CBR201707:

Initial Preventive Physical Examination/ Annual Wellness Visits

Webinar Questions & Answers

September 13, 2017

3:00 p.m. ET

Level II HCPCS codes are maintained and distributed by the Centers for Medicare & Medicaid Services (CMS).

CONTENTS

INTRODUCTION

These questions are excerpted from the **CBR201707: Initial Preventive Physical Examination (IPPE)/Annual Wellness Visits (AWVs)** webinar presented on Wednesday, September 13, 2017. You have the option to view the entire recording of the comparative billing report (CBR), listen to the audio-only version or view the webinar text. You may also open a PDF of the slides or select a specific section of the webinar. All of these options are available from the CBR website page titled **CBR201707 Webinar** (https://www.cbrinfo.net/cbr201707-webinar).

The CBR project has made every reasonable effort to ensure the accuracy of the information and web links provided in the CBR materials at the time of publication; however, Medicare policy changes frequently, so the information and links within the material may change without further notice. It is the responsibility of the provider to remain up-to-date with Medicare program requirements.

CBR materials are prepared as a service to the public and are not intended to grant rights or impose obligations. The information provided in the CBR is only intended to be a general summary. It does not supersede or alter the coverage and documentation policies outlined in the Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and National Coverage Determinations (NCDs) for the Medicare Administrative Contractors (MACs) or Durable Medical Equipment Medicare Administrative Contractors (DME MACs). All coverage and documentation policies are located on the Centers for Medicare & Medicaid Services (CMS) website on the page titled **Medicare Coverage Database** (https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx).

Please refer any specific questions you may have to the MAC or DME MAC for your region. We encourage providers to review the specific statutes, regulations, and other interpretive material for a full and accurate statement of their contents. A listing of all MACs can be accessed from the website of CMS at the following link: **Review Contractor Directory – InteractiveMap** (http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).

GENERAL

Q. When were the CBR letters sent to the physicians?

A. CBR201707 was disseminated on August 14, 2017 to approximately 9,000 Medicare providers who rendered services for IPPEs and AWVs, and billed claims with HCPCS codes G0402, G0438 and G0439. To view an example of this letter, select the following web link: **CBR201707 Sample CBR** (https://www.cbrinfo.net/cbr201707-sample-cbr).

Q. What was the link to contact my Medicare Administrative Contractor (MAC)?

A. To locate the MAC for your region, select the following web link: **Review Contractor Directory – InteractiveMap** (http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).

Q. Did I get a report because I'm billing my claims incorrectly?

A. No, receiving a CBR doesn't necessarily mean you're billing your claims incorrectly. It simply means that your billing is different than your peers. We understand that billing practices can vary for a number of reasons. Your billing could be different because you practice in a rural area, or because you treat a larger number of patients with more severe illnesses than your peers. If you have questions or concerns about your CBR, you can always contact the CBR Support Help Desk. Our phone number is 1-800-771-4430, or you can email us **CBRSupport@eglobaltech.com**.

Q. Are continuing education units (CEUs) available for attending a CBR webinar?

A. At this time, CMS does not offer CEUs for attending our CBR webinar; however, there are some professional organizations that may offer credit. For more information about CEUs, please select the following web link: **Continuing Education Credits** (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/Continuing-Education.html).

Q. How likely is it that an audit will result from this report?

A. The CBR letters are not public documents and are only disseminated to the individual providers; however, we are contracted by CMS to produce these reports and CMS does have

the authority to request any information or findings from the CBRs. We do not keep data on the likelihood of an audit for CBR recipients. We suggest that providers perform self-audits of their own from time to time to ensure that they are meeting the guidelines to support their billing. If you're interested in resources that may be helpful with setting up a self-audit process, please visit the following web page: **Self-Audit Help** (https://www.cbrinfo.net/self-audit-help.html).

