

# How to Document and Code Medicare Preventive Services

Think of this as your field guide to the rules surrounding Medicare preventive services.

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Preventive services are a great opportunity to provide high-quality patient care and increase practice revenue. However, like most services provided to Medicare beneficiaries, many preventive services have specific elements that must be captured in the documentation, and not all services are reimbursable when separately reported on the same date.

Previous articles in *Family Practice Management* have offered tips and tools for providing and documenting the initial preventive physical examination (IPPE, or “Welcome to Medicare” physical) and annual wellness visits (AWVs). (See the *FPM* topic collection at <http://bit.ly/1Uy2nqT>.) This article will focus on Medicare preventive services that may be provided in conjunction with an IPPE or AWV or as stand-alone services by family physicians.

## The IPPE, AWVs, and separately reportable preventive services

Any discussion of Medicare preventive services should start with the basic requirements for the IPPE, the initial AWV, and the subsequent AWV. (See “Elements of the IPPE and AWV,” page 10.) A review of what’s included in each of these Medicare preventive visits can make it easier to identify services that can be separately reported. Here are two examples:

- Advance care planning (CPT codes 99497-99498) is an element of the IPPE and not separately reportable; however, it *is* separately reportable with an AWV if you add modifier 33 to the advance care planning code. (See more information on modifier 33 in *FPM*’s “Coding & Documentation” department, page 38.)
- An electrocardiogram (G0403-G0405) may be separately reported in conjunction with the IPPE, but it is not covered as a preventive service with the AWV.

The table “Preventive services covered by Medicare in 2016,” page 13, shows which services are and are not separately reportable. It is based on published Medicare policy or National Correct Coding Initiative edits; however, practices should verify coverage with their region’s Medicare Administrative Contractor (MAC), as interpretations of separately reportable services may vary. ▶

### About the Author

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	IPPE - G0402	Initial AWW - G0438	Subsequent AWW - G0439
<b>Information gathering</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review the medical and social history with attention to modifiable risk factors:                             <ul style="list-style-type: none"> <li>• Past medical/surgical history,</li> <li>• Current medications and supplements,</li> <li>• Family history,</li> <li>• History of alcohol, tobacco, and illicit drug use,</li> <li>• Diet,</li> <li>• Physical activity.</li> </ul> </li> <li><input type="checkbox"/> Review potential risk factors for depression or other mood disorders</li> <li><input type="checkbox"/> Review functional ability and level of safety:                             <ul style="list-style-type: none"> <li>• Hearing impairment,</li> <li>• Activities of daily living,</li> <li>• Fall risk,</li> <li>• Home safety.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Establish the medical/family history:                             <ul style="list-style-type: none"> <li>• Past medical/surgical history,</li> <li>• Current medications and supplements,</li> <li>• Family history.</li> </ul> </li> <li><input type="checkbox"/> Review the patient's health risk assessment, which includes:                             <ul style="list-style-type: none"> <li>• Demographic data,</li> <li>• Self-assessment of health status,</li> <li>• Psychosocial risks,</li> <li>• Behavioral risks,</li> <li>• Activities of daily living (dressing, bathing, walking, etc.),</li> <li>• Instrumental activities of daily living (shopping, housekeeping, etc.).</li> </ul> </li> <li><input type="checkbox"/> Review potential risk factors for depression.</li> <li><input type="checkbox"/> Review functional ability and level of safety:                             <ul style="list-style-type: none"> <li>• Hearing impairment,</li> <li>• Activities of daily living,</li> <li>• Fall risk,</li> <li>• Home safety.</li> </ul> </li> <li><input type="checkbox"/> Establish a list of current providers and suppliers regularly involved in the individual's medical care.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Update the medical/family history:                             <ul style="list-style-type: none"> <li>• Past medical/surgical history,</li> <li>• Current medications and supplements,</li> <li>• Family history.</li> </ul> </li> <li><input type="checkbox"/> Review the updated health risk assessment, which includes:                             <ul style="list-style-type: none"> <li>• Demographic data,</li> <li>• Self-assessment of health status,</li> <li>• Psychosocial risks,</li> <li>• Behavioral risks,</li> <li>• Activities of daily living (dressing, bathing, walking, etc.),</li> <li>• Instrumental activities of daily living (shopping, housekeeping, etc.).</li> </ul> </li> <li><input type="checkbox"/> Update the list of current providers and suppliers regularly involved in the individual's medical care.</li> </ul>
<b>Exam/assessment</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Obtain the following:                             <ul style="list-style-type: none"> <li>• Height,</li> <li>• Weight,</li> <li>• Body mass index,</li> <li>• Blood pressure (BP),</li> <li>• Visual acuity,</li> <li>• Other items as appropriate.</li> </ul> </li> <li><input type="checkbox"/> Conduct end-of-life planning if the individual agrees.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Obtain the following:                             <ul style="list-style-type: none"> <li>• Height,</li> <li>• Weight,</li> <li>• BMI (or waist circumference),</li> <li>• BP,</li> <li>• Other items as appropriate.</li> </ul> </li> <li><input type="checkbox"/> Detect any cognitive impairment.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Obtain the following:                             <ul style="list-style-type: none"> <li>• Weight (or waist circumference),</li> <li>• BP,</li> <li>• Other items as appropriate.</li> </ul> </li> <li><input type="checkbox"/> Detect any cognitive impairment.</li> </ul>
<b>Counseling</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Educate, counsel, and refer based on the previous five elements.</li> <li><input type="checkbox"/> Educate, counsel, and refer for other preventive services. Create a brief written plan (e.g., a checklist) that includes:                             <ul style="list-style-type: none"> <li>• A once-in-a-lifetime screening electrocardiogram (G0403-G0405), as appropriate,</li> <li>• Other appropriate screenings and preventive services that Medicare covers.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Establish a written screening schedule, such as a checklist for the next 5 to 10 years, as appropriate.</li> <li><input type="checkbox"/> Establish a list of risk factors and conditions for which interventions are recommended or underway.</li> <li><input type="checkbox"/> Furnish personalized health advice and a referral as appropriate to health education or preventive counseling services or programs.</li> <li><input type="checkbox"/> Provide any other element determined appropriate through the National Coverage Determination process.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Update the written screening schedule developed at the initial AWW.</li> <li><input type="checkbox"/> Update the list of risk factors and conditions for which interventions are recommended or underway.</li> <li><input type="checkbox"/> Furnish personalized health advice and a referral as appropriate to health education or preventive counseling services or programs.</li> <li><input type="checkbox"/> Provide any other element determined appropriate through the National Coverage Determination process.</li> </ul>

