Laurie: One, the QIN site's quality innovation network team, welcomes you to today's webinar: Leveraging Wellness Visit with Medicare, Improving Income and Patient Outcomes. My name's Laurie Fink and I am the communication specialist for the improving outcomes by optimizing your EHR initiative. Before we get things started, I would like to take just a moment to review some housekeeping items.

All participant lines have been muted, and will remain in a listen-only mode. There'll be a question and answer session following the presentation. If a question comes to mind during the presentation, please feel free to type it in the chat window on the right of your screen and we will address it during the Q and A session. If you're not currently seeing the chat box, just go to the top right hand corner of your screen and there's a little icon up there for chat. Just click on that and that will open up your chat feature. You are welcome to type your questions in the chat box while the Q and A session is going on, or throughout the presentation. Please note that this webinar is being recorded, and will be posted on the Quality Insights website within the next week.

I would like to introduce our first presenter, Matt Allison. He is currently the health systems manager for Alabama for the American Cancer Society, and was recently employed by the Alabama Quality Improvement Organization. Matt has experience working with physician practices to improve outcomes. So time, I will hand things over to Matt.

Matt: I hope everyone's doing well today. Today, let's talk leveraging wellness visits with Medicare and how you need to improve our incomes and our income management only patient outcomes.

Just going to give you what I'm going to talk about. First, about why we want to choose the wellness exams and how I think they conditions. What they are, the different components of them, covered by Medicare for permission and wellness, and how do you code for that annual wellness.

Why we choose the wellness. Wellness exams are wellness visits for Medicare. The thing that pops out to me, it is an enhanced reimbursement. For a full wellness visit, Medicare will pay you on average across the country of $172. In their eyes, their exact language should not take more than 20 minutes of a health care professional's time. 172 bucks. That includes any reimbursement that may come as part of those tests that you may order just what amounts to the EN code alone is worth $172. Performed by mid-level or in some cases lower.

Other than that, to improve patient outcomes, I think it's self-explanatory is we have a chance to actually talk about prevention with our patients. It does give us an opportunity to impact things like cancer screenings, it also needs to be for disease, diabetes. Gives you an opportunity to talk about, not how do we treat

what is wrong, what can we do to keep some things from happening to you. Another relatively unique thing for Medicare.

That's something that they really only started covering in the last four years. For me, it gives you the ability to collect PQRS and Meaningful Use data. That being, PQR reimbursement is one that is geared around quality of care. Outcomes are going to be driven by how well you collect data. Whether something like the CMS value based modifier, does it employ a reporting system in PQRS? Electronic clinical managers as part of Meaningful Use. All those opportunities to measure performance and outcomes of a patient are going to be at the center of reimbursement. As much as annual wellness visit, allowing opportunity to collect that data in I think a meaningful way. Then I think with this as a health care community, we find ways to make sure that we're capturing all this data, that more and more is being regulated and demanded of us. As long as it is the data collection, it is just a talking. Not necessarily a lay in your hand. Hopefully that gives you an idea of why we want to choose wellness.

There we go. Who can actually perform it? Think there's another interesting misconception around the annual wellness visits. Actually pulled word for word from Medicare, so they cover an annual wellness visit every 12 months. It is operated and furnished by your physician, which obviously makes sense, PA, nurse practitioner, no big deal there, but a clinical nurse specialist or even a medical professional are allowed to bill for this as facilitated solely by that. If a physician is available and they have questions. So that is under direct supervision of a physician. It's kind of a way to see how they work.

We'll talk about improving the utilization of wellness visits. I want to make sure I make this clear. This, to me, is one of our big take away points from today. This is something that if you choose, can mostly be on the backs of a not a doctor, that the ancillary medical staff that perform these visits [inaudible 00:06:19]. Now, from a patient outcome standpoint, there are tangible benefits to doing this. From a physician, it may have a bigger impact on our ability to improve patient care. But we're going to improve utilization of this and everybody doesn't have all the free time in the world, we lean on our ancillary staff to do really all of this research if we so choose. That is totally acceptable. We'll still reimburse you for that $172. So who really is almost just about anybody that you could think.

