Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

Annual Wellness Visits: G0438-G0439: Medicare Puts Details of Annual Wellness Visit in Writing

Medicare creates new denial codes that will apply when you bill AWV incorrectly.

CMS has finally released written guidance on how you can bill the new annual wellness visit codes, and if the agency's recent transmittal is any indicator, MACs are already expecting to process quite a few denials due to claims errors.

CMS issued Transmittal 2109 on Dec. 3, which offers the first comprehensive outline of how you can submit claims for the new annual wellness visits (AWV) that were created as part of the Affordable Care Act. Effective Jan. 1, Medicare beneficiaries will be able to get a free annual health risk assessment starting the year after they first get their Welcome to Medicare (WTM) exam. No deductibles or coinsurance fees apply to the AWV.

You'll report the AWV with either G0438 (Annual wellness visit, initial) or G0439 (Annual wellness visit, subsequent) as of Jan. 1, 2011.

The AWV can be performed by a physician, a qualified NPP, or other health professional (for instance, a health educator, registered dietician, nutrition professional, or other licensed practitioner), the transmittal notes. Your Part B payer will reimburse one submission of G0438 per beneficiary per lifetime as long as you don't bill it within 12 months of the patient's WTM and you meet all of the other requirements, and then you'll code all subsequent AWVs with G0439.

Before reporting G0439, you must ensure that the patient has not received a previous AWV within the past 12 months, or the payer will reject the claim.

New Denial Codes Abound

Until Part B practices get accustomed to the new AWV requirements, Medicare expects to see a lot of denials for these services. Therefore, CMS created several new denial codes that you might find, including the following:

- Denial 20.12 -- This service was denied because Medicare only covers this service once a lifetime
- Denial 18.26 -- This service was denied because it occurred too soon after your last covered AWV; Medicare only covers one AWV within a 12-month period
- Denial 18.27 -- This service was denied because it occurred too soon after your Initial Preventive Physical Exam

Know These Carve-Out Rules

If, during the course of the AWV, the physician provides a significant, separately identifiable, medically necessary E/M service in addition to the AWV, you can report an E/M code (99201-99215) with modifier 25 appended to it. If any of the components of the E/M service overlap with services provided during the AWV, you should not include those items when calculating the most appropriate E/M level, the transmittal states.

For more information on the AWV benefit, including documentation specifics, visit www.cms.gov/transmittals/downloads/R2109CP.pdf.