My Notes on Today’s CMS Call on the Initial Preventive Physical Exam (Not a Physical Exam) and the Annual Wellness Visit

Today’s CMS call reviewed the guidelines for the IPPE (Initial Preventive Physical Exam) and the AWV (Annual Wellness Visit), what they include and how to code for them.

What is the IPPE (also called the “Welcome to Medicare Visit”)?

The IPPE is a one-time visit, covered within 12 months after the effective date of Part B coverage and including:

- Review of medical and social history.
- Review of risk factors for depression.
- Review of functional ability and level of safety.
- Measurement of height, weight, body mass index, blood pressure, visual acuity, and other factors deemed appropriate.
- Discussion of end-of-life planning, if agreed upon by the patient.
- Education, counseling and referrals based on results of review and evaluation services performed during the visit, including a brief written plan such as a checklist, and if appropriate, education, counseling and referral for obtaining an electrocardiogram (a/k/a EKG, ECG).
- Note that although the IPPE has the word “exam” in it, there is NO physical exam associated with it. Most

practices attempt to call it the **Welcome to Medicare Visit** and try never to use the word "exam" in association with it.

Who can provide the IPPE?

- Physician (doctor of medicine or osteopathy)
- Qualified non-physician practitioner including nurse practitioner physician assistant or Clinical nurse specialist

How is the IPPE Billed?

G0402
Initial preventive physical examination (not really an examination); face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment, plus ONE of the following if a electrocardiogram is done.

G0403
Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report.
G0404
Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination.
G0405
Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination.

What if the IPPE is provided in a facility?

These services typically are provided in a physician office,

however, when the services are provided in a facility, the following institutions can bill as follows:

- Hospitals for inpatients (TOB 12X) and outpatients (TOB 13x)
- Skilled Nursing Facilities for inpatients (TOB 22X)
- Rural Health Centers (TOB 71X)
- Federally Qualified Health centers (TOB 77X)
- Critical Access Hospitals (TOB 85X)

What diagnosis code should be used?

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 for the IPPE; therefore, Medicare providers should chose an appropriate ICD-9-CM diagnosis code.

How often can the IPPE and the screening EKG be performed?

The IPPE (G0402) is a one-time benefit that must be provided within 12 months of the effective date of a beneficiary’s Medicare Part B coverage. The screening EKG (G0403, G0404, G0405), when done as a referral from an IPPE, is also only covered once during a beneficiary’s lifetime.

How does the provider collect for the IPPE at time of service?

Effective for dates of services on or after January 1, 2011, the coinsurance or copayment and deductible are waived for the IPPE (G0402) only. The deductible and coinsurance still applies to the screening EKG.

What about screening for the abdominal aortic aneurysm (AAA)?

A one-time only ultrasound screening for an Abdominal Aortic Aneurysm (AAA) can be done as the result of a referral from an IPPE for Medicare beneficiaries with certain risk factors. The code for billing the AAA ultrasound screening is:

G0389

Ultrasound, B-scan and or real time with image documentation; AAA screening

Effective for dates of services on or after January 1, 2011, the co-insurance or co-payment and deductible are waived for the AAA ultrasound screening (G0389). For more information on the AAA ultrasound screening done as the result of a referral from an IPPE, please see the CMS Internet-Only Manual Pub. 100-04, chapter 18, section 110 on the CMS web site.

Please Note!
• The IPPE is a preventive wellness visit and not a routine physical examination.
• Medicare does not provide coverage for routine physical exams.

What if other services are provided during the IPPE?

If other evaluation and management services are provided in conjunction with the IPPE, use CPT Modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) as follows:

- Append to the additional E & M service denoting a separate Evaluation and Management (E/M) service

furnished with an IPPE.
- Cost sharing (coinsurance, copayment and deductible) applies to the additional (E/M) service.
- CPT codes 99201 –99215 may be reported depending on the clinical appropriateness of the circumstances.
- **Preventive services identified in CPT code range 99381 through 99397 are not covered by Medicare.**
- CMS speakers noted that they hoped physician offices would let patients know when they could incur out-of-pocket expenses.

NOTE: Some of the components of a medically necessary E/M service (e.g., a portion of history or physical exam portion) may have been part of the IPPE and should not be included when determining the most appropriate level of E/M service to be billed for the medically necessary, separately identifiable, E/M service.

What is the patient's role in preparing for the IPPE?