Here are a few examples with which you might not be familiar:

- High-intensity behavioral counseling to prevent sexually-transmitted infections (G0445) may be paid on the same date of service as an AWW but not an IPPE.
- Alcohol screening/counseling services (G0442-G0443) may be paid on the same date of service as another visit as long as the visit is not an IPPE.
- Prostate cancer screening by digital rectal examination (G0102) is not separately reportable with either an IPPE or AWW.



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- Pelvic examination (with or without specimen collection for smears and cultures) including external genitalia, urethral meatus, urethra, bladder, vagina, cervix, uterus, adnexa/parametria, or anus and perineum (9 elements).

Also, consider informing eligible patients about Medicare coverage of chronic care management (CCM) services and obtaining and documenting their written agreement to receive these services, which can be initiated after an evaluation and management (E/M) service such as the IPPE or AWW. (For more on CCM services, see *FPM*'s articles series at <http://bit.ly/1O69FkV>.)

### Documentation tips

The following tips address some commonly overlooked areas when documenting Medicare preventive services.

First, when providing an IPPE or AWW, be sure to document that you have performed all of the required elements of these services. When providing separately reportable services, remember that your documentation of the services must be separately identifiable in the medical record. For example, elements of the AWW cannot also be used to meet the requirements of another separate service. Each person making entries in the medical record should sign and date each entry. If your practice uses separate templates or notes for services provided on the same date, link the documentation so that medical records staff or reviewers are aware of the separate documentation for each service.

When you perform a screening electrocardiogram (ECG) in conjunction with an IPPE, as with a diagnostic ECG, the interpretation and report should be separately identifiable in the medical record and should detail findings, comparative data, and relevant clinical data. This may include axis, rhythm, rate, PR intervals, ST wave changes, and, when applicable, comparison to a prior ECG.

When providing services such as pathology, laboratory, and radiology, note that Medicare requires a physician order. Any services ordered should be specifically documented as part of the preventive service encounter. When a patient is eligible for services because of high risk (e.g., screening for hepatitis-C virus), your documentation should support this (e.g., history of illicit injection drug use). Medicare contractors may request the ordering physician's records to substantiate the services reported by the performing provider.

Finally, for cervical or vaginal cancer screening, pelvic and clinical breast examination (G0101), remember to include at least seven of the following 11 elements:

- Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge (1 element),
- Digital rectal examination including sphincter tone, presence of hemorrhoids, and rectal masses (1 element),

### Documenting time

In general, if the service descriptor in CPT includes a time (e.g., alcohol misuse screening and counseling, 15 minutes), Medicare requires that the time must be met or exceeded to report the service. You must document either start and stop times or total time spent providing the individual timed service. However, there are some exceptions. Medicare coverage determinations override the requirement to meet or exceed the time in the code descriptor for the following time-based services:

- For G0444, "annual depression screening, 15 minutes," the Centers for Medicare & Medicaid Services (CMS) will cover annual screening *up to 15 minutes* for Medicare beneficiaries when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.

