TIPS FROM OUR CONSULTANT

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CONFUSED ABOUT MEDICARE PREVENTATIVE VISITS? SO ARE YOUR PATIENTS!

Congress legislated coverage for two preventive visits for Medicare beneficiaries:

- Initial Preventive Physical Examination (IPPE), also referred to as the Welcome to Medicare Visit
- Annual Wellness Visit (AWV)
  - Initial
  - Subsequent

Even though these services have been covered for several years, physicians continue to have questions about who is eligible for a Medicare covered visit, what services are included in the visit, who can perform the visit, etc. Given all the questions surrounding these visits, we were asked to provide information about each visit

Medicare Part B Eligibility

While Medicare Part A is typically premium-free to anyone eligible for social security or railroad retirement benefits, or would be eligible for such benefits if the worker's quarters of coverage (QC) from government employment were regular social security QCs, Medicare Part B is voluntary and a beneficiary may refuse enrollment because the beneficiary is required to pay a premium for the coverage.

Depending on the beneficiary's circumstances, e.g., continues active employment and is covered under the employer's group health insurance, a beneficiary may choose to delay enrollment in Medicare.

The effective dates for Parts A and B are noted on the beneficiary's Medicare card. This information is also included on CMS Secure Net Access Portal (C-SNAP), the Wisconsin Physician Services (WPS) eligibility, patient information, and claims data.

Coverage for the IPPE and AWV

All new Medicare beneficiaries who are within the first 12 months of their first Medicare Part B coverage period may receive an IPPE. Thus, if a beneficiary's effective entitlement date is September 1, 2013 enrolled in Medicare in October 2013, the Welcome Visit must be performed no later than August 31, 2014. This is a one-time benefit.

Medicare covers an AWV for beneficiaries who:

- are not in the first 12 months of their first Part B coverage period and
- have not received an IPPE or AWV within the past 12 months

At least 11 months have passed following the month in which the IPPE or the last AWV was performed and billed to Medicare.

Medicare pays for only one initial AWV per beneficiary per lifetime, and pays for one subsequent AWV per year thereafter.

Members can access C-SNAP to confirm the date when the patient is eligible for their next AWV.

The IPPE is meant to be an introduction to Medicare and covered benefits. The intent of both visits is to help Medicare beneficiaries stay well. Physicians should focus on health promotion and disease prevention and detection.

Deductible and Coinsurance/Copayment

Medicare waives both the coinsurance/copayment and the Medicare Part B deductible for the IPPE and AWV. Thus, there is no out-of-pocket expense for these services.

Who May Perform the Preventive Visit?

IPPE

Either a physician (a doctor of medicine or osteopathy) or a qualified non-physician practitioner (a physician assistant, nurse practitioner, or certified clinical nurse specialist) must furnish the IPPE.

The provider performing the IPPE must be shown as the billing provider on the claim (Item 24j or its electronic equivalent). Services performed by a qualified non-physician practitioner cannot be billed by the supervising/collaborative physician because Medicare's "Incident To" rules do not apply.

AWV

Health professional can perform the IPPE. For purposes of the AWV, this term includes:

- a physician (a doctor of medicine or osteopathy),
- a qualified non-physician practitioner (a physician assistant, nurse practitioner, or certified clinical nurse specialist), or
- a medical professional (including a health educator, registered dietitian, nutrition professional, or other licensed practitioner), or a team of such medical professionals who are working under the direct supervision of a physician, must furnish the AWV. (Physician must be physically present in the office, but is not required to have a face-to-face encounter unless the physician is practicing in a Rural Health Clinic.)

Coding Requirements

CMS does not require a specific diagnosis code for the IPPE or the AWV. You may choose any appropriate diagnosis code, e.g., V70.0 routine general medical examination at a health care facility.

The IPPE is reported using *HCPCS* code:

- G0402 Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment
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The AWV is reporting using one of the following *HCPCS* codes:

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

Coverage of the Initial vs. Subsequent Annual Wellness Visit is based on whether the patient has previously received a Medicare covered AWV. It is NOT based on whether the patient has previously received a covered AWV from the individual physician or by the same group practice.

Components for IPPE and AWV

While similar, there are some differences in the required components for the IPPE, Initial AWV, and Subsequent AWV. We believe using a consistent template combining the components for each of these services into one document will make it much easier to perform and document the required services. We have underlined the requirements specific to the AWV in the event you choose to have more than one template.

