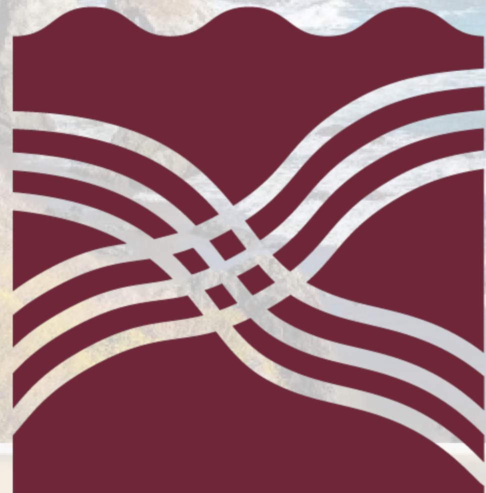

Provider Coding Intensity Webinar

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Learning Objectives

The participant will be able to identify and implement the components of an annual wellness visit (AWV) or initial preventive physical examination (IPPE) as an essential part of patient care and develop strategies to address common barriers to AWV/IPPE completion.

The participant will be able to connect AWV/IPPE completion and the impact on hierarchical condition categories (HCC) scores and the Medicare Advantage patient.

The participant will be able to relate the role of AWV/IPPEs in the management of chronic disease.

Agenda

- Introduction to annual wellness visit (AWV) and initial preventive physical examination (IPPE)
- AWV coding and implications for hierarchical condition categories (HCC) score
- The role of the AWV and IPPE in chronic disease management

AWV/IPPE Recap: What are they?

- An **annual wellness visit (AWV)** is an annual check-in with a provider focused on developing or updating a personalized prevention plan within Medicare Part B benefits. **Can take 40+ minutes**

- An **initial preventive physical examination (IPPE),** also called a “Welcome to Medicare” visit, is a **one-time** Medicare Part B benefit for newly enrolled beneficiaries designed to introduce patients to Medicare preventive services and assess their health status.

AWV / IPPE Regulations & Reimbursements

- **42 CFR § 410.15 (Regulations supporting AWVs)** Annual wellness visits providing personalized prevention plan services
- **42 CFR § 410.16 (Regulations supporting IPPEs)** Initial preventive physical examination: Conditions for and limitations on coverage
- Reimbursements
  - National average Centers for Medicare & Medicaid Services (CMS) reimbursement for first AWV = $160.44
  - Subsequent AWV = $128.03
  - IPPE = $160.76

Notable Differences

Requirements	AWV	IPPE
Can be performed by	MD or DO, PA, NP, or clinical nurse specialist or other medical professional or licensed practitioner working under direct supervision of a physician	MD or DO, PA, NP, or clinical nurse specialist
Review and administration (if needed) of Health Risk Assessment (HRA)	✓	
Establish individual and family medical history	✓	✓ Include review of social risk factors; particular attention to modifiable risk factors for disease
Social Determinants of Health (SDOH) risk assessment		✓

What a AWV is Not

- An AWV is **NOT** a physical exam.
- It differs from an IPPE, in that an IPPE can only occur within the 1st 12 months of Medicare Part B enrollment
- G0402 is for an IPPE
- G0438 is for the initial AWV
- G0439 are for subsequent AWVs

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Components of the AWV

- **Two goals of AWV**: preventive care and personalized prevention plan.
- Medicare regulations / guidance require core components of:
  - Health risk assessment (HRA) – a health status, injury and behavioral risk, and patient self-assessment questionnaire
  - Medical + Fam Hx update
  - Current Provider / Suppliers involved in patient's care
  - Measures of blood pressure, body mass index, etc.
  - Cognitive assessment
  - Functional ability and safety assessment
  - Personalized prevention plan
  - Counseling for health education and preventive services

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Key AWV Components

- **Cognitive impairment detection** – administering cognitive assessment tool
- **Functional ability and safety assessment** – addresses areas such as: activities of daily living, fall risk, home safety, vision, and hearing impairment
- **Personalized prevention plan** – written personalized prevention plan that includes:
    - A screening schedule for the next 5 to 10 years, e.g., mammograms, colonoscopies, immunizations
    - Health advice and appropriate referrals for health education, smoking, weight loss, nutrition counseling

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Typical IPPE components

- Review of medical and social history, health risk factors, functional ability
- Review of prescriptions and over-the-counter medications and providers
- Depression screening
- Physical exam
- Health education
- End-of-life planning (optional)
- If other evaluation and management related services are provided, they can be added to G0402

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An AWV+ Reasonable and Necessary

- **Medically reasonable and necessary** (a specifically defined and codified standard) can be added to an AWV **and CMS will reimburse**
- Additional diagnoses would be added and associated with an evaluation and management **(E/M) code with Modifier-25**

Medically Reasonable and Necessary

- **Medically reasonable and necessary** standard means:
  - Services that are appropriate and needed for diagnosis or treatment of an illness or injury, or to improve functioning of a malformed body member
  - Appropriate – generally accepted by the medical community
  - Excluded from this definition are experimental/investigational services
- Service / item should be provided efficiently, e.g., appropriate in a cost-effective setting

HCPCS and CPT?