CMS, the wellness exam, or the annual wellness visit, is the commitment, putting the appropriate use of the Medicare preventative services. Medicare covers a broad range of preventative things that detect disease, such as cancer, when it's treatable, and help us manage disease before it becomes complicated. This [inaudible 00:07:24], and this happened four years ago, January 1 of 2011 became the day that Medicare covered what amounted to just a true wellness visit, or a non-physical for their [inaudible 00:07:35] population. I want to make

that, make sure everybody understands that this is, and two months ago, the Secretary of Health and Human Services got up and talked about the commitment to prevention and some of these [inaudible 00:07:53] based purchasing concepts. This [inaudible 00:07:58] the foundation because we must shift from reactive care to more proactive care.

So we can adopt that, so I think the better we are [inaudible 00:08:07] position for reimbursement.

We began covering, as part of the Affordable Care Act, all preventative care. Anything that's a grade B or better from the US preventative service passes. Preventatives are passed forward first and available at no out-of-pocket cost to a patient. So two components of that from a visiting standpoint are something that we call the initial preventative physical exam, or the IPPE, or the commonly called the Welcome to Medicare plan. Then, and then they also began the coverage for the annual wellness visit. I'm sure everyone understands this is, to me, this is big point number two. Very, very different benefits. These are very, it's a different type of exam or visit with your physician. The IPPE or the Welcome to Medicare physical is an actual physical. This allows you to do, the only opportunity you can do a preventative EKG, do preventative chest X-ray and some other types of truly physical, you're laying your hands on someone and doing a full workup.

But the distinct difference between what Medicare wants for the annual wellness visit, that is it isn't a physical. They make a very strong distinction between that. This is not a doing visit, this is more of a talking visit. [inaudible 00:09:43] to talk about prevention, develop a preventative care plan and put that into action. It's not check reflexes or listening to their breathing. You choose to do that if you so wish but that is not how the benefit is necessarily structured from a reimbursement standpoint. Preventative services from physician exams, they also started covering screenings, such as mammograms, colonoscopies. They also are covering more vaccinations and then the one which I think is a unique thing, and again, limits to this idea that it's kind of a cultural shift that they're trying to start, it's [inaudible 00:10:23] allowing full coverage for preventative therapy and counseling. Obesity counseling and smoking cessation which historically have not been covered by Medicare now become easier to do and are much more supported financially.

Another benefit is covered every 12 months for a [inaudible 00:10:53] beneficiary. As they haven't had an initial physical or welcome to Medicare exam or wellness visit in the next 12 months, then you can [inaudible 00:11:04] no co-pay and no co-insurance. The elements are you understand you have to do a full history, so that medical, surgical, family, including medication and supplements and any other current providers. Again, these are things that we know are part

of those meaningful use objectives. Allowed to gather that information in a [inaudible 00:11:25] ancillary staff. We have to do an assessment or HRA, complete height, weight, BMI, blood [inaudible 00:11:34] and some other basic vitals. Cognitive function test, you develop a screening schedule. They are supposed to walk out of the office with a preventative care plan that has their screenings that they may need, whether that's cancer, whether that's heart disease, whether that's tobacco. Whatever they need from a preventative standpoint to leave with.

Also get to talk about risk factors and have personalized health advice into that screening schedule, hopefully you can come up with an actual physical thing that they kind of walk out of the office with. The big point to me, and this is something that Medicare really has been clear about, this is not a physical. This is not meant to be a physical. That's now how this benefit is structured, that's not how the reimbursement for it is scheduled. It is an answer for you to talk to them around prevention and what they need to do to stay healthy.

So just to kind of clarify last two points that we've talked about for the last 10 minutes or so, the purpose of the [inaudible 00:12:47] visits is not a physical exam. They can be performed by any qualified health professional. Does not specify that any lab tests must be included, however they can be ordered during that exam, that's not going to cause you any problems. And for a AAA screening, that actually cannot be ordered in a prevention sense as part of the annual wellness visit. Would actually be done as part of that initial welcome to Medicare visit, that IPPE. IPPE, full on physical and it's really initial preventative physical exam, it's in its name. The well visit is a chance to talk about wellness, not a physical.

