ANSWERS TO YOUR QUESTIONS ABOUT

Medicare Annual Wellness Visits

Our previous issue described the requirements and introduced an encounter form for documenting these visits. Now we answer your questions about this newest Medicare benefit.

The expansion of Medicare preventive services coverage that took effect on Jan. 1 of this year provides a valuable opportunity for you and your patients to focus on preventive screening and wellness, particularly in the context of an annual wellness visit (AWV), the newest Medicare benefit. However, providing and billing for such visits is, of course, complicated. Our January/February issue cover story (http://www.aafp.org/fpm/2011/0100/p22.html) provided an overview of Medicare preventive services and two tools to help you deliver, document and bill for them, but a single article could not cover all the details associated with these benefits. You responded with a number of good questions, the answers to which are given below.

What ICD-9 codes should be used with the HCPCS codes for annual wellness visits (G0438 and G0439)?

The Centers for Medicare & Medicaid Services (CMS) did not specify the ICD-9 codes that should be used. Individual Part-B contractors may designate specific codes, but typically ICD-9 codes in the V70 range have been accepted.

Do I understand correctly that, other than measuring vital signs, no physical exam is required?

The following vitals – height, weight, BMI or waist circumference, blood pressure and other measurements as appropriate – are the minimum requirements. Physicians must determine the level of physical examination necessary to create a personalized prevention plan based on the patient's risk factors and health goals and to encourage patient utilization of other preventive services, as this is the purpose of the AWV. Remember that you may provide other covered Medicare preventive services at the same encounter if indicated and your schedule permits, although you should check with the Medicare administrative contractor in your region to confirm that you will be paid for the additional service, as described in the next question.

If I perform the clinical breast and pelvic exam (G0101) at the same encounter as the AWV, will Medicare pay for the breast and pelvic exam in addition to the AWV?

CMS has yet to address this issue. It would be best to direct this question to your Medicare administrative contractor. For example, WPS, the contractor for Kansas, Missouri, Nebraska and Iowa, says, "Medicare can allow both services. However, you must carve out of your pricing for the AWV any services that may be duplicated in the screening breast or pelvic exam." ➤

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In other words, because WPS considers the breast and pelvic exam to overlap with the exam portion of the AWV, physicians must subtract the amount charged for the breast and pelvic exam from their usual charge for the AWV. The Pap smear collection and handling (Q0091) could probably be charged without a reduction of the AWV fee.

Does documenting that a patient was "alert and oriented x 3" (to person, place and time) cover the requirement to "review and document the detection of any cognitive impairment that the individual may have"?

Physicians have many questions about the complex rules for Medicare annual wellness visits (AWVs).

No. CMS defines the assessment as follows: "Detection of any cognitive impairment, for purposes of this section, means assessment of an individual's cognitive function by direct observation, with due consideration of information obtained by way of patient report, concerns raised by family members, friends, caretakers, or others."

Therefore, your documentation should include an assessment gained from observation, patient interview and input from caregivers present at the encounter. CMS does not require that physicians use a specific assessment tool, but the documentation should include evidence of assessment, such as notations of the patient's general appearance, affect, speech, memory and motor skills.

ICD-9 codes in the V70 range may be paired with the new G codes for annual wellness visits, unless individual Medicare contractors provide more specific instructions.

Does the initial annual wellness visit (HCPCS code G0438) apply only to patients who are new to my practice?

CMS has not indicated whether a breast and pelvic exam (G0101) are payable when provided with an AWV, so check with your Medicare contractor.

No. The AWV codes do not distinguish between new and established patients. Rather, the initial AWV is billed the first time a Medicare beneficiary receives an AWV that includes all of the elements required by CMS. The subsequent AWV code is reported for patients who have previously received an AWV service, whether at your practice or elsewhere.

It will be difficult to be certain whether one year has elapsed since the Welcome to Medicare visit or initial AWV if the patient is new to my practice. Is it necessary to provide patients with an Advance Beneficiary Notice (ABN) so that we can bill them should they receive the subsequent service prior to their eligibility?

No ABN is required, but it is a good idea to verify the patient's preventive services eligibility and provide those who request the service prior to eligibility with an ABN confirming their agreement to pay. Based on CMS instructions to Medicare contractors, claims for an AWV provided before 11 full months have passed since the last AWV will be denied with a "PR" code, indicating patient responsibility. Note that knowledge of the patient's past preventive services, such as last colonoscopy or the one-time benefit for the pneumococcal vaccination, will facilitate development of the preventive care plan at the annual wellness visits. If your practice is not using the 270/271 electronic eligibility transactions or another Medicare eligibility inquiry program, you may wish to consider options for incorporating this into your scheduling or pre-visit preparation processes.

