KNOWLEDGE • RESOURCES • TRAINING

Medicare Wellness Visits

QUICK START GUIDE

The Annual Wellness Visits video (https://www.youtube.com/watch?v=r7yOUaMJyJU&feature=youtu.be) helps health care professionals understand each of these exams and their purpose, and the requirements when submitting claims for them.

Medicare Coverage of Physical Exams

Initial Preventive Physical Exam (IPPE) (https://www.ecfr.gov/cgi-bin/text-idx?SID=36118cf6acf7b03ff0dbd7d0e2814720&mc=true&node=pt42.2.410&rgn=div5#se42.2.410_116)	Annual Wellness Visit (AWV) (https://www.ecfr.gov/cgi-bin/text-idx?SID=b88181e2130f26ae6c4741f95a518bbf&mc=true&node=se42.2.410_115&rgn=div8)	Routine Physical Exam (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c16.pdf#page=26) **(see Section 90)**
Review of medical and social health history and preventive services education	Visit to develop or update a personalized prevention plan	Exam performed without relationship to treatment or

✓ **Covered** only once within 12 months of Part B enrollment

✓ Patient pays nothing (if provider accepts assignment)

and perform a Health Risk Assessment (HRA)

✓ **Covered** once every 12 months

✓ Patient pays nothing (if provider accepts assignment)

diagnosis for a specific illness, symptom, complaint, or injury

✗ **Not covered** by Medicare; prohibited by statute (https://www.ecfr.gov/cgi-bin/text-idx?SID=1cffd549894abfbbe6e847ccb727b331&mc=true&node=pt42.2.411&rgn=div5), however some elements of a Routine Physical are covered by the IPPE, the AWV, or other Medicare benefits

✗ Patient pays 100% out-of-pocket

The term "patient" refers to a Medicare beneficiary.

COMMUNICATION AVOIDS CONFUSION

As a health care provider, you may recommend patients get services more often than Medicare covers, including the AWV, or you may recommend services Medicare doesn't cover. If this happens, please ensure patients understand they may have to pay some or all the cost. Communication is key to making sure patients understand why you are recommending certain services, and whether Medicare pays for them.

INITIAL PREVENTIVE PHYSICAL EXAMINATION (IPPE)

The IPPE is known as the "Welcome to Medicare" preventive visit. The IPPE goals are health promotion, and disease prevention and detection. Medicare pays for one patient IPPE per lifetime **not later than the first 12 months after the patient's Medicare Part B benefits eligibility date.**

Components of the IPPE

1. Review the patient's medical and social history

At a minimum, collect information about:

- Past medical and surgical history (experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments)
- Current medications and supplements (including calcium and vitamins)
- Family history (review of medical events in the patient's family, including conditions that may be hereditary or place the patient at risk)
- Diet
- Physical activities
- History of alcohol, tobacco, and illicit drug use

For information about Medicare coverage of substance use disorder services, refer to Medicare Coverage of Substance Abuse Services (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1604.pdf) and the Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/SBIRT_Factsheet_ICN904084.pdf) booklet.

2. Review the patient's potential risk factors for depression, including current or past experiences with depression or other mood disorders	You may select from various standardized screening tools designed for this purpose recognized by national professional medical organizations. For more information on depression screening, refer to the Depression Assessment Instruments (https://www.apa.org/depression-guideline/assessment) website.
3. Review the patient's functional ability and safety level	Use appropriate screening questions or standardized questionnaires recognized by national professional medical organizations to review, at a minimum, the following areas: • Activities of daily living (ADLs) • Fall risk • Hearing impairment • Home safety
4. Exam	Take the following: • Height, weight, body mass index, and blood pressure • Visual acuity screen • Other factors deemed appropriate based on the patient's medical and social history and current clinical standards
5. End-of-life planning, on patient agreement	End-of-life planning is verbal or written information given to the patient about: • The patient's ability to prepare an advance directive in case an injury or illness prevents the person from making health care decisions • If you agree to follow the patient's wishes expressed in an advance directive
6. Educate, counsel, and refer based on the previous components	Based on the results of the review and evaluation services in the previous components, give appropriate education, counseling, and referral.
7. Educate, counsel, and refer for other preventive services	Includes a brief written plan, such as a checklist, for the patient to get: • A once-in-a-lifetime screening electrocardiogram (EKG/ECG), as appropriate • The appropriate screenings and other preventive services Medicare covers in the AWV

IPPE Coding, Diagnosis, and Billing

Use the following HCPCS codes to file IPPE and ECG screening claims.

