FAQ: Medicare Annual Wellness Visits

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Purpose

This document aims to answer frequently asked questions about billing for Medicare Wellness Visits. Other opportunities for revenue generation are not discussed here. All services must be furnished in accordance with applicable State law.

For other billing information, please review other documents in the ASHP Resource Center.

Frequently Asked Questions

1. What are Medicare Wellness Visits?

Medicare wellness visits are preventive health appointments for Medicare beneficiaries that are designed to create or update a personalized prevention plan to prevent disease and disability based on current health and risk factors. These visits are covered under Medicare Part B and are available to beneficiaries at no cost.

There are two types of wellness visits:

1. Initial Preventative Physician Examination (IPPE) (i.e., "Welcome to Medicare" visit): This is a one-time visit available during the first 12 months of Part B coverage. It is the only wellness visit that includes a physical examination.
2. Annual Wellness Visit (AWV): After the IPPE visit, the AWVs are covered by Part B every 12 months. Medicare does not cover a routine physical examination within the AWVs.

2. What are the requirements for an AWV visit and the codes to be billed?

Visit Providers:
The IPPE is provided by a qualified healthcare provider (QHP), such as a physician, physician associate, nurse practitioner, or certified clinical nurse specialist. A pharmacist ***cannot*** be the sole provider of an IPPE visit, but they can participate in a co-visit model with a QHP. For example, the pharmacist can complete all elements of an AWV, then hand-off to a QHP to complete the remainder of the IPPE requirements. While details of the IPPE are out of the scope of this FAQ document, more information can be found here.

Unlike IPPEs, AWVs may be provided either by a QHP or a medical professional/team of professionals who are directly supervised by a physician. Pharmacists qualify to perform AWVs

as a medical professional under the direct supervision of a physician. When speaking with your billing department, you can direct them to the definition of a medical professional listed in the Centers for Medicare and Medicaid Services (CMS) Medicare Learning Network (MLN) document to include pharmacists under "other licensed practitioner" component since it does not explicitly list pharmacists.

AWV Types and Billing Codes:

AWVs can be billed if the patient is 1) not within the first 12 months of their Medicare Part B coverage period ***and*** 2) if it has been at least 12 months since the patients IPPE exam or previous AWV. Of note, some Medicare Advantage plans allow for an AWV on a once per calendar year basis.

Patients do not pay any coinsurance, co-pay, or deductible for the AWV. An AWV can be provided on the same day as another E/M visit by utilizing a "-25 modifier" when billing. Co-insurance, co-pay, and deductibles would apply to this E/M visit but not to the AWV component.

AWV Type	CPT Code	Descriptor
Initial	G0438	The first initial AWV at least 12 months after the IPPE; only billed once per patient lifetime.
Subsequent	G0439	All AWVs after the initial AWV.

While pharmacists are eligible service providers for AWVs, pharmacists do not serve as the billing provider for these encounters. AWV billing codes are billed under the physician providing direct supervision. All "incident to" billing rules need to be satisfied to provide and bill for AWVs.

For prolonged preventative services (beyond the typical service time of the primary procedure), CMS has developed time-based add-on codes. These codes can be used in addition to the Welcome to Medicare visit, and initial and subsequent wellness visits for wellness visits that are especially time-consuming. To bill the add-on code(s) below, the provider must meet the threshold time for the visit, and half of the prolonged services time. The extra time spent must be documented clearly in the note.

CPT Code	Descriptor
G0513	The first 30 minutes of prolonged preventive service(s); list separately in addition to IPPE/AWV code
G0514	Each additional 30 minutes of prolonged preventative service(s); list separately in addition to IPPE/AWV and G0513 codes for additional 30 minutes

AWV Requirements:

AWV Components Quick Overview. Please refer to the ABC guide for more detailed information.

	Initial AWV (G0438)	Subsequent AWV (G0439)
A: Acquire Information	Administer Health Risk Assessment (HRA)	**Update** HRA
	Administer Social Determinants of Health (SDOH) Risk Assessment[1]	**Update** SDOH Risk Assessment[1]
	Establish a list of current providers and suppliers	**Update** a list of current providers and suppliers
	Establish medical/family history	**Update** medical/family history
	Review current opioid prescriptions	Review current opioid prescriptions
	Review risk for substance use disorders (SUDs)[2]	Review risk for SUDs[2]
	Review risk for depression	
	Review functional ability and level of safety	
B: Begin Assessment	Assess height, weight, BMI, and blood pressure as well as others based on history	Assess weight and blood pressure as well as others based on history
	Detect cognitive impairment	Detect cognitive impairment
C: Counsel	Establish a written screening schedule	**Update** a written screening schedule
	Establish a list of risk factors with interventions	**Update** a list of risk factors with interventions
	Provide health advice including referrals and applicable counseling[2]	Provide health advice including referrals and applicable counseling[2]
	Provide advance care planning services[1]	Provide advance care planning services[1]

