2020 Provider Reference Guide

Adult Wellness Visits

Initial Preventive Physical Examination (IPPE): This initial visit will include a review of the member's medical and social health history, and preventive services education.

Annual Wellness Visit (AWV): Visit to develop or update a personalized prevention plan and perform a health risk assessment (HRA).

Routine Physical Examination: Exam performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.

Medicare covers an AWV providing Personalized Prevention Plan Services (PPPS) to members:

- **Who have not received an IPPE or AWV within the past 12 months.**
- **When the AWV is either the initial AWV or the subsequent AWV, but only one can be conducted within a 12-month period.**

How to Implement Best Practices and Improve Performance

- The purpose of an AWV is to get a comprehensive picture of the patient's health risks, goals, and barriers; also, to work with the patient/caregiver to create a plan for the patient's wellness and preventive care.
- An AWV should last longer than a typical office visit, ranging from 45 minutes to one hour, longer if doing initial or additional advanced care planning. An AWV is not the same as an IPPE or a yearly physical exam.
- Physicians (MD or DO) can perform the AWV, however, other licensed professionals such as a qualified non-physician practitioner (physician assistant, nurse practitioner, or certified clinical nurse specialist), health educator, registered dietitian, nutrition professional, or registered nurses can perform the AWV as long as they are working under the direct supervision of a physician.
- Subsequent AWV are the visits after the patient's initial AWV where you review and update all the components of the AWV. Be sure to check with your Electronic Health Record (EHR) vendor to see if they provide specific ways to document the initial and subsequent AWV.
- If you are unsure if the patient had an initial or subsequent AWV by another provider, you can, depending on where you practice, access information through the HIPAA Eligibility Transaction System (HETS) or through the provider call center Interactive Voice Responses (IVRs). Providers can also check with their Medicare Administrative Contractor (MAC) for options available to verify beneficiary eligibility.
- An AWV is a good opportunity to remind your patients of any other services they may need. For example:
  - —Are they due for a Colorectal Cancer Screening and would they be a candidate for home screening such as Cologuard?
  - —Are they due for Breast Cancer Screening and can you get that appointment set up before the visit is over to ensure better compliance?
  - —Remind them if they need a HbA1c lab testing, or nephropathy/diabetic retinal screening or monitoring.

Due to the COVID-19 pandemic, CMS expanded access to telemedicine services. For the duration of the COVID-19 pandemic CMS has waived restrictions that limit which patients may receive a telemedicine visits, eliminates geographical restrictions, and no longer requires the patient to travel to an originating site.