[inaudible 00:13:33] some basic coding that you need, you do need a diagnosis code just like any other Medicare claim. Doesn't really matter what that diagnosis code is. Obviously, 72% I think was the most recent number that I saw of Medicare patients that have at least one chronic illness. If by any chance you're lucky enough to have a large population of those folks that don't have any chronic problems, you can use any diagnosis code, a V code will work here. You just have to put something in, that's just a claims processing issue. It's a 12-month thing. The other thing that I want to, I find interesting, so from this visit, it does not prevent you from doing a regular E/M visit during the same date of service. It may present itself where you come in and you're having this wellness visit with somebody and it's being done by your nurse. You're just talking to them and that patient says,"You know what, I've been having gout issues in my big toe and I really want to talk to somebody about this today, I don't want to have to come back."

Okay, from a billing standpoint, that is actually totally fine. Now, the patient needs to understand that now they're going to have a co-pay and potentially a deductible for that other visit, you know, and we're going to talk about their gout because gout's not part of our wellness visit discussion. But to talk to my doctor about my acute issue or acute chronic disease kind of issue, that I am billed for that service and that visit the same day that I do a wellness exam. I do need to make sure I use a modifier 25 on that E/M coding. I also likely will need to make sure that more likely you're going to down code that E/M visit as well because they're not going to allow you to count some components of the visit twice. So if we're doing things like vitals and the histories, that part of a regular office visit, you can't in essence bill for that twice with a [inaudible 00:15:30] offices and add a wellness visit component, you need to be smart about how you're doing the appropriate level coding for your E/M.

It does allow for that and will pay you for it as long as you have that modifier 25 on your E/M visit. I'm going to kind of keep delivering this point, I want to make sure everyone understands that the wellness visit is not a physical. You don't really lay your hands on them if you don't want to.

With the different screenings that Medicare actually covers as part of their new benefit services coverage, when you take a screen, an EKG is covered, but only as a prevent measure is only available during the initial welcome to Medicare physical. It does have co-pay and co-insurance, it's not something that they will just allow you to do as part of the wellness visit. An ultrasound for a AAA, it's part of the initial physical. There's certain qualifications that a patient must meet. The co-pay and co-insurance for those can actually meet that criteria. [inaudible 00:16:40] screens for doing lipids, they will cover that every five years and they're no co-pay and no co-insurance. That can be done at any time and can [inaudible 00:16:51] as part of our wellness visit.

[inaudible 00:16:59] will allow us to do a one to two times a year, depending on what happens previously. You screen somebody for diabetes, they pay no co-insurance. Glaucoma can be an annual thing. It's interesting that that becomes something that a patient will have to pay an out-of-pocket expense for. Bone mass measurement would do every two years, no co-pay with that. Those can be scheduled from the annual wellness visit. Cancers, colorectal, prostate and lung are all covered and for the most part, I know it says DRE as part of the prostate. Because it's an actual procedure, they will have a co-pay deductible, but it [inaudible 00:17:41] honest. But no paying co-insurance really any of the cancer screenings. It will allow you to screen them for depression annually

Note past [inaudible 00:17:55] annually, it depends on their past five years worth of history, if they've had an abnormal one. If not, then they need to move to a less frequent [inaudible 00:18:09] schedule. They do cover a pelvic exam every

two years. They do a mammogram annually , all of those have no co-pays, no deductibles.

New ones I think are relatively interesting. They will allow you to screen them for alcohol misuse, there is a co-pay and deductible for that. STIs or STDs, it will allow for screening and at least somewhat surprising to me that it's also a no co-pay, no co-insurance. If you find it appropriate for a high risk person, they allow you to cover for HIV. I know it covers it for pregnancy, Medicare, we all know it doesn't have a lot of people who are below the age of 65 but if you do have someone that's on disability and Medicare in early age, then I guess you could have someone that's pregnant. That's a really small percentage of the Medicare population. But in circumstances, screening them for HIV is something they will cover for.

Vaccinations, flu, pneumonia, Hep B are also part of their schedule. They're all available at no co-pay, no co-insurance. The pneumonia is one I know is obviously pointed emphasis I think for CMS, it is one that they've been [inaudible 00:19:34] from a value based purchasing standpoint in the future. All vaccines that are not covered under Part B, Zoster and TDaP. TDaP where appropriate may be covered under Part D as part of medications instead of Part B that's under preventative services.

Again, [inaudible 00:19:57] that shift and kind of up to a point after, they cover some counseling now and some of these are relatively new, really have only been started in places in the past three or four years. Allow for diabetes self-management training. There are co-pays for that. Patient medical nutrition, they do allow for that to happen and behavioral therapy for CV, those are annual benefits that a patient can have. Let's move onto the next one.

