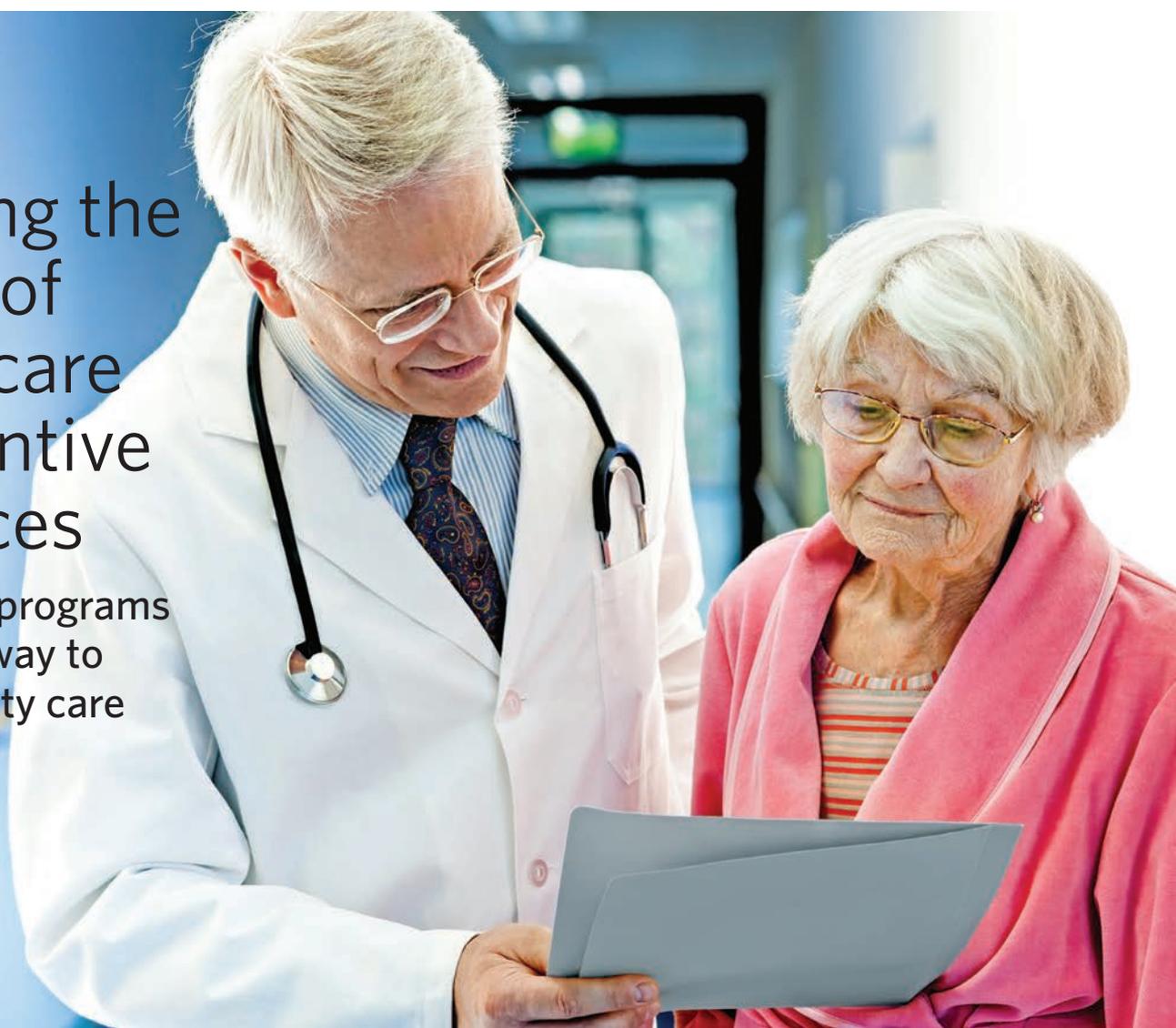


Making the most of Medicare Preventive Services

Wellness programs pave the way to high-quality care



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Medicare covers a range of preventive services to promote health by identifying and addressing problems early on when treatment is most effective. However, many eligible patients and some providers may not be fully aware of the benefits described in *Your Guide to Medicare's Preventive Services*.

