MLN6775421 – Medicare Wellness Visits (cms.gov)

DEFINITION

Initial Preventative Physical Exam (IPPE) - HCPCS:G0402

- A review of a patient's medical and social health history and includes education about preventative services.
- Also known as the "Welcome to Medicare Visit."
- Performed only once in a lifetime for patients within the first 12 months after their Part B benefits eligibility date

Annual Wellness Visit (AWV) - HCPCS: G0438/G0439

- An annual review of a patient's personalized prevention plan of services and includes a health risk assessment.
- *Initial Annual Wellness* (G0438): A patient's first annual wellness after an initial preventative visit is performed (12 months after IPPE) or as the patient's first AWV when no IPPE was performed
- *Subsequent Annual Wellness* (G0439): Each subsequent annual wellness visit 12 months after the last AWV or IPPE's date of service

Routine Physical Exam AKA

Initial/Periodic Comprehensive Preventive Medicine – CPT:99381-99397

- Used to report an annual preventive medicine visit for infants, children, adolescents, and adults (non-Medicare).
- Medicare doesn't cover this service. Medicare patient pays 100% out-of-pocket.
- Codes are broken up by new vs established patient and by age.
- Initial Comprehensive Preventive Medicine (99381-99387): For a new patient. Includes an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures.
- Periodic Comprehensive Preventive Medicine (99391- 99397): For an established patient. Includes an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures.

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COMPONENTS

Initial Annual Wellness Components

1. Perform an HRA
2. Establish the patient's medical and family history
3. Establish a current providers and suppliers list
4. Measure (weight, blood pressure, other routine measurements deemed appropriate)
5. Detect any cognitive impairments patients may have
6. Review the patient's potential depression risk factors
7. Review the patient's functional ability and level of safety
8. Establish an appropriate patient written screening schedule
9. Establish the patient's list of risk factors and conditions
10. Provide personalized patient health advice and appropriate referrals to health education or preventive counseling services or programs
11. Provide advanced care planning (ACP) at the patient's discretion
12. Review current opioid prescriptions
13. Screening for potential SUDS
14. Social Determinants of health (SDOH) Risk Assessment

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COMPONENTS

Subsequent AWV Components

1. Review and Update the HRA
2. Update the patient's medical and family history
3. Update current providers and suppliers list
4. Measure (weight, blood pressure, other routine measurements deemed appropriate)
5. Detect any cognitive impairments patients may have
6. Update the patient's written screening schedule
7. Update the patient's list of risk factors and conditions
8. As necessary, provide and update patient PPS, including personal health advice and appropriate referrals to health education or preventative counseling services or programs
9. Provide advance care planning (ACP) services at the patient's discretion
10. Review current opioid prescriptions
11. Screen for potential SUDs
12. Social Determinants of Health (SDOH) Risk Assessment: New element for 2024! New Webinar!

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WHO USES IT

Who can perform an Annual Wellness Visit?

- Medicare Part B covers the Annual Wellness Visit (AWV) if it is furnished by a:
  - Physician (doctor of medicine or osteopathic medicine)
  - Physician Assistant
  - Nurse Practitioner
  - Clinical Nurse Specialist
  - Medical professional (including a health educator, registered dietitian, nutritional professional, or other licensed practitioner) or a team of such medical professionals working under the direct supervision on a physician.

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WHEN TO USE IT

When to use the **Initial Annual Wellness**

- G0438 is to be used for a patient's first AWV after an IPPE was performed or as the patient's first AWV.
- If the patient comes in for their first AWV, but the patient has been enrolled in Medicare for more than 12 months, this code can be used even in no IPPE was billed.
- Can only be billed *once per lifetime* of the patient.

When to use the **Subsequent Annual Wellness**

- G0439 is used annually for Medicare beneficiaries who have already received an IPPE or initial AWV and are coming in for further annual wellness visits.
- Can be billed *once every 12 months*.

WATCH OUT!
When these codes are used within 12 months of a previous IPPE or AWV Medicare will deny the claim with the message that indicates the patient "reached the benefit maximum" for the time period. Verify the patient's eligibility before submitting the claim to avoid denials.

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DIAGNOSES

What diagnosis do I use??

CMS does not require you to use a specific IPPE or AWV diagnosis code. However, a diagnosis code is needed! You may choose any diagnosis code consistent with the patient's exam.

Examples of ICD-10-CM codes that can be used:

- Z00.00 Encounter for general adult medical examination *without* abnormal findings
- Z00.01 Encounter for general adult medical examination *with* abnormal findings
- Any additional diagnosis that the patient has that was addressed or examined. Don't forget to document!!

