Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-For-Service Health Care Professionals

News Flash – Beginning Jan 1, 2012, suppliers furnishing the technical component of advanced diagnostic imaging services for which payment is made under the physician fee schedule must be accredited by a CMS-designated accreditation organization. In the case where a physician chooses to contract out those services to an accredited mobile unit, the physician must be accredited in order to bill Medicare for such services. For more information regarding advanced diagnostic imaging, please visit http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html on the Centers for Medicare & Medicaid Services (CMS) website.

MLN Matters® Number: MM7079
Related Change Request (CR) #: 7079
Related CR Release Date: February 15, 2011
Effective Date: January 1, 2011
Related CR Transmittal #: R138BP and R2159CP
Implementation Date: April 4, 2011

Annual Wellness Visit (AWV), Including Personalized Prevention Plan Services (PPPS)

Note: This article was updated on March 27, 2013, to add a reference to MM8153, which is available at http:/www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8153.pdf, to provide information on how CMS recovers AWV overpayments. All other information remains the same.

Provider Types Affected

This article is for physicians, non-physician practitioners, and providers submitting claims to Medicare contractors (carriers, Medicare Administrative Contractors (MACs), and/or Fiscal Intermediaries (FIs) for services provided to Medicare beneficiaries.

Provider Action Needed

The Affordable Care Act provides for an Annual Wellness Visit (AWV), including Personalized Prevention Plan Services (PPPS) for Medicare beneficiaries as of January 1, 2011. CR 7079 provides the requirements for the AWV, which are

summarized in this article. Make sure billing staff are aware of these services and how to bill for them.

Background

Pursuant to section 4103 of the Affordable Care Act of 2010 , the Centers for Medicare & Medicaid Services (CMS) amended sections 411.15(a)(1) and 411.15 (k)(15) of 42 CFR (list of examples of routine physical examinations excluded from coverage) effective for services furnished on or after January 1, 2011. This amendment's expanded coverage is subject to certain eligibility and other limitations that allow payment for an AWV, including PPPS, for an individual who is no longer within 12 months after the effective date of his or her first Medicare Part B coverage period and has not received either an initial preventive physical examination (IPPE) or an AWV within the past 12 months. Medicare coinsurance and Part B deductibles do not apply to the AWV. The AWV will include the establishment of, or update to, the individual's medical and family history, measurement of his or her height, weight, body-mass index (BMI) or waist circumference, and blood pressure (BP), with the goal of health promotion and disease detection and fostering the coordination of the screening and preventive services that may already be covered and paid for under Medicare Part B.

Who is Eligible to Provide the AWV with PPPS?

- A physician who is a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Social Security Act (the Act); or,
- A physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5) of the Act); or,
- A medical professional (including a health educator, registered dietitian, or nutrition professional or other licensed practitioner) or a team of such medical professionals, working under the direct supervision (as defined in CFR 410.32(b)(3)(ii)) of a physician as defined in the first bullet point of this section.

What is Included in an Initial AWV with PPPS?

The initial AWV providing PPPS provides for the following services to an eligible beneficiary by a health professional:

- Establishment of an individual's medical/family history.
- Establishment of a list of current providers and suppliers that are regularly involved in providing medical care to the individual.

- Measurement of an individual's height, weight, BMI (or waist circumference, if appropriate), BP, and other routine measurements as deemed appropriate, based on the beneficiary's medical/family history.
- Detection of any cognitive impairment that the individual may have as defined in this section.
- Review of the individual's potential (risk factors) for depression, including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the health professional may select from various available standardized screening tests designed for this purpose and recognized by national medical professional organizations.
- Review of the individual's functional ability and level of safety based on direct observation, or the use of appropriate screening questions or a screening questionnaire, which the health professional may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations.
- Establishment of a written screening schedule for the individual, such as a checklist for the next 5 to 10 years, as appropriate, based on recommendations of the United States Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunization Practices (ACIP), as well as the individual's health status, screening history, and age-appropriate preventive services covered by Medicare.
- Establishment of a list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are underway for the individual, including any mental health conditions or any such risk factors or conditions that have been identified through an IPPE, and a list of treatment options and their associated risks and benefits.
- Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management, or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition.
- Any other element(s) determined appropriate by the Secretary of Health and Human Services through the National Coverage Determination (NCD) process.

What would be Included in a Subsequent AWV/PPPS?

In subsequent AWVs, the following services would be provided to an eligible beneficiary by a health professional:

- An update of the individual's medical/family history.
- An update of the list of current providers and suppliers that are regularly involved in providing medical care to the individual, as that list was developed for the first AWV providing PPPS.
- Measurement of an individual's weight (or waist circumference), BP, and other routine measurements as deemed appropriate, based on the individual's medical/family history.
- Detection of any cognitive impairment that the individual may have as defined in this section.
- An update to the written screening schedule for the individual, as that schedule is defined in this section, that was developed at the first AWV providing PPPS.
- An update to the list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are under way for the individual, as that list was developed at the first AWV providing PPPS.
- Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs.
- Any other element(s) determined by the Secretary through the NCD process.