Providers should encourage patient to come prepared with the following information:

- Medical records, including immunization records if the provider doesn't already have them;
- Family health history in as much detail as possible; and
- A full list of medications and supplements, including calcium and vitamins –how often and how much of each is taken. (Many providers ask patients to bring their actual medication and supplement bottles to every visit so a medication reconciliation can take place and improved communication about medication can take place.)

What is the AWV?

The Annual Wellness Visit (AWV) was created by the Affordable Care Act (ACA) and is a new benefit for 2011. Medicare beneficiaries are eligible for one AWV every 12 months after they have had Medicare Part B for more than 12 months. This is a "visit" and not a physical examination. Patients have a tendency to hear the word "Annual" and think they are getting an annual physical.

The beneficiary does not need to receive an IPPE to be eligible for an AWV. However, if the beneficiary did receive an IPPE, –s/he is eligible for an AWV 12 months following the IPPE.

What is included in the AWV?

Medical/family history

- List of current providers/supplier.
- Blood pressure, height, weight, and other routine measurements.
- Detection of any cognitive impairment.
- Review (potential) risk factors for depression, functional ability, and level of safety.
- A written screening schedule (such as a checklist) for next 5-10 years.
- Documentation of risk factors and conditions where interventions are recommended.
- Personalized health advice and referrals for health education and preventive counseling.

Subsequent AWVs:

- Update of medical/family history.
- Update of list of current providers/suppliers.
- Measurement of weight, blood pressure, and other routine

measurements.
- Detection of any cognitive impairment.
- Update to the written screening schedule.
- Update to the list of risk factors and conditions where interventions have been recommended.
- Update to the personalized health advice and referrals for health education and preventive counseling

Who can provide an AWV?

A “health professional” meaning a:

- Physician
- Physician assistant
- Nurse practitioner
- Clinical nurse specialist
- Medical professional (including a health educator, a registered dietitian, or nutrition professional, or other licensed practitioner) or a team of such medical professionals, working under the direct supervision of a physician

How should the AWV be coded?

The following G-codes identify the AWV for Medicare payment:
G0438

Annual wellness visit, including Personalized Prevention Plan Service, first visit
G0439

Annual wellness visit, including Personalized Prevention Plan Service, subsequent visit

Who can bill for the AWV?

These services typically are provided in a physician office.

When the services are provided in a facility, the following institutions can bill:

- Hospital inpatients (TOB 12X) and outpatients (TOB 13x)
- Skilled Nursing Facilities inpatients (TOB 22X) and outpatients (23X)
- Rural Health Centers (TOB 71X)
- Federally Qualified Health centers (TOB 77X)
- Critical Access Hospitals (TOB 85X)

Note: Medicare makes a single fee schedule payment for a beneficiary's AWV when provided in a physician office or hospital outpatient department.

What diagnosis should be used for the AWV?

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 for the AWV; therefore, Medicare providers should chose an appropriate ICD-9-CM diagnosis code or contact the local Medicare contractor for guidance.

How often can the AWV be performed

- First visit (G0438) – once in a lifetime
- Subsequent (G0439)-annually (after 12 full months have passed since the last AWV)

What should be collected at the time of service?

Effective for dates of services on or after January 1, 2011 co-payment or co-insurance and the Medicare Part B deductible are waived.

Please Note! AWV is a preventive wellness visit and not a routine physical examination. Medicare does not provide coverage for routine physical exams.

What if additional services are provided at the same time as the AWV:

If other evaluation and management services are provided in conjunction with the AWV, use CPT Modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) as follows:

- Append to the additional E & M service denoting a separate Evaluation and Management (E/M) service furnished with an IPPE.
- Cost sharing (co-insurance, co-payment and deductible) applies to the additional (E/M) service.
- CPT codes 99201 –99215 may be reported depending on the clinical appropriateness of the circumstances.
- **Preventive services identified in CPT code range 99381 through 99397 are not covered by Medicare,**
- CMS speakers noted that they hoped physician offices would let patients know when they could incur out-of-pocket expenses.

NOTE: Some of the components of a medically necessary E/M service (e.g., a portion of history or physical exam portion) may have been part of the AWV and should not be included when determining the most appropriate level of E/M service to be billed for the medically necessary, separately identifiable, E/M service.

What is the patient's role in preparing for the AWV?

