Centers for Medicare & Medicaid Services
Preventive Services: The Initial Preventive Physical Exam and
The Annual Wellness Visit
National Provider Call
Moderator: Leah Nguyen
March 28, 2012
2:30 p.m. ET

Contents

Disclaimers

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.

Operator: At this time, I would like to welcome everyone to the Medicare Preventive Services National Provider Call: the Initial Preventive Physical Exam and the Annual Wellness Visit Call.

All lines will remain in a listen-only mode until the question and answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. Thank you for your participation in today's call.

I will now turn the call over to Leah Nguyen. Thank you, ma'am. You may begin.

Introduction

Leah Nguyen: I am Leah Nguyen from the Provider Communications Group here at CMS, and I will serve as your moderator today. I would like to welcome you to this Medicare Preventive Services National Provider Call on the Initial Preventive Physical Exam and the Annual Wellness Visit.

During this National Provider Call, CMS subject matter experts will provide an overview of both services: when to perform them, who can perform them, who is eligible, and how to code and bill for each service. A question and answer session will follow the presentation.

Before we get started, I have a few announcements. This call is being recorded and transcribed. The audio recording and written transcript will be posted soon to the National Provider Calls and Events section of the Fee-For-Service National Provider Calls webpage.

There is a slide presentation for this session. If you've not already downloaded this presentation, you may do so now by going to the Fee-For-Service National Provider Calls webpage at www.cms.gov/npc. Again, that URL is www.cms.gov/npc. At the left side of the webpage, select "National Provider Calls and Events" then select the March 28 call from the list.

Please be aware that Continuing Education Credits may be awarded by the American Academy of Professional Coders, the American Health Information

Management Association, and the American Medical Billing Association for participation in CMS National Provider Calls.

Please see slide 52 of the presentation for more information. If you have any questions regarding the awarding of credits for this call, please contact that organization. We encourage you to retain your presentation materials and confirmation e-mails.

I would also like to thank those of you who submitted questions when you registered for today's call. Your questions were shared with the speakers to help prepare the slides and remarks for today's presentation.

Please note that although we may not be able to address every question submitted during registration, will we – we will review them to help us develop Frequently Asked Questions, educational products, or future messaging on these programs.

At this time, I would like to introduce our speakers who are subject matter experts on today's topic.

We are pleased to have with us Jamie Hermansen from the Office of Clinical Standards and Quality, Coverage and Analysis Group; Kathleen Kersell from the Center for Medicare, Provider Billing Group; Stephanie Frilling from the Center for Medicare, Hospital Ambulatory Policy Group; and Thomas Dorsey from the Center for Medicare, Provider Billing Group.

So now, it is my pleasure to turn the call over to our first speaker, Jamie Hermansen from the Office of Clinical Standards and Quality at CMS.

Initial Preventive Physical Examination Presentation

Jamie Hermansen: Thank you, Leah. I'd like to begin by providing some background information on the coverage for the IPPE, or the Initial Preventive Physical Examination.

Medicare coverage – Medicare Part B coverage of the IPPE was authorized by the Medicare Prescription Drug Improvement and Modernization Act of 2003 and later modified by the Medicare Improvements for Patients and Providers

Act of 2008, and implementing regulations for the IPPE are – can be found at 42 CFR, 410.16.

Regarding beneficiary eligibility and frequency, the IPPE is a one-time visit and is covered for beneficiaries within the first 12 months of Medicare Part B enrollment.

The IPPE is covered by Medicare Part B and furnished by a physician, physician assistant, nurse practitioner, or clinical nurse specialist.

And I'd now like to hand the call over to Stephanie Frilling.

Stephanie Frilling: Thank you, Jamie.

I'm Stephanie Frilling from the division of Practitioner Services in HAPG, and Jamie has asked me to address this slide as many questions requested from the registration page on incidents to billing and furnishing IPPE or the AWV.

From the collected questions, we know that many of you are very familiar with Medicare policies for billing and payment of incidents to services. However, the payment policy, furnishing services incident to a physician do not apply to the IPPE as this service has its own benefit category.

Slide eight is an overview of incident to billing rules that are recognized when services or supplies are furnished, incident to a physician's order.

In many cases, a nurse or other healthcare provider will furnish services where payment is commonly captured on the physician's claim. No separate Medicare claim is made to the non-physician provider.

The IPPE is not subject to incidents to billing and payment rules under Section 1861(s)(2)(a) of Social Security Act as the IPPE has its own benefit category established under Section 1861(ww) of the Act, and must meet the statutory requirements set forth in this Section of the Act.

Physicians and practitioners must meet specific benefit requirements for who may furnish an IPPE in order to bill for this service.

Jamie, thank you.

Jamie Hermansen: Thank you, Stephanie.

Moving on to slide nine, the following elements are included in the IPPE: a review of medical – in summary, it's the review of medical and social history, the reviews of potential risk factors for depression; functional ability and level of safety; measurement of height, weight, body mass index, blood pressure, and visual acuity screen, and other factors deemed appropriate.

Discussion of – it also includes the discussion of end-of-life planning upon agreement of the individual; along with education, counseling, and referrals based on results of review and evaluation of services performed during the IPPE, which also includes a brief written plan such as a checklist, and if appropriate, education counseling and referral for obtaining an electrocardiogram, also referred to as an EKG.

I will now hand the call over to Kathleen Kersell.

Kathleen Kersell: Hi. Thank you, Jamie.

If you're following along, we're on slide 10 and for the IPPE, slide 10, it gives you instructions on how to code for this service.

You would use Code G0402 to report the IPPE on your claim. The various components of the IPPE previously described on slide nine must be provided and documented in a beneficiary – in a beneficiary's medical record during the IPPE.

The people that can bill the IPPE are typically – well, sorry. Next question would be "Who can bill for the IPPE?"

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

for Inpatients on Type of Bill 12X and Outpatients, Type of Bill 13X; Skilled Nursing Facilities for inpatients, Type of Bill 22X; and Rural Health Centers, Type of Bill 71X; Federally Qualified Health Centers, Type of Bill 77X; and Critical Access Hospitals, Type of Bill 85X.

On slide 11, you just got diagnosis coding for the IPPE. Although a diagnosis code must be reported on the claim, there is no specific International Classification of Diseases, 9th Revision, Clinical Modification or ICD-9-CM diagnosis codes that are required for the IPPE.

Medicare providers should choose an appropriate ICD-9-CM diagnosis code. Examples for diagnosis code that could be included on the claim are V70.0, V70.3, or V70.9. They all could be considered acceptable diagnosis codes, as well as any other valid, appropriate diagnosis code.

You can also contact your Medicare contractor for any assistance with what type of diagnosis codes you want to have on the claim.

I also do want to point out that on slide 11, where I'm at right now, I said V70.3. That slide says "V70.8" and we will be posting a corrected slide that says "V70.3" and I do apologize for that error. But basically, any appropriate diagnosis code would be acceptable for billing an IPPE.

Now on slide 12, discussed frequency, "How often can the IPPE and the screening EKG be performed?"

