



Physician Services Version

KEY CONCEPTS OUTLINE **Module 13: Preventive Services**

I. Preventive Evaluation and Management Services

A. Initial Preventive Physical Exam ("IPPE")

1. An IPPE is a specialized preventive physical examination designed to screen Medicare beneficiaries for a variety of diseases. The goals of the IPPE are health promotion and disease detection. IPPEs are sometimes referred to as "Welcome to Medicare" physical exams. <January 2015 CMS Flyer on "ABCs of IPPE">
2. Limitations on Coverage
 - a. Frequency Limit
 - (i) Medicare allows only one IPPE for each beneficiary. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.(C)>
 - b. Timing Limitation
 - (i) An IPPE is only covered if the beneficiary receives the IPPE within twelve months after the effective date of his/her first Medicare Part B coverage. <42 CFR § 410.16(b), 410.16(a); Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.(C)>
 - c. The Qualified Practitioner Limitations
 - (i) Only IPPEs furnished by one of the following types of practitioners are covered:
 - (a) Physician (MD or DO),
 - (b) Physician Assistant,

(c) Nurse practitioner, or

(d) Clinical Nurse Specialist. <42 CFR § 410.16(b), 410.16(a); Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.(B)>

d. Scope of Services Limitation

(i) To be covered, the IPPE must include: <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1>:

- (a) Review of the beneficiary's medical and social history, including past medical and surgical history, current medications, family history, history of alcohol, tobacco and illicit drug use, diet, and physical activities;
- (b) A review of the beneficiary's potential risk factors for depression or other mood disorders based on the use of standardized screening tests;
- (c) A review of the beneficiary's functional ability and level of safety, including hearing impairment, activities of daily living, falls risk, and home safety;
- (d) An examination which includes measurement of the beneficiary's height, weight, body mass index, blood pressure; visual acuity screen, and other factors based on the beneficiary's medical and social history and the clinical standards;
- (e) End of life planning, upon consent of the individual, where verbal or written information may be obtained and used to prepare an advance directive in the case where an injury or illness causes the individual to be unable to make health care decisions; and
- (f) Education, counseling, a written plan for obtaining appropriate preventive services, and referrals, if appropriate, based on the results of the IPPE evaluation. <42 CFR § 410.16(b), 410.16(a)>

3. Billing Issues

a. Specific HCPCS codes have been developed for billing for IPPEs and related services:

- (i) G0402 – used to bill for the IPPE itself, including the face-to-face visit and related services. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.(E)>

- (a) If a medically necessary E/M service is provided at the same visit as the IPPE, an E/M code with the -25 modifier may also be billed, indicating that the E/M service was a significant, separately identifiable service from the IPPE. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.(G)>
- b. A referral for a screening electrocardiogram (EKG) may be made. When the screening EKG is performed as a result of the IPPE, specific HCPCS Level II codes are to be used. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.(E)>
 - (i) G0403 – used to bill for a 12 lead EKG furnished in connection with an IPPE when the test (technical component) and interpretation (professional component) were both furnished by the billing entity.
 - (ii) G0404 – used to bill for a 12 lead EKG furnished in connection with an IPPE when only the test (technical component) was furnished by the billing entity.
 - (iii) G0405 – used to bill for a 12 lead EKG furnished in connection with an IPPE when only the interpretation (professional component) was furnished by the billing entity. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.(E)>
- c. Prolonged Preventive Services <MLN Matters Article, MM10181>
 - (i) Effective January 1, 2018, Medicare established payment for prolonged preventive services when billed in addition to an applicable preventive service payable under the Medicare Physician Fee Schedule
 - (ii) Both deductible and coinsurance is waived
 - (iii) HCPCS Coding
 - (a) G0513 - Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (list separately in addition to code for preventive service)
 - (b) G0514 - Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (list separately in

addition to code G0513 for additional 30 minutes of preventive service

(iv) Effective January 1, 2019, both prolonged preventive services, G0513 and G0514 are payable as telehealth services <83 Fed. Reg. 60031>

d. Screening for Abdominal Aortic Aneurysm (AAA)

(i) Referral from an IPPE is no longer required. The 2014 Medicare Physician Fee Schedule Final Rule established a policy change. Effective January 27, 2014, Medicare beneficiaries eligible to receive ultrasound screening for abdominal aortic aneurysms (AAA screening) can be referred for this one-time benefit at any time.

(a) Policy change removed the IPPE related referral.

(ii) Provided on or after January 1, 2017

(a) 76706 – used to bill for a screening ultrasound for abdominal aortic aneurysm

(iii) Provided on or before December 31, 2016

(a) G0389 – used to bill for an ultrasound screening for abdominal aortic aneurysm

(iv) Payment may be made for a one-time ultrasound screening for AAA for beneficiaries who meet the following criteria:

(a) receives a referral for such an ultrasound screening from the beneficiary's attending physician, physician assistant, nurse practitioner or clinical nurse specialist;

(b) receives such ultrasound screening from a provider or supplier who is authorized to provide covered ultrasound diagnostic services;

(c) has not been previously furnished such an ultrasound screening under the Medicare Program; and

(d) is included in at least one of the following risk categories:

(1) has a family history of abdominal aortic aneurysm;

(2) is a man age 65 to 75 who has smoked at least 100 cigarettes in his lifetime; or

(3) 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 determination process.

4. Coinsurance and Deductible Applicability

a. The Part B coinsurance and deductible are applied to the IPPE services as follows:

(i) IPPE (G0402) – Effective January 1, 2011, the coinsurance is waived. <MLN Matters SE1023>

(a) The deductible for the IPPE was waived starting January 1, 2009.

(ii) EKG codes (G0403, G0404, G0405) – The deductible and the coinsurance apply. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1(D)>

(iii) AAA screening (76706) – Starting January 1, 2011, both the deductible and coinsurance are waived. <One Time Notification Manual, Transmittal 864>

(a) Prior to January 1, 2011, G0389 was exempt only from the deductible. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.A>

5. ABN/Limitation on Liability Issues

a. The ABN requirements applicable to IPPE services are as follows:

(i) IPPEs Furnished During the Twelve Month Eligibility Period

(a) Beneficiary Receives More Than One IPPE

(1) No ABN is required in order to hold the beneficiary liable for additional IPPEs furnished during the twelve-month eligibility period. <Medicare Claims Processing Manual, Chapter 18 § 80.8>

(ii) IPPEs Furnished After the Twelve Month Eligibility Period

- (a) An ABN should be issued to hold beneficiaries liable when they are receiving any IPPE outside the twelve-month eligibility period. <Medicare Claims Processing Manual, Chapter 18 § 80.8>

B. Annual Wellness Visit (AWV)

1. The AWV is a preventive physical exam which includes personal prevention plan services (PPPS). <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.A.2>
2. Limitations on Coverage
 - a. Frequency Limit
 - (i) Initial AWVs are a once in a lifetime benefit. Unlimited subsequent AWVs are allowed after sufficient time has passed. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.A.2>
 - b. Timing Limitation
 - (i) Medicare will pay for an initial AWV if a beneficiary is more than 12 months past the effective date of his/her Medicare Part B coverage and has not received either an IPPE or an AWV within the preceding 12 months. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.C.2>
 - (a) Beneficiaries in their first 12 months of Part B coverage will only be eligible for an IPPE. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.C.2>
 - (ii) Subsequent AWVs will be allowed after more than 12 months have passed from the initial AWV or a previous subsequent AWV. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.C.2; Medicare Claims Processing Manual, Chapter 18 § 140.6>
 - c. The Qualified Practitioner Limitations
 - (i) AWVs provided by the following types of practitioners are covered:
 - (a) Physician (MD or DO),
 - (b) Physician Assistant,
 - (c) Nurse practitioner,
 - (d) Clinical Nurse Specialist

- (e) Other types of medical professionals including a health educator, registered dietitian, nutrition professional or other licensed practitioner or a team of such medical professionals who are working under the direct supervision of a physician. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.B>

d. Scope of Services Limitation

- (i) To be covered, the initial AWW must include: <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.A.(2)>

- (a) Establishment of, or update to, the individual's medical/family history,
- (b) Measurement of height, weight, body mass index (BMI) or waist circumference, and blood pressure and other routine measurements as deemed appropriate,
- (c) Establishment of a list of current providers and suppliers that are regularly involved in providing medical care to the individual;
- (d) Detection of any cognitive impairment the individual may have,
- (e) Review of an individual's potential risk factors for depression,
- (f) Review of the individual's functional ability and level of safety,
- (g) Establishment of a written screening schedule checklist for the individual for the next 5 to 10 years, as appropriate,
- (h) Establishment of a list of risk factors and conditions of which primary, secondary, or tertiary interventions are recommended or underway for the individual, including any mental health conditions or any such risk factors or conditions that have been identified through an IPPE, and a list of treatment options and their associated risks and benefits, and
- (i) Provision of personalized health advice to the individual and referral, as appropriate, to health education or preventive counseling services. <Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.A.(2)>

- (ii) To be covered, the subsequent AWW must include:

- (a) Update to the individual's medical /family history,

- (b) Measurements of an individual's weight (or waist circumference), BP, and other routine measurements as deemed appropriate, based on the individual's medical and family history,
- (c) Update to the list of the individual's current medical providers and suppliers that are regularly involved in providing medical care to the individual,
- (d) Detection of any cognitive impairment that the individual may have,
- (e) Update to the individual's written screening schedule as developed at the first AWW providing PPPS,
- (f) Update to the individual's list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are underway for the individual, as that list was developed at the first AWW providing PPPS, and
- (g) Appropriate personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs.

3. Billing Issues

- a. Specific HCPCS codes were developed to describe AWW services effective January 1, 2011:
 - (i) G0438 – Annual wellness visit; includes a personalized prevention plan of service (PPPS), initial visit
 - (ii) G0439 – Annual wellness visit, includes PPPS, subsequent visit
<Medicare Claims Processing Manual, Chapter 12 § 30.6.1.1.F.(2)>
- C. Colorectal Cancer Screening < Medicare Benefit Policy Manual, Chapter 15 §280.2; Medicare Claims Processing Policy Manual, Chapter 18 §60>
 - 1. Coverage and Frequency is dependent upon the beneficiary's risk status
 - a. High Risk vs. Not High Risk
 - (i) High Risk for Colorectal Cancer
 - (a) Defined as an individual with

- (1) A close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp;
- (2) A family history of familial adenomatous polyposis;
- (3) A family history of hereditary nonpolyposis colorectal cancer;
- (4) A personal history of adenomatous polyps; or
- (5) A personal history of colorectal cancer; or
- (6) Inflammatory bowel disease, including Crohn's Disease, and ulcerative colitis. <42 CFR410.37 (a)(3)>

2. Colorectal Cancer Screening with Additional Procedures Performed

- a. When a beneficiary has a colorectal cancer screening test and additional services (diagnostic/therapeutic) during the same encounter, the beneficiary has a coinsurance liability
- b. Section 122 of the Consolidated Appropriations Act addressed the coinsurance and allowed CMS to implement the elimination of coinsurance over a period of time (2022 – 2030).
 - (i) 20 percent coinsurance if performed on or after January 1, 2020
 - (ii) 15 percent coinsurance for CYs 2023 – 2026
 - (iii) 10 percent coinsurance for CYs 2027-2029
 - (iv) 0 percent coinsurance beginning CY 2030

3. Fecal Occult Blood Test

- a. Coverage
 - (i) Aged 50 and older at normal risk for developing colorectal cancer; or
 - (ii) At high risk for developing colorectal cancer
- b. Copayment/coinsurance waived; Deductible waived
- c. Testing Frequency
 - (i) Once every 12 months

d. HCPCS Coding

- (i) 82270 - Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (e.g., patient was provided three cards or single triple card for consecutive collection)
- (ii) G0328 - Fecal Occult Blood Test (FOBT), immunoassay, 1-3 simultaneous

4. Cologuard Multitarget Stool DNA

a. Coverage

- (i) Aged 50 – 85 years;
- (ii) Asymptomatic; and
- (iii) older at normal risk for developing colorectal cancer; or
- (iv) At average risk for developing colorectal cancer

b. Copayment/coinsurance waived; Deductible waived

c. Testing Frequency

- (i) Once every three years

d. HCPCS Coding

- (i) 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

5. Flexible Sigmoidoscopy

a. Coverage

- (i) Aged 50 and older at normal risk for developing colorectal cancer; or
- (ii) At high risk for developing colorectal cancer

b. Copayment/coinsurance waived; deductible waived

c. Testing Frequency

- (i) High Risk -once every 48 months
- (ii) Not high risk - Within 10 years of a previous screening colonoscopy or once at least 119 months have passed from a previous screening sigmoidoscopy

d. HCPCS Coding

- (i) G0104 - Flexible Sigmoidoscopy

6. Screening Colonoscopy

a. Coverage

- (i) Aged 50 and older at normal risk for developing colorectal cancer; or
- (ii) At high risk for developing colorectal cancer

b. Copayment/coinsurance waived; deductible waived

c. Testing Frequency

- (i) High Risk -once every 24 months
 - (a) Exception: Previous screening flexible sigmoidoscopy - covered only after at least 47 months have passed
- (ii) Not high risk - Once every 10 years or 48 months after previous sigmoidoscopy

(iii)HCPCS Coding

- (a) G0105 - Colonoscopy (high risk)
- (b) G0121 - Colonoscopy (not high risk)

7. Screening Barium Enema

a. Coverage

- (i) Aged 50 and older at normal risk for developing colorectal cancer; or
- (ii) At high risk for developing colorectal cancer

b. Copayment/coinsurance waived; deductible waived

- c. Testing Frequency
 - (i) High risk - Once every 24 months
 - (a) when used instead of flexible sigmoidoscopy or colonoscopy
 - (ii) Not high risk - Once every 48 months
 - (a) when used instead of flexible sigmoidoscopy or colonoscopy
- d. HCPCS Coding
 - (i) G0106 - Barium Enema (alternative to G0104)
 - (ii) G0120 - Barium Enema (alternative to G0105)
- D. Screening Mammography <Medicare Benefit Policy Manual, Chapter 15 §280.3; Medicare Claims Processing Manual, Chapter 18 §20>
 - a. Coverage
 - (i) All women aged 35 and over
 - b. Copayment/coinsurance waived; deductible waived
 - c. Testing Frequency
 - (i) One baseline mammogram for women aged 35-39
 - (ii) For women 40 and over, screening mammography is covered annually
 - d. HCPCS Coding
 - (i) 77067 - Screening mammography, bilateral (2-view study of each breast), including CAD when performed
 - (ii) 77066 - diagnostic mammography, including (CAD) when performed; bilateral
 - (iii) 77065 - diagnostic mammography, including CAD when performed; unilateral
- E. Prostate Cancer Screening <Medicare Benefit Policy Manual, Chapter 15 §280.4; Medicare Claims Processing Manual, Chapter 18 §50>