Behavioral therapy for obesity, they will allow for multiple counseling sessions over a 6 to 12-month period. That versus some of the others is they do have certain thresholds that this patient must be losing weight. If they're going to obesity counseling and they're not actually making any impacts on their actual outcomes, the Medicade's not going to cover that forever. There's a certain window to sort of make some changes, but if the windows aren't happening, then the benefit kind of stops. Tobacco use, it allows you some cessation counseling. I'll tell you generally, I think that is an incredibly undercoded benefit. It doesn't pay out especially well but it's like $11 or $12 a pop, but if you spend more than I think a full minute talking about tobacco cessation and [inaudible 00:21:27] the use of tobacco products, that an E/M, an additional CPT code that you can bill, just a little bit can add up over time. Looked at that in Alabama several years ago, the utilization of that was like 1% or 2% of the patients. We know 20% of the Medicare population at least in Alabama smokes, so that was something that was probably undercoded , interesting opportunity for you.

You also can do counseling for alcohol abuse. Go ahead and make sure I note that that does not include dependency care. It allows you to talk to them about STIs or STDs twice a year. No co-pays for any of our counseling benefits, which is kind of nice.

There are a few things that you need to know from a coding standpoint. For one, that first one that you have with a patient, again, it pays about $172, so Medicare says it should take no longer than 20 minutes. The GO438 and any ICD to support that. Subsequent annual wellness visits, so when they come back a second year, Medicare thinks that those should take no more than 12, 15 minutes, so we're basically updating our records versus going back and doing all this from scratch. Again, makes sense. A different CPT code for it, GO439, reimbursement's a little lower. If you do have any additional E&M codes on the same date of service as the wellness visit, make sure you include that modifier 25 on that ancillary E&M visit.

This is kind of the print service coding worksheet. Sometimes Medicare can get a bad rap, I think they make their policies relatively transparent, at least compared to some. Some of their stuff coming out of the Medicare Learning Network I think is excellent. One of those documents. This kind of includes some screenshots on it for people who are going to be printing out the slides. At the end, there's also hyperlinks so that you can go and download those for yourself if you want it. It will go through what the service is, the codes that you need, the [inaudible 00:23:41] that support it, who is covered for that benefit, how benefit's covered and if there's any kind of co-pay and deductibles, it will outline that. All in the same things I kind of walked through today.

As you'll see, it's several pages long, it's about five. They also have some benefit, some outlines of the actual [inaudible 00:24:08] of how you actually would code for some of those wellness visit components. A tremendous resource to have at your disposal and once you've done it a few times, it makes fairly logical sense I think for just about every benefit provided.

Here's a list of some of those preventative care resources. Include a PDF that I link. It's a few other things around the annual wellness visits, including an ABCs on how to actually perform those which I think our speaker's going to go into with a little bit more detail. That's it for me, I appreciate you all listening and I look forward to questions at the end.

Laurie: All right, thank you so much, that was excellent information to share with our practices. At this time, we are going to introduce our next speaker, which is Dr. Sherry Lee. She is a solo physician from Florum Park, New Jersey, and specialized in internal medicine as well as obesity medicine. She will share with us how her

practice schedules, conducts and documents annual wellness visits with her Medicare beneficiaries. I will now hand things over to Dr. Lee.

Sherry: Hi, everyone. I'm Dr. Sherry Lee. I'm going to go over, talk about how my practice perform Medicare wellness visit. Okay, hold. Basically, it's team-based care involved with the patient, the family and the staff. [inaudible 00:25:47] which is through our EMR system to [inaudible 00:25:51] a list of our patients who is due for annual wellness exam. For those patients, we send out the patient portal to let them know they're due for a wellness visit. However, for lots of patients, the elderlies who don't have a computer, we make, my staff will make a phone call to them to get them scheduled.

We review upcoming dates of scheduled patients to determine who is due for wellness visit. For example, they come in for sick visit or for the routine follow-up visit, we take a look at the schedule to see when they're due for a wellness [inaudible 00:26:27] wellness visit, are they due one? If they're due one, we'll change the routine visit to wellness visit. We [inaudible 00:26:37] check upcoming visits to see if they're due for that. When patients check out after this routine visit or sick visit, I also look into when they need to come back. If they do wellness visit, we let them know, say when they're due for visits, they will make the schedule accordingly.

