Centers for Medicare & Medicaid Services
ABCs of the Initial Preventive Physical Examination and
Annual Wellness Visit National Provider Conference Call
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Operator: Welcome to the ABCs of the Initial Preventive Physical Examination and Annual Wellness Visit National Provider Conference Call.

All lines will remain in a listen-only mode until the question and answer session. Today's conference call is being recorded and transcribed. If anybody has any objections, you may disconnect at this time. Thank you for your participation in today's call. I will now turn the conference call over to Nicole Cooney. Thank you, Ma'am, you may begin.

Introduction

Nicole Cooney: Thank you, Michelle. Hi, everyone. I'm Nicole Cooney from the Provider Communications Group here at CMS.

I'd like to welcome you to our National Provider Call on the ABCs of the Initial Preventive Physical Exam and the Annual Wellness Visit. Subject matter experts are here today to discuss each of these services, when to conduct these services, who can perform each service, who is eligible, as well as coding and billing. A question and answer session will follow the presentation.

Before we get started, there are a few items that I need to cover. Number one, there is a slide presentation for today's session. If you have not already done so, this may be downloaded now from the CMS prevention page, which is located at www.cms.gov/prevntion and that's p-r-e-v-n-t-i-o-n, gen, g-e-n, info, i-n-f-o, all one word, that's www.cms.gov/prevntiongeninfo. And, again, prevention in that URL is missing an E, so it's p-r-e-v-n-t-i-o-n. Once you're on that site, at the left side of the web page, click on Provider Resources and scroll down to the Downloads section, where you'll find the slide presentation.

Number two, this call is being recorded and transcribed. An audio recording and written transcripts will be posted to the Medicare Learning Network multi-media page located at www.cms.gov/mlnproducts. Select the MLN multi-media tab on the left side of the web page.

And last, please be aware that continuing education credits may be awarded by the American Academy of Professional Coders or the American Health Information Management Association for participation in CMS National Provider calls. Please see slide 34 and 35 from today's presentation for more information.

If you have any questions regarding the awarding of credits for this call, please contact the organization. We encourage you to retain your presentation materials and confirmation e-mails. At this time, I would like to introduce our panel of speakers, or subject matter experts, at first, on today's topics.

We're pleased to have with us today Jamie Hermansen, Health Insurance Specialist in the office of Clinical Standards and Quality, Coverage and Analysis Group; Bridgitte Davis, Health Insurance Specialist in the Center for Medicare, Provider Billing Group; Stephanie Frilling in the Center for Medicare, Hospital and Ambulatory Policy Group; and Thomas Dorsey, Center for Medicare, Provider Billing Group. And now, it is my pleasure to turn the call over to our first speaker, Jamie Hermansen, from the Office of Clinical Standards and Quality here at CMS.

Jamie Hermansen: Thank you Nicole. Good afternoon, my name is Jamie Hermansen. It's my pleasure to speak with you today about Medicare's preventive services, specifically the Initial Preventive Physical Examination, also known as the Welcome to Medicare Visit, and the Annual Wellness Visit.

Starting on slide four, I would like to start by providing a brief overview of Medicare preventive services and then move into the specifics regarding coverage of the Welcome to Medicare Visit.

Health promotion and disease prevention are important to the Medicare program. The Medicare Modernization Act provided for a prevention visit that occurred within the first 12 months of obtaining Part B that we commonly refer to as the IPPE or the Welcome to Medicare Visit.

Section 101 of the Medicare Improvements for Patients and Providers Act of 2008 provided for coverage of additional preventive services that meet certain

criteria including reasonable and necessary – includes being reasonable and necessary for the prevention or early detection of illnesses and disease, recommended with a grade of A or B by the US Preventive Service Task Force, and appropriate for individuals entitled for benefits under Part A or enrolled in Part B.

The process utilized for additional preventive services is the National Coverage Determination process. The Affordable Care Act of 2010 provided several sections related – contains several sections related to preventive services including section 4103 that establishes an Annual Wellness Visit providing (inaudible) prevention services.

Initial Preventive Physical Examination (IPPE)

Now moving to slide six, I'd like to discuss the specifics of the Welcome to Medicare Visit.

The Welcome to Medicare Visit is only offered within the first 12 months of Part B enrollment and, in summary, it includes – the visit includes review of medical and social history; a 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. And upon agreement of the individual, a discussion of end-of-life planning; education, counseling, and referrals based on the results on the results of the services performed during the visit including a brief written plan such as a checklist, if appropriate; and if appropriate, education, counseling, and referral for obtaining an EKG.

For slide seven, the Welcome to Medicare Visit can be provided by a physician or qualified non-physician practitioner, which includes a nurse practitioner, physician assistant, or clinical nurse specialist.

This concludes my overview of coverage of the Welcome to Medicare Visit. I appreciate your attention and would now like to hand the call over to my colleague, Bridgitte Davis.

Bridgitte Davis: Good afternoon, I'm Bridgitte Davis from the Provider Billing Group, Division of Practitioner Claims Processing. The next couple of slides are going to inform you of policy codes for the IPPE. Starting on slide number eight, the code for billing for IPPT, excuse me, the IPPE and the screening EKG are: G0402 for the Initial Preventive Physical Examination, face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment.

And then the three G-codes for the EKG: G403 ***[Post Call Clarification – the correct code for this service is 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; and G0405, electrocardiogram, routine ECG with 12 leads, interpretation and report only, performed as a screening for the Initial Preventive Physical Examination.

Moving on to slide number nine, code G0402 must be used to report the IPPE. The various components of the IPPE previously described on slide six 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; and Critical Access Hospitals TOB 85X.

Slide 10 talks about diagnosis coding. Although a diagnosis code must be reported on the claim, there are no specific ICD-9 diagnosis codes that are required for the IPPE. Therefore, Medicare providers should choose an appropriate ICD-9 diagnosis code.

Slide 11 talks about frequency and how often IPPE and the screening EKG can 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 codes G0403, G0404, G0405, when done as a referral from an IPPE, is only covered once during a beneficiary's lifetime.

And slide 12 talks about coinsurance and deductible. Effective for dates of services on or after January 1, 2011, the coinsurance or copayment and deductible are waived for the IPPE code G0402 only. However, the deductible and coinsurance still applies to the screening EKG.

Slide 13, the IPPE related to screening for the Abdominal Aortic Aneurysm AAA. A one-time-only ultrasound screening for an Abdominal Aortic Aneurysm, AAA, can be done as the result of a referral from an IPPE for Medicare beneficiaries with certain risk factors. The code for billing the AAA ultrasound screening is G0389, the ultrasound, B-scan, and or real time with image documentation.

