TuftsMedicine

Comprehensive Visits with Complete Documentation of Chronic Conditions

What is a Comprehensive Visit?

An Annual Wellness Visit (AWV) is a free (co-payment and deductible don't apply) yearly "Wellness" visit with your provider to develop and update your personalized health plan to help prevent disease or disability. It can also help you address which areas of your health need attention, so they don't cause bigger issues later. Your doctor will assess how you are doing health-wise regardless of whether you are feeling symptoms or not. The Annual Wellness Visit is not a physical exam.

Comprehensive Visit = AWV + complete HCC documentation and coding

Why do Comprehensive Visits with Complete Documentation of Chronic Conditions Matter?

- Comprehensive Visits help clinicians and patients strengthen their relationship and partnership.
- A Comprehensive Visit provides an opportunity for clinicians to:
    - Identify and address developing problems before they become urgent or emergent.
    - Identify and/or review chronic conditions that have not been recently addressed.
- Accurate identification and documentation of our patients' chronic conditions helps us to better understand their needs and implement interventions to improve their clinical outcomes.
- The Annual Wellness Visit (AWV) component of the Comprehensive Visit adds value in the following ways:
    - Primary care providers have an opportunity to focus on preventive screenings, which helps keep the patient healthy and ensures that quality measure goals are achieved.
    - Patients with completed AWVs are attributed to the primary care provider who performed the AWV.
    - Patients with completed AWVs have a higher rate of care gap closure and are seen in the ED less frequently.

How do Comprehensive Visits Benefit Everyone?

Patient Benefits

- Patients value an opportunity to gain a holistic view of their chronic medical conditions, lower their disease burden and discuss preventative care issues with their clinician.
- Accurate documentation of chronic conditions allows Medicare Advantage plans to provide additional benefits such as lower or no co-pays for visits, assistance with transportation to medical appointments, etc.

Clinician Benefits

- Clinicians more effectively care for and partner with patients when they have a full picture of their health.
- A thorough review of the patient's conditions helps the primary care clinician coordinate care with specialists
- Appropriate documentation of chronic conditions allows for more meaningful computer decision support.
- The additional revenue associated with documentation of all of the patent's chronic conditions helps pay for the cost of team-based care.
- Drives patient attribution.

System Benefits

- Improves understand of the type of clinicians and teams needed to care for our patients.
- Accurate documentation of all chronic conditions helps capture the complexity of our patient populations and ensure adequate funding to care for them.
- Improves publicly reported clinical quality measure for the health system.