The IPPE, code 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, which is codes G0403, G0404, or G0405, as appropriate, can be done when they are done as a referral from an IPPE. It's also only covered once during a beneficiary's lifetime.

On slide 13 is the frequency of the EKG – the screening EKG for an IPPE and diagnostic EKG performed on the same day. A diagnostic EKG cannot be performed on the same day as the screening EKG for the IPPE unless it is medically necessary.

If a diagnostic EKG is performed on the same day as codes G0403, G0404, or G0405 and is deemed medically necessary, then the diagnostic EKG must be billed with Modifier 59. Otherwise, a diagnostic EKG cannot be done on the same day as a screening EKG.

Slide 14 about deductible and coinsurance for the IPPE, effective for dates of service on or after January 1st, 2011, the coinsurance and the deductible are waived for the IPPE for code G0402 only.

However, the deductible and coinsurance still apply to the screening EKG that can be done as a referral from an IPPE; therefore, codes G0403, G0404, and G0405 still have to have the deductible and coinsurance applied to them.

Next, slide 15 is for the IPPE-related screening for Abdominal Aortic Aneurysm. If you have an IPPE done, you can also provide for the beneficiaries a one-time only ultrasound screening for an Abdominal Aortic Aneurysm, or AAA, you know, that can be done as the result from an IPPE with certain – you know, if the beneficiary has certain risk factors.

The codes for billing the AAA ultrasound screening is G0389 and that's an Ultrasound, B-scan, and/or real time with image documentation, AAA screening.

Slide 16, more on the IPPE-related screening of – effective for dates of service on or after January 1st, 2011, the coinsurance and deductible are waived for the AAA screening, code G0389.

For more information on the AAA screening when done as the result of a referral from an IPPE, please see the CMS Internet-Only Manual Publication 100-04, Chapter 18, Section 110 on the CMS Web site. That CMS Web site is www.cms.gov/manuals/downloads/clm104c18.pdf.

Also, that manual section will give you all the requirements needed for beneficiary – you know, that a beneficiary must meet in order to be eligible to receive the AAA ultrasound screening.

Now from that, we're moving on to – I'll turn this over to Stephanie Frilling on slide 17. Thank you.

Stephanie Frilling: Thank you, Kathy, and again, this is Stephanie Frilling from the Division of Practitioner Services and I'll begin my presentation on slide 17.

We are very pleased to announce that twice as many IPP Exams were furnished in 2011 than in 2010. This is largely credited to Section 4104 of the Affordable Care Act where Congress waived cost sharing requirements for IPPE services furnished on or after January 1st, 2011.

Now, when a beneficiary receives an IPP Exam from a provider who accepts assignment, they will pay nothing for the visit.

In 2011, 235,000 beneficiaries, all within the first 12 months of Part B coverage, received the IPPE Physical Examination, providing an ongoing systematic foundation for wellness and prevention.

On slide 18, many questions were collected from the registration page regarding the IPPE service elements and those of a traditional annual physical examination. Medicare does not provide coverage for routine physical examinations and the IPPE is a preventive wellness examination and not the head-to-toe physical examination.

While there is some overlap, for example, the IPPE identifies health risk – health risk factors and takes routine measurements and updates the beneficiary's medical record, the focus of the IPPE is to furnish education counseling and prevention services that are appropriate for the individuals and available in Medicare.

During our last call in July of 2011, we received many questions from practitioners seeking advice on how to manage a patient's perception of an IPPE. Many practitioners indicated that beneficiaries were often expecting a routine annual checkup, and were confused when so much of a practitioner's time was dedicated to preventive counseling and education.

We have furnished much guidance on this issue over the last several months and many materials are available on the CMS Web site. And they can be reviewed at www.cms.gov/preventiongeneralinfo.

In particular, I'd like to mention the preventive screening checklist that you can give to your patients and where a physician and a patient can discuss and actually track preventive services available for the beneficiary.

Moving on, on slide 19, the best time to schedule an IPPE Exam for a patient is of course within the first 12 months of their Part B coverage, but also, when a beneficiary's health status is stable and the patient is open to discussing preventive and screening services available in Medicare.

Furthermore, in order to maximize the face-to-face time of the IPPE Exam, the patient should come prepared and ready to discuss their medical history, current treatment, medications, and to discuss and develop a preventive screening schedule.

While we believe that the IPPE is best furnished when a beneficiary's health status is stable, we recognize that some patients with a chronic or diagnostic condition present during the IPPE may require additional medically necessary Evaluation and Management Services.

On slide 20, we note that when an E and M service in the code range of not – of CPT code 99201 through 99215 are furnished during an IPPE visit, the practitioner must append Modifier 25 to the claim line for payment.

Cost sharing will apply to the E/M service that is furnished during the IPP Exam as the Affordable Care Act only waives the cost sharing requirement for the IPPE and not the E and M service.

While other preventive services, screenings and laboratory tests are not included in the IPPE, they may be furnished during the visit if they are appropriate for the individual. No modifier is required for billing other preventive services when furnished during the IPP Exam.

As a special note, Section 4104 of the Affordable Care Act also waives cost sharing for many preventive services. And the IPPE is a great opportunity to furnish or order preventive laboratory tests or get a flu shot.

On slide 23, once again from the registration page, many questions came around billing Medicare non-covered preventive physical examinations with an IPP Exam.

Non-covered preventive services including E and M services may be billed with an IPPE. However, we would hope that the provider would notify the patient that the additional services are non-covered by Medicare and that the payment for the additional non-covered preventive service will fall to the beneficiary.

We further note that non-covered E and M preventive services will have a substantial overlap in the service elements furnished at the IPPE, and that practitioners are responsible for billing appropriately when providing additional non-covered E/M preventive services.

We suggest that providers use some documentation, such as an ABN, to notify the patient that payment for the additional non-covered preventive service is not covered by Medicare.

On slide 24, we have posted the 2012 National Payment Rates for the Non-facility and for the Facility Payments for furnishing an IPPE. The link referenced from the slide is for the Physician Fee Schedule Look up Tool where a practitioner can look up the payment rate for a specific locality.

For those of you not familiar with the Look Up Tool, I encourage you to go to the site and give it a try, as payment rates for most physician services are available on the Look Up Tool.

Polling

Leah Nguyen: Thank you, Stephanie.

At this time, we will pause for a few minutes to complete keypad polling so that CMS has an accurate count of the number of participants on the line with

us today. Please note, there will be a few moments of silence while we tabulate the results.

Holley, we're ready to start polling.

Operator: CMS greatly appreciates that many of you minimize the Government's teleconference expense by listening to these calls together in your office using only one line.

Today, we would like to obtain an estimate of the number of participants in attendance to better document how many members of the provider community are receiving this valuable information.

At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number between two and eight. If there are nine or more of you in the room, enter 9.

Again, if you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number between two and eight. If there are nine or more of you in the room, enter 9.

Please hold while we complete the polling.

Please continue to hold while we complete the polling.

Thank you for your participation. I would now like to turn the conference back over to Leah Nguyen.

Leah Nguyen: Thank you, Holley. Now, we'll go back to Jamie Hermansen as we move into our next section on the Annual Wellness Visit.

Annual Wellness Visit Presentation

Jamie Hermansen: Thank you, Leah.

