to prevent human immunodeficiency virus (HIV), includes: HIV risk assessment (initial or continued assessment of risk), HIV risk reduction and medication adherence	

		A54.23, A54.24, A54.29, A54.31, A54.32, A54.33, A54.39, A54.41, A54.42, A54.43, A54.49, A54.5, A54.6, A54.81, A54.82, A54.83, A54.84, A54.85, A54.86, A54.89, A56.01, A56.02, A56.09, A63.8, A64, F11.10, F11.20, F11.21, F11.90, Z11.3, Z11.59, Z13.29, Z20.2, Z20.5, Z20.6, Z20.828, Z20.89, Z20.9, Z32.00, Z32.01, Z32.02, Z72.51, Z72.52, Z72.53, Z72.89, Z79.899, Z86.59, and Z87.898

Currently, under Medicare Part B, pharmacists are not eligible for direct payment for services furnished to Medicare patients. That is, if a pharmacist, under state scope of practice laws, furnishes counseling, injects a PrEP drug or orders PrEP, those services cannot be paid directly to the pharmacist and the drugs cannot be paid by Medicare Part B. Pharmacists may provide, when all conditions are met, services as auxiliary personnel "incident to" a physician's or other practitioner's service in certain settings. The incident to regulations require supervision by a physician or other practitioner, and such services would be billed by the supervising physician or practitioner. For further details regarding "incident to" services, we recommend that interested parties consult 42 CFR §§ 410.26 and 410.27 and https://www.cms.gov/medicare/payment/fee-schedules/physician-fee-schedule/advanced-practice-providers/incident-services-supplies.

HIV Screening for Community Care and MassHealth members

HIV screening for Community Care and MassHealth members is covered in accordance with the USPSTF A and B Recommendations in effecti at the time the service is rendered (Human Immunodeficiency Virus (HIV) Infection: Screening (Updated June 11, 2019).
A Recommendation: The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults aged 15 to 65 years. Younger adolescents and older adults who are at increased risk of infection should also be screened. See the Clinical Considerations section for more information about assessment of risk,
A Recommendation: The USPSTF recommends that clinicians screen for HIV infection in all pregnant persons, including those who present in labor or at delivery whose HIV status is unknown.

Current CDC guidelines recommend testing for HIV infection with an antigen/antibody immunoassay approved by the US Food and Drug Administration that detects HIV-1 and HIV-2 antibodies and the HIV-1 p24 antigen, with supplemental testing following a reactive assay to differentiate between HIV-1 and HIV-2 antibodies. If supplemental testing for HIV-1/HIV-2 antibodies is nonreactive or indeterminate (or if acute HIV infection or recent exposure is suspected or reported), an HIV-1 nucleic acid test is recommended to differentiate acute HIV-1 infection from a false-positive test result. (CDC 2018 Quick reference guide: Recommended laboratory HIV testing algorithm for serum or plasma specimens, Updated January 2018).

The USPSTF found insufficient evidence to determine appropriate or optimal time intervals or strategies for repeat HIV screening. However, repeat screening is reasonable for persons known to be at increased risk of HIV infection, such as sexually active men who have sex with men; persons with a sex partner who is living with HIV; or persons who engage in behaviors that may convey an increased risk of HIV infection, such as injection drug use, transactional sex or commercial sex work, having 1 or more new sex partners whose HIV status is unknown, or having other factors that can place a person at increased risk of HIV infection (see "Risk

Assessment"). Repeat screening is also reasonable for persons who live or receive medical care in a high-prevalence setting, such as a sexually transmitted disease clinic, tuberculosis clinic, correctional facility, or homeless shelter.

The CDC and ACOG recommend repeat prenatal screening for HIV during the third trimester of pregnancy in women with risk factors for HIV acquisition and in women living or receiving care in high-incidence settings, and the CDC notes that repeat screening for HIV during the third trimester may be considered in all women.