AWV requires a Health Risk Assessment (HRA) that at a minimum must include the following elements (updated at each AWV):

- Collects self-reported information the beneficiary knows;
- You or the beneficiary can administer the health risk assessment before, or as part of, the AWV encounter;
- Takes into account the communication needs of underserved populations, persons with limited English proficiency, and persons with health literacy needs, and is appropriately tailored to their needs;
- Takes no more than 20 minutes to complete; and
- At a minimum, addresses the following topics:
  - Demographic data;
  - Self-assessment of health status;
  - Psychosocial risks;
  - Behavioral risks;
  - Activities of Daily Living (ADLs) including but not limited to: dressing, bathing, and walking; and
  - Instrumental ADLs including but not limited to: shopping, housekeeping, and handling finances.

For more information about HRAs, CMS instructs providers to refer to the CDC website http://www.cdc.gov/policy/ohsc/HRA/FrameworkForHRA.pdf

The AAFP has an excellent Health Risk Assessment posted on the AAFP website at http://www.aafp.org/fpm/2012/0300/fpm20120300p11-rt1.pdf

1. Review of the beneficiary's medical and social history
   a. At a minimum, collect the following:
      - Past medical/surgical history (experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments) – (Updated at each AWV);
      - Current medications and supplements (including calcium and vitamins) – (Updated at each AWV);
      - Family history (review of medical events in the beneficiary's family, including diseases that may be hereditary or place the beneficiary at risk) – Medical events in the beneficiary's parents and any siblings and children, including diseases that may be hereditary or place the beneficiary at increased risks – (Updated at each AWV)
      - History of alcohol, tobacco, and illicit drug use;
      - Diet; and
      - Physical activities.

2. Review of the beneficiary's potential risk factors for depression and other mood disorders
   a. Use any appropriate screening instrument for beneficiaries without a current diagnosis of depression recognized by national professional medical organizations to obtain current or past experiences with depression or other mood disorders.

3. Review of the beneficiary's functional ability and level of safety

a. Use any appropriate screening questions or standardized questionnaires recognized by national professional medical organizations to review, at a minimum, the following areas:
   - Hearing impairment;
   - Activities of daily living;
   - Falls risk; and
   - Home safety.

b. AWV - Use direct observation of the beneficiary or any appropriate screening questions or a screening questionnaire

4. Physical examination
   a. Although the title of the IPPE includes "physical examination," only the following examination is required for an IPPE
   - height, weight, and blood pressure
   - visual acuity screen
   - measurement of body mass index (or waist circumference, if appropriate)
   - other factors (routine measurements) deemed appropriate based on the beneficiary's medical and social history and current clinical standards

   b. Detection of any cognitive impairment that the beneficiary may have
   - Assess the beneficiary's cognitive function by direct observation, with due consideration of information obtained by way of patient reports and concerns raised by family members, friends, caretakers, or others.

Even in 2014, Medicare does not cover "routine physical examinations." When an age appropriate comprehensive preventive physical examination is performed in addition to the IPPE/AWV, it may be separately reported using the appropriate *CPT* from the Preventive Medicine Section, e.g., 99385-99387 or 99395-99397.

The fee for this examination should reflect the additional preventive work not included in the IPPE/AWV. The beneficiary is financially responsible for the charges related to the additional examination.

WPS provides the following clarification:

In choosing the pricing for the yearly physical exam, you must remove any elements that are included in the IPPE/AWV. The provider would submit the IPPE/AWV in full with reduced pricing on the yearly physical exam. This would reduce the patient's liability.

5. End-of-life planning, upon agreement of the beneficiary
   a. End-of-life planning is verbal or written information provided to the beneficiary about:
      - The beneficiary's ability to prepare an advance directive in the case that an injury or illness causes the beneficiary to be unable to make health care decisions; and
      - Whether or not you are willing to follow the beneficiary's wishes as expressed in the advance directive.

   b. Establishment of a list of current providers and suppliers
      - Include current providers and suppliers that are regularly involved in providing medical care to the beneficiary

6. Education, counseling, and referral based on the previous five components
   a. Based on the results of the review and evaluation services provided in the previous five components, provide education, counseling, and referral as appropriate.

7. Education, counseling, and referral for other preventive services
   a. Includes a brief written plan, such as a checklist, to be given to the beneficiary for obtaining:

- A screening electrocardiogram (EKG/ECG), as appropriate

Only covered when ordered as part of an IPPE. All other screening ECGs are not covered by Medicare.

- Medicare-covered preventive services. The beneficiary appropriate screenings and other preventive services that Medicare covers.