Providers should encourage patient to come prepared with the following information:

- Medical records, including immunization records if the provider doesn't already have it;
- Family health history in as much detail as possible; and
- A full list of medications and supplements, including calcium and vitamins –how often and how much of each is taken. (Many providers ask patients to bring their actual medication and supplement bottles to every visit so a medication reconciliation can take place and improved communication about medication can take place.)

What is the proposed refinement to the AWV?

Medicare Physician Fee Schedule CY 2012 Proposed Rule suggests incorporating the use and results of a Health Risk Assessment into the provision of personalized prevention plan services during the AWV.

- The proposed rule text is available **here.**
- We welcome public comments before 5pm on August 30, 2011.
- Electronically through www.regulations.gov
- Hard copy (see instructions in the proposed rule)
- CMS staff cannot discuss this topic on today's call.

Q & A From the listeners (my

favorite!)

Q: As a RHC, we usually submit one line item for all services provided on a UB92. How are we supposed to bill this if we are providing both a preventive service and an E & M on the same day?

A: This question was not able to be answered. The listener was asked to send the question to the following email nationalprovidercall@cms.hhs.gov with the subject line reading “IPPE/AWV Call Question.”

Q: We are an Article 28 Institution (place of service 22) – do we still bill the APC separately from the facility?

A: There is not a separate facility payment available, so a single payment is made to the physician or the facility.

Q: We are a Critical Access Hospital – when we receive an order for an EKG or ultrasound AAA, what diagnosis is supposed to come from the physician so that it will pass muster in a review?

A: The initial answer said the EKG should have a screening diagnosis and the AAA should have a risk factor diagnosis, but after a discussion, the listener was asked to send the question to the following email: nationalprovidercall@cms.hhs.gov with the subject line reading “IPPE/AWV Call Question.”

Q: Does the IPPE have a physical exam as a component? If a physical exam is provided, should it be billed as a separate E & M?

A: No physical examination is included. If it is provided, it should be coded separately.

Q: Are there specific identified screening tools that must be used for the depression or mental acuity screening?

A: The physician may choose the screening tool for depression or mental acuity.

Q: We do provider-based billing and our system automatically splits the G code between facility and professional fees. How will we recoup the facility portion?

A: Only one payment is made based on the physician fee schedule.

Q: If Physician Assistants can perform IPPEs and AWVs, does this mean that the patient must be established since mid-level providers cannot care for new Medicare patients?

A: This question was not able to be answered. The listener was asked to send the question to the following email nationalprovidercall@cms.hhs.gov with the subject line reading "IPPE/AWV Call Question."

Q: Is the EKG and AAA screening benefits on the IPPE visit only? Will CMS ever add the EKG and AAA screening benefits to the AWV since so many patients don't take advantage of the IPPE?

A: We will take this under advisement.

Q: Can G0102 (digital rectal exam) be billed with an AWV?

A: Yes.

Q: RE: Referrals to personalized health advice, health education, etc? Are these services covered under Medicare or would these be out-of-pocket expenses for Medicare patients?

A: Would be out-of-pocket unless a covered service.

Q: Will mid-level providers performing AWVs be reimbursed the same as a physician providing the service?

A: This question was not able to be answered. The listener was asked to send the question to the following email

nationalprovidercall@cms.hhs.gov with the subject line reading "IPPE/AWV Call Question."

Q: Will everyone get the answers that were not provided today or just the person who sent the email?

A: CMS will not be compiling the answers, but will post frequently asked questions on their website.

Q: We are getting edits when billing the EKG with the IPPE and the EKG is being denied.

A.This question was not able to be answered. The listener was asked to send the question to the following email nationalprovidercall@cms.hhs.gov with the subject line reading "IPPE/AWV Call Question."

Q: Can V70.5 (unspecified health examination) be used as a diagnosis for IPPE or AWV?

A: Yes, any diagnosis can be used.

Q: Can a medically-necessary EKG (93000) be billed with a IPPE or AWV?

A: Yes.

Q: What should we do when a Medicare patient refuses the AWV and wants a traditional preventive visit? Do we get an ABN signed and charge the 99397 per the patient's request?

A: Yes. Treat the preventive service the way you would any other non-covered service.

Q: Can an IPPE be provided with a pap and pelvic?

A: Yes.

Q: If providing an IPPE, pap and pelvic, breast exam and a physical examination to a Medicare beneficiary, can the physician choose NOT to bill the patient for the physical

exam?

A: This question was not able to be answered. The listener was asked to send the question to the following email nationalprovidercall@cms.hhs.gov with the subject line reading "IPPE/AWV Call Question."

