Event Instructions

- Today’s event is a teleconference
- Slides will not be advanced during the presentation
- Attendees are instructed to refer to their handout material
- All lines will be placed on mute until the question and answer period
- There will be a live Q&A session after the presentation
- To participate in the teleconference please dial
  - Telephone number: 1-800-791-2345
  - Access code: 88096
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Today’s Agenda

- Background
- Initial Preventive Physical Examination and the Annual Wellness Visit
  - Who is eligible?
  - Who can render the services?
  - Coding guidelines
- Medicare Updates
- Question & Answer
- Closing Remarks
<table>
<thead>
<tr>
<th>ACRONYM</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>AWV</td>
<td>Annual Wellness Visit</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
</tr>
<tr>
<td>HRA</td>
<td>Health Risk Assessment</td>
</tr>
<tr>
<td>IPPE</td>
<td>Initial Preventive Physical Examination</td>
</tr>
<tr>
<td>MAC</td>
<td>Medicare Administrative Contractor</td>
</tr>
<tr>
<td>PPACA (also known as ACA)</td>
<td>Patient Protection and Affordable Care Act</td>
</tr>
<tr>
<td>PPPS</td>
<td>Personalized Prevention Plan Services</td>
</tr>
<tr>
<td>MPFS</td>
<td>Medicare Physician Fee Schedule</td>
</tr>
</tbody>
</table>
Your Initial Question to Ask

- Initial Preventive Physical Exam
  - Key Phrase: “Are you a brand new Medicare beneficiary?”

- Annual Wellness Visit
  - Key Phrase: “Have you been a Medicare beneficiary for more than one year?”
Before the IPPE and AWV

- Non-covered preventive exams include:
  - Codes listed with an “N” status indicator on the MPFS database
- Prior to 2009, there was no coverage for wellness examinations
- Started an evolution for newly enrolled Medicare and established beneficiaries
- Key legislation that impacted preventive services
  - Medicare Modernization Act of 2003
  - Affordable Care Act of 2010
**Services rendered from January 1, 2014 through June 30, 2014**
**Services rendered from January 1, 2014 through June 30, 2014**

<table>
<thead>
<tr>
<th>COUNT</th>
<th>G0402</th>
<th>G0438</th>
<th>G0439</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COUNT</strong></td>
<td>12,105</td>
<td>45,609</td>
<td>111,332</td>
</tr>
</tbody>
</table>

**Total Count IPPE & AWV**

- G0402
- G0438
- G0439

Data Analysis
Background (IPPE)

- Enacted into law by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (also known as the Medicare Modernization Act)

- Modified by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)
Eligibility and Frequency

- Beneficiary should be made aware of the following
  - The IPPE is also referred to as the “Welcome to Medicare” visit
  - It is a One-time visit
  - Medicare program will cover the benefit within the first 12 months of Medicare Part B enrollment
Who Can Furnish the IPPE?

- Physician (doctor of medicine or osteopathy)

- Qualified non-physician practitioner, which includes a:
  - Physician Assistant (PA)
  - Nurse Practitioner (NP)
  - Clinical Nurse Specialist (CNS)
Requirements for the IPPE

- IPPE will consist of the following:
  1. Review the patient’s medical and social history;
  2. Review potential risk factors for depression and other mood disorders;
  3. Review functional ability and level of safety;
  4. Measurement of height, weight, body mass index (BMI), and visual acuity screening;
  5. End-of-life planning (upon agreement of individual);
  6. Education, counseling and referral*
  7. Education, counseling and referral for preventive services, including brief written plan

*Based on review of the previous five components
What is Included in the IPPE?

