



Medicare Annual Wellness Visits



Updated: May 2019



COST TO THE PATIENT

ZERO!

No Deductible

No Copay

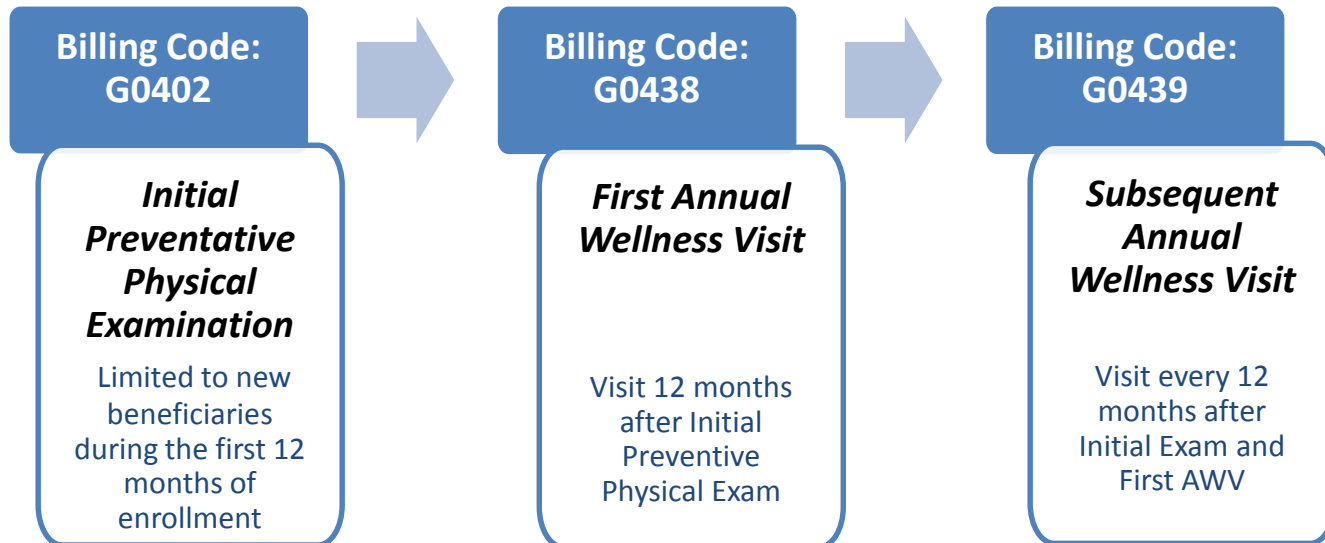




ANNUAL WELLNESS VISIT

Through the Affordable Care act, The Centers for Medicare and Medicaid Services (Also known as CMS) began paying doctors for yearly wellness visits that focus on preventive health. CMS acknowledged the value of preventive care as a means to better health for the Medicare population. These Annual Wellness Visits (AWV), if coded correctly, result in increased revenue for the practice and Annual Wellness Visits help to possibly identify health issues before they become worse.

Medicare will pay for an AWV once every twelve months and every patient is encouraged to have an Annual Wellness Visit. Medicare does require that certain criteria be met in order for the “wellness visit” code to be accurate. This is ***NOT*** a “hands-on” visit. A follow-up visit can be scheduled for any medical issues. There are currently three levels of payment for annual wellness visits:





WHY ANNUAL WELLNESS VISITS?

The AWW is not a routine physical checkup that some seniors may get from their physician. In fact, Fee For Service Medicare does not cover routine physical examinations. An AWW focuses strictly on preventive health.

Establish and update a personalized prevention plan of service

Review a patient's history, risk factors, and medication list



Personalized counseling and advice

No 'hands-on' exam
[Vital signs only]

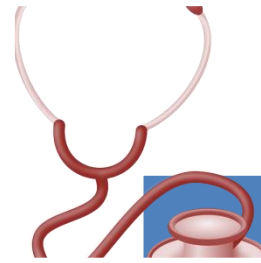


DIFFERENCE BETWEEN AN AWV AND PHYSICAL EXAM



ANNUAL WELLNESS VISIT

- A discussion
- Covered by Medicare yearly
- Requirements differ between type of AWV
- Has to be completed by a Qualified Professional under the direct supervision of a Physician
- Able to capture chronic conditions
- Additional services may be billed with AWV



PHYSICAL EXAM

- An exam
- Not covered by Fee For Service Medicare
- Requirements are based on Medical Decision Making Guidelines
- Has to be performed by a physician or qualified professional
- Able to capture chronic conditions
- Some plans allow preventive services to be billed



WHO CAN PERFORM AN AWV?