Code	Description	Guidance/Instructions
86701	HIV-1	For Community Care and MassHealth members, HIV screening is covered in accordance with the USPSTF A and B Recommendations in effect at the time the service is rendered: Human Immunodeficiency Virus (HIV) Infection: Screening (Updated June 11, 2019). ICD-10 Codes: Z11.4 - Encounter for screening for HIV O09.00-O09.93 Supervision of high risk pregnancy Z34.00-Z39.2 Encounter for supervision of normal pregnancy
86702	HIV-2	
86703	Antibody; HIV-1 and HIV-2, single result	
87389	HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result	
87535	HIV-1, amplified probe technique, includes reverse transcription when performed	
80081	Obstetric panel (includes HIV testing) This panel must include the following: Blood count, complete (CBC), and automated differential WBC count (85025 or 85027 and 85004) OR Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009) Hepatitis B surface antigen (HBsAg) (87340) HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result (87389) Antibody, rubella (86762) Syphilis test, non-treponemal antibody; qualitative (eg, VDRL, RPR, ART) (86592) Antibody screen, RBC, each serum technique (86850) Blood typing, ABO (86900) AND Blood typing, Rh (D) (86901)	

HIV screening for Medicare members

Screening for HIV is covered for Medicare plan members in accordance with Medicare NCD HIV Screening (210.7):

- Annually for patients ages 15–65, without regard to perceived risk
- Annually for patients younger than 15 and adults older than 65 at increased HIV risk
- For pregnant patients, 3 times per pregnancy:
  - When diagnosed as pregnant,
  - During third trimester, and
  - At labor, if their clinician orders it

Code	Description	Guidance/Instructions
G0432	Infectious agent antibody detection by enzyme immunoassay (eia) technique, hiv-1 and/or hiv-2, screening	For Medicare members, HIV screening is covered in accordance with Medicare NCD HIV Screening (210.7), Version 2, Effective 04/13/2015 ICD-10 Codes: • Increased risk factors not reported: Z11.4 • Increased risk factors reported: Z11.4 and
G0433	Infectious agent antibody detection by enzyme-linked immunosorbent assay (elisa) technique, hiv-1 and/or hiv-2, screening	
G0435	Infectious agent antibody detection by rapid antibody test, hiv-1 and/or hiv-2, screening	
G0475	Hiv antigen/antibody, combination assay, screening	
80081	Obstetric panel (includes HIV testing) This panel must include the following: Blood count, complete (CBC), and automated differential WBC count	

	(85025 or 85027 and 85004) OR Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009) Hepatitis B surface antigen (HBsAg) (87340) HIV-1 antigen(s), with HIV-1 and HIV-2 antibodies, single result (87389) Antibody, rubella (86762) Syphilis test, non-treponemal antibody; qualitative (eg, VDRL, RPR, ART) (86592) Antibody screen, RBC, each serum technique (86850) Blood typing, ABO (86900) AND Blood typing, Rh (D) (86901)	Z72.51, Z72.52, Z72.53, or Z72.89 • Pregnant patients: Z11.4 and Z34.00, Z34.01, Z34.02, Z34.03, Z34.80, Z34.81, Z34.82, Z34.83, Z34.90, Z34.91, Z34.92, Z34.93, O09.90, O09.91, O09.92, or O09.93

Lactation

Code	Description	Guidance/Instructions
S9443	Lactation classes, nonphysician provider, per session	Lactation counseling services performed within the scope of an office visit will not separately be reimbursed. Services may require member reimbursement.
E0603	Breast pump, electric (AC and/or DC), any type	Prior authorization may be required based on plan type.

Lung Cancer Screening

CMS reconsidered the NCD for lung cancer screening with low dose computed tomography (LDCT) (210.14) and determined that the evidence is sufficient to expand eligibility, effective February 10, 2022, to include Medicare beneficiaries who meet all of the following criteria:

- Age 50 – 77 years;
- 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; and
- Receive an order for lung cancer screening with LDCT.

Per NCD 210.14, before a Medicare beneficiary's first LDCT screening, the beneficiary must receive a counseling and shared decision-making visit that is appropriately documented in the beneficiary's medical records (see **Counseling and Shared Decision-Making Visit Prior to First Lung Cancer Screening for Medicare plan members** below).

