CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2575	**Date: October 26, 2012**
	Change Request 8107

SUBJECT: Editing Update for Annual Wellness Visit (AWV)

I. SUMMARY OF CHANGES: Currently, for claims with dates of service on and after January 1, 2011, processed on and after April 4, 2011, the business requirements in CR 7079 allowed for an AWV visit (HCPCS G0438 or G0439) on an institutional claim and a professional claim for the same patient on the same day. In some cases this has resulted in overpayments. This CR provides instructions for edits to be modified to only allow payment for either the practitioner or the facility for furnishing the AWV.

EFFECTIVE DATE: April 1, 2013
IMPLEMENTATION DATE: April 1, 2013

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	18/140.6/Common Working File (CWF) Edits

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

For Medicare Administrative Contractors (MACs):
The Medicare Administrative contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2575	Date: October 26, 2012	Change Request: 8107

SUBJECT: Editing Update for Annual Wellness Visit (AWV)

EFFECTIVE DATE: April 1, 2013
IMPLEMENTATION DATE: April 1, 2013

I. GENERAL INFORMATION

A. Background: Change Request (CR) 7079, Transmittal 2159, provided billing instructions for Annual Wellness Visit (AWV) services. Per CR 7079, providers may provide an initial AWV visit (HCPCS code G0438) to a beneficiary once in a lifetime. In addition, providers may provide a subsequent AWV (HCPCS code G0439) if the beneficiary has not received an Initial Preventive Physical Examination (IPPE) or an AWV within the past 12 months.

Currently, for claims with dates of service on and after January 1, 2011, processed on and after April 4, 2011, the business requirements in CR 7079 allowed for an AWV visit (HCPCS G0438 or G0439) on an institutional claim and a professional claim for the same patient on the same day. In some cases, this has resulted in overpayments. A separate instruction regarding the collection of overpayments will be forthcoming.

This CR provides instructions for edits to be modified to only allow payment for either the practitioner or the facility for furnishing the AWV. Typically when a preventive service is posted to a beneficiary's utilization history in the Common Working File, separate entities are posted for a 'professional' service (the professional claim for the delivery of the service itself) and a "technical" service (the institutional claims for a facility fee). In the case of AWV, since there is not a separate payment for a facility fee, the AWV claim will be counted as the 'professional' service by Medicare regardless of whether it is paid on a professional claim or an institutional claim.

B. Policy: As stated in the CY 2011 Outpatient Prospective Payment System (OPPS)/Ambulatory Surgical Center final rule (75 FR 72016), hospital outpatient facilities may bill for the first and subsequent AWVs providing Personalized Prevention Plan Services (PPPS), furnished to an eligible beneficiary and in a hospital outpatient facility. Section 4103(c)(3)(A) of the Affordable Care Act specifically excludes the AWV providing PPPS from payment under the OPPS and establishes payment for the AWV providing PPPS when performed in a hospital outpatient department under the Medicare Physician Fee Schedule (MPFS). CMS will accept claims for payment from facilities furnishing the AWV providing PPPS in a facility setting if no physician claim for professional services has been submitted to CMS for payment. That is, Medicare will pay either the practitioner or the facility for furnishing the AWV providing PPPS in a facility setting, and only a single payment under the MPFS will be allowed.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement.

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8107.1	Effective for claims processed on or after April 1, 2013, CWF shall post institutional (TOBs 12X, 13X, 22X, 23X, 71X, 77X, or 85X) and professional claims containing HCPCS code G0438 or G0439 as professional.										X	
8107.2	Effective for claims processed on or after April 1, 2013, CWF shall modify its existing AWV editing to allow payment for only one institutional (TOBs 12X, 13X, 22X, 23X. 71X, 77X, or 85X) or professional AWV claim, HCPCS code G0438, in a lifetime. Note: CWF shall edit against the first AWV date of service as follows: 1. When both institutional and professional services are paid and posted in history, edit against the professional service. 2. When only a professional service is paid and posted in history, edit against the professional service. 3. When only an institutional service is paid and posted in history, edit against the institutional service.										X	
8107.2.1	Contractors shall line-item deny claims for a first institutional or professional AWV claim, HCPCS G0438, where a previous first professional or institutional AWV claim, HCPCS G0438, is paid in history using the following messages: MSN 20.12: “This service was denied because Medicare only covers this service once a lifetime.” Spanish Version: "Este servicio fue negado porque Medicare sólo cubre este servicio una vez en la vida.”	X	X		X	X		X				

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	CARC 149: "Lifetime benefit maximum has been reached for this service/benefit category." RARC N117: "This service is paid only once in a patient's lifetime**.** Spanish Version: "Este servicio fue negado porque Medicare sólo cubre este servicio una vez en la vida." Group Code - PR											
8107.3	Effective for claims processed on or after April 1, 2013, for AWV HCPCS G0438 claims with both an institutional (TOBs 12X, 13X, 22X, 23X. 71X, 77X, or 85X) and professional posting for the same date of service, CWF shall create an edit and a trailer to reject the second claim.										X	
8107.3.1	When denying a second institutional or professional AWV claim, HCPCS code G0438, posting for the same date of service and processed on or after April 1, 2013, contractors shall use the following messages: MSN 20.12: "This service was denied because Medicare only covers this service once a lifetime." Spanish Version: "Este servicio fue negado porque Medicare sólo cubre este servicio una vez en la vida CARC 149: "Lifetime benefit maximum has been reached for this service/benefit category." RARC N117: "This service is paid only once in a patient's lifetime**.** Spanish Version: "Este servicio fue negado porque Medicare sólo cubre este servicio una vez en la vida." Group Code: CO	X	X		X	X		X				
8107.4	Effective for claims processed on or after April 1, 2013, CWF shall modify its existing AWV editing to										X	