By way of background, Medicare coverage for the Annual Wellness Visit was authorized by the Affordable Care Act of 2010, and implementing regulations were established at 42 CFR 410.15.

Coverage of the AWV became effective on January 1st, 2011, while the Affordable Care Act specified the provision of personalized prevention plan services—include and take into account the results of a health risk assessment, the statute also provided the secretary with additional time to develop guidance on health risk assessment.

As a result in the calendar year 2012 Physician Fee Schedule rule, we modified the AWV regulations to include the health risk assessment in the provision of supplies prevention plan services as part of the Annual Wellness Visit.

Moving on to slide 28 regarding beneficiary eligibility and frequency, a beneficiary is eligible to receive an Annual Wellness Visit if they have had Medicare Part B for longer than 12 months or 12 months after receiving their IPPE.

Now, we note that the beneficiary does not need to receive an IPPE to be eligible for an Annual Wellness Visit. And regarding frequency, the AWV is covered once every 12 months.

For slide 29 we discussed who can furnish an Annual Wellness Visit, which is – which we defined as a health professional which means a physician, physician assistant, nurse practitioner, clinical nurse specialist; or a medical professional including a health educator, a registered dietitian, nutrition professional, or other licensed practitioner; or a team of special medical professionals working under the direct supervision of a physician.

As we've discussed in the preamble to the Calendar Year 2011 Physician Fee Schedule Rule, we are not assigning particular tasks or restrictions for specific members of the team, and we believe it's better for supervising physicians to assign specific tasks to qualified team members as long as they are licensed in the state and working in their state's group of practice.

And, we also believe that this approach gives the physicians and the team the flexibility needed to address the beneficiary's particular needs on a particular day.

So I will now hand the call over to Stephanie Frilling.

Stephanie Frilling: Thanks, Jamie.

I'd like to confirm that like the IPPE, the AWV is not subject to incident to rules. And where the wellness visit is performed by a team of medical professionals working under the supervision of the physician, it is the supervising physician who will bill Medicare for the visit. Also, in response to questions collected up from the registration page, I would like to take this moment to clarify that direct supervision in the office setting means that a physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure or service.

Jamie Hermansen: Thank you, Stephanie. And moving on to slide 31, the Annual Wellness Visit is the visit that focus – that focuses on prevention wellness and the provision of personalized prevention plan services.

And in summary, the first annual wellness visit includes the following elements: A health risk assessment, which we will provide more information about shortly.

The establishment of an individual's medical and family history; establishment of a list of current providers and suppliers that are regularly involved in providing care to the beneficiary; measurement of blood pressure, height, weight, or waist circumference, if appropriate.

Detection of any cognitive impairment; and review of potential risk factors for depression, functional ability and level of safety; and the establishment of a written screening schedule such as a checklist for the next 5 to 10 years; a list of the risk factors and conditions where interventions are recommended; and

finally the furnishing of personalized health advice and referrals for health education and preventive counseling.

Moving on to slide 32, in general, the subsequent Annual Wellness Visit – you can see on that slide, the list of – a summary list of the elements. It's mostly focused on updating the information that was provided during the first Annual Wellness Visit or the most recent for you—subsequent visit, whichever visit they've most recently had. So, it has a similar look to the elements there.

Moving on to slide 33 which is focusing on changes for 2012, as I mentioned earlier, we modified the Annual Wellness Visit regulations to include and take into account the results of a health risk assessment, which in summary, collects self-reported information known to the beneficiary; which can be administered by a beneficiary or a health professional before or as part of the Annual Wellness Visit encounter; and take no more than 20 minutes to complete.

On slide 34, in summary, the health risk assessment addresses the following topics: demographic data, self assessment of health status, psychosocial risks, behavioral risks, activities of daily living, and instrumental activities of daily living.

We'd also like to point out that the Centers for Disease Control and Prevention, it published an article entitled "A Framework for Patient Centered Health Risk Assessment." And, this framework – this framework includes information on the use of health of HRAs and follow-up interventions that others have suggested that in – that can influence health behaviors.

Defining the HRA framework rationale for it's use, the history of health risk assessment and risk-adjusted set of HRA questions, which can be found in the – in Appendix A of that – of that publication. You can find a link to this publication on slide 50 of this presentation packet.

And finally, moving on to slide 35, in preparation for the Annual Wellness Visit, we're encouraging beneficiaries to bring the following information with

them to their appointment: any pertinent medical records; family health history; a list of medications and supplements, including calcium and vitamins that they may be taking; and a list of current providers and suppliers involved in their health care.

I'd like – would now like to hand the call over to Thomas Dorsey.

Thomas Dorsey: Thank you, Jamie.

My first slide, 36, concerns the required billing procedure codes that can be billed for each service. Two G-codes are used to identify the Annual Wellness Visit for purposes of Medicare payment: G0438 – Annual Wellness Visit, including Personalized Prevention Plan Service, first visit; and G0439 – Annual Wellness Visit, including the Personalized Prevention Plan Service, subsequent visit.

Now, who can bill for the Annual Wellness Visit? These services are typically provided in a physician's office. However, the services can be provided in a facility.

When the services are provided in a facility, the following institutions can bill: Hospital Inpatients – Type of Bill 12X, and Outpatients – Type of Bill 13X; Skilled Nursing Facilities Inpatients – Type of Bill 22X, and Outpatients 23X; Rural Health Centers – Type of Bill 71X; Federally Qualified Health Centers – Type of Bill 77X; and Critical Access Hospitals – Type of Bill 85X.

The next slide, 37, concerns diagnosis coding. Medicare claims must follow diagnosis code on the claim. However, although a diagnosis code must be included on the claim, there are no specific International Classification of Diseases named provision, Clinical Modification, ICD-9-CM diagnosis codes that are required for the Annual Wellness Visit.

Therefore, a Medicare provider should choose an appropriate ICD-9-CM diagnosis code or contact the local Medicare contractor for guidance.

A number of providers have been submitting Annual Wellness Visit claims with diagnosis code 70.0, routine general medical examination at a healthcare facility, and this code is being accepted.

Other examples are V70.3 to V70.9. As a note, the slide will be changed to show V70.3 instead of V70.8.

My next slide, slide 38, addresses frequency of services. The first Annual Wellness Visit can be billed only once in a lifetime using code G0438. The subsequent Annual Wellness Visit, G0439, can be billed annually provided that 11 full months have passed since the last Annual Wellness Visit.

Slide 39, frequency of EKG, points out that Medicare providers may perform a medically necessary diagnostic EKG on the same day that an Annual Wellness Visit G0438 or G0439 is performed. In the pay out, some claims for diagnostic EKGs performed on the same day as the Annual Wellness Visit have been denied.

CMS has made claims processing changes to allow payment for a diagnostic, medically necessary EKG performed on the same day as an Annual Wellness Visit. Providers that may have been denied a claim for a medically necessary diagnostic EKG performed because it was performed on the same day as an Annual Wellness Visit may contact their Medicare claims processing contractor and request after April 1, 2012 that their denied claim be adjusted for payment.

