Providing the Annual Wellness Visit (AWV)
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The Centers for Medicare & Medicaid Services (CMS) recognizes the crucial role that health care providers play in educating Medicare beneficiaries about potentially life-saving preventive services and screenings, and in providing these services. While Medicare pays for a variety of preventive benefits, many Medicare beneficiaries do not fully realize that using preventive services and screenings can help them live longer, healthier lives. As a health care professional, you can help your Medicare patients understand the importance of disease prevention, early detection, and lifestyle modifications that support a healthier life. This booklet can help you communicate with your patients about the Medicare-covered Annual Wellness Visit (AWV), as well as assist you in correctly billing for these services.

Overview

For dates of service on or after January 1, 2011, Medicare covers an AWV providing Personalized Prevention Plan Services (PPPS) at no cost to the beneficiary, so beneficiaries can work with you to develop and update a personalized prevention plan. This benefit provides an ongoing focus on prevention that adapts as a beneficiary’s health needs change over time.

NOTE: The AWV is a separate preventive service from the Initial Preventive Physical Examination (IPPE). For more information on the IPPE, refer to the “Quick Reference Information: The ABCs of Providing the Initial Preventive Physical Examination” educational tool at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MPS_QRI_IPPE001a.pdf on the CMS website.

Coverage Information

Medicare provides annual coverage of an AWV for beneficiaries:

➤ Who are no longer within 12 months after the effective date of their first Medicare Part B coverage period; and

➤ Who have not gotten either an IPPE or an AWV within the past 12 months (i.e., at least 11 full months after the IPPE or most recent AWV).

Medicare pays for only one first AWV per beneficiary per lifetime. However, a beneficiary may get subsequent AWVs annually. The elements included in the first and subsequent AWVs, and the codes to bill them, are different. These differences are detailed beginning on page 5.
NOTE: The AWV is a preventive wellness visit and is not a “routine physical checkup” that some seniors may get every year or two from their physician or other qualified non-physician practitioner. Medicare does not provide coverage for routine physical examinations.

Health Risk Assessment (HRA)

The AWV includes the review (and administration, if needed) of an HRA. A brief summary of the minimum elements included in the HRA is listed below. The HRA:

► Collects self-reported information known to the beneficiary;
► Can be administered by the beneficiary or health professional before, or as part of, the AWV encounter;
► Is appropriately tailored to and takes into account the communication needs of underserved populations, people with limited English proficiency, and people with health literacy needs;
► Takes no more than 20 minutes to complete; and
► At a minimum, addresses the following topics:
  ► Demographic data, including but not limited to age, gender, race, and ethnicity;
  ► Self-assessment of health status, frailty, and physical functioning;

Who Can Furnish an AWV?

The AWV must be furnished by a health professional, meaning:

► A physician;
► A physician assistant, nurse practitioner, or clinical nurse specialist; or
► A medical professional (including a health educator, a registered dietitian or nutrition professional, or other licensed practitioner) or a team of such medical professionals, working under the direct supervision of a physician.
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Psychosocial risks, including but not limited to depression/life satisfaction, stress, anger, loneliness/social isolation, pain, and fatigue;

Behavioral risks, including but not limited to tobacco use, physical activity, nutrition and oral health, alcohol consumption, sexual health, motor vehicle safety (seat belt use), and home safety;

Activities of Daily Living (ADLs), including but not limited to dressing, feeding, toileting, grooming, physical ambulation (including balance/risk of falls), and bathing; and

Instrumental Activities of Daily Living (IADLs), including but not limited to shopping, food preparation, using the telephone, housekeeping, laundry, mode of transportation, responsibility for own medications, and ability to handle finances.

Additionally, the Centers for Disease Control and Prevention (CDC) published “A Framework for Patient-Centered Health Risk Assessments: Providing Health Promotion and Disease Prevention Services to Medicare Beneficiaries” at http://www.cdc.gov/policy/oph/hra on the Internet. This framework includes sections about the following:

- HRA history,
- HRA framework,
- Rationale for HRA use,
- HRA use,
- Follow-up interventions that evidence suggests can influence health behaviors, and
- Suggested HRA questions.
First AWV Providing PPPS

The first AWV providing PPPS is a one-time Medicare benefit and must include the HRA and the following key elements furnished to an eligible beneficiary by a health professional:

► Review (and administration, if needed) of an HRA;
► Establishment of the beneficiary’s medical/family history, including, at a minimum:
  ▶ Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments;
  ▶ Use of or exposure to medications and supplements, including calcium and vitamins; and
  ▶ Medical events in the beneficiary’s parents and any siblings and children, including diseases that may be hereditary or place the beneficiary at increased risk;
► Establishment of a list of current providers and suppliers regularly involved in providing medical care to the beneficiary;
► An assessment, including measurement of the beneficiary’s:
  ▶ Height;
  ▶ Weight;
  ▶ Body mass index (or waist circumference, if appropriate);
  ▶ Blood pressure; and
  ▶ Other routine measurements as deemed appropriate, based on the beneficiary’s medical and family history;
► Detection of any cognitive impairment that the beneficiary may have (includes the assessment of a beneficiary’s cognitive function by direct observation, with due consideration of information obtained by way of patient reports or concerns raised by family members, friends, caretakers, or others);
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► Review of the beneficiary’s potential risk factors for depression, including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the health professional may select from various available standardized screening tests designed for this purpose and recognized by national professional medical organizations;

► Review of the beneficiary’s functional ability and level of safety, based on direct observation of the beneficiary, or any appropriate screening questions or a screening questionnaire, which the health professional may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations, including, at a minimum, assessment of the following:
  ► Hearing impairment,
  ► Ability to successfully perform ADLs,
  ► Fall risk, and
  ► Home safety;

► Establishment of a written screening schedule for the beneficiary, such as a checklist for the next 5 to 10 years, as appropriate, based on recommendations of the USPSTF and Advisory Committee of Immunizations Practices (ACIP), the beneficiary’s health status and screening history, and age-appropriate preventive services covered by Medicare;

► Establishment of a list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or underway for the beneficiary, including any mental health conditions or any such risk factors or conditions identified through an IPPE, and a list of treatment options and their associated risks and benefits; and

► Furnishing of personalized health advice to the beneficiary and a referral, as appropriate, to health education or preventive counseling services aimed at community-based lifestyle interventions to reduce health risks and promote self-management and wellness, weight loss, physical activity, tobacco-use cessation, fall prevention, and nutrition.
**Subsequent AWV**

All subsequent AWVs providing PPPS must include an update of the HRA and the following key elements furnished to an eligible beneficiary by a health professional:

► Review (and administration, if needed) of an updated HRA;

► An update of the beneficiary’s medical/family history;

► An update to the list of the beneficiary’s current medical providers and suppliers, as that list was developed for the first AWV providing PPPS or previous subsequent AWV providing PPPS;

► An assessment, including measurements of the beneficiary’s:
  ▶ Weight (or waist circumference, if appropriate),
  ▶ Blood pressure, and
  ▶ Other routine measurements as deemed appropriate, based on the beneficiary’s medical and family history;

► Detection of any cognitive impairment that the beneficiary may have (includes the assessment of a beneficiary’s cognitive function by direct observation, with due consideration of information obtained by way of patient reports or concerns raised by family members, friends, caretakers, or others);

► An update of the beneficiary’s written screening schedule, as that schedule was developed at the first AWV providing PPPS or previous subsequent AWV providing PPPS;

► An update of the list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or underway for the beneficiary, as that list was developed at the first AWV providing PPPS or previous subsequent AWV providing PPPS; and

► Furnishing of personalized health advice to the beneficiary and a referral, as appropriate, to health education or preventive counseling services or programs.
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Frequency

When calculating frequency to determine the 11 full months since the beneficiary’s IPPE or last AWV, the count starts with the month after the IPPE or most recent AWV.


Coinsurance or Copayment and Deductible

The beneficiary pays nothing (no coinsurance or copayment and no Medicare Part B deductible) for the AWV. Financial responsibilities may apply for the beneficiary if the provider does not accept assignment.

NOTE: Other Medicare-covered services provided at the same visit as the AWV may be subject to coinsurance or copayment and deductible, depending on their coverage guidelines.

Documentation

Medical records must document that a health professional provided, or provided and referred, all required elements of the AWV. You should use appropriate screening tools normally used in a routine physician’s practice.

If you also perform a significant, separately identifiable medically necessary Evaluation and Management (E/M) service, document this in the medical record. Include all referrals and a written medical plan in this documentation. For information on recording the appropriate clinical information in the beneficiary’s medical record, refer to the “Documentation Guidelines for Evaluation and Management (E/M) Services” for 1995 and 1997 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html on the CMS website.
## Coding and Diagnosis Information

### Procedure Codes and Descriptors

Use the following Healthcare Common Procedure Coding System (HCPCS) codes, listed in Table 1, to report the AWV.

**Table 1. HCPCS Codes for the AWV**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Code Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0438</td>
<td>Annual wellness visit; includes a Personalized Prevention Plan of Service (PPPS), initial visit</td>
</tr>
<tr>
<td>G0439</td>
<td>Annual wellness visit, includes a Personalized Prevention Plan of Service (PPPS), subsequent visit</td>
</tr>
</tbody>
</table>

HCPCS codes for the AWV do not include other preventive services covered separately under Medicare Part B. When performing these other preventive services, you must identify the services using the appropriate codes.