Q. How would your organization assist with meeting the MACRA requirements?

A. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is federal legislation that established new ways to pay physicians for treating Medicare beneficiaries. CBRs are educational and informational tools used to compare providers' billing and payment patterns, and are administered by CMS. CBRs are developed and disseminated under contract by eGlobalTech and sub-contractor, Palmetto GBA. If you'd like more information on MACRA and the CBR program, please select the following web links:

- **MACRA** (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html)
- **Comparative Billing Reports** (https://www.cbrinfo.net)

CLINICAL AND BILLING

Q. If feedback from the patient is already documented in the Health Risk Assessment (HRA), is that sufficient for the next subsequent AWV?

A. The purpose of the HRA is to identify health risks and, thereby, assist providers with improving the health outcomes of their Medicare patients. The provider and/or staff can assist the beneficiary with completing the HRA. In subsequent AWV visits, the patient (or caregiver as necessary) can review and update the answers to show any changes from the previous HRA. The Centers for Disease Control and Prevention (CDC) has an example of HRA questions located in the Appendix of the following publication: **A Framework for Patient-Centered Health Risk Assessments** (https://www.cdc.gov/policy/hst/hra/frameworkforhra.pdf).

Q. How should providers handle patients who prefer to have chronic medical conditions addressed at the same time as the AWV? Some patients want prescription refills, labs, referrals, etc. done during this visit.

A. The AWV is not a physical exam; however, if appropriate, evaluation and management (E/M) services, and other treatments, may be provided on the same day as the AWV. The E/M should be significant, separately identifiable, and medically necessary, and the documentation should include a clear history, examination, and medical decision making apart from any other services the physician performs. The E/M portion would be reported with Modifier 25 and would be subject to a co-payment. Per the *Medicare Claims Processing Manual*, "Some of the components of a medically necessary E/M service (e.g., a portion of the history or physical exam portion) may have been part of the IPPE or AWV and should not be included when determining the most appropriate level of E/M service." Detailed information on E/Ms can be found at the following web link: ***Medicare Claims Processing Manual*, Chapter 12, Section 30.6.1** (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf).

Q. Does the visual screening for an IPPE have to be done using the Snellen test or is an inquiry regarding patient's vision sufficient?

A. Medicare does not require that a specific test be used for the visual acuity screening. According to an article published on the U.S. National Library of Medicine database, MedlinePlus, "The visual acuity test is used to determine the smallest letters you can read on a standardized chart (Snellen chart) or a card held 20 feet (6 meters) away. Special charts are used when testing at distances shorter than 20 feet (6 meters). Some Snellen charts are actually video monitors showing letters or images." For more details, select the following web link: **MedlinePlus - Visual Acuity Test** (https://medlineplus.gov/ency/article/003396.htm).

Q. Is blood pressure a new requirement for IPPE/AWV?

A. Blood pressure measurement is a component of both the IPPE and AWV; however, the IPPE and AWV are not considered physical exams or evaluation and management (E/M) services. To view more information about these preventive measures, select the following web links:

- **The ABCs of the Annual Wellness Visit (AWV)** (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_Chart_ICN905706.pdf)
- **The ABCs of the Initial Preventive Physical Examination (IPPE)** (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf)

Q. Must a qualified NPP see the patient in order to be reimbursed for these services? We are a rural health clinic (RHC), and a health educator performs our IPPEs and AWVs.

A. According to **e-CFR, Title 42**, the IPPE can be performed by a physician or non-physician practitioner, such as a physician assistant, nurse practitioner, or certified clinical nurse specialist; however, a health educator is not listed as one of the providers who can perform an IPPE. Per the *Medicare Benefit Policy Manual*, in addition to the health professionals mentioned above, an AWV can also be done by a health educator, registered dietitian, nutrition professional or other licensed professional, or a team of medical professionals who are directly supervised by a physician. For more detailed information about qualified health professionals, please select the following web links:

- ***Medicare Benefit Policy Manual*, Chapter 15 Section 280.5 (Health Professional)** (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf)
- **e-CFR, Title 42 Chapter IV, Subpart B, Section 410.16** (https://www.ecfr.gov/cgi-bin/text-idx?SID=fe166b27a56addf8cc7a0f2c6b138156&mc=true&node=se42.2.410_116&rgn=div8)

Q. Is documentation required when billing the AWV with Advance Care Planning (ACP) and a separately identifiable E/M service at one visit?

