

The ABCs of the Initial Preventive Physical Exam and the Annual Wellness Visit

National Provider Call
July 21, 2011

Today's Panel of Experts

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Introduction



Medicare & Preventive Services Historical Perspective

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- Statutory mandates
- Medicare Prescription Drug and Modernization Act (MMA) 2003
- Medicare Improvements for Patients and Providers Act (MIPPA) 2008
- Affordable Care Act (ACA) 2010

Initial Preventive Physical Examination (IPPE)

Also known as the
Welcome to Medicare Visit



What is the IPPE?

- One-time visit, covered within first 12 months of Part B enrollment and includes –
 - Review of medical and social history
 - Review of potential (risk factors) for depression
 - Review of functional ability and level of safety
 - Measurement of height, weight, body mass index, blood pressure, visual acuity screen, and other factors deemed appropriate
 - Discussion of end-of-life planning, upon agreement of the individual
 - Education, counseling and referrals based on results of review and evaluation services performed during the visit, including a brief written plan such as a checklist, and if appropriate, education, counseling and referral for obtaining an electrocardiogram (a/k/a EKG, ECG)

Jamie
Hermansen

Who Can Provide an IPPE ?

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

How to Code

The codes for billing the IPPE and the screening EKG are below:

HCPCS Code	Code Descriptor
G0402	Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment
G0403	Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report
G0404	Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination
G0405	Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination

How to Code

Code G0402 **must** be used to report the IPPE. The various components of the IPPE previously described on slide 6 must be provided and documented in a beneficiary's medical record during the IPPE.

Who can bill for the IPPE?

These services typically are provided in a physician office. When the services are provided in a facility, the following institutions can bill:

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

Diagnosis Coding

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

ICD-9-CM Notice

The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) is published by the United States Government. A CD-ROM, which may be purchased through the Government Printing Office, is the only official Federal government version of the ICD-9-CM. ICD-9-CM is an official Health Insurance Portability and Accountability Act standard.

Frequency

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

Kathleen Kersell

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

Coinsurance & Deductible

Kathleen Kersell

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

However, the deductible and coinsurance still applies to the screening EKG.

IPPE-Related Screening for Abdominal Aortic Aneurysm (AAA)

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

G0389 – Ultrasound, B-scan and or real time with image documentation; AAA screening

IPPE-Related Screening for Abdominal Aortic Aneurysm (AAA)

Effective for dates of services on or after January 1, 2011, the coinsurance or copayment and deductible are waived for the AAA ultrasound screening (G0389).

For more information on the AAA ultrasound screening done as the result of a referral from an IPPE, please see the CMS Internet-Only Manual Pub. 100-04, chapter 18, section 110 on the CMS web site at:

<http://www.cms.gov/manuals/downloads/clm104c18.pdf>

The IPPE is NOT a Routine Physical Exam

- The IPPE is a preventive wellness visit and not a routine physical examination.
- Medicare does not provide coverage for routine physical exams.

Stephanie Frilling

Providing E/M Services in Addition to an IPPE

CPT Modifier 25 (*Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*).

- Appended to claims denoting a separate Evaluation and Management (E/M) service furnished with an IPPE.
- Cost sharing (coinsurance, copayment and deductible) applies to the additional (E/M) service.
- CPT codes 99201 – 99215 may be reported depending on the clinical appropriateness of the circumstances.
- Preventive services identified in CPT code range 99381 through 99397 are not covered by Medicare.

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

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Preparing Patients for the IPPE

Providers can help Medicare beneficiaries get ready for their IPPE by encouraging them to come prepared with the following information:

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

Stephanie Frilling

Need More Information?

Medicare Learning Network® (MLN) Products

Quick Reference Information: The ABCs of Providing the Initial Preventive Physical

Examination http://www.CMS.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf

The Guide to Medicare Preventive Services, Chapter 1

http://www.CMS.gov/MLNProducts/downloads/mps_guide_web-061305.pdf

Manual References

Claims Processing Manual

Pub. 100-04, Chapter 18, Section 80

<http://www.cms.gov/manuals/downloads/clm104c18.pdf>

and

Chapter 12, Section 30.6.1.1 <http://www.cms.gov/manuals/downloads/clm104c12.pdf>.

