My Notes on Today's CMS Call on the Initial Preventive Physical Exam (Not a Physical Exam) and the Annual Wellness Visit

Today's CMS call reviewed the guidelines for the IPPE (Initial Preventive Physical Exam) and the AWV (Annual Wellness Visit), what they include and how to code for them.

What is the IPPE (also called the "Welcome to Medicare Visit")?

The IPPE is a one-time visit, covered within 12 months after the effective date of Part B coverage and including:

- Review of medical and social history.
- Review of risk factors for depression.
- Review of functional ability and level of safety.
- Measurement of height, weight, body mass index, blood pressure, visual acuity, and other factors deemed appropriate.
- Discussion of end-of-life planning, if agreed upon by the patient.
- Education, counseling and referrals based on results of review and evaluation services performed during the visit, including a brief written plan such as a checklist, and if appropriate, education, counseling and referral for obtaining an electrocardiogram (a/k/a EKG, ECG).
- Note that although the IPPE has the word "exam" in it, there is NO physical exam associated with it. Most

practices attempt to call it the **Welcome to Medicare Visit** and try never to use the word “exam” in association with it.

Who can provide the IPPE?

- Physician (doctor of medicine or osteopathy)
- Qualified non-physician practitioner including nurse practitioner physician assistant or Clinical nurse specialist

How is the IPPE Billed?

G0402
Initial preventive physical examination (not really an examination); face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment, plus ONE of the following if a electrocardiogram is done.

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.

What if the IPPE is provided in a facility?

These services typically are provided in a physician office,

however, when the services are provided in a facility, the following institutions can bill as follows:

- Hospitals for inpatients (TOB 12X) and outpatients (TOB 13x)
- Skilled Nursing Facilities for inpatients (TOB 22X)
- Rural Health Centers (TOB 71X)
- Federally Qualified Health centers (TOB 77X)
- Critical Access Hospitals (TOB 85X)

What diagnosis code should be used?

Although a diagnosis code must be reported on the claim, there are no specific International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis codes that are required for the IPPE; therefore, Medicare providers should chose an appropriate ICD-9-CM diagnosis code.

How often can the IPPE and the screening EKG be performed?

The IPPE (G0402) is a one-time benefit that must be provided within 12 months of the effective date of a beneficiary's Medicare Part B coverage. The screening EKG (G0403, G0404, G0405), when done as a referral from an IPPE, is also only covered once during a beneficiary's lifetime.

How does the provider collect for the IPPE at time of service?

Effective for dates of services on or after January 1, 2011, the coinsurance or copayment and deductible are waived for the IPPE (G0402) only. The deductible and coinsurance still applies to the screening EKG.

What about screening for the abdominal aortic aneurysm (AAA)?

A one-time only ultrasound screening for an Abdominal Aortic Aneurysm (AAA) can be done as the result of a referral from an IPPE for Medicare beneficiaries with certain risk factors. The code for billing the AAA ultrasound screening is:

G0389

Ultrasound, B-scan and or real time with image documentation; AAA screening

Effective for dates of services on or after January 1, 2011, the co-insurance or co-payment and deductible are waived for the AAA ultrasound screening (G0389). For more information on the AAA ultrasound screening done as the result of a referral from an IPPE, please see the CMS Internet-Only Manual Pub. 100-04, chapter 18, section 110 on the CMS web site.

Please Note!
• The IPPE is a preventive wellness visit and not a routine physical examination.
• Medicare does not provide coverage for routine physical exams.

What if other services are provided during the IPPE?

If other evaluation and management services are provided in conjunction with the IPPE, use CPT Modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) as follows:

- Append to the additional E & M service denoting a separate Evaluation and Management (E/M) service

furnished with an IPPE.

- Cost sharing (coinsurance, copayment and deductible) applies to the additional (E/M) service.
- CPT codes 99201 –99215 may be reported depending on the clinical appropriateness of the circumstances.
- **Preventive services identified in CPT code range 99381 through 99397 are not covered by Medicare.**
- CMS speakers noted that they hoped physician offices would let patients know when they could incur out-of-pocket expenses.