### Diagnosis Requirements

Although you must report a diagnosis code on the claim, Medicare does not require a specific International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis code for the AWV. Contact your local Medicare Contractor for further guidance.

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**Coming Soon!**

**International Classification of Diseases, 10th Revision, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS)**

For more information, visit [http://www.cms.gov/Medicare/Coding/ICD10](http://www.cms.gov/Medicare/Coding/ICD10) on the CMS website.
Billing Requirements

When you provide a significant, separately identifiable medically necessary E/M service in addition to the AWV, use a Current Procedural Terminology (CPT) code in the range of 99201 – 99215 (depending on the clinical appropriateness of the encounter). Report the E/M code with modifier -25, identifying the service as a significant, separately identifiable, E/M service from the reported AWV code.

Billing and Coding Requirements When Submitting Professional Claims

When you submit professional claims to carriers or A/B Medicare Administrative Contractors (MACs), report the appropriate HCPCS code and the corresponding ICD-9-CM diagnosis code in the X12 837-P (Professional) electronic claim format. You must also include Place of Service (POS) codes on all professional claims to indicate where you provided the service. For more information on POS codes, visit http://www.cms.gov/Medicare/Coding/place-of-service-codes on the CMS website.

NOTE: If you qualify for an exception to the Administrative Simplification Compliance Act (ASCA) requirement, you may use Form CMS-1500 to submit these claims on paper. All providers must use Form CMS-1500, version 08-05, when submitting paper claims. For more information on Form CMS-1500, visit http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/16_1500.html on the CMS website.

Electronic Claims Requirements

ASCA requires providers to submit claims to Medicare electronically, with limited exceptions. For more information about the electronic formats, visit http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/HealthCareClaims.html on the CMS website.

Billing and Coding Requirements When Submitting Institutional Claims

When you submit institutional claims to Fiscal Intermediaries (FIs) or A/B MACs, report the appropriate HCPCS code, revenue code, and the corresponding ICD-9-CM diagnosis code in the X12 837-I (Institutional) electronic claim format.

NOTE: If an institution qualifies for an exception to the ASCA requirement, it may use Form CMS-1450 to submit these claims on paper. All providers must use Form CMS-1450 (UB-04) when submitting paper claims. For more information on Form CMS-1450, visit http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/15_1450.html on the CMS website.

Types of Bill (TOBs) for Institutional Claims

The FI or A/B MAC pays for the AWV when submitted on the following TOBs, listed in Table 2. For further guidance on the appropriate revenue code, contact your local Medicare Contractor.
Table 2. Facility Types and TOBs for the AWV

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>TOB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Inpatient (Part B)</td>
<td>12X</td>
</tr>
<tr>
<td>Hospital Outpatient</td>
<td>13X</td>
</tr>
<tr>
<td>Skilled Nursing Facility (SNF) Inpatient Part B</td>
<td>22X</td>
</tr>
<tr>
<td>SNF Outpatient</td>
<td>23X</td>
</tr>
<tr>
<td>Rural Health Clinic (RHC)</td>
<td>71X</td>
</tr>
<tr>
<td>Federally Qualified Health Center (FQHC)</td>
<td>77X</td>
</tr>
<tr>
<td>Critical Access Hospital (CAH)</td>
<td>85X</td>
</tr>
</tbody>
</table>

Additional Billing Instructions for FQHCs and RHCs

The professional component of preventive services is within the scope of covered FQHC or RHC services. The professional component is a physician’s interpretation of the results of an examination. For instructions on billing the professional component, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1039.pdf on the CMS website.

The technical component is services rendered outside the scope of the physician’s interpretation of the results of an examination. If you perform technical components of services, not within the scope of covered FQHC or RHC services, in association with professional components, how you bill depends on whether the FQHC or RHC is independent or provider-based:

► **For Provider-Based FQHCs or RHCs:** Bill the technical component of the service on the TOB for the base provider and submit to the FI or A/B MAC in the 837-I format. For more information on billing instructions for provider-based FQHCs or RHCs, visit http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html on the CMS website and choose the appropriate chapter based on your facility type.

► **For Independent FQHCs or RHCs:** Bill the technical component of the service to the carrier or A/B MAC in the 837-P format. For more information on billing instructions for independent FQHCs or RHCs, visit http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf and http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf on the CMS website.
Payment Information

Professional Claims

When you bill your carrier or A/B MAC, Medicare pays for the AWV under the Medicare Physician Fee Schedule (MPFS).

As with other MPFS services, the non-participating provider reduction and limiting charge provisions apply to all AWV services.