IPPE HCPCS Codes and Descriptors

G0402

	Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment
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
G0468*	Federally qualified health center (FQHC) visit, IPPE or AWV; a FQHC visit that includes an initial preventive physical examination (IPPE) or annual wellness visit (AWV) and includes a typical bundle of Medicare-covered services that would be furnished per diem to a beneficiary receiving an IPPE or AWV

* For more information on how to bill HCPCS code G0468 refer to the Medicare Claims Processing Manual, Chapter 9, Section 60.2 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf#page=15).

Diagnosis

You must report a diagnosis code when submitting an IPPE claim. Medicare does not require you to document a **specific** IPPE diagnosis code, so you may choose any diagnosis code consistent with the patient's exam.

Billing

Medicare Part B covers an IPPE when performed by a:

- Physician (a doctor of medicine or osteopathy)
- Qualified non-physician practitioner (a physician assistant, nurse practitioner, or certified clinical nurse specialist)

When you furnish an IPPE and a significant, separately identifiable medically necessary Evaluation and Management (E/M) service, Medicare may pay the additional service. Report the additional Current Procedural Terminology (CPT) code (99201–99215) with modifier –25. That portion of the visit **must be** medically necessary and reasonable to treat the patient's illness or injury, or to improve the functioning of a malformed body member.

ANNUAL WELLNESS VISIT (AWV) HEALTH RISK ASSESSMENT (HRA)

The AWV includes a HRA. The following table includes a summary of the minimum elements in the HRA. For more information, refer to the Centers for Disease Control and Prevention's (CDC's) A Framework for Patient-Centered Health Risk Assessments (https://www.cdc.gov/policy/hst/HRA/FrameworkForHRA.pdf), including:

- Evidence suggests HRA use and follow-up interventions can positively influence health behaviors
- The definition of the HRA framework and rationale for its use
- Guidance on HRA use, reduction of health disparities, and improving health outcomes through identification of modifiable health risks and provision of behavior change interventions
- A sample HRA

Initial AWV Components: Applies the First Time a Patient Gets an AWV

Perform an HRA	• Get patient self-reported information
	  ◦ You or the patient complete the HRA before or during the AWV; it should take no more than 20 minutes
	• Consider the best way to communicate with underserved populations, people with limited English proficiency, health literacy needs, and persons with disabilities
	• At a minimum, get information on the following topics:
	  ◦ Demographic data
	  ◦ Health status self-assessment
	  ◦ Psychosocial risks including but not limited to depression/life satisfaction, stress, anger, loneliness/social isolation, pain, and fatigue
	  ◦ Behavioral risks including but not limited to tobacco use, physical activity, nutrition and oral health, alcohol consumption, sexual health, motor vehicle (for example, seat belt use), and home safety
	  ◦ Activities of Daily Living (ADLs) including dressing, feeding, toileting, grooming, physical ambulation including balance/risk of falls and bathing; and Instrumental ADLs (IADLs), including using the telephone, housekeeping, laundry, mode of transportation, shopping, housekeeping, managing medications, and handling finances

1. Establish the patient's medical and family history	At a minimum, document the following: • Medical events of the patient's parents, siblings, and children including conditions that may be hereditary or place the patient at increased risk • Past medical and surgical history including experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments • Use of or exposure to medications and supplements, including calcium and vitamins
2. Establish a list of current providers and suppliers	Include current patient providers and suppliers that regularly give medical care, including behavioral health care.
3. Measure	Take the following:

	• Height, weight, body mass index (BMI); or waist circumference, if appropriate, and blood pressure • Other routine measurements deemed appropriate based on medical and family history
4. Detect any cognitive impairment the patient may have	Assess cognitive function by direct observation, considering information from the patient, family, friends, caregivers, and others. You may also consider the use of a brief cognitive test as well as health disparities, chronic conditions, and other factors that contribute to increased risk of cognitive impairment. For more information, refer to the National Institute on Aging's Alzheimer's and Dementia Resources for Professionals (https://www.nia.nih.gov/health/alzheimers-dementia-resources-for-professionals) website.
5. Review the patient's potential risk factors for depression, including current or past experiences with depression or other mood disorders	You may select from various available standardized screening tools designed for this purpose recognized by national professional medical organizations. For more information on depression screening, refer to the Depression Assessment Instruments (https://www.apa.org/depression-guideline/assessment) website.
6. Review the patient's functional ability and level of safety	Use direct patient observation, or select appropriate questions from various available screening questionnaires, or use standardized questionnaires recognized by national professional medical organizations to assess, at a minimum, the following topics: • Ability to perform ADLs • Falls risk • Hearing impairment • Home safety
7. Establish an appropriate written screening schedule for the patient, such as a checklist for the next 5 to 10 years	Base written screening schedule on the: • United States Preventive Services Task Force (https://www.uspreventiveservicestaskforce.org) and Advisory Committee on Immunization Practices (https://www.cdc.gov/vaccines/acip) recommendations • Patient's HRA, health status and screening history, and age-appropriate preventive services Medicare covers
8. Establish a list of patient risk factors and conditions where primary, secondary, or tertiary interventions are recommended or underway	Include the following: • Mental health conditions including depression, substance use disorder(s) (https://www.samhsa.gov/find-help/disorders), and cognitive impairment • IPPE risk factors or conditions identified • Treatment options and associated risks and benefits
9. Give the patient personalized health advice and appropriate referrals to health education or preventive counseling services or programs	Include referrals to educational and counseling services or programs aimed at:

- Community-based lifestyle interventions to reduce health risks and promote self-management and wellness,
  - Fall prevention
  - Nutrition
  - Physical activity
  - Tobacco-use cessation
  - Weight loss

  including:
  - Cognition

10. Give advance care planning services at the patient's discretion

Advance Care Planning is a discussion between you and the patient about:

- The patient's preparation of an advance directive in case an injury or illness prevents the person from making health care decisions
- Future care decisions that may need to be made
- How the patient can let others know about care preferences
- Caregiver identification
- Explanation of advance directives, which may involve completing standard forms

"Advance directive" is a general term that refers to various documents such as a living will, instruction directive, health care proxy, psychiatric advance directive, or health care power of attorney. It is a document that appoints an agent and/or records a person's wishes about their medical treatment to be used at a future time when the individual is unable to speak for themselves. For more information, refer to the Advance Care Planning (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf) fact sheet.

Subsequent AWV Components: Applies for all Subsequent AWVs After a Patient's First AWV

1. Review and update Health Risk Assessment (HRA)

- Collect patient self-reported information
  - You or the patient can update the HRA before or during the AWV encounter; it should take no more than 20 minutes
- At a minimum, address the following topics:
  - Demographic data
  - Health status self-assessment
  - Psychosocial risks including but not limited to depression/life satisfaction, stress, anger, loneliness/social isolation, pain, and fatigue
  - Behavioral risks including but not limited to tobacco use, physical activity, nutrition and oral health, alcohol consumption, sexual health, motor vehicle (for example, seat belt use), and home safety
  - ADLs including dressing, feeding, toileting, grooming, physical ambulation including balance/risk of falls and bathing; and Instrumental ADLs (IADLs), including using the telephone, housekeeping, laundry, mode of transportation, shopping, housekeeping, managing medications, and handling finances

2. Update the patient's medical/family history	At a minimum, update and document the following: • Medical events of the patient's parents, siblings, and children including conditions that may be hereditary or place the patient at increased risk • Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments • Use of, or exposure to, medications and supplements, including calcium and vitamins
3. Update the list of current providers and suppliers	Include current providers and suppliers regularly involved in delivering the patient's medical care, including any providers and suppliers added as a result of the first AWV Personalized Prevention Plan Services (PPPS), and any behavioral health providers.
4. Measure	Take the following: • Weight (or waist circumference, if appropriate) and blood pressure • Other routine measurements deemed appropriate based on medical and family history
5. Detect any cognitive impairment the beneficiary may have	Assess cognitive function by direct observation, considering information from the patient, family, friends, caregivers, and others. You may also consider the use of a brief cognitive test as well as health disparities, chronic conditions, and other factors that contribute to increased risk of cognitive impairment. For more information, refer to the National Institute on Aging's Alzheimer's and Dementia Resources for Professionals (https://www.nia.nih.gov/health/alzheimers-dementia-resources-for-professionals) website.
6. Update the patient's written screening schedule	Base written screening schedule on the: • United States Preventive Services Task Force (https://www.uspreventiveservicestaskforce.org/) and Advisory Committee on Immunization Practices (https://www.cdc.gov/vaccines/acip) recommendations • Patient's HRA, health status and screening history, and age-appropriate preventive services Medicare covers
7. Update the patient's list of risk factors and conditions where primary, secondary, or tertiary interventions are recommended or underway	Include the following: • Mental health conditions including depression, substance use disorder(s) (https://www.samhsa.gov/find-help/disorders), and cognitive impairment • Risk factors or conditions identified • Treatment options and associated risks and benefits
8. As necessary, give and update the patient's PPPS, which includes personalized patient health advice and referral(s) to health education or	Include referrals to educational and counseling services or programs aimed at:

preventive counseling services or programs when needed	• Community-based lifestyle interventions to reduce health risks and promote self-management and wellness,
	  ◦ Fall prevention
	  ◦ Nutrition
	  ◦ Physical activity
	  ◦ Tobacco-use cessation
	  ◦ Weight loss
	including: ◦ Cognition

9. Give advance care planning services at the patient's discretion	Advance Care Planning is a discussion between you and the patient about: • The patient's preparation of an advance directive in case an injury or illness prevents the person from making health care decisions • Future care decisions that may need to be made • How the patient can let others know about care preferences • Caregiver identification • Explanation of advance directives, which may involve completing standard forms "Advance directive" is a general term that refers to various documents such as a living will, instruction directive, health care proxy, psychiatric advance directive, or health care power of attorney. It is a document that appoints an agent and/or records a person's wishes about their medical treatment to be used at a future time when the individual is unable to speak for themselves. For more information, refer to the Advance Care Planning (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf) fact sheet.

AWV Coding, Diagnosis, and Billing

Coding

Use the following HCPCS codes to file AWV claims.

AWV HCPCS Codes and Descriptors

G0438	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit
G0439	Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit
G0468*	Federally qualified health center (FQHC) visit, IPPE or AWV; a FQHC visit that includes an initial preventive physical examination (IPPE) or annual wellness visit (AWV) and includes a typical bundle of Medicare-covered services that would be furnished per diem, to a patient receiving an IPPE or AWV

* For more information on how to bill HCPCS code G0468, refer to the Medicare Claims Processing Manual, Chapter 9, Section 60.2 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf#page=15).

Diagnosis

You must report a diagnosis code when submitting an AWV claim. Since Medicare does not require you to document a **specific** AWV diagnosis code, you may choose any diagnosis code consistent with the patient's exam.

Billing

Medicare Part B covers an AWV if performed by a:

- Physician (a doctor of medicine or osteopathy)
- Qualified non-physician practitioner (a physician assistant, nurse practitioner, or certified clinical nurse specialist)
- Medical professional (including a health educator, registered dietitian, nutrition professional, or other licensed practitioner), or a team of medical professionals directly supervised by a physician

When you furnish an AWV and a significant, separately identifiable, medically necessary Evaluation and Management (E/M) service, Medicare may pay for the additional service. Report the additional Current Procedural Terminology (CPT) code with modifier –25. That portion of the visit **must be** medically necessary and reasonable to treat the patient's illness or injury, or to improve the functioning of a malformed body member.

You can only bill either G0438 or G0439 once in a 12-month period. G0438 is for the first AWV and G0439 is for subsequent AWVs. Remember, you must not bill G0438 or G0439 within 12 months of a previous G0402 (IPPE) billing for the same patient. Medicare denies these claims with a message of "Benefit maximum for this time period or occurrence has been reached" and "Consult plan benefit documents/guidelines for information about restrictions for this service."

Advance Care Planning (ACP) is an Optional AWV Element

ACP is the face-to-face conversation between a Medicare physician (or other qualified health care professional) and a patient to discuss the patient's health care wishes and medical treatment preferences if they become unable to speak or make decisions about their care. At the patient's discretion, you can give the ACP at the time of the AWV.

Coding

Use the following CPT codes to file ACP claims as an optional AWV element.

ACP CPT Codes and Descriptors

99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), 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	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)

Diagnosis

You must report a diagnosis code when submitting an ACP claim as an optional AWV element. Since Medicare does not require you to document a specific ACP diagnosis code as an optional AWV element, you may choose any diagnosis code consistent with a patient's exam.

Billing

Medicare waives both the ACP coinsurance and the Medicare Part B deductible (https://www.medicare.gov/your-medicare-costs) when:

- Given on the same day as the covered AWV
- Given by the same provider as the covered AWV
- Billed with modifier –33 (Preventive Service)
- Billed on the same claim as the AWV

Medicare waives the ACP deductible and coinsurance 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.

