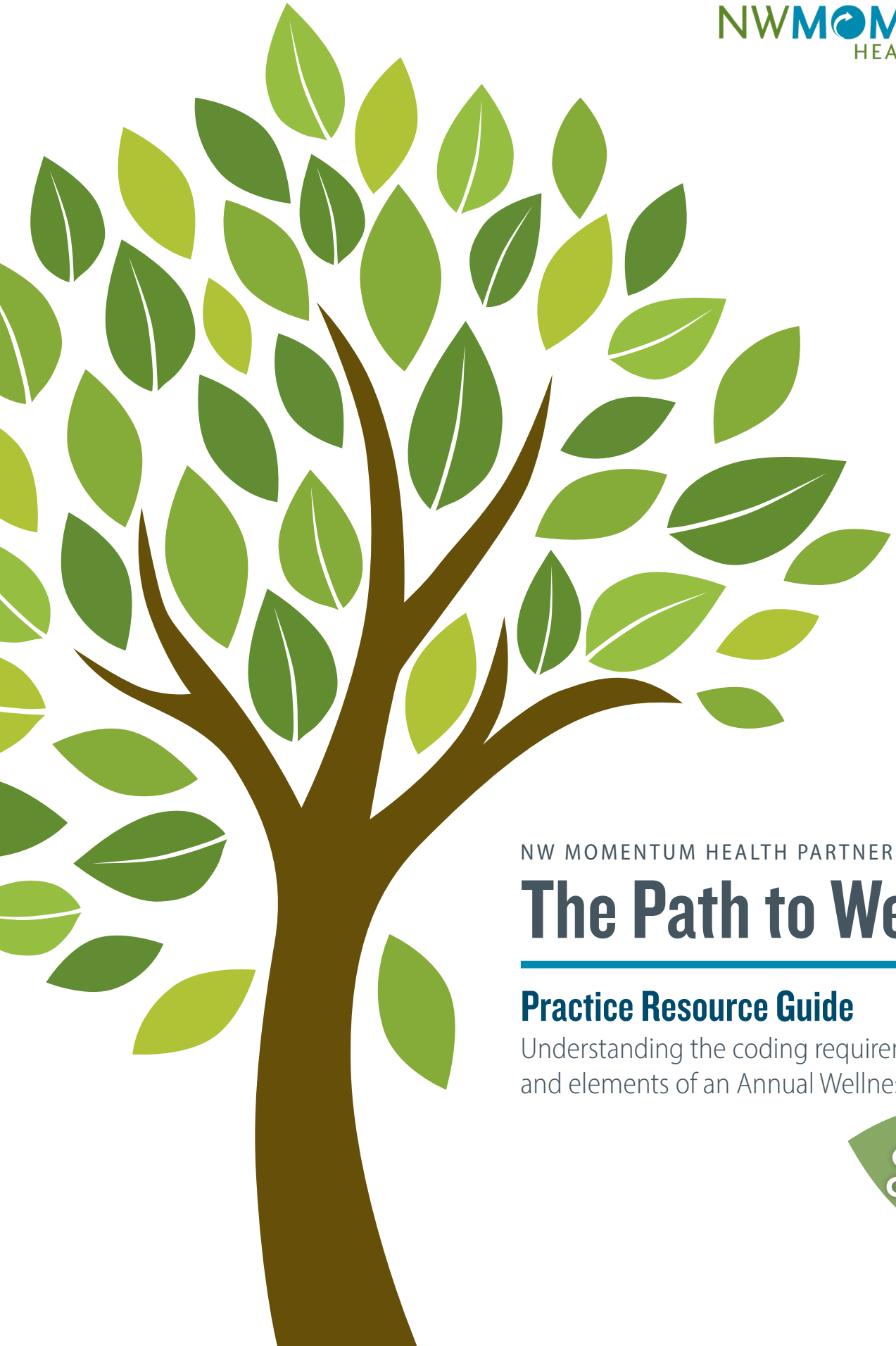
NW MOMENTUM HEALTH PARTNERS



NW MOMENTUM HEALTH PARTNERS ACO

The Path to Wellness

Practice Resource Guide

Understanding the coding requirements and elements of an Annual Wellness Visit.

CODING COUNTS!

Frequently asked questions

1. Why is the Annual Wellness Visit (AWV) important?

The Centers for Medicare and Medicaid Services (CMS) pays claims based on the overall health status of original Medicare (Next Generation ACO beneficiaries) patients. Diagnoses codes are used to determine the level of severity of illness, risk and resource utilization. These factors are critical to payer and provider contracts, specifically elements such as reimbursement rates and value-based incentive payments.

