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Internal Medicine Coding Alert

CPT 2011: 5 Tips to Sail You through G0438, G0439 Coding Scenarios

Boost your revenue by reporting new annual wellness visits correctly

If you want your annual visit claims to be picture perfect in 2011, then follow these five tips to avoid future denials and keep your internist's claim on the fast track to success.

Background: The Affordable Care Act (ACA) extended preventive coverage to more than 88 million patients covered by health insurance, and Medicare has codified that benefit in the form of an annual wellness visit. Medicare valued the new annual wellness codes based on a level 4, problem-oriented new and established E/M service.

The two new codes are:

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

Tip 1: Apply G0438 to Second Year of Coverage

Be wary of applying these codes to new Medicare patients coming in to your physician's practice in 2011.

The reason is that Medicare will only reimburse the initial visit (G0438) during the **second** year the patient is eligible for Medicare Part B. In other words, during the first year of the patient's coverage, Medicare will only cover the Initial Preventive Physical Exam (IPPE), also known as the Welcome to Medicare exam.

Tip 2: CMS Limits G0438 to One Physician

If your physician sees the patient for the initial visit (G0438) and the patient sees a different physician for the next annual wellness visit, that second physician will only receive reimbursement for the subsequent visit (G0439), despite having never seen the patient before.

Here's why: CMS has indicated that when a patient returns to the same or new physician in a third year, they might only pay for the subsequent visit, says **Melanie Witt, RN, COBGC, MA,** an independent coding consultant in Guadalupita, N.M. "It is therefore important that you convey this information to any new physician the patient sees."

Tip 3: Add Preventive Service Codes, If Performed

You can bill the new annual visit codes in addition to any other preventive service, such as G0102 (Prostate cancer screening; digital rectal examination) and/or Q0091 (Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory) in the covered year.

Keep in mind: You won't need to append any modifier (such as 25, Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) for this combination because the G codes are not problem-oriented E/M services to which that modifier applies. If you do report the annual codes with a problem-oriented E/M service (with modifier 25 appended to the problem-oriented code), CMS indicates that this situation should be "rare, due to the nature of the wellness visit requirements which are very time intensive," Witt says. "They also expect that given these requirements, you will not bill the patient for a non-covered preventive service in addition."

Tip 4: Document the Required Elements

Before you can bill the new annual visit codes, the physician or physician team must document certain elements. At a minimum, documented elements should:

- Establish or update the individual's medical and family history
- List the individual's current medical providers and suppliers
- Record measurements of height, weight, body mass index (or waist circumference, if appropriate), blood pressure, and other routine measurements
- Detect any cognitive impairment
- Review of the individual's potential (risk factors) for depression (during the patient's first annual wellness visit)
- Review of the individual's functional ability and level of safety (during the patient's first annual wellness visit)
- Furnish personalized health advice and, as appropriate, referrals to health education or preventive counselingservices or programs.
- Voluntary advance care planning, upon agreement with the individual.

The provider should also establish or update a screening schedule for the next 5 to 10 years, advises **Kent J. Moore,** manager of healthcare delivery and financing systems for the American Academy of Family Physicians (AAFP) in Leawood, Kan. These include screenings appropriate for the general population and any additional screenings that might be appropriate because of the individual patient's risk factors. In addition, Moore recommends establishing or updating a list of risk factors and conditions for which the provider recommends interventions (or which are already being treated). Treatment options and their associated risks and benefits should also be noted.

In the future, any other element determined appropriate through the national coverage determination process will also have to be performed and documented.

Heads up: Notice that your physician isn't required to complete a physical examination other than vital signs and other routine measurements. CMS clarified that these above elements are the minimum to get by. If your provider feels that more should be documented, then he should do so, but CMS will not give any extra credit. Also, you should not bill the annual wellness visit as an "incident-to" service. When a team of medical professionals are working together to provide the service, the billing physician must provide direct supervision.

Tip 5: CMS Waives the Deductible and Copay

Under provisions listed in the ACA, all plans (private and government funded) covered by the rules contained in the Act must offer coverage of a comprehensive range of preventive services that are recommended by experts and the U.S. Preventive Services Task Force (USPSTF) with a grade of A (strongly recommends) or grade B (recommends). This means these codes fall under coverage that does **not** impose any costsharing requirements.

Translation: To comply with this requirement, Medicare waived both the copay and the deductible for a patient's annual wellness visits, the IPPE exam, and other preventive services that meet the "A" and "B" USPTF recommendations.

Screening laboratory services have always been exempt from the copay and deductible, but they're not alone. CMS waives both the deductible and copay in 2011 for several covered preventive services other than lab tests (CPT 8xxxx or HCPCS G codes):

- IPPE exam: G0402
- Smoking and Tobacco Cessation Counseling: G0436, G0437
- Screening Pelvic/Breast exam: G0101
- Screening Pap Smear Collection: Q0091
- Medical Nutrition Therapy Services: 97802-97804, G0270-G0271
- Screening Mammography: 77052, 77057, G0202
- Bone Mass Measurement: G0130, 77078-77083, 76977
- Colon Cancer Screening: G0104, G0105, G0121, G0328.

Cutting edge: According to a member of the CPT Editorial Panel at the AMA annual CPT Symposium in November 2010, CPT will be adding a new modifier 33 to indicate that the service you're billing does not permit cost sharing under the

ACA rules. In the future, you would add this modifier when you submit a claim for a mandated preventive service to a private payer, this member said. "That modifier does not appear in the 2011 CPT book, but might be added at a later date, so stay tuned," Witt says.