Effective March 9, 2021, the USPSTF recommends annual screening for lung cancer with low-dose computed tomography (LDCT) in adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. Previously the USPFTS recommended screening in adults aged 55 to 80 years with a 30 pack-year smoking history. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.

Code	Description	Guidance/Instructions
71271	Computed tomography (CT), thorax, low dose for lung cancer screening, without contrast material(s)	Prior authorization is required for LDCT for lung cancer screening (CPT 71271) for commercial and MassHealth ACO plan members.

	Note: Effective January 1, 2021 HCPCS code G0297 has been replaced by new CPT code 71271.	Effective September 1, 2021, prior authorization is not required for CPT 71271 for Medicare Advantage, NaviCare and PACE plan members. For commercial and MassHealth members, annual lung cancer screening using LDCT is covered in accordance with the USPSTF Recommendation for Lung Cancer Screening (updated March 9, 2021). For Medicare members, annual lung cancer screening using LDCT is covered in accordance with the Medicare NCD for Lung Cancer Screening with Low Dose Computed Tomography (210.14).[6] ICD-10-CM Diagnosis Codes: F17.210, F17.211, F17.213, F17.218, F17.219, Z87.891

Counseling and Shared Decision-Making Visit Prior to First Lung Cancer Screening for Medicare plan members

Code	Description	Guidance/Instructions
G0296	Counseling visit to discuss need for lung cancer screening using low dose CT scan (LDCT) (service is for eligibility determination and shared decision making)	Covered for Medicare plan members only. This counseling visit is required prior to the first lung cancer screening using LDCT per Medicare NCD for Lung Cancer Screening with Low Dose Computed Tomography (210.14). The counseling and shared decision–making visit must be appropriately documented in the plan member's medical records. ICD-10-CM Diagnosis Codes: F17.210, F17.211, F17.213, F17.218, F17.219, Z87.891

[6] LDCT lung cancer screening for Medicare members must be furnished in a radiology imaging facility that utilizes a standardized lung nodule identification, classification and reporting system per Medicare NCD 210.14. Additionally, the reading radiologist must must have board certification or board eligibility with the American Board of Radiology or equivalent organization..

Osteoporosis Screening

Code	Description	Guidance/Instructions
77080	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)	Only considered preventive if billed within the USPSTF recommendation for women 65 years and older or those with an increased risk below 65 as outlined in a formal clinical risk assessment tool

Other Preventive wellness screenings

Code	Description	Guidance/Instructions
80048	Basic metabolic panel (Calcium, total)	No specific billing instructions
80061	Lipid panel	
82043	Albumin; urine (eg, microalbumin), quantitative	
83036	Hemoglobin; glycosylated (A1C)	

Preventive Exams

Annual well visits with a primary care provider are covered for plan members 18 years of age and older, Well child visits are covered according to the schedule of well-child visits in the American Academy of Pediatrics (AAP)/Bright Futures Recommendations for Preventive Pediatric Health Care. For additional information on well-child visits, see Fallon Health's Well-Baby/Well-Child Care payment policy.

Note: Although well visits (CPT 99381-99387 and 99391-99397) are not covered by Original Medicare, an Annual Physical Examination is an added benefit for Fallon Medicare Plus, NaviCare and PACE members.

MassHealth ACO and Community Care members

For MassHealth ACO and Community Care members, comprehensive preventive medicine codes (99381–99387 and 99391–99397) may be used to report annual well-woman examinations and determined by the age of the patient and whether she is considered a new or established patient to the physician or practice. Depending on the circumstances, either Z01.411, Encounter for gynecological examination (general) (routine) with abnormal findings, or Z01.419, Encounter for gynecological examination (general) (routine) without abnormal findings, may be used as the ICD-10-CM diagnosis code for the annual exam performed by an obstetrician–gynecologist. Neither Z00.00, Encounter for general adult medical examination without abnormal findings, nor Z00.01, Encounter for general adult medical examination with abnormal findings, is appropriate when the visit is performed by an obstetrician–gynecologist.

