Annual Wellness Visit: What's in it for Me?

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Dr. Cuenca earned his medical degree at Western University of Health Sciences in Pomona, California, and completed his family medicine residency at the Scripps Family Medicine Residency Program, Chula Vista, California. Subsequently, he completed a one-year fellowship in primary care sports medicine at Western University of Health Sciences Osteopathic Postdoctoral Training Institute (OPTI-West)/San Diego Sports Medicine and Family Health Center. Over the years, he has served in multiple clinical faculty appointments and has lectured at both local and national conferences on the topics of family medicine, sports medicine, and practice management. Currently, he enjoys serving as a volunteer assistant clinical professor for the University of California, Irvine medical school and as a preceptor for students in Chapman University's Physician Assistant program. He also serves on the editorial advisory board for *FPM* journal, which has published several articles he has authored over the years. An avid runner and third-degree black belt in Tang Soo Do, a karate-based Korean martial art, Dr. Cuenca endeavors to live a healthy, balanced lifestyle and encourages his patients to do the same.

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Learning Objectives

1. Identify techniques to improve specificity and accuracy of coding and billing practices.
2. Determine areas of opportunity for maximizing revenue through appropriate billing and coding.
3. Evaluate current quality improvement initiatives/processes to ensure sustainability.
4. Utilize best practices to optimize clinical, financial, and operational performance.

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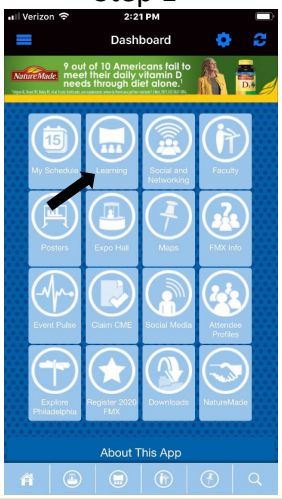
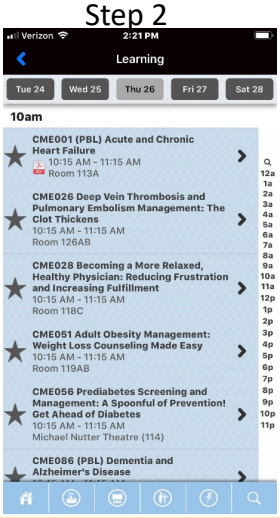
Audience Engagement System

Step 1



Step 2



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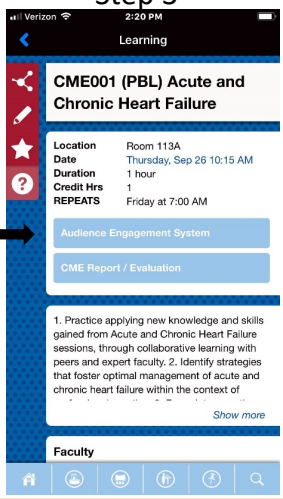

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It all began 9 years ago…

Official White House Photo by Pete Souza
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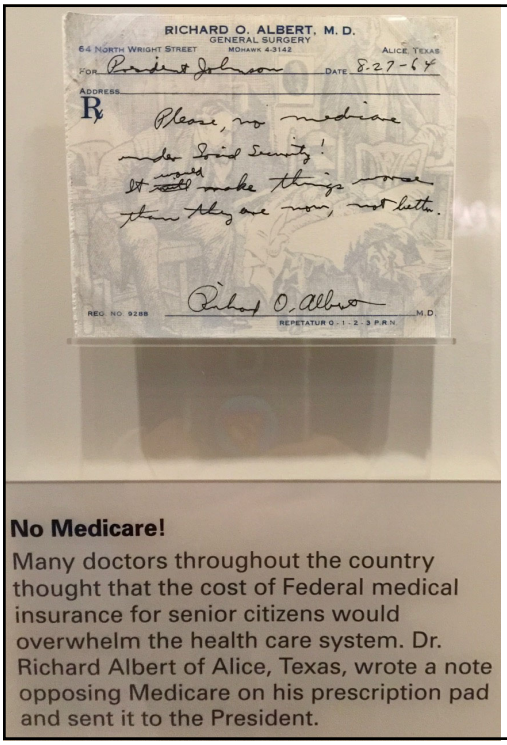
http://www.flickr.com/photos/speakerpelosi/4458512106/



No Medicare!
Many doctors throughout the country thought that the cost of Federal medical insurance for senior citizens would overwhelm the health care system. Dr. Richard Albert of Alice, Texas, wrote a note opposing Medicare on his prescription pad and sent it to the President.

"Please, no Medicare under Social Security!"

"It would make things worse than they are now, not better."

Personal Photo, taken May 2, 2019. LBJ Library, Austin, TX

The Patient Protection and Affordable Care Act of 2010

- Under the Affordable Care Act, Medicare pays in full, without patient co-pays or deductibles, for the initial "Welcome to Medicare" exam, the Annual Wellness Visit, and many recommended preventive services
- January 1, 2011; this benefit extends to all Medicare beneficiaries (including those with Medicare Advantage insurance)
- January 1, 2012: Centers for Medicare & Medicaid Services (CMS) required that a health risk assessment (HRA) be completed as part of the Annual Wellness Visit

Health Risk Assessment

- Health Risk Assessment: Identifying health behaviors and risk factors that the provider can discuss with the patient in an effort to reduce risk factors and related diseases.
  - Centers for Disease Control and Prevention developed a "framework" for the HRA in a December 2011 report. Major focus areas include physical activity, tobacco/alcohol use, nutrition, depression/anxiety, seat belt use, social/emotional support, pain, ADLs, sleep.

Downloadable HRA Form - FPM Toolbox
https://www.aafp.org/fpm/2012/0300/fpm20120300p11-rt1.pdf

Are we doing AWV? If so, what difference does it make?

- 2011: 7.5% of patients received an AWV
- 2014: 15.6%
- Ganguli, I. et., al. (Feb 2018)
  - Research supported in part by a grant from the NIH's National Institute on Aging
  - Compared practices of AWV "adopters" to "non-adopters" Medicare claims data up to 2015
    - AWV "non-adopters": provided no AWV
    - AWV "adopters: provided AWV to at least 25% of their patients
    - visit rates lower among practices caring for underserved populations
      - Such as racial minorities, dually enrolled in Medicaid, living in rural settings
    - Practices that adopted AWV generated greater revenue
      - Higher reimbursement rates for AWV, co-billing with a problem-based visit, and preventive services provided

Are we doing AWV? If so, what difference does it make?

