Centers for Medicare & Medicaid Services
Preventive Services: The Initial Preventive Physical Exam and
The Annual Wellness Visit
National Provider Call
Moderator: Leah Nguyen
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Podcast 2 of 3: The Annual Wellness Visit

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Leah Nguyen: Welcome to the second of three podcasts from the Medicare Preventive Services National Provider Call on the Initial Preventive Physical Exam and the Annual Wellness Visit. This educational call was hosted by the CMS Provider Communications Group within the Center for Medicare on Wednesday, March 28, 2012.

In this second podcast, Jaime Hermansen from the Coverage & Analysis Group, Thomas Dorsey from the Provider Billing Group, and Stephanie Frilling from the Hospital Ambulatory Policy Group discuss the Annual Wellness Visit.

Now, we'll go back to Jamie Hermansen as we move into our next section on the Annual Wellness Visit.

Annual Wellness Visit Presentation

Jamie Hermansen: Thank you, Leah.

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

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

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

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

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

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

As we've discussed in the preamble to the Calendar Year 2011 Physician Fee Schedule Rule, we are not assigning particular tasks or restrictions for specific members of the team, and we believe it's better for supervising physicians to assign specific tasks to qualified team members as long as they are licensed in the state and working in their state's group of practice.
And, we also believe that this approach gives the physicians and the team the flexibility needed to address the beneficiary's particular needs on a particular day.

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

Stephanie Frilling: Thanks, Jamie.

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

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

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

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

Detection of any cognitive impairment; and review of potential risk factors for depression, functional ability and level of safety; and the establishment of a written screening schedule such as a checklist for the next 5 to 10 years; a list of the risk factors and conditions where interventions are recommended; and finally the furnishing of personalized health advice and referrals for health education and preventive counseling.

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

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

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

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

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

And finally, moving on to slide 35, in preparation for the Annual Wellness Visit, we're encouraging beneficiaries to bring the following information with them to their appointment: any pertinent medical records; family health history; a list of medications and supplements, including calcium and vitamins that they may be taking; and a list of current providers and suppliers involved in their health care.

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

Thomas Dorsey: Thank you, Jamie.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

We are encouraged by these results.

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

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

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

Following along on slide 44, the first and subsequent AWV Visits may be billed with any medically necessary evaluation management service like the IPPE, when billing additional E /M services, we would hope that providers would inform the patient of cost sharing requirements for the additional services, and append payment modifiers 25 to the claim line submitted for payments.

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

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

Since that call, we have worked with contractors to remove any system edits that reject these services from being furnished during an AWV visit. If a

practitioner has a rejected claim, and it has been denied payments, they are welcome to resubmit those claims for payment at this time.

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

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

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

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

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

I would like to make a note of some special sites. The first slide references the Medicare Learning Network publications where questions regarding AWV elements can be answered. The second slide indicates the Medicare internet manual sections while largely drafted for contractor instructions, it does

furnish important guidance on billing and payment procedures, including the use of modifier 25.

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

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

Leah Nguyen: Thank you, Stephanie. On slide 50, you will find helpful websites for health professionals and beneficiaries, and on slide 51, you will find some websites with more information on Medicare's preventive servicesm including Medicare Learning Network resources and the CMS prevention webpage, and slide 52 provides the continuing education information that I referenced at the start of the call.

Thank you for listening to this Medicare Preventive Services educational podcast. The information in this podcast was correct as of the date it was recorded. This podcast is not a legal document. Official Medicare program legal guidance is contained in the relevant statutes, regulations, and rulings.

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