WHAT YOU NEED TO KNOW ABOUT THE Medicare Preventive Services Expansion

This guidance and our downloadable tools will make the new rules easier to implement.

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Through passage of the Patient Protection and Affordable Care Act (ACA), Congress expanded the preventive care benefits available under Medicare Part B beginning this month. In addition to the existing Welcome to Medicare visit (or Initial Preventive Physical Exam, IPPE) for new Part B beneficiaries, Medicare now covers an annual wellness visit (AWV) for personal prevention plan services.

The Centers for Medicare & Medicaid Services (CMS) hopes that the new benefit will lead to increased utilization of other preventive services covered under Part B. Coverage for individual preventive services has improved as well. The ACA increased the Medicare payment to 100 percent for those preventive services that the United States Preventive Services Task Force (USPSTF) recommends with a grade of A or B for any indication or population, assuming the services are appropriate for the patient. Only four of the longer-established Medicare preventive service benefits do not meet this criterion: digital rectal examination furnished as a prostate cancer screening service; glaucoma screening; diabetes self-management training services; and barium enema furnished as a colorectal cancer screening service. Note that some preventive services such as the prostate specific antigen test have traditionally been covered at 100 percent because they are paid under the laboratory fee schedule.

A table that lists all 2011 Medicare preventive services benefits is available online in the *FPM* digital edition at http://www.nxtbook.com/nxtbooks/aafp/

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fpm_20110102/#/28 or on the *FPM* web site at http://www.aafp.org/fpm/2011/0100/p22.html.

Providing the annual wellness visit

Required elements for first and subsequent AWVs are listed in the boxes below and on page 25 and are incorporated in an encounter form (available online in the *FPM* digital edition at http://www.nxtbook.com/nxtbooks/aafp/fpm_20110102/#/30 or on the *FPM* web site at http://www.aafp.org/fpm/2011/0100/p22.html). The AWV may be provided by one or more of the following health professionals:

- A physician who is a doctor of medicine or osteopathy,
- A physician assistant, nurse practitioner or clinical nurse specialist,
- A health professional (including a health educator, registered dietitian, nutrition professional or other licensed practitioner, or a team of such health professionals) working under the direct supervision of a physician (i.e., in the office suite where the physician is available if needed). ➤

ELEMENTS OF THE INITIAL ANNUAL WELLNESS VISIT

Establishment of the patient's medical and family history:

- Past medical and surgical history, including illnesses, hospital stays, operations, allergies, injuries and treatments.
- Use or exposure to medications and supplements, including calcium and vitamins.
- Medical events experienced by the beneficiary's parents and any siblings and children, including diseases that may be hereditary or place the individual at increased risk.

Establishment of a list of current providers and suppliers who are regularly involved in providing medical care to the individual.

Measurement of the individual's height, weight, body mass index (or waist circumference, if appropriate), blood pressure and 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 by direct observation, with due consideration of information obtained by way of patient report or concerns raised by family members, friends, caretakers or others.

Review of the individual's 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 screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations.

Review of the individual's functional ability and level of safety, based on direct observation or the use of appropriate screening questions or a screening questionnaire, which the health professional may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations. This includes at minimum review or screening for hearing impairment, ability to perform activities of daily living, fall risk and home safety.

Establishment of the following:

- A written screening schedule, such as a checklist, for the next 5 to 10 years as appropriate, based on recommendations of the USPSTF and the Advisory Committee on Immunization Practices, and the individual's health status, screening history and age-appropriate preventive services covered by Medicare.
- A list of risk factors and conditions for which primary, secondary or tertiary interventions are recommended or are underway, including any mental health conditions or any such risk factors or conditions that have been identified through an initial preventive physical examination (IPPE), and a list of treatment options and their associated risks and benefits.

Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self management, or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention and nutrition.

"Voluntary advance care planning," which means verbal or written information regarding the following areas:

- An individual's ability to prepare an advance directive in the case where an injury or illness causes the individual to be unable to make health care decisions.
- Whether or not the physician is willing to follow the individual's wishes as expressed in an advance directive.

Article Web Address: http://www.aafp.org/fpm/2011/0100/p22.html

CMS DOES NOT PROHIBIT BILLING FOR THE TREATMENT OF ACUTE AND CHRONIC CONDITIONS AT THE SAME TIME AS A PREVENTIVE SERVICE.

The supervising physician would bill Medicare Part B for the visit when the service is provided by a licensed health professional or team of health professionals. This service is not subject to the "incident to" provisions that apply to other physician services, but direct physician supervision is required.

Health care reform legislation expanded Medicare benefits for preventive services.

An annual wellness visit is now covered.

Individual services recommended by the USPSTF with a grade of A or B are no longer subject to deductible and coinsurance.