A. Documentation should always support any service that is billed. According to Chapter 18 of the *Medicare Claims Processing Manual*, "When ACP services are provided as a part of an AWV, practitioners would report CPT® code 99497 (and add-on CPT® code 99498 when applicable) for the ACP services in addition to either of the AWV codes (G0438 or G0439). The deductible and coinsurance for ACP will only be waived when billed with modifier 33 on the same day and on the same claim as an AWV (code G0438 or G0439), and must also be furnished by the same provider. Waiver of the deductible and coinsurance for ACP is limited to once per year. Payment for an AWV is limited to once per year." Per Chapter 12 of the *Medicare Claims Processing Manual*, "CPT® Modifier 25 shall be appended to the medically necessary E/M service identifying this service as a significant, separately identifiable service." The E/M portion would be reported with modifier 25 and would be subject to a co-payment. For complete details, select the following web links:

- ***Medicare Claims Processing Manual*, Chapter 18, Section 140.8** (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf)
- ***Medicare Claims Processing Manual*, Chapter 12, Section 30.6.1** (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf)

Q. Am I understanding correctly that depression screening is bundled into the subsequent AWV?

A. The AWV requires the provider to review a beneficiary's potential risk for depression or other mental health conditions; however, the provider is not required to perform a depression screening during the AWV. A separate depression screening is covered annually for each beneficiary who has Original Medicare. Per the *Medicare Learning Network®* publication titled **Medicare Preventive Services:** "Screening must be furnished in primary care settings with staff-assisted depression care supports in place to ensure accurate diagnosis, effective treatment, and follow-up," and should be billed with HCPCS code G0444 (annual depression screening, 15 minutes). The co-payment, coinsurance and deductible are waived for depression screenings. To review more information on screenings covered by Medicare, select the following web link: **Medicare Preventive Services** (https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html).

Q. To complete assessments specified in the AWV, must the provider complete a review of systems (ROS) and an exam of the patient, and how is the hands-on part of the physical examination supposed to be billed?

A. ROS is not listed as a component of the AWV; however, we're providing the definition of ROS as outlined in the **1997 Documentation Guidelines for Evaluation and Management Services**: "A review of systems (ROS) is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced. Information included in the review of systems is used to identify the patient problem, assist in the arrival at a diagnosis, identify differential diagnoses, and determine the testing necessary to attain a definitive diagnosis." The specific components of the AWV are outlined in the *Medicare Learning Network* publication titled **The ABCs of the Annual Wellness Visit (AWV).** To access the publications mentioned, select the following web links:

- **1997 Documentation Guidelines for Evaluation and Management Services** (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf)
- **The ABCs of the Annual Wellness Visit (AWV)** (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_Chart_ICN905706.pdf)

Q. When I see a new patient, how do I know if the patient is eligible for an IPPE or AWV, or whether one was done in the past?

A. It is best to contact your MAC to assist you with verifying beneficiary eligibility, as there are different ways to determine AWV eligibility. You may access the information through the Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS) or through the provider call center's Interactive Voice Responses (IVRs) operated by your MAC. For your convenience, we have provided web links below to access your MAC's contact information and to find more details on these systems:

- **Claim Status Request and Response** (https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/ClaimStatus.html)
- **How to Get Connected – HETS 270/271** (https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/HowtoGetConnectedHETS270271.html)
  Review Contractor Directory – Interactive Map (https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/)

Q. If HCPCS G0439 is billed in a patient's first year on Medicare, will service be denied? What if it is billed in the second year before HCPCS G0438?

A. According to the *Medicare Claims Processing Manual*, "Medicare pays for only one first AWV (HCPCS G0438), per beneficiary per lifetime. All subsequent AWVs must be billed using HCPCS G0439." The initial, or first, AWV (HCPCS code G0438) should be billed *after* the first 12 months of coverage, and before the subsequent AWV (HCPCS code G0439). The initial AWV should not be billed during the first 12 months after a beneficiary's Medicare Part B coverage begins. For more information, select the following web link: ***Medicare Claims Processing Manual*, Chapter 12, Section 30.6.1.1** (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf).

Q. Is cognitive impairment counted if the provider uses patient interaction to determine impairment, or is a Mini-Cog required?