<table>
<tr><th></th><th>(Welcome to Medicare IPPE)</th><th>Initial
Annual Wellness Visit</th><th>Subsequent
Annual Wellness Visit</th></tr>
<tr><td>GOALS</td><td>• Review of medical and social history
• Preventive serves education</td><td>• Develop Personalized Prevention Plan
• Help prevent disease and disability.
• Based on current health and risk factors</td><td>• Update personalized Prevention Plan
• Help prevent disease and disability.
• Based on current health and risk factors</td></tr>
<tr><td>ELIGIBILITY FREQUENCY COVERAGE</td><td>• Within 12 months of patient's Medicare Part B Benefits eligibility date
(Covered only once)</td><td>• After 12 Months
• Following patient's Medicare Part B benefits eligibility date
• No IPPE or AWV within past 12 months
(Covered only Once)</td><td>• Covered once every 12 months.
• Must not be billed within 12 months of previous Billing of G0402, G0438, G0439</td></tr>
<tr><td>BILLING CODES</td><td>• G0402
Initial preventive physical examination: face to face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment</td><td>• GO438
Annual Visit includes a personalized prevention plan of service (PPS) initial visit</td><td>• G0439
Annual Wellness visit, includes a personalized prevention plan of service (PPS), Subsequent Visit</td></tr>
<tr><td>DIAGNOSIS CODES</td><td colspan="3">You are not required to report a specific diagnosis code for these visits. Report <u>ALL</u> diagnosis codes consistent with the patient's visit.</td></tr>
<tr><td></td><td colspan="3">SHARED COMPONENTS</td></tr>
<tr><td>All required components of the IPPE (G0402) and of the First Annual (G0438) and Subsequent AWV (G0439) should be completed prior to submitting a claim for these services</td><td colspan="3">• Medical, family, and social history: review current medications and supplements (including calcium and vitamins.
• Health Risk Assessment (HRA)-Demographic data, health status, behavioral risks, Activities of Daily Living (ADL)
• Measure-Blood pressure height, weight, BMI, or waist circumference – see next line. These are the exam components.
• Exam based on the patient's conditions (optional) from CMS, includes height, weight, BP, visual acuity screen, BMI, and other factors deemed appropriate based on the beneficiary's medical, social history, and current clinical standards.
• Screenings:
Depression:
-included in IPPE and Initial AWV
-not included in Subsequent AWV
-May be provided and billed separately with GO444 Annual Depression screening, 15 minutes
-Documentation MUST support at least 8 minutes spent on Screening to bill.
Fall risk, hearing impairment, substance use disorders (SUDs), tobacco use.
• Review current opioid prescriptions, including Opioid Use Disorder (OUD) risk factors.
• Preventative services screening schedule
• Provide personalized health advice and referrals.</td></tr>
<tr><td></td><td colspan="3">UNIQUE COMPONENTS</td></tr>
<tr><td></td><td colspan="2">IPPE (G0402)</td><td>AWV – First AWV (G0438) and Subsequent AWV (G0439)</td></tr>
<tr><td></td><td colspan="2">• Vision screening <u>(see exam-based components) Hearing impairment. Hearing impairment is a component of G0402 & G0438, but not G0439.</u>
• End-of-life planning, on patient agreement
• Once-in a lifetime screening EKG/ECG as appropriate: G0304, G0404 or G0405</td><td>• List of risk factors and ALL conditions where interventions are recommended or underway including status and treatment options.
• Cognitive screening
• List of providers and suppliers
• Provide Advance Care Planning (ACP) services, at patient's discretion(optional)</td></tr>
<tr><td>ADDITIONAL INFORMATION</td><td colspan="3">• The IPPE and AWVs are NOT routine physical exams (99397) and DO NOT include any clinical laboratory tests. <u>If labs are ordered, do not link the lab to Z00.00/1. These diags represent an APE and Medicare will deny. Labs should be linked to the diagnosis they are ordered for.</u>
-Referrals may be made for such tests as part of these visits, if appropriate
-Coinsurance, copayment, and Medicare Part B deductible is NOT waived for tests.
• Coinsurance, copayment, and Medicare part B deductible are waived for IPPE and AWV services.
• Separate evaluation and Management (E/M) service may be billed with modifier -25 at the time of these visits.
-Service must be significant, separately identifiable, and medically necessary to treat illness, injury or improve functioning of a malformed body part. (This must be a new problem or worsening of an existing problem.)
-Patients are required to pay applicable coinsurance, copayments, and deductibles associated with separate E/M services and should be notified of such prior to providing this service.
• For preventive services covered under Medicare Part B that can be billed in addition to AWV's and for all other general services, the correct procedure code is billed e.g., Advance Care Planning/ explanation/discussion, first 30 minutes-99497 with modifier-33(Preventive Services)]
-Document total time for ACP discussion
-Must be done by same provider on same DOS as AWV</td></tr>
</table>

Medicare Wellness Visits: Medicare Wellness Educational Tool Website

- **Quick Start Guide:** Includes an Annual Wellness Video
- **Components**: IPPE ("Welcome to Medicare" Preventive Visit), Initial &Subsequent AWVs
- **Know the Differences**
- **FAQS**
- **Resources**

Medicare Preventive Services: Medicare Preventative Services Educational Tool Website

Documentation Tips

The primary purpose of the AWV is to create or update personalized the beneficiary's prevention plans. They are also an efficient way to capture all risk assessing conditions that must reported on an annual basis.

