Everything You Ever Wanted to Know About the Global Surgical Package: Coding and Billing for the GSP

If you do the professional fee (pro-fee) coding or billing for surgeries, you know that the rules surrounding the Global Surgical Package (GSP) are many and can be complex. CMS just published a new fact sheet on the GSP and it's a great recap for coders and billers.

The global surgical package, also called global surgery, includes all necessary services normally furnished by a surgeon before, during, and after a procedure. Medicare payment for the surgical procedure includes the **pre-operative, intra-operative** and **post-operative** services routinely performed by the surgeon or by members of the same group with the same specialty. **Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician.**

Is the global surgery payment restricted to hospital inpatient settings?

Global surgery applies in any setting, including an inpatient hospital, outpatient hospital, Ambulatory Surgical Center (ASC), and physician's office. Visits to a patient in an intensive care or critical care unit are also included in the global surgical package if made by the surgeon.

How is Global Surgery classified?

There are **three** types of global surgical packages based on the number of post-operative days.

Zero Day Post-operative Period (endoscopies and some minor procedures)

- No pre-operative period • No post-operative days
- Visit on day of procedure is generally not payable as a separate service

Ten-day Post-operative Period, (other minor procedures)

- No pre-operative period
- Visit on day of the procedure is generally not payable as a separate service
- Total global period is 11 days. Count the day of the surgery and 10 days following the day of the surgery

Ninety-day Post-operative Period (major procedures)

- One day pre-operative included
- Day of the procedure is generally not payable as a separate service
- Total global period is 92 days. Count 1 day before the day of the surgery, the day of surgery, and the 90 days immediately following the day of surgery

Where can I find the post-operative periods for covered surgical procedures?

The Medicare Physician Fee Schedule (MPFS) look- up tool provides information on each procedure code, including the global surgery indicator (available at: http://www.cms.gov/apps/physician-fee-schedule/

overview.aspx). The payment rules for global surgical packages apply to procedure codes with global surgery indicators of 000, 010, 090, and, sometimes, YYY.

- Codes with “000” are endoscopies or some minor surgical procedures (zero day post-operative period).
- Codes with “010” are other minor procedures (10-day post-operative period).
- Codes with “090” are major surgeries (90-day post-operative period)
- Codes with “YYY” are contractor-priced codes, for which contractors determine the global period. The global period for these codes will be 0, 10, or 90 days. Note: not all contractor-priced codes have a “YYY” global surgical indicator. Sometimes the global period is specified as 000, 010, or 090.

While codes with “ZZZ” are surgical codes, they are add-on codes that are always billed with another service. There is no post-operative work included in the MPFS payment for the “ZZZ” codes. Payment is made for both the primary and the add-on codes, and the global period assigned is applied to the primary code.

What services are included in the global surgery payment?

The following services are included in the global surgery payment when furnished by the physician who furnishes the surgery:

- Pre-operative visits after the decision is made to operate. For major procedures, this includes pre-operative visits the day before the day of surgery. For minor procedures, this includes pre-operative visits the day of surgery;
- Intra-operative services that are normally a usual and

necessary part of a surgical procedure.

- All additional medical or surgical services required of the surgeon during the post-operative period of the surgery because of complications, which do not require additional trips to the operating room;
- Follow-up visits during the post-operative period of the surgery that are related to recovery from the surgery;
- Post-surgical pain management by the surgeon;
- Supplies, except for those identified as exclusions; and
- Miscellaneous services, such as dressing changes, local incision care, removal of operative pack, removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.

What services are not included in the global surgery payment?

- Treatment for post-operative complications requiring a return trip to the Operating Room (OR). An OR, for this purpose, is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient’s room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient’s condition was so critical there would be insufficient time for transportation to an OR);
- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately;

- Immunosuppressive therapy for organ transplants;
- Critical care services (Current Procedural Terminology (CPT) codes 99291 and 99292) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician.

How are minor procedures and endoscopies handled?

Minor procedures and endoscopies have post-operative periods of 10 days or zero days (indicated by 010 or 000, respectively). For 10-day post-operative period procedures, Medicare does not allow separate payment for post-operative visits or services within 10 days of the surgery that are related to recovery from the procedure. If a diagnostic biopsy with a 10-day global period precedes a major surgery on the same day or in the 10-day period, the major surgery is payable separately. Services by other physicians are generally not included in the global fee for minor procedures.