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ADDITIONAL SERVICES

Depression Screening / Patient Health Questionnaire (PHQ-9)

- A Patient Health Questionnaire is a type of depression screen that is a self-report measure designed to screen depressive symptoms.
- To be properly reimbursed the medical professional must have the PHQ9 form scanned into the medical record or have the results documented in the AWV note.
- How to code:
  - G0444 Annual depression screening, 5 to 15 minutes
  - Z13.31 Encounter for screening for depression
  - Any other existing depression diagnoses that the patient has can be added to the depression screening claim

This service can ONLY be billed with SUBSEQUENT AWV. It is a component of G0402 and G0438 and cannot be billed separately.

WARNING: Not all MACS are created equal! Make sure to verify with your MAC to determine if modifiers such as -25 or -59 are necessary when coding AWV with these services.

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ADDITIONAL SERVICES

Advance Care Planning (ACP)

MLN909289 – Advance Care Planning (cms.gov)

- ACP is a face-to-face conversation between a physician (or other qualified health care professional) and a patient to discuss their health care wishes and treatment if they become unable to communicate or make decisions.
- The conversation and time spent must be documented in the AWV note.
- How to code:
  - **99497**: Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
  - **99498**: Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)

CMS does not require a specific ACP diagnosis code, so you may choose any diagnosis code consistent with a patient's exam. For instance, Z00.00 or Z00.01 may be added.

CMS waives the ACP Part B deductible and coinsurance when performed on the same day, by the same provider, and billed on the same claim as the AWV. Append modifier 33 (Preventive Services) to the ACP CPT to have the deductible and coinsurance waived.

WARNING: Not all MACS are created equal! Make sure to verify with your MAC to determine if modifiers such as -25 or -59 are necessary when coding AWV/IPPE with these services.

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ADDITIONAL SERVICES

NEW Social Determinants of Health (SDOH) Risk Assessment

- SDOH are non-medical factors that influence health outcomes such as income, unemployment, housing, and food insecurity.
- CMS offers screening tools to help capture the information just like the Depression Screen tools.

How to Code:

- G0136 Administration of a standardized, evidence-based social determinants of health risk assessment tool, 5-15 minutes
- Document the performance of the Risk Assessment and the result within the visit note.
  - Example with negative result: SDOH Risk Assessment – Negative, no risk identified (Z13.89 – Encounter for screening for other disorder
  - Example with positive result: SDOH Risk Assessment – Positive, patient has housing instability and may be homeless by the end of the week. This was discussed in detail, and we developed the following plan. (Z59.811 – Housing instability, housed, with risk of homelessness/imminent risk of homelessness)

Diagnoses codes Z55-Z65 are specifically related to SDOH and can be added to the claim if the result reveals the patient is experiencing such circumstance.

CMS will accept claim for SDOH Risk Assessment starting July 1, 2024!

CMS waives the SDOH Risk Assessment Part B deductible and coinsurance when performed on the same day, by the same provider, and billed on the same claim as the AWV. Append modifier 33 (Preventive Services) to the ACP CPT to have the deductible and coinsurance waived.

**Check out our latest Webinar "Reimbursement & Documentation for Social Determinants of Health Risk Assessment for more information about this new screening tool - *stalkinghorsellc.com/shop*

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EVALUATION AND MANAGEMENT SERVICES?

What happens if the patient comes in with an acute complaint or an uncontrolled chronic condition during an AWV/IPPE?

A separate E/M code may be reported!

CMS states:

- "When you provide an IPPE [or AWV] and a significant, separately identifiable, medically necessary evaluation and management (E/M) service, we may pay for the additional service."

How to Code:

- Report the separate E/M code (99202-99205, 99211-99215) with modifier 25
- The diagnosis that was separately treated during the AWV is attached to the E/M claim
- Make sure the documentation reflects the medical necessity to treat the illness or injury that was addressed!

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EVALUATION AND MANAGEMENT SERVICES

EXAMPLE: A patient comes in for their Subsequent AWV. During the blood pressure check the provider notices that their blood pressure is elevated. After discussing this with the patient the provider determines that the patient's hypertension is uncontrolled. The provider decides to increase the patient's hypertension medication and see them in three months for a follow up. The provider documents the uncontrolled hypertension along with the medication changes. All other elements of the AWV are documented in the note as well.

- A significant, separately identifiable, medically necessary evaluation and management (E/M) service is supported based on the providers documentation of a chronic illness with exacerbation and medication management provided. These services are NOT included in the AWV.
- Codes for E/M: 99214-25, I10
- Codes for AWV: G0439, Z00.01, I10

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