

How to bill Medicare's Initial Preventive Physical Exam (IPPE) and Annual Wellness Visit (AWV)

CMS created the Initial Preventive Physical Exam (IPPE) in 2005, for patients in their first six months of Medicare eligibility, then added an annual wellness visit (AWV) service in the 2011 Medicare Physician Fee Schedule. Not only does the agency allow physicians and NPPs to furnish these encounter, it also allows NPPs to bill this new service incident to, without the physician needing to be in the same room.

The wellness visit consists of up to nine separate clinical criteria that must be met in order to be billed. Many of these are routine tasks such as taking vitals, performing detailed histories and compiling medication lists, which can be handled by NPPs, while more specialized services that a patient requires, such as smoking cessation counseling, nutrition education and weight management can be handled by registered dietitians or nutritionists, CMS says.



Teams can efficiently perform the wellness visit at your practice without the physician ever seeing the patient. They can bill the service under the physician's NPI incident-to.

The AWV is billed with two codes, **G0438** and **G0439**, which are based on relative value units (RVUs) for 99204 and 99214 respectively. Bill G0438 for a patient's first-ever AWV, and G0439 for each subsequent AWV which a patient may receive the rest of his or her life.

Note: A patient who had the Welcome to Medicare visit (the IPPE) will not be eligible for his or her initial AWV for 12 months. Be sure to check the date of a patient's Welcome to Medicare visit before scheduling the AWV in 2011. The AWV must be at least 12 months after the IPPE.



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Here's a finalized list of CMS's required criteria for this copay-free service:

- Establish/update individual medical and family history.
- Create/update list of current providers and suppliers, and medications including supplements such as vitamins.

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- Measure height, weight, body mass index (BMI) or waist circumference, blood pressure and heart rate.
- Check for signs of any cognitive impairment.
- Screen for depression and functional status.
- Establish/update schedule of screening services for the next 5-10 years.
- Establish/update list of risk factors and conditions.
- Furnish personalized health advice and referral where needed to health education or prevention counseling services or programs.

Avoid AWV confusion, wasted money when billing initial visits

Spend a few minutes calling your Medicare administrative contractor (MAC) or using its electronic portal to track whether your patient already received an initial annual wellness visit (AWV). If you don't and the patient hasn't had that initial AWV, you could be squandering an extra \$55 by billing the subsequent instead of initial AWV.

Even though 2011 was the first year Medicare began covering AWV codes – **G0438** (initial visit) and **G0439** (subsequent visit) – and 11 months must pass after the initial visit's month before you may bill the subsequent, an alarming number of subsequent visits were billed and paid that year. At least 380,000 subsequent visits were billed in 2011, only 10.8% of which were denied, according to a NPP analysis of 13.6 million Medicare records. You won't get a denial if you bill the subsequent visit when you should have reported the initial code. But you'll also miss out on about \$50.

Here are two primary areas of confusion that could cause you to select G0439 when G0438 is appropriate:

You are confusing AWV terminology of initial and subsequent visits with E/M terminology for initial and established patient visits. Some practices don't realize that initial AWV codes do apply to your established patients and are automatically billing AWVs for them as subsequent without bothering to read the regulation.

You or your patient is mixing up the AWV with the "Welcome to Medicare" exam. Some practices see that the patient has already been billed for G0402 (Initial preventive physical exam [IPPE] or "Welcome to Medicare" visit), and incorrectly assume the AWV – which must occur at least 12 months after the IPPE – is the subsequent AWV.

Steps to AWV billing accuracy

Lean on MACs to provide a patient-specific billing history. If the patient cannot remember receiving an AWV or IPPE from a previous provider, ask the patient in what state(s) he or she received medical care in the past few year and contact the MAC for that jurisdiction.

Check whether your MAC has an accurate electronic portal that allows you to search for patients' wellness visit histories. At least one MAC, Palmetto GBA, allows you to log into a portal on its website and search for the date of service for any previous wellness visits, a Palmetto spokesperson says.

Resubmit as a subsequent AWV if you get denied because the initial AWV was already billed for a patient. That's how Midlothian Family Practice responds on the few occasions it receives such denials for its nearly 20 providers conducting AWVs, Kesler says. The documentation still supports the G0439, so long as you had the patient fill out a health risk assessment, a new requirement in 2012.

Resubmit as an IPPE if your AWV is denied because the patient was in his or her first year of Medicare eligibility. The documentation should still support the IPPE, but the IPPE documentation will not support the AWV because of the HRA form, Kesler says.

Health risk assessments now required for the AWV

You must have patients complete a health risk assessment when billing annual wellness visits (AWVs).

The HRA is a form your practice will use that patients must complete either before or during an AWV. It's intended to be a plain-English form that takes 20 minutes or less to complete, and asks patients a wide variety of questions to help determine their risk factors. CMS wants your providers to incorporate HRAs in their AWV, and specifically, in giving patients the personalized prevention plan that's already a requirement of the AWV.

Here's a list of the components an HRA must contain (you can add more than these if you want):

- Demographic data, including but not limited to age, gender, race, and ethnicity.
- Self-assessment of health status, frailty, and physical functioning.
- Psychosocial risks, including but not limited to depression/life satisfaction, stress, anger, loneliness/social isolation, pain, or fatigue.
- Behavioral risks, including but not limited to tobacco use, physical activity, nutrition and oral health, alcohol consumption, sexual practices, motor vehicle safety (seat belt use), and home safety.
- Activities of daily living, including but not limited to dressing, feeding, toileting, grooming, physical ambulation (including balance/risk of falls), and bathing.
- Instrumental activities of daily living, including but not limited to shopping, food preparation, using the telephone, housekeeping, laundry, mode of transportation, responsibility for own medications, and ability to handle finances.

The provider who sees the patient can then use the completed HRA to help develop the personalized prevention plan that's part of the AWV. For all subsequent AWV patients, who already have an HRA, you must ask them to update the HRA as needed, if at all, CMS writes.

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CMS doesn't have plans to issue a standardized form, but you can use the template at the end of this chapter to create one for your practice. Remember that HRAs should be written in simple language that someone with a 5th or 6th grade education can understand.

NPPs can smooth AWV workflow

Here's a sample workflow practices can use to leverage NPPs and non-clinical staff to comply with the HRA requirement and bill for AWVs:

Use front desk to manage patient expectations early on. Patients often believe the AWV is basically a free physical, and get confused when they don't get a physical "hands-on" exam. Develop a script for your front desk that tells patients the AWV is about "looking at your health data and giving you a plan to stay healthy" over the next five to 10 years, he suggests. Warn patients that when they bring up an unrelated short-term problem that needs to be addressed in the same visit, such as a stubborn cough, that requires a separate service (E/M visit) to be billed and this means a copay may be owed.

Have non-clinical staff gather data and ensure HRAs are completed. The HRA requires you to collect patient information such as how they exercise, what they eat routinely and their psychosocial status. You can have patients submit this information online before they step foot in the office, or have them complete a paper form in the waiting room, but either way it's a good idea to have non-clinical staff verify that the forms are as complete as possible before an AWV patient is seen by a PA or NP.

Use NPPs to carry out the clinical aspects of visit. Gathering and/or updating patient data makes up a significant part of both the initial and subsequent wellness visit, but when it comes to interpreting that information and turning it into a personalized prevention plan as required by CMS, a clinician needs to be involved and that clinician can be an NP or PA, CMS says.

Physicians still provide supervision. Even when your NPs and PAs carry out the portions of the AWV that require clinical judgment and interpretation, you can bill G0438 or G0439 at the full fee schedule rate so long as a physician was there to provide supervision, CMS says.