We generate the templates in our EMR systems to generate the documentation of wellness visit. [inaudible 00:27:09] support care plan was generated. When a patient comes in, we give them a questionnaire to fill out. Medical system will choose many mental status exams. Go to next step. These are the forms we normally use when patients sitting in the waiting room, they are going to fill out the form. For the patients if they are coming back still, to see if they're going to have a wellness visit, we give them the forms, they can go home to fill that out and bring it back. A questionnaire including specialists involved in their care, so a question about mental states and depression. Safety questions, diet and exercise questions. They're also going to be filling out their medication list and including the supplement. Their smoking history, alcohol histories as well as reviews of symptoms. In the review of symptoms, they're going to write down when they're due for colonoscopies, when they had a mammography or the cardiologist visit as well as a bone density test and eye exam.

EMR systems, we have a standing order set in place. During the visit, we review their flu vaccine for the flu season, we pretty much give everyone who [inaudible 00:28:33] shot. We also review the pneumonia vaccine, give pneumonia vaccine if needed. Hepatitis B vaccine usually only for high risk patients. We screen the depression, use a depression screening tool as well as alcohol screening tool. We screen for tobacco, smoking histories, if any patient who currently smokes, we also do smoking cessation discussion about it.

When patients walk out from the office, they have the prescription for the mammographies, the colonoscophies or the bone density test, we give them the script. We also have a plan for care provided when they come in for the visit at the end of visit. The form we normally use when patients come in and we go over their questionnaire one-by-one and also at the end of visit, we discuss about their prevention, about the vaccinations, the eye exam, when they take the bone density test. When they do, they're going to have a discussion with them. I would talk about [inaudible 00:29:45], if people have diabetes, overweight, we can talk about the diet plan and talk about the weight reduction. For people who, we also talk mention about the [inaudible 00:29:55] directive, do they have one with them. If they do, we ask them for a copy of it. If they don't have one, we can talk about it and discuss what it is about.

For people who do not have the glaucoma screening, we recommend them to go to the ophthalmologist as well as if they have not had a PAP smear, we recommend the GYN exam and they, we don't do the PAP smear in my office, we usually recommend them to a GYN physician.

This is generated from our coding. Usually when people have a first-time wellness visit, we code as a G0438, we use the second code V70.0. If we give a flu vaccine, we add the flu vaccine adding as well as pneumonia vaccine if the pneumonia vaccine was given. In my office, we do the EKG, the patient has any cardiovascular disease with family, blood pressure problems, if they have diagnosis of cholesterol, diabetes, we do the EKG. We do the EKG [inaudible 00:31:05] for the people who have the cardiovascular risk fact. In my office, we do the blood work, so we also code it at [inaudible 00:31:14]. For alcohol screening and the depressive screening, we also code for that Medicare to pay for this performance. We use the diagnosis code with the CV code VCW.0.

If my patients coming, if they have a blood pressure medication need to be adjusted, if they have diabetes, review their glucose or any other medical issues, we also add office visit code [inaudible 00:31:42] 214 or 90213, depends on the level of the visit. But make sure we add the 24 or 25 modify code for that.

For the subsequent visit, everything pretty much the same except we use the G0439 code instead with these G0438 code.

It's challenging to do the wellness visit because it takes extra time for us and we have to track the patient who's due for one and who had one done for to make the effort for the physician as well as the staff. However, you do increase in revenue for the wellness visit, [inaudible 00:32:33] your E&M codes. It's better outcome for the patient and also we be able to report the necessary date for meaningful use. Also, [inaudible 00:32:44] data [inaudible 00:32:46] report that. And also maintain health partnership with the beneficiary and family. That's

about my talk, [inaudible 00:32:59] questions and just thank you for joining me and any question, I can answer.

Laurie: Dr. Lee, at this time we're going to begin the question and answer portion of the webinar. If anybody has any questions, please feel free to type them in chat box on the right of your screen. If you've already submitted a question via the chat feature during the presentation, we'll address it now. I'm going to go ahead and mute all of our panelists so they can chime in. Attendees, if you could please put your phones on mute, that would be great.

Our first question ask, does the annual wellness visit go towards the patient deductible co-insurance?