For zero day post-operative period procedures, operative visits beyond the day of the procedure are not included in the payment amount for the surgery. Post- procedure is payable separately.

Physicians Who Furnish the Entire Global Package

Physicians who furnish the surgery and furnish all of the usual pre-and post-operative work may bill for the global package by entering the appropriate CPT code for the surgical procedure only. Separate billing is not allowed for visits or other services that are included in the global package.

When different physicians in a group practice participate in the care of the patient, the group practice bills for the

entire global package if the physicians reassign benefits to the group. The physician who performs the surgery is reported as the performing physician.

Physicians Who Furnish Part of a Global Surgical Package

More than one physician may furnish services included in the global surgical package. It may be the case that the physician who performs the surgical procedure does not furnish the follow-up care. Payment for the post-operative, post-discharge care is split among two or more physicians where the physicians agree on the transfer of care.

When more than one physician furnishes services that are included in the global surgical package, the sum of the amount approved for all physicians may not exceed what would have been paid if a single physician provided all services, except where stated policies allow for higher payment. For instance, when the surgeon furnishes only the surgery and a physician other than the surgeon furnishes pre-operative and post-operative inpatient care, resulting in a combined payment that is higher than the global allowed amount.

The surgeon and the physician furnishing the post-operative care must keep a copy of the written transfer agreement in the beneficiary’s medical record. Where a transfer of care does not occur, the services of another physician may either be paid separately or denied for medical necessity reasons, depending on the circumstances of the case.

Split global-care billing does not apply to procedure codes with a zero day post-operative period.ite.

Using Modifiers “-54” and “-55”

Where physicians agree on the transfer of care during the global period, services will be distinguished by the use of

the appropriate modifier:

- Surgical care only (modifier “-54”); or
- Post-operative management only (modifier “-55”).

For global surgery services billed with modifiers “-54” or “-55,” the same CPT code must be billed. The same date of service and surgical procedure code should be reported on the bill for the surgical care only and post- operative care only. The date of service is the date the surgical procedure was furnished.

- Modifier “-54” indicates that the surgeon is relinquishing all or part of the post-operative care to a physician.
- Modifier “-54” does not apply to assistant at surgery services.
- Modifier “-54” does not apply to an ASC’s facility fees.
- The physician, other than the surgeon, who furnishes post- operative management services, bills with modifier “-55.”
- Use modifier “-55” with the CPT code for global periods of 10 or 90 days.
- Report the date of surgery as the date of service and indicate the date care was relinquished or assumed. Physicians must keep copies of the written transfer agreement in beneficiary’s medical record.
- The receiving physician must provide at least one service before billing for any part of the post-operative care.
- This modifier is not appropriate for assistant at surgery services or for ASC’s facility fees.

Exceptions to the Use of Modifiers “-54” and “-55”

- Where a transfer of care does not occur, occasional post-discharge services of a physician other than the

surgeon are reported by use of the appropriate level E/M code. No modifiers are necessary on the claim.

- Physicians who provide follow-up services for minor procedures performed in emergency departments bill the appropriate level of E/M code, without a modifier.
- If the services of a physician other than the surgeon are required during a post-operative period for an underlying condition or medical complication, the other physician reports the appropriate level E/M code. No modifiers are necessary on the claim. An example is a cardiologist who manages underlying cardiovascular conditions of a patient.

Preoperative Billing

E/M Service Resulting in the Initial Decision to Perform Surgery

E/M services on the day before major surgery or on the day of major surgery that result in the initial decision to perform the surgery are not included in the global surgery payment for the major surgery and, therefore, may be billed and paid separately.

In addition to the E/M code, modifier “-57” (Decision for surgery) is used to identify a visit that results in the initial decision to perform surgery.

The modifier “-57” is not used with minor surgeries because the global period for minor surgeries does not include the day prior to the surgery. Where the decision to perform the minor procedure is typically done immediately before the service, it is considered a routine pre-operative service and a visit or consultation is not billed in addition to the procedure. Carriers/MACs may not pay for an E/M service billed with the modifier “-57” if it was provided on the day of or the day before a procedure with a 0 or 10 day global surgical period.

Day of Procedure Billing

Significant, Separately Identifiable E/M Service by the Same Physician on the Same Day of the Procedure

Modifier “-25” (Significant, separately identifiable E/M service by the same physician on the same day of the procedure), indicates that the patient’s condition required a significant, separately identifiable E/M service beyond the usual pre-operative and post- operative care associated with the procedure or service.