The deductible and coinsurance apply when you give the ACP outside of the covered AWV. There are no limits on the number of times you can report ACP for a given patient in a given time period. When billing this patient service multiple times, document the change in the patient's health status and/or wishes regarding their end-of-life care.

PREPARING ELIGIBLE MEDICARE PATIENTS FOR THE AWV

Providers can help eligible Medicare patients prepare for their AWV by encouraging them to bring the following information:

- Medical records, including immunization records
- A detailed family health history
- A full list of medications and supplements, including calcium and vitamins, and how often and how much of each they take
- A full list of current providers and suppliers involved in providing care, including community-based providers (for example, personal care, adult day care, and home-delivered meals) and behavioral health specialists

IPPE, AWV, AND ROUTINE PHYSICAL – KNOW THE DIFFERENCES

IPPE (https://www.ecfr.gov/cgi-bin/text-idx?SID=36118cf6acf7b03ff0dbd7d0e2814720&mc=true&node=pt42.2.410&rgn=div5#se42.2.410_116)**:**

The IPPE is also known as the "Welcome to Medicare" preventive visit. The IPPE goals are health promotion, and disease prevention and detection.

Medicare pays for one patient IPPE per lifetime not later than the first 12 months after the patient's Medicare Part B benefits eligibility date.

Medicare pays the IPPE costs if the provider accepts assignment.

AWV (https://www.ecfr.gov/cgi-bin/text-idx?SID=b88181e2130f26ae6c4741f95a518bbf&mc=true&node=se42.2.410_115&rgn=div8)**:**

Medicare covers an AWV that delivers Personalized Prevention Plan Services (PPPS) for patients who:

- Are no longer within 12 months after the patient's Medicare Part B benefits eligibility date
- Did not get an IPPE or AWV within the past 12 months
- Medicare pays the AWV costs if the provider accepts assignment and the deductible does not apply

Routine Physical Exam (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c16.pdf#page=26)**:**

Exam performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury

- Medicare does not cover the Routine Physical; it is prohibited by statute (https://www.ecfr.gov/cgi-bin/text-idx?SID=1cffd549894abfbbe6e847ccb727b331&mc=true&node=pt42.2.411&rgn=div5), however some elements of a Routine Physical are covered by the IPPE, the AWV, or other Medicare benefits
- Patient pays 100% out-of-pocket

AWV/IPPE FREQUENTLY ASKED QUESTIONS (FAQS)

What are the other Medicare Part B preventive services?

- Advance Care Planning (ACP) as an Optional AWV Element
- Alcohol Misuse Screening and Counseling
- Annual Wellness Visit (AWV)
- Bone Mass Measurements
- Cardiovascular Disease Screening
- Colorectal Cancer Screening
- Counseling to Prevent Tobacco Use
- Depression Screening
- Diabetes Screening
- Diabetes Self-Management Training (DSMT)
- Flu, Pneumococcal, and Hepatitis B Shots and their Administration
- Glaucoma Screening
- Hepatitis B Screening
- Hepatitis C Screening
- Human Immunodeficiency Virus (HIV) Screening
- Intensive Behavioral Therapy (IBT) for Cardiovascular Disease (CVD)
- IBT for Obesity
- Initial Preventive Physical Examination (IPPE)
- Lung Cancer Screening
- Medical Nutrition Therapy (MNT)
- Medicare Diabetes Prevention Program
- Prolonged Preventive Services
- Prostate Cancer Screening
- Screening for Cervical Cancer with Human Papillomavirus (HPV) Tests
- Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling (HIBC) to Prevent STIs
- Screening Mammography
- Screening Pap Tests
- Screening Pelvic Examination (includes a clinical breast examination)
- Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)

For additional information on each Medicare preventive service, refer to the MLN's Medicare Preventive Services (https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html)educational tool.

Is the IPPE the same as a patient's yearly physical?

No. The IPPE is not a routine physical that some older adults may get periodically from their physician or other qualified non-physician practitioner. The IPPE is an introduction to Medicare and covered benefits and focuses on health promotion, disease prevention, and detection to help patients stay well. CMS encourages providers to inform patients about the Annual Wellness Visit and perform such visits. **The Social Security Act (SSA) explicitly prohibits Medicare coverage for routine physical examinations.**

Is the AWV the same as a patient's yearly physical?

No. The AWV is not a routine physical that some older adults may get periodically from their physician or other qualified non-physician practitioner. **Medicare does not cover routine physical examinations.**

Are clinical laboratory tests part of the IPPE or AWV?