<table>
<thead>
<tr>
<th>Acquire Beneficiary History</th>
<th>Elements</th>
</tr>
</thead>
</table>
| □ 1. Review of the beneficiary's medical and social history | At a minimum, collect the following:  
- Past medical/surgical history (experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments);  
- Current medications and supplements (including calcium and vitamins);  
- Family history (review of medical events in the beneficiary's family, including diseases that may be hereditary or place the beneficiary at risk);  
- History of alcohol, tobacco, and illicit drug use;  
- Diet; and  
- Physical activities. |
| □ 2. Review of the beneficiary's potential risk factors for depression and other mood disorders | Use any appropriate screening instrument for beneficiaries without a current diagnosis of depression recognized by national professional medical organizations to obtain current or past experiences with depression or other mood disorders. |
| □ 3. Review of the beneficiary's functional ability and level of safety | Use any appropriate screening questions or standardized questionnaires recognized by national professional medical organizations to review, at a minimum, the following areas:  
- Hearing impairment;  
- Activities of daily living;  
- Falls risk; and  
- Home safety. |

## Billing Requirements

### Codes Used to Bill the IPPE

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>G0402</strong>: Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment</td>
<td>Initial Preventive Exam</td>
</tr>
<tr>
<td><strong>G0403</strong>: Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report</td>
<td>EKG for initial prevent exam</td>
</tr>
<tr>
<td><strong>G0404</strong>: Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination</td>
<td>EKG tracing for initial prev</td>
</tr>
<tr>
<td><strong>G0405</strong>: Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination</td>
<td>EKG interpret &amp; report preve</td>
</tr>
</tbody>
</table>
Initial Preventive Physical Exam

- **HCPCS code G0402** must be used to report the IPPE
  - All of the components of the IPPE must be provided and documented in a beneficiary’s medical record
  - Although a diagnosis code must be reported on the claim, there are no specific International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis codes that are required
  - You will choose the appropriate diagnosis code
    - For example, diagnosis code V70.0, V70.3, or V70.9 could be considered an acceptable diagnosis

- Deductible and co-insurance is waived
**IPPE and Routine ECG**

- **HCPCS codes G0403, G0404, and G0405 are used**

- Effective January 1, 2009, the screening ECG is billable when it is a result of a referral from an IPPE

- Deductible and co-insurance is applicable
A diagnostic ECG cannot be performed on the same day as the screening ECG for the IPPE unless it is medically necessary.

If a diagnostic ECG performed on the same day as codes G0403, G0404, or G0405 is deemed medically necessary, then the diagnostic ECG must be billed with modifier 59.
Non-covered Preventive Services

- Medicare non-covered preventive services may also be billed with an IPPE visit

  - The provider may issue an Advance Beneficiary Notice of Non-Coverage (ABN) to notify the patient that payment for the additional non-covered preventive services will fall to the beneficiary

  - All of the service elements of the IPPE exam must be furnished in order to bill Medicare for the IPPE
Background (AWV)

- Enacted into law by the Section 4103 of the Patient Protection and Affordable Care Act of 2010 (also called the Affordable Care Act)

- Change Request 7079 laid the framework for the implementation
Eligibility and Frequency (AWV)

- Eligible Medicare beneficiaries
  - Are no longer within 12 months after the effective date of his or her first Medicare Part B coverage period
  - Have not received either an initial preventive physical examination (IPPE) or an AWV within the past 12 months

- Benefit includes an initial and subsequent visit

- Only available once every 12 months
Who Can Furnish AWV?

- Physician
- Physician Assistant, Nurse Practitioner or Clinical Nurse Specialist
- Medical Professional
  - Health educator, registered dietitian or nutrition professional or team of professionals
  - Under the direct supervision of a physician
## Requirements for the AWV

<table>
<thead>
<tr>
<th>Initial</th>
<th>Subsequent</th>
</tr>
</thead>
<tbody>
<tr>
<td>A health risk assessment (HRA)</td>
<td>Review of updated HRA</td>
</tr>
<tr>
<td>Establishment of a current list of provider and suppliers</td>
<td>Update medical and family history</td>
</tr>
<tr>
<td>Review of medical and family history</td>
<td>Update of list of current providers and suppliers</td>
</tr>
<tr>
<td>Measurement of height, weight, BMI, and blood pressure</td>
<td>Measurement of weight and blood pressure</td>
</tr>
<tr>
<td>Review of potential risk factors for depression and other mood disorders</td>
<td>Detection of cognitive impairment the patient may have</td>
</tr>
<tr>
<td>Review of functional ability and level of safety</td>
<td>Update of the written screening schedule</td>
</tr>
<tr>
<td>Review of functional ability and level of safety</td>
<td>Update of the list of risk factors</td>
</tr>
<tr>
<td>Detection of any cognitive impairment the patient may have</td>
<td>Provision of personalized health advice and referral</td>
</tr>
<tr>
<td>Establishment of a written screening schedule</td>
<td></td>
</tr>
<tr>
<td>Establishment of a list of risk factors</td>
<td></td>
</tr>
<tr>
<td>Provision of personalized health advice and referral</td>
<td></td>
</tr>
</tbody>
</table>
What is Included in the AWV?