- US Dept. Health & Human Services (Dec 2017)
  - 2015 analysis: Improved immunization rates when AWV utilized
    - PCV13: 33% AWV vs. 14% no AWV
    - Influenza: 64% AWV vs. 44% no AWV

Challenges of Providing Medicare Wellness Exams

- Time
  - In order to fulfill expectations of Medicare Wellness Visits, there are multiple elements that need to be included
  - Physician/Provider and supportive staff challenged to complete all elements in an allotted patient time slot
- Volume
  - The Affordable Care Act expanded coverage to all Medicare beneficiaries, increasing the volume of these types of visits

Challenges of Providing Medicare Wellness Exams

- Knowledge
  - Multiple types of Wellness exams and different types of Medicare insurance coverage creates confusion of what is expected during these visits by the physician
  - The patient is also confused about what the purpose of the wellness visit and what services are covered during their visit based on their insurance
- Missing Elements
  - If any elements are missing from the wellness visit, then billing cannot be submitted correctly

WIFM?

WIFM

- What's In It For Me?
- What's In It For My Patients?
- What's In It For My Practice/Organization?

Quality Measures

- AWV closes many pay-for-performance quality measure gaps
  - Core Quality Measures Collaborative
    - Created in 2014, includes federal, state, and commercial insurance plan leaders, CMS and National Quality Forum leaders, and national physician organizations
    - Goal: establish broadly agreed upon core quality measures that could be used across payers
    - AAFP has recommended that payers offering alternative payment models for primary care incorporate the core measure set for "Accountable Care Organizations, Patient Centered Medical Homes, and Primary Care"
  - Integrated HealthCare Association's California-based Value Based P4P (VBP4P) program
  - National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measures.
  - Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program (MSSP) have specific quality measures for the 2018 and 2019 quality reporting years.

MEASURE	SOURCE
Adult body mass index (BMI) assessment • Calculate BMI at annual visit (HEDIS, IHA). • Provide follow-up plan for abnormal BMI ranges (Collaborative). – Ages 18-64: Less than 18.5 or more than 25 – Ages 65 and over: Less than 23 or more than 30	Collaborative, HEDIS, IHA, MSSP
Advance care planning • Discuss advance care planning or include the patient's advance care plan in the medical record.	HEDIS
Aspirin use and discussion • Discuss risks and benefits of preventive aspirin use in men ages 46-79 and women ages 56-79.	HEDIS
Breast cancer screening • Provide mammogram within the past 27 months.	Collaborative, HEDIS, IHA, MSSP
Cervical cancer screening • Conduct Pap smear without HPV co-testing within the past three years for women ages 21-64. • Conduct Pap smear with HPV co-testing within the past five years for ages women 30-64. • Do not perform a Pap smear for anyone younger than 21.	Collaborative, HEDIS, IHA
Colorectal cancer screening • Perform colonoscopy in past 10 years, flexible sigmoidoscopy in past five years, or fecal occult blood test annually.	Collaborative, HEDIS, IHA, MSSP
Fall risk management • Document any falls in the past 12 months, discuss falls or problems with balance or walking, treat balance or walking problems, and recommend how to prevent falls.	HEDIS, MSSP
Functional status assessment • Evaluate activities of daily living annually.	HEDIS
Management of urinary incontinence in older adults • Document any urinary incontinence symptoms in the past six months and how it affects the patient's life, and discuss treatment options.	HEDIS

Medication review • Reconcile prescription and nonprescription drugs, vitamins, herbal remedies, and other supplements at least once a year.	HEDIS
Osteoporosis testing in older women • Complete at least one dual-energy X-ray absorptiometry (DEXA) scan in women ages 65-85.	HEDIS
Pain screening • Perform a pain evaluation or document a pain management plan at least once a year.	HEDIS
Physical activity in older adults • Document level of exercise, and advise patient to start, increase, or maintain current level of exercise.	HEDIS
Screening for clinical depression and follow-up plan • Perform depression screening and determine follow-up plan.	MSSP
Special needs plan care management • Perform a health risk assessment annually.	HEDIS
Statin therapy for patients with cardiovascular disease • Prescribe a moderate- or high-intensity statin for patients with atherosclerotic cardiovascular disease (males ages 21-75 and females ages 40-75).	HEDIS, IHA, MSSP
Tobacco use screening and cessation intervention • Screen for smoking and counsel the patient to stop smoking.	MSSP
Vaccinations • Administer influenza and pneumococcal vaccines.	IHA, HEDIS, MSSP

Poll Question 1

Which of the following is true?

A. The "Welcome to Medicare " (aka Initial Preventive Physical Examination) is a detailed exam that includes a thorough history, head to toe physical exam, and discussion of preventive services that includes a written plan

B. In order to adequately assess hearing, an audiogram is recommended during the IPPE or AWV

C. A Registered Dietitian may perform the AWV

D. The IPPE and AWV are a covered benefit under Part A Medicare

Providers of IPPE/AWV

- IPPE
  - Physician
  - Other qualified non-physician practitioner
    - Physician assistant
    - Nurse practitioner
    - Clinical nurse specialist
- AWV
  - Same as IPPE
  - Medical professional (including a health educator, a registered dietitian, nutrition professional, or other licensed practitioner) or a team of such medical professionals working under the direct supervision of a physician
    - The physician or non-physician practitioner who is billing Medicare for the service must be present in the office suite (not in the exam room) and immediately available to provide assistance and direction throughout the time the service is being provided

Definitions

- IPPE: "Welcome to Medicare" (Initial PREVENTIVE Physical Examination)
- AWV: Annual Wellness Visit
- IPPE vs. AWV:
  - IPPE is one-time initial preventive physical exam ("WELCOME TO MEDICARE" physical exam) within the first 12 months of patient's enrollment under Part B Medicare
  - AWV is a preventive physical exam for patients enrolled AFTER the first 12 months of enrollment (2 categories)
    - AWV, Initial Visit): covered 12 months after enrollment in Medicare or 12 months after the IPPE
    - AWV, Subsequent Visit): performed 12 months after AWV, Initial
- IPPE/AWV is a REVIEW of the patient's health, **NOT** a comprehensive physical "head to toe" exam
  - satisfactory to perform a **FOCUSED PHYSICAL EXAM** based on history
  - an overview of patient health and focuses on developing a plan to keep the patient healthy

What if the patient brings up other issues?

By the way…..

- If a patient brings up other issues outside of the IPPE/AWV (such as "oh by the way" or "laundry list"), then it is up to the provider to code a -25 modifier and 99213/4/5 as appropriate per clinical judgment
- Routine Physical Exams ARE NOT an Original/Straight Medicare covered benefit. If a Medicare patient is scheduled for IPPE/AWV and requests a Routine Physical, they must sign an ABN form because they will be responsible for the visit.
  - If you bill a Medicare patient for code 99387 or 99397, document the fact that the service was provided per patient's request, ABN was obtained, and make sure your progress note supports this service.
- **Scripting is important for scheduling AWV**

SCHEDULING RESOURCE FOR MEDICARE WELLNESS VISITS

To aid communication between patients and our staff when patients call to schedule any type of Medicare wellness visit, we developed a resource for schedulers that includes definitions, tips, and sample scripts.