NOTE: Some of the components of a medically necessary E/M service (e.g., a portion of history or physical exam portion) may have been part of the IPPE and should not be included when determining the most appropriate level of E/M service to be billed for the medically necessary, separately identifiable, E/M service.

What is the patient's role in preparing for the IPPE?

Providers should encourage patient to come prepared with the following information:

- Medical records, including immunization records if the provider doesn't already have them;
- Family health history in as much detail as possible; and
- A full list of medications and supplements, including calcium and vitamins –how often and how much of each is taken. (Many providers ask patients to bring their actual medication and supplement bottles to every visit so a medication reconciliation can take place and improved communication about medication can take place.)

What is the AWV?

The Annual Wellness Visit (AWV) was created by the Affordable Care Act (ACA) and is a new benefit for 2011. Medicare beneficiaries are eligible for one AWV every 12 months after they have had Medicare Part B for more than 12 months. This is a “visit” and not a physical examination. Patients have a tendency to hear the word “Annual” and think they are getting an annual physical.

The beneficiary does not need to receive an IPPE to be eligible for an AWV. However, if the beneficiary did receive an IPPE, –s/he is eligible for an AWV 12 months following the IPPE.

What is included in the AWV?

Medical/family history

- List of current providers/supplier.
- Blood pressure, height, weight, and other routine measurements.
- Detection of any cognitive impairment.
- Review (potential) risk factors for depression, functional ability, and level of safety.
- A written screening schedule (such as a checklist) for next 5-10 years.
- Documentation of risk factors and conditions where interventions are recommended.
- Personalized health advice and referrals for health education and preventive counseling.

Subsequent AWVs:

- Update of medical/family history.
- Update of list of current providers/suppliers.
- Measurement of weight, blood pressure, and other routine

measurements.
- Detection of any cognitive impairment.
- Update to the written screening schedule.
- Update to the list of risk factors and conditions where interventions have been recommended.
- Update to the personalized health advice and referrals for health education and preventive counseling

Who can provide an AWV?

A “health professional” meaning a:

- Physician
- Physician assistant
- Nurse practitioner
- Clinical nurse specialist
- Medical professional (including a health educator, a registered dietitian, or nutrition professional, or other licensed practitioner) or a team of such medical professionals, working under the direct supervision of a physician

How should the AWV be coded?

The following G-codes identify the AWV for Medicare payment:
G0438

Annual wellness visit, including Personalized Prevention Plan Service, first visit
G0439

Annual wellness visit, including Personalized Prevention Plan Service, subsequent visit

Who can bill for the AWV?

These services typically are provided in a physician office.

When the services are provided in a facility, the following institutions can bill:

- Hospital inpatients (TOB 12X) and outpatients (TOB 13x)
- Skilled Nursing Facilities inpatients (TOB 22X) and outpatients (23X)
- Rural Health Centers (TOB 71X)
- Federally Qualified Health centers (TOB 77X)
- Critical Access Hospitals (TOB 85X)

Note: Medicare makes a single fee schedule payment for a beneficiary's AWV when provided in a physician office or hospital outpatient department.

What diagnosis should be used for the AWV?

Although a diagnosis code must be reported on the claim, there are no specific International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis codes that are required for the AWV; therefore, Medicare providers should chose an appropriate ICD-9-CM diagnosis code or contact the local Medicare contractor for guidance.

How often can the AWV be performed

- First visit (G0438) – once in a lifetime
- Subsequent (G0439)-annually (after 12 full months have passed since the last AWV)

What should be collected at the time of service?

Effective for dates of services on or after January 1, 2011 co-payment or co-insurance and the Medicare Part B deductible are waived.

Please Note! AWV is a preventive wellness visit and not a routine physical examination. Medicare does not provide coverage for routine physical exams.