Health Risk Assessment (HRA)

- HRA was included in the Annual Wellness visit in 2012
  - It should be included either prior to or as a part of the PPPS

- The HRA
  - Collects self-reported information known to the beneficiary
  - Can be administered by beneficiary or health professional before, or as part of, the annual wellness visit
  - Takes no more than 20 minutes to complete
Framework for Patient Centered: HRA

- Published by the Centers for Disease Control (CDC)
- Includes section about
  - History of HRAs
  - Definition of the HRA framework
  - Rationale for its use
  - Follow-up interventions that influence health behavior
  - Suggested set of HRA questions

## Billing Requirements (AWV)

### Codes Used to Bill the AWV

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0438: Annual wellness visit, includes a personalized prevention plan of service (PPPS), first visit</td>
<td>Annual wellness first</td>
</tr>
<tr>
<td>G0439: Annual wellness visit, includes a personalized prevention plan of service (PPPS), subsequent visit</td>
<td>Annual wellness subseq</td>
</tr>
</tbody>
</table>
Billing Requirements (AWV)

- The initial AWV (G0438) is a once in a lifetime benefit
- The subsequent AWV (G0439) is a benefit that can be administered on an annual basis
  - Given the fact that 11 months have passed since the last AWV
- Deductible and coinsurance are waived
- Although a diagnosis code must be reported on the claim, there are no specific ICD-9-CM diagnosis codes required for the AWV
- Medicare providers should chose an appropriate ICD-9-CM diagnosis code
  - For example, diagnosis code V70.0, V70.3, or V70.9 could be considered an acceptable diagnosis
2014 Payment Rates

- The Medicare fee allowable for HCPCS codes G0402, G0438 and G0439 are located on the Medicare Physician Fee Schedule.

- You can access your locality fee schedule amount via the
  - Cahaba GBA website at https://apps.cahabagba.com/fees/getPhysician.do,
  - OR;
Change Request 8153

- Effective date: July 1, 2013
- Implementation date: July 1, 2013
- Recovery of Annual Wellness Visit Overpayments
- Provides instructions to contractors to initiate a recovery process

Resources

MLN Matters Article 7012: Waiver of Coinsurance and Deductible for Preventive Services

MLN Matters Article 7079: Annual Wellness Visit, Including Personalized Prevention Plan Services

MLN Matters Article 6223: Update to the IPPE benefit
CLAIM SUBMISSION TIPS
# Top Reasons for Denials

<table>
<thead>
<tr>
<th>Claim denied because</th>
<th>Remittance Advice Code states</th>
<th>You should</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duplicate claims submitted prior to claim adjudication</td>
<td><strong>CO 18</strong>: Exact duplicate claim/service</td>
<td>Verify if there is a pending claim that is currently on the payment floor.</td>
</tr>
<tr>
<td>The IPPE service billed with Modifier 25</td>
<td><strong>CO 4</strong> - The procedure code is inconsistent with the modifier used or a required modifier is missing</td>
<td>Correct your claim and resubmit for payment consideration. This is considered a returned as unprocessable denial and you will not have appeal rights.</td>
</tr>
<tr>
<td>AWV code is submitted for a newly enrolled Medicare beneficiary</td>
<td><strong>N30</strong>: Recipient ineligible for this service</td>
<td>Verify the entitlement date for your patient. If they are newly enrolled in the Medicare program (within 12 months), you may need to bill the IPPE code.</td>
</tr>
</tbody>
</table>
## Reasons for Reopening Requests