- a. Coverage
 - (i) Male beneficiaries aged 50 and older
 - (a) Coverage begins day after 50th birthday
 - b. HCPCS Coding
 - (i) G0102 - Digital Rectal Exam (DRE)
 - (ii) G0103 - Prostate Specific Antigen (PSA) test
 - c. Coinsurance and Deductible
 - (i) G0102 - Copayment/coinsurance applies; Deductible applies
 - (ii) G0103 - Copayment/coinsurance waived; Deductible waived
 - d. Digital Rectal Exam (DRE) is bundled into a covered evaluation and management service when furnished on the same calendar date.
 - e. Testing Frequency
 - (i) Covered Annually
- F. Sexually Transmitted Infections (STIs) Screening <Medicare National Coverage Determinations Manual, Chapter 1 §210.10; Medicare Claims Processing Manual, Chapter 18 § 170>
- 1. Coverage is provided for beneficiaries must meet all of the following criteria:
 - (i) Sexually active adolescents and adults at increased risk for STIs
 - (a) High Risk/Increased Risk is based on the United States Preventive Services Task Force (USPSTF) guidelines and can include any of the following:
 - (1) Multiple sex partners
 - (2) Using barrier protection inconsistently
 - (3) Having sex under the influence of alcohol or drugs
 - (4) Having sex in exchange for money or drugs

(5) Age

a. Specific to chlamydia and gonorrhea

- i. Women 24 years of age or younger and sexually active

(6) Having an STI within the past year

(7) IV drug use - for hepatitis B only

(8) Males – men having sex with men (MSM) and engaged in high risk sexual behavior, but no regard to age

- (ii) Referred by primary care provider and provided by Medicare-eligible primary care provider in primary care setting

2. Frequency is variable and based on gender, risk, and specific STI

a. Screening for chlamydia, gonorrhea, and syphilis in women at increased risk who are not pregnant

- (i) Annual Occurrence

b. Syphilis screening in men at increased risk

- (i) Annual Occurrence

c. Screening for chlamydia and gonorrhea in pregnant women who are at increased risk for STIs and continued increased risk for the second screening

- (i) Up to two occurrences per pregnancy

d. Screening for syphilis in pregnant women; up to two additional occurrences in the third trimester and at delivery if at continued increased risk for STIs

- (i) Not of high risk - One occurrence per pregnancy

- (ii) Up to two additional occurrences in the third trimester and at delivery if at continued increased risk for STIs

e. Screening for hepatitis B in pregnant women;

- (i) One occurrence per pregnancy; and

- (ii) One additional occurrence at delivery if at continued increased risk for STIs

3. HCPCS Codes

a. Chlamydia

- (i) CPT codes: 86631, 86632, 87110, 87270, 87320, 87490, 87491, and 87810

b. Gonorrhea

- (i) CPT codes: 87590, 87591, 87850

c. Syphilis

- (i) 86592 - Syphilis test, non-treponemal antibody; qualitative
- (ii) 86593 - Syphilis test, non-treponemal, quantitative
- (iii) 86780 - Treponema pallidum

G. High Intensity Behavioral Counseling (HIBC) to Prevent STIs < Medicare National Coverage Determinations Manual, Chapter 1 §210.10; Medicare Claims Processing Manual, Chapter 18 §50>

1. Program intended to promote sexual risk reduction or risk avoidance. The program is flexibility to meet patient need but must include the following topics:

- a. Education;
- b. Skills training, and
- c. Guidance on how to change sexual behavior.

2. Coverage

- a. Available for all sexually active adolescents and for adults at increased risk for STIs, if referred for this service by a primary care provider and provided by a Medicare eligible primary care provider in a primary care setting.

3. Frequency

- a. Up to two 20-30 minute, face-to-face HIBC sessions annually
- 4. HCPCS Coding
 - a. G0445 - Semiannual high intensity behavioral counseling to prevent STIs, individual, face-to-face, includes education skills training and guidance on how to change sexual behavior, 30 minutes

H. Intensive Behavioral Therapy (IBT)

1. IBT for Obesity <Medicare Claims Processing Manual, Chapter 18 §200; Medicare National Coverage Determination Chapter 1 §210.12>
 - a. Coverage
 - (i) Beneficiaries with Medicare Part A or B coverage;
 - (ii) Obesity diagnosis (BMI \geq 30 kg/m²);
 - (iii) competent at time of counseling; and
 - (iv) The counseling furnished by qualified primary care physician or other primary care practitioner in primary care setting
 - b. Copayment/coinsurance waived; Deductible waived
 - c. Frequency
 - (i) First month: One face-to-face visit every week
 - (ii) Months two - six: One face-to-face visit every other week
 - (iii) Months 7 - 12: One face-to-face visit every month when certain requirements are met
 - (a) At the six-month visit, reassessment of obesity and determination of amount of weight loss must be performed
 - (b) To be eligible for additional face-to-face visits occurring once a month for additional six months, Medicare beneficiaries must have lost at least three kg
 - (c) For Medicare beneficiaries who do not achieve weight loss of at least three kg during first six months, reassessment of their readiness to change and Body Mass Index (BMI) is appropriate after additional six-month period

- d. Counseling Requirements
 - (i) Based on the USPTFS “Five A’s Approach”
 - (ii) Assess: Ask about or assess behavioral health risks and factors affecting choice of behavior change goals/methods
 - (iii) Advise: Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits
 - (iv) Agree: Collaboratively select appropriate treatment goals and methods based on patient's interest in and willingness to change behavior
 - (v) Assist: Using behavior change techniques (self-help and/or counseling), aid patient in achieving agreed upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate
 - (vi) Arrange: Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust treatment plan as needed, including referral to more intensive or specialized treatment
- e. HCPCS Coding
 - (i) G0447 - Face-to-face behavioral counseling for obesity, 15 minutes
 - (ii) G0473 - Face-to-face behavioral counseling for obesity, group (two–10), 30 minutes
- 2. IBT for Cardiovascular Disease <Medicare Claims Processing Manual, Chapter 18 §160; Medicare National Coverage Determination Chapter 1 §210.11>
 - a. Coverage
 - (i) Beneficiaries with Medicare Part A or B coverage;
 - (ii) competent at time of counseling; and
 - (iii) Furnished by qualified primary care physician or other primary care
 - b. Payable once per year
 - c. Copayment/coinsurance waived; Deductible waived
 - d. Required Therapy Components

- (i) Encouraging aspirin use for men ages 45-79 and women ages 55-79;
- (ii) High blood pressure screening for adults ages 18 and older; and
- (iii) Intensive behavioral counseling to promote a healthy diet for adults with hypertension, advancing age, and other known risk factors for cardiovascular- and diet-related chronic disease.

3. Counseling Requirements

- a. Based on the USPTFS “Five A’s Approach” (as stated above in the Intensive Behavioral Therapy section).

4. HCPCS Coding

- a. G0446 - Annual, face-to-face intensive behavioral therapy for cardiovascular disease

II. Vaccines

A. Pneumococcal Pneumonia Vaccination (PPV)

1. Medicare covers an initial pneumococcal vaccine who never received the vaccine under Medicare Part B.
2. A different, second pneumococcal vaccine 1 year after the first vaccine was administered. < *Medicare Benefit Policy Manual*, Chapter 15 § 50.4.4.2(A)(2)>
3. Medicare coverage requirements align with those made by the Advisory Committee on Immunization Practices (ACIP).
4. Coverage does not require a practitioner order or supervision.
5. No annual limit associated with the PPV; therefore, A/B MACs determine whether the services are medically necessary. < *Medicare Claims Processing Manual* Chapter 18 §10.1.2>
6. Adults 65 or Over:
 - a. ACIP recommends that adults aged 65 or over , not previously vaccinated with the pneumococcal conjugate vaccine (PCV) or who previous history is unknown, receive one dose of PCV (either PCVV20 or PCV15).

- b. When PCV15 is used it is to be followed by a dose of 23-valent pneumococcal polysaccharide vaccine (PPSV23).

7. Adults 19-64 with Underlying Condition or Other Risk Factors

- (i) For those not have not previously received PCV or whose previous vaccination history is unknown should receive 1 dose of PCV (either PCV20 or PCV15). When PCV15 is used, it should be followed by a dose of PPSV23

B. Hepatitis B Vaccine

1. Covered under Part B for hepatitis B vaccine and its administration, furnished to a Medicare beneficiary who is at high or intermediate risk of contracting hepatitis B. < *Medicare Benefit Policy Manual*, Chapter 15 § 50.4.4.2(B)>

a. High Risk Groups Include:

- (i) ESRD patients;
- (ii) Hemophiliacs who receive Factor VIII or IX concentrates;
- (iii) Clients of institutions for the mentally retarded;
- (iv) • Persons who live in the same household as a Hepatitis B Virus (HBV) carrier;
- (v) Homosexual men;
- (vi) Illicit injectable drug abusers; and
- (vii) Persons diagnosed with diabetes mellitus

b. Intermediate Risk Groups

- (i) Staff in institutions for the mentally retarded; and
- (ii) Workers in health care professions who have frequent contact with blood or blood-derived body fluids during routine work.

- c. Vaccine administration requires an order provided by of a doctor of medicine or osteopathy, by a doctor of medicine or osteopathy, or by home health agencies, skilled nursing facilities, ESRD facilities, hospital outpatient departments, and persons recognized under the incident to physician services provision of law.

C. COVID-19 Vaccine

1. Medicare coverage is provided for COVID-19 vaccines, additional doses, and booster doses.
 - a. Includes bivalent and updated vaccines.
2. Can be provided without physician's order or supervision.
3. Providers and practitioners can participate in the CDC COVID 19 vaccination program.
 - a. Administer the vaccine with no out-of-pocket cost to your patients for the vaccine or administration of the vaccine.
 - b. Vaccinate everyone, including the uninsured, regardless of coverage or network status.
 - c. Providers and Practitioners cannot:
 - (i) Balance bill for COVID-19 vaccinations;
 - (ii) Charge your patients for an office visit or other fee if COVID-19 vaccination is the only medical service given; or
 - (iii) Require additional medical or other services during the visit as a condition for getting a COVID-19 vaccination.
4. Appropriate HCPCS codes, payment allowances, and effective dates can be found at:

D. Monkey Pox Vaccine

1. Effective July 26, 2022, the Monkey Pox vaccine and administration are covered under Medicare.
 - a. The vaccine product is provided by the federal government.
 - (a) The no-charge product code will be addressed/adjusted during claims processing; therefore, product HCPCS codes are to be reported on the claim.
 - (b) Patient cost-sharing is only applicable to the administration codes.
 - b. Vaccine products are reported with CPT codes 90611 and 90622

- c. Administration is reported with CPT codes 90471 or 90472.

III. Medicare Diabetes Prevention Program Expanded Model (MDPP)

A. Overview

1. A program consisting of evidence-based set of services aimed to help prevent the onset of type 2 diabetes among Medicare beneficiaries with an indication of prediabetes. < Medicare Diabetes Prevention Program (MDPP) Expanded Model Fact Sheet>

B. Supplier Enrollment <MDPP Provider Enrollment Fact Sheet; Fact Sheet Final Policies for the Medicare Diabetes Prevention Program Expanded Model in the Calendar Year 2018 Physician Fee Schedule Final Rule>

1. Supplier enrollment begins January 1, 2018 and will continue on a rolling basis.
2. To enroll as an MDPP supplier an entity must satisfy the following criteria and meet all other Medicare enrollment requirements:
 - a. At the time of enrollment has full CDC DPRP recognition.
 - b. Obtain and maintain an active and valid TIN and NPI at the organizational level.
 - c. Pass the application screening at a high categorical risk level § 424.518(c).
 - d. All coaches who will be furnishing MDPP services on the entity's behalf must obtain and maintain active and valid NPIs.
 - e. Submit a roster of all coaches who will be furnishing MDPP services on the entity's behalf. The roster must include:
 - (i) Coaches' first and last names,
 - (ii) SSN, and
 - (iii) NPI.
3. Utilize the MDPP-specific application, CMS-20134
 - (i) Items exceeding \$100 in retail value must:
 - (a) Remain the property of the MDPP supplier; and

(b) Be retrieved from the MDPP beneficiary at the end of the engagement incentive period. The MDPP supplier must document all retrieval attempts, including the ultimate date of retrieval.

(1) Documented diligent, good faith attempts to retrieve items of technology – considered to meet the requirements of retrieval.

C. Beginning April 1, 2018, MDPP Services will be available to eligible Medicare beneficiaries.

1. Eligible beneficiaries are those who:

- a. Are enrolled in Medicare Part B;
- b. Have a body mass index (BMI) of at least 25, or at least 23 if self-identified as Asian
- c. Meet 1 of the following 3 blood test requirements within the 12 months of the first core session:
 - (i) A hemoglobin A1c test with a value between 5.7 and 6.4%, or
 - (ii) A fasting plasma glucose of 110-125 mg/dL, or
 - (iii) A 2-hour plasma glucose of 140-199 mg/dL (oral glucose tolerance test)
- d. Have no previous diagnosis of type 1 or type 2 diabetes (other than gestational diabetes) and
- e. Do not have end-stage renal disease (ESRD)

D. Beginning January 1, 2022 – the program will be a 12-month program.

- 1. Beneficiaries enrolled prior to January 1, 2022, will complete the 24-month program previously associated with the MDPP.
- 2. Structured sessions utilizing a “coach” and presenting a Center of Disease Control curriculum to provide training for changes in diet and physical activity while provided weight loss strategies and attendance goals.
 - a. Three components:
 - (i) Core Sessions

- (a) MDPP suppliers must offer a minimum of 16 sessions, offered at least a week apart, during the first 6 months;
- (b) Available to eligible beneficiaries regardless of weight loss and attendance; and
- (c) MDPP suppliers must use a CDC-approved curriculum to guide sessions.

(ii) Core Maintenance Sessions

- (a) Months 7-12;
- (b) Sessions are available to eligible beneficiaries regardless of weight loss and attendance; and
- (c) MDPP suppliers must use a CDC-approved curriculum to guide sessions.
- (d) Beneficiaries must attend at least one in-person core maintenance session in months 10-12 and achieve or maintain 5% weight loss in months 10-12 to be eligible for coverage of the first ongoing maintenance session interval.

(iii) Ongoing Maintenance Sessions

- (a) Duration – 12 months divided into 4 intervals
- (b) MDPP suppliers must offer monthly maintenance sessions for an additional 12 months; and
- (c) Coverage is offered in three month intervals for monthly maintenance sessions, provided that beneficiaries maintain weight loss and attendance goals. Beneficiaries must attend at least 2 sessions and maintain 5% weight loss within an ongoing maintenance session interval to be eligible for the next ongoing maintenance session interval.