For your patients, Medicare's Annual Wellness Visit is a way for your practice to keep them as healthy as possible. As health care moves from volume to value based models, the AWV addresses gaps in care and can enhance the quality of care delivered.

2. Who is eligible for an Annual Wellness Visit (AWV)?

Medicare Fee-for-Service patients are eligible for the initial AWV if they have been enrolled in Medicare for MORE than 12-months and have not received the Welcome to Medicare visit within the past 12 months.

3. Is the AWV the same as the Welcome to Medicare Visit / Initial Preventive Physical Exam (IPPE)?

No. The Welcome to Medicare visit or IPPE is a once per lifetime benefit that may be provided only during the first 12 months of the patient's enrollment in Medicare Part B. The AWV can be provided annually once per 12-month period thereafter.

4. Can evaluation and management (E/M) services be provided the same day as the AWV?

Yes. The appropriate E/M service may be billed in addition to the AWV. Report the Current Procedural Terminology (CPT) code with the modifier 25. Documentation should be made in the medical record to establish medical necessity of the additional E/M service. The E/M service is subject to co-payment/ co-insurance.

Note: An AWV cannot be provided in conjunction with an acute E/M service.

5. Does the deductible or coinsurance/copayment apply to the AWV?

No. Medicare waives both the coinsurance or copayment and the Medicare Part B deductible for the AWV.

For more information

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Practice Resource Guide

INITIAL PREVENTIVE PHYSICAL EXAMINATION		MEMBER RESPONSIBILITY / FREQUENCY	MED-PAR FEE SCHEDULE / RVUS
G0402	**Initial preventive physical exam** provided within the first 12 months of Part B coverage eligibility	$0.00 / Once in a lifetime	$169.27 / 4.86
ANNUAL WELLNESS VISIT (AWV) WITH PERSONALIZED PLAN SERVICES (PPPS)			
G0438	**Annual wellness visit, initial visit** *Must not be in the first 12 months of Part B coverage eligibility and must not have received an IPPE or AWV within the last 12 months*	$0.00 / Once in a lifetime	$168.92 / 4.85
G0439	**Annual wellness visit, subsequent visit** *Must not be in the first 12 months of Part B coverage eligibility and must not have received an IPPE or AWV within the last 12 months*	$0.00 / Annually	$133.35 / 3.83
PREVENTIVE SERVICES			
G0446	**Face-to-face intensive behavioral therapy for cardiovascular disease,** individual, 15 minutes	$0.00 / Annually	$26.65 / .77
G0447	**Face-to-face behavioral counseling for obesity,** 15 minutes (must spend 8 or more minutes)	$0.00 / First month; One face-to-face weekly, Months 2-6; One face-to-face visit every other week Months 7-12; One face-to-face visit monthly	$26.65 / .77
G0473	**Face-to-face behavioral counseling for obesity,** group (2-10), 30 minutes. *Must be billed with one of the following diagnoses: Z68.30 - Z68.39 or Z68.41 - Z68.45*		$12.88 / .37
G0442	**Annual alcohol misuse screening**, 15 minutes (must spend 8 or more minutes)	$0.00 / Annually	$18.92 / .54
G0443	**Brief face-to-face behavioral counseling for alcohol misuse,** 15 minutes for those who screen positive (must spend 8 or more minutes)	$0.00 / 4x per year	$26.65 / .77
G0444	**Annual depression screening**, 15 minutes (must spend 8 or more minutes)	$0.00 / Annually	$18.92 / .54
99406	**Smoking and tobacco-use cessation counseling visit, intermediate,** greater than 3 minutes up to 10 minutes	$0.00 / Two attempts per year, each attempt may include a maximum of 4 sessions either intermediate or intensive	$15.62 / .45
99407	**Smoking and tobacco-use cessation counseling visit, intensive,** greater than 10 minutes		$28.75 / .74