Slide 14, effective for dates of services on or after January 1, 2011, the coinsurance or copayment and deductible are waived for the AAA ultrasound G0389. For more information on the AAA ultrasound screening done as a result of the referral from an IPPE, please see the CMS Internet-Only Manual Publication 100-4, chapter 18, section 110 on the CMS website at www.cms.gov/manuals m-a-n-u-a-l-s /downloads d-o-w-n-l-o-a-d-s /clm104c18.pdf.

And now I'm going to turn the call over to Stephanie Frilling.

Stephanie Frilling: Thank you, Bridgitte. Again, I'm Stephanie Frilling from the Division of Practitioner Services and the Hospital Ambulatory Policy Group, and I will begin my portion of the presentation on slide number 15, the IPPE is NOT a routine physical exam.

As noted early in the presentation, Section 611 of the Medicare Prescription Drug Improvement Modernization Act 2003 authorized Medicare to furnish an Initial Preventive Physical Examination to beneficiaries and allows for payment of the service under Medicare Part B. The benefit is a once-in-a-

lifetime service and must be furnished within the first 12 months of a beneficiary's Part B coverage.

Medicare will only recognize G0402 for payment of the IPPE. If a screening electrocardiogram is furnished with the IPPE, the EKG will be billed with its own unique HCPCS Code, G0403, G0404, or G0405, as appropriate.

The IPPE's unique focus and promotion of prevention, services, health education, and health counseling services available to Medicare beneficiaries separates this service from a routine physical examination.

Medicare does not provide coverage for routine physical examinations that are typically identified in the E/M Preventive Medicine CPT code range of 99381 through 99397.

We recognize that the IPPE may have substantial overlaps in service elements with the routine physical examinations, such as body measurement, blood pressure, and the identification and review of health status and risk factors.

But the IPPE is a unique Medicare service. The statutory requirements of the IPPE require practitioners to furnish education, counseling, and appropriate health referrals and to furnish a brief written plan to the individual for obtaining the appropriate screening and other preventive services which are separately covered under Medicare Part B.

Slide 16, providing E/M services in addition to an IPPE, to specify use CPT Modifier 25. Medicare allows copayment for payments ***[Post Call Clarification: The speaker intended to start this sentence as "Medicare allows for payment…"]*** of medically necessary evaluation and management services that are furnished during the same visit as the IPPE. When E/M services are clinically appropriate, physicians and non-physician practitioners would bill Medicare with the appropriate E/M CPT code identified in the E/M Service CPT code range of 99201 through 99215, along with Modifier 25, significant separately identifiable evaluation and management service of same physician on the same day of the procedure or other service.

We would hope that a practitioner would inform the beneficiary that additional E/M services are subject to cost sharing, and coinsurance, copayments, and deductible will apply to the additional E/M service as cost sharing waivers are limited to the IPPE service only. The IPPE does not include other preventive services that are currently covered and paid under section 1861 of the Social Security Act.

Medicare allows for payment of preventive services furnished in the same visit as the IPPE as we believe this is both appropriate and convenient for the beneficiary. Like the IPPE, Section 4104 of the Affordable Care Act also waives cost sharing for many preventive services that Medicare covers.

Non-covered preventive services, including E/M services, may also be billed with an IPPE visit. 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 services will fall to the beneficiary.

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

Slide 17, preparing patients for the IPPE. 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 in Medicare. Providers shall encourage the beneficiary to bring a list of all current health providers and discuss treatments, medications, supplements including vitamins, and to review preventive screening services and update their medical history.

I will now turn the presentation back to Nicole.

Nicole Cooney: OK. For more information about the IPPE, slide 18 directs you to additional products that the Medicare Learning Network offers, including a Quick Reference Guide and the larger Guide to Medicare Preventive Services Chapter 1, specifically, the IPPE. And we also notice the manual reference that I believe was cited earlier in the publication.

So, at this point, we're going to switch to our Annual Wellness Visit portion of the call, and we'll go back to Jamie Hermansen.

Annual Wellness Visit (AWV)

Jamie Hermansen: Thank you, Nicole.

To bring your attention to slide 20, first topic would be Medicare Physician Fee Schedule calendar year 2012. First, the proposed rule includes a proposal to incorporate the use and results of a Health Risk Assessment into the provision of personalized prevention plan services during the Annual Wellness Visit. This slide provides the web address where you can find the proposed rule.

While the CMS staff are not able to discuss the proposed rule as part of today's call, we welcome public comments on the proposed rule which are due by 5 p.m. on August 30, 2011. Complete instructions for submitting comments are available in the proposed rule.

Moving on to slide 21. Effective January 1, 2011, Medicare covers an Annual Wellness Visit providing Personalized Prevention Plan Services once every 12 months. Regulations are established at 42 CFR 410.15 for this new benefit.

Regarding Medicare eligibility, beneficiaries are eligible to receive an Annual Wellness Visit if the individual is no longer within 12 months after the effective date of his or her first Part B coverage period.

Please note that beneficiaries did not need to receive the Welcome to Medicare Visit to be eligible to receive an Annual Wellness Visit. However, if the beneficiary received a Welcome to Medicare Visit, the beneficiary will be eligible to receive an annual awareness visit 12 months after they received their Welcome to Medical Visit.

For slide 22, I would like to now discuss what is included in an Annual Wellness Visit. In summary, the first AWV includes the following elements: establishment of an individual's medical and family history and a list of current providers and suppliers that are regularly involved in providing

medical care to the individual; measurement of an individual's height, weight, body mass index or waist circumference; blood pressure and other routine measurements as deemed appropriate based on the beneficiary's medical and family history; detection of any cognitive impairment; review of the individual's potential risk factors for depression or other mood disorders; review of the individual's functional ability and level of safety; establishment of a written screening schedules for the individual such as a checklist for the next five to 10 years; establishment of a list of risk factors and conditions for which interventions are recommended and a list of treatment options and their risks and benefits; and finally, furnishing personalized health advice and referral as appropriate for health education or preventive counseling services or programs.

Moving to slide 23, subsequent AWVs include: update to the individual's medical and family history; updates to the list of current providers or suppliers involved in providing care to the individual; measurement of the individual's weight or waist circumference; blood pressure or other routine measurements as deemed appropriate based on the individual's medical and family history; detection of any cognitive impairment that the individual may have; update to the written screening schedule for the individual that was developed during the first Annual Wellness Visit; an update to the list of risk factors and conditions for which interventions are recommended that was developed at the first Annual Wellness Visit; the furnishing of personalized health advice and referral as appropriate to help educate on preventive counseling services or programs.