Billing Requirements

Two new HCPCS codes, G0438 - Annual wellness visit, includes a personalized prevention plan of service (PPPS), first visit, (Short descriptor – Annual wellness first) and G0439 - Annual wellness visit, includes a personalized prevention plan of service (PPPS), subsequent visit, (Short descriptor – Annual wellness subseq) will be implemented January 1, 2011, through the Medicare Physician Fee Schedule Database (MPFSDB) and Integrated Outpatient Code Editor (IOCE).

Effective for services on or after January 1, 2011, Medicare contractors will pay claims containing these codes provided the requirements for coverage and eligibility are met. Institutional providers need to submit these claims via Types of Bill (TOB) 12X, 13X, 22X, 23X, 71X, 77X, or 85X. Institutional providers will be paid as follows:

- For services performed on a 12X TOB and 13X TOB, hospital inpatient Part B and hospital outpatient, payment shall be made based on the MPFS.
- For TOBs 22X and 23X, skilled nursing facilities will be paid based on the MPFS.
- Rural Health Clinics (TOB 71X) and Federally Qualified Health Centers (TOB 77X) will be paid based on the all-inclusive rate. However, for TOBs 71X and 77X, the AWV does not qualify for separate payment with another encounter.
- For services performed on an 85X TOB, Critical Access Hospital (CAH), pay based on reasonable cost.
- CAHs claims (submitted on TOB 85X with revenue codes 096X, 097X, and 098X) will be paid based on MPFS.
- For inpatient or outpatient services in hospitals in Maryland, make payment according to the Health Services Cost Review Commission.

Other Billing Requirements

Remember that G0438 is for the first AWV only. Thus, submission of G0438 for a beneficiary for whom a claim with code G0438 has already been paid will result in a denial of the later G0438 with a Claim Adjustment Reason Code (CARC) of 149 (Lifetime benefit maximum has been reached for the service/benefit category.) and a Remittance Advice Remarks Code (RARC) of N117 (This service is paid only once in a patient's lifetime.).

Remember also that the G0438 or G0439 must not be billed within 12 months of a previous billing of a G0402 (IPPE), G0438, or G0439 for the same beneficiary. Such subsequent claims will be denied with a CARC of 119 (Benefit maximum for this time period or occurrence has been reached) and a RARC of N130 (Consult plan benefit documents/guidelines for information about restrictions for this service).

If a claim for a G0438 or G0439 is submitted within the first 12 months after the effective date of the beneficiary's first Medicare Part B coverage, it will also be denied as that beneficiary is eligible for the IPPE or "Welcome to Medicare" physical. Such claims with G0438 or G0439 will be denied with a CARC of 26 (Expenses incurred prior to coverage) and a RARC of N130.

Additional Information

The official instruction, CR 7079, was issued to your carrier, FI, or A/B MAC via two transmittals. The first modified the Medicare Claims Processing Manual and it is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2159CP.pdf on the CMS website. The second transmittal updates the Medicare Benefit Policy Manual, which is at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R138BP.pdf on the CMS website. See these two transmittals for more complete details regarding this benefit.

If you have questions, please contact your carrier, FI, or A/B MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

You may also want to review MLN Matters® Article MM8107 (http:/www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8107.pdf) that alerts providers that Medicare will pay either the practitioner or the facility for furnishing the Annual Wellness Visit, but only a single payment will be allowed under the MPFS for the AWV on the same date. The payment will be based on the first claim received.

Note: This article was previously revised on February 17, 2011, to reflect changes made to CR 7079. The changes made were the deletion of "voluntary advance care planning" as a specified element of the AWV, clarification that payment methodology for Types of Bill (TOB) 12X and 13X is based on the Medicare Physician Fee Schedule, and that for TOBs 71X and 77X, the AWV does not qualify for separate payment with another encounter. The CR transmittal numbers, CR release date, and the Web addresses for accessing CR 7079 were also changed.

News Flash - It's a Busy Time of Year. Make each office visit an opportunity to talk with your patients about the importance of getting the seasonal flu vaccination and a one-time pneumococcal vaccination. Remember, Medicare pays for these vaccinations for all beneficiaries with no co-pay or deductible. The seasonal flu and invasive pneumococcal disease kill thousands of people in the United States each year, most of them 65 years of age or older. The Centers for Disease Control and Prevention (CDC) also recommends that health care workers and caregivers be vaccinated against the seasonal flu. Protect your patients. Protect your family. Protect yourself. Get Your Flu Vaccine - Not the Flu. Remember – Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is NOT a Part D covered drug. For information about Medicare's coverage of the influenza vaccine and its administration, as well as related educational resources for health care professionals and their staff, please visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Flu_Products.pdf and http://www.cms.gov/Medicare/Prevention/Immunizations/index.html on the Centers for Medicare & Medicaid Services (CMS) website.