- b. Given that MDPP is a once in a lifetime benefit, the program must be portable and make up sessions available.
- c. Beneficiaries are able to change MDPP suppliers.
 - (i) Example: Dual cities, beneficiary relocation, and freedom of choice
- d. Make up Sessions must be available

(i) Can be in person or virtual

(a) In-person

- (1) Must use same curriculum as session missed
- (2) Maximum of one per week;
- (3) Maximum of one per day of regularly scheduled sessions

(b) Virtual

- (1) Same requirements as in-person make-up sessions;
- (2) Only by beneficiary request;
- (3) Compliant with Diabetes Prevention Recognition Program (DPRP) virtual standards;
- (4) Maximum of 4 during the core services period, of which no more than 2 are core maintenance sessions;
- (5) Maximum of 3 that are ongoing maintenance sessions; and
- (6) Weight loss measurements taken cannot be used for payment or eligibility.
- (7) All sessions, except the first session, may be provided as a virtual make up session.
- (8) Modifier -VM should be appended to the appropriate HCPCS code to indicate the make-up session was provided via a virtual setting. <82 Federal Register, 53287>
 - a. VM - Medicare diabetes prevention program (MDPP) virtual make-up session

3. MDPP Payment Structure and HCPCS Coding

a. Core Sessions <Medicare Diabetes Prevention Program (MDPP) Quick Reference Guide to Payment and Billing>

(i) Attendance

(a) One Session Only

(1) HCPCS G9873 - First Medicare Diabetes Prevention Program (MDPP) core session was attended by an MDPP beneficiary under the MDPP Expanded Model (EM). A core session is an MDPP service that: (1) is furnished by an MDPP supplier during months 1 through 6 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for core sessions.

(b) Four Sessions

(1) HCPCS G9874 – Four total Medicare Diabetes Prevention Program (MDPP) core sessions were attended by an MDPP beneficiary under the MDPP Expanded Model (EM). A core session is an MDPP service that: (1) is furnished by an MDPP supplier during months 1 through 6 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for core sessions.

(c) Nine Sessions

(1) HCPCS G9875 – Nine total Medicare Diabetes Prevention Program (MDPP) core sessions were attended by an MDPP beneficiary under the MDPP Expanded Model (EM). A core session is an MDPP service that: (1) is furnished by an MDPP supplier during months 1 through 6 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for core sessions.

(d) The five percent weight loss goal is not required to receive payment for core sessions.

b. Core Maintenance Sessions

(i) Attendance

(a) Two Sessions with Weight Loss

(1) HCPCS G9878 - Two Medicare Diabetes Prevention Program (MDPP) core maintenance sessions (MS) were attended by an MDPP beneficiary in months 7-9 under the MDPP Expanded Model (EM). A core maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 7 through 12 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions. The beneficiary achieved

at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at a core maintenance session in months 7-9.

(b) Two Sessions without Weight Loss

(1) HCPCS G9877 - Two Medicare Diabetes Prevention Program (MDPP) core maintenance sessions (MS) were attended by an MDPP beneficiary in months 10-12 under the MDPP Expanded Model (EM). A core maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 7 through 12 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions. The beneficiary did not achieve at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at a core maintenance session in months 10-12.

(c) Additional payment for the achievement and maintenance of the five percent weight loss goal during the first 12 months (core and

a. HCPCS G9880 - the MDPP beneficiary achieved at least 5% weight loss (WL) from his/her baseline weight in months 1-12 of the MDPP services period under the MDPP Expanded Model (EM). This is a one-time payment available when a beneficiary first achieves at least 5% weight loss from baseline as measured by an in-person weight measurement at a core session or core maintenance session.

c. Ongoing Maintenance Sessions

(i) Payment is only made when weight loss goal is achieved and maintained.

(ii) Interval One – Months 13-15

(a) Attendance – Two sessions

(1) HCPCS G9882 – Two Medicare Diabetes Prevention Program (MDPP) ongoing maintenance sessions (MS) were attended by an MDPP beneficiary in months 13-15 under the MDPP Expanded Model (EM). An ongoing maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 13 through 24 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-

approved DPP curriculum for maintenance sessions. The beneficiary maintained at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at an ongoing maintenance session in months 13-15

(iii)Interval Two – Months 16-18

(a) Attendance – Two Sessions

(b) HCPCS G9823 - Two Medicare Diabetes Prevention Program (MDPP) ongoing maintenance sessions (MS) were attended by an MDPP beneficiary in months 16-18 under the MDPP Expanded Model (EM). An ongoing maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 13 through 24 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions. The beneficiary maintained at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at an ongoing maintenance session in months 16-18.

(iv)Interval Three – Months 19-21

(a) Attendance – Two sessions

(b) HCPCS G9884 - Two Medicare Diabetes Prevention Program (MDPP) ongoing maintenance sessions (MS) were attended by an MDPP beneficiary in months 19-21 under the MDPP Expanded Model (EM). An ongoing maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 13 through 24 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions. The beneficiary maintained at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at an ongoing maintenance session in months 19-21.

(v) Interval Four – Months 22-24

(a) Attendance -2 sessions

(b) HCPCS G9885 - Two Medicare Diabetes Prevention Program (MDPP) ongoing maintenance sessions (MS) were attended by an MDPP beneficiary in months 22-24 under the MDPP Expanded

Model (EM). An ongoing maintenance session is an MDPP service that: (1) is furnished by an MDPP supplier during months 13 through 24 of the MDPP services period; (2) is approximately 1 hour in length; and (3) adheres to a CDC-approved DPP curriculum for maintenance sessions. The beneficiary maintained at least 5% weight loss (WL) from his/her baseline weight, as measured by at least one in-person weight measurement at an ongoing maintenance session in months 22-24.

- (c) Additional payment for the achievement and maintenance of the five percent weight loss goal during the first 12 months (core and core maintenance sessions)

- a. HCPCS G9881 - The MDPP beneficiary achieved at least 9% weight loss (WL) from his/her baseline weight in months 1-24 under the MDPP Expanded Model (EM). This is a one-time payment available when a beneficiary first achieves at least 9% weight loss from baseline as measured by an in-person weight measurement at a core session, core maintenance session, or ongoing maintenance session.

- (d) Bridge Payment <Fact Sheet: Final Policies for the Medicare Diabetes Prevention Program Expanded Model in the Calendar Year 2018 Physician Fee Schedule Final Rule>

- (1) Payable in circumstances where the beneficiary changes MDPP suppliers. A one-time, \$25.00 payment is made to the MDPP supplier furnishing services for the first time to a beneficiary who has previously received services from a different MDPP supplier.

- a. Promotes freedom of supplier choice for beneficiaries; and
 - b. Offsets the financial risk the subsequent MDPP supplier takes on by furnishing services to a beneficiary changing MDPP suppliers during the MDPP services period

- (2) HCPCS G9890 - Bridge Payment: A one-time payment for the first Medicare Diabetes Prevention Program (MDPP) core session, core maintenance session, or ongoing maintenance session furnished by an MDPP supplier to an MDPP beneficiary during months 1-24 of the MDPP Expanded Model (EM) who has previously received MDPP services from a different MDPP

supplier under the MDPP Expanded Model. A supplier may only receive one bridge payment per MDPP beneficiary.

(e) Informational Only Reporting

- (1) HCPCS G9891 - MDPP session reported as a line-item on a claim for a payable MDPP Expanded Model (EM) HCPCS code for a session furnished by the billing supplier under the MDPP Expanded Model and counting toward achievement of the attendance performance goal for the payable MDPP Expanded Model HCPCS code. (This code is for reporting purposes only).
- (2) No payment is associated with this code.
- (3) Used to report attendance at sessions that are not associated with a performance goal.
 - a. These codes should be listed on the same claim as the payable code with which they are associated.
 - i. Example:
 - ii. When submitting a claim to report beneficiary attendance for the fourth session of the core sessions the following would be reported:
 - iii. HCPCS G9874 – 4th session, payment (payable code)
 - iv. G9891 – reported once for beneficiary attendance of sessions 2 and 3.

4. MDPP Documentation Requirements <82 Federal Register, 53366>

- (i) Documentation must include (at minimum) the following:
 - (a) Organizational information:
 - (1) MDPP supplier name, CDC DPRP number, and NPI.
 - (b) Basic beneficiary information for each MDPP beneficiary in attendance, must include:
 - (1) Beneficiary name, HICN, or MBI, age.
 - (c) Evidence of beneficiary eligibility.

- (d) Documentation of the type of session
 - (1) i.e. core session, a core maintenance session, an ongoing maintenance session, an in-person make-up session, or a virtual make-up session.
- (e) Identification of which CDC-approved DPRP curriculum was associated with the session.
- (f) The NPI of the coach who furnished the session.
- (g) The date and place of service of the session.
- (h) Each MDPP's beneficiary's weight and date weight taken, in a form and manner as specified by CMS.
- (i) Any engagement incentives provided to the MDPP beneficiaries
 - (1) The date the item or service is furnished.
 - (2) (The identity of the MDPP beneficiary to whom the item or service is furnished.
 - (3) The agent of the MDPP supplier that furnished the item or service, if applicable.
 - (4) A description of the item or service.
 - (5) The retail value of the item or service.
 - (6) Documentation establishing that the item or service was furnished to the MDPP beneficiary during the engagement incentive period.
 - (7) For any incentives to be used by the beneficiary on an ongoing basis during the engagement incentive period, documentation must indicate that MDPP beneficiary is in the engagement incentive period at the time the MDPP has possession or access to the item furnished by the MDPP supplier.

Excerpt from the Medicare Benefit Policy Manual¹²⁻³¹

Chapter 15

2. At a frequency of once every 10 years (i.e., at least 119 months have passed following the month in which the last covered G0121 screening colonoscopy was performed); and
3. If the individual would otherwise qualify to have covered a G0121 screening colonoscopy based on the above (see §§280.2.2.D.1 and 2) **but** has had a covered screening flexible sigmoidoscopy (code G0104), then the individual may have a covered G0121 screening colonoscopy only after at least 47 months have passed following the month in which the last covered G0104 flexible sigmoidoscopy was performed.

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 appropriate diagnostic procedure classified as a colonoscopy with biopsy or removal should be billed and paid rather than code G0121.

E. Screening Barium Enema Examinations (codes G0106 and G0120)

Screening barium enema examinations are covered as an alternative to either a screening sigmoidoscopy (code G0104) or a screening colonoscopy (code G0105) examination. The same frequency parameters for screening sigmoidoscopies and screening colonoscopies above apply.

In the case of an individual aged 50 or over, payment may be made for a screening barium enema examination (code G0106) performed after at least 47 months have passed following the month in which the last screening barium enema or screening flexible sigmoidoscopy was performed. For example, the beneficiary received a screening barium enema examination as an alternative to a screening flexible sigmoidoscopy in January 1999. The count starts beginning February 1999. The beneficiary is eligible for another screening barium enema in January 2003.

In the case of an individual who is at high risk for colorectal cancer, payment may be made for a screening barium enema examination (code G0120) performed after at least 23 months have passed following the month in which the last screening barium enema or the last screening colonoscopy was performed. For example, a beneficiary at high risk for developing colorectal cancer received a screening barium enema examination (code G0120) as an alternative to a screening colonoscopy (code G0105) in January 2000. The count starts beginning February 2000. The beneficiary is eligible for another screening barium enema examination (code G0120) in January 2002.

The screening barium enema must be ordered in writing after a determination that the test is the appropriate screening test. Generally, it is expected that this will be a screening double contrast enema unless the individual is unable to withstand such an exam. This means that in the case of a particular individual, the attending physician must determine that the estimated screening potential for the barium enema is equal to or greater than the screening potential that has been estimated for a screening flexible sigmoidoscopy, or for

a screening colonoscopy, as appropriate, for the same individual. The screening single contrast barium enema also requires a written order from the beneficiary's attending physician in the same manner as described above for the screening double contrast barium enema examination.

280.2.3 - Determining Whether or Not the Beneficiary is at High Risk for Developing Colorectal Cancer

(Rev. 194, Issued: 09-03-14, Effective: Upon Implementation of ICD-10, Implementation: Upon Implementation of ICD-10)

A. Characteristics of the High Risk Individual



An individual at high risk for developing colorectal cancer has one or more of the following:

- A close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp;
- A family history of familial adenomatous polyposis;
- A family history of hereditary nonpolyposis colorectal cancer;
- A personal history of colorectal cancer;
- A personal history of adenomatous polyps;
- Inflammatory bowel disease, including Crohn's Disease, and ulcerative colitis.

B. Partial List of ICD-9-CM Codes Indicating High Risk (for Services before Implementation of ICD-10)

Listed below are some examples of diagnoses that meet the high risk criteria for colorectal cancer. This is not an all-inclusive list. There may be more instances of conditions which may be coded and could be at the medical directors' discretion.

- **Personal History**
 - V10.05 - Personal history of malignant neoplasm of large intestine
 - V10.06 - Personal history of malignant neoplasm of rectum, rectosigmoid junction, and anus
- **Chronic Digestive Disease Condition**
 - 555.0 - Regional enteritis of small intestine
 - 555.1 - Regional enteritis of large intestine
 - 555.2 - Regional enteritis of small intestine with large intestine
 - 555.9 - Regional enteritis of unspecified site
 - 556.0 - Ulcerative (chronic) enterocolitis
 - 556.1 - Ulcerative (chronic) ileocolitis
 - 556.2 - Ulcerative (chronic) proctitis
 - 556.3 - Ulcerative (chronic) proctosigmoiditis

- o 556.8 - Other ulcerative colitis
- o 556.9 - Ulcerative colitis, unspecified (nonspecific PDX on the MCE)

- **Inflammatory Bowel**

- o 558.2 - Toxic gastroenteritis and colitis
- o 558.9 - Other and unspecified noninfectious gastroenteritis and colitis

C. Partial List of ICD-10-CM Codes Indicating High Risk (for Services after Implementation of ICD-10)

Code	Description
K50.00	Crohn's disease of small intestine without complications
K50.011	Crohn's disease of small intestine with rectal bleeding
K50.012	Crohn's disease of small intestine with intestinal obstruction
K50.013	Crohn's disease of small intestine with fistula
K50.014	Crohn's disease of small intestine with abscess
K50.018	Crohn's disease of small intestine with other complication
K50.019	Crohn's disease of small intestine with unspecified complications
K50.10	Crohn's disease of large intestine without complications
K50.111	Crohn's disease of large intestine with rectal bleeding
K50.112	Crohn's disease of large intestine with intestinal obstruction
K50.113	Crohn's disease of large intestine with fistula
K50.114	Crohn's disease of large intestine with abscess
K50.118	Crohn's disease of large intestine with other complication
K50.119	Crohn's disease of large intestine with unspecified complications
K50.80	Crohn's disease of both small and large intestine without complications
K50.811	Crohn's disease of both small and large intestine with rectal bleeding
K50.812	Crohn's disease of both small and large intestine with intestinal obstruction
K50.813	Crohn's disease of both small and large intestine with fistula
K50.814	Crohn's disease of both small and large intestine with abscess
K50.818	Crohn's disease of both small and large intestine with other complication
K50.819	Crohn's disease of both small and large intestine with unspecified complications



Replacement of Mammography HCPCS Codes, Waiver of Coinsurance and Deductible for Preventive and Other Services, and Addition of Anesthesia and Prolonged Preventive Services

MLN Matters Number: MM10181 **Revised**

Related Change Request (CR) Number: 10181

Related CR Release Date: August 18, 2017

Effective Date: January 1, 2018

Related CR Transmittal Number: R3844CP

Implementation Date: January 2, 2018

Note: This article was revised on February 9, 2018, to reposition text under different headers on page 2. All other information is unchanged

PROVIDER TYPES AFFECTED

This MLN Matters Article is intended for providers submitting claims to Part A & B Medicare Administrative Contractors (MACs) for services furnished to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10181 provides for the replacement of HCPCS codes G0202, G0204, and G0206 with Current Procedural Terminology (CPT) codes 77067, 77066, and 77065, effective January 1, 2018. CR 10181 also applies the waiver of deductible and coinsurance to 76706, 77067, prolonged preventive services, and anesthesia services furnished in conjunction with and in support of colorectal cancer services. Make sure your billing staffs are aware of these changes.