DEFINITIONS

Medicare wellness visits			Routine office visit/exam
Welcome to Medicare visit (also known as Initial Preventive Physical Examination, or IPPE) Medicare pays 100%. Covered only once in a lifetime; must be provided within the first 12 months of patient's enrollment in Medicare. A focused physical exam, review of the patient's health, and development of a plan to keep the patient healthy. Not a comprehensive, "head-to-toe" physical.	**Annual wellness visit (AWV)** Medicare pays 100%. Initial AWV covered 12 months after enrollment in Medicare or 12 months after the Welcome to Medicare visit. Subsequent AWVs may be provided annually. A focused physical exam, review of the patient's health, and development of a plan to keep the patient healthy. Not a comprehensive, "head-to-toe" physical.	**Preventive physical exam** Not covered by traditional Medicare but may be covered by Medicare Advantage plan; provided at patient's request. A comprehensive, not focused, "head-to-toe" physical exam.	**Evaluation and management visit** Subject to the patient's deductible/coinsurance/co-pay. A problem-oriented visit; may be described by patient or physician as follow-up appointment or recheck.

TIPS

The Welcome to Medicare visit and annual wellness visit are to review the patient's wellness and develop a plan to keep the patient healthy. They include a focused physical exam – not a comprehensive, "head-to-toe" physical exam.

If the patient has one or two additional medical problems, the physician may choose to treat these at the same time as the wellness visit. This additional service will be billed separately and, therefore, is subject to the Medicare deductible/coinsurance/co-pay.

If the patient has multiple medical conditions that need treatment, we recommend scheduling a regular office visit and explaining that the wellness visit can be scheduled when he or she is feeling better.

If the patient requests a comprehensive physical exam in addition to a wellness visit, two separate appointments may be needed. Schedule the wellness visit and recommend that the patient schedule the comprehensive physical exam (which is not covered by Medicare) after the wellness visit if it still seems necessary.

Family Practice Management

SAMPLE SCRIPTS

1

Patient: "I've heard Medicare is covering physicals." Or "I want to schedule a complete physical exam."

Scheduler: "Are you calling to schedule the new annual wellness visit benefit that is covered by Medicare or are you wanting the Welcome to Medicare visit, which is available to anyone in their first year of Medicare coverage?"

Note: If the patient wants the Welcome to Medicare visit, jump to Script 2.

Patient: "I would like to schedule the annual wellness visit."

Scheduler: "The annual wellness visit is an overview of your health and focuses on developing a plan to keep you healthy. Just so you know, it does not include or replace a complete, 'head-to-toe' physical exam."

Patient: "I understand. I would like to schedule the annual wellness visit. I only have a few minor concerns."

Scheduler: "I'll be happy to schedule your annual wellness visit. Please understand if the doctor addresses your additional medical concerns, that service will be subject to your Medicare deductible or coinsurance."

Note: Schedule the annual wellness visit appointment and recommend the patient read his or her Medicare information about what to expect during the annual wellness visit.

2

Patient: "I want to schedule my Welcome to Medicare visit."

Scheduler: "When did your Medicare start?"

Note: If patient enrolled in Medicare more than 12 months ago, skip the following question.

Scheduler: "Have you previously had a Welcome to Medicare visit?"

Note: If no, schedule the appointment and recommend the patient read his or her Medicare information about what to expect during the Welcome to Medicare visit.

If yes, or if more than 12 months has passed since the Welcome to Medicare visit, continue. If less than 12 months has passed, instruct the patient to call back to schedule an annual wellness visit when appropriate.

Scheduler: "You are not eligible for the Welcome to Medicare visit [give reason, reference the patient's answer to above questions], however, we can schedule you for an annual wellness visit. The annual wellness visit is an overview of your health and focuses on developing a plan to keep you healthy. Just so you know, it does not include or replace a complete, 'head-to-toe' physical exam."

Patient: "I understand. I would like to schedule the annual wellness visit. I only have a few minor concerns."

Scheduler: "I'll be happy to schedule your annual wellness visit. Please understand if the doctor addresses your additional medical concerns, that service will be subject to your Medicare deductible or coinsurance."

Note: Schedule the annual wellness visit appointment and recommend the patient read his or her Medicare information about what to expect during the annual wellness visit.

Physician/Provider Expectations for IPPE or AWV

- Perform a focused physical exam…..NOT A COMPREHENSIVE PHYSICAL EXAM) for IPPE and AWV
- Review the completed screening tests for Depression, Functional ability, and cognitive impairment and make the final diagnosis
- End of Life Planning **(POLST)** if needed/Advanced Directive
- Education, counseling, and referral based on History and Exam
- **Complete a brief written plan** and give to the beneficiary for obtaining the appropriate screenings and other preventive services that are covered as separate Medicare Part B benefits.
- **Report HCC codes for Medicare Advantage patients**
- Physicians can bill IPPE/AWV visit codes in addition to any other preventive services provided

Physician/Provider Expectations for IPPE or AWV

- What is a "focused" physical exam?
  - IPPE
    - Height, Weight, Blood Pressure, BMI, Visual Acuity Screen
    - Any "physical exam" deemed appropriate by medical and social history
  - MWI
    - Height, Weight, Blood Pressure, BMI
    - Any "physical exam" deemed appropriate by medical and social history
  - MWS
    - Weight, Blood Pressure
    - Any "physical exam" deemed appropriate by medical and social history
- Should directly observe for signs of cognitive impairment or decline; provider may elicit feedback and information from family members or caretakers

Cognitive screening

- As many as 81% of patients who meet criteria for dementia have not received a formal diagnosis
- CMS does not require or recommend a specific tool
- Alzheimer's association expert workgroup recommendation:
  - If **"yes"** answered for memory loss, confusion, or need for assistance with ADLs, then use structured assessment
    - Mini-Cog
    - General Practitioner Assessment of Cognition
    - Memory Impairment Screen
- Identifying patients with cognitive impairment and dementia provides opportunities to connect them resources, support, and opportunities for **Advance Care Planning**.
  - 2013 study of hospitalized adults < 6 months life expectancy
    - 48% had documented health care preferences
    - 73% named a health care agent
    - 30% discussed wishes with PCP

Physician/Provider Expectations for IPPE or AWV

- At a minimum, for a very healthy patient with no indication to perform a "focused" hands-on physical exam, you can satisfactorily meet the exam requirements with Vital signs alone

- Personalized Prevention Plan Services (PPPS): A "written plan" such as a checklist for the next 5-10 years provided to the patient
  - Age appropriate preventive services Medicare covers
  - United States Preventive Services Task Force (USPSTF) and Advisory Committee on Immunization Practices (ACIP) recommendations
  - Health status and screening history
  - Treatment options of any mental health conditions identified
  - Personalized health advice and/or referrals to health education or preventive counseling services (weight loss, tobacco cessation, nutrition, etc.)