For providers:

- ✓ Document the Chief Compliant as AWV. Z00.00 or Z00.01, encounter for adult APE or any other appropriate diagnosis code can be used to report the service.
- ✓ In the A&P, report any chronic conditions the patient has to the highest level of specificity. Providers cannot bill for stable, chronic illnesses at the AWV; however, this is the ideal visit to capture conditions that satisfy our risk contracts.
- ✓ Chronic conditions must be acknowledged and reported annually.
- ✓ If a problem is addressed at the AWV, an E/M can also be reported if the note identifies the problem in a chief complaint, and there is an assessment and plan. Some secondary payers will reimburse for an annual physical.

Documenting and coding the AWVs to capture all services and avoiding denials:

Denial Reason (Most common): AWV is given too soon, the wrong AWV is provided, or the patient received this service with another provider. When the encounter for an AWV is opened for a provider, make sure the provider knows which AWV they are providing. If the patient has a secondary insurance, and they may be eligible to also receive an annual physical exam, please alert the provider to this so both services are billed.

- Welcome to Medicare, also known as the IPPE (G0402). A patient is eligible for the IPPE within the first 12 months of Part B eligibility regardless of age. This is a "use it or lose it" benefit and the goal is health promotion, disease prevention and detection. The IPPE is also the one and only time Medicare will pay for an EKG with a preventative diagnosis.
- In the second year of Part B, the patient is eligible for their First Annual Wellness Visit (G0438).
- Every subsequent year, the patient is eligible for their Subsequent Annual wellness visit (G0439).
- The diagnosis used to support any of the AWVs can be Z00.00 or any other appropriate diagnosis. However, if the provider is ordering other services such as labs or x-rays, and they have Medicare only, linking the service order to a Z00.00/Z00.01 will result in a denial.

Denial Reason: Encounter components are missing:

- All components unique to each AWV must be addressed. These components are defined by Medicare. Please refer to the chart attached for the components of each exam.

Denial Reason: Billing an unsupported, additional problem visit on the same day as the AWV.

- Providers cannot charge for a separate and identifiable problem visit at the same time as the AWV unless documentation supports the problem. This includes documenting a separate chief complaint, problem pertinent exam, and an A&P specific to the problem.
- If a patient presents with stable, chronic conditions, a separate E/M cannot be billed, even if the provider refills prescriptions or tweaks the dosage of an existing medication. If, however, the provider spends an additional 30 minutes beyond the service allotted for the AWV, a prolonged preventative charge can be reported, G0513 – each additional 30 minutes. Under these circumstances the provider must document the following attestation, "In addition to the AWV, I spent an additional XX minutes with the patient...." Then briefly describe what was covered within this time. If the visit extends another 30 minutes beyond the first 30 minutes, the provider can also bill G0514. The time rule applies to prolonged time, meaning that a unit of time is met when the mid-point, plus one-minute passes. Therefore, prolonged care G0513 can be submitted if the provider documents a minimum of 16 minutes of time beyond the base AWV.

Physician Education and Optimization:
Missed Opportunity, Advanced Care Planning - It is recommended the patient receive their Advanced Care Planning (ACP) service on the same day as the AWV. When ACP is received on the same day as the AWV there is no cost sharing to the patient. In these circumstances, please append Modifier 33 to the ACP CPT code 99497 (ACP).

Capturing Risk Assessing Conditions:

- Because many of the Medicare contracts risk assess, the AWVs are a great opportunity to acknowledge, document, and submit conditions that risk assess. The provider must document the patient's chronic diagnosis with a status. For example, "Patient has DM2, controlled on Metformin," OR "Patient has congestive heart failure and pacemaker, managed by Dr. Smith." Each problem should be reported to the highest degree of specificity to more accurately capture the ACO Risk scores.
- Ensure providers review the patient's active problem list in the EMR. Additionally if the practice participates in services provided by the risk adjustment coding team review any flagged conditions the provider should be aware of assessing. It is up to the provider to determine whether these conditions are still active, if they need to be modified, or removed. All risk assessing conditions must be acknowledged and reported annually.