The language and policy referred to in this article are included in Chapter 18, Sections 20 and 240 (new) of the "Medicare Claims Processing Manual", which is included as an attachment to CR 10181.

BACKGROUND

Replacement of Mammography HCPCS Codes

Effective for claims with dates of service on or after January 1, 2018, the following HCPCS codes are being replaced:

- G0202 - "screening mammography, bilateral (2-view study of each breast), including computer-aided detection Computer-Aided Detection (CAD) when performed"

- G0204 - “diagnostic mammography, including when performed; bilateral” and
- G0206 - “diagnostic mammography, including CAD when performed; unilateral”



These codes are being replaced by the following CPT codes:

- 77067 - “screening mammography, bilateral (2-view study of each breast), including CAD when performed”
- 77066 - “diagnostic mammography, including (CAD) when performed; bilateral” and
- 77065 - “diagnostic mammography, including CAD when performed; unilateral”.

As part of the January 2017 HCPCS code update, code G0389 was replaced by CPT code 76706. Type of Service (TOS) “5” was assigned to 76706, and the coinsurance and deductible were waived.

Effective January 1, 2018, the TOS for 76706 will be changed to “4” as part of the 2018 HCPCS update; the coinsurance and deductible will continue to be waived.

Summary of Changes: For claims with dates of service January 1, 2017, through December 31, 2017, report HCPCS codes G0202, G0204, and G0206. For claims with dates of service on or after January 1, 2018, report CPT codes 77067, 77066, and 77065 respectively.



Prolonged Preventive Services

Effective for claims with dates of service on or after January 1, 2018, prolonged preventive services will be payable by Medicare when billed as an add-on to an applicable preventive service that is payable from the Medicare Physician Fee Schedule, and both deductible and coinsurance do not apply. G0513 and G0514 for prolonged preventive services will be added as part of January 1, 2018, HCPCS update and the coinsurance and deductible will be waived.

Anesthesia Services

Section 4104 of the Affordable Care Act defined the term “preventive services” to include “colorectal cancer screening tests,” and as a result, it waives any coinsurance that would otherwise apply under Section 1833(a)(1) of the Social Security Act (the Act) for screening colonoscopies.

In addition, the Affordable Care Act amended Section 1833(b)(1) of the Act to waive the Part B deductible for screening colonoscopies, which includes anesthesia services as an inherent part of the screening colonoscopy procedural service. These provisions are effective for services furnished on or after January 1, 2011.

In the Calendar Year (CY) 2018 Physician Fee Schedule (PFS) Final Rule, the Centers for Medicare & Medicaid Services (CMS) modified reporting and payment for anesthesia services furnished in conjunction with and in support of colorectal cancer screening services. .

Anesthesia services furnished in conjunction with and in support of a screening colonoscopy are reported with CPT code 00812 (Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy). CPT Code 00812 will be added as part of January 1, 2018 HCPCS update. Effective for claims with dates of service on

or after January 1, 2018, Medicare will pay claim lines with new CPT code 00812 and waive the deductible and coinsurance.

When a screening colonoscopy becomes a diagnostic colonoscopy, anesthesia services are reported with CPT code 00811 (Anesthesia for lower intestinal endoscopic procedures, endoscopy introduced distal to duodenum; not otherwise specified) and with the PT modifier. CPT code 00811 will be added as part of the January 1, 2018 HCPCS update. Effective for claims with dates of service on or after January 1, 2018, Medicare will pay claim lines with new CPT code 00811 and waive only the deductible when submitted with the PT modifier.

ADDITIONAL INFORMATION

The official instruction, CR10181, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3844CP.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/>.

DOCUMENT HISTORY

Date of Change	Description
February 9, 2018	Article was revised to reposition text under different headers on page 2.
November 24, 2017	Initial article released.

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(d) * * *

(3) * * *

(i) Classified as high quality/low cost receive an upward adjustment of +3x (rather than +2x); and

(ii) Classified as either high quality/average cost or average quality/low cost receive an upward adjustment of +2x (rather than +1x).

PART 424—CONDITIONS FOR MEDICARE PAYMENT

■ 13. The authority citation for part 424 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

■ 14. Section 424.55 is amended by adding paragraph (d) to read as follows:

§ 424.55 Payment to the supplier.

* * * * *

(d) For purposes of claims for services submitted by an MDPP supplier (as defined at § 410.79(b) of this chapter), Medicare deems such claims to have been assigned by the beneficiary (or the person authorized to request payment on the beneficiary's behalf) and the assignment accepted by the MDPP supplier.

§ 424.59 [Removed]

■ 15. Remove § 424.59.

■ 16. Subpart I, consisting of §§ 424.200 through 424.210, is added to read as follows:

Subpart I—Requirements for Medicare Diabetes Prevention Program Suppliers and Beneficiary Engagement Incentives Under the Medicare Diabetes Prevention Program Expanded Model

Sec.

424.200 Scope.

424.205 Requirements for Medicare Diabetes Prevention Program suppliers.

424.210 Beneficiary engagement incentives under the Medicare Diabetes Prevention Program expanded model.

Subpart I—Requirements for Medicare Diabetes Prevention Program Suppliers and Beneficiary Engagement Incentives Under the Medicare Diabetes Prevention Program Expanded Model

§ 424.200 Scope.

This subpart specifies the requirements for Medicare Diabetes Prevention Program suppliers and beneficiary engagement incentives under the Medicare Diabetes Prevention Program expanded model.

§ 424.205 Requirements for Medicare Diabetes Prevention Program suppliers.

(a) *Definitions.* In addition to the definitions specified at § 410.79(b) and

§ 414.84(a) of this subchapter, the following definitions apply to this section:

Administrative location means a physical location associated with the MDPP supplier's operations where they are the primary operator in the space, from where coaches are dispatched or based, and where MDPP services may or may not be furnished.

Coach means an individual who furnishes MDPP services on behalf of an MDPP supplier as an employee, contractor, or volunteer.

Coach eligibility end date means the end date indicated by the MDPP supplier in submitting a change to the supplier's MDPP enrollment application in accordance with paragraph (d)(5) of this section that removed the coach's information, or the date the supplier itself was revoked from or withdrew its Medicare enrollment as an MDPP supplier.

Coach eligibility start date, means the start date indicated by the MDPP supplier when submitting the coach's information on the MDPP enrollment application.

Community setting means a location where the MDPP supplier furnishes MDPP services outside of their administrative locations. A community setting is a location open to the public not primarily associated with the supplier. Community settings may include, for example, church basements or multipurpose rooms in recreation centers.

Eligible coach means an individual who CMS has screened and has determined can provide MDPP services on behalf of an MDPP supplier in accordance with paragraph (e) of this section.

Ineligible coach means an individual whom CMS has screened and has determined cannot provide MDPP services on behalf of an MDPP supplier in accordance with paragraph (e) of this section.

MDPP interim preliminary recognition means a status that CMS has granted to an entity in accordance with paragraph (c) of this section.

(b) *Conditions for MDPP supplier enrollment.* An entity may enroll as an MDPP supplier only if it satisfies the following requirements and all other applicable Medicare enrollment requirements:

(1) Has either an MDPP preliminary recognition, as defined in paragraph (c)(1) of this section or a full CDC DPRP recognition.

(2) Maintains an active and valid TIN and NPI at the organizational level.

(3) Has passed screening requirements as follows:

(i) Upon initial enrollment, at a "high" categorical risk in accordance with § 424.518(c)(2); and

(ii) Upon revalidation, at a "moderate" categorical risk in accordance with § 424.518(b)(2).

(4) Maintains, and submits to CMS through the CMS-approved enrollment application, a roster of all coaches who will be furnishing MDPP services on the entity's behalf that includes each coach's first and last names, middle initial (if applicable), date of birth, Social Security Number (SSN), active and valid NPI, coach eligibility start date, and coach eligibility end date (if applicable). This roster must be updated in accordance with paragraph (d)(5) of this section.

(5) Meets and certifies in its CMS-approved enrollment application that it meets and will continue to meet the supplier enrollment standards described in paragraph (d) of this section.

(6) Revalidates its Medicare enrollment every 5 years after the effective date of enrollment.

(c) *MDPP preliminary recognition.* For the purposes of this section, an MDPP preliminary recognition may include either:

(1) Any preliminary recognition established by CDC for the purposes of the DPRP; or

(2) An MDPP interim preliminary recognition.

(i) *MDPP interim preliminary recognition application period.* Entities may apply to CDC for CMS' MDPP interim preliminary by submitting information at the time and in the form and manner specified by CMS.

(ii) *MDPP Interim preliminary recognition requirements.* An entity may qualify for MDPP interim preliminary recognition if—

(A) The entity has pending CDC recognition.

(B) The entity submits a full 12 months of performance data to CDC on at least one completed cohort. The 12 month data submission includes at least 5 participants who attended at least 3 sessions in the first 6 months and whose time from first session attended to last session of the lifestyle change program was at least 9 months, at least 60 percent of whom attended at least 9 sessions in months 1 through 6, and at least 60 percent of whom attended at least 3 sessions in months 7 through 12.

(d) *Medicare Diabetes Prevention Program supplier standards.* An MDPP supplier must meet and must certify in its CMS-approved enrollment application that it meets and will continue to meet the following standards.

(1) The MDPP supplier must have and maintain MDPP preliminary recognition, as defined under paragraph (c)(1) of this section, or a full CDC DPRP recognition.

(2) The MDPP supplier must not currently have its billing privileges terminated for-cause or be excluded by a State Medicaid agency.

(3) The MDPP supplier must not include on the roster of coaches, described in paragraph (b)(4) of this section and updated in accordance with paragraph (d)(5) of this section, nor permit MDPP services to be furnished by, any individual coach who meets any of ineligibility criteria outlined in paragraph (e)(1) of this section.

(4) The MDPP supplier must maintain at least one administrative location. All administrative locations maintained by the MDPP supplier must be located at an appropriate site and be reported on the CMS-approved enrollment application. An appropriate site for such an administrative location would include all of the following characteristics:

(i) Signage posted on the exterior of the building or suite, in a building directory, or on materials located inside of the building. Such signage may include, for example, the MDPP supplier's legal business name or DBA, as well as hours of operation.

(ii) Open for business during stated operational hours.

(iii) Employees, staff, or volunteers present during operational hours; and

(iv) Not a private residence.

(5) The MDPP supplier must update its enrollment application within 30 days of any changes of ownership, changes to the coach roster (including due to coach ineligibility or because the coach is no longer an employee, contractor, or volunteer of the MDPP supplier), and final adverse action history, and report all other changes, including but not limited to changes in the MDPP supplier's administrative location(s), to CMS within 90 days of the reportable event.

(6) The MDPP supplier must maintain a primary business telephone that operates either at administrative locations described in paragraph (d)(4) of this section or directly where services are furnished, if services are furnished in community settings. The associated telephone number must be listed with either the legal or doing business as name of the supplier in public view, including on Web sites, flyers, and materials.

(7) The MDPP supplier must not knowingly sell to or allow another individual or entity to use its supplier billing number.

(8) Subject to paragraph (d)(8)(i) of this section, the MDPP supplier must not deny an MDPP beneficiary access to MDPP services during the MDPP services period described in § 410.79(c)(2) of this chapter, including on the basis of the beneficiary's weight, health status, or achievement of performance goals.

(i) Suppliers may deny an MDPP beneficiary access to MDPP services during the MDPP services period only under one of the following conditions:

(A) The MDPP beneficiary no longer meets the eligibility criteria for MDPP services under § 410.79(c)(1) of this chapter.

(B) The MDPP supplier lacks the self-determined publicly-posted capacity to furnish MDPP services to a given MDPP beneficiary.

(C) The MDPP supplier determines that the MDPP beneficiary significantly disrupts the session for other MDPP beneficiaries or becomes abusive.

(ii) MDPP suppliers must maintain a record of the number of MDPP beneficiaries for whom it declined access away for the reasons outlined in paragraphs (d)(8)(i)(B) and (C) of this section, to include the date each such beneficiary was declined access. For beneficiaries who were declined access for the reasons described in paragraph (d)(8)(i)(C) of this section, the MDPP supplier must document details of the occurrence(s), including date(s) of the behavior, any remediation efforts taken by the MDPP supplier, and final action (for example, dismissal from an MDPP session or denial from future sessions) in the beneficiary's MDPP records.

(9) The MDPP supplier and other individuals or entities performing functions or services related to MDPP services on the MDPP supplier's behalf must not unduly coerce an MDPP beneficiary's decision to change or not to change to a different MDPP supplier, including through the use of pressure, intimidation, or bribery.

(10) Except as allowed under paragraph (d)(8) of this section, the MDPP supplier must offer an MDPP beneficiary no fewer than all of the following:

(i) 16 in-person core sessions no more frequently than weekly for the first 6 months of the MDPP services period, which beginnings on the date of attendance at the first such core session.

(ii) 1 in-person core maintenance session each month during months 7 through 12 (6 months total) of the MDPP services period.

(iii) 1 in-person ongoing maintenance session each month for months 13 through 24 of the MDPP services period, as long as the beneficiary maintains

eligibility to receive such services in accordance with § 410.79(c)(1)(ii) and (iii) of this chapter.

(11) Before the initial core session is furnished, the MDPP supplier must disclose detailed information about the set of MDPP services to each MDPP beneficiary to whom it wishes to begin furnishing MDPP services. Such information must include all of the following:

(i) Eligibility requirements under § 410.79(c)(1) of this chapter, including the once-per-lifetime nature of MDPP services.

(ii) Minimum coverage requirements under § 410.79(c)(2).

(iii) The MDPP supplier standards as specified in paragraph (d) of this section.

(12) The MDPP supplier must answer MDPP beneficiaries' questions about MDPP services and respond to MDPP-related complaints within a reasonable timeframe. An MDPP supplier must implement a complaint resolution protocol and maintain documentation of all beneficiary contact regarding such complaints, including the name and Medicare Beneficiary Identifier of the beneficiary, a summary of the complaint, related correspondences, notes of actions taken, and the names and/or NPIs of individuals who took such actions on behalf of the MDPP supplier. Failure to maintain a complaint resolution protocol or to retain information regarding MDPP related complaints in accordance with paragraph (g) of this section may be considered evidence that the MDPP supplier standards have not been met. This information must be kept at each administrative location and made available to CMS or its contractors upon request.

(13) The MDPP supplier must maintain a crosswalk file which indicates how beneficiary identifications for the purposes of CDC performance data requirements correspond to corresponding beneficiary health insurance claims numbers or Medicare Beneficiary Identifiers for each MDPP beneficiary receiving MDPP services from the MDPP supplier. The MDPP supplier must submit the crosswalk file to CMS or its contractor.