Matt: I think I can answer that. The [inaudible 00:34:00] ... opportunity to provide your patient [inaudible 00:34:08] benefit cycle, which falls typically in the calendar year. [inaudible 00:34:11] February, if their [inaudible 00:34:19] and their deductible is reset, then they can come in for the wellness visit and not have any out-of-pocket expenses. But make sure they code for additional services out of that like another [inaudible 00:34:32] visit or a lab or something that's not [inaudible 00:34:36] in nature, fees and deductibles could apply.

Laurie: Okay. Another question asked, and this is to Dr. Lee, what other staff in your office does annual wellness visits? Do you do them yourself or do you have other staff also do the annual wellness visit?

Sherry: Usually, I do any wellness visit. My staff will do the vital signs, the mental state exam and that's about it, make sure that the form was properly filled out. Basically, I'm solo practitioner so I'm the one doing the wellness visits.

Laurie: Another question asks are there specific diagnosis codes that should be used when billing for an annual wellness visit?

Sherry: V70.0, that's the only code I basically use for the wellness exam.

Matt: I'll just say that that's probably the one I would advise everyone use as well, but the Medicare policy will state that they will support anything as long as the diagnosis code is linked to that G code. Yeah, the V code would work for every patient, but if you had another diagnosis that were included from [inaudible 00:35:54] or whatever, they could, you could [inaudible 00:35:58] as well.

Laurie: Can you bill for depression screening as well as an evaluation and management visit?

Sherry: Usually, the code for a depression screening is a G0444.

Laurie: Okay, and for Lee, what EMR system are you currently using? We had one attendee ask.

Sherry: We use eClinicalWorks. We do eClinicalWorks templates, I build it on my own. [inaudible 00:36:32] have all the elements you would need required for the Medicare annual wellness visits.

Laurie: Here's another question. The patient was scheduled for the annual wellness visit, however, when they were in the office, several medical issues were brought up and addressed during the visit. Okay to bill an additional E&M code at the same time as the annual wellness visit?

Sherry: Absolutely. I use the G code for the wellness visit and I use the [inaudible 00:37:05] E/M code, for example 9214 or 9213 but I add a modify code with 99214, 99213. Medicare do pay both, Medicare pays for the wellness visit at no deductible, no co-insurance, but you do have deductible co-insurance for the 99214, 99213.

Laurie: The depression screening, is this screening the nine-question screen?

Sherry: You have two questions. One is currently depressed? And question two, do you have interest to perform the normal things you enjoy to do? If those questions say no to those questions, then you don't have to go further, but if any of the two questions is answered yes, you need to ask within the last two weeks how frequently they feel depressed, [inaudible 00:38:04] and so on, so forth and the questions will be started from there.

Laurie: Another question asks can more than one provider perform an annual wellness visit for the same patient in the same year?

Sherry: I don't think so. Medicare only allow pay once within, has to be 12 months from last wellness visit so any other practitioner perform the wellness visit, you will not be able to [inaudible 00:38:33], you'll not be able to get paid for it.

Matt: Right. With that, there's not necessarily an easy way to find that out either. If it's a relatively new patient, there is an element of risk involved. But you should know that that's, that definitely can happen.

Laurie: Another question asks, can you explain again how you bill for an annual wellness visit, with 9214 or 9213?

Sherry: 9214, 99213, which one you use really depends on your level of service for this visit. [inaudible 00:39:20] really have nothing to do with your wellness visit, just normally you're taking care of a patient in your office for the blood pressure,

diabetes, the gout or cold symptoms, you bill with the level of the visit, you bill usually whatever level I, what code, based on what people claim for the wellness visit. They have a code says that you cannot build 99214, has to be 99213 because that is not high level visit, then you add the modified code for that, the 99214 with the diagnose code for the cold or virus, whatever the [inaudible 00:39:52] code and send in addition to that, use the wellness G code. The G0439 or G0438 with the ICD 9 code as D70.0.

Laurie: Questions everyone? Matt, sorry ...

Matt: No, I was going to say you could put the modifier 25 on them but then if you had additional ICDs to support E&M, you obviously want to link those. You could choose to link them to the wellness visit, but it would [inaudible 00:40:27]. That was it.