[1]Optional AWV element; [2]Ancillary counseling/screening codes below

Ancillary Counseling/Screening Codes that may be Billed for During AWVs for Eligible Patients

CPT Code	Descriptor	Billing Notes
99497	Advance care planning, first 30 min	Bill with -33 modifier
99498	Advance care planning, each additional 30 min	Bill with -33 modifier
G0136	SDOH risk assessment, 5-15 min	Bill with -33 modifier
G0296	Counseling to discuss need for lung cancer screening using LDCT	
G0442	Alcohol misuse screening, 15 min	Cannot be billed with G0444
G0444	Depression screening, 15 min	Subsequent AWV only; cannot be billed with G0442
G0446	Cardiovascular disease counseling, 15 minutes	
G0447	Obesity counseling, 15 min	
99406	Smoking cessation, 3-10 min	
99407	Smoking cessation, >10 min	

3. What is Medicare Reimbursement for AWVs and Ancillary Counseling/Screening Codes?

Exact payment information can be found at CMS Physician Fee Schedule Look-up Tool and is dependent upon geography and if the billing location is a facility or non-facility setting.
Be sure to regularly review the MAC* regulations in your region as each MAC has the discretion to interpret the regulations and provide additional requirements. More information regarding your state's MAC can be found at Find Your Medicare Administrative Contractor (MAC)

**Note: Medicare Administrative Contractors (MACs) are third parties which have responsibility for processing Medicare Part A and B and durable medical equipment claims for a specific geographic region. This entity administers the operational contract between Medicare and healthcare providers.*

4. What additional information is available for required assessments and screenings during a Medicare AWV?

CMS does not require the use of specific screening tools for the AWV components, and some elements may be evaluated informally vs. formally (ie, Cognitive Assessment, etc.). However, suggested validated tools and resources for each component are listed below.

Health Risk Assessment (HRA):
CMS provides minimum elements that must be addressed including demographics, self-assessment of health status, psychosocial risks, behavioral risks, and activities of daily living and instrumental activities of daily living. CDC provides A Framework for Patient-Centered Health Risk Assessments. Some HRAs may be found online, but it is recommended to review copyright information prior to utilizing in clinical practice.

Depression Screening
Examples of validated tests that can be considered in this setting are the Patient Health Questionnaire (PHQ-2) or (PHQ-9), as well as the Geriatric Depression Scale (GDS).

Fall Risk Assessment
Assessing fall risk is a minimum requirement for reviewing functional ability and level of safety. CDC provides materials for providers as part of their stopping elderly accidents, deaths, and injuries (STEADI) program. Examples of validated observed assessments include the 30-second chair stand, the 4-stage balance test, and the timed "Get Up and Go" test.

Cognitive Assessment
The Alzheimer's Association published recommendations on cognitive assessment during Medicare AWVs. Examples of assessments include the Mini-Cog, Montreal Cognitive Assessment (MoCA), General Practitioner Assessment of Cognition (GPCOG), or Memory Impairment Screen (MIS).

SDOH Risk Assessment
Possible evidence-based tools include the CMS Accountable Health Communities (AHC) tool, the Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE), tool, and instruments identified for Medicare Advantage Special Needs Population Health Risk Assessment.

Age-based Screenings
The US Preventive Services Task Force's (USPTF) provides recommendations for screenings in primary care practice. These screenings can be filtered by several categories, including age. One can also download the Prevention TaskForce app, which incorporates age, gender, and select behavioral risk factors to develop a list of screening recommendations.

Immunizations
The CDC ACIP develops recommendations for U.S. immunizations, including ages when vaccines should be given, number of doses, time between doses, and precautions and contraindications.

Advance Care Planning
The CMS Advance Care Planning Fact Sheet provides in-depth information regarding advance care planning discussion and billing.

Opioid Use in Chronic Pain
The HHS Pain Management Best Practices Inter-Agency Task Force Report has more information on options for pain management.

SUD Screening
The National Institute on Drug Abuse has screening and assessment tools. Implementing Drug and Alcohol Screening in Primary Care is a helpful resource.