On to my last slide, slide 40, this points out that from the Annual Wellness Visit, the annual Medicare Part B deductible is waived as is the normal coinsurance.

This slide also points out that the Annual Wellness Visit is effective for services on or after January 1, 2011. And now, I will return the presentation over to my colleague, Stephanie Frilling.

Stephanie Frilling: Thanks, Tom. And I will begin on slide 41 with AWV utilization. I'm pleased to announce that 2,599,512 AWV visits were furnished in 2011, the first year of this visit.

So in all cases, the first annual visit recognized by G0438 was billed. For the first two months of 2012, 319,106 first Annual Wellness Visits were furnished to beneficiaries and 92,285 subsequent visits recognized by G0439 were furnished to the beneficiaries.

We are encouraged by these results.

On slide 42, like the IPPEs, the AWV is a face-to-face preventive visit for beneficiaries and not a head-to-toe physical examination. The Annual Wellness Visit includes a personalized prevention plan of service known in Medicare as the PPPS. Section 4103 of the Affordable Care Act specifically intended this visit to furnish personalized health advice, referrals as appropriate to health education, preventative counseling services or programs aimed at reducing identified risk factors and promoting self management and wellness.

The AWV, like the IPPE, is best furnished to a beneficiary when their health status is stable and they are open to discussing preventive and screening services available on Medicare. We ask providers to be thoughtful regarding the best timing of the AWV to maximize its impact on a beneficiary's health.

A provider shall encourage beneficiaries to complete the HRA prior to the visit so that the patient and the provider can maximize the face-to-face time and allow the preventive follow up where health risks are continuously monitored and preventive and screening services, health education, health counseling services are promoted to foster health awareness and self-management for the beneficiary.

Following along on slide 44, the first and subsequent AWV Visits may be billed with any medically necessary evaluation management service like the IPPE, when billing additional E /M services, we would hope that providers would inform the patient of cost sharing requirements for the additional

services, and append payment modifiers 25 to the claim line submitted for payments.

Modifier 25 indicates a separately identifiable E/M service by the same physician on the same day of the procedure or other service. Cost sharing requirements will apply to the E /M services furnished and a beneficiary will be responsible for any deductibles, coinsurance or copayments that may result from the additional service.

On slide 45, the AWV does not include other preventive services that are currently covered and paid under section 1861 of the Social Security Act, but they may be furnished during an AWV visit when appropriate for the individuals. On our last call, in July of 2011, several commenters noted that some contractors were rejecting claims for preventive and diagnostic services. One such preventive service was prostate screening cancer, code G0102 for digital rectal exam, and the diagnostic EKG service that Tom had mentioned earlier.

Since that call, we have worked with contractors to remove any system edits that reject these services from being furnished during an AWV visit. If a practitioner has a rejected claim, and it has been denied payments, they are welcome to resubmit those claims for payment at this time.

On slide 46, from the registration page, many questions came in on billing and Medicare non-covered preventive physical examination with an AWV visit. Non-covered preventive services including preventive E and M services may be billed with an AWV visit. And like the IPPE, we suggest that the provider use an ABM to notify the patient that payments for the additional non-covered preventive service is not covered by Medicare.

We further note that a carve-out billing is not possible with the AWV as all of the elements must be furnished in order to bill for this service. Non-covered E and M preventive services will have substantial overlap with the service elements furnished in the AWV visit and practitioners and providers are responsible for billing appropriately when providing additional non-covered E and M preventive services.

Moving along on slide 47, the AWV has a single Medicare non-facility payment rate under the PFS of $155.89 for the initial AWV visit and $110.96 for subsequent visits. In our 2012 physician fee schedule final rule, we finalized additional minutes for these services to include inclusion of the HRA during the visit.

While we believe that the HRA is best completed prior to the AWV, we recognize that many beneficiaries will not be able to complete the forms without assistance from a healthcare professional, and we have allowed for the assistance in the payment rates.

Slides 48, and 49, the remaining slides from my section furnished links for additional preventive services, and I encourage all of our listeners to review these materials and share them with your beneficiaries when appropriate.

I would like to make a note of some special sites. The first slide references the Medicare Learning Network publications where questions regarding AWV elements can be answered. The second slide indicates the Medicare internet manual sections while largely drafted for contractor instructions, it does furnish important guidance on billing and payment procedures, including the use of modifier 25.

And lastly, you can direct your patients to the general preventive service resources and preparing them for the AWV visit and as mentioned earlier, this is where you will find the checklist that may be helpful in developing screening schedules for beneficiaries.

Thank you for the opportunity to present today and I will now return the call to Leah.

Leah Nguyen: Thank you, Stephanie. On slide 50, you will find helpful websites for health professionals and beneficiaries, and on slide 51, you will find some websites with more information on Medicare's preventive servicesm including Medicare Learning Network resources and the CMS prevention webpage, and

slide 52 provides the continuing education information that I referenced at the start of the call.

We have now completed the presentation portion of this call, and we will move on to the question and answer session. Before we begin, I would like to remind everyone that this call is being recorded and transcribed.

Before asking your question, please state your name and the name of your organization. In an effort to get to as many of your questions as possible, we ask that you limit your questions to just one.

All right, Holley, you may open the lines for questions.

Question and Answer Session

Operator: All right, to ask a question, press star followed by the number one on your touchtone phone. To remove yourself from the queue, please press the pound key. Please state your name and organization prior to asking a question and pick up your handset before asking your question to assure clarity.

Please note your line will remain open during the time you are asking your question so anything you say or any background noise will be heard in the conference.

Please hold while we compile the Q&A roster.

And your first question comes from the line of Stacey Josephson.

Stacey Josephson: My question is regarding well-women visits; that was not a topic that was covered today. Where can I find more information?

Jamie Hermansen: Can you hold on for just a moment?

Medicare does cover pap test and pelvic exams with clinical breast exam. Additional information regarding those Medicare preventive benefits can be found in the Your Guide to Medicare Preventive Benefits. Unfortunately, I do not have the link with me, but if you would like to e-mail that question, we can make sure you got the link to that.

Stacey Josephson: OK. Thank you.

Leah Nguyen: And the e-mail address, if you like to send that in, is on slide 53.

Stacey Josephson: Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Todd Solomon.

Todd Solomon: Yes, hello. I'm wondering about billing for separate E and M code during a wellness exam for treating a chronic condition such as, maybe uncontrolled diabetes or hypertension, where they may require a change in medication, if that could be billed as a separate service?

Stephanie Frilling: Yes, they can. We do believe that it would be convenient and appropriate to address chronic conditions during the AWV so if it is medically necessary, you would bill the additional E and M service and append modifier 25 to that claim line for payment.

Todd Solomon: Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Betsy Miller.

Betsy Miller: Hi, I work in an OB GYN office also and I pretty much have the question of, I mean, can you at least say if anything has changed for the well woman care in the GYN setting? Is it still every other year unless you're high risk? Or, because that was the main reason I was listening in today.

Leah Nguyen: Can you hold on for one moment?

Betsy Miller: Sure.