Institutional Claims

When you bill your FI or A/B MAC, Medicare payment for the AWV depends on the type of facility providing the service. Table 3 lists the type of payment that facilities get.

Table 3. Facility Payment Methods for the AWV

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>Basis of Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Inpatient (Part B)*</td>
<td>MPFS</td>
</tr>
<tr>
<td>Hospital Outpatient</td>
<td>MPFS</td>
</tr>
<tr>
<td>SNF Inpatient Part B**</td>
<td>MPFS</td>
</tr>
<tr>
<td>SNF Outpatient</td>
<td>MPFS</td>
</tr>
<tr>
<td>RHC</td>
<td>All-Inclusive Payment Rate</td>
</tr>
<tr>
<td>FQHC</td>
<td>All-Inclusive Payment Rate</td>
</tr>
<tr>
<td>CAH</td>
<td>Method I: 101% of reasonable cost for technical component(s) of services</td>
</tr>
<tr>
<td></td>
<td>Method II: 101% of reasonable cost for technical component(s) of services, plus 115% of MPFS non-facility rate for professional component(s) of services</td>
</tr>
</tbody>
</table>

* Medicare pays Maryland hospitals for inpatient or outpatient services according to the Maryland State Cost Containment Plan.

** The SNF consolidated billing provision allows separate Medicare Part B payment for an AWV for beneficiaries in a skilled Part A SNF stay; however, the SNF must submit these services on a 22X TOB. AWV services provided by other facility types for beneficiaries in a skilled Part A stay must be paid by the SNF.

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Reasons for Claim Denial

Medicare may deny coverage of the AWV in several situations, including:

- The beneficiary previously got a first AWV.
- You billed a subsequent AWV less than 12 months after the previous covered AWV.

You may find specific payment decision information on the Remittance Advice (RA). The RA includes Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide additional information on payment adjustments. For the most current listing of these codes, visit [http://www.wpc-edi.com/reference](http://www.wpc-edi.com/reference) on the Internet. You can obtain more information about claims from your carrier, FI, or A/B MAC.
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Resources

For more information about the AWV, refer to the resources listed in Tables 4 and 5. For educational products for Medicare Fee-For-Service health care professionals and their staff, information on coverage, coding, billing, payment, and claim filing procedures, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/PreventiveServices.html on the CMS website, or scan the Quick Response (QR) code to the right with your mobile device.

Table 4. Provider Resources

<table>
<thead>
<tr>
<th>Resource</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACIP Recommendations and Guidelines</td>
<td><a href="http://www.cdc.gov/vaccines/pubs/ACIP-list.htm">http://www.cdc.gov/vaccines/pubs/ACIP-list.htm</a></td>
</tr>
<tr>
<td>CMS Beneficiary Notices Initiative (BNI)</td>
<td><a href="http://www.cms.gov/Medicare/Medicare-General-Information/BNI">http://www.cms.gov/Medicare/Medicare-General-Information/BNI</a></td>
</tr>
</tbody>
</table>
Table 4. Provider Resources (cont.)

<table>
<thead>
<tr>
<th>Resource</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Physician Fee Schedule (MPFS)</td>
<td><a href="http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched">http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched</a></td>
</tr>
<tr>
<td>Medicare Preventive Services General Information</td>
<td><a href="http://www.cms.gov/Medicare/Prevention/PreventionGenInfo">http://www.cms.gov/Medicare/Prevention/PreventionGenInfo</a></td>
</tr>
</tbody>
</table>
### Table 5. Beneficiary Resources

<table>
<thead>
<tr>
<th>Resource</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Improving Medicare in 2011: Annual Wellness Visits” Video</td>
<td><a href="http://www.youtube.com/watch?v=Yz2vBKgkFFc">http://www.youtube.com/watch?v=Yz2vBKgkFFc</a></td>
</tr>
<tr>
<td>“Medicare &amp; You: Stay Healthy with Medicare’s Preventive Benefits” Video</td>
<td><a href="http://www.youtube.com/watch?v=mBCF0V4RA0&amp;feature=relmfu">http://www.youtube.com/watch?v=mBCF0V4RA0&amp;feature=relmfu</a></td>
</tr>
</tbody>
</table>
| Medicare Beneficiary Help Line and Website                              | Telephone:  
Toll-Free: 1-800-MEDICARE (1-800-633-4227)  
TTY Toll-Free: 1-877-486-2048  
Website: [http://www.medicare.gov](http://www.medicare.gov) |
This page intentionally left blank.
The Medicare Learning Network® (MLN), a registered trademark of CMS, is the brand name for official CMS educational products and information for Medicare Fee-For-Service Providers. For additional information, visit the MLN’s web page at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo on the CMS website.