Resources and References:

1. CMS Medicare Wellness Visits
2. CDC HRA Framework
3. CDC STEADI – Older Adult Fall Prevention
4. Medical AWV Algorithm for Assessment of Cognition
5. Alzheimer's Association Recommendations for Operationalizing the Detection of Cognitive

Impairment During the Medicare Annual Wellness Visit in a Primary Care Setting
6. SDOH Risk Assessment
7. USPTF
8. CMS Medicare Preventative Services
9. CDC ACIP
10. CMS Advance Care Planning Fact Sheet
11. HHS Pain Management Best Practices Inter-Agency Task Force Report
12. Implementing Drug and Alcohol Screening in Primary Care

5. What are the opportunities and challenges for pharmacist provided Medicare AWVs?

Opportunities:
Since Medicare AWVs are billable services, one of the biggest advantages to pharmacists and their corresponding practice sites are the opportunities to generate direct revenue.

In a 2014 study, Park et al. determined that the average reimbursement for an initial AWV (G0438) was ~$162 and a subsequent AWV (G0439) was ~$107. Park and colleagues also estimated ~1,070 AWVs would cover a pharmacist's salary and benefits at $120,000/year. This ends up being ~20 AWVs/week or 4 AWVs/day.

Mack et al. found that reimbursement from AWVs increased by approximately $31,000 (adjusting for inflation in 2022) when completed by a pharmacist vs. a QHP. Pharmacist provided AWVs also improved HEDIS measure completion and star ratings, when compared to QHP-provided AWVs.

For the best estimation of reimbursement rates in a specific region, it is recommended to utilize the CMS Physician Fee Schedule Look-Up Tool.

Challenges:
One key challenge is getting support for pharmacist provided visits. Below are recommended elements to increase this support:

- Identifying key stakeholders
- Focus on time saving benefits for physicians, which can allow them time for more acute visits
- Pharmacist intervention data
    - Warshany K, Sherrill C, Cavanaugh J, Ives TJ, Shilliday BB. Medicare annual wellness visits conducted by a pharmacist in an internal medicine clinic. *Am J Health-Syst Pharm*. 2014; 71: 44 – 49.
    - Sewell MJ, Riche D, Fleming JW, Malinowski SS, Jackson RT. Comparison of pharmacist and physician managed annual medicare wellness services. *J Manag Care Spec Pharm*. 2016;22(12): 1412-16.
    - Hohmann LA, Hastings TJ, Qian J, Curran GM, Westrick SC. Medicare Annual Wellness Visits: A Scoping Review of Current Practice Models and Opportunities for Pharmacists. *J Pharm Pract*. 2020;33(5):666-681. doi:10.1177/0897190019847793
- Increased revenue opportunities
    - Park I, Sutherland SE, Ray L, Wilson CG. Financial implications of pharmacist led

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    - Mack K, Henneman A, Snyder T. Impact of pharmacist-provided Medicare annual wellness visits and chronic care management on reimbursement and quality measures in a privately owned family medicine clinic. *Am J Health Syst Pharm*. 2023;80(Suppl 4):S143-S150. doi:10.1093/ajhp/zxad046
- Patient satisfaction data
    - Sherrill C, Cavanaugh J, Shilliday BB. Patient satisfaction with medicare annual wellness visits administered by a clinical pharmacist practitioner. *J Manag Care Spec Pharm*. 2017;23(11):1125-29.
- Focused review of medication list
    - Tran T, Miller H, Ivy D, et al. Evaluation of pharmacist involvement in Medicare wellness visits. *J Pharm Pract*. 2020;33(6):745-748. doi:10.1177/0897190019827126
- Care gap closure in a value-based-care world
    - Mack K, Henneman A, Snyder T. Impact of pharmacist-provided Medicare annual wellness visits and chronic care management on reimbursement and quality measures in a privately owned family medicine clinic. *Am J Health Syst Pharm*. 2023;80(Suppl 4):S143-S150. doi:10.1093/ajhp/zxad046
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    - Osae S, Young H, Fricks W, Zillich A. Evaluation of quality measure attainment with pharmacist-delivered Medicare annual wellness visits. *J Am Pharm Assoc*. 2022;62(2):559-563. doi:10.1016/j.japh.2021.10.030

6. What data should you collect to show success or to identify areas for improvement?

Helpful data to report may include: number of patients seen, reimbursement amounts, number and type of interventions made, number and type of medication related problems (MRPs) identified, percent completion of preventative screening items. Depending on the state's pharmacist scope of practice in place, orders/recommendations for additional screening items may include: immunizations completed same day, referrals for vision, audiology, mammogram, colonoscopy, DEXA, AAA, necessary maintenance lab work (ie, HBgA1c or fasting lipid panel), and other care gap closures.