Poll Question 2

When performed as part of the Annual Wellness Visit/IPPE, which of the following preventive services will the patient be responsible for a co-payment

A. Cardiovascular risk reduction counseling
B. Digital rectal exam
C. Alcohol screening
D. Pelvic and breast exam
E. Advance Care Planning

Covered Preventive Services

HCPCS codes with wRVU
(based on national payment amount information)

The following are HCPCS codes and ICD-10 codes for wellness visits that may be provided in an office visit.

RVU and payment information from 2019 Medicare Physician Fee Schedule for exams performed in the office, National data listed

Excluded are other preventive services that do not generated wRVU (such as immunizations, diagnostic imaging, etc.)

Source: https://www.cms.gov/apps/physician-fee-schedule/overview.aspx

https://www.aafp.org/fpm/2016/0700/p9.html

Code	Description	wRVUs	Allowable charges*	Requires copayment, coinsurance, or deductible?
G0402	"Welcome to Medicare" visit (IPPE)	2.43	$169.02	Waived
G0438	Initial annual wellness visit (AWV)	2.43	$174.43	Waived
G0439	Subsequent AWV	1.50	$118.21	Waived
G0101	Pelvic and breast exam (covered annually only if patient is at high risk for developing cervical or vaginal cancer, or is of childbearing age with abnormal Pap test within past three years or every two years for women at normal risk)	0.45	$39.64	Waived
G0102	Prostate cancer screening; digital rectal examination	0.17	$22.70	Not waived
G0403	Electrocardiogram, with interpretation and report (separately reported with an IPPE only)	0.17	$17.30	Not waived
G0442	Alcohol misuse screening (separately reported with an AWV only)	0.18	$18.38	Waived
G0443	Face-to-face behavioral counseling for alcohol misuse, 15 minutes (maximum of four per year) (separately reported with an AWV only)	0.45	$26.67	Waived
G0444	Depression screening (separately reported with a subsequent AWV only)	0.18	$18.38	Waived
G0445	High-intensity behavioral counseling to prevent STIs, performed semi-annually, 30 minutes	0.45	$28.11	Waived

G0446	Intensive behavioral counseling for cardiovascular disease (CVD), 15 minutes, including: • Encouraging aspirin use to prevent CVD for men ages 45-79 and women ages 55-79; • Screening for high blood pressure in adults 18+; • Providing intensive behavioral counseling to promote a healthy diet for adults with cardiovascular risk factors.	0.45	$26.67	Waived	
G0447	Face-to-face behavioral counseling for obesity (BMI greater than 30), 15 minutes, including: • Screening for obesity using BMI; • Dietary assessment; • Intensive behavioral counseling and behavioral therapy to promote weight loss, diet, and exercise.	0.45	$26.31	Waived	
99406	Tobacco use counseling, three to 10 minutes (maximum of eight per year if combined with 99407)	0.24	$15.14	Waived	
99407	Tobacco use counseling, more than 10 minutes (maximum of four per year)	0.50	$28.83	Waived	
99497	Advance care planning, first 30 minutes (separately reported with an AWV only)	1.50	$86.49	Waived when furnished with AWV (use -33 modifier)	
99498	Advance care planning, additional 30 minutes (separately reported with an AWV only)	1.40	$76.04	Waived when furnished with AWV (use -33 modifier)	

G0442: Alcohol misuse screening

- The USPSTF considers 3 tools as the instruments of choice
  - Alcohol Use Disorders Identification Test (AUDIT)
    - most widely studied for detecting alcohol misuse
  - The abbreviated AUDIT-Consumption (AUDIT-C)
  - Single-question screening
    - National Institute on Alcohol Abuse and Alcoholism (NIAAA) recommends asking “How many times in the past year have you had 5 [for men] or 4 [for women and all adults older than 65 years] or more drinks in a day?”

G0443: Alcohol misuse counseling

- The 5A's approach adopted by the USPSTF:
  - Assess: Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/methods.
  - Advise: Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.
  - Agree: Collaboratively select appropriate treatment goals and methods based on the patient's interest in and willingness to change the behavior.
  - Assist: Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.
  - Arrange: Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=347&ncdver=1&bc=AgAAgAAAAAAA&

https://www.uspreventiveservicestaskforce.org/Page/Name/behavioral-counseling-interventions-an-evidence-based-approach

G0444: Depression screening

- Patient Health Questionnaire (PHQ-2 or PHQ-9)
- Geriatric Depression Scale in older adults
- Edinburgh Postnatal Depression Scale (EPDS) in postpartum and pregnant women

G0446: Face to face intensive behavioral therapy for CVD

- CMS covers intensive behavioral therapy for CVD (aka CVD risk reduction visit), which consists of the following three components:
  - encouraging aspirin use for the primary prevention of CVD when the benefits outweigh the risks for men age 45-79 years and women 55-79 years;
  - screening for high blood pressure in adults age 18 years and older; and
  - intensive behavioral counseling to promote a healthy diet for adults with hyperlipidemia, hypertension, advancing age, and other known risk factors for cardiovascular- and diet-related chronic disease.

G0447: Intensive Behavioral Therapy (IBT) for Obesity

- CMS covers intensive behavioral therapy for obesity, defined as a body mass index (BMI) ≥ 30 kg/m^2, for the prevention or early detection of illness or disability.
- Intensive behavioral therapy for obesity consists of the following:
  - Screening for obesity in adults using measurement of BMI calculated by dividing weight in kilograms by the square of height in meters (expressed kg/m^2);
  - Dietary (nutritional) assessment; and
  - Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on diet and exercise.

HCPCS code	Description	Copay/coinsurance/Deductible
G0109	DM Self management training. Refer to DM team for group sessions…Initial year: up to 10 hours of initial training within a continuous 12 month period. Subsequent years: up to 2 hours follow up training each calendar year	**Applies**
G0117	Glaucoma screening by ophtho. Refer to ophtho if: • Has diabetes • Family history of glaucoma • African-American age ≥ 50 • Hispanic Americans ≥ 65	**Applies**
G0270/G0271	Medical Nutrition Therapy. Refer to Nutritionist team. 15/30 min. First year: 3 hours counseling. Subsequent years: 2 hours	Waived

Covered Preventive Services: Labs & Imaging

Covered Preventive Services: Labs & Imaging

Preventive Service	Lab/Imaging	Eligibility	Frequency	Copay/coinsurance/deductible
Bone Mass Measurements	DEXA, US Bone density-peripheral sites, CT Bone density-axial skeleton, SEXA	Estrogen-deficient women at risk for osteoporosis and individuals with: vertebral abnormalities, receiving glucocorticoid therapy > 3 months, primary hyperparathyroidism, monitoring response to osteoporosis drug therapy	Every 2 years of more frequently if medically necessary	Waived
CVD screening	Lipid panel	All beneficiaries	Every 5 years	Waived
Colorectal cancer screening	Cologuard, FOBT, Flex sig, Colonoscopy, barium enema	Cologuard: 50-85 y/o, asymptomatic, average risk All others: 50+ y/o	• Cologuard: every 3 years. • FOBT: annually. • Flex sig: every 2 years. • Colonoscopy: every 10 years. • Barium enema: every 2 years	**Copayment/coinsurance applies to barium enema**; all others waived