On slide 24, the Annual Wellness Visit can be furnished by 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.

I appreciate your attention and I will now hand this call over to my colleague, Thomas Dorsey. Thank you.

Thomas Dorsey: Thank you, Jamie. Good afternoon. I am pleased to speak to you this afternoon.

My first slide, 25, concerns the required billing procedure code and who can bill for each of the service.

Two G-codes are used to identify the Annual Wellness Visit for purposes of Medicare payment. They are 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 Annual Wellness Visit? These services are typically provided in a physician's office. However, the services can also be provided in a facility. When these services are provided in the facility, certain institutions can bill. These are: hospital inpatients and outpatients, Skilled Nursing Facilities inpatients and outpatients, Rural Health Centers, Federally Qualified Health Centers, and Critical Access Hospitals.

Our next slide, slide 26, concerns diagnosis coding. Medicare claims must have a diagnosis on the claims. However, although a diagnosis code must be encoded on the claim, there are no specific ICD-9-CM diagnosis codes that are required to be included on Annual Wellness Visit bill. Therefore, medical providers should chose an ICD-9-CM diagnosis code or contact local Medicare Contractor for appropriate guidance.

Our next slide, slide 27, addresses the frequency of services. The first Annual Wellness Visit can be billed 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.

Going to slide 28. This points out that for the Annual Wellness Visit, the annual Medicare Part B deductible is waived, as is normal copayment or coinsurance. The slide also points out that the Annual Wellness Visit is effective for services provided on or after January 1, 2011.

In slide 29, my last slide, this indicates that the Annual Wellness Visit is a preventive wellness visit, and not a routine physical examination. Medicare does not provide coverage for routine physical exams.

I am now going to turn the presentation over to Stephanie Frilling, who is going to talk about providing Evaluation and Management services in addition to the Annual Wellness Visit.

Stephanie Frilling: Thank you, Tom. We'll begin on slide number 30, providing E/M Services in addition to an AWV.

First and subsequent AWV visits may be billed with any medically necessary Evaluation and Management service. Like the IPPE, when billing additional E/M services furnished in the same visit as the AVW, we would hope the providers would inform their patient of cost sharing requirements for the additional service and append payment Modifier 25 to the E/M claim line submitted for payment. Cost sharing requirements will apply to the additional E/M service, and the beneficiary will be responsible for any deductibles and coinsurance or copayments that may result from additional services.

As with the IPPE, additional preventive services may be furnished in the same visit as the AWV, although we continue to believe that it would be difficult to distinguish an AWV from another preventive medicine E/M service. In particular, the AWV elements have substantial overlaps in the service components of the non-covered preventive medicine E/M CPT codes of 99381 through 99397.

Slide 31, preparing patients for the AWV. 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 a beneficiary's health.

Providers shall encourage the beneficiary to bring a list of current health

Providers, medications, supplements, and vitamins to review and update their medical history for preventive and screening services.

The annual nature of an AWV visit allows for preventive follow up where health risks are continuously monitored and prevention services, screening services, health education, and health counseling services are promoted to foster health awareness and self management.

Thank you for the opportunity to present today. And Nicole?

Resources & Continuing Education Information

Nicole Cooney: Thanks, Stephanie.

On slide 32, there are some references there for more information regarding MLN products for the Annual Wellness Visit that we currently have available. There's a "Quick Reference Guide," an MLN Matters articles, as well as Chapter 4 in the "Guide Medicare Preventive Services." And we've also included manual references for your convenience.

And slide 33 covers Medicare's more resources to learn more about Medicare's preventive services, including general resources from the Medicare Learning Network, as well as CMS' prevention website. I did reference that earlier in the call.

And slide 34 and 35 just go over more information on obtaining continuing education credits from the associations that I referenced at the beginning.

So, with that, we've now completed the presentation portion of this call and will move on to the Q&A 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 and in an effort to get to with many of your questions as possible, we ask that you limit your questions to just one.

OK and Michelle, you may open the line for questions.

Question and Answer Session

(NOTE: Responses to outstanding questions are available at http://www.cms.gov/MLNProducts/Downloads/IPPE_AWVQuestions.pdf)

Operator: Thank you. We will now open the lines for question and answer session. To ask a question, press star followed by the number 1 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 lines will remain open during the time that you're asking your question, so anything you say or any background noise will be heard into the conference.

And your first question comes from the line of Ann Carl. Your line is open.

Ann Carl: Hi, we're a rural health facility and we're wondering in breaking this out, normally we submit a one-line item for payment and now, how's that affected with submitting these G-codes?

Nicole Cooney: Hold on, we're getting the right person to the mic.

Ann Carl: OK.

Bill Ruiz: Hi, this is Bill Ruiz. Can you repeat that question again?

Ann Carl: How do you do?

Nicole Cooney: Are you still there?

Ann Carl: I'm still here.

Nicole Cooney: Can you repeat your question for us, please?

Ann Carl: OK. So, we're a rural health care facility, and typically, on the UB-92 we submit one charge for all services provided that day.

How, in billing the G-codes for either- any of these preventive services that beneficiaries are eligible for, how is that affected? Do we need to put another line item with these G-codes on there? Or how is that going to work? And how does the overall total payment should we expect? Should we expect that

it's still the one flat fee for the rural health care payment and you were just going to break it out differently for the patient and, in fact, the patient has less of a coinsurance responsible for that entire visit? Or what should our expectations be?

Bill Ruiz: You bill for one line item with the code.

Ann Carl: But how will you know that the part of that is the preventive service so that the Fiscal Intermediary applies the payment appropriately for the patient? Because as I understand it, the patient is not going to have a coinsurance for that piece of it. So, if we're providing a standard E/M service that same day and also components of these preventive services, how is the beneficiary benefiting from this?

Bill Ruiz: Right now I don't have an answer for you. I'm going to have to take this question back to my division.

Ann Carl: Well, I'm a bit concerned because this has been going on since January, and I…

Bill Ruiz: This is so specific to RHCs, so I need to take this back.

Ann Carl: All right.

Nicole Cooney: Thank you. Next question, Michelle.

Operator: Yes. Your next question comes from the line of Nancy Sanchez Cotto. Your line is open.

Nancy Sanchez Cotto: Hi. Nancy Sanchez Cotto, Montefeur. We're an article 28 institution, so if I understand this correctly, we can bill the G-code for the wellness as well as the evaluation and management on the APC. Is that correct? For the institutional claim?

Nicole Cooney: What is an article 28 institution?

Nancy Sanchez Cotto: It's an institution, a place of service 22.

Chris Smith Ritter: A hospital?