Where can we learn about conducting electronic eligibility inquiries to determine our patient's eligibility for Medicare preventive services?

You may contact your Medicare administrative contractor, your practice management software vendor or your claims clearinghouse for specific information on options available to you. These will likely include the 270/271 electronic inquiries that are conducted like electronic claims submissions, with the 270 sending your inquiries and the 271 returning the report to you. Another option may be to use the online provider-service portal offered by the Medicare administrative contractor; this may be less expensive and meet your needs if you don't

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expect to make daily inquiries. However, the 270/271 transactions likely allow for batch inquiries that could save time and effort when inquiries for multiple patients are necessary. These resources can also help determine which patients have Medicare Advantage coverage or have Medicare as a secondary payer.

What is the definition of a "health professional" or "health educator," both of which may provide AWVs if working under the supervision of a physician, according to the regulations? Do these individuals need to have received formal education leading to a specific degree, or can they be trained?

Neither the legislation that expanded the preventive services benefits (the Affordable Care Act) nor the regulations that CMS created and implemented provide an answer to this question. Given that, the criteria may boil down to whether the person is licensed in the state, working within the scope of practice allowed by the state and, as you said, under the direct supervision of a physician. The concept of team care should enable physicians to include the licensed professionals who are best suited to provide a portion of the AWV service, based on individual patients' needs. Remember that "direct supervision" requires the physician to be in the office suite and readily available to offer assistance and direction as needed. The AWV should be billed by the supervising physician.

Note that the regulations allow physician assistants, nurse practitioners and clinical nurse specialists to provide the AWV. Physician supervision of these health care providers should align with state requirements. For instance, where direct supervision of nurse practitioners is not required, the nurse practitioner may provide and bill for the AWV under his or her NPI number.

Can I still provide a preventive service as described by CPT codes 99387 and 99397 to Medicare patients who wish to have a routine physical that doesn't include all the elements of an AWV?

Yes. The CPT preventive service codes could be submitted when the elements required for an AWV are not provided but the service meets CPT's definition of an age- and gender-appropriate preventive medicine service. These services are still not covered by Medicare Part B and as such are an out-of-pocket expense to the patient. If you provide a Medicare-covered service (such as a breast or pelvic exam) on the same date, you must subtract the Medicare payment for the covered service from your usual charge for the preventive service before billing the patient.

If a patient requests a head-to-toe physical and the AWV, may I bill for both?

CMS stated in the final rule for the 2011 Medicare Physician Fee Schedule that both services may be billed but also noted that "it would be difficult to distinguish an AWV from another preventive medicine E/M service furnished in the same encounter that would be reported under a preventive medicine services E/M CPT code as there is substantial overlap in the components of CPT codes 99381 through 99397 and HCPCS codes G0438 and G0439 reported for the AWV." If you choose to provide and bill for both services on the same date, you should take into account the overlap of elements such as history and counseling when determining what to charge the patient for the non-covered preventive service (99381-99397).

How does payment for the AWV compare to payment for a preventive service described by CPT codes 99387 or 99397?

Since there is no Medicare coverage for the preventive services visits described by CPT, these codes are not priced in the Medicare Physician Fee Schedule. However, CMS does assign relative value units (RVUs) to them. The RVUs for the initial annual wellness visit are higher than the RVUs for either of the preventive services visits, and the RVUs for the subsequent annual wellness visit are lower than these. Here are the total RVUs assigned to each of the relevant services: G0438 – 4.74, G0439 – 3.16, 99387 – 4.16, and 99397 – 3.48. In general, the higher the RVUs, the higher the payment.

We hope these answers will make it a bit easier to provide your patients with the preventive services they need. FPM

Send additional questions or comments to **fpmedit@aafp.org.**

If eligibility is uncertain and cannot be determined prior to the visit, ask the patient to sign an Advance Beneficiary Notice so that you may bill the patient directly if necessary.

Routine physicals may still be provided and billed with CPT codes 99387 or 99397, although they are still not covered by Medicare.

You may bill for an AWV and routine physical provided at the same encounter, but you should consider the degree of overlap when deciding how much to charge the patient for the noncovered routine physical.