- Physicians
- Qualified Non-Physician Practitioners, such as Nurse Practitioners (NP) or Physician Assistant (PA)
- Medical Professional who is supervised by a Physician

WHO IS ELIGIBLE FOR AN AWV?

- Patients with Medicare Part B for more than 12 months
- Patients who have not had a “Welcome to Medicare” visit or Annual Wellness Visit in the past 12 months



TYPES OF ANNUAL WELLNESS VISITS

Initial Preventive Physical Examination / "Welcome to Medicare" [G0402]

Once in a lifetime benefit

Must be completed within 12 months of Medicare Part B enrollment

Has to be performed by a Qualified Medical Professional

Vitals / Visual Exam

Captures Chronic Conditions

Initial Annual Wellness Visit [G0438]

Once in a lifetime benefit

Covered 12 months after Initial Preventive Physical Examination/"Welcome to Medicare Visit"

Has to be performed by a Qualified Medical Professional

A discussion

Captures Chronic Conditions

Subsequent Annual Wellness Visit [G0439]

Covered once every 12 months (after patient has completed their Initial AWV)

Covered 12 months after Initial AWV

Has to be performed by a Qualified Medical Professional

A discussion

Captures Chronic Conditions



REQUIREMENTS

Initial Preventive Physical Examination “Welcome to Medicare”

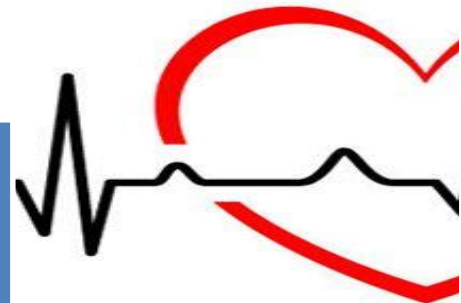
- Review of medical and social history
- Review of potential risk factors for depression
- Review of functional ability and level of safety
- Exam to include vitals, visual acuity screening, and any other appropriate factors based on the patients medical and social history
- End of life planning [Optional if beneficiary agrees]
- Education, counseling, and referrals based on above components
- Education, counseling, and referrals for other preventive services



If medically necessary, E/M Services may also be billed separately using modifier -25



Screening EKG is covered but is subject to deductible and copay





REQUIREMENTS

Initial Annual Wellness Visit

- Complete a Health Risk Assessment
- Establish a list of current providers
- Establish medical and family history
- Review functional ability and level of safety
- Review potential risk factors for depression
- Obtain patient measurements: Height, Weight, BMI and Blood Pressure
- Detect any cognitive impairments
- Establish a written screening schedule
- Establish a list of risk factors and conditions for intervention
- Furnish personalized health advice and referrals, as necessary
- End of life planning [Optional if beneficiary agrees]