The comprehensive nature of a preventive medicine code reflects an age and gender appropriate examination. Comprehensive preventive medicine codes include any of the following components:

- Counseling/anticipatory guidance/risk factor reduction interventions
- Age and gender appropriate comprehensive history
- Age and gender appropriate comprehensive physical examination (if performed) including, in most cases, but not limited to:
  - Gynecological exam
  - Breast exam
  - Collection of a Pap smear specimen
- Discussions about the status of previously diagnosed stable conditions
- Ordering of appropriate laboratory/diagnostic procedures and immunizations
- Discussions about issues related to the patient's age or lifestyle

Code	Description	Guidance/Instructions
99381	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)	**ICD-10 Codes** **Well child:** Z00.110, Health supervision for newborn under 8 days old Z00.111, Health supervision for newborn 8 to 28 days old Z00.121, Routine child health exam with abnormal findings Z00.129, Routine child health exam without abnormal findings **Well adult:** Z00.00, Encounter for general adult medical examination without abnormal findings, nor Z00.01, Encounter for general adult medical examination with abnormal findings
99382	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)	
99383	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years)	
99384	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)	
99385	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years	
99386	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years	
99387	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older	
99391	Periodic comprehensive preventive medicine reevaluation and management of an individual	

	including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year)	
99392	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)	
99393	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years)	
99394	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)	
99395	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years	
99396	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 40-64 years	
99397	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 65 years and older	

Medicare Wellness Visits

Initial Preventive Physical Examination

The Initial Preventive Physical Examination (IPPE) is also known as the "Welcome to Medicare Preventive Visit." Despite its name, the IPPE does not include an extensive physical examination. Rather, this service focuses on health promotion and disease prevention and detection. The IPPE may be performed by a physician (doctor of medicine or osteopathy) or by a qualified nonphysician practitioner (physician assistant, nurse practitioner, or clinical nurse specialist), not later than 12 months after the date the individual's first coverage begins under Medicare Part B.

The IPPE is a review of a patient's medical and social health history and includes education about other preventive services.

The IPPE includes:
(1) Review of the individual's medical and social history with attention to modifiable risk factors for disease detection,
(2) Review of the individual's potential (risk factors) for depression or other mood disorders,
(3) Review of the individual's functional ability and level of safety;
(4) An examination to include measurement of the individual's height, weight, body mass index, blood pressure, a visual acuity screen, and other factors as deemed appropriate, based on the beneficiary's medical and social history;
(5) End-of-life planning, upon agreement of the individual.
(6) Review current opioid prescriptions
(7) Screening for potential substance use disorders
(8) Educate, counsel and refer based on previous components
(9) Educate, counsel, and refer for other preventive services

A routine electrocardiogram (EKG) is covered as an optional component of the IPPE. The IPPE EKG must be billed with G0403, G0404 or G0405.

Resources:
Medicare Claims Processing Manual, Chapter 18, Section 80
42 CFR § 410.16 - Initial preventive physical examination: Conditions for and limitations on coverage.
MLN Educational Tool: Medicare Wellness Visits: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html

Annual Wellness Visit

An annual wellness visit (AWV), including personalized prevention plan, is covered when performed by a qualified health professional, for a Medicare beneficiary who is no longer within 12 months after the effective date of his/her first Medicare Part B coverage period, and has not received either an initial preventive physical examination (IPPE) or an AWV within the past 12 months. An AWV is a review of a patient's personalized prevention plan of services and includes a health risk assessment.

A qualified health professional for the purposes of providing an AWV includes:
- A physician who is a doctor of medicine or osteopathy; or,
- A physician assistant, nurse practitioner, or clinical nurse specialist
- A medical professional (including a health educator, registered dietitian, or nutrition professional or other licensed practitioner) or a team of such medical professionals, working under the direct supervision of a physician

The initial AWV (G0438) includes the following services:
- Perform health risk assessment
- Establish the patient's medical and family history
- Establishment of a list of current providers and suppliers that are regularly involved in providing medical care to the individual