Practice Resource Guide

PREVENTIVE SERVICES (continued)		MEMBER RESPONSIBILITY / FREQUENCY	MED-PAR FEE SCHEDULE / RVUS
99497	**Advanced care planning**, first 30 minutes – must spend between 16 and 45 minutes in the planning, explanation, discussion and perhaps form completion	* $0.00 / Annually	$85.36 / 2.46
99498	**Advanced care planning**, additional 30 minutes – service is performed when the time required to perform 99497 is greater than 45 minutes * In order for there to be no member cost-share, the service must be provided at the time of the AWV and must be billed using modifier 33	* $0.00 / Annually	$73.83 / 2.13
DIAGNOSTIC TESTS TO CONSIDER			
76977	**Ultrasound bone density measurement and interpretation**, peripheral site(s), any method (only one of these can be done once every 2 yrs.)	$0.00 / Once every two years	$7.22 / .21
77078	**Computer tomography, bone mineral density study,** 1 or more sites; axial skeleton; e.g., hips, pelvis, spine (only one of these can be done once every 2 yrs.)	$0.00 / Once every two years	$81.99 / Capped portion
77080	**Dual-energy X-ray absorptiometry (DXA) bone density study,** 1 or more sites; axial skeleton; e.g., hips, pelvis, spine (only one of these can be done once every 2 yrs.)	$0.00 / Once every two years	$38.99 / 1.11
77081	**DXA, bone density study**, 1 or more sites; appendicular skeleton (peripheral); e.g. radius, wrist, heel (only one of these can be done once every 2 yrs.)	$0.00 / Once every two years	$32.26 / .92
G0130	**Single energy X-ray absorptiometry (SEXA) bone density study,** 1 or more sites, appendicular skeleton (peripheral); e.g., radius, wrist, heel (only one of these can be done once every 2 yrs.)	$0.00 / Once every two years	$36.85 / 1.05
G0102 **G0103**	**Digital rectal exam (DRE)** **Prostate specific Antigen Test** *Must be billed with Z12.5*	$0.00 / Annually Co-insurance or co-pay applies / Annually	$23.17 / .66 $25.23 / Lab
80061	**Lipid panel,** includes: • 82465 – Cholesterol, serum total • 83718 Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) • 84478 – Triglycerides *Must be billed with diagnoses code Z13.6*	$0.00 / Once every five years	$13.39 / Lab
82947 **82950** **82951**	**Glucose; quantitative, blood** (except reagent strip) **Glucose; post glucose dose** (includes glucose) **Glucose; tolerance test (GTT),** 3 specimens (includes glucose) *Must be billed with Z13.1*	$0.00 / Two screenings for beneficiaries diagnosed with prediabetes and one screening annually if not diagnosed with prediabetes or never tested	$3.93 / Lab $4.75 / Lab $12.87 / Lab

Common conditions to consider

CONDITIONS	ICD-10 CODES AND DESCRIPTIONS	HCC CATEGORY and DESCRIPTION/ COMMUNITY NON-DUAL AGED WEIGHT
Is the patient insulin dependent? Insulin dependence is specific to patients with type 2 diabetes or secondary diabetes.	Z79.4 – Long term (current) use of insulin	19 / .105
Is the patient protein-calorie malnourished?	E44.0 – Moderate protein-calorie malnutrition	21 / .455
Is the patient alcohol or drug dependent?	F10.2 – Alcohol dependence F11.x – F15.x – (based on type of drug) drug dependence	55 / .329
Does the patient have major depressive disorder? Document the episode (single or recurrent), severity (mild, moderate or severe – without or with psychotic features) or the remission status.	F32.0-F32.5 – Major depressive disorder, single episode F33.0 – F33.5 – Major depressive disorder, recurrent	59 / .309
Does the patient have a tracheostomy or is the patient dependent on a respirator?	Z93.0 Tracheostomy status Z99.11 Dependence on respirator (ventilator status)	82 / 1.0
Is the patient on renal dialysis or noncompliant with renal dialysis?	Z99.2 – Dependence on renal dialysis Z91.15 – Patient's noncompliant with renal dialysis	134 / .435
Does the patient have an artificial opening (for example, gastrostomy, ileosomy, colostomy, cystostomy)?	Z93.x – Artificial opening status	188 / .534
Is the patient a lower limb amputee?	Z89.4x-Z89.5x Acquired absence of toe(s), foot, ankle, and leg below the knee	189 / .519
Does the patient have a major organ transplant (for example, heart, lung, liver, bone marrow, peripheral stem cells, pancreas, intestines)?	Z94.1 – Z94.84 – Transplanted organ and tissue status	186 / .832
Does the patient have HIV status?	Z21 – Asymptomatic human immunodeficiency virus (HIV) infection status	1 / .335

***MED-PAR fee schedule values based on MAC locality 0240299**
**** NOTE: All conditions that affect the composite picture of the patient's health status need to be recorded at least once per year.**

For more information

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