REQUIREMENTS

Subsequent Annual Wellness Visit

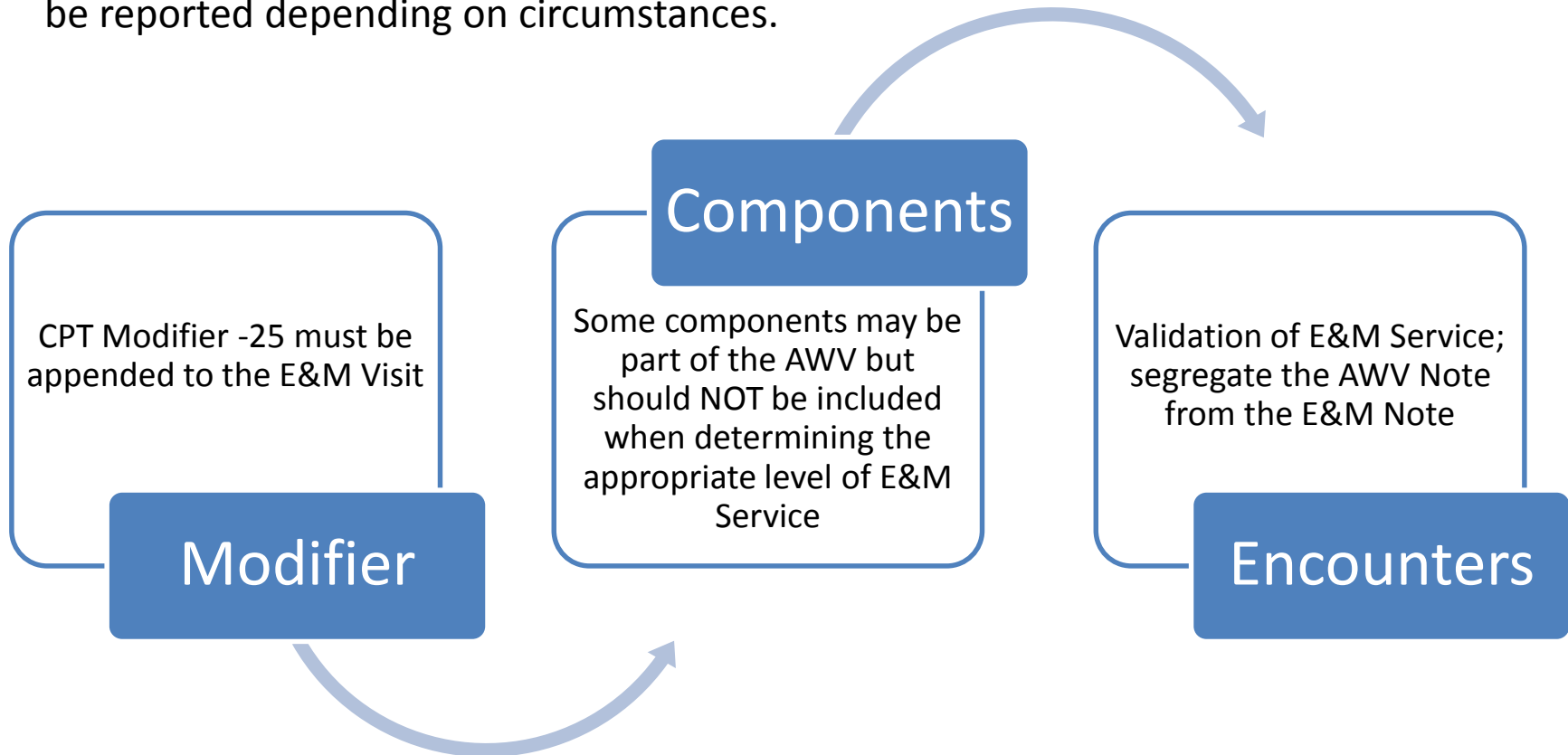
- Update Health Risk Assessment
- Update list of current providers
- Update medical and family history
- Review functional ability and level of safety
- Review potential risk factors for depression
- Obtain patient measurements: Height, Weight, BMI and Blood Pressure
- Detect any cognitive impairments
- Update the written screening schedule completed during the Initial AWW
- Update the list of risk factors and conditions for intervention
- Furnish personalized health advice and referrals, as necessary
- End of life planning [Optional if beneficiary agrees]





EVALUATION AND MANAGEMENT SERVICES [E/M]

When a physician provides a significant, separately identifiable medically necessary E&M Service in addition to the Annual Wellness Visit, CPT Codes 99201-99215 may be reported depending on circumstances.





HEALTH RISK ASSESSMENT

At a minimum,
address the following:

Demographic
Information

Self-
assessment of
health status

Psychosocial
Risk

Behavioral
Risks

Activities of
Daily Living

- ✓ Health Risk Assessment information can be completed by the patient at the visit or prior to the visit in order to save time.
- ✓ ADLs include but are not limited to: dressing, bathing, walking, shopping, housekeeping, medications and handling finances.