As a result, patients may be missing out on a long-term wellness program to help them prevent illness, stay healthy and live longer. Practices that fail to educate physicians, other practitioners and their patients about these services may be missing out on significant revenue.

It is important that providers raise patient awareness and follow Medicare guidelines to correctly perform the components required for preventive service visits, including timing and documentation requirements for wellness visits that complement preventive care.

Three types of wellness visits

Medicare covers three types of wellness visits that are restricted to certain time frames and services. The timing is critical for both providers and beneficiaries to ensure eligibility, service delivery and proper reimbursement.

G0402 is the procedure code for an initial preventive physical exam (IPPE), also known as a "Welcome to Medicare preventive visit." New beneficiaries are eligible during the first 12 months of Part B enrollment. The purpose of the IPPE is to introduce the patient to Medicare preventive services and complete seven required components:

- Review medical and social history.
- Review potential risk factors for depression and other mood disorders.
- Review functional ability and level of safety.
- Conduct basic exam.
- Discuss end-of-life planning.

- Educate, counsel and refer based on previous components.
- Refer for other preventive services based on a written plan.

Within 12 months of an IPPE, a patient is eligible for an initial annual wellness visit (AWV), which is coded as G0438. If an IPPE was not completed, the patient is eligible for the initial AWV after the initial 12 months of Part B coverage. Both the IPPE and initial AWV are once-in-a-lifetime benefits. In addition to the components required for the IPPE, the initial AWV requires:

- Administering a health risk assessment (HRA)
- Establishing a list of current providers and suppliers
- Detecting any cognitive impairment
- Establishing a written screening schedule for preventive services
- Establishing a list of risk factors with interventions underway
- Providing personalized health counseling

In the 12 months after the initial AWV, a patient is eligible for a subsequent AWV, coded G0439. Thereafter, the patient is eligible for an ongoing subsequent AWV 12 months after the previous AWV. Each annual

visit includes a follow-up exam in addition to updates to components completed during previous visits.

Billing guidelines

If your practice does not properly perform and document the required elements for each type of visit, you are not eligible to bill for the service. For example, if all requirements for a patient's IPPE are not completed and documented, then the visit is essentially unbillable.

According to Medicare guidelines, the IPPE can be billed by a physician, qualified nurse practitioner, certified nurse specialist or physician assistant. AWVs can be billed by a broader variety of professionals: a physician or qualified nonphysician provider or medical professional, including health educator, registered dietitian, nutritional professional or other licensed practitioner or team of medical professionals working under the direct supervision of a physician.

When to bill both wellness and sick visits

Determining when to bill a separate E&M visit can be difficult. How do you define work that extends above and beyond wellness visit requirements? For example, during an IPPE or AWV, a patient with a history of skin cancer complains of a skin lesion with



Figure 1. Medicare Preventive Services visits

| Requirement | IPPE | Initial AWV | Subsequent AWV |
|---------------------------------------------------------------------------|------|-------------|----------------|
| Beneficiary information | | | |
| Document medical and social history | X | X | Update |
| Document potential risk factors for depression and other mood disorders | X | X | |
| Document functional ability and level of safety | X | X | |
| Administer Health Risk Assessment (HRA) | X | X | Update |
| Establish a list of current providers and suppliers | | X | Update |
| Exam/Discussion | | | |
| Conduct exam | X | X | X |
| Discuss end-of-life planning, on agreement of the beneficiary | X | | |
| Detect any cognitive impairment | | X | X |
| Counseling | | | |
| Educate, counsel and refer based on the beneficiary and exam components | X | | |
| Educate, counsel and refer for other preventive services | X | | |
| Establish a written screening schedule for preventive services | | X | Update |
| Establish a list of risk factors with interventions underway | | X | Update |
| Furnish personalized health advice (e.g., referrals for health education) | | X | Update |

irregular borders. This may require a more detailed exam, a biopsy and a referral to a dermatologist — sufficient services to justify billing for a separate visit.