- Use modifier “-25” with the appropriate level of E/M service.
- Use modifiers “-24” (Unrelated E/M service by the same physician during a post-operative period) and “-25” when a significant, separately identifiable E/M service on the day of a procedure falls within the post-operative period of another unrelated, procedure.
- Different diagnoses are not required for reporting the E/M service on the same date as the procedure or other service. Both the medically-necessary E/M service and the procedure must be appropriately and sufficiently documented by the physician or qualified nonphysician practitioner in the patient’s medical record to support the claim for these services, even though the documentation is not required to be submitted with the claim.

Claims for Multiple Surgeries

Multiple surgeries are separate procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day for which separate payment may be allowed. Co-surgeons, surgical teams, or assistants at surgery may participate in performing multiple surgeries on the same patient on the same

day.

Surgeries subject to the multiple surgery rules have an indicator of “2” in the Physician Fee Schedule look-up tool. The multiple procedure payment reduction will be applied based on the MPFS approved amount and not on the submitted amount from the providers. The major surgery may or may not be the one with the larger submitted amount.

Multiple surgeries are distinguished from procedures that are components of or incidental to a primary procedure. These intra-operative services, incidental surgeries, or components of more major surgeries are not separately billable.

There may be instances in which two or more physicians each perform distinctly different, unrelated surgeries on the same patient on the same day (for example, in some multiple trauma cases). When this occurs, the payment adjustment rules for multiple surgeries may not be appropriate.

Claims for Co-Surgeons and Team Surgeons

Under some circumstances, the individual skills of two or more surgeons are required to perform surgery on the same patient during the same operative session. This may be required because of the complex nature of the procedures and/or the patient’s condition. In these cases, the additional physicians are not acting as assistants at surgery.

The following billing procedures apply when billing for a surgical procedure or procedures that require the use of two surgeons or a team of surgeons:

- If two surgeons (each in a different specialty) are required to perform a specific procedure, each surgeon bills for the procedure with a modifier “-62” (Two surgeons). Co-surgery also refers to surgical procedures involving two surgeons performing the parts of the procedure simultaneously, i.e., heart transplant or

bilateral knee replacements. Certain services that require documentation of medical necessity for two surgeons are identified in the MPFS look-up tool.

- If a team of surgeons (more than 2 surgeons of different specialties) is required to perform a specific procedure, each surgeon bills for the procedure with a modifier "-66" (Surgical team). Certain services, as identified in the MPFS look- up tool, submitted with modifier "-66" must be sufficiently documented to establish that a team was medically necessary. All claims for team surgeons must contain sufficient information to allow pricing "by report."
- If surgeons of different specialties are each performing a different procedure (with specific CPT codes), neither co-surgery nor multiple surgery rules apply (even if the procedures are performed through the same incision). If one of the surgeons performs multiple procedures, the procedure rules apply to that surgeon's services.

Post-operative Period Billing

Unrelated Procedure or Service or E/M Service by the Same Physician During a Post-operative Period

Two modifiers are used to simplify billing for visits and other procedures that are furnished during the post-operative period of a surgical procedure, but not included in the payment for surgical procedure.

- Modifier "-79" (Unrelated procedure or service by the same physician during a post-operative period). The physician may need to indicate that a procedure or service furnished during a post- operative period was unrelated to the original procedure. A new post-operative period begins when the unrelated procedure is billed.

- Modifier “-24” (Unrelated E/M service by the same physician during a post-operative period). The physician may need to indicate that an E/M service was furnished during the post-operative period of an unrelated procedure. An E/M service billed with modifier “-24” must be accompanied by documentation that supports that the service is not related to the post-operative care of the procedure.

Return to the OR for a Related Procedure during the Post-Operative Period

When treatment for complications requires a return trip to the OR, physicians bill the CPT code that describes the procedure(s) performed during the return trip. If no such code exists, use the unspecified procedure code in the correct series, i.e., CPT code 47999 or 64999. The procedure code for the original surgery identical procedure is repeated. In addition to the CPT code, physicians report modifier “-78” (Unplanned return to the operating or procedure room by the same physician following initial procedure for a related procedure during the post-operative period).