- Our Clerical Error Reopening department receive adjustments when claims have denied when

<table>
<thead>
<tr>
<th>Problem</th>
<th>Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>The incorrect preventive service code has been billed.</td>
<td>Request a reopening with the corrected information. Resubmit the claim with the corrected code.</td>
</tr>
<tr>
<td>A provider bills the appropriate code but is unaware that another provider has already billed the code.</td>
<td>Verify the patient’s eligibility by using the InSite web portal.</td>
</tr>
</tbody>
</table>
Example of Reopening


- An adjustment was requested by the provider. A request was made to change the code to HCPCS code G0402.
Example of Reopening


- An adjustment was requested by the provider. A request was made to change the code to HCPCS code G0402.
Things to Consider

- Verify allowable amounts on your Remittance Advice (RA)

- Adjusted claims will appear on your RA with a region code 46, 57, or 83 depending on the state jurisdiction
  
  - For example your adjusted claim will show an internal claim number (ICN) listed as 4614225999990 for a Part B Georgia provider
Things to Consider

- Inform your patients prior to the appointment
  - Prepare a checklist with the description of the IPPE and AWV
  - Provide an explanation on the lack of a physical examination
  - Coordinate with front office staff

- Use the Quick Reference Information for preventive services resource guide
  - Provides a description of the service, HCPCS/CPT code, frequency, diagnosis and beneficiary responsibility
Frequently Asked Questions

- **Question:** The patient wants the AWV before it has been 12 months since the previous AWV or Initial Preventive Physical Examination (IPPE). Must I provide the patient with an Advance Beneficiary Notice of Noncoverage (ABN)?
  - **Answer:** The timing of these services is a statutory benefit and therefore services outside the payable periods do not require an ABN.

- **Question:** The beneficiary just became eligible for Medicare. Will Medicare pay for an AWV?
  - **Answer:** During the first year of Medicare enrollment, the patient is not eligible for the AWV. Medicare can allow the IPPE (Welcome to Medicare visit) during this time. The AWV could be payable by Medicare after the first year of enrollment and only if it has been more than 11 full months following the IPPE (if the patient received the IPPE).

- **Question:** The patient scheduled the encounter for an IPPE/AWV. However, once in the office, they also brought up several medical conditions. Can I bill for the IPPE/AWV in addition to the medically necessary Evaluation and Management (E/M) procedure code?
  - **Answer:** You can bill for both services when the E/M service is significant and separately identifiable from the AWV. Providers should report modifier 25 when appropriate. Some of the components of a medically necessary E/M service may have been part of the IPPE/AWV and should not be included when determining the most appropriate E/M procedure code. Please see the information in the CMS IOM Publication 100-04, Chapter 12, Section 30.6.1.1 and 30.6.2 to determine specific billing instructions.
## Comparison of the IPPE and AWV Codes

<table>
<thead>
<tr>
<th></th>
<th>IPPE</th>
<th>Initial AWV</th>
<th>Subsequent AWV</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligibility</strong></td>
<td>Within the first 12 months of Medicare Part B eligibility</td>
<td>After 12 months of Part B eligibility and more than 12 months since the IPPE was performed</td>
<td>Every year after the initial AWV. Must be 11 full months after the month of the last AWV</td>
</tr>
<tr>
<td><strong>HCPCS Codes</strong></td>
<td>G0402</td>
<td>G0438</td>
<td>G0439</td>
</tr>
<tr>
<td><strong>Eligible Providers</strong></td>
<td>Physician (doctor of medicine or osteopathy), Other qualified non-physician practitioner (physician assistant, nurse practitioner, or clinical nurse specialist)</td>
<td>Physician (doctor of medicine or osteopathy), Physician assistant, Nurse practitioner, Clinical nurse specialist, and Medical professional (including a health educator, a registered dietitian, nutrition professional, or other licensed practitioner) or a team of such medical professionals working under the direct supervision of a physician (doctor of medicine or osteopathy)</td>
<td></td>
</tr>
<tr>
<td><strong>Miscellaneous</strong></td>
<td>✓ Paid based on MPFS&lt;br&gt;✓ Deductible and co-insurance is waived&lt;br&gt;✓ Separate Evaluation &amp; Management services can be provided and billed with modifier 25 at the time of these visits provided that the services are significant, separately identifiable, and medically necessary services.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CMS Manual Regulations

Medicare Claims Processing Manual - Pub. 100-04
Chapter 12, Section 30.6.1.1

Chapter 18, Section 80

Medicare Benefit Policy Manual - Pub. 100-02, Chapter 15, Section 280
MEDICARE UPDATE

MEDICARE UPDATES
Would you like to be a Volunteer Tester for ICD-10?