Jamie Hermansen: This is Jamie Hermansen again and my suggestion, again, if you are looking for specifics regarding Medicare coverage of those types of preventive

services regarding, you know, pap tests, and pelvic exams, and/or mammography, and related to that is to go to that publication, The Guide to Medicare's Preventive Services which is available on our Web site.

Betsy Miller: Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Lynn Evans.

Lynn Evans: Hi, I have a question regarding the codes and the billing. If the IPPE is to be billed, the G0402 codes, I'm wondering, and it's not a head-to-toe physical exam, I'm wondering how the V70.9 code is appropriate?

Kathleen Kersell: This is Kathy Kersell, the examples in the slides of V70.0, V70.3, and V70.9, they are basically just examples of, you know, diagnosis codes that could be used on the claims when billing for the IPPE, and they basically represent, just like, general or nondescript exams. Any appropriate diagnosis code would be acceptable on the claim and they were just basically given as examples. You do not have to use any of those diagnosis codes when you bill for an IPPE but they were basically just examples. We have been asked questions in the past, like, "is it OK if I use that diagnosis code?" So that is why we include it as an example.

Lynn Evans: But, isn't that incorrect billing if you bill for having done a general physical exam but you didn't actually do one?

Kathleen Kersell: Well, like I said, these were just examples because any appropriate diagnosis is acceptable, and it was my understanding that – like V70.9, I don't have the exact description in front of me at this moment…

Lynn Evans: It's general physical exams.

Kathleen Kersell: General, and V70.0 also falls under that type of…

Lynn Evans: Right V70.3 is other medical exams for admin purposes. I just – I'm just not – I guess it's just not clear to me because they are completely different things.

If the IPPE is not – essentially not hands on, it's not a head-to-toe physical and you bill for one, I think that is where the confusion is for providers.

Kathleen Kersell: Well, as I said before, you do not have to use those diagnosis codes but we have had providers just ask if they could bill those in the past and basically since there is no diagnosis requirement other than you have to have a valid diagnosis code on the claim, we have said if the claim comes in with that diagnosis code for that IPPE service, you will not have a denied claim. It will pay.

But again, that is you know, any appropriate valid diagnosis code is acceptable. If you are not comfortable with using any of those diagnosis codes in the examples, then you don't have to use them but you do have to have a valid diagnosis code on the claim.

Lynn Evans: OK, thank you.

Kathleen Kersell: You're welcome.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Andrea Sailas.

Andrea Sailas: Hi, I just needed a more of a clarification. I just wanted to make sure that the G0102 you stated was payable with the Annual Wellness Visit and the IPPE. Is that correct?

Stephanie Frilling: I'm sorry, I didn't catch the codes that you said. Was it G0102?

Andrea Sailas: Yes, just prostate exam, is that payable with both of those screening codes?

Stephanie Frilling: It is. It is.

Andrea Sailas: OK great. Thank you very much.

Female: Sure.

Operator: Your next question comes from the line of Sheila Hale.

And that question has been withdrawn. Your next question comes from the line of Teri Pokorny.

Teri Pokorny: Yes, I just have a question on the subsequent visits. Now they have their annual wellness, and you use a G0438. Now, the next year, do you use this or is this for a subsequent visit to go over everything?

Thomas Dorsey: This is Tom Dorsey, as a – you only can use the G0438 one time, so the next year, you would have to use a G0439.

Teri Pokorny: OK. Thank you.

Leah Nguyen: Thank you.

Operator: And your next question comes from the line of Suzanne Hopman.

Suzanne Hopman: Hi, I'm sorry, I just wanted to take myself off of mute. My question is in regard to the items that are required for the Annual Wellness Visit, if a physician or, you know, the practice in general, the provider, doesn't do one of the components, let us just say home safety – is this a billable service or should we be looking at using an ABN if not all elements are there? Or do you have a guideline as to how many elements must be there versus not be there, et cetera, et cetera?

Female: Regarding the elements included in the Annual Wellness Visit, I would refer you back to the slides that list the – the list of – that list those specifications and if you look at I believe it's slide 31 and slide 32 of our presentation. The other thing I know that we have put out several publications and quick reference sheet that provide additional information about that. So those may be helpful as well.

And we can provide – if you would like to e-mail your question in, we can provide you links to those documents.

And then as well as the – I can also provide you, if you would like to go ahead and send in that question, I think we can provide you additional feedback regarding that question.

And more information can be found on slide 48, the links to the publications that were referenced. Thank you.

Suzanne Hopman: OK, thank you.

Operator: Your next question comes from the line of Jessica Hemmesch.

Jessica Hemmesch: Hello, I have a kind of a similar question having to do with the IPPE, though. If the patient is being seen for eye care by another provider and they may have just had their vision screened recently, then they present for the IPPE. Is the lack of a vision screen during that IPPE a problem or could they just say, "sees their eye doctor regularly?" Would that suffice and be OK and not screen the vision at that visit?

Leah Nguyen: Could you hold on for just a moment?

I'm sorry, if you can go ahead and send that to the e-mail address listed on slide 53 and you can put it to Jamie Hermansen's attention that would be great. We will get back to you on that.

Jessica Hemmesch: OK.

Leah Nguyen: Great, thank you.

Operator: Your next question comes from the line of Tori Swanson.

And that question has been withdrawn. Your next question comes from the line of Trisha Proctor.

Trisha Proctor: We are an FQ facility and we are wondering: is an IPPE and an AWV mandatory? Because our physicians and our patients also expect the usual comprehensive preventive visit.

And not all providers are doing the IPPE or an Annual Wellness Visit because we don't really have all those checklists in place so we are concerned that are we missing something that we are mandated to do in lieu of the preventive service? Or is it OK if the provider doesn't do an IPPE or an Annual Wellness Visit at the patient request?

Leah Nguyen: Could you hold on for just a moment?

Hi, actually, we need to do a little more research on that if you could e-mail your question to the address listed on slide 53 to Jamie Hermansen's attention and we will get back to you on that.

Thank you.

Operator: And your next question comes from the line of Arline Kirkus.

Arline Kirkus: Hey, I had a question about AAAs. If a patient has risk factors and is not eligible for an IPPE, they have already past that 12 months, can they be referred for an AAA during their annual well?

Kathleen Kersell: Hi this is Kathy Kersell, and the screening AAA is only payable if done as a referral from an IPPE for those beneficiaries that have specific risk factors. You know, being that the – I'm referring to the screening code, the G – I don't have that code in front of me – G0389, that code can only be billed as a referral from an IPPE, and so…

Arline Kirkus: And so if they never had an IPPE, because now they're 75 or, you know, 68 or something, we can't now refer them for that because they have missed that opportunity?

Kathleen Kersell: Not for that code, that is correct.

Arline Kirkus: OK, very good. Thank you.

Operator: Your next question comes from the line of Tina Pravarish.

Tina Pravarish: Yes, I was just wondering for the IPPE and AWV, is it any physician specialty can perform this, like a neurologist, gynecologist, podiatrist…?

Jamie Hermansen: This is Jamie. We designate in the regulations that a physician… actually can you give us just a second please?

Tina Pravarish: Sure.

Leah Nguyen: Hello, we are still looking into the answer, just one moment.

Tina Pravarish: Thank you.

