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Part B Insider (Multispecialty) Coding Alert

Annual Wellness Visits: G0438-G0439: Find Out What the MACs Are Saying About the New AWV Codes

Tip: Don't get discouraged if your claims were denied--many carriers are reprocessing.

Less than a year ago, practices got the good news that Medicare will cover an annual wellness visit (AWV) for Part B beneficiaries effective Jan. 1. Last month, CMS announced the new codes for the AWVs, and it looked like processes were working smoothly -- until it came time for claims submissions. Then the denials began to arrive, puzzling practices that submitted what they thought were clean claims.

The MACs may have hit a few speedbumps while processing the first of the AWV claims, but are attempting to get their systems rolling smoothly as January closes out for codes G0438 (Annual wellness visit, initial) and G0439 (Annual wellness visit, subsequent). Following are the answers to several questions -- straight from the MACs themselves -- which may help you ensure that your claims go through smoothly.

Question 1: Which Diagnosis Code Should We Use? Several subscribers have told the Insider that they submitted their AWV claims using ICD-9 code V70.0 (Routine general medical examination at a health care facility), but faced immediate denials due to MACs claiming that this is the wrong diagnosis code.

Answer: It appears that those denials were the result of a computer glitch that made the AWV codes non-payable when billed with V70.0, but some payers have already fixed this problem.

National Government Services, a Part B payer in four states, sent out a notification on Jan. 25 stating that they "omitted the editing for diagnosis code V70.0 that is allowable with HCPCS codes G0438 and G0439, and claims that were initially denied are being reprocessed.

Pinnacle Business Solutions, a Part B MAC in two states, ran a notification on its Web site on Jan. 21 stating that a system error in the claims processing system incorrectly denied claims for G0438-G0439 between Jan. 1 and Jan 20. "A mass adjustment will be done to reprocess any claims incorrectly denied," the MAC said. "Providers do not need to take any action on these claims."

Question 2: Can We Bill An E/M With the AWV? In some cases, your physician may address a separate problem during the annual wellness visit that he treats separately, but coders aren't sure whether this service should be bundled into the AWV visit.

Answer: You can report an E/M visit along with the AWV codes G0438 and G0439. "Medicare will, when clinically appropriate, allow payment for a medically necessary E/M service (CPT codes 99201-99215) at the same visit as the AWV," says an information sheet on the **Trailblazer Health Enterprises** Web page, a Part B payer in five states. "The modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) should be added to the E/M code to identify the service as a significant, separately identifiable service from the AWV," it notes.

Question 3: Is It Necessary to Let 365 Days Pass Between A Patient's Annual Wellness Visits? CMS has referred to the rule that "one year" must pass between visits, but coders have interpreted the one-year rule differently and aren't sure how many days must pass.

Answer: WPS Medicare, a Part B payer in four states, answers this question on its Web site, saying that you don't need to let 365 days pass between visits. "Medicare has instructed contractors that 11 months must pass between visits," the MAC says on its site at www.wpsmedicare.com/j5macpartb/resources/provider_types/awv-faq.shtml.

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