Nancy Sanchez Cotto: Yes. We can bill the G-codes for the physician and the APC, basically. In other words, there'd be two claims as we do with every other visit. I'm just confirming that.

Chris Smith Ritter: This is for the Annual Wellness Visit?

Nancy Sanchez Cotto: We'll bill – the physician will bill the Annual Wellness Visit and there will be a 9921 something for the APC and any other service that might be billed with it.

Chris Smith Ritter: I'm not sure we're understanding. Are you billing – is the physician performing two separate…

Nancy Sanchez Cotto: The physician is performing the provider service, the G-code, in outpatient hospital setting. So, we can bill for the outpatient hospital as well, is the question.

Chris Smith Ritter: No. The Annual Wellness Visit is authorized for a single payment from the physician fee schedule, and so one single payment is made for the service.

Nancy Sanchez Cotto: I'm not sure you under – it's the outpatient claim for – are you familiar with hospital services, APC billing or should I take this elsewhere?

Chris Smith Ritter: There's a single – the authorization for the – this is Chris Smith Ritter with the Division of Practitioner Services, formerly with the Division of Outpatient Care. There is a single payment that's made for the Annual Wellness Visit.

There's no separate facility payment identified for the outpatient hospital. So, whichever claim's – a single payment made either to the physician or to the hospital.

Nancy Sanchez Cotto: OK.

Operator: And your next question comes from the line of Christy Knutzen. Your line is open.

Christy Knutzen: Yes this is Christy Knutzen from Olivance County Memorial Hospital. We are a Critical Access Hospital and I'm wondering when we perform a component of the IPPE such as the EKG or the AAA, on the order that we received from the physician, is it sufficient that they just say – you know, they order the EKG and they just say, IPPE? Or on the – for the AAA, for the aortic aneurism, do they need to also list the risk factor?

Jyme Schafer: It's a how do you bill question. How do you bill for this?

Christy Knutzen: It's a question on what we require on our order before we even perform the service.

Nicole Cooney: Give us just one second?

Christy Knutzen: OK.

Jyme Schafer: So, was the question for medical review purposes or billing question?

Christy Knutzen: Well, I don't want to perform an EKG or an aortic aneurism and then have the claim be reviewed and be told that my order isn't sufficient because I didn't receive an appropriate diagnosis from the doctor at the time that they ordered the test.

Jyme Schafer: You want the diagnosis code then…

Christy Knutzen: The diagnosis code is whatever the doctor's going to tell me is the diagnosis for the test. So, if they just tell me that it's a screening, if that's the only thing they tell me is screening, I need to support, in order to pay for that AAA, do I need to have on record that I know what that risk factor is that qualifies that patient to have the aortic aneurism test? Such as smoking- I believe a history of smoking is one of the risk factors that will allow a patient have it covered AAA, and do I need to have that in my record somewhere that that patient had a history of smoking? Or is it just adequate that I have an order from the physician that says, screening?

Stephanie Frilling: Hello, this is Stephanie Frilling from the Division of Practitioner Services. It just has to be referred to as a screening EKG and be resulting from the IPPE.

[Post Call Clarification: CMS notes that the appropriate diagnosis code, XXXX, must also be used.]

Christy Knutzen: And the same with the aortic aneurism? AAA?

Stephanie Frilling: That's correct.

Jamie Hermansen: Hi, this is Jamie Hermansen and I'm – we would just also – regarding the AAA, we would also like to note that there are specific coverage requirements for that particular benefit. So, we just want you to note to draw your attention to that as well.

Christy Knutzen: Do I need to screen for that at the time that I get the order to make sure that, that – that they have met those requirements? I'm going to be held accountable for knowing that that risk factor exists.

Bridgitte Davis: If you could send your question in, we could do more research on your issue and get back to you, and please reference IPPE/AWV call in the subject matter line.

Christy Knutzen: OK, thank you very much.

Nicole Cooney: Thank you.

Operator: And your next question comes from Lucia Set. Your line is open.

Lucia Set: Yes. Hi. This is Dr. Set, and I just want to know in that preventive visit, the first initial one, if we do a physical exam over there like we do our examination when the patient come for the initial visit, is that to be included in the protocol? Or it is just those few four or five, the first slide which showed six points, that's what you'll really need for the payment.

Nicole Cooney: Give us just one second.

Jamie Hermansen: For the Welcome to Medicare, it is the components that were listed on the slides.

Lucia Set: OK. And also I have another question. Like if you do like a rectal screening on this patient because we are doing an examination? So, we have to code this as separate like hemoccult or something, we have to do it as or bill later as separate testing, right?

Stephanie Frilling: I apologize. Could you say what kind of screen again?

Lucia Set: Like rectal exam. If I do a prostate exam, like patients when they come for initial visit, they want you to examine the patient, so we are examining the patient from head to toe. And we do a prostate exam, we do a rectal exam like for hemoccult slide to see the – well, this is like a screening test. My question is whether this is paid?

This has to be paid billed separately? Like we did a hemoccult and what code we have to put for that? Well, like a patient on (inaudible) the update of family history, the update of provider. Are they – take blood pressure and do the depression screening and cognitive impairment, that's it? That's what is included in the initial or/and the subsequent visit? That's it? They don't require to examine the patient? I mean I'm just curious about that.

Stephanie Frilling: Yes that's correct. But you may provide additional preventive services that are appropriate during the visit and you may bill for those separately. So, we laid out on the slides exactly what is – the Welcome to Medicare Visit and the Annual Wellness Visit. Those are the required elements.

Lucia Set: Right, like when I did the initial- like this exam for a patient, initial visit. I did a rectal exam and then saw- then I did a hemoccult testing from the patient, which is like testing for any blood in the stool. And I billed it and Medicare denied it. So, they said the proper billing is – I don't know what is the code for that and…

Joe Chin: This is Joe Chin, Medical Officer in Coverage and Analysis. Just to point out one point to that you mentioned, with the office-based hemoccult screening. If that's for colorectal cancer screening, the recommendation is that, that is not an office-based test, and it really encompasses three samples that's taken out home.

Lucia Set: Oh, I understand. So, what I'm doing in the office is not paid, but if I gave him, give the patient slides, three slides to bring back, that's paid, right? Is that what you're saying?

Joe Chin: When they return your samples, that can be considered a colorectal cancer screening.

Lucia Set: OK. I got it. All right thank you so much.

Nicole Cooney: Thank you. Next question, Michelle.

Operator: Yes. Your next question comes from the line of Judy Sandredo. Your line is open.