Jamie Hermansen: Hi, this is Jamie Hermansen and we – in the regulations for health professionals, we define a physician as, "a physician who is a doctor of medicine or osteopathy as defined in section 1861 R1 of the Act."

It could be an M.D. or D.O.

Tina Pravarish: So as long as it's an M.D. or D.O. they are fine, it doesn't matter what specialty.

Jamie Hermansen: We don't – the regulation is silent on that.

Tina Pravarish: OK, thank you.

Jamie Hermansen: Thank you.

Operator: And your next question comes from the line of Ramona McCubbins.

Ramona McCubbins: Hi yes, we are a rural health clinic, and I would like to know, when doing the IPPE, I know it covers the screening EKG and also an AAA ultrasound. Can those two screenings be done on the same day as the IPPE or does it have to be on a separate day?

Kathleen Kersell: Hi, this is Kathy Kersell. They can all be done on the same day but keep in mind that the AAA screening does have specific coverage that has to be met.

Ramona McCubbins: OK. And you also said that a screening PSA can be done during that physical – that IPPE?

Kathleen Kersell: Yes.

Ramona McCubbins: Ok. All right, and one more question, as a rural health clinic, I know that they all roll up into a one line thing, they're not separate.

They do not normally recognize modifiers, would I still need to use the modifier on an E and M service along with the IPPE?

Bill Ruiz: Hi, this is Bill Ruiz. Yes you have to use the 52 series modifier.

Ramona McCubbins: OK.

Bill Ruiz: And the HCPCS code.

Ramona McCubbins: OK. Yes I do know that code is separate from my E and M code, they're the only two that do not roll up together so that it is recognized that an IPPE was done on that day. But I just did not know whether I should go ahead and put the 25 modifier on the office visit or not.

Bill Ruiz: I believe you have to put, yes.

Ramona McCubbins: OK, all right. Thank you.

Bill Ruiz: You're welcome.

Operator: And your next question comes from the line of Sherry Lonewolf.

Sherry Lonewolf: Hi, this is Sherry Lonewolf and I'm calling from Cheraw Family Medicine, I'm confusing myself, if I got a new Medicare patient that is coming in and he is getting a head-to-toe physical, do I use the G0402 or am I supposed to use the G0402 plus the G0438?

Stephanie Frilling: Hi, this is Stephanie Frilling. No, Sherry, neither the G4 or the IPPE or the AWV are a head-to-toe physical. So this would be – you're discussing three specific services: non-covered routine head-to-toe physical examination, and

then the IPPE, and then the AWV. And for the preventive physicals, it would depend – the eligibility will depend on if the beneficiary had been enrolled in Medicare longer than twelve months or less than twelve months.

Sherry Lonewolf: OK, OK, thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Teri Coy.

Teri Coy: Yes, I have a question regarding the Annual Wellness Visit and the subsequent. In the slide page 28, it talks about the annual wellness is 12 months following the IPPE but the subsequent annual is 11 months following the initial annual so I want to clarify if those are both correct so that the other one, it doesn't actually have to be 365 days in between?

Jamie Hermansen: Hi, this is Jamie Hermansen. We would – in defining that 12-month period, we have instructed our Medicare contractors that it's basically you are counting 11 full months.

Teri Coy: OK.

Jamie Hermansen: From either one of those dates.

Teri Coy: From both of them. OK. So the 11 full months applies so they would have – let's say the 15th of the month and they come in a year later but have it at the tenth, those three days shy is not going to make a difference?

Thomas Dorsey: No, it shouldn't make a difference.

Teri Coy: OK, that is what I want to make sure because we have been trying to do that at this point. OK.

All right. Thank you.

Teri Coy: Thank you.

Leah Nguyen: You're welcome.

Operator: And your next question comes from the line of Lori Jepson.

Lori Jepson: Hi, this is Lori Jepson from North Dakota. My question has to do with the coder that asked on the head-to-toe physical, the V70.0, which requires a physical exam. Wouldn't it be better to code either education or medical information under a V65.49, or a treatment plan, V65.49?

Kathleen Kersell: Hi, this is Kathy Kersell. Yes, you can use those diagnosis codes if that is what you prefer. The reason we use the ones we did in the examples, we have received questions on those diagnosis codes in the past, and, again, any valid appropriate diagnosis code is what you should put on the claim. You should not have any problems with the diagnosis codes you mentioned.

Lori Jepson: OK, thank you.

Kathleen Kersell: You're welcome.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Anne Herrick.

Anne Herrick: Thank you. I was wondering if there was a true 12-month separation that would need to occur between the initial IPPE and the first annual AWV visit?

Jamie Hermansen: Thanks, that is a great question…within our claims processing instructions to the Medicare contractors in defining that 12-month period, we said that the contractor needs to count 11 full months from that date.

Anne Herrick: OK. Thank you.

Jamie Hermansen: You're welcome.

Operator: Your next question comes from the line of Patina Johnson.

Patina Johnson: Hi, I'm kind of confused on the EKG part. I know that you stated that if you had any EKGs denied for diagnostics, you can re-file or appeal after April 1.

My question is does the screening EKG, what code would you use for that if you are not using a diagnostic, would it be the V70.0?

Kathleen Kersell: Hi, this is Kathy Kersell. The screening EKG codes that are optional that are done and as a referral of an IPPE, any diagnosis code would be appropriate for them as well because they are screening diagnosis codes.

Of course, the diagnostic EKG needs a valid diagnosis but again, for the IPPE screening EKG codes that are done as a referral from the IPPE, you should be OK with any diagnosis code as long as it's a valid code.

Patina Johnson: Are we able to do the screening EKGs through the AWV?

Kathleen Kersell: No, you are not.

Patina Johnson: OK.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Linda Oliver.

Linda Oliver: Thank you, Linda Oliver from Atrius Health, my question has to do with the HRA. Is that a required component of the Annual Wellness Visit and if so, is that incorporated or included in the coding? I believe you said it was if the provider or the provider needs to help the beneficiary. And the last question about the HRA, does that need to be done annually as well?

Jamie Hermansen: Hi, this is Jamie again, the – the statute requires that the HRA be included and taken into account in the provision of personalized prevention plan services, which are part of the Annual Wellness Visit.

However, and so that is the first question. Can you repeat the second half of your question, please?

Linda Oliver: Is the HRA required each year? And then the last question is, I believe you said that the time that the provider spends with the beneficiary if they don't complete it is also included in the G0438 or G0439 coding.

Jamie Hermansen: Regarding your second question about the subsequent visits, we have – within the subsequent visits, we have – it states that the HRA would need to be updated.

Stephanie Frilling: Yes, this is Stephanie Frilling. And yes, during our 2012 rulemaking, we did increase the minutes for the IPPE, the first and the subsequent to include additional time for completing the HRA in the office during the visit.

Linda Oliver: Thank you.

Operator: Your next question comes from the line of Carol Aiken.
And that question has been withdrawn. Your next question comes from the line of Denise Blackiston.

Denise Blackiston: Yes, hello. I would just like to confirm on page seven, who can furnish the IPPE welcome to Medicare visit, you do have physician, you do have your qualified non-physician practitioners, your PAs, nurse practitioners, and CNS. Is it true that this cannot be incident to, so the nurse practitioner saw the patient, it would not bill under the MDs number?