(14) The MDPP supplier must submit performance data for MDPP beneficiaries who attend ongoing maintenance sessions with data elements consistent with the CDC's DPRP standards for data elements required for the core services period.

(15) The MDPP supplier must allow CMS or its agents to conduct onsite inspections or recordkeeping reviews in order to ascertain the MDPP supplier's

compliance with these standards, and must adhere to the documentation requirements as outlined in paragraph (g) of this section.

(e) *Coach eligibility*—(1) *Criteria*. To furnish MDPP services to a beneficiary, an MDPP coach must not:

(i) Currently have Medicare billing privileges revoked and be currently subject to the reenrollment bar.

(ii) Currently have its Medicaid billing privileges terminated for-cause or be excluded by a State Medicaid agency.

(iii) Currently be excluded from any other Federal health care program, as defined in 42 CFR 1001.2, in accordance with section 1128, 1128A, 1156, 1842, 1862, 1867 or 1892 of the Act.

(iv) Currently be debarred, suspended, or otherwise excluded from participating in any other Federal procurement or nonprocurement program or activity in accordance with the Federal Acquisition Streamlining Act implementing regulations and the Department of Health and Human Services nonprocurement common rule at 45 CFR part 76.

(v) Have, in the previous 10 years, one of the following State or Federal felony convictions:

(A) Crimes against persons, such as murder, rape, assault, and other similar crimes for which the individual was convicted, as defined under 42 CFR 1001.2, had a guilty plea or adjudicated pretrial diversion.

(B) Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, as defined under 42 CFR 1001.2, had a guilty plea or adjudicated pretrial diversion.

(C) Any felony that placed Medicare or its beneficiaries at immediate risk, such as a malpractice suit that results in the individual being convicted, as defined under 42 CFR 1001.2, had a guilty plea or adjudicated pretrial diversion of criminal neglect or misconduct.

(D) Any felonies for which the individual was convicted, as defined under 42 CFR 1001.2, had a guilty plea or adjudicated pretrial diversion that would result in mandatory exclusion under section 1128(a) of the Act.

(2) *CMS determination of coach eligibility*. CMS will screen each individual identified on the roster of coaches included with the supplier's enrollment application described in paragraph (b)(4) of this section and updated in accordance with paragraph (d)(5) of this section to verify that the individual coach does not meet any of the conditions specified in paragraph

(e)(1) of this section and that the coach can provide MDPP services on behalf of an MDPP supplier. For each individual coach successfully screened by CMS, his or her eligibility start date becomes effective and remains effective until an MDPP supplier or CMS takes action that results in an eligibility end date.

(f) *Effective date for billing privileges*.

(1) For MDPP suppliers initially enrolling and for newly established administrative locations that result in a new enrollment record or Provider Transaction Access Number, the effective date for Medicare billing privileges for MDPP suppliers is—

(i) The later of—

(A) The date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor;

(B) The date of filing of a corrective action plan that was subsequently approved by a Medicare contractor; or

(C) The date that the supplier first began furnishing services at a new administrative location that resulted in a new enrollment record or Provider Transaction Access Number.

(ii) Under no circumstances should the effective date of billing privileges for any MDPP supplier be prior to April 1, 2018.

(2) For any newly established administrative locations that do not result in a new enrollment record or Provider Transaction Access Number, the existing billing privilege effective date for their Provider Transaction Access Number will apply, but not earlier than April 1, 2018.

(g) *Documentation retention and provision requirements*. An MDPP supplier must maintain all documentation related to participation in the MDPP in accordance with all applicable Federal and State laws. The MDPP supplier must provide to CMS, a contractor acting on CMS' behalf, the Office of the Inspector General, and the Comptroller General or their designee(s) scheduled and unscheduled access to the MDPP supplier's records, including, but not limited to, all books, contracts, records, documents, and other evidence sufficient to enable the audit, evaluation, inspection, or investigation of the MDPP supplier's compliance with the MDPP expanded model's requirements, including the MDPP expanded model requirements for in-kind beneficiary incentive engagements in § 424.210 of this chapter in the event that the MDPP supplier chooses to offer such incentives to any MDPP beneficiary.

(1) The documentation for the first core session must be established contemporaneous with the furnishing of

MDPP services and must include at least all of the following:

(i) Organizational information, including MDPP supplier name, CDC DPRP number, and NPI.

(ii) Basic beneficiary information for each MDPP beneficiary in attendance, including but not limited to beneficiary name, HICN, or MBI, age.

(iii) Evidence that each such beneficiary satisfied the eligibility requirements under § 410.79(c) of this chapter at the time of service.

(2) The documentation for each MDPP session attended by an MDPP must be established contemporaneous with the furnishing of MDPP services and must include at least all of the following:

(i) Documentation of the type of session, whether a core session, a core maintenance session, an ongoing maintenance session, an in-person make-up session, or a virtual make-up session.

(ii) Identification of which CDC-approved DPRP curriculum was associated with the session.

(iii) The NPI of the coach who furnished the session.

(iv) The date and place of service of the session.

(v) Each MDPP's beneficiary's weight and date weight taken, in a form and manner as specified by CMS.

(3) If an MDPP supplier chooses to offer in-kind beneficiary engagement incentives to MDPP beneficiaries as permitted under § 424.210, the records maintained by the MDPP supplier in accordance with this section must also include the information required by § 424.210(e).

(4) An MDPP supplier is required to maintain and handle any beneficiary information related to MDPP, including Personally Identifiable Information (PII) and Protected Health Information (PHI), as would be required under HIPAA, other applicable state and federal privacy laws, and CMS standards.

(5) The MDPP supplier's records must include an attestation from the MDPP supplier that, as applicable, the MDPP beneficiary for which it is submitting a claim—

(i) Has attended their first, fourth or ninth core session, as applicable, if the claim submitted is for a performance payment under § 414.84(b)(1), (2), or (3) of this chapter.

(ii) Has attended at least three core maintenance sessions, achieved required minimum weight loss, or both, as applicable, if the claim submitted is for a performance payment under § 414.84(b)(4) of this chapter.

(iii) Has achieved the required minimum weight loss and attended at least three ongoing maintenance

sessions within an ongoing maintenance session interval, if the claim submitted is for a performance payment under § 414.84(b)(5) of this chapter, if the claim submitted is for a performance payment under § 414.84(b)(6) of this chapter.

(iv) Has achieved required minimum weight loss as measured in-person during a core session or core maintenance session furnished by that supplier, if the claim submitted is for a performance payment under § 414.84(b)(6) of this chapter.

(v) Has achieved at least a 9-percent weight loss percentage as measured in-person during a core session, core maintenance session, or ongoing maintenance session furnished by that supplier, if the claim submitted is for a performance payment under § 414.84(b)(7) of this chapter.

(6) The MDPP supplier must maintain all records required under this section for a period of 10 years from the last day of the MDPP beneficiary's receipt of MDPP services provided by the MDPP supplier or from the date of completion of any audit, evaluation, inspection, or investigation, whichever is later, unless either of the following apply:

(i) CMS determines that there is a special need to retain a particular record or group of records for a longer period and notifies the MDPP supplier at least 30 calendar days before the normal disposition rate; or

(ii) There has been a dispute or allegation of fraud or similar fault against the MDPP supplier, in which case the records must be maintained for an additional 6 years from the date of any resulting final resolution of the dispute or allegation of fraud or similar fault, as defined at § 405.902 of this chapter.

(h) *Denial or revocation of MDPP supplier enrollment.* (1) An MDPP supplier is subject to enrollment denial or revocation of its MDPP supplier enrollment for one or more of the following reasons:

(i) *Failure to meet enrollment requirements.* The MDPP supplier does not satisfy the conditions specified in paragraph (b) of this section.

(A) An enrollment denial under this paragraph (h)(1)(i) is considered an enrollment denial under § 424.530(a)(1).

(B) A revocation under this paragraph (h)(1)(i) is considered a revocation under § 424.535(a)(1).

(C) An MDPP supplier that does not satisfy the requirements in paragraph (b)(1) of this section may become eligible to bill for MDPP services again if it successfully achieves MDPP preliminary recognition or full CDC DPRP recognition, and successfully

enrolls again in Medicare as an MDPP supplier after any applicable reenrollment bar has expired.

(ii) *Failure to meet MDPP supplier standards.* The MDPP supplier fails to meet the standards specified in paragraph (d) of this section.

(A) An enrollment denial under this paragraph (h)(1)(ii) is considered an enrollment denial under § 424.530(a)(1).

(B) A revocation under this paragraph (h)(1)(ii) is considered a revocation under § 424.535(a)(1).

(iii) *Application of existing enrollment denial reasons.* One of the enrollment denial reasons specified in § 424.530(a) applies.

(iv) *Application of existing revocation reasons.* One of the revocation reasons specified in § 424.535(a) applies.

(v) *Use of an ineligible coach.* (A) The MDPP supplier knowingly allows an ineligible coach to furnish MDPP services to Medicare beneficiaries. Knowingly means that the MDPP supplier received an enrollment denial or revocation notice based on failing to meet the standard specified in § 424.205(d)(3), was provided notice by CMS or contractors working on its behalf of this coach's ineligibility including the reason(s) for ineligibility, submitted a corrective action plan (CAP) to remove the coach and become compliant therefore maintaining its enrollment, but continued to allow the coach to provide MDPP services in violation of the CAP.

(B) Revocation under this paragraph (h)(1)(v) is subject to the following requirements:

(1) The revocation becomes effective 30 days after CMS or the CMS contractor mails notice of its determination to the MDPP supplier.

(2) For the revocation authority under this paragraph (h)(1)(v), MDPP suppliers are barred from participating in the Medicare program from the date of the revocation, which begins 30 days after CMS or its contractor mails notice of the revocation, until the end of the reenrollment bar, which lasts a minimum of 1 year, but not greater than 3 years, depending on the severity of the basis for revocation.

(3) A revoked MDPP supplier must, within 60 calendar days after the effective date of revocation, submit all claims for items and services furnished before the date of the revocation letter.

(2) An MDPP supplier may appeal an enrollment denial or revocation decision in accordance with the procedures specified in part 498 of this chapter. References to suppliers in that section apply to MDPP suppliers.

§ 424.210 Beneficiary engagement incentives under the Medicare Diabetes Prevention Program expanded model.

(a) *Definitions.* In addition to the definitions specified at § 410.79(b) and § 424.205(a) of this chapter, the following definition applies to this section:

Engagement incentive period means the period of time during which an MDPP supplier may furnish in-kind beneficiary engagement incentives to a given MDPP beneficiary to whom the MDPP supplier is furnishing MDPP services. This period begins when an MDPP supplier furnishes any MDPP service to an MDPP eligible beneficiary and ends when one of the following occurs, whichever occurs first:

(i) The MDPP beneficiary's MDPP services period ends as described in § 410.79(c)(3) of this chapter.

(ii) The MDPP supplier knows the MDPP beneficiary will no longer be receiving MDPP services from the MDPP supplier.

(iii) The MDPP supplier has not had direct contact, either in-person, by telephone, or via other telecommunications technology, with the MDPP beneficiary for more than 90 consecutive calendar days during the MDPP services period.

(b) *General.* An MDPP supplier may choose to furnish an item or service as an in-kind beneficiary engagement incentive to an MDPP beneficiary only during the engagement incentive period, subject to the following conditions:

(1) The item or service must be furnished directly to an MDPP beneficiary by an MDPP supplier or by an agent of the MDPP supplier, such as a coach, under the MDPP supplier's direction and control.

(2) The item or service must be reasonably connected to the CDC-approved DPP curriculum furnished to the MDPP beneficiary during a core session, core maintenance session, or ongoing maintenance session furnished by the MDPP supplier.

(3) The item or service must be a preventive care item or service or an item or service that advances a clinical goal, as specified in paragraph (d) of this section, for an MDPP beneficiary by engaging him or her in better managing his or her own health.

(4) The item or service must not be tied to the receipt of items or services outside of the MDPP services.

(5) The item or service must not be tied to the receipt of items or services from a particular provider, supplier, or coach.

(6) The availability of the item or service must not be advertised or promoted as an in-kind beneficiary

engagement incentive available to an MDPP beneficiary receiving MDPP services from the MDPP supplier except that an MDPP beneficiary may be made aware of the availability of the item or service at the time the MDPP beneficiary could reasonably benefit from it during the engagement incentive period.

(7) The cost of the item or service must not be shifted to another Federal health care program, as defined at section 1128B(f) of the Act.

(8) The cost of the item or service must not be shifted to an MDPP beneficiary.

(c) *Technology furnished to an MDPP beneficiary.* In-kind beneficiary engagement incentives involving technology furnished by an MDPP supplier to an MDPP beneficiary are subject to the following conditions:

(1) Items or services involving technology may not, in the aggregate, exceed \$1,000 in retail value for any one MDPP beneficiary.

(2) Items or services involving technology must be the minimum necessary to advance a clinical goal, as specified in paragraph (d) of this section, for an MDPP beneficiary.

(3) Items involving technology exceeding \$100 in retail value must—

(i) Remain the property of the MDPP supplier; and

(ii) Be retrieved from the MDPP beneficiary at the end of the engagement incentive period. The MDPP supplier must document all retrieval attempts, including the ultimate date of retrieval, in accordance with paragraph (e)(3) of this section. Documented diligent, good faith attempts to retrieve items of technology will be deemed to meet the retrieval requirement.

(d) *Clinical goals of the MDPP expanded model.* The following are the clinical goals for MDPP beneficiaries that may be advanced through in-kind beneficiary engagement incentives:

(1) Attendance at core sessions, core maintenance sessions, or ongoing maintenance sessions.

(2) Weight loss.

(3) Long-term dietary change.

(4) Adherence to long-term health behavior changes.

(e) *Documentation of beneficiary engagement incentives.* In addition to the documentation requirements at § 424.205(g), an MDPP supplier must maintain documentation of items and services furnished as in-kind beneficiary engagement incentives that exceed \$25 in retail value.

(1) The documentation must be established contemporaneous with the furnishing of the in-kind items and services and must include at least the following:

(i) The date the item or service is furnished.

(ii) The identity of the MDPP beneficiary to whom the item or service is furnished.

(iii) The agent of the MDPP supplier that furnished the item or service, if applicable.

(iv) A description of the item or service.

(v) The retail value of the item or service.

(vi) Documentation establishing that the item or service was furnished to the MDPP beneficiary during the engagement incentive period.

(2) Documentation regarding items or services that are furnished to the MDPP beneficiary for use on an ongoing basis during the engagement incentive period, including items involving technology exceeding \$100 in retail value, must also include contemporaneous documentation establishing that the MDPP beneficiary is in the engagement incentive period throughout the time period that the MDPP beneficiary possesses or has access to the item or service furnished by the MDPP supplier.

(3) The documentation regarding items involving technology exceeding \$100 in retail value must also include contemporaneous documentation of any attempt to retrieve the item as required by paragraph (c)(3)(ii) of this section.