Colleen Falstead: Yes. This is Colleen Falstead with Southwest Medical Center. On Annual Wellness Visit, previously we were told there were certain depression screening forms that needed to be done by the doctor. Has this changed? And can they assess this on their own? Or any of this changed or is it still the same? We were to go by certain guideline.

Jamie Hermansen: This is Jamie Hermansen with CMS again. And you were asking about depression screening, is that correct?

Colleen Falstead: Right. Because we've been to these seminars before and I mean there were certain, I guess forms or something the doctor had to use that were nationally based, I'm assuming, like a lot of other doctors used.

Like the cognitive skill and the depression, right? They have certain criteria that they have to follow to show proof of these findings.

Jamie Hermansen: Thank you for clarifying it. I think this is a great question. What I can tell you is based on the – in the regulation, in the final rule, we indicated "Review of the individual potential risk factors for depression including current or past experiences with depression or other mood disorders based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the health professional may select from various available

standardized screening tests designed for this purpose and recognized by national medical professional organizations."

So, we are providing the physicians the flexibility to choose their particular, you know, the particular screening instruments.

Colleen Falstead: We still have to do that, right?

Jamie Hermansen: Yes. Sounds like it. Yes.

Colleen Falstead: OK I have que – are you there?

Jamie Hermansen: Yes, I am. How can I help you?

Colleen Falstead: I want to go back to that stool hemoccult test. That code reads one to three slides. If the doctor is doing a physical exam or whatever, the patient's having rectal bleeding or anything – maybe- I'm not going to rectal bleeding, forget that. If the patient's having – you know, the doctors checking on him, he's age 50 and he does hemoccult stool slide, why would that not get paid if the doctor does it in the office? Because the code does read one to three slides.

Joe Chin: I think that question really is along the lines of appropriate colorectal screening, and studies have shown that if you have an appropriate screening for colorectal cancer, the one-time office-based type of hemoccult test is, is not as sensitive or specific for colorectal cancer. So, the recommendation to use when you're using the fecal occult blood test as colorectal cancer screening is to have the patient provide the samples- three samples at most- really outside the office setting. And there are, depending on which type of hemoccult blood test you take or use, there are potentially some criteria for when to take the samples and some dietary restrictions that may influence the test.

So, it really depends on which specific fecal occult blood test that you're using, and if there are any other constraints about how to take that test.

Colleen Falstead: Well, can we charge for them when we give them the slides? Because if they don't return them, then we're losing the money on the slides.

Joe Chin: Yes, we certainly understand that, and that's been raised. The service is really for colorectal cancer screening then – from a patient's standpoint, you would want to have the results and certainly the samples to send in for testing.

Colleen Falstead: OK.

Nicole Cooney: Thank you for your question. I'm sorry we're going to have to move on.

Michelle, next question, please?

Operator: Yes. Your next question comes from the line of Tracy Jones. Your line is open.

Tracy Jones: Yes. I think I'm going to defer my question.

Nicole Cooney: OK. Next question, Michelle?

Operator: And your next question comes from the line of Sarah Newport. Your line is open.

Sarah Newport: Hi, my name is Sarah Newport and I am calling from the Goodall Hospital. And my question is in regards to the separating of the Annual Wellness Visit and the routine physical exam because patients, when looking at your Medicare.gov website, are under the impression they are the same thing.

They're being told that they're getting a comprehensive physical and evaluation, and a wellness visit and a physical exam, when it's a routine physical exam, are very different. Is there going to be more education for patients as far as what the differences are?

Nicole Cooney: One moment, please.

Operator: And your next question comes from the line of Ann Rankin. Your line is open.

Nicole Cooney: Michelle, can we go back to the last call there? We were conferencing.

Operator: I apologize. If the last caller could please queue up her question again? Press star 1 please. And Ms. Newport, your line is open.

Sarah Newport: Thank you.

Jyme Schafer: Thanks very much for that comment and we'll have to review our materials. Thank you very much.

Sarah Newport: OK.

Nicole Cooney: OK. Next question please, Michelle?

Operator: Yes and we do have the line of Ann Rankin again. Your line is open, Ma'am.

Ann Rankin: Hi, this is Ann Rankin and I'm with Sanford Health. My question is regarding billing, provider-based billing, PBB billing that we currently do. It's kind of the same question that was asked previously by another attendee, but in our system, when you bill like a G-code or an E&M code, it automatically splits between professional and facility side. And so what you're saying is we cannot bill a facility fee even though there's nurse's time involved, there could be supplies involved that would be a facility cost?

Chris Smith Ritter: That's right. The statute specifically required that OPPS not cover the Annual Wellness and that it be paid through the physician fee schedule, and in the implementation of that, that means that a single payment is made for the provision of that service.

Ann Rankin: So, would that be the same for the prevent med codes then? We should not be billing a facility fee on the prevent med codes- like 99397 either?

Chris Smith Ritter: I believe, those are the non-covered codes, but other preventive services that are provided certainly would be paid for to the Hospital Outpatient Prospective Payment System.

Ann Rankin: OK, well that's what I needed to know. Thank you.

Nicole Cooney: Next question, Michelle?

Operator: Yes. And your next question comes from the line of Annesa Borche. Your line is open.

Annesa Borche: Hi. You mentioned that physician assistants can perform the IPPE and the AWV services. Does the patient need to be an established patient for a PA to perform these services or is this an exception? Because from my understanding, a PA can't see a new patient or treat a new patient.

Jamie Hermansen: One moment please. We just need to discuss this for just a second.

Jamie Hermansen: Hi, this is Jamie Hermansen, again. We appreciate you holding. We would suggest you send that question in, because we will need to go back and take a look and do some more research on that particular issue.

Annesa Borche: OK. Thank you.

Jamie Hermansen: Thanks.

Operator: And your next question comes from the line of Jennifer Montgomery. Your line is open.

Jennifer Montgomery: Hi. It's a two-part question. Currently the screening EKGs, G0403 and G0405, are only permitted when performed with the IPPE, the same with the AAA screening. I'm wondering if there are plans to also have them permitted with the one-time Annual Wellness Visit of G0438, because many of the patients have not taken advantage of the IPPE, therefore kind of lose this as a benefit. And I'm wondering, you know, if CMS is planning to eventually add those to the parameters along with the initial Annual Wellness Visit.

Jamie Hermansen: Hey, that's a great question. Currently those particular provisions are based on statute, but we will take it under consideration.

Jennifer Montgomery: OK, thank you.

Jamie Hermansen: You're welcome. Thank you.

Operator: And your next question comes from the line of Dr. Annura De Silva. Your line is open.