No. The IPPE and AWV do not include any clinical laboratory tests, but you may make appropriate referrals for these tests as part of the IPPE or AWV.

Do deductible or coinsurance/copayment apply for the IPPE?

No. Medicare waives both the coinsurance/copayment and the Medicare Part B deductible for the IPPE (HCPCS code G0402). Neither is waived for the screening ECG (HCPCS codes G0403, G0404, or G0405).

Do deductible or coinsurance/copayment apply for the AWV?

No. Medicare waives the AWV coinsurance or copayment and the Medicare Part B deductible.

If a patient enrolls in Medicare in 2020, can they have the IPPE in 2021 if it was not performed in 2020?

A patient who has not yet had an IPPE and whose initial enrollment in Medicare Part B began in 2020 is eligible for an IPPE in 2021 as long as it is done within 12 months of the patient's first Medicare Part B enrollment effective date.

CMS suggests providers check with their Medicare Administrative Contractor (MAC) for available options to verify patient eligibility. If you have questions, contact your MAC (http://go.cms.gov/MAC-website-list).

Who is eligible for the AWV?

Medicare covers an AWV for all patients who are no longer within 12 months after the eligibility date for their first Medicare Part B benefit period and who did not have an IPPE or an AWV within the past 12 months. **Medicare pays for only one IPPE per patient per lifetime and one additional AWV per year thereafter.**

Can I bill an electrocardiogram (EKG) and the AWV on the same date of service?

Generally, you may give other medically necessary services on the same date of service as an AWV. The deductible and coinsurance or copayment apply for these other medically necessary and reasonable services.

How do I know if a patient already got their first AWV from another provider and know whether to bill for a subsequent AWV even though this is the first AWV I gave to this patient?

You have different options for accessing AWV eligibility information depending on where you practice. You may access the information through the HIPAA (Health Insurance Portability and Accountability Act) Eligibility Transaction System (HETS) (https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/Index) or through the provider call center Interactive Voice Responses (IVRs).

CMS suggests providers check with their Medicare Administrative Contractor (MAC) for available options to verify patient eligibility. If you have questions, contact your MAC (http://go.cms.gov/MAC-website-list).

RESOURCES

The Medicare Preventive Services webpage (https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo) lists educational products for Medicare Fee-for-Service providers and their staff about preventive services, coverage, coding, billing, payment, and claim filing procedures.

42 Code of Federal Regulations 410.15 (AWV service policy) (https://www.ecfr.gov/cgi-bin/text-idx?SID=b88181e2130f26ae6c4741f95a518bbf&mc=true&node=se42.2.410_115&rgn=div8)

42 Code of Federal Regulations 410.16 (IPPE service policy) (https://www.ecfr.gov/cgi-bin/text-idx?SID=36118cf6acf7b03ff0dbd7d0e2814720&mc=true&node=pt42.2.410&rgn=div5#se42.2.410_116)

Advance Care Planning (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf)

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

AWV: Medicare Claims Processing Manual, Chapter 18, Section 140 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf)

AWV/IPPE: Medicare Claims Processing Manual, Chapter 12 Section 30.6.1.1, Section 30.6.6, Section 100.1.1.C (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf)

AWV/IPPE: Medicare Diabetes Prevention Program (MDPP) Expanded Model (https://go.cms.gov/mdpp)

CMS Provider Minute: Preventive Services (pointers to help you submit correct documentation and avoid claim denials) (https://www.youtube.com/watch?v=-tuMWM4KeZg&feature=youtu.be&list=PLaV7m2-zFKpigb1UvmCh1Q2cBKi1SGk-V)

CMS Roadmap Strategy to Fight the Opioid Crisis (https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Opioid-epidemic-roadmap.pdf)

IPPE: Medicare Claims Processing Manual, Chapter 9 Section 60.2 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf)

IPPE: Medicare Claims Processing Manual, Chapter 18, Section 80 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf)

MLN Matters® Article MM9271, Advance Care Planning (ACP) as an Optional Element of an Annual Wellness Visit (AWV) (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9271.pdf)

MLN Matters Article SE18004, Review of Opioid Use During the Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV) (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/se18004.pdf)

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

Reducing Opioid Misuse (https://www.cms.gov/about-cms/story-page/reducing-opioid-misuse)

Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (https://www.congress.gov/bill/115th-congress/house-bill/6)