What if additional services are provided at the same time as the AWV:

If other evaluation and management services are provided in conjunction with the AWV, use CPT Modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) as follows:

- Append to the additional E & M service denoting a separate Evaluation and Management (E/M) service furnished with an IPPE.
- Cost sharing (co-insurance, co-payment and deductible) applies to the additional (E/M) service.
- CPT codes 99201 –99215 may be reported depending on the clinical appropriateness of the circumstances.
- **Preventive services identified in CPT code range 99381 through 99397 are not covered by Medicare,**
- CMS speakers noted that they hoped physician offices would let patients know when they could incur out-of-pocket expenses.

NOTE: Some of the components of a medically necessary E/M service (e.g., a portion of history or physical exam portion) may have been part of the AWV and should not be included when determining the most appropriate level of E/M service to be billed for the medically necessary, separately identifiable, E/M service.

What is the patient's role in preparing for the AWV?

Providers should encourage patient to come prepared with the following information:

- Medical records, including immunization records if the provider doesn't already have it;
- Family health history in as much detail as possible; and
- A full list of medications and supplements, including calcium and vitamins –how often and how much of each is taken. (Many providers ask patients to bring their actual medication and supplement bottles to every visit so a medication reconciliation can take place and improved communication about medication can take place.)

What is the proposed refinement to the AWV?

Medicare Physician Fee Schedule CY 2012 Proposed Rule suggests incorporating the use and results of a Health Risk Assessment into the provision of personalized prevention plan services during the AWV.

- The proposed rule text is available **here.**
- We welcome public comments before 5pm on August 30, 2011.
- Electronically through www.regulations.gov
- Hard copy (see instructions in the proposed rule)
- CMS staff cannot discuss this topic on today's call.

Q & A From the listeners (my

favorite!)

Q: As a RHC, we usually submit one line item for all services provided on a UB92. How are we supposed to bill this if we are providing both a preventive service and an E & M on the same day?

A: This question was not able to be answered. The listener was asked to send the question to the following email nationalprovidercall@cms.hhs.gov with the subject line reading "IPPE/AWV Call Question."

Q: We are an Article 28 Institution (place of service 22) – do we still bill the APC separately from the facility?

A: There is not a separate facility payment available, so a single payment is made to the physician or the facility.

Q: We are a Critical Access Hospital – when we receive an order for an EKG or ultrasound AAA, what diagnosis is supposed to come from the physician so that it will pass muster in a review?

A: The initial answer said the EKG should have a screening diagnosis and the AAA should have a risk factor diagnosis, but after a discussion, the listener was asked to send the question to the following email: nationalprovidercall@cms.hhs.gov with the subject line reading "IPPE/AWV Call Question."

Q: Does the IPPE have a physical exam as a component? If a physical exam is provided, should it be billed as a separate E & M?

A: No physical examination is included. If it is provided, it should be coded separately.

Q: Are there specific identified screening tools that must be used for the depression or mental acuity screening?

A: The physician may choose the screening tool for depression or mental acuity.

Q: We do provider-based billing and our system automatically splits the G code between facility and professional fees. How will we recoup the facility portion?

A: Only one payment is made based on the physician fee schedule.

Q: If Physician Assistants can perform IPPEs and AWVs, does this mean that the patient must be established since mid-level providers cannot care for new Medicare patients?

A: This question was not able to be answered. The listener was asked to send the question to the following email nationalprovidercall@cms.hhs.gov with the subject line reading "IPPE/AWV Call Question."

Q: Is the EKG and AAA screening benefits on the IPPE visit only? Will CMS ever add the EKG and AAA screening benefits to the AWV since so many patients don't take advantage of the IPPE?

A: We will take this under advisement.

Q: Can G0102 (digital rectal exam) be billed with an AWV?

A: Yes.

Q: RE: Referrals to personalized health advice, health education, etc? Are these services covered under Medicare or would these be out-of-pocket expenses for Medicare patients?

A: Would be out-of-pocket unless a covered service.

Q: Will mid-level providers performing AWVs be reimbursed the same as a physician providing the service?