- An examination to include measurement of the individual's height, weight, body mass index, blood pressure, a visual acuity screen, and other factors as deemed appropriate, based on the beneficiary's medical and social history;
- Detection of any cognitive impairments the patient may have
- Review of the individual's potential (risk factors) for depression or other mood disorders
- Review the patient's functional ability and level of safety
- Establishment of the following:
    - A written screening schedule for the individual such as a checklist for the next 5 to 10 years, as appropriate
    - A list of risk factors and conditions for which primary, secondary or tertiary interventions are recommended or are underway for the individual
- Provide personalized prevention plan services (PPPS), including personalized health advice and appropriate referrals to health education or preventive counseling services or programs
- Provide advance care planning (ACP) services at the patient's discretion
- Review any current opioid prescriptions
- Screen for potential substance use disorders
- Furnish a social determinants of health (SDOH) risk assessment at the discretion of the health professional and the beneficiary

Subsequent AWVs (G0439) include the following services:

- Review (and administration, if needed) of an updated health risk assessment
- Update of the individual's medical and family history
- Update of the list of current providers and suppliers that are regularly involved in providing medical care to the individual
- An examination to include measurement of the individual's height, weight, body mass index, blood pressure, a visual acuity screen, and other factors as deemed appropriate, based on the beneficiary's medical and social history
- Detection of any cognitive impairments the patient may have
- Update the following:
    - The written screening schedule for the individual that was established at the initial AWV
    - The list of risk factors and conditions for which primary, secondary or tertiary interventions are recommended or are underway for the individual, that was established at the initial AWV or a subsequent AWV
- As necessary, provide and update personalized prevention plan services (PPPS), including personalized health advice and appropriate referrals to health education or preventive counseling services or programs
- Provide advance care planning (ACP) services at the patient's discretion
- Review any current opioid prescriptions
- Screen for potential substance use disorders
- Furnish a social determinants of health (SDOH) risk assessment at the discretion of the health professional and the beneficiary

The health risk assessment (HRA) collects self-reported information about the beneficiary. It can be administered independently or by a health care professional. It is tailored to and takes into account the communication needs of the beneficiary. It takes no more than 20 minutes to complete and includes the following components:

- Demographic data, including but not limited to age, gender, race, and ethnicity.
- Self assessment of health status, frailty, and physical functioning.
- Psychosocial risks, including but not limited to, depression/life satisfaction, stress, anger, loneliness/social isolation, pain, and fatigue.
- Behavioral risks, including but not limited to, tobacco use, physical activity, nutrition and oral health, alcohol consumption, sexual health, motor vehicle safety (seat belt use), and home safety.
- Activities of daily living (ADLs), including but not limited to, dressing, feeding, toileting, grooming, physical ambulation (including balance/risk of falls), and bathing.

- Instrumental activities of daily living (IADLs), including but not limited to, shopping, food preparation, using the telephone, housekeeping, laundry, mode of transportation, responsibility for own medications, and ability to handle finances.

Starting in 2024, an annual social determinants of health (SDOH) risk assessment is an optional element of the AWV. This assessment must follow standardized, evidence-based practices and ensure communication aligns with the patient's educational, developmental, and health literacy level, as well as being culturally and linguistically appropriate. The SDOH risk assessment is:

- Provided on the same day as the AWV
- Provided by the same provider as the AWV
- Billed with HCPCS code G0136 and modifier 33
- Billed on the same claim as the AWV

Resources:
Medicare Benefit Policy Manual, Chapter 15, Section 280.5
Medicare Claims Processing Manual, Chapter 18, Section 140
42 CFR § 410.15 Annual wellness visits providing Personalized Prevention Plan Services: Conditions for and limitations on coverage
MLN Educational Tool: Medicare Wellness Visits: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html

Significant, separately identifiable, medically necessary evaluation and management (E/M) services may be reported at the same visit as the IPPE or AWV when clinically appropriate. Physicians and qualified nonphysician practitioners use CPT codes 99202-99215 to report an E/M with CPT modifier 25 to indicate that the E/M is a significant, separately identifiable service from the IPPE or AWV.