Use of Telemedicine for Annual Wellness Visits

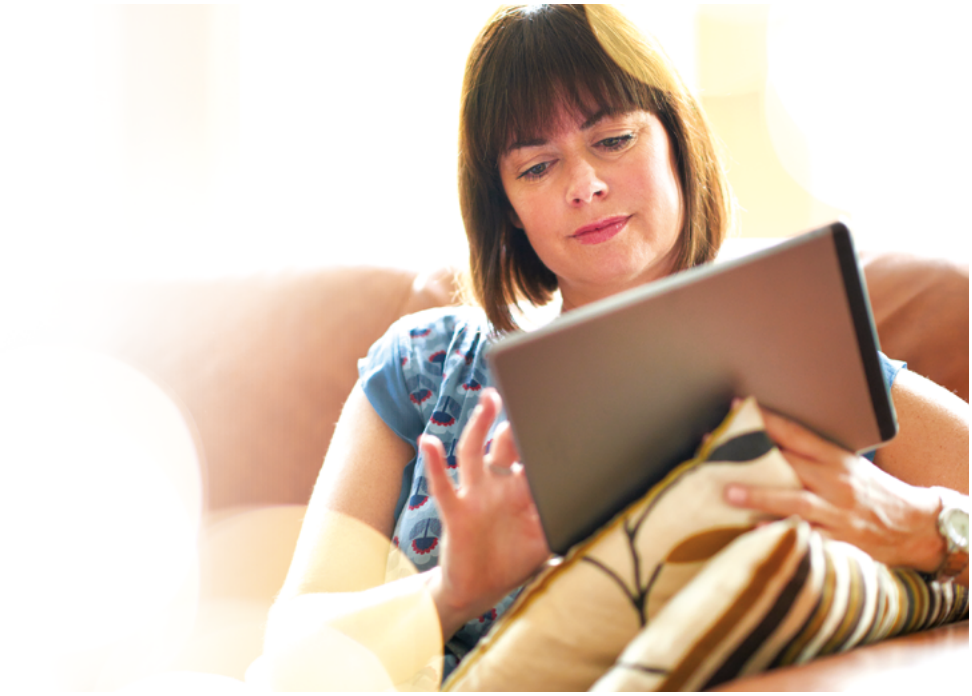
- Performing AWV via telemedicine helps to keep the provider engaged with their patients when they cannot be seen by the traditional office visit. Telemedicine helps patients avoid taking undue risk for in-person visits when it may be detrimental to their health and well-being.
- Telemedicine requires real-time audio and video, where patients and their care team can interact with each other. If clinical staff other than the PCP is performing the telemedicine AWV then the clinical staff need to be under direct supervision of the provider. This means that the provider must either be in the same location as the clinical staff, such as an office suite, or must be able to immediately join the audio and video telemedicine visit.
- On April 30, 2020, CMS expanded regulations to allow certain telemedicine services to be provided as audio-only visits. The initial and subsequent AWV are an allowable audio-only service during the COVID-19 pandemic. For additional information on other audio-only allowable telemedicine services you may visit: **cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes**.
- Documentation of patients' verbal consent to AWV telemedicine services is required and best practice is to have a two clinical person/patient consent.

- For some patients, it may be beneficial to have a family member or caregiver present during a telemedicine visit to help with questions, etc. Documentation of the patient's consent for them to be part of the visit is also required.
- To satisfy the provider "face-to-face" requirement during an office visit, the provider can meet with the patient over telemedicine as well, reviewing those areas that another clinician covered. For an audio-only visit, the provider can verbally speak with the patient. Remember to document that the audio-only visit was conducted due to the COVID-19 pandemic and this is only acceptable during the public health emergency. To review this rule and others that pertain to the public health emergency please go to: **cms.gov/files/document/covid-final-ifc.pdf**.

Providers can help patients prepare for an AWV by telemedicine in various ways, such as:

- Sending an information packet prior to the visit that lets them know what the visit will be like, how long it may take, who from the provider's office will be a part of the visit, and how they will be connected.
- Have the patient complete and send in their HRA prior to the visit so that the provider can review beforehand.
- Remind the patient to have all their medications with them during the visit, in the bottles they were originally filled in.
- Advise the patient to have available during the visit the names and phone numbers of other providers they see, and medical companies they use (for example, if they are on oxygen, receive home delivered meals, attend adult day care, etc.).

Pre-planning a telemedicine visit with your patient will go a long way in the success of the visit.



Components of the Annual Wellness Visit

- The HRA can be completed prior to the visit or during the visit but the information needs to be discussed and documented.
- Perform a complete medication reconciliation including the name of ordering providers if different and the pharmacy where they fill scripts.
- Establish the beneficiary's medical and family history.
- Establish a list of current providers and suppliers.
- Measure height, weight, BMI, and blood pressure. Include other measurements as deemed appropriate based on patient's medical history. If the patient self-reports the information, then document that this was self-reported due to the COVID-19 pandemic. If you are unable to obtain this information, then document unable to obtain and note reason.
- Assess for cognitive impairment.
- Assess for depression using a validated standardized tool such as the PHQ-9.
- Assess functional ability including occurrences of falling, hearing impairment, visual acuity, and overall safety. Include information about home safety and fall risk.
- Establish health goals, screening schedule, and immunizations needed over the next 5 to 10 years with the patient.
- Assess and establish a list of the patient risk factors, conditions and interventions, and recommendations for care.
- Provide the patient with personalized health advice and appropriate referrals based on assessed needs. This includes a health education or preventive counseling services or programs for areas such as, but not limited to, tobacco cessation, weight loss, nutrition, mental health counseling, etc. Document all health advice and referrals provided to the patient.
- Assess advanced care planning needs and be prepared to furnish information for future care needs, advanced directives, etc.