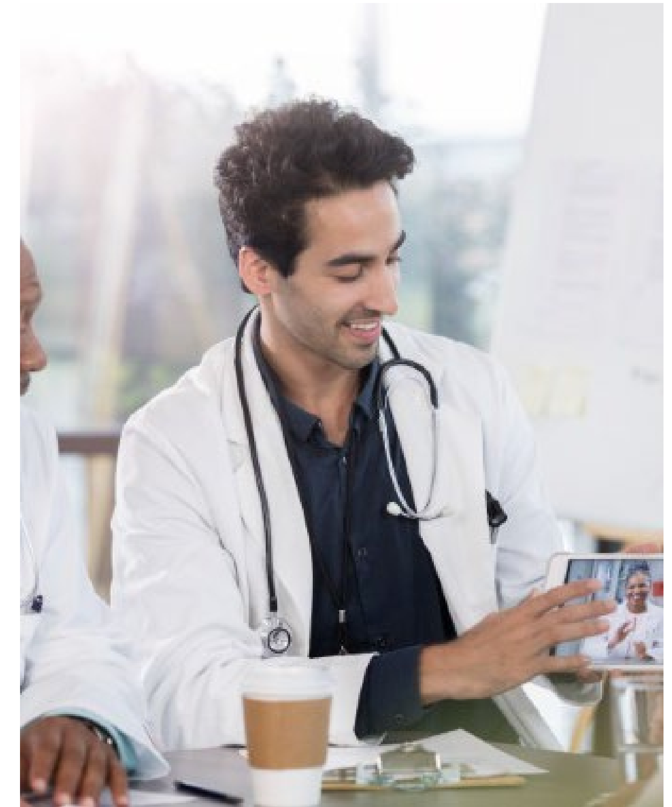
- Current Procedural Terminology (CPT) codes
  - Managed by American Medical Association, used to describe medical, surgical, and diagnostic services and procedures performed by physicians and other health care providers, e.g., labor performed.
  - Five-digit numeric codes:
    - 99213, 99203 outpatient office codes for E/M for established vs new patient
    - 90630: influenza virus vaccine.
  - **Also referred to as Level 1 HCPCS codes**

HCPCS and CPT?

- Healthcare Common Procedure Coding System (HCPCS) codes
  - Two-levels
    - Level 1: CPT codes; CPT codes can be called HCPCS codes
    - Level 2: Managed by CMS
  - Level 2 HCPCS Codes – **used to describe medical products, supplies and services not covered by CPT codes**, e.g., describes materials and specific equipment
    - e.g., ambulance services, durable medical equipment, prosthetics and orthotics, some drugs
    - Structured as a single alphabetical letter followed by four numeric digits: AXXXX, BXXXX
    - G0438: AWV, J1050: medroxyprogesterone injection, EO601: CPAP device

AWV+ E/M Modifier-25

- Append Modifier-25: When billing an AWV on same day as an additional E/M service, the E/M code must have Modifier-25 appended
- Modifier-25 indicates that a:
  - "Significant, separately identifiable evaluation and management service" performed by same qualified health care professional on same day as a procedure or other service. It signals to Medicare that the E/M service was not part of the initial procedure (here, an AWV) and warrants separate payment.
- Separately billed E/M service should also be linked to specific condition diagnosis codes



CMS Medicare Learning Network (MLN) Booklet MLN006764 September 2024

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AWV+ Example Scenario

- **42 CFR § 410.15 AWV providing personalized prevention plan services**
- During exam, patient mentions new, persistent headaches. The MD takes a history present illness (HPI) of the headaches, performs a neurological exam beyond the scope of AWV, orders an MRI. Practice would bill:
  - G0439 (a subsequent AWV), with preventive diagnostic code, e.g., Z00.00
  - Appropriate E/M code 99213/99214 visit for the HA management
  - E/M code would have Modifier-25 (99213-25)

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Significant, Separately Identifiable E/M Service

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- For Modifier-25 E/M service must be distinct and medically necessary from other same day procedure / service:
  - **Different Problem:** Patient comes in for mole removal, during visit patient presents with acute abdominal pain, and a separate HPI, exam, medical decision-making: Yes, Modifier-25.
  - Separate Work/Time: E/M service must involve work (HPI, medical decision-making, or total time based on billing, that is above and beyond the usual work assigned with the procedure / visit patient presented for).
  - If the E/M service could be seen as a “quick look,” or courtesy check in the chart, or minimal E/M service, it would not meet “significant, separate identifiable E/M service.” For example, a medication refill, checking lateral right knee pain if someone getting a procedure related to medial right knee pain.