Code	Description	Guidance/Instructions
G0402	Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of medicare enrollment	ICD-10 Codes No specific diagnosis codes are required. The provider should report diagnosis codes consistent with the member's exam
G0403	Electrocardiogram, routine ecg with 12 leads; performed as a screening for the initial preventive 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 preventive physical examination	
G0405	Electrocardiogram, routine ecg with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination	
G0438	Annual wellness visit, includes a personalized prevention plan of service (PPPS), first visit	
G0439	Annual wellness visit, includes a personalized prevention plan of service (PPPS), subsequent visit	
G0136	Administration of a standardized, evidence-based social determinants of health risk assessment tool, 5-15 minutes	

Screenings for Postpartum Depression and Major Depressive Disorder for Community Care Members

The Plan provides coverage for postpartum depression and major depressive disorder screening for Community Care members in accordance with Commonwealth of Massachusetts Division of Insurance Filing Guidance Notice 2025-B, Date: March 4, 2025.

Screenings for postpartum depression and major depressive disorder is covered for postnatal individuals, defined as an individual who:
(i) is within 12 months of giving birth;
(ii) is a biological parent or an adoptive or foster parent that is within 12 months from assuming custodial care of a child; or
(iii) has lost a pregnancy due to a stillbirth, miscarriage or a medical termination within the previous 12 months.

Every postnatal individual who receives health care services from a primary care provider, obstetrician, gynecologist, certified nurse midwife or licensed certified professional midwife shall be offered a screening for postpartum depression or major depressive disorder and, if the postnatal individual does not object to such screening, such primary care provider, certified nurse-midwife or licensed certified professional midwife shall ensure that the postnatal individual is appropriately screened for postpartum depression or major depressive disorder in line with evidence-based guidelines.

- A primary care provider is a health care professional qualified to provide general medical care for common health care problems, who (i) supervises, coordinates, prescribes or otherwise provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii) maintains continuity of care within the scope of practice;
- A certified nurse midwife is a nurse licensed under M.G.L. c. 112, §80B and authorized to practice midwifery under M.G.L. c. 112, §80C; and
- A licensed certified professional midwife is a health care practitioner licensed by the board of registration of midwifery under M.G.L. c. 112, §293.

Every postnatal individual whose infant receives health care services from a pediatrician shall be offered a screening for postpartum depression or major depressive disorder by the infant's pediatrician, and, if the postnatal individual does not object to such screening, such pediatrician shall ensure that the postnatal individual is appropriately screened for postpartum depression or major depressive disorder in accordance with evidence-based guidelines.

If a health care professional administering a screening in accordance with this section determines, based on the screening methodology administered, that the postnatal individual is likely to be suffering from postpartum depression or major depressive disorder, such health care professional shall discuss available treatments for postpartum depression or major depressive disorder, including pharmacological treatments, and provide an appropriate referral to a mental health clinician. Such treatments are subject to the Plans review of the medical necessity of the requested care according to the medical necessity guidelines.

If the obstetrician, gynecologist, certified nurse midwife or licensed certified professional midwife is providing the global obstetrical service (and reporting a global code), the Plan considers screening depression as part of the global service and does not reimburse additionally for the service.

Code	Description	Guidance/Instructions
96160	Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument	ICD10 Codes Z13.31 Encounter for screening for depression Z13.32 Encounter for screening for maternal depression
96161	Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the	

	patient, with scoring and documentation, per standardized instrument	
96127	Brief emotional/behavioral assessment (eg, depression inventory, attention deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument	

Screening Pap Tests and Pelvic Examinations for Early Detection of Cervical or Vaginal Cancer (NCD 210.1)

A screening pelvic exam (includes a clinical breast exam) and a screening Pap test are covered for Fallon Medicare Plus, NaviCare and PACE members subject to the following frequency and other limitations:

- Annually (or 11 months past 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 the past 36 months
- Once every 24 months (or 23 months passed following the month of the last covered exam) for low-risk women

High risk factors for cervical and vaginal cancer are:

- Early onset of sexual activity (under 16 years of age)
- Multiple sexual partners (five or more in a lifetime)
- History of sexually transmitted disease (including HIV infection)
- Fewer than three negative or any pap smears within the previous seven years; and
- DES (diethylstilbestrol) - exposed daughters of women who took DES during pregnancy.