Annura De Silva: Yes. Hi. Thank you. My name is Dr. De Silva calling from West Haven Medical Group. My question is when we do these physical exams, we always do blood work on the patients and they may actually not have a proper diagnosis for hyperlipidemia or whatever else we want to test. Do you plan to cover for any of these blood tests that we should perform when we do visit like this?

Jyme Schafer: We do have a provider reference for the preventive services that we cover, and I believe that is listed in a link here that we provided to you. So, we do provide and pay for a number of services and I would suggest that you check those out and if you have any further questions, please e-mail us after that. Thank you very much. These are excellent questions.

Annura De Silva: Thank you.

Operator: And your next question comes from the line of Carol Ann Schultz. Our line is open.

Carol Ann Schultz: Good morning. One of my questions was answered regarding the beneficiaries' education, and I agree with that caller. Patients are very confused they think they're coming for a comprehensive physical exam and appreciate you looking at your brochures. Another question is can we bill a digital rectal exam- which another provider brought up, the code is G0102. Can we bill that with AWP or an IPPE on the same date of service?

Stephanie Frilling: Hello, this is Stephanie Frilling, and yes, you can. ***[Post Call Clarification: CMS is now working to standardize contractor billing edits to allow this service. Please contact your claims processing contractor for specific billing instructions.]***

Carol Ann Schultz: Awesome. Thank you very much.

Nicole Cooney: Next question, please, Michelle.

Operator: Yes. Your next question comes from Steven Cherlock. Your line is open.

Steven Cherlock: Hi. I have two questions. You make reference to personalized health advice and referrals for health education and preventive counseling. Could you be more specific as to what type of personalized health advice and referrals exactly to what type of practitioners that would provide health education and preventive counseling?

Jamie Hermansen: Thank you for your question. This is Jamie Hermansen, and what I can do is just reference back to the regulation, where we said "…the furnishing of personalized health advice to the individual and referral is appropriate to health education or preventive counseling services or programs aimed at reducing identified risk factors and increasing self management or community-based lifestyle intervention to reduce health risk and promote self management and wellness including weight loss, physical activities, smoking cessation, fall prevention, and nutrition."

Does that answer your question?

Steven Cherlock: Well, no. Is it- are these referrals to other entities that would charge the patient out of pocket or are these referrals to entities that are covered under some type of Medicare reimbursement?

Jyme Schafer: That depends on who and what you refer them for.

Steven Cherlock: So, if I have an overweight patient who's not diabetic or has kidney disease, as far as I know, there's no Medicare reimbursement for any type of weight loss program. Is that correct?

Joe Chin: Currently we also have a code ***[Post Call Clarification – the speaker intended to say "coverage"]*** decision opened to look at intensive behavioral therapy for obesity, which was defined as a body mass index of greater or equal 30 kilograms per meter square. So in that sense, we are looking at obesity as a particular entity. For other services, it would depend on what type of really counseling or education you're looking at and whether the primary physician is comfortable in providing those types of counseling education services.

Steven Cherlock: Right, so just to follow up on my question. I guess my concern is that as you know most physicians are not trained in nutrition, exercise physiology, stress management other than writing pharmaceuticals, and so as part of the requirement here, you are asked and required to make referrals which typically would require out-of-pocket payments the part of the patient to access those referrals under current legislation and regulations. So, is it simply good enough to tell a patients to go see somebody or do an obligation to actually identify parties that will actually be able to see the patient and the patient will be able to afford to be seen.

Joe Chin: I think those are very good points. We ultimately would like to have, if we were talking about education or counseling, is to really have some change in behavior from that point of view your reference is to that. So, I think that's an area that hasn't been, you know, fully addressed and I believe that you're raising. If the primary provider of the annual wellness is not comfortable, is not properly trained to provide some of the counseling services, how do you actually get those services done? And that may really depend on having a group of physicians that actually can provide the services, you know, really focusing on providing the Annual Wellness Visits, you know, specifically. So, I believe, possibly one way to look at it is to have individuals that are comfortable and providers that are comfortable and trained to do the kind of services as the first choice in providing the Annual Wellness Visits.

Steven Cherlock: OK. One other quick question in regards to those practitioners and physician assistants performing the Annual Wellness Visit, is that subject to the incident to rules or do they get reimbursed at 100 percent of the code?

Chris Smith Ritter: Can you send that question in and we're going to look at the incident-to policies?

Steven Cherlock: Sure.

Nicole Cooney: Thank you. We're going to need to move on. Next question, Michelle?

Operator: Yes your next question comes from the line of Judie Schneider. Your line is open.

Judie Schneider: Hello, this is Judie Schneider from Patients First Health Care. My questions have already been asked, but I guess now my question is, will we be provided these answers? Will they be available to everyone or just the person that e-mails the question?

Nicole Cooney: Well, that is a good question. What we will be doing is looking at the questions. If there are frequently asked questions that are raised, we will be adding those to the CMS website, developing additional messaging, and that sort of thing. We won't be compiling a document of questions asked and answered to send out to participants.

So, unfortunately, we're not able to do that. But I would encourage you that if you do have a question that we don't get to today or you still don't feel that it is answered, please e-mail it to us because that will help us to determine frequently asked questions, further messaging, and reviewing and creating new educational products. So, thank you.

Judie Schneider: OK, thank you.

Nicole Cooney: Next question, Michelle?

Operator: Yes, your next question comes from the line of Caroline DelaCour. Your line is open.

Caroline DelaCour: Yes. I'd like to know for the Annual Well Visit, whether the initial or the subsequent, can we bill the EKG procedure code, the 9300? Because we're seeing as far as, that is bundled.

Jamie Hermansen: So, for- the Annual Wellness Visit does not typically include an EKG. So, that would be a separately billable service, and the deductible or coinsurance will apply on that.

Caroline DelaCour: Yes, I understand that but I'm saying like, right now we're getting like an edit, saying that it's bundled, but it shouldn't be bundled. It should be OK to bill both together, correct?

Nicole Cooney: Hi. Could you send in the specifics on your question?

Caroline DelaCour: OK.

Nicole Cooney: Thank you.

Caroline DelaCour: So, I should send an e-mail? Yes, OK. Thank you.

Nicole Cooney: Next question, Michelle?

Operator: Your next question comes from the line of James Schoemarker. Your line is open.

Nicole Cooney: Hello? Are you there? You're on the line with us.

Operator: Would like me to go the next question?

Nicole Cooney: Please.

Operator: And your next question comes from the line of Doctor Ram Ramstel. Your line is open.

Ram Ramstel: Hi. This is Dr. Ramstel from Multi-Disciplinary Medical Academy. We've discussed this before on the annual health and the IPPE. V70.5, is that what we're supposed to advise people to use, which is health examination of defined subpopulations, or is this unspecified general medical exam?