Coding and billing

CMS determined initial values for the first AWV by cross-walking the service with a 99204 new patient office visit and for the subsequent AWV by cross-walking the service with a 99214 established patient office visit. For 2010, the national average Part B allowable for 99204 was $155.23. For 99214, it was $99.93. The 2011 fees for the first and subsequent annual wellness visits were not yet available at press time, but they will be comparable.

The following codes should be used for reporting AWVs:

- G0438 (Annual wellness visit; includes a personalized prevention plan of service (PPPS), first visit),
- G0439 (Annual wellness visit; includes a PPPS, subsequent visit).

The code for the IPPE is still G0402 (Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment). If you provide an ECG with the IPPE, report code G0403 for the full service, G0404 for tracing only without interpretation and report, or G0405 for interpretation and report only.

Physicians furnishing a preventive medicine evaluation and management (E/M) service that does not meet the requirements for the IPPE or the AWV should continue to report one of the preventive medicine E/M codes in the range of 99381 through 99397 as appropriate. These codes are still not covered by Medicare.

Another change, which may help promote utilization of the colorectal cancer screening benefit, is waiver of the Part B deductible when a diagnostic colonoscopy results from a flexible sigmoidoscopy, screening colonoscopy or barium enema. When the screening test becomes a diagnostic service, a new HCPCS modifier, "PT - Colorectal cancer screening test, converted to diagnostic test or other procedure," should be added to the diagnostic procedure code that is reported instead of the HCPCS code for screening colonoscopy, screening flexible sigmoidoscopy or barium enema.

Same-day problem-oriented services

CMS does not prohibit billing for the treatment of acute and chronic conditions at the same time as a preventive service, but it would

ELIGIBILITY FOR WELLNESS VISITS

Benefit	Part B coverage history	Frequency limitation
Initial Preventive Physical Exam (IPPE)	Coverage began <12 months prior to date of service	Cannot have had a previous IPPE
Initial Annual Wellness Visit (AWV)	Coverage began >12 months prior to date of service	12 months have passed since patient had IPPE or patient has had no IPPE
Subsequent AWV	Coverage began >12 months prior to date of service	12 months have passed since patient had last AWV

prefer the preventive service to be separately provided when the patient is stable and physically receptive. If the services are reported on the same day, a CPT code for a medically necessary E/M visit may be used along with modifier 25 to designate the E/M visit as a separately identifiable service from the initial or subsequent wellness visit.

Providing both a preventive service and a problem-oriented service at the same encounter could require scheduling more than the 40 minutes intended for the initial AWV or 25 minutes for the subsequent AWV. Patient education about the time needed for a wellness visit and the practical need for addressing non-urgent conditions at a separate encounter may be necessary.

Scheduling and verifying eligibility

Your staff will need to watch for three things when scheduling Medicare patients for wellness visits:

- Does the patient have a specific, problem-oriented health concern that may affect scheduling?
- On what date did the patient's Part B coverage begin?
- Has the patient received either an IPPE or AWV in the past 12 months?

If your practice transmits and receives electronic eligibility transactions (270/271) from Medicare, your staff can verify eligibility from the 271 Eligibility Response Transaction report. This will include the last dates and next eligible dates for preventive services.

The table on page 24 lists the two elements that determine a Medicare patient's eligibility for the AWV and IPPE.

About the Author

Cindy Hughes is the AAFP's coding and compliance specialist and is a contributing editor to *Family Practice Management*. Author disclosure: nothing to disclose.

ELEMENTS OF SUBSEQUENT ANNUAL WELLNESS VISITS

An update of the individual's medical and family history.

An update of the list of current providers and suppliers who are regularly involved in providing medical care to the individual, as that list was developed for the first AWV providing personalized prevention plan services.

Measurement of an individual's weight (or waist circumference), blood pressure and 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.

An update to both of the following:

- The written screening schedule for the individual that was developed at the first AWV providing personalized prevention plan services.
- The list of risk factors and conditions for which primary, secondary or tertiary interventions are recommended or are underway for the individual – the list that was developed at the first AWV providing personalized prevention plan services.

Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs.

"Voluntary advance care planning," which means verbal or written information regarding the following areas:

- An individual's ability to prepare an advance directive in the case where an injury or illness causes the individual to be unable to make health care decisions.
- Whether or not the physician is willing to follow the individual's wishes as expressed in an advance directive.

New challenges, new opportunities

Changes to Medicare's coverage of preventive services will present some challenges, including managing increased demand for appointments. However, the coverage expansion provides a great opportunity to increase the amount of preventive care your patients receive. These wellness visits should also create time for you to talk with your patients about prevention and for your patients to become comfortable talking about their health risks and those problems patients don't bring up because they are too embarrassing or "just part of getting old." Make the most of it. FPM

Send comments to **fpmedit@aafp.org.**