A screening pelvic examination (including a clinical breast examination) should include at least seven of the following eleven elements:

- Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge.
- Digital rectal examination including sphincter tone, presence of hemorrhoids, and rectal masses. Pelvic examination (with or without specimen collection for smears and cultures) including:
- External genitalia (for example, general appearance, hair distribution, or lesions).
- Urethral meatus (for example, size, location, lesions, or prolapse).
- Urethra (for example, masses, tenderness, or scarring).
- Bladder (for example, fullness, masses, or tenderness).
- Vagina (for example, general appearance, estrogen effect, discharge lesions, pelvic support, cystocele, or rectocele).
- Cervix (for example, general appearance, lesions, or discharge).
- Uterus (for example, size, contour, position, mobility, tenderness, consistency, descent, or support).
- Adnexa/parametria (for example, masses, tenderness, organomegaly, or nodularity).
- Anus and perineum.

For Medicare members, G0101 and Q0091 may be reported with an annual wellness visit (G0402, G0438, G0439, G0468), when performed.
It is not appropriate to bill G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination) and/or Q0091 (Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory) in addition to a comprehensive preventive medicine service code (99381-99387 and 99391-99397), as the preventive medicine service codes include an age and gender appropriate examination.

NCCI Procedure-to-Procedure (PTP) Edit Specific Issues:

1. HCPCS code G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination) may be reported with evaluation and management (E/M) services under certain circumstances. If a Medicare covered reasonable and medically necessary E/M service requires breast and/or pelvic examination, HCPCS code G0101 shall not be additionally reported. However, if the Medicare covered reasonable and medically necessary E/M service and the screening service, G0101, are unrelated to one another, both HCPCS code G0101 and the E/M service may be reported appending modifier 25 to the E/M service CPT code. Use of modifier 25 indicates that the E/M service is significant and separately identifiable from the screening service, G0101.
2. HCPCS code Q0091 (Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory) describes the services necessary to procure and transport a pap smear specimen to the laboratory. If an E/M service is performed at the same patient encounter solely for the purpose of performing a screening pap smear, the E/M service is not separately reportable. However, if a significant, separately identifiable E/M service is performed to evaluate other medical problems, the screening pap smear and the E/M service may be reported separately. Modifier 25 should be appended to the E/M CPT code indicating that a significant, separately identifiable E/M service was rendered.

Code	Description	Guidance/Instructions
G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	NCD Screening Pap Smears and Pelvic Examinations for Early Detection of Cervical or Vaginal Cancer (210.2) ICD-10 Codes • High risk: Z72.51, Z72.52, Z72.53, Z77.29, Z77.9, Z91.89, Z92.850, Z92.858, Z92.86, Z92.89 • Low risk: Z01.411, Z01.419, Z12.4, Z12.72, Z12.79, Z12.89
Q0091	Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory	

Syphilis Screening

Code	Description	Guidance/Instructions
86592	Syphilis test, non-treponemal antibody; qualitative (eg, VDRL, RPR, ART)	The USPSTF has recommends screening for Pregnant Women and those with Those with Increased Risk Use an appropriate pregnancy screening code or for those with increased risk Z11.3: Encounter for screening for infections with a predominantly sexual mode of transmission
86593	Syphilis test, non-treponemal antibody; quantitative	

Tobacco Cessation Counseling

Code	Description	Guidance/Instructions

99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	Use diagnosis code Z78.871(Personal history of nicotine dependence) Pharmacy benefits are also available for smoking cessation please consult the Plan's website here Services for non-pregnant adults and pregnant woman should be performed based upon the USPTF Recommendation
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes Not covered for MassHealth ACO plan members)	
S9453	Smoking cessation classes, nonphysician provider, per session	

Vaccines: Please see the Plan's Vaccination Payment Policy.

