

# PAYMENT



## Reimbursement Tips:

### FQHC Requirements for Medicare Initial Preventive Physical Exam (IPPE) & Annual Wellness Visits (AWV) as Qualifying Visits for Care Management

An IPPE or AWV performed on Medicare Part B patients qualifies as an “initiating” visit for care management conducted within the year prior to starting. This allow FQHCs to be reimbursed for care management services, including Chronic Care Management (CCM), Behavioral Health Integration (BHI), and/or Psychiatric Collaborative Care Model (CoCM), for substance use disorders.

#### Program Requirements

Medicare requires a face-to-face initiating visit (i.e., IPPE, AWV or any Evaluation and Management Visit [E&M]) with the billing practitioner for new patients or established patients not seen within one (1) year prior to starting care management services.

#### Patient Eligibility & Consent

Eligible patients include those with current and valid Medicare Part B benefits. Since only one provider per patient may be paid for care management services, it important to verify that no other provider has reported the service during the year. CMS/Medicare recommends determination of AWV and IPPE eligibility through the HIPAA Eligibility Transaction System, the provider call center’s Interactive Voice Response (IVR), or by reaching out to your Medicare Administrative Contractor (MAC). If billing these services to Medicare Advantage plans, make certain to understand their coverage guidelines.

At FQHCs under **Medicare**, a new patient is someone who has not received any Medicare-covered professional health service (medical or mental health) from any site within the FQHC organization, or from any practitioner within the FQHC organization, within the past 3 years from the date of service. Dental service would not count as dental is not covered by Medicare. This definition differs from the traditional CPT definition of a new patient. FQHCs are encouraged to educate staff of the variance and may choose to use a single definition.

#### Timeframe & Services

CMS/Medicare covers several types of initiating visits, including IPPE, AWV, and E/M. The initiating visit is not part of care management services and it is billed separately. If a comprehensive IPPE, AWV, or E/M was billed for an established FQHC patient within the past year, an initiating visit is not required.

The following Medicare Part B payment parameters are important to know:

- Initial IPPE** Billable once per patient per lifetime (not per provider) and rendered within 12 months of the initial Medicare Part B enrollment date.
- Initial AWV** Billable after the first 12 months of Medicare Part B enrollment have passed, after the IPPE.
- Subsequent AWV** Billable once every 12 months after the Initial AWV.

#### Initiating Visit

Comprehensive initiating visits can include an IPPE, AWV, or E/M. For the purposes of an initiating visit, the service should be performed in an authorized location, including: the health center, the patient’s residence (i.e., certain homebound patients or those in assisted living facilities), or Part A covered skilled nursing facilities.

#### Authorized Provider/Staff

Authorized practitioners (see table below) are considered primary care providers and must provide the key face-to-face service elements for the IPPE and AWV.

For the AWVs, a health educator, Registered Dietitian, nutrition professional, or other licensed practitioner is eligible to perform some elements of the AWV under direct supervision of a Physician, which includes a face-to-face interaction documented by the primary provider. Services provided by non-primary care providers are subject to State law, licensure, and scope of practice definitions.

VISIT TYPE	TREATING (BILLING) PROVIDER				
	Physicians (MD or DO)	Non-Physician Practitioners			
		NP	PA	CNM	CNS
IPPE	x	x	x		x
AWV	x	x	x		x

Physicians: Medical Doctor (MD) or Doctor of Osteopathy (DO).

Non-Physician Practitioners include: Nurse Practitioners (NP), Physician Assistants (PA), Certified Nurse Midwives (CNM), Clinical Nurse Specialists (CNS).

## Reimbursement Tips: FQHC Requirements for Medicare IPPE & AWW as Qualifying Visits for Care Management

### Documentation

Documentation requirements for an IPPE and AWW are as follows:

#### *IPPE documentation*

##### History

- Past medical and surgical history (experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments)
- Current medications and supplements (including calcium and vitamins)
- Family history (review of medical events in the beneficiary's family, including conditions that may be hereditary or place the beneficiary at risk)
- History of alcohol, tobacco, and illicit drug use
- Diet
- Physical activities
- Opioid use: If patient is using opioids, assess the benefits of non-opioid pain therapies
- Review of potential risk factors for depression and other mood disorders

**Appropriate screening questions or standardized questionnaires recognized by national professional medical organizations.** Review at a minimum, the following areas:

- Activities of daily living
- Fall risk
- Hearing impairment
- Home safety

##### Physical Examination

- Height, weight, body mass index, and blood pressure
- Visual acuity screen
- Other factors deemed appropriate based on the beneficiary's medical and social history and current clinical standards

##### End-of-Life Planning

- Is beneficiary able to prepare an advance directive in case an injury or illness makes them unable to make health care decisions?
- Are you willing to follow the beneficiary's wishes as expressed in an advance directive?