Jyme Schafer: So, that's another excellent question, thank you very much.

Ram Ramstel: I can't see it being anything else. It's got to be one or the other.

Stephanie Frilling: There's no specific diagnosis code. Provider should just choose an appropriate ICD-9-CM diagnosis code…

Ram Ramstel: But our concern- our concern is, is that if you're using the G-code and you

have a Modifier 25 on your problem focused exam, you have to have something to tie that G-code off to, to separate them. You can't use the same diagnosis, otherwise, it'll get denied.

Stephanie Frilling: Right, so just choose an appropriate diagnosis.

Ram Ramstel: The V code is OK? I'm still on, Michelle?

Operator: Yes, you are…

Kathy Kersell : Hi, this is Kathy Kersell . I'm sorry, I'm struggling with laryngitis and trying to talk. I hope you can hear me OK. For the Initial Preventive Physical Exam or the Annual Wellness Visit, you can use any diagnosis code. There's not a specific one
that's required for it to be billed, but you just – if you use V7.0 ***[Post-Call Clarification – the speaker intended to reference the V70.0 diagnosis code]*** or the, I think there's a, V70.9, I don't have a list in front of me, there shouldn't be any…

Ram Ramstel: Yes, there's a - yes. There's the V70.8 and a V70.9, one's specified and one's unspecified.

Kathy Kersell : So, the thing you want to keep in mind is that on each line item, the G-codes for either the Annual Wellness or the Initial Preventive Physical ,which is the Welcome to Medicare Visit, that diagnosis pointer for that G-code could be the V70.9 or V70.0, but then in the other line items that you have on your claim, you'd have to point to a different diagnosis.

So, if you put in something else, like you wanted to start some other test or something else you needed to do, you'd have to point to some other valid diagnosis for that line item. But again, back to the Annual Wellness and the Welcome to Medicare Visit, any diagnosis should work. You should not have to worry about using the V7.0***[Post Call Clarification – the speaker intended to reference the V70.0 diagnosis code]*** and getting denied. You then, if it happens, you should let us know.

Ram Ramstel: OK. So, we should tell them to use the unspecified general medical exam…

Kathy Kersell : You get to choose which diagnosis code that you want, but those would be acceptable.

Nicole Cooney: OK. We're going to have to move on. Thank you for your question. Next question, Michelle.

Operator: And your next question comes from the line of Becky Murphy. Your line is open.

Rebecca Murphy: Hello, yes. My name is Rebecca Murphy. I represent the Family Practice Center, and I would like to know with billing an office code for annual wellness with the 93000, how can we get that paid, the 93000?

Stephanie Frilling: What service is that code?

Rebecca Murphy: It's the EKG code.

Jamie Hermansen: Just a moment, please. Screening EKG or a diagnostic?

Rebecca Murphy: This is diagnostic. OK.

Stephanie Frilling: A medically necessary EKG would be an appropriate service to bill with the annual visit.

Rebecca Murphy: Did you say it's inappropriate?

Stephanie Frilling: It is appropriate…it needs a diagnosis code…

Rebecca Murphy: It is appropriate? OK.

Stephanie Frilling: It needs to be billed with the appropriate diagnosis codes.

Rebecca Murphy: OK. I have another question. Will Medicare be paying the V70.0 diagnosis?

Pat Gill: What diagnosis…is that routine care? What is that diagnosis?

Rebecca Murphy: Yes, it is routine care.

Pat Gill: Right, if it's still with the Annual Wellness Visit or the IPPE, it should get paid. As we've said it before, if that's not happening, please let us know.

Rebecca Murphy: OK.

Nicole Cooney: OK. Thank you. I'm going to have to move on because we're running out of time. Next question, Michelle.

Operator: The next question comes from the line of Rebecca Van Diver, your line is open.

Rebecca Van Diver: Good afternoon – I'm from PMPC Atlanta and we want to know what we do when a patient refuses to have the AWV done and wants to have the old – preventive service 99397, are we allowed to do that and bill the patient for it?

Jamie Hermansen: It's up to the patient. It is up to the patient, you know, what type of you know, services they would you know, they would like to prefer and obvious (inaudible) to me going to be discussing that with their physicians. I'm not sure that we can necessarily comment or not.

Rebecca Van Diver: OK. So, would we have to get an ABN from the patient saying they are refusing the covered AWV in lieu of the non-covered preventive.

Chris Smith Ritter: So, the 99213 code is not covered by Medicare.

Rebecca Van Diver: The 99397 is not covered by Medicare, we realize that. The patient does not want the covered service, they want the non-covered and want to pay for it. Are we allowed to do that and if so, do we have to get them to sign an ABN stating they were refusing the cover service in lieu of the non-covered?

Chris Smith Ritter: Yes, this is right, this is the treatment of this would be no different from any non-covered service. I understand the ABN is specific to covered services, so you would treat those as any other non-covered service that you are providing.

Rebecca Van Diver: So, we can provide the 99397 and bill the patient?

Chris Smith Ritter: Again, this is no different than any other non-covered service.

Rebecca Van Diver: OK. Thank you.

Nicole Cooney: Thank you. Next question, Michelle.

Operator: Your next question comes from the line of Cindy Knox, your line is open.

Cindy Knox: This is Cindy Knox with Carter OB/GYN. Can you bill the first initial IPPE along with the G02 – I mean G0101 and Q0091 which is the pap and pelvic?

Stephanie Frilling: You may. You may bill preventive services with the IPPE.

Cindy Knox: OK, thanks.

Nicole Cooney: Thank you. Next question, Michelle.

Operator: Your next question comes from the line of Cathy Hill. Your line is open.

Cathy Hill: This is Cathy Hill from Physicians Practice Organization and in regards to the IPE and the AWV not being a routine physical, our providers are not comfortable with only performing the five or six points that are required for these services. So, when our patients come in, the females, we are also doing the pap and pelvic which I understand that we can bill.

But we are also reviewing all of their symptoms and doing a head to toe physical. Do our providers have to bill the 99397 as well, because they technically are performing a comprehensive physical on top of the IPPE and the AWV, or can they not choose to bill that to the patient?

Jyme Schafer: OK, first, let me start out that the IPPE is a little bit misnamed. It's not really a physical exam, here, what we are referring to as the annual – the Welcome to Medicare visit, and also the Annual Wellness Visit. So, this is a series of

preventive medicine visits that is allowed for in statute. So this is different than what many people think of as a complete physical exam. I think we all have ...

Cathy Hill: Correct.

