Annual Wellness Visit (AWV)

Are you familiar with the benefits and requirement of AWV? This will hopefully answer all your questions. The Centers for Medicare & Medicaid Services expanded coverage to allow for an Annual Wellness Visit (AWV) including personalized prevention plan services (PPPS) for an individual who is no longer within 12 months of the effective date of his/her first Medicare Part B coverage period, and has not received either an initial preventive physical examination (IPPE) or an AWV with the past 12 months. Medicare coinsurance and Part B deductibles do not apply.

CMS has created two new codes:

G0438 - Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) first visit

G0439 - Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) subsequent visit

G0438 is the initial AWV and would be a one time benefit. Any subsequent services would be billed using the G0439. Medicare does not apply deductible and coinsurance for an AWV. The patient would have no responsibility. If the patient has had one previously from their former doctor, the correct code is G0439. Medicare determines whether the AWV is an initial or subsequent visit based on the patient and not the person providing the service. There is no specific diagnosis code required, a preventative code would do.

Medicare will look to verify that at least 11 full months have passed since the last AWV.

During the first year of Medicare enrollment, the patient is not eligible for the AWV. Medicare can allow the IPPE (Welcome to Medicare visit) during this time. The AWV could be payable by Medicare after the first year of enrollment and only if it has been more than 11 full months following the IPPE, if the patient revceived the IPPE.

The following is included in the initial AWV with Personalized Preventative Plan Services (PPPS) to the eligible beneficiary.

- Establishment of the patient's medical/family history
- Establishment of providers and suppliers that are regularly involved in providing medical care to the individual.
- Measurement of an individual's height, weight, BMI (or waist circumference, if appropriate) B/P, and other routine measurement as deemed appropriate, based on the benficiary's medical/family history.
- Detection of any cognitive impairment that the individual may have as defined in this section.

- Review of the individual's potential (risk factors) for depression, including current or past experiences with depression or other mood disorders.

- Review the individual's functional ability and level of safety based on direct observation or appropriate screening.

- Establish a written screening schedule for the individual such as a check list for the next 5-10 years based on the United States Preventative Services Task Force.

- Establish a list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or in process.

- Furnish personalized health advice to the individual and a referral, as needed, to health education or preventive counseling services or programs to reduce identified risk factors such as weight loss, physical activity, smoking cessation and nutrition.

If the provider wishes to order additional diagnostic services, ie. Chest x-ray, EKG and certain blood tests, they are not part of the AWV, and medical necessity would be required.

You can bill for both an E/M service and AWV if E/M is significant and separately identifiable from the AWV. Providers should report modifier 25 when appropriate. Some of the components of a medically necessary E/M service may have been part of the AWV and should not be included when determining the most appropriate E/M procedure code.

If one year has not elapsed between the Initial Preventive Physical Exam (IPPE) and the AWV, the CWF (Common Working File) will count 11 full months starting with the month a beneficiary's IPPE is paid in the history file.

- Remittance Reason Code 119: Benefit maximum for this time period or occurrence has been reached.
- Remittance Remarks Code N130: Consult plan benefit documents/guidelines for information about restrictions for this service.
- Group Code: PR (Patient Responsibility)

An RN or LPN can perform the visit. They need to be under the direct supervision of a physician and the state license needs to allow for them to do all the components of the service. This requires the supervising doctor be in the office and available to answer questions at the time the service is performed. The charge is billed under the supervising physician.