(4) The MDPP supplier must retain and provide access to the documentation required in this section in accordance with § 424.205(g).

■ 17. Section 424.502 is amended by revising the definition for “Institutional provider” to read as follows.

§ 424.502 Definitions.

* * * * *

Institutional provider means any provider or supplier that submits a paper Medicare enrollment application using the CMS-855A, CMS-855B (not including physician and nonphysician practitioner organizations), CMS-855S, CMS-20134, or an associated Internet-based PECOS enrollment application.

* * * * *

■ 18. Section 424.516 is amended by revising paragraph (e) introductory text to read as follows.

§ 424.516 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare program.

* * * * *

(e) *Reporting requirements for all other providers and suppliers.* Reporting requirements for all other providers and suppliers not identified in paragraphs (a) through (d) of this section, with the exception of MDPP suppliers whose

reporting requirements are established at § 424.205(d), must report to CMS the following information within the specified timeframes:

* * * * *

■ 19. Section 424.518 is amended by adding paragraphs (b)(1)(xi) and (c)(1)(iii) to read as follows:

§ 424.518 Screening levels for Medicare providers and suppliers.

* * * * *

(b) * * *

(1) * * *

(xi) Revalidating MDPP suppliers.

* * * * *

(c) * * *

(1) * * *

(iii) Prospective (newly enrolling) MDPP suppliers

* * * * *

PART 425—MEDICARE SHARED SAVINGS PROGRAM

■ 20. The authority citation for part 425 continues to read as follows:

Authority: Secs. 1102, 1106, 1871, and 1899 of the Social Security Act (42 U.S.C. 1302, 1306 1395hh, and 1395jjj).

■ 21. Section 425.20 is amended by revising the definitions of “Primary care physician” and “Primary care services” to read as follows:

§ 425.20 Definitions.

* * * * *

Primary care physician means:

(1) For performance years 2012 through 2015, a physician included in an attestation by the ACO as provided under § 425.404 for services furnished in an FQHC or RHC, or a physician who has a primary care specialty designation of internal medicine, general practice, family practice, or geriatric medicine;

(2) For performance years 2016 through 2018, a physician included in an attestation by the ACO as provided under § 425.404 for services furnished in an FQHC or RHC, or a physician who has a primary care specialty designation of internal medicine, general practice, family practice, geriatric medicine, or pediatric medicine; and

(3) For performance year 2019 and subsequent years, a physician who has a primary care specialty designation of internal medicine, general practice, family practice, geriatric medicine, or pediatric medicine.

Primary care services means the set of services identified by the HCPCS and revenue center codes designated under § 425.400(c).

* * * * *

■ 22. Section 425.112 is amended —

■ a. In paragraph (a)(3)(i) by removing the phrase “Explain how it will require

ACO participants” and adding in its place the phrase “Require ACO participants”;

■ b. In paragraph (a)(3)(ii) by removing the phrase “Explain how it will employ its internal assessments” and adding in its place the phrase “Employ its internal assessments”;

■ c. Revising paragraph (b)(4)(ii).

The revision reads as follows:

§ 425.112 Required processes and patient-centeredness criteria.

* * * * *

(b) * * *

(4) * * *

(ii) Have a written plan to:

(A) Implement an individualized care program that promotes improved outcomes for, at a minimum, the ACO’s high-risk and multiple chronic condition patients.

(B) Identify additional target populations that would benefit from individualized care plans. Individualized care plans must take into account the community resources available to the individual.

(C) Encourage and promote use of enabling technologies for improving care coordination for beneficiaries. Enabling technologies may include one or more of the following:

(1) Electronic health records and other health IT tools.

(2) Telehealth services, including remote patient monitoring.

(3) Electronic exchange of health information.

(4) Other electronic tools to engage beneficiaries in their care.

(D) Partner with long-term and post-acute care providers, both inside and outside the ACO, to improve care coordination for its assigned beneficiaries.

■ 23. Section 425.204 is amended by—

■ a. Revising paragraph (c)(1) introductory text;

■ b. Removing paragraph (c)(5)(iii);

■ c. Redesignating paragraph (c)(5)(iv) as new paragraph (c)(5)(iii); and

■ d. Revising paragraph (d).

The revisions read as follows:

§ 425.204 Content of the application.

* * * * *

(c) * * *

(1) As part of its application, an ACO must certify that the ACO satisfies the requirements set forth in this part. Upon request, the ACO must submit the following supporting materials to demonstrate that it satisfies the requirements set forth in this part:

* * * * *

(d) *Distribution of savings.* As part of its application to participate in the Shared Savings Program, an ACO must

certify it has a mechanism and plan to receive and use payments for shared savings, including criteria for distributing shared savings among its ACO participants and ACO providers/suppliers.

* * * * *

■ 24. Section 425.306 is amended by revising paragraph (b)(2) to read as follows:

§ 425.306 Participant agreement and exclusivity of ACO participants.

* * * * *

(b) * * *

(2) Each ACO participant that submits claims for services used to determine the ACO’s assigned population under subpart E of this part must be exclusive to one Shared Savings Program ACO. If, during a benchmark or performance year (including the 3-month claims runout for such benchmark or performance year), an ACO participant that participates in more than one ACO submits claims for services used in assignment under subpart E of this part, then:

(i) CMS will not consider any services billed through the TIN of the ACO participant when performing assignment under subpart E of this part for the benchmark or performance year.

(ii) The ACO may be subject to the pre-termination actions set forth in § 425.216, termination under § 425.218, or both.

■ 25. Section 425.400 is amended by adding paragraph (a)(1)(iii) and revising paragraph (c) to read as follows:

§ 425.400 General.

(a) * * *

(1) * * *

(iii) In determining final assignment for a benchmark or performance year, CMS will exclude any services furnished during the benchmark or performance year that are billed through the TIN of an ACO participant that is an ACO participant in more than one ACO.

* * * * *

(c) Primary care services for purposes of assigning beneficiaries are identified by selected HCPCS/CPT codes, or revenue center codes.

(1) Primary care service codes are as follows:

(i) For performance years 2012 through 2015:

(A) CPT codes:

(1) 99201 through 99215.

(2) 99304 through 99340.

(3) 99341 through 99350.

(B) HCPCS codes G0402 (the code for the Welcome to Medicare visit) and G0438 and G0439 (codes for the annual wellness visits).

(C) Revenue center codes 0521, 0522, 0524, and 0525 submitted by FQHCs (for services furnished prior to January 1, 2011), or by RHCs.

(ii) For performance year 2016 as follows:

(A) CPT codes:

(1) 99201 through 99215.

(2) 99304 through 99340.

(3) 99341 through 99350.

(4) 99495, 99496, and 99490.

(B) HCPCS codes:

(1) G0402 (the code for the Welcome to Medicare visit) and

(2) G0438 and G0439 (codes for the annual wellness visits).

(3) G0463 for services furnished in ETA hospitals.

(C) Revenue center codes 0521, 0522, 0524, and 0525 submitted by FQHCs (for services furnished prior to January 1, 2011), or by RHCs.

(iii) For performance years 2017 and 2018 as follows:

(A) CPT codes:

(1) 99201 through 99215.

(2) 99304 through 99318 (excluding claims including the POS 31 modifier).

(3) 99319 through 99340.

(4) 99341 through 99350.

(5) 99495, 99496, and 99490.

(B) HCPCS Codes:

(1) G0402 (the code for the Welcome to Medicare visit) and

(2) G0438 and G0439 (codes for the annual wellness visits).

(3) G0463 for services furnished in ETA hospitals.

(C) Revenue center codes 0521, 0522, 0524, and 0525 submitted by FQHCs (for services furnished prior to January 1, 2011), or by RHCs.

(iv) For performance year 2019 and subsequent performance years as follows:

(A) CPT codes:

(1) 99201 through 99215.

(2) 99304 through 99318 (excluding claims including the POS 31 modifier).

(3) 99319 through 99340.

(4) 99341 through 99350.

(5) 99487 and 99489.

(6) 99495, 99496, and 99490.

(B) HCPCS Codes:

(1) G0402 (the code for the Welcome to Medicare visit) and

(2) G0438 and G0439 (codes for the annual wellness visits).

(3) G0463 for services furnished in ETA hospitals.

(4) G0506 (code for chronic care management).

(5) G0502, G0503, G0504 and G0507 (codes for behavioral health integration).

■ 26. Section 425.404 is amended by—

■ a. Amending the introductory text by removing the phrase “with two special conditions:” and adding in its place the phrase “with special conditions:”;

- b. Revising paragraphs (a) and (b).
The revisions read as follows:

§ 425.404 Special assignment conditions for ACOs including FQHCs and RHCs.

* * * * *

(a) For performance years 2012 through 2018—

(1) Such ACOs are required to identify, through an attestation, physicians who directly provide primary care services in each FQHC or RHC that is an ACO participant and/or ACO provider/supplier in the ACO.

(2) Under the assignment methodology in § 425.402, CMS treats a service reported on an FQHC/RHC claim as a primary care service—

(i) If the claim includes a HCPCS or revenue center code that meets the definition of primary care services under § 425.20;

(ii) Performed by a primary care physician if the NPI of a physician identified in the attestation provided under paragraph (a)(1) of this section is reported on the claim for a primary care service (as described in paragraph (a)(2)(i) of this section) as the attending provider; and

(iii) Performed by a non-physician ACO professional if the NPI reported on the claim for a primary care service (as described in paragraph (a)(2)(i) of this section) as the attending provider is an ACO professional but is not identified in the attestation provided under paragraph (a)(1) of this section.

(b) For performance year 2019 and subsequent performance years, under the assignment methodology in § 425.402, CMS treats a service reported on an FQHC/RHC claim as a primary care service performed by a primary care physician.

§ 425.500 [Amended]

- 27. Section 425.500 is amended by—
- a. In paragraph (e)(2) by removing the phrase “of this section is less than 90 percent, absent unusual circumstances,” and adding in its place the phrase “of this section is less than 80 percent, absent unusual circumstances,”; and
- b. In paragraph (e)(3) by removing the phrase “determines there is a match rate of less than 90 percent, the ACO” and adding in its place the phrase “determines there is a match rate of less than 80 percent, the ACO”.

§ 425.502 [Amended]

- 28. Section 425.502 is amended in paragraph (a)(5) by removing the phrase “or causes patient harm.” and adding in its place the phrase “or causes patient harm, or when there is a determination under the Quality Payment Program that the measure has undergone a substantive change.”

- 29. Section 425.602 is amended by adding paragraphs (a)(1)(ii)(A) through (C) to read as follows:

§ 425.602 Establishing, adjusting, and updating the benchmark for an ACO's first agreement period.

(a) * * *

(1) * * *

(ii) * * *

(A) For agreement periods beginning before 2018, this calculation considers all individually beneficiary identifiable payments, including interim payments, made under a demonstration, pilot or time limited program.

(B) For agreement periods beginning in 2018 and subsequent years, this calculation considers individually beneficiary identifiable final payments made under a demonstration, pilot or time limited program.

(C) For the 2018 performance year and subsequent performance years in agreement periods beginning in 2015, 2016 and 2017, the benchmark is adjusted to reflect only individually beneficiary identifiable final payments made under a demonstration, pilot or time limited program.

* * * * *

- 30. Section 425.603 is amended by adding paragraphs (c)(1)(ii)(A) through (C) and (e)(2)(ii)(A) through (C) to read as follows:

§ 425.603 Resetting, adjusting, and updating the benchmark for a subsequent agreement period.

* * * * *

(c) * * *

(1) * * *

(ii) * * *

(A) For agreement periods beginning before 2018, considers all individually beneficiary identifiable payments, including interim payments, made under a demonstration, pilot or time limited program.

(B) For agreement periods beginning in 2018 and subsequent years, considers individually beneficiary identifiable final payments made under a demonstration, pilot or time limited program.

(C) For the 2018 and 2019 performance years in agreement periods beginning in 2017, the benchmark is adjusted to reflect only individually beneficiary identifiable final payments made under a demonstration, pilot or time limited program.

* * * * *

(e) * * *

(2) * * *

(ii) * * *

(A) For agreement periods beginning before 2018, considers all individually beneficiary identifiable payments,

including interim payments, made under a demonstration, pilot or time limited program.

(B) For agreement periods beginning in 2018 and subsequent years, considers individually beneficiary identifiable final payments made under a demonstration, pilot or time limited program.

(C) For the 2018 and 2019 performance years in agreement periods beginning in 2017, risk adjusted county fee-for-service expenditures are adjusted to reflect only individually beneficiary identifiable final payments made under a demonstration, pilot or time limited program.

* * * * *

- 31. Section 425.604 is amended by adding paragraphs (a)(6)(ii)(A) and (B) to read as follows:

§ 425.604 Calculation of savings under the one-sided model.

(a) * * *

(6) * * *

(ii) * * *

(A) For performance years beginning before 2018, these calculations will take into consideration all individually beneficiary identifiable payments, including interim payments, made under a demonstration, pilot or time limited program.

(B) For performance year 2018 and subsequent performance years, these calculations will take into consideration individually beneficiary identifiable final payments made under a demonstration, pilot or time limited program.

* * * * *

- 32. Section 425.606 is amended by adding paragraphs (a)(6)(ii)(A) and (B) to read as follows:

§ 425.606 Calculation of shared savings and losses under Track 2.

(a) * * *

(6) * * *

(ii) * * *

(A) For performance years beginning before 2018, these calculations will take into consideration all individually beneficiary identifiable payments, including interim payments, made under a demonstration, pilot or time limited program.

(B) For performance year 2018 and subsequent performance years, these calculations will take into consideration individually beneficiary identifiable final payments made under a demonstration, pilot or time limited program.

* * * * *

- 33. Section 425.610 is amended by adding paragraphs (a)(6)(ii)(A) and (B) to read as follows:

§ 425.610 Calculation of shared savings and losses under Track 3.

(a) * * *

(6) * * *

(ii) * * *

(A) For performance years beginning before 2018, these calculations will take into consideration all individually beneficiary identifiable payments, including interim payments, made under a demonstration, pilot or time limited program.

(B) For performance year 2018 and subsequent performance years, these calculations will take into consideration individually beneficiary identifiable final payments made under a demonstration, pilot or time limited program.

* * * * *

§ 425.612 [Amended]

■ 34. Section 425.612 is amended by removing paragraphs (a)(1)(i)(A)(4) and (a)(1)(i)(C).

Dated: October 23, 2017.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: October 24, 2017.

Eric D. Hargan,

Acting Secretary, Department of Health and Human Services.

[FR Doc. 2017-23953 Filed 11-2-17; 4:15 pm]

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Fact Sheet: Final Policies for the Medicare Diabetes Prevention Program Expanded Model in the Calendar Year 2018 Physician Fee Schedule Final Rule


On November 2, 2017, the Centers for Medicare & Medicaid Services (CMS) issued the Calendar Year (CY) 2018 Physician Fee Schedule (PFS) final rule, which finalizes policies to implement the Medicare Diabetes Prevention Program (MDPP) expanded model starting in 2018. The MDPP expanded model will allow Medicare beneficiaries to access evidence-based diabetes prevention services, with the goal of a lower rate of progression to type 2 diabetes, improved health, and reduced spending. This model is an expansion of the Diabetes Prevention Program (DPP) model test, which was tested through the Center for Medicare and Medicaid Innovation's Health Care Innovation Awards.