Stephanie Frilling: Yes, that is right. For the non-physician practitioners that are allowed to furnish the service, they would bill under their own Medicare number.

Denise Blackiston: OK, and then on page 29 to confirm who can furnish the Annual Wellness Visit? You do have medical professionals including health educators, registered dieticians, and so forth to other licensed practitioners or a team of such medical professionals and it's my understanding that this would consist of the LR – the licensed registered – the registered nurse, the RN.

Jamie Hermansen: As we discussed in the preamble during the calendar year 2011 physician fee schedule rule, we are not assigning particular tasks or restrictions to specific members of the team. And we believe that it's better for the supervising physician to assign specific tasks to qualified team members as long as they are licensed in the state and working within their state's scope of practice.

This approach would give the physicians and the team the flexibility needed to address a beneficiary's particular need on a particular day and it also

empowers the physician to determine whether a specific medical professional would be – who will be working on his or her wellness team are needed or needed on a particular day.

And the physician would be able to determine the appropriate – the coordination of various team members during the Annual Wellness Visit.

Denise Blackiston: And this would be billed, the annual wellness or the subsequent – would be billed under the physician – the MD? And if it were – the nurse practitioner seeing the patient, it could still be billed – I mean it would be billed under the MDs, is what I thought you had said.

Stephanie Frilling: That is correct, that is right. Yes, the AWV is not sub-incident to, so they can only be billed under the physician.

Denise Blackiston: And that would be…

Stephanie Frilling: Or they should bill it…Or an MD could bill it under his/her own Medicare number.

Denise Blackiston: The direct supervision of a physician who is in the office that day…

Stephanie Frilling: Right, and we are using the direct supervision in the office setting which means that the physician has to be present in the office suite and immediately available.

Denise Blackiston: OK, yes, ma'am. Thank you so much for your time.

Female: Sure.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Donna Morrissey.

Donna Morrissey: Hi, my question is regarding the codes for the IPPE and the AWV. Are they the same if it is a new patient or an established patient?

Stephanie Frilling: Hi, this is Stephanie Frilling. And yes, you would bill the same code.

Donna Morrissey: OK. Thank you very much.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Dean Ruth.

Anne Ford: Hi, this is actually (Anne Ford) and I'm from North Carolina. I have a question on the clarification for rural health clinics, if we bill for the AWV, can we also bill for another E and M service that same day?

We are billing on a type of bill 77X.

Bill Ruiz: This is Bill Ruiz and yes, you can.

And again, you report on both lines of 52 modifier…

Anne Ford: OK. I guess I'm not familiar with the 52. So you put a 52 on your – on the Annual Wellness Visit and on the other E and M codes.

Bill Ruiz: That is correct.

With your charges, you are still getting one flat rate for being counted.

Anne Ford: So there is no additional reimbursement for the…

Bill Ruiz: For AWV, no.

Only for IPPE because two payments, when you bill IPPE and a lot of service on the same day.

Anne Ford: So you get two payments if you are just splitting the allowance between the two codes?

Bill Ruiz: With the IPPE?

Anne Ford: Yes, and the E and M.

Bill Ruiz: No, with the IPPE, you get two payments at the all inclusive rate, two separate payments, that applies only to IPPE and any of the E and M or any other service.

Not AWV, you still get one flat rate payment.

Anne Ford: OK, I get you. OK thank you.

Operator: Your next question comes from the line of Jay Rodriguez.

And that question has been withdrawn. Your next question comes from the line of Anita Robinson.

Anita Robinson: Hi, I wanted to know that if you have established patients already being treated annually for preventive services, which I think you have identified as a non-covered routine, can the IPPE be initiated by the Medicare beneficiary?

Leah Nguyen: Can you hold on for one moment?

Anita Robinson: Sure.

Stephanie Frilling: Hello, this is Stephanie Frilling. So are you saying an existing patient that you furnished routine physicals for and they become Medicare eligible? Or are you saying that – a patient that you have been furnishing non-preventive physicals for, or – excuse me – preventive physicals or routine physicals and now they are requesting an IPPE?

Anita Robinson: Yes, the latter.

Stephanie Frilling: The latter.

Anita Robinson: Yes.

Jamie Hermansen: I mean, if they are requesting that, you have not – you know, if they – if you have not submitted, you know…

Stephanie Frilling: They have to be within the first 12 months of the Part B coverage but if they haven't been furnished, an IPPE report, it wouldn't go against the frequency edit.

Thomas Dorsey: Right, within the first 11 months.

Female: And we would suggest that…

Thomas Dorsey: 11 full months.

Jamie Hermansen: We suggest that you take a look at the, you know, the list of elements that are included in the IPPE as well as the Annual Wellness Visit when you are preparing to provide those services.

Anita Robinson: OK. Thank you.

Leah Nguyen: Thank you.

Operator: And your next question comes from the line of Frances Powers.

Frances Powers: If a patient misses the IPPE, can they have an AWV, and if so, how is this – does it take much – the same format, then, as the IPPE? And in terms of the every 12 months, could it actually then be every 11 months apparently from what you have been saying?

Jamie Hermansen: Hi, this is Jamie Hermansen again. A patient does not need to receive an IPPE in order to be eligible for the Annual Wellness Visit. To be eligible for the Annual Wellness Visit, they just need to have Medicare Part B for longer than 12 months and then they are eligible for the Annual Wellness Visit every 12 months.

And in defining the – defining that 12-month parameter, we have instructed our contractors to count 11 full months from either the time that they received their IPPE if they did receive one or since their last Annual Wellness Visit.

Frances Powers: Thank you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Stephen Swetech.

Female: Come on now, ask your question.

Male: Pick it up, pick it up, pick it up.

Stephen Swetech: Hey, this is Dr. Swetech, how are you? Thanks for your venue.

I got a question, I heard that you guys had – we were doing that digital rectal exam and I use a, probably, a Medicare number 0107G but I heard you guys had given another number. The other thing is that it rejected a bunch of those and I had trouble finding the female digital rectal code.

Do you have that?

Leah Nguyen: Hold on for one moment.

Stephen Swetech: Bring me the – are you there?

Bring me the – IQ. What was the other choice?

Leah Nguyen: Hello, if you wouldn't mind, could you e-mail that question to us to the e-mail address listed on slide 53 and we will look into it for you.

Stephen Swetech: I don't have the slide 53 under me, do you have that available or…

Leah Nguyen: That e-mail address is prevenetionnpc@cms….

Stephen Swetech: CMS – dot org or what?

Leah Nguyen: It's preventionNPC@cms.hhs.gov.

Stephen Swetech: The other thing that I – if I could – if you wouldn't trouble – what happened is, now with these additional requirements on the health referral and things, I'm going to send these patients to a GI guy and I'm going to have the colonoscopy if they have any neurological problems, I refer them out if they are depressed.

Is that good enough to write it or do we have to have a special form for that?

Leah Nguyen: Hold on for one moment.