Q: We are having problems with Medicare beneficiaries turning down the IPPE or AWV, asking for an annual physical examination (preventive service), then getting a bill, then calling Medicare and the Medicare rep telling the patient that they should never have been charged.

A: The speakers asked for details about the caller's experience in an email to: nationalprovidercall@cms.hhs.gov with the subject line reading "IPPE/AWV Call Question."

Q: On the Medicare Preventive Physical Exam form, what is the "Up and Go" test?

A: This question was not able to be answered due to the form not being recognized. The listener was asked to send the form to the following email nationalprovidercall@cms.hhs.gov with the subject line reading "IPPE/AWV Call Question."

Q: We are having problems with patients asking for the AWV, but presenting with medical issues. The patients want the service without having to pay the deductible or co-insurance.

A: You can bill for an E & M in addition to the AWV, but the deductible and co-insurance will apply.

Note: if you have a question that was not answered today, you can send it to the following email nationalprovidercall@cms.hhs.gov with the subject line reading "IPPE/AWV Call Question." Every question will not be able to be answered, but they will try to answer as many as possible.

Mary Pat's Suggestions to CMS for future calls:

1. Don’t make presenters with laryngitis participate.
2. Coach all presenters in speaking for an audio presentation – speak slowly, speak loudly, don’t move your head around (causes volume spikes and dips) and be cautious of the auditory disruption turning papers and coughing causes, OR
3. Have a professional or experienced speaker present the slides – no commentary is being given so the CMS experts aren’t needed to speak through the slides.
4. Have one facilitator delegating each question to a specific expert to answer it.

Providing and Billing for the Flu Vaccine: Guidance from CMS, the CDC and the Affordable Care Act

Update posted 8-14-2012: For flu shot updates for the 2012-2013 influenza season, click here.

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Update posted 9-22-2011: For flu shot updates for the 2011-2012 influenza season, click here.

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Update Posted 12-20-2010 – Medicare posted code changes for flu vaccines billed to Medicare after January 1, 2011. Click here for the changes.

For dates of service on or after September 1, 2010, the

corrected Medicare Part B payment allowance for CPT 90655 is $14.858.

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It’s that time again, and despite delayed deliveries to some hospitals and practices, the word on the street is that there will be enough flu vaccine (171 million doses) this year for all who want a flu shot.

Image via Wikipedia

The Center for Disease Control (CDC) recommends that everyone 6 months and older get a flu shot. Each year’s flu vaccine cocktail is unique and this season’s (2010-2011) flu vaccine will protect against three different flu viruses: an H3N2 virus, an influenza B virus and the H1N1 virus that caused so much illness last season.

The Affordable Care Act and the Influenza Vaccine

Just in time for flu season is the Affordable Care Act’s emphasis on preventive care. The ACA states:

> *This influenza season, children 6 months through 18 years, certain high-risk adults 19 through 49 years, and adults 50 years and older who are enrolled in **new** group and individual health plans will be eligible to receive the seasonal flu vaccine **without cost-sharing** when provided by an in-network provider. Beginning in the plan year that starts after March 2, 2011, all adults 19-49 years of age will be eligible to receive the seasonal flu vaccine with no cost-sharing requirements when provided by an in-network provider.*

This is great news for the patient and for healthcare in general. You may consider it good news or bad news, depending on your view of the whole flu shot process. Here’s how it works in many practices:

1. The vaccine is ordered in the spring, with everyone trying hard to guess correctly how many patients will want flu shots in 6 months.
2. The vaccine arrives in the fall and the first hurdle is pricing it, as you will have to decide how much to mark it up to cover the cost of the ordering, handling and stocking and possibly a teeny profit.
3. The administration of the vaccine also has to be priced to cover the cost of supplies (syringe, alcohol swab, sometimes a bandaid, printed Vaccine Administration Sheets) and the cost of labor (assessing the patient to make sure they can get the flu shot, giving the shot, and documenting the lot numbers in case of a recall.)
4. The next decision is disbursement. Do you have a flu shot clinic and have people get in line for the flu shot, or do you take flu shot appointments, do you give flu shots during regular appointments, or some combination thereof? What about drive-through flu clinics? Do people sit in the parking lot for 15 minutes to make sure there are no bad after-effects? How do you let patients know about your flu shot plans without costly postcards or advertisements?
5. Then, there is policy setting for patients whose insurance covers the flu shot and for patients whose insurance does not. Do you collect and refund if necessary, or do you not collect and bill the patient after insurance responds (Jaws theme music here, please.)