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	reject to contractors institutional (TOBs 12X, 13X, 22X, 23X. 71X, 77X, or 85X) or professional AWV claims, HCPCS code G0439, if a previous institutional or professional claim AWV, HCPCS code G0438 or G0439, is paid in history within the past 12 months. CWF shall count 11 full months starting with the month after the month of a beneficiary's last AWV, HCPCS G0438 or G0439, is paid in the history file. **NOTE:** CWF shall edit against the first AWV date of service as follows: 1. When both institutional and professional services are paid and posted in history, edit against the professional service. 2. When only a professional service is paid and posted in history, edit against the professional service. 3. When only an institutional service is paid and posted in history, edit against the institutional service.											
8107.4.1	When denying claims for a subsequent institutional or professional AWV claim, HCPCS G0439, because a previous institutional or professional AWV claim, HCPCS G0438 or G0439, is paid in history within the past 12 months, contractors shall use the following messages: MSN 18.26: "This service was denied because it occurred too soon after your last covered Annual Wellness Visit. Medicare only covers one Annual Wellness Visit within a 12-month period." Spanish Version: "Este servicio fue negado porque ocurrió antes del período de 12 meses de su última Visita Anual de Bienestar. Medicare sólo paga por una Visita Anual de Bienestar dentro de un período de 12 meses." CARC 119: "Benefit maximum for this time period or	X	X		X	X		X				

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	occurrence has been reached." RARC N130: "Consult plan benefit documents/ guidelines for information about restrictions for this service." Group Code – PR											
8107.5	Effective for claims processed on or after April 1, 2013, for AWV HCPCS G0439 institutional (TOBs 12X, 13X, 22X, 23X. 71X, 77X, or 85X) claims and professional AWV HCPCS G0439 claims posting for the same date of service, CWF shall create an edit and a trailer to reject the second claim.										X	
8107.5.1	When denying a second institutional or professional AWV claim, HCPCS code G0439, posting for the same date of service and processed on or after April 1, 2013, contractors shall use the following messages: MSN 7.1 - This is a duplicate of a charge already submitted. Spanish Version: "Este es un duplicado de un cargo previamente sometido." CARC B13: "Previously Paid. Payment for this claim/service may have been provided in a previous payment." RARC N130: "Consult plan benefit documents/ guidelines for information about restrictions for this service." Group Code – CO	X	X		X	X		X				
8107.6	Effective for claims processed on and after April 1, 2013, CWF shall apply appropriate updates to the Next Eligible dates for AWV claims, HCPCS G0438 and G0439, based on business requirements 8107.1 through 8107.5.							X			X	MBD NGD

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	NOTE: Appropriate updates include modifications to the HIMR (PRVN), Provider Inquiry, HUQA, and Extract Records on the Next Generation Desktop (NGD) and the Medicare Beneficiary Database (MBD). Previously, the next eligible date was based on CWF editing which allowed one professional and one institutional posting for a given date of service within coverage limits											
8107.6.1	Effective with claims processed on or after April 1, 2013, the next Eligible date will be computed based on the date of the last paid professional posting where both the professional and institutional postings are paid in history for a given date of service or where only a professional service is posted and paid in history. Note: Where only an institutional posting exists for the last paid date of service in history, the next eligible date will be determined based on the date of the posted institutional service.							X			X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
8107.7	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X		X	X		

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): William Ruiz, 410-786-9283 or william.ruiz@cms.hhs.gov (For Part A Claims Processing), Tom Dorsey, 410-786-7434 or Thomas.Dorsey@cms.hhs.gov (For Part B Claims Processing) , Twi Jackson, 410-786-1159 or Twi.Jackson@cms.hhs.gov (Payment Policy)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

Section B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

140.6 – Common Working File (CWF) Edits

(Rev. 2575, Issued: 10-26-12, Effective: 04-01-13, Implementation: 04-01-13)

Effective for claims with dates of service on and after January 1, 2011, CWF shall reject:

- AWV claims for G0438 when a previous (first) AWV, HCPCS code G0438, is paid in history regardless of when it occurred.

- AWV claims when a previous AWV, G0438 or G0439, is paid in history within the previous 12 months.

- *Beginning January 1, 2011*, AWV claims when a previous IPPE, HCPCS code G0402, is paid in history within the previous 12 months.

- AWV claims (G0438 and G0439) billed for a date of service within 12 months after the effective date of a beneficiary's first Medicare Part B coverage period.

The following change shall be effective for claims processed on or after April 1, 2013. Typically, when a preventive service is posted to a beneficiary's utilization history, separate entries are posted for a "professional" service (the professional claim for the delivery of the service itself) and a "technical" service (the institutional claims for a facility fee). However, in the case of AWV services, since there is no separate payment for a facility fee, the AWV claim will be posted as the "professional" service only, regardless of whether it is paid on a professional claim or an institutional claim.