In a less obvious example, a patient may mention worsening asthma symptoms and request a new prescription. If this requires testing, evaluation and medication management — separate from an IPPE or AWV exam — the provider can bill for a separate sick visit. All requirements for the IPPE or AWV still must be met in addition to documentation that supports billing an E&M visit.

When not to bill both visits

Consider the case of a patient who comes in for a wellness visit (IPPE or AWV) and also needs hypertension medication refilled. If the patient has well-controlled hypertension and normal blood pressure at the time of the visit and has been on the same medication for years, then the prescription refill can be included with the wellness exam. A separate E&M visit is not warranted.

To avoid confusion, providers should establish a consistent policy that clarifies when to bill a separate sick visit. Documentation must reflect both services separately to support separate billing. In addition, it is important to inform patients of this policy so they are not surprised by a copay for the sick visit part of the encounter. Some practices require that patients make another appointment to discuss sickness. Others choose to allow “reasonable” discussion and not bill separately. The best approach is to establish clear guidelines that support your practice while also encouraging patient satisfaction.

Coding conundrum

All practitioners should know that proper billing requires accurate and timely coding. However, there is no designated diagnosis code for any of the wellness visits. When coding claims, the following codes are suggested:

- Z00.00: Encounter for general adult medical examination without abnormal findings — wellness only; no separate E&M services
- Z00.01: Encounter for general adult medical examination with abnormal findings — if addressing a separate issue and billing a separate E&M code

Pricing and payment

Payment for preventive services varies based on locality. To determine accurate pricing, physicians need to know the work RVU (wRVU), which is part of the equation used to determine pricing according to the Medicare Physician Fee Schedule. The rest of the equation

changes, resulting in a different dollar amount, based on whether your practice is standalone or owned by a larger facility. For example, here are the prices for Colorado:

- IPPE: \$170.17 (nonfacility)/\$130.10 (facility), wRVU 2.43
- Initial AWV: \$173.70 (same for nonfacility or facility), wRVU 2.43
- Subsequent AWV: \$117.71 (same for nonfacility or facility), wRVU 1.50

Audits

While wellness billing is not new, its various aspects continue to cause confusion and come up during audits. For example, consider the case in which a provider has billed an AWV for a 65-year-old patient. The question is did the provider mean to bill AWV or IPPE? From an outside perspective, if a patient is 65 — assumed to be in the first year of Medicare enrollment — billing for the IPPE would be correct. In any case, timing can be confusing for practitioners and patients. Audit outcomes can help inform provider and patient education initiatives.

Promoting patient awareness

Practices need to prompt their patients to take advantage of wellness visits. Do new beneficiaries typically read Medicare packets received from Centers for Medicare and Medicaid Services (CMS) and seek out services? Many do not. The information can be overwhelming, leaving enrollees unaware of available benefits. How can providers take a proactive approach?

First, identify patients turning 65 who will be enrolled in Medicare and eligible for the IPPE during the first 12 months. Then, send a simple “Welcome to Medicare wellness” notice inviting them to schedule the initial visit. For patients who complete the IPPE, follow up with AWV reminders.

To help patients remember when they are due for their next preventive service, Medicare provides a practical Preventive Services checklist that patients can use to track their preventive services. To help providers determine eligibility for the next service and avoid denial due to frequency edits, CMS suggests contacting your eligibility service vendor or checking your Medicare Administrative Contractor’s eligibility services.

Many physicians may not realize the missed opportunities for every eligible patient in their locality. In the new world of value-based care, promoting patient awareness of Medicare preventive services is crucial for clinical and financial purposes. ■

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Resources for Medicare Preventive Services

Medicare Preventive Services: mgma.org/mps-reference

The ABCs of the Initial Preventive Physical Examination (IPPE): mgma.org/mps-ippe

The ABCs of the Annual Wellness Visit (AWV): mgma.org/mps-awv