- For G0445, "high intensity behavioral counseling to prevent sexually transmitted infection, face-to-face, individual, includes education, skills training, and guidance on how to change sexual behavior, performed semiannually, 30 minutes," CMS will cover up to two individual *20- to 30-minute* sessions annually for Medicare beneficiaries.

Another exception is 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 professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate." In this case, the CPT midpoint rule applies, which states that "a unit of time is attained when the midpoint is passed." Therefore, advance care planning can be reported after 16 minutes of service. Of course, double check with your payers, as they may have a different policy.

### Counseling and intensive behavioral therapy (IBT) services

Coverage requirements for certain counseling and therapy services provided in family medicine settings can be a

source of confusion, so here are some important points to keep in mind.

**Advance care planning (99497-99498).** This is considered a covered preventive medicine service (i.e., the patient has no out-of-pocket cost) when provided in conjunction with an AWV and reported with preventive service modifier 33. However, with the IPPE, this service is integral and not separately reported. If the patient receiving the IPPE does not want to discuss advance care planning, simply document that end-of-life planning was offered but refused.

**Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes (G0443).**

Before you provide behavioral *counseling* for alcohol misuse, the patient must have received an annual alcohol misuse *screening*, 15 minutes (G0442) in the same 12-month period. The screening includes obtaining agreement for behavioral counseling. The first session of behavioral counseling may be provided on the same date as the screening, but the time must be met or exceeded and documented for each service. Medicare covers four counseling sessions within a 12-month period.

**Annual face-to-face IBT for cardiovascular disease (CVD), individual, 15 minutes (G0446).** IBT for CVD must include encouraging aspirin use for the primary prevention of CVD when the benefits outweigh the risks for men age 45 to 79 years and women age 55 to 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. Counseling is covered once every two years.

**Face-to-face behavioral counseling for obesity, 15 minutes (G0447), and face-to-face behavioral counseling for obesity, group (2-10), 30 minutes (G0473).** IBT for obesity includes screening for obesity in adults using body mass index measurement, dietary assessment, and intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on diet and exercise. Medicare covers up to 22 visits in a 12-month period for those who see adequate weight loss in the first six months of therapy. You must document a six-month reassessment of obesity and weight loss of at least 3 kg to substantiate additional face-to-face visits once per month for six months.

**High-intensity behavioral counseling to prevent sexually transmitted infections (G0445).** This is defined as a program to promote sexual risk reduction or risk avoidance, which includes three broad topics: education, skills training, and guidance on how to change sexual behavior.

**Counseling to discuss lung cancer screening by low**



*Advance care planning.*

**dose computed tomography (CT) scan (G0296).**

Physicians and their staff must do the following :

- Determine beneficiary eligibility including age 55 to 77, no signs or symptoms of lung cancer, cigarette smoking of at least 30 pack-years, and, for former smokers, the number of years since quitting,

- Determine whether the patient will benefit from the screening by using shared decision making, including a discussion of benefits and harms of screening, follow-up diagnostic testing, over-diagnosis, false positive rate, and total radiation exposure,

- Counsel the patient on the importance of adhering to annual lung cancer low dose CT screening, the impact of comorbidities, and his or her ability or willingness to undergo diagnosis and treatment,

- Counsel the patient on the importance of abstaining from cigarette smoking and, if appropriate, provide information about tobacco-cessation interventions,

- If appropriate, furnish a written order for lung cancer screening with low dose CT. Written orders for lung cancer low dose CT screenings must be appropriately documented in the medical record and must contain the following information: beneficiary date of birth, actual pack-year smoking history (number), current smoking status, the number of years since quitting smoking (for former smokers), a statement that the beneficiary is asymptomatic (no signs or symptoms of lung cancer), and the ordering physician's National Provider Identifier (NPI).

The counseling and shared decision making may be repeated prior to subsequent lung cancer screening by low dose CT but must again include all of the above elements.

**Putting preventive services into practice**

The eligibility, frequency limitations, documentation, and bundling of preventive services may appear overwhelming. However, the IPPE and AWV are ideal visits at which to inventory which preventive services will benefit the individual patient and to create a plan for providing them. Although the MAC for your region may not allow separate reporting of behavioral counseling services on the same date as the IPPE or AWV, the preventive visit is an ideal time to explain these benefits to your patient and obtain the patient's agreement to schedule future services. **FPM**

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