##### **Education, Counseling, or Referrals (Optional) Once-in-a Lifetime Screening EKG performed**

#### *Initial AWW documentation*

1. Perform a Health Risk Assessment (HRA) completed by the patient or during the visit including, but not limited to, psychosocial and behavioral risks and Activities of Daily Living (ADL).

2. Establish the patient's medical and family history paying recommended attention to Opioid Use Disorders (OUD) and exposure to medications and supplements (including calcium and vitamins).
3. Establish a list of current providers and suppliers who provide regular care.
4. Obtain height, weight, BMI, or waist circumference, if appropriate, and blood pressure.
5. Detect any cognitive impairment by direct observation and information from the patient, family members, and others.
6. Review risk factors for depression, considering current or past experiences with depression or other mood disorders.
7. Review the patient's functional ability and level of safety related to the ADL, fall risk, hearing impairment, and home safety.
8. Establish a written screening schedule, such as a checklist, for the next 5-10 years.
9. Establish a list of risk factors and conditions for which various interventions are recommended or already underway.
10. Furnish the patient with personalized health advice/referrals to health education or preventive counseling services or programs.
11. At the patient's discretion, offer Advanced Care Planning (ACP) services.

#### *Subsequent AWW documentation*

The AWW is not a "routine physical". It includes no physical exam beyond height/weight/BMI/blood pressure.

1. Review and update an HRA if you performed the Initial or other Annual AWW.
2. Update the patient's medical/family history.
3. Update the list of current providers and suppliers.
4. Obtain the patient's weight (or waist circumference, if appropriate), blood pressure, and other routine measurements.
5. Detect any cognitive impairment using direct observation or a brief validated structured cognitive assessment tool.
6. Update the written screening schedule based on the [USPSTF](#) and the [ACIP](#).
7. Update the list of patient risk factors for which assorted interventions are recommended or underway.
8. Furnish and update, as necessary, the patient's Personalized Prevention Plan Services (PPPS). Include advice and/or referrals to health education or preventive counseling services or programs.
9. Furnish, at the patient's discretion, any advanced care planning services.

## Reimbursement Tips: FQHC Requirements for Medicare IPPE & AWW as Qualifying Visits for Care Management

### Coding & Billing

Medicare will pay the FQHC PPS G Code at a FQHC's billed charge or the annual PPS rate maximum, whichever is less. If a FQHC does not set charges above the potential payment ceiling, they will receive the lesser of the two. All IPPE and AWW encounters receive a 34.16% increase according to the guidelines below.

Medicare's FQHC PPS G Codes afford 34.16% payment increase for new patients. For instance, coding G0468 for an IPPE or AWW affords a FQHC opportunity to see a 34.16% increase (up to \$232.77) in Medicare payment according to the [CMS Benefits Policy Manual Chapter 9 Section 30.2](#).

WHAT PROVIDER CODES	Services	What FQHC bills to CMS	CMS/Medicare 2020 Fees
<b>G0402</b>	Initial Preventive Physical Examination (IPPE); face-to-face visit during first 12 months of Medicare Part B enrollment.	G0468	\$232.77*
<b>G0438</b>	Annual Wellness Visit (AWV) billable after the first 12 months of Medicare Part B enrollment.		
<b>G0439</b>	Annual Wellness Visit (AWV), subsequent visit, billable once every 12 months after the Initial AWV.		
<b>Varies</b>	Initiating Visit: A comprehensive Evaluation and Management service qualifies for new patients (not seen within the past 3 years by a FQHC provider covered by Medicare) or patients not seen in more than a year prior to service commencement. Levels 2 through 5 E/M visits (CPT codes 99202-99205 and 99212-99215) also qualify.	G0466 G0467	\$232.77* \$173.50*

#### Notes:

- Rates here are based on the 2020 Medicare Physician Fee Schedule (PFS); no Geographical Adjustment Factor (GAF) or Geographic Practice Cost Index (GPCI) has been applied. FQHCs can expect the payment to be slightly higher or lower depending on the GAF/GPCI.
- \$173.50 and \$232.77 are the FQHC unadjusted CMS PPS rate ceilings for established and new patients, respectively. The PPS rate is adjusted when a FQHC furnishes care to a new patient of the FQHC, or for an IPPE or AWW. The adjustment is made to the base rate, thus increasing reimbursement. FQHCs are paid either their PPS G Code charge or these fees; whichever is less.