ADVANCED CARE PLANNING

Advanced Care Planning is a face to face conversation between a qualified healthcare professional and the beneficiary

Discussion about the patients wishes regarding medical care preferences should they become unable to speak for themselves

CPT CODES AND DESCRIPTION

99497

Advance Care Planning including the explanation and discussion of advance directives such as standard forms, by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

Use modifier -33 when billing with AWW, deductible and copay are waived

99498

Advance Care Planning including the explanation and discussion of advance directives such as standard forms, by the physician or other qualified health care professional; each additional 30 minutes

List and bill separately in addition to code for primary procedure





PREVENTIVE SERVICES

- Alcohol Misuse Screening and Counseling
- Bone Mass Measurement
- Cardiovascular Disease Screening Test
- Colorectal Cancer Screening
- Counseling to Prevent Tobacco Use
- Depression Screening
- Diabetes Screening
- Diabetes Self-Management Training
- Glaucoma Screening
- Influenza Vaccination
- Intensive Behavioral Therapy for Cardiovascular Disease
- Intensive Behavioral Therapy for Obesity
- Pneumococcal Vaccination
- Prostate Cancer Screening
- Screening Mammography





ALCOHOL MISUSE SCREENING AND COUNSELING

HCPCS/CPT CODES

G0442: Annual Alcohol Misuse Screening, 15 minutes

G0443: Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes

ICD-10 CODES

See the [CMS ICD-10 Webpage](#) for individual CRs and coding translations for ICD-10 and contact your MAC for guidance

<https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html>

WHO IS COVERED

Screening: All Medicare Beneficiaries are eligible

Counseling: Medicare beneficiaries who screen positive are eligible for counseling when all of the following are true:

- Competent and alert at the time counseling is provided
- Counseling furnished by a qualified PCP or other primary care practitioner in a primary care setting

FREQUENCY

Annually for G0442

For those who screen positive, 4 times per year for G0443

MEDICARE BENEFICIARY PAYS

ZERO

Copayment/Coinsurance Waived
Deductible Waived



BONE MASS MEASUREMENT

HCPCS/CPT CODES

76977: Ultrasound bone density measurement and interpretation, peripheral site[s], any method

77078: Computed tomography, bone mineral density study, 1 or more sites; axial skeleton

77080: Dual-energy X-ray absorptiometry [DXA], bone density study, 1 or more sites; axial skeleton

77081: DXA, bone density study, 1 or more sites; appendicular skeleton

ICD-10 CODES

See the [CMS ICD-10 Webpage](#) for individual CRs and coding translations for ICD-10 and contact your MAC for guidance

<https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html>

WHO IS COVERED

Medicare Beneficiaries who fall into at least one category:

- Women determined to be estrogen deficient and at clinical risk for osteoporosis
- Individuals with vertebral abnormalities
- Individuals getting [or expecting to get] glucocorticoid therapy for more than 3 months
- Individuals with primary hyperparathyroidism
- Individual being monitored to assess response to U.S. Food and Drug Administration approved osteoporosis drug therapy

FREQUENCY

Every 2 Years

More frequently if medically necessary

MEDICARE BENEFICIARY PAYS

ZERO

Copayment/Coinsurance Waived

Deductible Waived



CARDIOVASCULAR DISEASE SCREENING TEST

HCPCS/CPT CODES

80061: Lipid Panel, this panel must include the following

- 82465 Cholesterol, serum, total
- 83718 Lipoprotein, direct measurement, high density cholesterol
- 84478 Triglycerides

ICD-10 CODES

Z13.6

WHO IS COVERED

All Medicare Beneficiaries without apparent signs or symptoms of cardiovascular disease

FREQUENCY

Once every 5 years

MEDICARE BENEFICIARY PAYS

ZERO

Copayment/Coinsurance Waived
Deductible Waived



COLORECTAL CANCER SCREENING

HCPCS/CPT CODES

- G0104: Flexible Sigmoidoscopy
- G0105: Colonoscopy [High Risk]
- G0121: Colonoscopy [Not High Risk]
- G0328: Fecal Occult Blood Test, immunoassay, 1-3 simultaneous
- G0464: Colorectal Cancer Screening; stool-based DNA and fecal occult hemoglobin

ICD-10 CODES

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For Cologuard Multitarget Stool DNA Test, Z12.11 and Z12.12

WHO IS COVERED

Cologuard:

- All Medicare Beneficiaries who fall into all of the following categories
 - Aged 50 to 85
 - Asymptomatic
- At average risk of developing colorectal cancer

Screening colonoscopies, FOBTs, flexible sigmoidoscopies

- All Medicare Beneficiaries who fall into at least one of the following categories
 - Aged 50 or older who are at normal risk of developing colorectal cancer
 - At high risk of developing colorectal cancer