OK, so we will look into that as well. If you could just e-mail all of your questions to the e-mail address that we provided, and we will get back to you as soon as possible.

Stephen Swetech: That kind of throws us at a disadvantage because we are very – I'm a very busy doc so when you tell us to e-mail on it, I probably – I don't know if I'm going to be able to – I'll try…

Leah Nguyen: OK.

Stephen Swetech: The fact is we probably aren't going to get the answers to the question. Thank you.

Leah Nguyen: You're welcome.

Operator: Thank you. Your next question comes from the line of Barb Oliver.

Barb Oliver: When a patient is ordered an abdominal aortic aneurism screening with the IPPE, can you go ahead and use any diagnostic code on that?

Kathleen Kersell: This is Kathy Kersell, the AAA screening does have specific coverage criteria required so you would want to code the diagnosis appropriate to that coverage criteria. If you want to have – find more information about the ultrasound screening for the abdominal aortic aneurism, the AAA screening, you can go to the CMS Web site and look in the internet-only manual, publication 100-4, chapter 18, section 110.

And in that section, you will find all the coverage requirements.

Barb Oliver: For the diagnostic screening codes.

Kathleen Kersell: This would be the ultrasound AAA screening as a referral for an IPPE. You know, that is not the same thing as a diagnostic AAA screening code…

Barb Oliver: Well, I meant that the – the code that we just use a V81.2 which is a cardiovascular screen.

Barb Oliver: So that the ultrasound can be paid for.

Kathleen Kersell: You are talking about a specific diagnosis code?

Barb Oliver: Correct.

Kathleen Kersell: Well, again, I'm going to have to refer you to the coverage requirement for the AAA screening and you would have to look at those and then determine if that beneficiary is eligible for the AAA screening, you would have to use a diagnosis that would fit the criteria listed in the IOM.

Barb Oliver: So in reading that, the only requirement I have seen is that they have to have a history of smoking.

Kathleen Kersell: For an AAA screening, there is more than just a history of smoking. And – you know, I mean if you want to have us – respond through e-mail, we could ask that you put your question to us and send it to the e-mail address, but the AAA screening, again, can only be done as a referral from an IPPE and that is G0389, and it does have limited coverage.

Barb Oliver: OK, thank you.

Leah Nguyen: Thank you.

Operator: You're next question comes from the line of John Florence.

John Florence: Hey. How are you doing? Hello?

Leah Nguyen: Yes, we are here.

John Florence: Hey, how are you doing? I have a quick question. Is there a specific form for the health risk assessment that I can – that is accessible?

Jamie Hermansen: Hi, this is Jamie Hermansen. My suggestion would be to take a look at these CDC – the Centers for Disease Control framework and that particular publication provides information about the health risks assessment and also you may want to take a look at appendix A of that document because it provides some examples of questions.

So that would be my suggestion. Slide 50 of your presentation slide deck has a link to that document.

John Florence: OK. A second part of that question now, also, once that – once it is completed, as a physician, do you scan that into the charts? How do we capture all of that information during that particular visit for electronic health records purposes?

Jamie Hermansen: Again, my suggestion would be to go to the CDC framework document, and it will give you some additional information about the health risks assessment, that would be your best bet.

But as well as, if you would like to e-mail your question and we could provide additional feedback after the call.

John Florence: OK, and so – pertaining to other questions, is there a particular timeframe that I could go out and access the transcript in the other questions that has been addressed by other peers?

Leah Nguyen: Yes, we will be posting a transcript and audio file shortly, and we will send out an announcement when it is available.

John Florence: OK. Thank you very much.

Operator: Your next question comes from the line of Ashley Perry.

Operator: That question has been withdrawn. Your next question comes from the line of Leslie Ash.

Leslie Ash: Hi, I was wondering, when we do a non-covered physical on a Medicare patient, so that would be an E and M code, and in the same year, they go on

Medicare and we are doing this, we get an ABN or whatever, and then they have their IPPE, the fact that we have billed out preventive care physical will not make the IPPE deny, correct?

Stephanie Frilling: Yes, I'm sorry, this is Stephanie Frilling from CMS. Yes, that is correct.

Leslie Ash: OK, good.

And then also we have had several instances of our IPPEs being denied as already having been performed because another specialist apparently has done them. Will there be on the Medicare Web site, at some point in time, where we can check benefits to make sure that a patient hasn't already had that done?

Stephanie Frilling: Hold on for one moment.

We believe that you can always call your Medicare claims processing contractor to check that eligibility but what we are not sure on here is if that would go across – because there are many contractors so if it was in a different state or something like that, maybe it wouldn't show up for you.

So if you could please e-mail it to my attention and we will get an answer for you on that.

Leslie Ash: And I guess the other thing that we ran into here, which maybe is a little odd. We have had a patient who was previously on Medicare, say, ten years prior, gone off Medicare, and been reestablished with Medicare with a new Medicare card showing an effective date, and then when we billed an IPPE for her, it was denied because she really was not a new Medicare patient but that was – I mean we have no way of knowing that.

Again, I guess, Medicare eligibility hopefully would – if you go online with that, would be a help to us?

Jamie Hermansen: Thank you, it's a great question. And within the regulations for the IPPE as well as the Annual Wellness Visit, we talk about as far as the IPPE is their first – within 12 months of their first Part B enrollment period, so…

Leslie Ash: Right, which says that they can go off part B. And then they can go back on it which on the card, it doesn't say that they were part B you know, ten years ago so I guess for people maybe I don't know if there is somewhere that you can make people aware of that, that that can be an issue and we run into it.

Jamie Hermansen: Yes, we understand and we will look into that.

Leslie Ash: OK, thank you.

Additional Information

Leah Nguyen: Thank you. Unfortunately, that is all the time we have for questions. If we did not get to your question today, you can e-mail it to us at PreventionNPC@cms.hhs.gov.

That e-mail address is also listed on slide 53. If you have a question for a particular speaker, please reference their name in the subject line. We will also be researching all questions and we will post responses as appropriate to the CMS website and an announcement will go out when these are posted.

Before we end the call, for the benefit of those who may joined the call late, please note that Continuing Education credits may be awarded by the American Academy of Professional Coders, the American Health Information Management Association, or the American Medical Billing Association for participation in CMS National Provider Calls.

Please see slide 52 of the presentation for more detail.

On slide 54, you will find information and a URL to evaluate your experience with today's National Provider Call. Evaluations are anonymous and strictly confidential. All registrants of today's call will also receive an e-mail from the CMS National Provider Call resource box within two business days regarding the opportunity to evaluate this call.

You may disregard this e-mail if you have already completed the evaluation.

We appreciate your feedback.

I would like to thank everyone for participating in today's call. An audio recording and a written transcript will be posted soon to the National Provider Calls and Events section of the Fee-For-Service National Provider Calls webpage at www.cms.gov/npc.

Again, my name is Leah Nguyen and it has been a pleasure serving as your moderator today. I would like to thank our presenters, Jamie Hermansen, Kathleen Kersell, Stephanie Frilling, Thomas Dorsey, and Bill Ruiz for their participation.

Have a great day, everyone.

Operator: Thank you for participating in today's call, you may now disconnect.

END