- Cahaba GBA is currently soliciting for a sample of 50 participants
- Submit the volunteer form to us by October 3, 2014
- Selected testers will be notified by October 24, 2014
- Please refer to our “Featured News” section on the Cahaba GBA website at www.cahabagba.com
URGENT! Deadline for groups to participate in the 2014 PQRS Group Practice Reporting Option (GPRO)

Must register by September 30, 2014

You will need to register through the PV-PQRS Registration System at https://portal.cms.gov

Applicable to groups with 10 or more eligible professionals

Avoid the automatic negative two percent Value Modifier payment adjustment in CY 2016

Additional information located at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Self-Nomination-Registration.html
PV-PQRS Registration System

Physician Value

The physician value portal allows physician group practices to select their PQRS reporting mechanism, if applicable, elect Consumer Assessment of Healthcare Providers and Systems (CAHPS), and view their Quality and Resource Use Reports.

Help Desk Contact Information
1-888-794-8433
pvhelpdesk@cms.hhs.gov

CMS.gov | Enterprise Portal
Centers for Medicare & Medicaid Services

Health Care Quality Improvement System  Provider Resources

CMS Secure Portal

To log into the CMS Portal a CMS user account is required.

Login to CMS Secure Portal

Forgot User ID?
Forgot Password?
New User Registration

CMS Enterprise Portal  MACBIS  Medicare Shared Savings Program  Physician Value  Open Payments
Contractor Updates

- **Comprehensive Error Rate Testing (CERT)**
  - Revised timeline to submit initial documentation rescinded
    - Providers were told to begin submitting initial CERT documentation in 60 days effective January 1, 2014
    - Timeline remains 75 days

- **Recovery Auditor**
  - Delay in the award of new Recovery Auditor contracts
  - Recovery Auditors are allowed to restart reviews
    - Handled on an automated basis
    - Limited number of complex review of topics selected by CMS
  - CMS remain hopeful that new RA contracts will be awarded this year
A Message From Provider Enrollment

- Due to higher than normal volumes of application receipts, some providers may experience a processing delay.

- In order to avoid any delay in processing your Medicare enrollment:
  - Ensure all sections of the enrollment application(s)/form(s) are complete.
  - Provide any supporting documentation.
  - Make sure you provide the email address for the contact person listed on the Medicare application.

SECTION 13: CONTACT PERSON

If questions arise during the processing of this application, the fee-for-service contractor will contact the individual shown below. If the contact person is either an authorized or delegated official, check the appropriate box below.

- [ ] Contact an Authorized Official listed in Section 15.
- [ ] Contact a Delegated Official listed in Section 16.
SELF-SERVICE TOOLS
InSite Portal

- Cahaba GBA launched a new web portal in June 2014
- User can access claim status and Medicare eligibility
What is InSite

- *InSite* is a self-service application which will provide access to real-time information over the internet via a secure portal.

- Similar options available
  - Interactive Voice Response (IVR)
  - Provider Contact Center (PCC), *if IVR is not available*

- All you need is Internet Access and an E-mail address.

- There is no cost to access *InSite*.
Main Landing Page (InSite)
QUESTIONS

General inquiries should be referred to the Provider Contact Center

For Jurisdiction 10 (AL, GA, TN providers):
877-567-7271

Questions related to electronic billing issues should be referred to the

EDI Help Line:
866-582-3253
Evaluate Today’s Teleconference

- We value your opinion and appreciate your feedback and comments regarding today’s event
- Take a moment to complete the Online Evaluation
- Thank you for your participation!