The Medicare Diabetes Prevention Program expanded model is a structured intervention with the goal of preventing progression to type 2 diabetes in individuals with an indication of pre-diabetes. The clinical intervention consists of a minimum of 16 intensive "core" sessions of a Centers for Disease Control and Prevention (CDC) approved curriculum furnished over six months in a group-based, classroom-style setting that provides practical training in long-term dietary change, increased physical activity, and behavior change strategies for weight control. After completing the core sessions, less intensive follow-up meetings furnished monthly will help ensure that participants maintain healthy behaviors. The primary goal of the expanded model is at least 5 percent weight loss by participants.

The Calendar Year 2017 Medicare Physician Fee Schedule (CY 2017 PFS) final rule, published in November 2016, established the expansion and aspects of the expanded model policy framework. The CY 2018 PFS final rule finalizes additional policies necessary for suppliers to begin furnishing MDPP services nationally in 2018, including the MDPP payment structure, as well as additional supplier enrollment requirements and supplier compliance standards aimed to enhance program integrity. This final rule also finalizes amendments to policies in the CY 2017 PFS final rule regarding MDPP services and beneficiary eligibility. Highlights of these policies are summarized below. Services furnished under the MDPP expanded model will be furnished in-person, except for limited virtual make-up sessions.

The final rule appeared in the November 2, 2017 Federal Register and can be downloaded from the [Federal Register](#).

Effective Dates

 ***Effective Dates of MDPP Services, Enrollment and Billing Privileges:*** The CY 2018 PFS final rule establishes that MDPP services may begin being furnished on April 1, 2018. Prospective MDPP suppliers may begin enrolling on January 1, 2018 on a rolling basis. MDPP suppliers will enroll through a new, MDPP-specific enrollment application, which will be available prior to January 1, 2018. For approved applications submitted prior to April 1, 2018, the effective date of billing privileges will be April 1, 2018. For all approved applications submitted after April 1, 2018, the effective date of billing privileges will be the date the application was submitted. For any applications denied for non-compliance but approved after submission of a corrective action plan (CAP), the effective date for billing privileges will be the date the CAP was submitted. In

no circumstances, however, will the effective date be before the supplier first began furnishing services at a new administrative location.

MDPP Services, Beneficiary Eligibility & Payment

Diabetes Diagnosis during the MDPP Services Period: In the CY 2017 PFS final rule, we established eligibility criteria for beneficiaries to receive the set of MDPP services. Individuals with a previous diagnosis of diabetes (with the exception of gestational) are not eligible to receive MDPP services. In this rule, however, we finalized that if a beneficiary develops diabetes during the MDPP services period, this diagnosis would not prevent the beneficiary from continuing to receive MDPP services.

Ongoing Maintenance Sessions: We have finalized a one-year limit on ongoing maintenance sessions (assuming attendance and weight loss performance goals are met), which makes the total MDPP services period two years, consisting of one year of core and core maintenance sessions followed by up to one year of ongoing maintenance sessions, depending on eligibility, as described below. We finalized that MDPP beneficiaries must attend at least two out of three monthly ongoing maintenance sessions and maintain 5% weight loss at least once in the previous ongoing maintenance session interval to be eligible for additional intervals after the first.

Payment Structure: We finalized a performance-based payment structure, which ties payment to performance goals based on attendance and/or weight loss, as displayed in the table below. The final payment structure values beneficiary weight loss most significantly, as weight loss is a key indicator of success among individuals participating in a DPP due to the strong association between weight loss and reduction in the risk of type 2 diabetes. The final payment structure also values beneficiary attendance throughout the first year core services because, in the DPP model test, session attendance was associated with greater weight loss. Suppliers will receive payment for beneficiaries who attend at least two out of three monthly sessions within a core or ongoing maintenance interval, given other payment requirements are satisfied.

We have finalized and published corresponding Healthcare Common Procedure Coding System (HCPCS) G-codes that MDPP suppliers will use to submit claims for payment when all the requirements for billing the codes have been met.

Performance Goal	Performance Payment Per Beneficiary (<i>with</i> the required minimum weight loss)	Performance Payment Per Beneficiary (<i>without</i> the required minimum weight loss)
1 st core session attended	\$25	\$25
4 total core sessions attended	\$50	\$50
9 total core sessions attended	\$90	\$90
2 sessions attended in first core maintenance session interval (months 7-9 of the MDPP core services period)	*\$60	\$15
2 sessions attended in second core maintenance session interval (months 10-12 of the MDPP core services period)	*\$60	\$15

Performance Goal	Performance Payment Per Beneficiary (<i>with</i> the required minimum weight loss)	Performance Payment Per Beneficiary (<i>without</i> the required minimum weight loss)
5 percent weight loss achieved	\$160	\$0
9 percent weight loss achieved	\$25	\$0
2 sessions attended in ongoing maintenance session interval (4 consecutive 3-month intervals over months 13-24 of the MDPP ongoing services period)	*\$50	**\$0
Total performance payment	\$670	\$195

* = The required minimum weight loss from baseline must be achieved or maintained during the core maintenance session 3-month interval or maintained during the ongoing maintenance session 3-month interval.

** = A beneficiary attends at least 1 core session during the core services period to initiate the MDPP services period; must attend at least 1 session during the final core maintenance session 3-month interval; and must achieve or maintain the required minimum weight loss at least once during the final core maintenance session 3-month interval to have coverage of the first ongoing maintenance session interval. Then, a beneficiary must attend at least 2 sessions and maintain the required minimum weight loss at least once during an ongoing maintenance session 3-month interval to have coverage of the next ongoing maintenance session interval.

Bridge Payment: In cases where a beneficiary changes MDPP suppliers, we will provide a one-time \$25 bridge payment to an MDPP supplier for furnishing its first session to an MDPP beneficiary who has previously received MDPP services from a different MDPP supplier.

The bridge payment will account for the financial risk a subsequent MDPP supplier takes on by furnishing services to a beneficiary changing MDPP suppliers during the MDPP services period and helps ensure beneficiary freedom of choice of supplier. MDPP suppliers may need to obtain a beneficiary's MDPP record from the previous MDPP supplier as part of the billing supplier's documentation to demonstrate that the attendance and weight loss, if applicable, performance goal(s) for the performance payment were achieved.

MDPP Supplier Enrollment & Compliance

MDPP Preliminary Recognition: In this rule, we have finalized that an entity may be eligible to enroll in Medicare as an MDPP supplier if it has achieved MDPP preliminary recognition (either MDPP interim preliminary recognition or CDC preliminary recognition, when established) or CDC full recognition. Our intent with MDPP interim preliminary recognition is to bridge the gap until any CDC preliminary recognition standards are established and to allow organizations who have met this standard to enroll in Medicare.


Entities that have not yet reached CDC full recognition status may be able to enroll as an MDPP supplier if they meet MDPP interim preliminary recognition standards with a 12-month data submission to CDC. If CDC establishes its preliminary recognition standard through the 2018 Diabetes Prevention Recognition Program Standards, we intend to ensure the transition to CDC preliminary recognition does not disrupt MDPP supplier status.

MDPP Supplier Standards: We finalized standards to protect against fraud, waste, and abuse and to ensure fidelity to the MDPP expanded model. These standards are designed to make sure


MDPP suppliers are operational, protect beneficiary access and service quality, and provide program integrity safeguards. These standards also establish eligibility requirements for coaches who furnish services on behalf of MDPP suppliers. If an MDPP supplier reports an ineligible coach, CMS may take administrative action to deny or revoke the MDPP supplier's enrollment. We finalized that a MDPP supplier could respond to the enrollment denial or revocation by submitting a CAP that would include the removal of the coach from its roster.

Revalidation: While CMS will screen newly enrolling MDPP suppliers at high categorical risk (as established in the CY 2017 PFS), we finalized that MDPP suppliers that are revalidating their enrollment will be screened at moderate categorical risk level. This means that revalidating MDPP suppliers would not have to undergo the same high risk screening requirements, such as fingerprinting and background checks for those individuals who maintain a 5% or greater direct or indirect ownership interest in the supplier. We also finalized the policy that MDPP suppliers revalidate every five years after their initial enrollment.

Beneficiary Engagement Incentives

 ***Beneficiary Engagement Incentives:*** We finalized that an MDPP supplier may choose to provide in-kind patient engagement incentives to a MDPP beneficiary to assist the supplier in furnishing high quality services and engaging in health behavior change programs that lead to improved beneficiary health and reductions in Medicare spending. We finalized certain conditions on these incentives to ensure that their provision is solely for the purpose of achieving the MDPP expanded model goal of engaging beneficiaries in making sustainable, healthy behavior changes to reduce their risk of type 2 diabetes.

Make-Up Sessions

 We finalized the proposal to allow in-person suppliers to offer make-up sessions, including a limited number of virtual make-up sessions, to beneficiaries who miss a regularly scheduled session. In the final rule, we outline the requirements for make-up sessions and we define “virtual make-up session”.

Medicare Diabetes Prevention Program (MDPP)¹²⁻⁵⁰

Expanded Model Fact Sheet

Overview of MDPP

The MDPP expanded model includes an evidence-based set of services aimed to help prevent the onset of type 2 diabetes among Medicare beneficiaries with an indication of prediabetes. MDPP services will be available to eligible beneficiaries nationwide beginning April 1, 2018 under a performance-based payment model through the CMS Innovation Center.

Questions about MDPP



What is covered through the model?

- Structured sessions with a coach, using a CDC-approved curriculum to provide training in dietary change, increased physical activity, and weight loss strategies
- 12 months of core sessions for beneficiaries with an indication of prediabetes, and an additional 12 months of ongoing maintenance sessions for participants who meet weight loss and attendance goals.



How does the model pay for MDPP services?

MDPP suppliers are paid performance-based payments through the CMS claims system. Medicare payments to suppliers will range, and can be up to \$670 per beneficiary over 2 years, depending on beneficiaries' attendance and weight loss.



What does this mean for beneficiaries?

Beginning April 1, 2018, eligible beneficiaries have coverage of MDPP services with no cost-sharing through Medicare-enrolled MDPP suppliers.

Eligible beneficiaries are those who:

- Are enrolled in Medicare Part B
- Have a body mass index (BMI) of at least 25, or at least 23 if self-identified as Asian
- Meet 1 of the following 3 blood test requirements within the 12 months of the first core session:
 - A hemoglobin A1c test with a value between 5.7 and 6.4% , or
 - A fasting plasma glucose of 110-125 mg/dL, or
 - A 2-hour plasma glucose of 140-199 mg/dL (oral glucose tolerance test)
- Have no previous diagnosis of type 1 or type 2 diabetes (other than gestational diabetes)
- Do not have end-stage renal disease (ESRD)



Although a referral from a physician is not required for beneficiaries to participate in MDPP services, clinicians have an important role to play in helping beneficiaries understand their risk of diabetes and their treatment options. This is particularly important because only 14% of adults aged 65 and older with prediabetes are aware of their condition. Clinicians may help Medicare patients obtain the blood tests they need to become aware of their risk and recommend they participate in MDPP services.



What does this mean for organizations that wish to deliver MDPP services?

Organizations who wish to furnish MDPP services to beneficiaries and bill Medicare for those services must enroll in Medicare as an MDPP supplier.

To enroll as an MDPP supplier, organizations must:

- Have MDPP preliminary recognition or full CDC DPRP recognition
- Have an active and valid tax-identification number (TIN) or national provider identifier (NPI)
- Pass enrollment screening at the high categorical risk level
- On the MDPP enrollment application, submit a list of MDPP coaches who will lead sessions, including full name, date of birth, social security number (SSN), and active and valid NPI and coach eligibility end date (if applicable)
- Meet MDPP supplier standards and requirements, and other requirements of existing Medicare providers or suppliers
- Revalidate its enrollment every 5 years



Key Dates

- **January 2018**– MDPP supplier enrollment begins
- **April 2018**– Enrolled MDPP suppliers may begin furnishing services and billing Medicare

Resources and Support



Email: mdpp@cms.hhs.gov



Visit: <http://go.cms.gov/mdpp>

Quick Reference Guide to Payment and Billing

This reference guide provides a snapshot of the MDPP payment structure and corresponding Healthcare Common Procedure Coding System (HCPCS) G-codes. This guide **only** applies to services furnished to beneficiaries receiving Medicare Part B coverage via Medicare Fee-for-Service (FFS).

MDPP Payment Structure

Maximum possible payment per eligible beneficiary: \$670

	CORE SESSIONS (16 SESSIONS) Months 0-6	CORE MAINTENANCE SESSIONS INTERVAL 1 (3 SESSIONS) INTERVAL 2 (3 SESSIONS) Months 7-12		ONGOING MAINTENANCE SESSIONS INTERVAL 1 (3 SESSIONS) INTERVAL 2 (3 SESSIONS) INTERVAL 3 (3 SESSIONS) INTERVAL 4 (3 SESSIONS) Months 13-24			
Attendance only	Attend 1 session total: \$25 (G9873) Attend 4 sessions total: \$50 (G9874) Attend 9 sessions total: \$90 (G9875)	Attend 2 sessions (without at least 5% WL): \$15 (G9876)	Attend 2 sessions (without at least 5% WL): \$15 (G9877)	5% WL and attendance must be achieved to receive payment during ongoing maintenance sessions			
Attendance and Weight Loss (WL)	5% WL is not required to receive payment	or Attend 2 sessions (with at least 5% WL): \$60 (G9878)	or Attend 2 sessions (with at least 5% WL): \$60 (G9879)	Attend 2 sessions (with at least 5% WL): \$50 (G9882)	Attend 2 sessions (with at least 5% WL): \$50 (G9883)	Attend 2 sessions (with at least 5% WL): \$50 (G9884)	Attend 2 sessions (with at least 5% WL): \$50 (G9885)
Additional Codes	5% WL achieved: \$160 (G9880)						
	9% WL achieved: \$25 (G9881)						
	Bridge payment: \$25 (G9890)						
	Report attendance at sessions that are not associated with a performance goal. Non-payable codes should be listed on the same claim as the payable code with which they are associated : \$0 (G9891)						

• HCPCS G-codes and their payment amounts are **bolded** next to each payment description

★ Represents when a specific performance goal (i.e., attendance, weight loss) must be met for the beneficiary to be eligible to continue receiving services

Understanding the MDPP Payment Structure

CORE SESSIONS	CORE MAINTENANCE SESSIONS	ONGOING MAINTENANCE SESSIONS
<ul style="list-style-type: none">Beneficiaries must attend one core session to initiate MDPP servicesA supplier can be paid based on the beneficiary's attendance, regardless of the beneficiary's weight loss	<ul style="list-style-type: none">Payments are made in two 3-month intervalsA supplier is paid if a beneficiary meets attendance goalsA supplier is paid more if the beneficiary also meets the 5% weight loss goal during the interval	<ul style="list-style-type: none">Payments are made in four 3-month intervalsA supplier is only paid if the beneficiary attends two ongoing maintenance sessions and meets the 5% weight loss goal during the interval