FREQUENCY

TEST	NORMAL RISK	HIGH RISK
Cologuard	Once every 3 years	-
Screening FOBT	Every Year	Every Year
Screening Flexible Sigmoid	Once every 4 years	Once every 4 years
Screening Colonoscopy	Every 10 years	Every 2 years

MEDICARE BENEFICIARY PAYS

G0104, G0105, G0121, G0328, G0464

ZERO

Copayment/Coinsurance Waived
Deductible Waived

G0106 and G0120

Copayment/Coinsurance Applies
Deductible Waived

Append modifier –PT to CPT Code in the surgical range of 10000 to 69999



COUNSELING TO PREVENT TOBACCO USE

HCPCS/CPT CODES

99406: Smoking/Tobacco-Use Cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes

99407: Smoking/Tobacco-Use Cessation counseling visit; intensive, greater than 10 minutes

ICD-10 CODES

F17.200, F17.201, F17.210, F17.211, F17.220, F17.221, F17.290, F17.291, T65.211A, T65.212A, T65.213A, T65.214A, T65.221A, T65.222A, T65.223A, T65.224A, T65.291A, T65.292A, T65.293A, T65.294A, and Z87.891

NOTE: Additional ICD-10 Codes May Apply

WHO IS COVERED

Outpatient and hospitalized Medicare beneficiaries for whom all of the following are true:

- Use Tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease
- Competent and alert at the time counseling is provided
- Counseling furnished by a qualified PCP or other primary care practitioner in a primary care setting

FREQUENCY

- Two Cessation attempts per year

Each attempt may include a maximum of 4 intermediate or intensive sessions, with the total annual benefit covering up to 8 sessions per year

MEDICARE BENEFICIARY PAYS

ZERO

Copayment/Coinsurance Waived
Deductible Waived



DEPRESSION SCREENING

HCPCS/CPT CODES

G0444: Annual Depression Screening,
15 minutes

ICD-10 CODES

See the [CMS ICD-10 Webpage](#) for individual CRs and coding translations for ICD-10 and contact your MAC for guidance

<https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html>

WHO IS COVERED

All Medicare Beneficiaries

Must be furnished in a primary care setting that has staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment, and follow-up

FREQUENCY

Annually

MEDICARE BENEFICIARY PAYS

ZERO

Copayment/Coinsurance Waived
Deductible Waived



DIABETES SCREENING

HCPCS/CPT CODES

82947: Glucose; quantitative, blood
[Except reagent strip]

82950: Glucose; post glucose dose
[includes glucose]

82951: Glucose; tolerance test [GTT], 3
specimens [includes glucose]

ICD-10 CODES

Z13.1

WHO IS COVERED

Medicare Beneficiaries with certain
risk factors for diabetes or diagnosed
with pre-diabetes

FREQUENCY

- Two screening tests per year for Medicare Beneficiaries diagnosed with pre-diabetes
- One screening per year if previously tested but not diagnosed with pre-diabetes or if never tested

MEDICARE BENEFICIARY PAYS

ZERO

Copayment/Coinsurance Waived
Deductible Waived

Append modifier –TS when submitting
claims for Medicare Beneficiaries with
pre-diabetes



DIABETES SELF-MANAGEMENT TRAINING [DSMT]

HCPCS/CPT CODES

G0108: DSMT, individual, per 30 minutes

G0109: DSMT, group [2 or more], per 30 minutes

ICD-10 CODES

See the [CMS ICD-10 Webpage](#) for individual CRs and coding translations for ICD-10 and contact your MAC for guidance

<https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html>

WHO IS COVERED

Certain Medicare Beneficiaries when all of the following are true:

- Diagnosed with diabetes
- Receive an order for DSMT from the physician or qualified NPP treating the Medicare Beneficiaries diabetes

FREQUENCY

Initial Year: Up to 10 hours of initial training within a continuous 12 month period

Subsequent Years: Up to 2 hours of follow-up training each year after the initial year

MEDICARE BENEFICIARY PAYS

Copayment/Coinsurance Applies
Deductible Applies



GLAUCOMA SCREENING

HCPCS/CPT CODES

G0117: By an optometrist or ophthalmologist

G0118: Under the direct supervision of an optometrist or ophthalmologist

ICD-10 CODES

Z13.5

WHO IS COVERED

Medicare Beneficiaries who fall into at least one of the following categories:

- Have diabetes mellitus
- Have a family history of glaucoma
- Are African-Americans aged 50 and older
- Are Hispanic-Americans aged 65 and older

FREQUENCY

Annually for covered Medicare Beneficiaries

MEDICARE BENEFICIARY PAYS

Copayment/Coinsurance Applies
Deductible Applies



INFLUENZA VIRUS VACCINE AND ADMINISTRATION

HCCPS/CPT CODES

Influenza Virus Vaccine: 90630, 90653, 90654, 90655, 90656, 90657, 90661, 90662, 90672, 90673, 90674, 90685, 90686, 90687, 90688, Q2035, Q2036, Q2037, Q2038, Q2039

Administration of Influenza Virus Vaccine: G0008

ICD-10 CODES

Z23

WHO IS COVERED

All Medicare Beneficiaries

FREQUENCY

Once per influenza season

Medicare covers additional flu shots if medically necessary

MEDICARE BENEFICIARY PAYS

ZERO

Copayment/Coinsurance Waived
Deductible Waived



INTENSIVE BEHAVIORAL THERAPY [IBT] FOR CARDIOVASCULAR DISEASE [CVD]

HCPSCS/CPT CODES

G0446: Annual, face-to-face intensive behavioral therapy for cardiovascular disease, 15 minutes

ICD-10 CODES

See the [CMS ICD-10 Webpage](#) for individual CRs and coding translations for ICD-10 and contact your MAC for guidance

<https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html>

WHO IS COVERED

Medicare beneficiaries when all of the following are true:

- Competent and alert at the time counseling is provided
- Counseling furnished by a qualified PCP or other primary care practitioner in a primary care setting

FREQUENCY

Annually for covered Medicare Beneficiaries

MEDICARE BENEFICIARY PAYS

ZERO

Copayment/Coinsurance Waived
Deductible Waived



INTENSIVE BEHAVIORAL THERAPY [IBT] FOR OBESITY

HCPCS/CPT CODES

G0447: Face-to-face behavioral counseling for obesity, 15 minutes
G0473: Face-to-face behavioral counseling for obesity, group [2-10], 30 minutes

ICD-10 CODES

Z68.30, Z68.31, Z68.32, Z68.33, Z68.34, Z68.35, Z68.36, Z68.37, Z68.38, Z68.39, Z68.41, Z68.42, Z68.43, Z68.44, or Z68.45

WHO IS COVERED

Medicare beneficiaries when all of the following are true:

- Obesity (Body Mass Index [BMI] \geq 30 Kilograms [kg] per meter squared)
- Competent and alert at the time counseling is provided
- Counseling furnished by a qualified PCP or other primary care practitioner in a primary care setting

FREQUENCY

- First Month: One face-to-face visit every week
 - Months 2-6: One face-to-face visit every other week
 - Months 7-12: One face-to-face visit every month if certain requirements are met
- At 6-month visit, a reassessment of obesity and a determination of the amount of weight loss must be performed*

MEDICARE BENEFICIARY PAYS

ZERO

Copayment/Coinsurance Waived
Deductible Waived



PNEUMOCOCCAL VACCINE AND ADMINISTRATION

HCPCS/CPT CODES

90670: Pneumococcal Conjugate Vaccine

90732: Pneumococcal Polysaccharide Vaccine

G0009: Administration

ICD-10 CODES

Z23

WHO IS COVERED

All Medicare Beneficiaries

FREQUENCY

-An initial Pneumococcal Vaccine to Medicare Beneficiaries who never received the vaccine under Medicare Part B

-A different, second Pneumococcal Vaccine 1 year after the first vaccine was administered

MEDICARE BENEFICIARY PAYS

ZERO

Copayment/Coinsurance Waived
Deductible Waived



PROSTATE CANCER SCREENING

HCPCS/CPT CODES

G0102: Digital Rectal Exam [DRE]
G0103: Prostate Specific Antigen
Test [PSA]