A: This question was not able to be answered. The listener was asked to send the question to the following email

nationalprovidercall@cms.hhs.gov with the subject line reading "IPPE/AWV Call Question."

Q: Will everyone get the answers that were not provided today or just the person who sent the email?

A: CMS will not be compiling the answers, but will post frequently asked questions on their website.

Q: We are getting edits when billing the EKG with the IPPE and the EKG is being denied.

A.This question was not able to be answered. The listener was asked to send the question to the following email nationalprovidercall@cms.hhs.gov with the subject line reading "IPPE/AWV Call Question."

Q: Can V70.5 (unspecified health examination) be used as a diagnosis for IPPE or AWV?

A: Yes, any diagnosis can be used.

Q: Can a medically-necessary EKG (93000) be billed with a IPPE or AWV?

A: Yes.

Q: What should we do when a Medicare patient refuses the AWV and wants a traditional preventive visit? Do we get an ABN signed and charge the 99397 per the patient's request?

A: Yes. Treat the preventive service the way you would any other non-covered service.

Q: Can an IPPE be provided with a pap and pelvic?

A: Yes.

Q: If providing an IPPE, pap and pelvic, breast exam and a physical examination to a Medicare beneficiary, can the physician choose NOT to bill the patient for the physical

exam?

A: This question was not able to be answered. The listener was asked to send the question to the following email nationalprovidercall@cms.hhs.gov with the subject line reading "IPPE/AWV Call Question."

Q: We are having problems with Medicare beneficiaries turning down the IPPE or AWV, asking for an annual physical examination (preventive service), then getting a bill, then calling Medicare and the Medicare rep telling the patient that they should never have been charged.

A: The speakers asked for details about the caller's experience in an email to: nationalprovidercall@cms.hhs.gov with the subject line reading "IPPE/AWV Call Question."

Q: On the Medicare Preventive Physical Exam form, what is the "Up and Go" test?

A: This question was not able to be answered due to the form not being recognized. The listener was asked to send the form to the following email nationalprovidercall@cms.hhs.gov with the subject line reading "IPPE/AWV Call Question."

Q: We are having problems with patients asking for the AWV, but presenting with medical issues. The patients want the service without having to pay the deductible or co-insurance.

A: You can bill for an E & M in addition to the AWV, but the deductible and co-insurance will apply.

Note: if you have a question that was not answered today, you can send it to the following email nationalprovidercall@cms.hhs.gov with the subject line reading "IPPE/AWV Call Question." Every question will not be able to be answered, but they will try to answer as many as possible.

Mary Pat's Suggestions to CMS for future calls:

1. Don’t make presenters with laryngitis participate.
2. Coach all presenters in speaking for an audio presentation – speak slowly, speak loudly, don’t move your head around (causes volume spikes and dips) and be cautious of the auditory disruption turning papers and coughing causes, OR
3. Have a professional or experienced speaker present the slides – no commentary is being given so the CMS experts aren’t needed to speak through the slides.
4. Have one facilitator delegating each question to a specific expert to answer it.

Updated 2011 CMS Policies: Incentive Payments, GPCI Revisions, Multiple Procedure Payment Reductions for Therapy, and Modification of Multiple Procedure Payment Policy for Advanced Imaging Services

Elimination of Deductible and Coinsurance for Most Preventive Services

Effective January 1, 2011, the Affordable Care Act waives the Part B deductible and the 20 percent coinsurance that would otherwise apply to most preventive services.

Note: I covered this in my post here and it's pretty straightforward.

Coverage of Annual Wellness Visit (AWV) Providing a Personalized Prevention Plan

The Affordable Care Act extends the preventive focus of Medicare coverage, which currently pays for a one-time initial preventive physical examination (IPPE or the "Welcome to Medicare Visit"), to provide coverage for annual wellness visits in which beneficiaries will receive personalized prevention plan services (PPPS). The law states that the AWV will include at least the following six elements, as determined by the Secretary of Health and Human Services:

- Establish or update the individual's medical and family history;
- List the individual's current medical providers and suppliers and all prescribed medications;
- Record measurements of height, weight, body mass index, blood pressure and other routine measurements;
- Detect any cognitive impairment
- Establish or update a screening schedule for the next 5 to 10 years including screenings appropriate for the general population, and any additional screenings that may be appropriate because of the individual patient's risk factors; and
- Furnish personalized health advice and appropriate

referrals to health education or education or preventive services.