Does Medicare pay for flu shots?

Medicare pays 100% of the allowable for influenza vaccine (and

pneumococcal vaccines) and the administration of the vaccines without any out-of-pocket costs to the patient. One flu vaccine is allowable per flu season, but Medicare will pay for a second flu shot if a physician determines and documents the medical necessity. A physician's order is not necessary and a physician's supervision is not necessary – that's why patients are able to get a flu shot at the drugstore. A patient can receive a flu shot twice in one calendar year by getting a flu shot late in one season and getting a flu shot early in the next season.

How should a provider that is not enrolled in Medicare bill for the flu vaccine?

CMS typically does not allow non-enrolled providers to treat Medicare beneficiaries, however, CMS is allowing them to give flu shots this year. Beneficiaries can receive a flu vaccine from any licensed physician or provider. However, the billing procedure will vary depending on whether the physician or provider is enrolled in the Medicare Program.

If you are not a Medicare-enrolled physician or provider who gives a flu vaccine to a Medicare beneficiary, you can ask the beneficiary for payment at the time of service. The beneficiary can then request Medicare reimbursement. Medicare reimbursement will be approximately $18 for each flu vaccine.

Image via Wikipedia

To request reimbursement, the beneficiary will need to obtain and complete form **CMS 1490S**. So the beneficiary may receive reimbursement, you will need to provide the beneficiary with a receipt for the flu vaccine that has the following information written or printed on it:
”¢   The doctor's or provider's name and address

”¢ Service provided (“flu vaccine”)
”¢ Date flu vaccine received
”¢ Amount paid

What codes are used for flu shots?

For flu vaccine and vaccine administration, the following codes are used.

Effective September 1, 2009, (no 2010 changes have been announced) the Medicare Part B payment allowances for influenza vaccines are as follows:

- For HCPCS 9**0655**, the payment will be $15.447: Influenza virus vaccine, split virus, preservative free, for children 6- 35 months of age, for intramuscular use
- For HCPCS code **90656**, the payment will be $12.541: Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years and above, for intramuscular use
- For HCPCS code **90657**, the payment will be $15.684: Influenza virus vaccine, split virus, for children 6-35 months of age, for intramuscular use;
- For HCPCS code **90658**, the payment will be $11.368: Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use
- HCPCS **90660** (FluMist, a nasal influenza vaccine) may be covered if the local Medicare contractor determines its use is medically reasonable and necessary for the beneficiary. When payment is based on 95 percent of the Average Wholesale Price (AWP), the Medicare Part B payment allowance for CPT 90660 is $22.316 (effective September 1, 2009).

G0008 is the Medicare HCPCS for Administration of influenza virus vaccine, including FluMist. Other payers usually require use of 90465, 90466, 90467, 90468, 90471, 90472, 90473

or 90474 for administration of the vaccine.

The associated ICD-9 codes for flu shots are:

V04.81 Influenza
V06.6 Pneumococcus and Influenza (both vaccines at one visit)

Other resources:

- Get your practice and your staff ready for flu season by following the guidelines I write about **here**.
- Free downloads from the CDC **here.**
- MedLine Plus Articles, Downloads and Resources **here**
- Article: **Mandating Influenza Vaccine – One Hospital's Experience** (MedScape free account required)
- National Foundation for Infectious Diseases: **Influenza**
- National Influenza Vaccine Summit: **Prevent Influenza**
- Vaccine Education Center at Children's Hospital of Philadelphia (CHOP) -Influenza: What You Should Know (pdf) **EnglishSpanish**
- Medicare Preventive Services Quick Reference Information Chart: Medicare Part B Immunization Billing (Influenza, Pneumococcal, and Hepatitis B) is available **here** (pdf.)
- For information on roster billing (billing for many patients at one time) see the Medicare Claims Processing Manual for Preventive and Screening Services (Chapter 18) **here** (pdf) Section 10-3.

NOTE: Beneficiaries have been advised to contact the Inspector General hotline at 1-800-HHS-TIPS (1-800-447-8477) to file a complaint if they believe their physician or provider charged an unfair amount for a flu vaccine.

Related articles

- Providing and Billing for the Flu Vaccine: Guidance from CMS, the CDC and the Affordable Care Act (managemypractice.com)