HCPCS G-Code	Description	VM Allowed*	Payment
Core Sessions			
G9873	MDPP beneficiary attended the first MDPP core session.	No	\$25
G9874	MDPP beneficiary attended a total of 4 MDPP core sessions.	Yes	\$50
G9875	MDPP beneficiary attended a total of 9 MDPP core sessions.	Yes	\$90
Core Maintenance Sessions			
G9876	MDPP beneficiary attended 2 MDPP core maintenance sessions in months 7-9.	Yes	\$15
G9877	MDPP beneficiary attended 2 MDPP core maintenance sessions in months 10-12.	Yes	\$15
G9878	MDPP beneficiary attended 2 MDPP core maintenance sessions in months 7-9, and achieved the 5% weight loss from his/her baseline weight. Use G9878 or G9876.	Yes	\$60
G9879	MDPP beneficiary attended 2 MDPP core maintenance sessions in months 10-12, and achieved the 5% weight loss from his/her baseline weight. Use G9879 or G9877.	Yes	\$60
Ongoing Maintenance Sessions			
G9882	MDPP beneficiary attended 2 MDPP ongoing maintenance sessions in months 13-15, and achieved the 5% weight loss from his/her baseline weight during the interval.	Yes	\$50
G9883	MDPP beneficiary attended 2 MDPP ongoing maintenance sessions in months 16-18, and achieved the 5% weight loss from his/her baseline weight during the interval.	Yes	\$50
G9884	MDPP beneficiary attended 2 MDPP ongoing maintenance sessions in months 19-21, and achieved the 5% weight loss from his/her baseline weight during the interval.	Yes	\$50
G9885	MDPP beneficiary attended 2 MDPP ongoing maintenance sessions in months 22-24, and achieved the 5% weight loss from his/her baseline weight during the interval.	Yes	\$50
Additional Codes			
G9880	MDPP beneficiary achieved at least 5% weight loss from his/her baseline weight in months 1–12. This is a one-time payment available when a beneficiary first achieves at least 5% weight loss from baseline as measured by an in-person weight measurement at a core session or core maintenance session.	No	\$160
G9881	MDPP beneficiary achieved at least 9% weight loss from his/her baseline weight in months 1–24. This is a one-time payment available when a beneficiary first achieves at least 9% weight loss from baseline as measured by an in-person weight measurement at a core session, core maintenance session, or ongoing maintenance session.	No	\$25
G9890	Bridge Payment: A <u>one-time payment</u> for the first MDPP core session, core maintenance session, or ongoing maintenance session furnished by an MDPP supplier to an MDPP beneficiary during months 1–24. This occurs when a beneficiary has previously received his/her first core session from a different MDPP supplier. A supplier may only receive one bridge payment per MDPP beneficiary.	Yes	\$25
G9891	MDPP session reported as a line item on a claim for MDPP services. This is a non-payable code for reporting services of sessions furnished to MDPP beneficiaries (i.e. core sessions 2-3, 5-8, 10-16, and maintenance sessions before achievement of a performance goal)	Yes	\$0

*This column indicates whether a claim may be reported with virtual make-up session modifier (VM). The beneficiary must be weighed during an in-person session.

- HCPCS G-codes are used when submitting claims to bill Medicare for payment. MDPP HCPCS G-codes may be used only one time per eligible beneficiary (except for G9890 and G9891)
- The initial session (G9873) or bridge payment (G9890) claim **must** be submitted before any other claims will be paid
- MDPP suppliers should submit claims **when a performance goal is met**
- Use the non-payable G-code (G9891) to report attendance at sessions that are **not** associated with a performance goal. These codes should be listed on the **same claim** as the payable code with which they are associated (e.g., report G9891 for sessions 2 and 3 if you are reporting G9874 for session 4 attendance)
- Each HCPCS G-code should be listed with the corresponding session date of service and rendering coach National Provider Identifier (NPI)
- If a beneficiary switches suppliers, the new supplier may receive a bridge payment (G9890) for the first MDPP session furnished to that beneficiary. **More than one** supplier may claim a bridge payment for the same beneficiary
- The Virtual Modifier, "VM", should be appended to the end of any G-code that is associated with a session that was furnished as a virtual make-up session (e.g., G9891VM)

Need more information?



Visit: <http://go.cms.gov/mdpp>



Email: mdpp@cms.hhs.gov





Call: 877-906-4940

Medicare Diabetes Prevention Program (MDPP) 12-55

Expanded Model Roles Fact Sheet

The MDPP expanded model aims to prevent the onset of type 2 diabetes among Medicare beneficiaries who have an indication of prediabetes. The MDPP expanded model is a CMS Innovation Center nationwide model test that builds on the National Diabetes Prevention Program (National DPP) led by the Centers for Disease Control and Prevention (CDC). CMS and CDC have distinct but complementary roles related to the MDPP expanded model.



CMS is implementing and evaluating the MDPP expanded model. In this role, CMS:	CDC is overseeing and assuring the quality of the National DPP. In this role, CDC:
 Defines the MDPP set of services and the MDPP services period covered under Medicare	 Develops and maintains the CDC National DPP Diabetes Prevention Recognition Program (DPRP) Standards
 Provides resources to support successful supplier enrollment and claims submissions	 Evaluates organizations for achievement and ongoing maintenance of recognition status, per the current DPRP Standard
 Reviews and processes Medicare enrollment applications of organizations with CDC preliminary or full recognition	 Maintains a national registry of recognized organizations, including those with CDC preliminary or full recognition
 Provides resources to verify certain elements of beneficiary eligibility for MDPP	 Provides resources to support organizations in achieving and maintaining CDC recognition
 Processes claims submitted by MDPP suppliers for payment	 Reviews and approves alternative curricula submitted by organizations seeking recognition
 Monitors MDPP suppliers' compliance with Medicare requirements, including the MDPP supplier standards	 Updates National DPP curricula as necessary based on current evidence

Organizations should contact:

CMS if they already have CDC DPRP recognition and are interested in enrolling as a Medicare supplier, or if they have questions about MDPP set of services, Medicare enrollment, payment, or supplier standards. For more information, visit:

<http://go.cms.gov/mdpp>

CDC if they are interested in obtaining recognition, have questions about the DPP curriculum or evidence base, or are interested in learning more about best practices in DPP delivery. For more information, visit:

<https://www.cdc.gov/diabetes/prevention/lifestyle-program/index.html>



Visit:

<http://go.cms.gov/mdpp>



Ask a Question:

<https://cmsorg.force.com/mdpp/>



Medicare → MDPP Basics

Medicare Diabetes Prevention Program (MDPP) Basics

The Center for Medicare and Medicaid Innovation [Medicare Diabetes Prevention Program \(MDPP\) site](#) is the primary source for information and resources regarding the MDPP. A brief overview of the MDPP is provided below.

The MDPP expanded model allows Medicare beneficiaries to access evidence-based diabetes prevention services with the goal of a lower rate of progression to type 2 diabetes, improved health, and reduced spending. MDPP suppliers began enrolling in Medicare on January 1, 2018, and began furnishing MDPP services and billing Medicare for MDPP services on April 1, 2018.

Medicare Advantage plans are also required to offer the benefit to their members. To learn more please see the [Medicare Advantage Plans and the MDPP](#) section below.

Some key differences between the CDC recognition requirements and the MDPP benefit should be noted, including:



- Age of beneficiaries (limited to those enrolled in Medicare Part B)
- CDC-recognized organization eligibility criteria versus MDPP supplier organization eligibility criteria

CMS has provided an [interactive map](#) showing MDPP suppliers in the United States. Use the map to help find MDPP suppliers in your area.

A list of frequently asked questions about the MDPP and answers from CMS can be found [here](#).

Medicare DPP Promotional Materials for Part B Beneficiaries with resources specific to promoting the Medicare DPP to Medicare Part B beneficiaries and their health care providers that CDC has developed are available [here](#).

MDPP Services



- The MDPP is covered under Medicare Part B as a preventive service once per lifetime.
- Medicare cost sharing does not apply to MDPP services.
- Benefit description:
 - Core services period is 12 months: 16 weekly core sessions over months 1-6, and 6 monthly core maintenance sessions in months 6-12
 - Sessions are approximately one hour each
 - No minimum or maximum number of beneficiaries per session
 - Limited in-person and/or remote makeup sessions may be provided
- MDPP suppliers may use any CDC-approved lifestyle change program curriculum
- Although virtual makeup sessions are approved, 100% virtual delivery of DPP services is not currently approved.
- MDPP suppliers must apply for and receive MDPP supplier status prior to receiving reimbursement for MDPP services.
- MDPP suppliers must currently have either CDC Preliminary Recognition or CDC Full Recognition applying.

Beneficiary Eligibility Criteria & Referrals



- Eligibility criteria:
 - Are enrolled in Medicare Part B (for more information see CMS's [Checking Medicare Eligibility](#) document);
 - BMI ≥ 25 ; ≥ 23 if self-identified as Asian;
 - A1c (HbA1c) between 5.7 and 6.4%, or a fasting plasma glucose of 110-125 mg/dL, or a 2-hour post-glucose challenge of 140-199 mg/dL (oral glucose tolerance test) within the previous 12 months;
 - Have no previous diagnosis of type 1 or type 2 diabetes with the exception of a previous diagnosis of gestational diabetes; and
 - Does not have end-stage renal disease (ESRD) at any point during the MDPP services period.
- The MDPP benefit is available for coverage only once per lifetime.
- Although referrals are not required, the following referrals are allowed, as long as blood test results indicate eligibility:
 - Self-referral from participant
 - Community referral
 - Physician referral
 - Other health care practitioner referral

Preventing Diabetes in Your Medicare Population Video: The AMA Ed Hub™ created a 4-minute overview for healthcare providers that explains Medicare DPP services, beneficiary eligibility, and the benefits of referring patients to the program.

MDPP Supplier Eligibility & Enrollment

MDPP suppliers must 1) enroll under Medicare; and 2) have CDC full recognition or CDC preliminary recognition. For more information on full and preliminary CDC recognition see [Requirements for CDC Recognition](#).

- MDPP suppliers must also maintain at least one administrative location—a non-private residence—and a primary business telephone number.
- All “lifestyle coaches” (who are employed by an MDPP supplier) must obtain an NPI, which will be reported with Medicare claims
 - To be eligible to provide MDPP services, coaches may not have had Medicare billing privileges revoked or have been convicted of a felony within the last 10 years.
 - Individual coaches cannot apply to be an MDPP supplier.
 - Individual coaches should be compliant with the CDC Recognition Standards coach requirements
- All CDC-recognized organizations must enroll in Medicare as MDPP suppliers to furnish and bill P services.
- Existing Medicare suppliers must enroll as MDPP suppliers to offer the program.
- If an MDPP supplier’s Medicaid billing privileges are revoked, Medicare billing privileges will also be revoked.
- MDPP suppliers must submit a roster of coach NPIs, names, and social security numbers upon application for enrollment.
- MDPP supplier enrollment began January 1, 2018.

More CMS resources for MDPP Supplier enrollment, located on the [Center for Medicare and Medicaid Innovation MDPP site](#), include:



- [MDPP Supplier Roadmap \(Overview of the MDPP Supplier Journey\)](#)
- [MDPP Enrollment \(How to Prepare for Enrollment\)](#)
- [CMS/CDC Roles Fact Sheet \(Outlines Roles of CMS/CDC\)](#)

MDPP Orientation Video: Provides a 5-minute overview of MDPP, including introductory information on enrollment and MDPP services.

Payment for MDPP Services

MDPP services are paid for through a performance-based payment methodology that is updated annually for inflation.

The following table details the [CMS Calendar Year MDPP Payment Rates](#) and the maximum reimbursement available per beneficiary:



MDPP 2023 Payments Per Beneficiary:

Performance Goal	Payment (with minimum weight loss)	Payment (without minimum weight loss)
Core Sessions		
1 st Core session attended		\$38
4 Total core sessions attended		\$115
9 Total core sessions attended		\$191
Maximum Total Payment for Core Sessions		\$344
Core Maintenance Sessions		
2 Sessions attended in months 7–9	\$101	\$76
2 Sessions attended in months 10–12	\$101	\$76
Maximum Total Payment for Core Maintenance Sessions	\$202	\$152
Weight Loss Performance Payments		
5% Weight loss achieved (months 1–12)	\$184	\$0
9% Weight loss achieved (at any point during months 1–24)	\$38	\$0
Maximum Additional Weight Loss Performance Payments	\$222	\$0
Maximum Total Payments*,**	\$768	\$496

Content last updated: January 19, 2023

*If a beneficiary switches MDPP suppliers, a one-time bridge payment of \$38 is available to the new supplier.

Beneficiary Engagement Incentives

- If an MDPP supplier offers an in-kind incentive, the item or service must be provided during the MDPP services period and must have a reasonable connection to the CDC-approved curriculum.
- Cost of incentives must not be shifted to another Federal health care program or to a beneficiary.
- MDPP suppliers must maintain documentation of incentives that individually exceed \$25 in retail value; incentives involving technology may not, in aggregate, exceed \$1,000 in retail value for any one MDPP beneficiary.

Medicare Advantage Plans and the MDPP

All Medicare beneficiaries have access to MDPP services. There are two ways in which Medicare beneficiaries can receive these benefits:

- Through original Medicare, which is comprised of Part A (hospital services) and Part B (outpatient medical services), or
- Through Medicare Part C, also known as Medicare Advantage.

Original Medicare is administered directly by the federal government, and beneficiaries may receive care from any provider that accepts Medicare. Medicare Advantage (MA) provides Medicare benefits through approved private insurance companies, rather than directly through the federal government, and generally receive care from a specific network of providers. MA plans must provide enrollees with all Medicare Part A and Part B services, but they may also cover additional benefits, such as dental or vision care.

CMS has released guidance for Medicare Advantage plans, including an [MA Fact Sheet](#) and [document](#) that contains Medicare Advantage-related extracts from the MDPP Calendar Year 2018 Physician Fee Schedule Final Rule. For more information, visit the [Center for Medicare and Medicaid Innovation](#) MDPP site.

In addition to these resources, CMS, the National Association of Chronic Disease Directors (NACDD), and Leavitt Partners worked collaboratively to host an [informational webinar](#) on how MDPP suppliers can work with MA plans. An accompanying [resource](#) was developed that details the information presented during the webinar.

Additional Guidance

It is important to note that there are some aspects of the program that have not yet been finalized or that CMS is continuing to monitor. It is expected that additional guidance on these elements will be detailed in future rulemaking. Some of the policies that may be forthcoming include:

- Virtual delivery – CMS is considering implementing a separate model under CMS' Innovation Center to test

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and evaluate virtual DPP services. The model would run in parallel with the MDPP Expanded Model.

- Program integrity safeguards
- Verification processes used by MDPP suppliers to determine whether beneficiaries have enrolled in the program in the past
- Application processes and ongoing technical support of MDPP suppliers

If you have any further questions, please visit the [MDPP Supplier Support Center](#).

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