CMS has developed two separate Level II HCPCS codes for the first annual wellness visit (G0438 – Annual wellness visit, including personalized prevention plan services, first visit), to be paid at the rate of a level 4 office visit for a new patient (similar to the IPPE), and for subsequent annual wellness visits (G0439 – Annual wellness visit, including personalized prevention plan services, subsequent visit), to be paid at the rate of a level 4 office visit for an established patient.

Note: Payment for annual wellness visits (AWV) is now covered by Medicare and the payment will be equivalent to a established level 4 visit. I've received a lot of questions about who can perform the PPPS and CMS says "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."

An evaluation and management code (EM) may be billed with the annual wellness visit if the EM service is medically necessary. If so, a modifier 25 must be appended to the EM service and the documentation for the EM service must have no components of the annual wellness visit used in determining the level of service for the EM visit. A separate note containing the history, exam and medical decision making, relative to the presenting problem, must be separately documented.

Incentive Payments to Primary Care Practitioners for Primary Care Services

The Affordable Care Act provides for incentive payments equal

to 10 percent of a primary care practitioner's allowed charges for primary care services under Part B, furnished on or after January 1, 2011, and before January 1, 2016. Under the final policy, primary care practitioners are: (1) physicians who have a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; as well as nurse practitioners, clinical nurse specialists, and physician assistants; and (2) for whom primary care services accounted for at least 60 percent of the practitioner's Medicare Physician Fee Schedule (MPFS) allowed charges for a prior period as determined by the Secretary of Health and Human Services.

The law also defines primary care services as limited to new and established patient office or other outpatient visits (CPT codes 99201 through 99215); nursing facility care visits, and domiciliary, rest home, or home care plan oversight services (CPT codes 99304 through 99340); and patient home visits (CPT codes 99341 through 99350).

In the final rule with comment period, CMS excluded consideration of allowed charges for hospital inpatient care and emergency department visits in determining whether the 60 percent primary care threshold is met. These exclusions will make it easier for practitioners of eligible specialties to become eligible for the payment incentive program. The incentive payments will be made quarterly based on the primary care services furnished in CY 2011 by the primary care practitioner, in addition to any physician bonus payments for services furnished in Health Professional Shortage Areas (HPSAs). CMS will determine a practitioner's eligibility for incentive payments in CY 2011 using claims data and the provider's specialty designation from CY 2009 for practitioners enrolled in CY 2009. For newly enrolled practitioners, CMS will use claims data from CY 2010 to make an eligibility determination regarding CY 2011 incentive payments. For subsequent years, CMS will revise the list of

primary care practitioners on a yearly basis, based on updated data regarding an individual's specialty designation and percentage of allowed charges for primary care services.

Note: There is nothing to count or report: the bonuses arrive quarterly. Providers in HPSAs will receive two bonuses. Want to know if you're in a HPSA? Click here.

Incentive Payments for Major Surgical Procedures in Health Professional Shortage Areas

The Affordable Care Act also calls for a payment incentive program to improve access to major surgical procedures "" defined as those with a 10-day or 90-day global period under the MPFS "" that are furnished by physicians in HPSAs on or after January 1, 2011, and before January 1, 2016. To be eligible for the incentive payment, the physician must be enrolled in Medicare as a general surgeon. The amount of the incentive payment is equal to 10 percent of the MPFS payment for the surgical services furnished by the general surgeon. The incentive payments will be made quarterly to the general surgeon when the major surgical procedure is furnished in a zip code that is located in a HPSA. CMS will use the same list of HPSAs that it has used under the existing HPSA bonus program.