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AWVs, Coding, and HCC Scores

- HCCs: diagnoses grouped into categories with similar clinical characteristics and similar costs.
    - HCC 18: DM with complications
        - E11.40: T2DM with diabetic neuropathy, unspecified
        - E11.51: T2DM with diabetic peripheral angiopathy w/o gangrene
    - HCC 9: Metastatic cancer and acute leukemia
        - C78.00: Secondary malignant neoplasm, unspecified lung
        - C79.51: Secondary malignant neoplasm of bone

AWVs, Coding, and HCC Scores

- HCC score (risk score): a numerical value that quantifies the predicted cost of care for an individual relative to an (normalized) average Medicare beneficiary.
  - The value is based on a CMS formula / statistical model that reflects the patient's HCC codes and categories from the previous year, HCC category weights, demographic data, a normalization factor specific to the patient population and institutional status to calculate a risk score
    - A score of 1.0 represents the average predicted cost of a Medicare beneficiary
    - A score greater than 1.0 indicates a predicted higher than average cost
    - A score less than 1.0 indicates a predicted lower than average cost
- Risk adjustment: These scores are used in risk adjustment payment models for plans and providers to have necessary resources for patient care.

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AWVs, Coding, and HCC Scores

- How AWV or IPPE Coding affects HCC score, risk adjustment and ultimately, reimbursement.
  - In addition to the preventive visit nature of an AWV, crucially, providers are expected to comprehensively review patient's medical history and accurately and **specifically code patient's current health status.**
  - For example, patient comes in for AWV in 2025. MD reviews chart and in problem list from 2024: **E11.9, Type 2 DM, uncomplicated**. During this AWV, member describes symptoms of gastroparesis and over the past year a gastric emptying study had been performed, optional more specific coding **could** include:

AWVs, Coding, and HCC Scores

- **E11.49** - Type 2 diabetes mellitus with other diabetic neurological complication AND **K31.84** – Gastroparesis
- OR if there were a positive gastric emptying and a positive monofilament test: **E11.42** - Type 2 diabetes mellitus with diabetic polyneuropathy AND **K31.84** – Gastroparesis
- So, member's updated 2025 problem list and encounter codes will include these codes.

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AWVs, Coding, and HCC Scores

If same patient also in 2024 had I10 Essential (primary) HTN, (for years) and since 2024, has had a high urine albumin/creatinine ratio and drop in GFR, this pt may now have **I12.9 Hypertensive CKD with stage 1 through stage 4.**

However, we stress these are possibilities, not certainties, **because Partnership is not suggesting how you code, only that you code with specificity** to reflect your patient's actual current health status.

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AWVs, IPPEs, and Chronic Diseases

- How accurate AWV or IPPE coding affects chronic disease management.
- Continuing with the previous patient example, if the 2025 AWV has coding with specificity, CMS will use the 2025 encounter data in its prospective risk adjustment model.
- They will apply their hierarchical rules to calculate a Risk Adjustment Factor (RAF) score from HCCs in 2025 and patient demographics for an updated RAF score for 2026.
- This RAF score will be used to provide 2026 plan reimbursement reflective of member’s 2025 health status.
- This reimbursement is used to fund quality improvement and other community provider incentive programs.

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Effects of Coding Acuity

- Increase the accuracy of reported conditions for patients during the calendar
- Subsequently, with proper coding, the number of resolved chronic conditions for all members should increase
  - Chronic conditions will be properly identified for patients
  - As providers re-assess and treat these conditions, evaluation and treatment efforts will follow as medically appropriate

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The Path to Quality Improvement

- Conduct robust AWVs / IPPEs
- Focus on chronic condition management
- Identify high risk patients
- Include SDOHs
- Invest in coding education and training
- Ensure accuracy and specificity
- Promote team-based care coordination
- Optimize electronic health records (EHR)
- Engage patients in their care
- Monitor and evaluate performance

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On the Horizon

- Potential legislative action to address Medicare Advantage reform
  - Improving Seniors’ Timely Access to Care Act – addresses prior authorization concerns and aims to streamline the process
- New risk adjustment model proposed: No Unreasonable Payments, Coding or Diagnoses for the Elderly (No UPCODE) Act
  - Aims to improve the way Medicare Advantage plans assess patients’ health risks and reduce overpayments for care
  - The proposed model would use **two years** of retrospective diagnostic data
  - Hopes to close the gap between how a patient is assessed under traditional Medicare and Medicare Advantage

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Summary and Recap

- AWVs and IPPEs are important parts of a complete approach to care for the CMS patient.
- While it can be challenging to schedule IPPEs and AWVs, CMS, in certain circumstances, allows for same-day, same-provider coding to reflect additional medically reasonable and necessary services provided.
- These services must be separately identifiable and correctly coded (Modifier-25).
- Coding with specificity is important because it accurately describes the patient at that moment in time and helps CMS direct proper resources for disease management.
- Coding with specificity leads to accurate identification, evaluation, medically necessary treatment and resolution of chronic conditions which can lead to chronic condition decreases among the patient population.

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Questions

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Evaluation

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Contact Us

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