A. According to **e-CFR, Title 42**, "Detection of any cognitive impairment means assessment of an individual's cognitive function by direct observation, with due consideration of information obtained by way of patient report, concerns raised by family members, friends, caretakers or others…Review of the individual's potential (risk factors) for depression, including current or

past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the health professional may select from various available standardized screening tests designed for this purpose and recognized by national medical professional organizations." Please contact the MAC for your region if you need additional assistance. For more information, select the following web link: **e-CFR, Title 42 Chapter IV, Subpart B, Section 410.15** (https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=bf51e94acc4a25757858ee16462f60a1&mc=true&n=pt42.2.410&r=PART&ty=HTML#se42.2.410_15).

Q. Must subsequent AWVs (HCPCS G0439) be 12 months apart or 365 days apart?

A. Subsequent AWVs may be provided and billed every 12 months. Please check with your regional MAC to determine the date your beneficiary is eligible. Your MAC's contact information can be accessed at this web link: **Review Contractor Directory – Interactive Map** (https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).

Q. Does the HRA have to be a form that the patient fills out, or can ancillary staff ask the questions and document the answers electronically?

A. Medicare does not require a specific HRA form. The ancillary staff and/or the caregiver may assist the beneficiary with completing the form. The CDC provides a sample HRA form in the Appendix of this publication: **A Framework for Patient-Centered Health Risk Assessments** (https://www.cdc.gov/policy/hst/hra/frameworkforhra.pdf).

REPORT SPECIFICS

Q. What is the average percentage of Medicare Wellness completion per year?

A. Our analysis of Medicare Part B claims shows that there were approximately 128,300 providers who submitted claims for IPPE/AWV with dates of service between April 1, 2016 and March 31, 2017. These providers submitted claims for a total of over 7.3 million beneficiaries. On average, each provider performed about 57 IPPEs/AWVs per year.

Q. Our report seems intimidating as our numbers come out significantly higher. Does this CBR mean we are an outlier since we have a high percentage of AWV and E/M services billed on the same day? Couldn't the other side of the coin be that the comparison venues aren't billing all that they should?

A. CBR201707 is a an analysis of the billing patterns associated with IPPEs and AWVs for an individual provider as compared to the billing patterns of his/her peers. This CBR letter does not indicate any wrong-doing, and is meant for educational purposes based on the literature included in the references and resources section of this CBR. Receiving a comparison of *Significantly Higher* means that the statistical tests show that your billing patterns are different than your peers. This does not necessarily mean that you are an outlier. Also, all statistics supplied in this analysis are based only on the information obtained from the claims. No additional documentation was reviewed, nor special circumstances considered when making these calculations, such as patient acuity levels, or specialties and subspecialties of the provider. If you have additional questions and/or concerns about your CBR, please contact our CBR Support Help Desk by telephone at 1-800-771-4430 or by email at **CBRSupport@eglobaltech.com**.

Q. Is the current table of charges including the E/M charges, or just the additional screening tests, such as the end-of-life counseling code?

A. Table 2 includes only the claims information for HCPCS codes G0402, G0438, and G0439; however, Table 4 includes information on all Medicare Part B claims that were submitted by the same provider of the IPPE/AWV for the same beneficiary and date of service. If you would like to see more information about the tables, select the following web links:

- **CBR201707 Sample CBR** (https://www.cbrinfo.net/cbr201707-sample-cbr)
- **CBR201707 Statistical Debriefing** (https://www.cbrinfo.net/cbr201707-statistical-debriefing.html)

Q. Do these numbers contemplate an organization's success in meeting other quality measures in other federal and payer quality programs? If not, is there an intent to marry those various programs up?

A. CBR201707 is an analysis of IPPE/AWV claims and any additional claims and procedures that were performed on the same day of the wellness visit. This report does not attempt to demonstrate the other quality measures that the provider may be meeting. We are reviewing ways of analyzing the entire provider's practice for future reports.

Q. Do these numbers take into account organizations that screen upcoming provider appointments, and then perform an IPPE or AWV on the same date as the upcoming scheduled office visit or E/M service?