Covered Preventive Services: Labs & Imaging

Preventive Service	Lab/Imaging	Eligibility	Frequency	Copay/coinsurance/deductible
Diabetes screening	Fasting blood glucose or glucose tolerance test	Any one of the following: Hypertension, Dyslipidemia, BMI ≥ 30, previous hx elevated impaired fasting glucose or glucose tolerance. At least 2 of the following: BMI ≥ greater than 25, but < 30, family history of diabetes; Age ≥ 65; hx of gestational diabetes mellitus, or of delivering a baby weighing greater than 9 pounds.	Pre-diabetic patients: every 6 months Otherwise annually	Waived

Covered Preventive Services: Labs & Imaging

Preventive Service	Lab/Imaging	Eligibility	Frequency	Copay/coinsurance/ deductible
Hepatitis B virus screening	Nonpregnant: HBsAg, anti-HBsAg, anti-HBc Pregnant: HBcAb, HBsAb, immunoassay HBsAg	Asymptomatic, nonpregnant adolescents and adults at high risk for HBV infection Pregnant women	• Annually: high risk patients who do not receive hepatitis B vaccination • Once for pregnant women at the first prenatal visit for each pregnancy and rescreening at the time of delivery for those with new or continued risk factors	Waived

Covered Preventive Services: Labs & Imaging

Preventive Service	Lab/Imaging	Eligibility	Frequency	Copay/coinsurance/deductible
Hepatitis C virus screening	Hep C Ab	At least one of the following: • high risk for HCV infection • born between 1945 and 1965 • had a blood transfusion before 1992	Once for Medicare beneficiaries born from 1945 through 1965 who are not considered high risk Annually for high risk with continued illicit injection drug use since the prior negative screening test	Waived
HIV screening	HIV	All beneficiaries	Annually: Age 15 to 65 Annually Age < 15 and > 65 who are at increased risk for HIV infection Pregnant: 3 times per pregnancy • At pregnancy diagnosis • During the third trimester • At labor if ordered by clinician	Waived

Poll Question 3

Which of the following asymptomatic patients are eligible for lung cancer screening with a low dose CT chest scan?

A. 78 y/o male who smokes 34 pack years
B. 58 y/o female who smoked 1 pack/day and quit smoking 12 years ago
C. 62 y/o female who smoked 25 pack-years and quit 5 years ago
D. 53 y/o male who smokes 1 pack per day since he was 22 years old
E. 76 y/o female who smoked 40-pack years and quit 17 years ago

Covered Preventive Services: Labs & Imaging

Preventive Service	Lab/Imaging	Eligibility	Frequency	Copay/coinsurance/ deductible
Lung cancer screening	Low dose CT chest	Aged 55 through 77 Asymptomatic (no signs or symptoms of lung cancer) Tobacco smoking history of at least 30 pack-years (one pack-year = smoking one pack per day for one year; 1 pack = 20 cigarettes) Current smoker or one who has quit smoking within the last 15 years	Annually	Waived

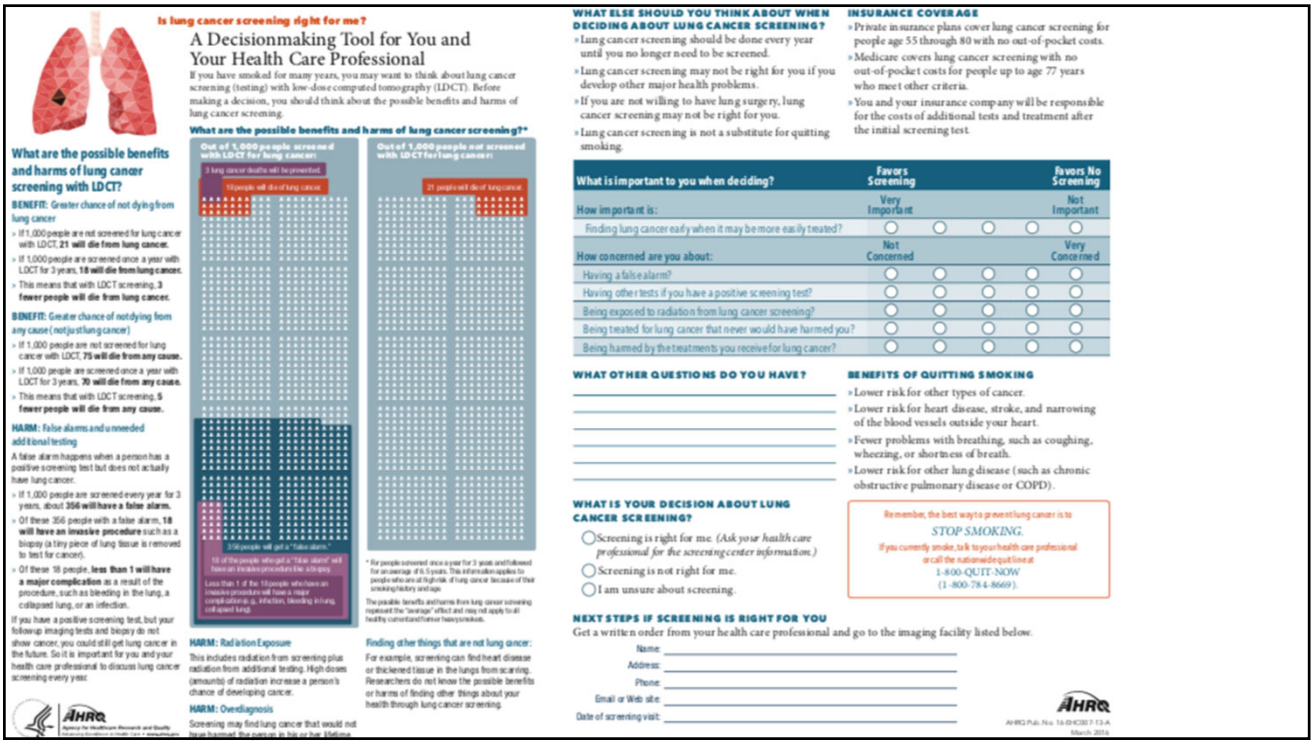
G0296: Lung Cancer Screening Counseling

Must include all of the following elements:

- Determination of beneficiary eligibility including age, absence of signs or symptoms of lung cancer, a specific calculation of cigarette smoking pack-years; and if a former smoker, the number of years since quitting
- Shared decision-making, including the use of one or more decision aids, to include
  - benefits and harms of screening, follow-up diagnostic testing, over-diagnosis, false positive rate, and total radiation exposure;
  - Counseling on the importance of adherence to annual lung cancer LDCT screening, impact of co-morbidities, and ability or willingness to undergo diagnosis and treatment;
  - Counseling on the importance of maintaining cigarette smoking abstinence if former smoker; or the importance of smoking cessation if current smoker and, if appropriate, furnishing of information about tobacco cessation interventions; and,
  - If appropriate, the furnishing of a written order for lung cancer screening with LDCT.

wRVU: .52

- AHRQ downloadable .pdf (free for patients and clinicians to download)
  - https://effectivehealthcare.ahrq.gov/decision-aids/lung-cancer-screening/static/lung-cancer-screening-patient-encounter.pdf



Is lung cancer screening right for me?