This service is optional, but if done correctly, as it requires additional time, may be an additional billable service without a co-pay.

2020 Coding Tips

ADVANCED CARE PLANNING (ACP) AS AN OPTIONAL ELEMENT OF AN AWV

ACP is the face-to-face conversation between a physician (or other qualified health care professional) and a patient to discuss the patient's wishes and preferences for medical treatment if they are unable to speak or make decisions in the future. You can provide the ACP at the time of the AWV, at the patient's discretion.

ACP is allowable by telehealth during the COVID-19 pandemic and may be billed as an audio-only visit.

ACP CPT CODES AND DESCRIPTORS: Use the following codes for inperson, telehealth, or audio-only visits during the COVID-19 pandemic.

99497	Advanced care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when preformed), by the physician or other qualified health care professional, first 30 minutes, face to face with the patient, family member(s), and/or surrogate.
99498	Advanced care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when preformed), by the physician or other qualified health care professional; each additional 30 minutes, face to face with the patient, family member(s), and/or surrogate.
1123F (CPT-CPT-II)	ACP discussed and documented ACP or surrogate decision maker documented in the medical.
1124F (CPT-CPT-II)	ACP discussed and documented in the medical record, patient did not wish or was not able to name a surrogate decision maker or provide an ACP.
1157F (CPT-CPT-II)	ACP or similar legal document present in the medical record.
1158F (CPT-CPT-II)	ACP discussion documented in the medical record.
S0257 (HCPCS)	Counseling and discussion regarding advance directives or end of life care planning and decisions, with patient and/or surrogate (list separately in addition to code for appropriate evaluation and management service).
Z66	Do Not Resuscitate.

Diagnosis: You must report a diagnosis code when submitting a claim for ACP as an optional element of an AWV. Since you are required to document a specific diagnosis code for ACP as an optional element of AWV, you may choose any diagnosis code consistent with a patient's exam.

Medicare waives the deductible and coinsurance for ACP once per year when billed with the AWV. If the AWV billed with ACP is denied for exceeding the once per year limit, Medicare will apply the ACP deductible and coinsurance.

Note: The deductible and coinsurance apply when ACP is provided outside the covered AWV.

Note: There are no limits on the number of times you can report ACP for a given patient in a given time period. Likewise, CMS established no frequency limits. When you bill the service multiple times for a given patient, document the patient's changed health status and wishes regarding their end-of-life care.

USE THE FOLLOWING HCPCS CODES TO FILE CLAIMS FOR AWV

AWV HCPCS CODES AND DESCRIPTORS: Use the following codes for inperson, teleheath, or audio-only visits during the COVID-19 pandemic.

G0438	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit.
G0439	Annual wellness visit; includes a PPS, subsequent visit.
G0468	Billing a federally qualified health center AWV along with the typical bundle of Medicare-covered serves. For more information on how to bill HCPCS G0468, refer to the Medicare Claims Processing Manual, Chapter, Section 60.2.

Diagnosis: You must report a diagnosis code when submitting a claim for the AWV. Since you are not required to document a specific diagnosis code for the AWV, you may choose any diagnosis code consistent with the patient's exam.

TELEHEALTH CODES AND DESCRIPTORS

Telehealth Modifier 95	Synchronous telemedicine service rendered via real-time
Telehealth Modifier GT	Via interactive audio and video telecommunication systems
Telehealth POS 02	Point of Service

TELEPHONE VISIT CODES

CPT	98966, 98967, 98968, 99441, 99442, 99443

Reference: Medicare Learning Network, CMS, cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AWV-Chart-ICN905706TextOnly.pdf