A. This analysis does not take previously scheduled screenings or appointments into consideration. Unfortunately, we do not have access to that type of information.

Q. What does CMS intend to do with the data, as this limited view indicates these providers as skewed from their peers?

A. The information supplied in the CBR was only sent to the individual provider so that he/she can see how his/her billing patterns compare to his/her peers. Since we are contracted by CMS, they can request any information found in the analyses; however, these reports are meant for educational purposes and do not indicate any wrong-doing.

Q. On the CBR report received, is it considered a red flag to Medicare to have significantly higher rate than peers?

A. CBR201707 is a an analysis of the billing patterns associated with IPPEs and AWVs for an individual provider as compared to the billing patterns of his/her peers. This report is meant for educational purposes, and is an opportunity for providers to ensure they are billing claims correctly and following Medicare guidelines. Providers with a comparison of *Significantly Higher* in any of the metrics and with at least $15,000 and 80 beneficiaries for the IPPE/AWV codes were sent a letter; however, this does not indicate any wrong-doing. Receipt of a CBR means that you have billing patterns that differ from your peers.

Q. When the statistical analysis was done, were the number of screenings provided factored into the final costs? If a physician has made an effort to do the appropriate preventive screenings for their patients, it may cause the reimbursement to be higher than a doctor who is only doing a basic wellness visit without screenings.

A. Table 4 of the CBR is a comparison of the **Average Allowed Charges of all Medicare Part B Services per Beneficiary Submitted with each HCPCS Code** (IPPE/AWV). This measure was

included in the analysis since IPPE/AWV are preventive services and the deductible and co-insurance are waived. However, any additional screening or services submitted would be billed separately. This analysis demonstrates how your billing patterns compare to your peers.

Q. Why does using E/M with AWV make you a higher cost provider when you are trying to prevent the patient from coming back to the office?

A. An E/M service may be billed with the IPPE/AWV code only if a significant, separately identifiable, medically necessary problem is addressed during the visit. We are not suggesting any wrong-doing, but ask that you keep documentation to justify your billings.

Q. Have you notified all of the providers who have billing patterns that are significantly below their peers?

A. CMS has contracted with us to help protect the Medicare Trust Fund and effectively manage Medicare resources. Providers with *Significantly Higher* comparisons should be able to justify their billings with proper documentation.

REFERENCES

CBR201707 Webinar (https://www.cbrinfo.net/cbr201707-webinar)

Medicare Coverage Database (https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx)

Review Contractor Directory – InteractiveMap (http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/)

CBR201707 Sample CBR (https://www.cbrinfo.net/cbr201707-sample-cbr)

Continuing Education Credits (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/Continuing-Education.html)

Self-Audit Help (http://www.cbrinfo.net/self-audit-help.html)

MACRA (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html)

Comparative Billing Reports (https://www.cbrinfo.net)

***Medicare Claims Processing Manual*, Chapter 12, Section 30.6.1** (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf)

MedlinePlus - Visual Acuity Test (https://medlineplus.gov/ency/article/003396.htm)

The ABCs of the Annual Wellness Visit (AWV) (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_Chart_ICN905706.pdf)

The ABCs of the Initial Preventive Physical Examination (IPPE) (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf)

A Framework for Patient-Centered Health Risk Assessments (https://www.cdc.gov/policy/hst/hra/frameworkforhra.pdf)

***Medicare Benefit Policy Manual*, Chapter 15 Section 280.5** (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf)

e-CFR, Title 42 Chapter IV, Subpart B, Section 410.16 (https://www.ecfr.gov/cgi-bin/text-idx?SID=fe166b27a56addf8cc7a0f2c6b138156&mc=true&node=se42.2.410_116&rgn=div8)

***Medicare Claims Processing Manual*, Chapter 18, Section 140.8** (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf)

Medicare Preventive Services (https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html)

1997 Documentation Guidelines for Evaluation and Management Services (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf)

Claim Status Request and Response
(https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/ClaimStatus.html)

How to Get Connected – HETS 270/271 (https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/HowtoGetConnectedHETS270271.html)

CBR201707 Statistical Debriefing (https://www.cbrinfo.net/cbr201707-statistical-debriefing.html)