Laurie: Thanks, Matt. We have another question that asks does the annual wellness visit and yearly physical exams need be done so many months apart?

Matt: You will not get paid if they had the initial welcome to Medicare, that IPPE, within 12 month, you'll not be able to get paid for the wellness visit until the 12 months has passed.

Sherry: Occasionally, my staff schedules the patients within the, like, a little bit over 11 months, not 12 months yet, we did not get paid for that. So I have to make sure it's exactly 12 months apart or a little bit over 12 months.

Matt: And a lot of the annual services, say with the mammograms, they actually allow you to bill for it after 11 months. They give you a little bit of a window so that way if I had it on in January 1st and I came in a year later and got it on December 15th, then I'm more or less a year out. A lot of Medicare stuff gives you an 11-month recurrence. That isn't the case with the wellness visit, it's a hard 12-month [inaudible 00:41:44] on.

Laurie: In regards to the AAA screening, Matt said that we could not order this during the annual wellness visit, but the CNS online, which is on the CNS website, states that it does not have to be ordered during the IPPE, elaborate on that Matt?

Matt: I actually pulled up that PDF as we were kind of discussing and I saw that it went into effect November 18th and I wasn't aware of that policy change, but yes, that can now be ordered outside of the IPPE from just a true preventative screening standpoint. I didn't know that. [inaudible 00:42:23].

Laurie: I have another question that asks, if you are ordering a lipid panel to be done at the lab, how would I code this for the patient so that it's covered?

Sherry: The annual wellness visit, usually you don't order the bloodwork. For the lab, usually I do have to have a medical reason. For example, you can order the CMPs, electromagnetic biological profile, you can order the cholesterol issues, hyperlipidemia or hyper diagnoses of hypertension or diabetes, you can order the A1C. So if you have [inaudible 00:43:07] medical issues, not just [inaudible 00:43:10] any wellness visit. Any wellness visit, I don't think any laboratory can be ordered in the code.

Matt: That's what I'm understanding as well.

Laurie: If screening is positive for depression in the annual wellness visit, can you do a full depression screening and bill for it?

Sherry: Yes, we do do that. If a patient has the depression screening come back positive, you do code it with the G0444 code, but we're also treating it and you're probably going to add the 99213 E/M code to discuss medications or put the patient on anti-depressant. You're probably going to use a regular E/M code.

Laurie: Okay. A little bit more clarification in regards to the yearly physicals. The question asks what about yearly physicals after the initial physical? Do the year physicals need to be 12 months apart?

Matt: It will not cover a physical beyond the first 12 months of their enrollment within Medicare as a beneficiary. So Medicare 65 when I turn, you know, in the next 12 months, the window to get that physical, the IPPE physical. Beyond that, they will not pay for a physical. Even if I haven't had one and I'm 70 years old and been on Medicare for five years, the IPPE would not be [inaudible 00:44:43]. It's only a benefit in the first 12 months.

Laurie: [inaudible 00:44:51] the wellness visit and treat the acute problem at the same visit and don't add the E/M with the modifier of 25 and you are audited, wouldn't that be under-coding?

Matt: I would [inaudible 00:45:09] get you in trouble because you didn't bill for something, you're just not reimbursed for the work that you did. I think it's a simple thing to avoid.

Sherry: Usually when I have anything not related with the wellness visit, I do use the E/M code to make sure we get properly paid for what we're doing.

Laurie: Can we do an annual wellness visit during the first enrollment year or can we only do an IPPE?

Sherry: My understanding, you can only do IPPE. It can be different with I think the GO402 for the visit, and the G0403 for the EKG. EKG will be part of IPPE.

Matt: Yeah, the Medicare enrollment, a patient is not eligible for the annual wellness visit. The Medicare only allows for that Welcome to Medicare IPPE visit during that initial 12 months. They would be payable for care. After the first year and only if it's been 12 months since their IPPE.

Laurie: We've addressed all the questions that have been answered. I'll pause another 30 seconds or so to see if anyone has any additional questions. Are you scanning your questionnaire into the EMR or are you having someone input the information before you see the patient?

Sherry: Usually, afterwards, we do scan in the, there's a form. I do it only in my EMR but also the staff will scan in the questionnaire to the computer in the patient's documents as well. More things to know, [inaudible 00:47:19] wrong or right. When you did IPPEs, after 12 months when you do the wellness visit, you only can use the subsequent, that is G0439, you cannot G0438. You only can use subsequent;.