With the Affordable Care Act having eliminated co-insurance for Medicare Part B beneficiaries receiving covered preventive care, FQHC patients receiving an IPPE or AWW will have no coinsurance for these services.

CMS/Medicare statutorily excludes coverage for Periodic Preventive Visits (PPV: i.e., 99381-99387 & 99391-99397). History and Exam documentation for the PPV is commensurate with the age and sex of the patient. Since PPV is not covered by Medicare, it is recommended to have the patient sign an Advanced Beneficiary Notice (ABN) advising them of the non-covered nature of the PPV.

If a provider deems it appropriate to also code for an acute problem/issue that is "significantly and separately identifiable" from the IPPE, or AWW (i.e., -25 modifier eligible), a separate SOAP note is necessary to support the additional billing of the problem E&M: i.e., 99201-99205 or 99212-99215.

### **HCPCS Coding Options (apply modifiers, as applicable):**

- 92002-92004 or 92012-92014 for eye exams
- 97802-97803 for medical nutrition services
- 99201-99205 for new patient office/outpatient visits
- 99212-99215 for established patient office visits
- 99304-99318 for assorted nursing facility visits
- 99324-99328 and 99334-99337 for domiciliary/rest home visits
- 99341-99350 for patient home visits
- 99406-99407 for smoking cessation services
- 99497 for advanced care planning
- G0101 for cancer screening/pelvic/breast exam
- G0102 for prostate cancer screening (DRE)
- G0108 for diabetes management training
- G0117-G0118 for glaucoma screening
- G0270 for medical nutrition services
- G0296 for counseling for lung cancer screening
- G0442-G0443 for alcohol screening
- G0444 for depression screening
- G0445 for intensive behavioral counseling for STDs
- G0446 for intensive counseling for cardiovascular disease
- G0447 for intensive behavioral counseling for obesity
- G0490 for home visits by RN, LPN
- Q0091 for obtaining screen pap smear

## Reimbursement Tips: FQHC Requirements for Medicare IPPE & AWW as Qualifying Visits for Care Management

### **Mental Health Visits:**

- 90791-90792 for Psychiatric diagnostic evaluation
- 90832, 90834, 90837 for Psychotherapy
- 90845 for Psychoanalysis

### **All IPPE and AWW PPS G Codes are eligible for a 34.16% increase in payment:**

- G0402: Initial preventive physical examination, face-to-face visit, and services limited to a new beneficiary during the first 12 months of Medicare enrollment.
- G0403-G0405: to bill for a screening electrocardiogram rendered with an IPPE. These codes: correspond with CPT codes 93000-93010. The “global code” (i.e., 93000 or G0403) includes owning the equipment, “tracing” or capture of the rhythm strip, and professional interpretation. Code 93005 is “technical component only” (i.e., 93005 or G0404) and represents payment for owning the equipment and capture of the rhythm strip but not interpretation/reading. Code 93010 or G0405 represent “interpretation/reading” only.
- To avoid providers coding for a specific payer vs. the preferred method of just coding for what was done, it is recommended to only allow providers to capture 93000-93010 and for the billing team to crosswalk for Medicare IPPE services.
- For FQHC Medicare billing, the PPS G codes cover all professional services. As such, if only billing for the technical component (i.e., 93005 or G0304), these should be submitted on the ANSI 837-P vs. the ANSI 837-I.

- G0438: Annual wellness visit, which includes a personalized prevention plan of service (PPS), and initial visit.
- G0439: Annual wellness visit, which includes a personalized prevention plan of service (PPS), and subsequent visit.

## References

- [CMS Benefits Policy Manual Chapter 18 Preventive and Screening Services – section 80.](#)



- [CMS Initial Preventive Physical Exam Fact Sheet](#)
- [CMS Annual Wellness Visit Fact Sheet](#)
- [CMS Frequently Asked Questions on the IPPE and AWW](#)
- [CMS Benefits Policy Manual Chapter 18 Preventive and Screening Services – section 140.](#)
- [Specific Payment Codes for the Federally Qualified Health Center Prospective Payment System \(FQHC PPS\)](#).
- [CMS Evaluation and Management Services Guide.](#)

*\*Note: CMS IPPE and AWW Fact Sheets were created for fee-for-service providers, so while these documents contain valuable information on proper documentation, FQHC billing guidance differs. Follow the items included in this Reimbursement Tips document.*