A Decisionmaking Tool for You and Your Health Care Professional

If you have smoked for many years, you may want to think about lung cancer screening (testing) with low-dose computed tomography (LDCT). Before making a decision, you should think about the possible benefits and harms of lung cancer screening.

What are the possible benefits and harms of lung cancer screening with LDCT?

What are the possible benefits and harms of lung cancer screening?*

Out of 1,000 people screened with LDCT for lung cancer:

Out of 1,000 people not screened with LDCT for lung cancer:

BENEFIT: Greater chance of not dying from lung cancer

- If 1,000 people are not screened for lung cancer with LDCT, 21 will die from lung cancer.
- If 1,000 people are screened once a year with LDCT for 3 years, 18 will die from lung cancer.
- This means that with LDCT screening, 3 fewer people will die from lung cancer.

BENEFIT: Greater chance of not dying from any cause (not just lung cancer)

- If 1,000 people are not screened for lung cancer with LDCT, 75 will die from any cause.
- If 1,000 people are screened once a year with LDCT for 3 years, 70 will die from any cause.
- This means that with LDCT screening, 5 fewer people will die from any cause.

HARM: False alarms and unneeded additional testing

A false alarm happens when a person has a positive screening test but does not actually have lung cancer.

- If 1,000 people are screened every year for 3 years, about 356 will have a false alarm.
- Of these 356 people with a false alarm, 18 will have an invasive procedure such as a biopsy (a tiny piece of lung tissue is removed to test for cancer).
- Of these 18 people, less than 1 will have a major complication as a result of the procedure, such as bleeding in the lung, a collapsed lung, or an infection.

If you have a positive screening test, but your follow-up imaging tests and biopsy do not show cancer, you could still get lung cancer in the future. So it is important for you and your health care professional to discuss lung cancer screening every year.

HARM: Radiation Exposure

This includes radiation from screening plus radiation from additional testing. High doses (amounts) of radiation increase a person's chance of developing cancer.

HARM: Overdiagnosis

Screening may find lung cancer that would not have harmed the person in his or her lifetime.

Finding other things that are not lung cancer:

For example, screening can find heart disease or thickened tissue in the lungs from scarring. Researchers do not know the possible benefits or harms of finding other things about your health through lung cancer screening.

* For people screened once a year for 3 years and followed for an average of 6.5 years. This information applies to people who are at high risk of lung cancer because of their smoking history and age.

The possible benefits and harms from lung cancer screening represent the "average" effect and may not apply to all healthy current and former heavy smokers.

WHAT ELSE SHOULD YOU THINK ABOUT WHEN DECIDING ABOUT LUNG CANCER SCREENING?

- Lung cancer screening should be done every year until you no longer need to be screened.
- Lung cancer screening may not be right for you if you develop other major health problems.
- If you are not willing to have lung surgery, lung cancer screening may not be right for you.
- Lung cancer screening is not a substitute for quitting smoking.

INSURANCE COVERAGE

- Private insurance plans cover lung cancer screening for people age 55 through 80 with no out-of-pocket costs.
- Medicare covers lung cancer screening with no out-of-pocket costs for people up to age 77 years who meet other criteria.
- You and your insurance company will be responsible for the costs of additional tests and treatment after the initial screening test.

What is important to you when deciding?	Favors Screening				Favors No Screening
How important is:	Very Important				Not Important
Finding lung cancer early when it may be more easily treated?	○	○	○	○	○
How concerned are you about:	Not Concerned				Very Concerned
Having a false alarm?	○	○	○	○	○
Having other tests if you have a positive screening test?	○	○	○	○	○
Being exposed to radiation from lung cancer screening?	○	○	○	○	○
Being treated for lung cancer that never would have harmed you?	○	○	○	○	○
Being harmed by the treatments you receive for lung cancer?	○	○	○	○	○

WHAT OTHER QUESTIONS DO YOU HAVE?

BENEFITS OF QUITTING SMOKING

- Lower risk for other types of cancer.
- Lower risk for heart disease, stroke, and narrowing of the blood vessels outside your heart.
- Fewer problems with breathing, such as coughing, wheezing, or shortness of breath.
- Lower risk for other lung disease (such as chronic obstructive pulmonary disease or COPD).

Remember, the best way to prevent lung cancer is to STOP SMOKING.

If you currently smoke, talk to your health care professional or call the nationwide quit line at 1-800-QUIT-NOW (1-800-784-8669).

WHAT IS YOUR DECISION ABOUT LUNG CANCER SCREENING?

- ○ Screening is right for me. (*Ask your health care professional for the screening center information.*)
- ○ Screening is not right for me.
- ○ I am unsure about screening.

NEXT STEPS IF SCREENING IS RIGHT FOR YOU

Get a written order from your health care professional and go to the imaging facility listed below.

Name: _____

Address: _____

Phone: _____

Email or Web site: _____

Date of screening visit: _____

AHRQ Pub. No. 16-EHC007-13-A
March 2016

Covered Preventive Services: Labs & Imaging

Preventive Service	Lab/Imaging	Eligibility	Frequency	Copay/coinsurance/ deductible
Prostate cancer screening	PSA	Males ≥ 50 years old	Annually	Waived
Cervical or vaginal cancer screening	Cervical pap testing with HPV co-testing Cervical or vaginal pap testing	Cervical pap w/ HPV co-testing: women age 30-65 years old Cervical or vaginal pap smear alone: all female patients	Cervical pap w/ HPV co-testing: every 5 years Cervical/vaginal alone: • Annually if at high risk due to abnormal Pap test within past 3 years • Every 2 years for women at low risk	Waived