Note: 10% bonus for general surgeons in HPSAs. Want to know if you're in a HPSA? Click here.

Revisions to the Practice Expense

Geographic Adjustment

As required by the Medicare law, CMS adjusts payments under the MPFS to reflect local differences in practice costs. CMS assigns separate geographic practice cost indices (GPCIs) to the work, practice expenses (PE), and malpractice insurance cost components of each of more than 7,000 types of physicians' services. The final rule with comment period discusses CMS' analysis of PE GPCI data and methods, and incorporates new data as part of the sixth GPCI update, while maintaining the current GPCI cost share weights pending the results of further CMS and Institute of Medicine studies.

The Affordable Care Act establishes a permanent 1.0 floor for the PE GPCI for frontier states (currently, Montana, Wyoming, Nevada, North Dakota, and South Dakota). The Affordable Care Act limits recognition of local differences in employee wages and office rents in the PE GPCIs for CYs 2011 and 2012 as compared to the national average. Localities are held harmless for any decrease in CYs 2011 and 2012 in their PE GPCIs that would result from the limited recognition of cost differences. CMS will continue to review the GPCIs in CY 2011, in accordance with the Affordable Care Act provision that requires the Secretary of Health and Human Services to analyze current methods of establishing PE GPCIs in order to make adjustments that fairly and reliably distinguish the costs of operating a medical practice in the different fee schedule areas.

Note: Check your GPCI (pronounced "gypsy") for changes this year and every year. The GPCI changes the RVU values so they are specific to your location.

Where do I find my GPCI? Click here, click on Physician Fee Schedule Search at the top, click to accept the AMA terms, click on Geographic Practice Cost Index, enter your locality and click submit.

Improved Access to Certified Nurse-Midwife Services

The Affordable Care Act increases the Medicare payment for certified nurse-midwife services from 65 percent of the PFS amount for the same service furnished by a physician to 100 percent of the PFS amount for the same service furnished by a physician (or 80 percent of the actual charge if that is less). The increased payment amount is effective for services furnished on or after Jan. 1, 2011.

Misvalued Codes under the Physician Fee Schedule

The Affordable Care Act requires CMS to periodically review and identify potentially misvalued codes and make appropriate adjustments to the relative values of the services that may be misvalued. CMS has been engaged in a vigorous effort over the past several years to identify and revise potentially misvalued codes. The final rule with comment period identifies additional categories of services that may be misvalued, including codes with low work RVUs commonly billed in multiple units per single encounter and codes with high volume and low work RVUs. The final rule also includes CMS' response to recommendations from the American Medical Association (AMA) Relative Value Update Committee (RUC) for CY 2011 regarding the work or direct practice expense inputs for 325 CPT codes.

Note: People and organizations are always lobbying to change the work or practice expense component of RVUs and some portion of the codes change every year. Make sure your computer is updated with the correct RVU components and total so your productivity reports are spot on.

Multiple Procedure Payment Reduction Policy for Therapy Services

The Affordable Care Act requires CMS to identify and make adjustments to the relative values for multiple services that are frequently billed together when a comprehensive service is furnished. CMS is adopting a multiple procedure payment reduction (MPPR) policy for therapy services in order to more appropriately recognize the efficiencies when combinations of therapy services are furnished together. The policy, as described in the CY 2011 MPFS final rule with comment period, states that the MPPR for "always" therapy services will reduce by 25 percent the payment for the practice expense component of the second and subsequent therapy services furnished by a single provider to a beneficiary on a single date of service. This policy will apply to all outpatient therapy services paid under Part B, including those furnished in office and facility settings.

Since publication of the CY 2011 MPFS final rule with comment period, this policy has been modified by the Physician Payment and Therapy Relief Act of 2010. Per this Act, CMS will apply the CY 2011 MPFS final rule policy of a 25 percent MPPR to therapy services furnished in the hospital outpatient department and other facility settings that are paid under section 1834(k) of the Social Security Act (referring to durable medical equipment), and a 20 percent therapy MPPR will apply to therapy services furnished in clinicians' offices and other settings that are paid under section 1848 (payments to physicians) of the Act.