Vision Screening

Code	Description	Guidance/Instructions
99172	Visual function screening, automated or semi-automated bilateral quantitative determination of visual acuity, ocular alignment, color vision by pseudoisochromatic plates, and field of vision (may include all or some screening of the determination[s] for contrast sensitivity, vision under glare)	The UPSTF indicates screening should be done for children 3-5 years. Recommendation Utilize an encounter code for in the Z00.1 (Encounter for newborn, infant and child health examinations) range.
99173	Screening test of visual acuity, quantitative, bilateral	

Place of service

This policy applies to services rendered in all settings.

Policy history

Origination date: 01/01/2012

Previous revision date(s): 11/01/2014 - Updated discussion of preventive services with evaluation and management codes and moved to Fallon Health template.
11/01/2015 - Annual review and moved to new plan template.
07/01/2016 - Added codes 99497 and 99498.

Connection date & details: May 2017 – Annual review.
July 2018 – Annual review, no updates.
January 2019 – Added coding to billing/coding section.
January 2020 – Annual review, no updates.
July 2021 – Updated Billing/coding guidelines for colorectal cancer screening, hearing screening in children, Hepatitis C virus screening and lung cancer screening.
October 2021 - Updated to reflect that prior authorization is not required for LDCT for lung cancer screening (CPT 71271) for Medicare members.
January 2022 - Updated to include coverage and billing and coding instructions for HIV Preexposure Prophylaxis (PrEP); and billing and coding instructions for screening for behavioral health conditions for MassHealth ACO members from birth to 21 years.

April 2022 – Updated to include new lung cancer screening with low dose computed tomography eligibility criteria for Medicare plan members.
January 2023 – Updated Unhealthy Alcohol Use in Adults, added Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse for Medicare members, added Screening for asymptomatic bacteriuria in adults, updated Developmental and Behavioral Health Screening in Pediatric Primary Care, updated Colorectal Cancer Screening.
April 2023 – Added CPT 84703, 84705 and 87535 to Recommended CPT codes for PrEP billing; updated HIV Screening section.
January 2024 – Under Coding/billing guidelines, updated codes for screening mammography, also under Coding/billing guidelines, updated to include instructions related to the use of new ICD-10-CM diagnosis code Z29.81 for encounters related to HIV pre-exposure prophylaxis (PrEP).
April 2024 – Under Billing/coding guidelines, updated Unhealthy Alcohol Use in Adults: Screening and Behavioral Counseling Interventionsto indicate that CPT 99408, 99409 is payable for MassHealth ACO, NaviCare and Summit ElderCare PACE plan members effective 7/1/2023; under Depression Screening, clarified that G0444 is not covered for MassHealth ACO members.
July 2024 – Under Billing/coding guidelines, removed S0610, S0612 and S0613 under Preventive Exams; added new section for Medicare Wellness Visits; added new section for Screening Pap Tests and Pelvic Examinations for Early Detection of Cervical or Vaginal Cancer (NCD 210.1).
April 2025 – Under Billing/coding guidelines, added new section for Pre-Exposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) Prevention for Medicare members; renamed MassHealth Developmental and Behavioral Health Screening in Pediatric Primary Care, MassHealth Parent and Caregiver Depression, Developmental, or Autism Spectrum Disorder Screening, and updated coverage to indicate that parent and caregiver postpartum depression screening should occur at every preventive pediatric visit from the one-month visit to the twelve-month visit, consistent with Chapter 186 of the Acts of 2024; added new section for Screenings for Postpartum Depression and Major Depressive Disorder for Community Care Members; updated Annual Depression Screening for Medicare Members to indicate that annual depression screening may be delivered via telehealth.
January 2026 – Under Reimbursement, updated Breast Cancer Screening in accordance with Chapter 231 of the Acts or 2024, updated Fluoride Varnish Services for MassHealth ACO members in accordance with MassHealth Transmittal Letter ALL-252, updated Hepatitis C screening for Medicare members in accordance with Transmittal R13423CP, updated Colorectal Cancer Screening for Medicare members in accordance with Transmittal R13295CP, added new section for MassHealth Perinatal Depression Screening in accordance with MassHealth All Provider Bulletin 405.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.