ICD-10 CODES

Z12.5

WHO IS COVERED

All male Medicare Beneficiaries
aged 50 and older

FREQUENCY

Annually for male covered
Medicare Beneficiaries aged 50
or older

MEDICARE BENEFICIARY PAYS

G0102: Deductible Applies
Copayment/Coinsurance Applies

G0103: Deductible Waived
Copayment/Coinsurance Waived



SCREENING MAMMOGRAPHY

HCPCS/CPT CODES

77057: Screening Mammography, bilateral

77063: Screening digital breast tomosynthesis; bilateral

G0202: Screening Mammography, producing direct 2-D digital image, bilateral, all views

ICD-10 CODES

Z12.31

WHO IS COVERED

All female Medicare Beneficiaries 40 or older for an annual screening

FREQUENCY

Aged 35-39: One Baseline
Aged 40 and older: Annually

MEDICARE BENEFICIARY PAYS

ZERO

Deductible Waived
Copayment/Coinsurance Waived

If billing a screening mammogram and a diagnostic mammogram on the same day, use modifier –GG to show a screening mammogram turned into a diagnostic mammogram



ADDITIONAL PREVENTIVE SERVICES

TEST	CODES	FREQUENCY
Hepatitis C Virus Screening	G0472	<ul style="list-style-type: none"> - Annually for High Risk Patients - Once in a Lifetime for Beneficiaries born between 1945 and 1965
Human Immunodeficiency Virus Screening	80081, G0432, G0433, G0435, G0475	<ul style="list-style-type: none"> - Annually for Medicare Beneficiaries between the ages of 15 and 65 without risk - Annually for Medicare Beneficiaries younger than 15 and older than 65 who are at risk for HIV Infection
Medical Nutrition Therapy	97802, 97803, 97804, G0270, G0271	<ul style="list-style-type: none"> - First Year: 3 Hours of one-on-one counseling - Subsequent Years: 2 Hours
Screening for Cervical Cancer with Human Papillomavirus Testing	G0476	Once every 5 years
Screening for Lung Cancer	G0296, G0297	Annually for covered Medicare Beneficiaries



ADDITIONAL PREVENTIVE SERVICES

TEST	CODES	FREQUENCY
Hepatitis B Virus Vaccination and Administration	90739, 90740, 90743, 90744, 90746, 90747, G0010	Scheduled dosages required
Screening for Sexually Transmitted Infections	86631, 86632, 87110, 87270, 87320, 87490, 87491, 87810, 87590, 87591, 87850, 87800, 86592, 86593, 86780, 87340, 87341, G0445	Annually
Screening Pap Test	G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091	<ul style="list-style-type: none"> - Annually for women at high risk - Every 2 Years for women at normal risk
Screening Pelvic Examinations	G0101	<ul style="list-style-type: none"> - Annually for women at high risk - Every 2 Years for women at normal risk
Ultrasound Screening for Abdominal Aortic Aneurysm	G0389	Once in a Lifetime



RECAP

- The Annual Wellness Visit has different components than a traditional physical
- Fee For Service Medicare does **NOT** pay for a physical exam, only an Annual Wellness Visit; An AWV is **NOT** a physical exam and does **NOT** include a hands-on visit
- An Annual Wellness Visit does **NOT** have to be performed by a physician but by a Qualified Medical Professional under direct supervision of a Physician

G0402

Initial Preventive Physical Examination [IPPE]
‘Welcome to Medicare Exam’

Any appropriate code is accepted

G0438

Annual Wellness Visit, includes a personalized prevention plan of service [PPPS], *first visit*

Any appropriate code is accepted

G0439

Annual Wellness Visit, includes a personalized prevention plan of service [PPPS], *subsequent visit*

Any appropriate code is accepted



SOURCES

DEPARTMENT OF HEALTH AND HUMAN SERVICES:

The ABCs of the Annual Wellness Visit

Published April 2017

Retrieved from https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AWV_Chart_ICN905706.pdf

DEPARTMENT OF HEALTH AND HUMAN SERVICES:

The ABCs of the Initial Preventive Physical Examination [IPPE]

Published April 2017

Retrieved from https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MPS_QRI_IPPE001a.pdf

DEPARTMENT OF HEALTH AND HUMAN SERVICES:

Medicare Preventive Services

Published January 2018

Retrieved from <https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html>

ADDITIONAL RESOURCES

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html?redirect=/mlnproducts/35_preventiveservices.asp