The physician may also need to indicate that another procedure was performed during the post-operative period of the initial procedure. When this subsequent procedure is related to the first procedure, and requires the use of the operating room, this circumstance may be reported by adding the modifier “-78” to the related procedure.

Staged or Related Procedure or Service by the Same Physician During the Post-operative Period

Modifier “-58” (Staged or related procedure or service by the same physician during the post-operative period) was established to facilitate billing of staged or related surgical procedures done during the post-operative period of the first procedure. Modifier “-58” indicates that the

performance of a procedure or service during the post-operative period was:

- Planned prospectively or at the time of the original procedure;
- More extensive than the original procedure; or
- For therapy following a diagnostic surgical procedure.

Modifier “-58” may be reported with the staged procedure’s CPT code. A new post-operative period begins when the next procedure in the series is billed.

In addition to the CPT code, physicians report modifier “-78” (Unplanned return to the operating or procedure room by the same physician following initial procedure for a related procedure during the post-operative period).

The physician may also need to indicate that another procedure was performed during the post-operative period of the initial procedure. When this subsequent procedure is related to the first procedure, and requires the use of the operating room, this circumstance may be reported by adding the modifier “-78” to the related procedure.

Critical Care

Critical care services furnished during a global surgical period for a seriously injured or burned patient are not considered related to a surgical procedure and may be paid separately under the following circumstances.

Pre-operative and post-operative critical care may be paid in addition to a global fee if:

- The patient is critically ill and requires the constant attendance of the physician; and
- The critical care is above and beyond, and, in most instances, unrelated to the specific anatomic injury or general surgical procedure performed.

Such patients are potentially unstable or have conditions that could pose a significant threat to life or risk of prolonged impairment.

In order for these services to be paid, two reporting requirements must be met:

- CPT codes 99291/99292 and modifier "-25" for pre-operative care or "-24" for post-operative care must be used; and
- Documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed must be submitted. An ICD-10 code for a disease or separate injury which clearly indicates that the critical care was unrelated to the surgery is acceptable documentation.

Health Professional Shortage Area (HPSA) Payments for Services Which are Subject to the Global Surgery Rules

HPSA bonus payments may be made for global surgeries when the services are provided in HPSAs. The following are guidelines for the appropriate billing procedures:

- If the entire global package is provided in a HPSA, physicians should bill for the appropriate global surgical code with the applicable HPSA modifier.
- If only a portion of the global package is provided in a HPSA, the physician should bill using a HPSA modifier for the portion which is provided in the HPSA.

Billing Wrong Surgical or Other Invasive Procedures Performed on a Patient, Surgical or Other Invasive Procedures

Performed on the Wrong Body Part, and Surgical or Other Invasive Procedures Performed on the Wrong Patient

Providers are required to append one of the following applicable Healthcare Common Procedure Coding System modifiers to all lines related to the erroneous surgery or surgeries:

- PA: Surgery Wrong Body Part
- PB: Surgery Wrong Patient; or
- PC: Wrong Surgery on Patient.

For more information, refer to the "National Coverage Determination Manual," Chapter 1, Part 2, Section 140.6 "Wrong Surgical or Other Invasive Procedure Performed on a Patient," 140.7 "Surgical or Other Invasive Procedure Performed on the Wrong Body Part," and 140.8 "Surgical or Other Invasive Procedure Performed on the Wrong Patient" available at http://www.cms.gov/manuals/downloads/ ncd103c1_Part2.pdf on the CMS website.

References:

- Payment rates and indicators (including the global surgery indicator) can be found in the MPFS look-up tool available at http://www.cms.gov/apps/physician-fee-schedule/overview.aspx on the CMS website.
- For more information, refer to The Payment System Fact Sheet "Medicare Physician Fee Schedule" (MPFS), which provides a brief overview of the MPFS, available at http://www.cms.gov/MLNProducts/downloads/ MedcrePhysFeeSchedfctsht.pdf on the CMS website.
- For more information on Billing Wrong Surgical or Other Invasive Procedures, refer to the "Medicare Claims Processing Manual" (Chapter 32, Section 230 – Billing Requirements for Special Services) available at http://

www.cms.gov/manuals/downloads/clm104c32.pdf on the CMS website.

- "Medicare Claims Processing Manual" (Chapter 12, Section 40.2 – Physicians/Nonphysician Practitioners) available at http://www.cms.gov/manuals/downloads/clm104c12.pdf on the CMS website.

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.