Stephanie Frilling

Annual Wellness Visit (AWV)



Jamie
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Proposed Refinement to the AWW

- Medicare Physician Fee Schedule CY 2012 Proposed Rule proposed to incorporate the use and results of a Health Risk Assessment into the provision of personalized prevention plan services during the AWW.
- The proposed rule text is available at the following address:
<http://www.cms.gov/PhysicianFeeSched/PFSFRN/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=4&sortOrder=descending&itemID=CMS1249142&intNumPerPage=10>
- We welcome public comments due by 5pm on August 30, 2011.
 - Electronically through www.regulations.gov
 - Hard copy (see instructions in the proposed rule)
- CMS staff cannot discuss this topic on today's call.

What is the AWW?

- Regulations at 42 CFR 410.15.
- New benefit for CY 2011
- Beneficiary Eligibility:
 - One AWW every 12 months.
 - Available after beneficiary has had Part B for longer than 12 months.
 - NOTE: beneficiary does not need to receive an IPPE to be eligible for AWW. However - if the beneficiary received an IPPE, – she/he is eligible for an AWW 12 months following the IPPE.

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

Subsequent AWWs

- Update of medical/family history
- Update of list of current providers/suppliers
- Measurement of weight, blood pressure, and other routine measurements
- Detection of any cognitive impairment
- Update to:
 - Written screening schedule
 - List of risk factors and conditions where interventions recommended.
- Personalized health advice and referrals for health education and preventive counseling

Who Can Provide an AWW ?

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

How to Code

The following G-codes identify the AWW for Medicare payment:

- **G0438** (Annual wellness visit, including Personalized Prevention Plan Service, first visit), and
- **G0439** (Annual wellness visit, including Personalized Prevention Plan Service, subsequent visit).

Who can bill for the AWW?

These services typically are provided in a physician office. When the services are provided in a facility, the following institutions can bill:

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

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

Thomas Dorsey

Diagnosis Coding

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

Thomas Dorsey

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How often can the AWV be performed?

- First visit (G0438)- once in a lifetime
- Subsequent (G0439)- annually (after 11 full months have passed since the last AWV)

Thomas Dorsey

Coinsurance & Deductible

- Effective for dates of services on or after January 1, 2011
- Copayment or coinsurance and the Medicare Part B deductible are waived

Thomas Dorsey

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Thomas Dorsey

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- Family health history, in as much detail as possible;
- A full list of medications and supplements, including calcium and vitamins – how often and how much of each is taken; and
- A full list of current providers and suppliers involved in providing care.

Stephanie Frilling

Need More Information?

MLN Products

Quick Reference Information: The ABCs of Providing the Annual Wellness Visit

http://www.CMS.gov/MLNProducts/downloads/AWV_Chart_ICN905706.pdf

MM7079: Annual Wellness Visit (AWV), Including Personalized Prevention Plan Services (PPPS)

<http://www.cms.gov/MLNMattersArticles/downloads/MM7079.pdf>

The Guide to Medicare Preventive Services, Chapter 4

http://www.CMS.gov/MLNProducts/downloads/mps_guide_web-061305.pdf

Manual References

Medicare Benefit Policy Manual

Publication 100-02, Chapter 15, Section 280.5

<http://www.cms.gov/manuals/downloads/bp102c15.pdf>

Medicare Claims Processing Manual

Publication 100-04, Chapter 12, Section 30.6.1.1

<http://www.cms.gov/manuals/downloads/clm104c12.pdf>

Chapter 18, Section 140

<http://www.cms.gov/manuals/downloads/clm104c18.pdf>

Stephanie Frilling

Learn More About Medicare's Preventive Services

General Preventive Services Resources from the MLN

The Guide to Medicare Preventive Services

http://www.CMS.gov/MLNProducts/downloads/mps_guide_web-061305.pdf

MLN Preventive Services Products Page

http://www.cms.gov/MLNProducts/35_PreventiveServices.asp

CMS' Prevention Website

<http://www.cms.gov/PrevntionGenInfo>

Continuing Education Information

Continuing education credits may be awarded by the American Academy of Professional Coders (AAPC) or the American Health Information Management Association (AHIMA) for participation in CMS National Provider Call.

- American Academy of Professional Coders (AAPC)

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Continuing Education Information

American Health Information Management Association (AHIMA)

AHIMA credential-holders may claim 1 CEU per 60 minutes of attendance at an educational program. Maintain documentation about the program for verification purposes in the event of an audit. A program does not need to be pre-approved by AHIMA, nor does a CEU certificate need to be provided, in order to claim AHIMA CEU credit. For detailed information about AHIMA's CEU requirements, see the Recertification Guide on AHIMA's web site.

Please note: The statements above are standard language provided to CMS by the AAPC and the AHIMA. If you have any questions concerning either statement, please contact the respective organization, not CMS.

Questions?