- Other Medicare Part B Preventive Services

  As applicable, the following preventive services should be ordered during the IPPE/AWV and included on the Patient's Personalized Prevention Plan Services (PPPS) which is provided to the patient during/following the visit.

  - Abdominal Aortic Aneurysm (AAA)
  - Bone Mass Measurements
  - Cardiovascular Disease Screening Blood Tests
  - Colorectal Cancer Screening
  - Counseling to Prevent Tobacco Use for Asymptomatic Patients
  - Diabetes Screening Tests
  - Diabetes Self-Management Training (DSMT)
  - Glaucoma Screening
  - Human Immunodeficiency Virus (HIV) Screening
  - Influenza, Pneumococcal, and Hepatitis B Vaccinations and their Administration
  - Intensive Behavioral Therapy (IBT) for Cardiovascular Disease (CVD), also referred to as a CVD risk reduction visit
  - IBT for Obesity
  - Medical Nutrition Therapy (MNT)
  - Prostate Cancer Screening
  - Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse
  - Screening for Depression in Adults
  - Screening Mammography
  - Screening Pap Tests and Pelvic Examination
  - Sexually Transmitted Infections (STIs) Screening and High Intensity Behavioral Counseling (HIBC) to Prevent STIs

  CMS has a Quick Reference Guide for Preventive Services on its website at http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/downloads/MPS_QuickReferenceChart_1.pdf This summary document includes the following information

- Service *HCPCS/CPT* codes
- *ICD-9* codes
- Who is covered
- Coverage frequency
- What the beneficiary Pays

b. Establishment of a written screening schedule for the beneficiary, such as a checklist for the next 5 to 10 years as appropriate – (Updated at each AWV)

- Base written screening schedule on
- Age-appropriate preventive services Medicare Covers
- Recommendations from the United States Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunization Practices (ACIP
- The beneficiary's health status and screening history

8. Establishment of a list of risk factors and conditions for which the primary, secondary, or tertiary interventions are recommended or underway for the beneficiary
   a. Include the following
      - Any mental health conditions or any such risk factors or conditions identified as a result of previous and current preventive visits
      - A list of treatment options and their associated risks and benefits

9. Furnishing of personalized health advice to the beneficiary and a referral, as appropriate, to health education or preventive counseling services
   a. Includes referrals to programs aimed at
      - Community-based lifestyle interventions to reduce health risks and promote self-management and wellness
      - Fall prevention
      - Nutrition
      - Physical activity
      - Tobacco-use cessation
      - Weight loss

The AAFP has an excellent combined template posted on the AAFP website at http://www.aafp.org/fpm/2011/0100/fpm20110100p22-rt3.pdf Since the USPSTF recommends the screening, this template needs to be updated to remove the requirement that the Screening AAA Ultrasound be ordered in conjunction with an IPPE. Due to the Affordable Care Act, the Centers for Medicare and Medicaid Services eliminated the requirement that the test had to be ordered during an IPPE.

According to the Medicare Final Rule published in the December 10, 2013 Federal Register, effective January 1, 2014, a screening AAA ultrasound is now covered once in the patient's lifetime when the following requirements are met

- has not been previously furnished AAA screening under the Medicare program
- has a family history of AAA
- a man age 65 to 75 who has smoked at least 100 cigarettes in his lifetime

Can a Problem-Oriented Evaluation and Management Service be Performed on the Same Day as an IPPE or AWV?

Medicare may pay for a significant, separately identifiable, medically necessary evaluation and management (E/M) billed with *CPT* codes 99201 – 99215) provided in conjunction with an IPPE or AWV as long as the visit is "medically necessary to treat the beneficiary's illness or injury or to improve the functioning of a malformed body member." Modifier -25 must be appended to the problem-oriented E/M code.

WPS provides the following clarification:

When billing for an E/M and the IPPE/AWV on the same day, the provider must remove those portions of the E/M that are included in the IPPE/AWV. You cannot include any duplicative services in the coding of the E/M. Once that process is complete, you would then look to see if the E/M met the Modifier 25 guidelines for a significant, separately identifiable service. If the E/M is a great amount of additional work over and above what would be performed in the IPPE/AWV, then you may append modifier 25 to the E/M procedure code. If it is not, then bill the IPPE/AWV only.

Given this clarification, due to the Past, Family, and Social history required by the IPPE/AWV, it would be difficult to meet the E/M coding requirements for a level of care greater than 99202 for a new patient.