Matt: Yeah, after that, the G0348 if you want to think about it this way, is billable only once for every Medicare beneficiary. When someone bills for that, in essence, it's payable one time in their lifetime. It would then be subsequent depending on the doctor.

Laurie: Question asks is the EKG covered for an annual wellness visit or do you need an accompanying ICD9 code? Same for [spirometry 00:48:12].

Sherry: I usually use the E/M code to [inaudible 00:48:18] the EKG. I don't think Medicare will cove it in the wellness visit. You have to have the diagnosis, the reason why you do the EKG same as the reason why you do [inaudible 00:48:29], you cannot do it as a part of the routine code and the visit, as the regular physical code.

Matt: If you're doing just an EKG for truly preventative screening, then it is only covered during that IPPE physical. Now, there's typically a reason you're ordering an EKG, you have some concern about something else, which means they probably have a diagnosis code that you're trying to uncover at a minimum, which is a totally different thing than just truly prevention. But again, an EKG is only available through that welcome to Medicare IPPE exam. It is not part of the annual wellness visit. [inaudible 00:49:13] you can get it in that first 12 months.

Laurie: Do you have to have an IPPE or can we do an annual wellness visit their second year even though they have not had the IPPE in the first year?

Matt: Yeah. Yes, [inaudible 00:49:36] the wellness visit for a patient regardless if they've had the welcome to Medicare exam or not.

Laurie: Question asks after the IPPE, 13 months later we do an annual wellness visit with code G0438. 13 months later, G0439, or is it G0349 since they had the IPPE?

Sherry: After IPPE, you only can use the G0439, not G0438.

Matt: The answer is maybe you could use the G0438 even if they've had the welcome to Medicare, but I don't know. Maybe that is not the case. I'll see if I can find out.

Laurie: How can you know that the IPPE has been billed if the patient went somewhere else before seeing you?

Sherry: If he does not know, there's no way we can find out. Usually, patient, you can ask them, say, "Well did any physician you've been seeing before did the wellness exam?" Sometimes the patient may not know what that means, you can go more detailed, say, "Okay, when you go the doctor, did they spend time with you? Did they ask you questions about your depression," so far and so forth because it kind of gives them an idea whether the visit they had is possibly more like I'm going in because my blood pressure is high or they go in because I don't have any complaints just that had a bunch of screening test done. It kind of gives them those idea.

Laurie: Any other questions? We'll pause for another minute here to see if anyone wants to ask another question. Good thing we waited. Does IPPE and the annual wellness visit apply the same way to traditional Medicare and Medicare Advantage patients?

Sherry: Not sure about that. For the Medicare, they usually pay, for me actually [inaudible 00:52:22] because they have a commercial plan, they don't have regular Medicare. Usually I don't code a G code, I just use the physical code, this is a 99396 or 9386, I use the routine physical code, I don't use the Medicare one as the visit code anymore. That's how I approach it.

Matt: Let me just add one more slight clarification there. For all Advantage plans, they must offer at least the same amount of coverage as Medicare, however, they can offer additional things from a reimbursement standpoint like an actual physical. Medicare doesn't cover physical, an Advantage plan may and it probably pays out better. That allows you to, you need to choose appropriately, but covered by Medicare, my understanding is all Advantage plans have to offer at least the same amount of coverage. Typically they offer more, it's part of their incentives to try to get people to use them instead of [inaudible 00:53:25].

Sherry: I don't know.

Laurie: Okay. Looks like we've addressed all of the questions that have been asked. Thank you, Matt, Alison, and Dr. Lee, thanks so much for joining us today. Thank everyone on the line for joining us to learn more about the Medicare annual wellness [inaudible 00:53:57]. If you have any additional questions, reach out to your local quality insights team member. The member contact information is posted on your screen at this time. [inaudible 00:54:09] that we will add the presentation slides and recording of today's event to our website. You will be able to access them at www.qualityinsights-qin.org. The events will be listed under the events tab as an archived event.

Now, there will be a very brief evaluation at the close of this session. Please take a minute to complete it. It helps us to plan future programs. With that, I'd like to thank you again for taking time out of your day to join us for this session. Have a great day.

Matt: Bye.

Laurie: Thank you.