Note: The reduction applies solely to the practice expense (PE) portion of the fee schedule payment for "Always Therapy Services" when more than one service is provided the same patient on the same day. "Always therapy" services are always considered to be therapy regardless who provides the service (qualified therapist, physician, non-physician practitioner

(NPP)). This is the list of services being referred to:

- 92506””Speech /hearing evaluation
- 92507””Speech/hearing therapy
- 92508””Speech/hearing therapy
- 92526””Oral function therapy
- 92597””Oral speech device evaluation
- 92604””Exam for speech device
- 92609””Use of speech device service
- 96125””Standardized cognitive performance test
- 97001””PT evaluation
- 97002””PT re-evaluation
- 97003””OT evaluation
- 97001””OT re-evaluation
- 97012””Mechanical traction
- 97016””Vasopneumatic device
- 97018””Paraffin bath
- 97022””Whirlpool
- 97024””Diathermy (microwave)
- 97026””Infrared
- 97028””Ultraviolet
- 97032””Electrical stimulation
- 97033””Electric current
- 97034””Contrast bath
- 97035””Ultrasound
- 97036””Hydrotherapy
- 97110””Therapeutic exercise
- 97112””Neuromuscular reeducation
- 97113””Aquatic therapy
- 97116””Gait training
- 97124””Massage
- 97140””Manual therapy
- 97150””Group therapeutic
- 97530””Therapeutic activities
- 97533””Sensory integration
- 97535””Self-care management
- 97537””Community work reintegration

- 97542””Wheelchair management
- 97750””Physical performance test
- 97755””Assistive technology assessment
- 97760””Orthotic management & training
- 97761””Prosthetic training
- 97762””Checkout for orthotic or prosthetic use
- G0281””Electrical stimulation for ulcers (unattended)
- G0283””Electrical stimulation other than wound (unattended)
- G0329””Electromagnetic therapy for ulcers

Modification of Equipment Utilization Factor and Modification of Multiple Procedure Payment Policy for Advanced Imaging Services

The Affordable Care Act adjusts the equipment utilization rate assumption for expensive diagnostic imaging equipment. Effective January 1, 2011, CMS will assign a 75 percent equipment utilization rate assumption to expensive diagnostic imaging equipment used in diagnostic computed tomography (CT) and magnetic resonance imaging (MRI) services. In addition, beginning on July 1, 2010, the Affordable Care Act increased the established MPFS multiple procedure payment reduction for the technical component of certain single-session imaging services to consecutive body areas from 25 to 50 percent for the second and subsequent imaging procedures performed in the same session.

Note: These are the services that were added by this policy:

- 70496-CT angiography, head
- 70498-CT angiography, neck
- 70544-MR angiography head w/o dye
- 70545-MR angiography head w/dye
- 70546-MR angiography head w/o & w/dye
- 70547-MR angiography neck w/o dye

- 70548-MR angiography neck w/dye
- 70549-MR angiography neck w/o & w/dye
- 71275-CT angiography, chest
- 71555- MRI angiography chest w/ or w/o dye
- 72159-MRI angiography spine w/o & w/dye
- 72191-CT angiography, pelvis w/o & w/ dye
- 72198-MRI angiography pelvis w/ or w/o dye
- 73206-CT angio upper extremity w/o & w/dye
- 73225-MR angio upper extremity w/o & w/dye
- 73706-CT angiography lower ext w/o & w/dye
- 73725-MR angio lower extremity w or w/o dye
- 74175-CT angiography, abdomen w/o & w/ dye
- 74185-MRI angiography, abdomen w/ or w/o dye
- 75565-Cardiology MRI velocity flow map add-on
- 75574-CT angiography heart w/3d image
- 75635-CT angiography abdominal arteries
- 76380-CAT scan follow-up study
- 77079-CT bone density, peripheral

Image via Wikipedia