Covered Preventive Services: Labs & Imaging

Preventive Service	Lab/Imaging	Eligibility	Frequency	Copay/coinsurance/deductible
STI screening	Chlamydia, Gonorrhea, Syphilis, Hepatitis B (HBsAg)	Sexually active adolescents and adults at increased risk for STIs	Non-pregnant women: Annually for chlamydia, gonorrhea, and syphilis Up to two occurrences per pregnancy of screening for chlamydia and gonorrhea One occurrence per pregnancy of screening for syphilis in pregnant women: • Up to two additional occurrences in the third trimester and at delivery One occurrence per pregnancy of screening for hepatitis B in pregnant women: • One additional occurrence at delivery if at continued increased risk for STIs Men: Annually for syphilis	Waived

Covered Preventive Services: Labs & Imaging

Preventive Service	Lab/Imaging	Eligibility	Frequency	Copay/coinsurance/deductible
Abdominal aortic aneurysm screening	Ultrasound, abdominal aorta	CMS states: beneficiaries with "certain risk factors for AAA" Consider USPSTF recommendations: • Men 65-75 y/o who have **EVER** smoked: **GRADE B RECOMMENDATION** • Men 65-75 y/o who have **NEVER** smoked: **GRADE C RECOMMENDATION** with risk factors Risk factors: first-degree relative with an AAA; history of other vascular aneurysms, coronary artery disease, cerebrovascular disease, atherosclerosis, hypercholesterolemia, obesity, and hypertension. https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/abdominal-aortic-aneurysm-screening	Once in lifetime	Waived

Time-Based Coding

Some preventive services require documentation of time spent:

Preventive Service	Time	wRVU
Alcohol misuse counseling	15 minutes	0.45
CVD counseling	15 minutes	0.45
Obesity counseling	15 minutes	0.45
STI prevention counseling	30 minutes	0.45
Advance care planning (first 30 min/additional 30 min)	30 minutes	1.50/1.40

Are You Up-To-Date on Your Preventive Services?

Medicare covers a full range of preventive services to help keep you healthy and help find problems early, when treatment is most effective. Ask your doctor which of these services is right for you.

✔	Preventive service	Date	Notes
	One time "Welcome to Medicare" Preventive Visit—within the first 12 months you have Medicare Part B (Medical Insurance)		
	Yearly "Wellness" Visit—get this visit 12 months after your "Welcome to Medicare" preventive visit or 12 months after your Part B effective date		
	Abdominal Aortic Aneurysm Screening		
	Alcohol Misuse Screening and Counseling		
	Bone Mass Measurement (Bone Density Test)		
	Cardiovascular Disease (Behavorial Therapy)		
	Cardiovascular Screenings (cholesterol, lipids, triglycerides)		
	Colorectal Cancer Screenings		
	Depression Screening		
	Diabetes Screening		
	Diabetes Self-management Training		

Free for patients and clinicians to download

https://www.medicare.gov/Pubs/pdf/11420-Preventive-Services-Card.pdf

✔	Preventive Service	Date	Notes
	Flu Shot		
	Glaucoma Test		
	Hepatitis B Shot		
	Hepatitis B Virus (HBV) infection screening		
	Hepatitis C Screening		
	HIV Screening		
	Lung Cancer Screening		
	Mammogram (screening for breast cancer)		
	Medical Nutrition Therapy Services		
	Medicare Diabetes Prevention Program		
	Obesity Screening and Counseling		
	Pap Test and Pelvic Exam (includes a breast exam)		
	Pneumococcal Shots		
	Prostate Cancer Screening		
	Sexually Transmitted Infection Screening and Counseling		
	Smoking and Tobacco Use Cessation		

Your "Guide to Medicare Preventive Services" has more information about these and other preventive services, including costs and conditions that may apply. Visit **Medicare.gov/publications**.

Paid for by the Department of Health & Human Services.

CMS Product No. 11420
Revised September 2018

Free for patients and clinicians to download

https://www.medicare.gov/Pubs/pdf/11420-Preventive-Services-Card.pdf

Comparing wRVUs…

HCPCS CODE	DESCRIPTION	wRVUs
99203	New patient office visit: level 3	1.42
99204	New patient office visit: level 4	2.43
99205	New patient office visit: level 5	3.17
99213	Established patient office visit: level 3	.97
99214	Established patient office visit: level 4	1.50
99215	Established patient office visit: level 5	2.11
99387	New patient preventive visit age 65+	2.50
99397	Established patient preventive visit age 65+	2.00

Case Studies

A 67-year-old male, who is an established patient of your practice, is seeing you for an initial AWV. His chronic problems include hypertension and dyslipidemia.

He is taking hydrochlorothiazide 25 mg per day and atorvastatin 20 mg at bedtime.

His history and the health risk assessment he completed confirm he has smoked one pack of cigarettes per day for 34 years and quit about 10 years ago. He does not have an advance directive. He rarely drinks alcohol, and his PHQ-2 depression screening score is zero.

His vital signs are stable with good blood pressure control. His BMI is 33.7. He requests a digital rectal exam (DRE) because his father had prostate cancer.

You create the patient's personalized prevention plan and discuss your clinical recommendations with the patient, who agrees to receive several preventive services. You order the labs and imaging, provide counseling focused on several of the patient's health risk behaviors, and recommend a follow-up visit in six months or sooner if needed to address test results.

A 67-year-old male

Initial AWV

His chronic problems include hypertension and dyslipidemia.

He has smoked one pack of cigarettes per day for 34 years and quit about 10 years ago.

He does not have an advance directive.

He rarely drinks alcohol

His PHQ-2 depression screening score is zero.

His BMI is 33.7.

He requests a digital rectal exam (DRE) because his father had prostate cancer.

Poll Question 4

Which of the following preventive care service cannot be separately reported during this visit?

A. Intensive behavioral counseling for cardiovascular disease (CVD)
B. Counseling visit to discuss need for lung cancer screening
C. Advance care planning
D. Alcohol screening
E. Depression screening
F. Counseling for obesity
G. Prostate cancer screening with a DRE

HCPCS CODE	DESCRIPTION	wRVUs
G0438	Initial annual wellness visit	2.43
G0442	Alcohol misuse screening	.18
99497-33	Advance Care planning	1.50
G0446	Intensive behavioral counseling for cardiovascular disease (CVD)	.45
G0447	Face-to-face behavioral counseling for obesity	.45
G0296	Counseling visit to discuss need for lung cancer screening	.52
G0102	DRE for prostate cancer screening	.17

Recommended covered preventive services

- Lipid panel
- Diabetes screening
- Hepatitis C screening
- Lung Cancer screening with Low Dose CT Chest **Potential wRVU: 5.7**
- Pneumococcal vaccine
- PSA
- AAA screening with abdominal ultrasound

A 77-year-old female, who is an established patient of your practice, is seeing you for her first AWV. She has a Medicare Advantage insurance plan. Her previous office visit was about nine months ago. She has diabetes, hypertension, peripheral neuropathy, glaucoma, mild major depression, anxiety, and COPD. She is due for her routine lab work and is requesting refills of all her medications. She would like a flu shot, but the rest of her immunizations are current.

