

Internal Medicine Coding Alert

Preventive Medicine: Report Annual Wellness Visit With Appropriate Payer Rules

Hint: Use correct modifiers when reporting other same day services.

When your internal medicine physician performs an annual wellness visit (AWV) for a Medicare patient, you will need to check on the patient's date of enrollment with Medicare and whether or not the patient has had an AWV in the past to report the visit correctly. You should also be informed about what other preventive services that you can report separately with the AWV codes.

Background: Because of the Affordable Care Act (ACA), millions of Medicare patients receive preventive coverage in the form of an annual wellness visit. When your internist performs an annual wellness visit, you will report the service with one of these two HCPCS codes:

- G0438--Annual wellness visit; includes a personalized prevention plan of service [PPS], initial visit
- G0439--Annual wellness visit; includes a personalized prevention plan of service [PPS], subsequent visit.

Report G0438 Only For Second Year of Coverage

When reporting an annual wellness visit, you report G0438 beginning the second year the patient is eligible for Medicare Part B. 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 visit. You report this initial visit within the first 12 months of enrollment with the HCPCS code, G0402 (Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment).

You cannot report G0402 if your physician conducts an initial preventive exam after the patient's first 12 months following Medicare enrollment. If 12 months have already passed, then you should consider reporting the visit with G0438 or G0439.

"Also, Medicare only covers an AWV if the beneficiary has not gotten either an initial preventive physical exam (IPPE) or another AWV within the past 12 months (that is, at least 11 months have passed following the month in which the IPPE or the last AWV was performed)," points out an experienced coder.

Don't Report G0438 For Each New Physician

If your internist sees the patient for the initial visit (G0438) and then the patient sees a different physician for the next annual wellness visit, that second physician should report the AWV with a subsequent visit code (G0439), despite having never seen the patient before.

Here's why: Like with HCPCS code G0402, which is paid only once for a particular patient when a physician performs an initial preventive physical examination (within the first 12 months of enrollment), G0438 is also paid only once per beneficiary, whether the patient sees the same or any other physician in the second year for an annual wellness visit. Once reimbursement for G0438 has been claimed, for subsequent years, annual wellness visits will have to be reported with G0439, irrespective of whether or not the patient is visiting the same physician or a new physician.

"In other words, 'initial' and 'subsequent' are entirely relative to the beneficiary," the specialist observes. "A beneficiary can have only one initial AWV in his or her lifetime. After that, any AWV is considered 'subsequent,' regardless of who provides it."

You have different options for accessing AWV eligibility information depending on the jurisdiction where you practice. CMS suggests you check with your Medicare Administrative Contractor to see what options are available to check beneficiary eligibility in your area.

Include Appropriate Documentation or Face Denial

When reporting annual wellness visit codes, the physician must document certain elements. At a minimum, documented elements should:

- Results of a health risk assessment (HRA) administered to the patient
- Establish or update the individual's medical and family history
- Establish or update the list the individual's current medical providers and suppliers
- Establish or update a screening schedule for the next 5 to 10 years that includes screenings appropriate for the general population and any additional screenings that might be appropriate because of the individual patient's risk factors
- 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 counseling services or programs.

"The HRA, which is self-reported beneficiary information, can be completed by the beneficiary before the visit or by the provider or beneficiary during the visit," he notes. "At a minimum, it should address demographic data, self-assessment of health status, psychosocial risks, behavioral risks, and activities of daily living. Information obtained through the HRA can inform the rest of visit, such individual risk factors and personalized health advice."

Heads up: Notice that the provider 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 solely as an "incident-to" service. If you are working as a team of medical professionals to provide the service, the billing physician must provide direct supervision and be involved in the provision of the service.

AWV carries no Deductible and Coinsurance

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 indicates to you that these codes fall under coverage that does **not** impose any patient cost sharing requirements.

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

Screening laboratory services have always been exempt from coinsurance and deductible, but they're not alone. Some of the other services for which CMS waives both the deductible and coinsurance as covered preventive services include:

- 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.

Report Additional Preventive Services When Performed

You can bill the AWV 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 for this combination because the G codes are not problem-oriented E/M services. If you do report the annual wellness visit codes with a problem-oriented E/M service, you will need to append a modifier such as 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service) to the E/M code that you are reporting. However, CMS indicates that this situation should be "rare, due to the nature of the wellness visit requirements which are very time intensive." CMS also expects that given these requirements, you will not typically bill the patient for a non-covered preventive service (e.g. 99397), in addition to the AWV.