Jyme Schafer: …our own ideas as to what that is. So, I will –I want to make the distinct point here that these visits are very different from that and what is included, what we pay for in these visits, is enumerated in what we've given you and we also have a provider and beneficiary material that..

Cathy Hill: Right, I understand that and we are providing just those points that you have given us on the slides. But our patients are also wanting their normal things that they would have done during the comprehensive physical that the previous caller was talking about in regards to the 99397.

So, in addition to the IPPE and the AWV that our physicians have performed,

they are going ahead at the same visit reviewing all the symptoms that they normally would during the uncovered physical for Medicare. They are doing the pap and pelvic and the breast exam.

And I'm just asking, you know, they are not wanting their patients to have to get an extra charge. And so because they are doing these services at the IPPE and the AWV – the other one that is not required- do they still have to bill the patient the 99397 or can they choose not to?

I'm just trying to avoid- I don't want this to come back as an undercoding issue.

Cathy Hill: Because in the past we would bill the 99397. We would split bill the pap and the pelvic and the breast exam, and that patient had a minimum cost to them when they have the non-covered physical. But that has changed now.

Chris Smith Ritter: So – and I think this aligns with what we heard before and I think you are asking about the overlap. We would like to think about that a little bit can you send that question in?

Cathy Hill: Yes.

Cathy Hill: OK, thank you.

Nicole Cooney: Thank you.

Next question, Michelle.

Operator: Your next question comes from the line of Angie Price. Your line is open.

Angie Price: Hi, we are having problems with beneficiaries that are receiving their – they are coming in and they are asking for their yearly checkup and we provide them with the preventative medicine service and they get billed for it.

Then they call and they complain because they say that Medicare is supposed to be paying this. And when they call Medicare, the phone reps are telling the patients that we should be billing the covered preventative medicine service and not the non-covered service.

And so then the beneficiaries are calling back and yelling at us because we're billing them incorrectly. Is there education that is going out to the phone reps that are talking to the beneficiaries to explain the difference between these services when the beneficiaries call?

Jyme Schafer: We thank you for bringing this to our attention, we need to look into this matter a little bit and then see what we find out.

Nicole Cooney: If you could e-mail the specific details of your situation ...

Angie Price: We have called. We have specific patient examples. I mean, they are really irate.

Nicole Cooney: OK, that is good. If you can give us that example in writing. We don't have folks from that side of the house here and so we need to dig in to this a little bit more and make sure we talk to the right people for you.

Thank you very much.

Angie Price: OK, thank you.

Operator: And your next question comes from the line of Patty Bickerstaff. Your line is open.

Patty Bickerstaff: Hello, I have a question about the Medicare preventive physical exam form? Under functional ability, safety, and screening, there is a question that says was the patient's up and go test unsteady or longer than 30 seconds?

Can you tell me what that up and go test is?

Jamie Hermansen: Can you provide us with more information regarding – I think it may be good if you can provide us with the specific form that you are talking about. What I can tell you if you talk to me about – you were saying you were talking about the functional ability and the level of safety, is that correct?

Patty Bickerstaff: Yes.

Jamie Hermansen: OK, and as far as the – is this in regards to the Annual Wellness Visit or the IPPE?

Patty Bickerstaff: The Annual Wellness Visit.

Jamie Hermansen: Then the regulation – it states that the review of functional ability and level of safety is based on direct observation or the use of approved – appropriate screening questions or a screening questionnaire, which the health professional can find in the section. They select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national provider and medical associations.

Patty Bickerstaff: Where can I get those?

Jyme Schafer: Again, we provided flexibility to the providers to choose which one they would like to use.

Patty Bickerstaff: You don't have a specific – what type that we could go through for Medicare?

Jamie Hermansen: Not currently, we are allowing providers the flexibility to choose what they are comfortable with.

Patty Bickerstaff: OK, thank you.

Jamie Hermansen: …what's appropriate for the patient.

Patty Bickerstaff: OK, thank you.

Nicole Cooney: OK, Michelle, we are ready for our final question.

Operator: Yes, and your final question comes from the line of Ms. Veronica Avert, your line is open.

Veronica Avert: Hi, this is Veronica Avert - Pritchett Provider Network.

We are a family practice. And I guess I don't – I guess the question hasn't been answered but when patients are asking this well – not wellness but the preventative exam- whether which one out of the three that it is a new patient or established. The patients are wanting that exam but yet they are presenting problems or are sick. Are we to not bill the preventative and bill just like a 99213 office visit if it is an established patient?

Or should we you know, put that as an additional?

Veronica Avert: Patients are wanting – they want to pay the no deductible, the no co insurance, they are wanting that benefit. Just because the education – you know, that they know that it's an option for them. Do we have to do that? Is that – if the

patient is wanting just that because they don't want to have to pay the deductible and coinsurance?

Stephanie Frilling: Well, you can bill medically necessary E/M services with the Annual Wellness Visit and you would append Modifier 25 to that line on the service. And it would be appropriate to provide, you know, medical treatment for an acute condition at the time of an AWV.

Veronica Avert: Right.

OK.

Stephanie Frilling: Does that answer your question?

Veronica Avert: Yes. And the second thing on –on the slide eight, on the G0403 and G0405, they're both the same thing, are they not? They say the same thing but in- they're inverse like they're – I'm trying to find out if they are different. It is performed as a screening for initial preventative physical examination with interpretation and report, and the other one says interpretation and report only performed at the screening for the initial preventative physical examination.

Kathy Kersell: Hi, this is Kathy Kersell. The G0403 is the screening EKG. It's the complete procedure, it's supposed to include the interpretation as well as, you know, and the tracing. The G0404 is for tracing only and G0405 is the interpretation and report only.

But all three of these G-codes for the screening EKG , those are the ones that are done as a referral from an IPPE or the Welcome to Medicare Visit.

So, I'm trying to think if that clears it up for you?

Veronica Avert: Ma'am it is. I thank you.

Kathy Kersell: You're welcome.

Nicole Cooney: OK, unfortunately, that is all that time that we have for questions today.

Before we end the call, for the benefit of those of you who may have joined the call late, please note that continuing education credits may be awarded by the American Academy of Professional Coders or the American Health Information Management Association for participation in CMS National Provider Calls. Please see slide 34 and 35 of the slide presentation for more details.

We would like to thank everyone for participating in today's call. An audio recording and written transcript will be posted to the MLN multimedia section of the Medicare Learning Network product web page at www.cms.gov/mlnproducts in about two weeks.

I would like to thank all of the speakers here with me today, as well as all the experts in the room who helped us answer questions.

Have a great day.

Operator: This concludes today's conference call, you may now disconnect.

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