7. What are the suggested steps to starting a Medicare AWV service?

Identify eligible patients:

- Patients with Medicare for greater than one year are eligible for an AWV completed by a pharmacist. A report could be pulled to identify these patients in the clinic. If the service is looking to focus on the elderly or those at "high-risk" for medication-related problems, you could filter your report based on age (≥ 66), and/or number of chronic medications (≥ 6).
- Referrals from providers for patients who qualify and are due for an AWV and/or patients who

meet pre-determined "high risk" criteria (i.e., high number of chronic medications and/or chronic conditions).

- Run a report of all AWV codes charged in the past year to show potential gaps and opportunities and calculate potential revenue opportunities from data.
- Market to patients in the clinic by posting flyers in the waiting room or in exam rooms and/or send letters to eligible patients. Emphasize that it is a ***covered*** service provided every year by Medicare with no direct patient cost. Additional services provided on the same day are subject to traditional fees.
- Market to providers
    - Consider pilot with a couple of providers and then present follow up data about interventions, revenue generated, etc.
    - Present opportunities from data reports above, including potential revenue generation.

Design visit procedures and tools required:

- Due to the requirements of a Medicare AWV, these visits are typically a lengthier visit compared to other pharmacist-managed visits. CMS recommends 40 minutes for an initial AWV and 20 minutes for subsequent AWV. However, generally pharmacist-managed AWV range from 40-60 minutes for initial and subsequent visits. One may consider allotting more time, if available, when beginning the service, and adjusting visit times as providers become more comfortable with procedures.
- Create a note template to increase efficiency in documentation or consider reviewing/revising existing note templates that other providers use in clinic for Medicare AWVs, if available. If note templates are already available, we would recommend ensuring additional 'pharmacy-specific' sections are included to assist with data collection, such as medication safety concerns, recommendations made, list of referrals and/or lab orders completed.
- Create a patient education section and/or file of handouts based on health-related concerns identified in the HRA, such as fall risk, home safety issues, alcohol misuse, etc. Consider reaching out to the Information Technology (IT) department, as some Electronic Health Records (EHRs) are capable of creating an individualized patient education section based on the inputted HRA responses.
- Create an HRA tool. Examples and templates can be found on the CDC website.
- Determine which assessment tools you will use for depression and cognitive impairment screenings, SDOH risk assessment, and reviewing functional ability. Build these tools into your note template if possible.
- Identify which outcomes to track and build a framework to do so. The ability to demonstrate success within your specific clinic and institution is important to build support for AWVs as a pharmacy-driven service.

ASHP Certificate: Billing and Reimbursement for Patient Care Clinical Services

The Billing and Reimbursement for Patient Care Clinical Services Certificate is intended for pharmacists who are engaged in providing clinical services in a variety of practice settings, and others who are involved in billing for these services. Mary Ann Kliethermes, BS Pharm, PharmD, FAPhA, FCIOM; a recognized leader in reimbursement for pharmacist care services; serves as the editor for this one-of-a-kind, comprehensive resource. Through recorded presentations and readings, this Certificate's curriculum includes, but is not limited to, the following topics:

- Language of healthcare billing
- Reimbursement models including fee-for-service and value-based care models
- Medicare, Medicaid, and commercial insurance payers
- Rules related to eligibility of healthcare professionals to bill for services
- Collaborative practice agreements
- Medical vs. prescription benefits
- Payer mix
- "Incident to" as a billing mechanism
- Facility fee billing
- Care management services – chronic care, principal care, and transitional care
- Medicare Annual Wellness Visits
- Medicare Diabetes Prevention Program and Diabetes Self-Management Training
- Medication Therapy Management
- Continuous glucose monitoring and home INR monitoring
- Telehealth
- Reimbursement in federally qualified health centers (FQHCs) and rural health clinics (RHCs)
- Pharmacist prescribing and reimbursement opportunities at the state level
- Building the business case for pharmacist patient care clinical services
- Outside opportunities to fund patient care clinical services
- Preparing for successful implementation and growth of services
- Engaging with commercial insurance payers to be reimbursed for patient care clinical services
- Healthcare billing cycle
- Electronic billing
- Managing claims before and after adjudication
- Staying current with billing and reimbursement rules and opportunities

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