Her list of medications includes metformin 500 mg twice a day, sitagliptin 50 mg daily, lisinopril 10 mg daily, gabapentin 300 mg three times per day, albuterol as needed, tiotropium daily, alprazolam 0.25 mg daily as needed, sertraline 50 mg daily, and dorzolamide ophthalmic twice a day.

She has tried in the past to wean herself off the alprazolam but needs it to control her anxiety; she fills her prescription for 30 pills every three or four months, which you confirm via a controlled substance prescription database. Her history, along with her health risk assessment, shows she drinks up to three to four glasses of wine per day. She does not have an advance directive. Her vital signs are stable with good blood pressure control, and her BMI is 22.4.

You address her concerns and order labs appropriate to her chronic medical conditions, refill her medications, order a flu shot, provide counseling related to her health risk behaviors, and discuss your preventive service recommendations as part of her personalized prevention plan.

Given the complexity of her health status, you ask her to schedule a follow-up appointment in one week to go over her lab results. Also, because the patient is a Medicare Advantage beneficiary, you remember to assess and report risk-adjusted diagnoses and HCC codes.

77-year-old female

Seeing you for her first AWV

She has a Medicare Advantage insurance plan

She has diabetes, hypertension, peripheral neuropathy, glaucoma, mild major depression, anxiety, and COPD. She is due for her routine lab work and is requesting refills of all her medications

She has tried in the past to wean herself off the alprazolam but needs it to control her anxiety; she fills her prescription for 30 pills every three or four months, which you confirm via a controlled substance prescription database

Drinks up to three to four glasses of wine per day

She does not have an advance directive

You remember to assess and report risk-adjusted diagnoses and HCC codes

HCPCS CODE	DESCRIPTION	wRVUs
G0438	Annual Wellness Visit: Initial	2.43
G0442	Alcohol misuse screening	.18
G0443	Face-to-face behavioral counseling for alcohol misuse	.45
99497-33	Advance Care planning	1.50
G0446	Intensive behavioral counseling for CVD	.45
99214-25	Level 4 established patient office visit	1.50

RISK ADJUSTED ICD-10	DESCRIPTION
E11.59	Type 2 DM w/ other circulatory complications
E11.42	Type 2 DM w/ diabetic polyneuropathy
E11.39	Type 2 DM w/ other diabetic ophthalmic complication
F32.0	Mild major depressive disorder
J44.9	COPD
F13.20	Anxiolytic dependence

Recommended covered preventive services
- DEXA scan
- Flu vaccine

Potential wRVU: 6.51

A 57-year-old female, who is an established patient of your practice, recently became disabled. She now has dual insurance coverage with Medicare and Medicaid. She is scheduled for her "Welcome to Medicare" visit. She was seeing a partner of yours who recently retired, and she has transferred to you for care.

Her last visit was four weeks ago, and her diabetes lab work at that time showed that her A1C was 6.7 and her LDL was 94. She had her annual eye exam two months ago. She has diabetes, hypertension, and end-stage renal disease (ESRD).

Her list of medications includes insulin glargine 10 units at bedtime, insulin aspart on a sliding scale, amlodipine 5 mg daily, and pravastatin 10 mg at bedtime.

Her history, along with her health risk assessment, shows that she has multiple sex partners. She does not drink alcohol and does not smoke. Her PHQ-2 depression screening is 0. Her last mammogram was three years ago, and her last Pap smear was six years ago. She has not received her pneumococcal vaccine. She has never had a colonoscopy or fecal occult blood testing. Her vital signs are stable with good blood pressure control and a BMI of 27.1.

She has been feeling sick for the last two weeks with sinus infection symptoms. You treat her for a sinus infection, perform a gynecologic exam and Pap smear, and update her pneumococcal vaccination.

You discuss and then order screens for hepatitis B, hepatitis C, HIV, and sexually transmitted infections (STIs), in addition to a mammogram. You also agree to make referrals for a colonoscopy and medical nutrition therapy for ESRD. Finally, you ask her to follow up in four to six months or as needed.

A 57-year-old female

She is scheduled for her "Welcome to Medicare" visit.

She has diabetes, hypertension, and end-stage renal disease (ESRD).

She has multiple sex partners

She does not drink alcohol

Her PHQ-2 depression screening is 0

You treat her for a sinus infection, perform a gynecologic exam and Pap smear,

Poll Question 5

Which of the following preventive care service cannot be separately reported during this visit?

A. STI prevention counseling
B. Alcohol screening
C. Pelvic and breast exam
D. Pap smear

HCPCS CODE	DESCRIPTION	wRVUs
G0402	"Welcome to Medicare" visit/IPPE	2.43
G0445	High-intensity behavioral counseling to prevent STIs	.45
G0446	Intensive behavioral counseling for CVD	.45
G0101	Pelvic and breast exam	.45
Q0091	Screening Pap smear	.37
99213, modifier 25	Established patient office visit: level 3	.97

Recommended covered preventive services

- Fecal occult blood testing
- Colonoscopy referral
- Hepatitis B screening
- Hepatitis C screening
- HIV screening
- Pneumococcal vaccine
- Medical nutrition therapy referral for ESRD
- STI screening
- Mammogram

Potential wRVU: 5.12

Poll Question 6

What is the maximum number of times per year you can perform and bill for Advance Care Planning?

A. One
B. Two
C. Three
D. Four
E. No limit

HCPCS code	ICD-10	Description	wRVUs	Copay/coinsurance/Deductible
99497	Z71.89	Advance Care planning, first 30 min	1.50	Waived for ACP when furnished with AWV (-33 modifier) **-25 modifier:** **Part B cost sharing applies**
99498	Z71.89	Advance Care planning, additional 30 min	1.40	Waived for ACP when furnished with AWV (-33 modifier) **-25 modifier:** **Part B cost sharing applies**

Effective January 1, 2016, the Centers for Medicare & Medicaid Services (CMS) pays for Advance Care Planning (ACP)

There are **no limits** on the number of times you can report ACP for a given patient in a given time period. When billing the service multiple times for a given patient, **document the change in the patient's health status and/or wishes regarding their end-of-life care.**

Some people may need ACP multiple times in a year if they are quite ill and/or their circumstances change. Others may not need the service at all in a year.

https://www.cms.gov/Outreach-and-Education/Medicare-LeMLNProducts/Downloads/AdvanceCarePlanning.pdf arning-Network-MLN/

Practice Recommendations

- Recognize that the AWV is an opportunity to perform a preventive evaluation for our senior population and to serve as a revenue stream
- Performing AWVs assists in achieving quality metrics and meeting measures
- Use the free, downloadable Preventive Services Checklist and the Lung Cancer Screening Decision-Making Tool
- Don't forget to capture risk adjustment factor scores for patients with Medicare Advantage plans during the AWV

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Questions

FMX

Suggested Readings

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