GUIDELINES
This policy does not certify benefits or authorization of benefits, which is designated by each individual policyholder contract. Paramount applies coding edits to all medical claims through coding logic software to evaluate the accuracy and adherence to accepted national standards. This guideline is solely for explaining correct procedure reporting and does not imply coverage and reimbursement.

DESCRIPTION
Initial Preventive Physical Examination (IPPE) (G0402) also known as the Welcome to Medicare Visit. The goals of the IPPE are health promotion and disease prevention and detection. This code can only be billed when the services are provided during the first twelve months the patient is enrolled in Medicare Part B. The IPPE is a single once-per-lifetime benefit.

First Annual Wellness Visit (AWV) (G0438) includes a personalized prevention plan service (PPPS). This code can only be used for a beneficiary who is no longer within the first twelve months after the effective date of Medicare Part B coverage; and if he/she has not already received either an IPPE or an AWV within the past twelve months. Medicare pays for only one initial AWV per beneficiary per lifetime.

Subsequent AWV’s (G0439) include a PPPS also. This code is to be used in the years subsequent to the submission of G0438 for the initial AWV, even if the patient switches to a new physician. Medicare pays annually after eleven full months have passed since the last AWV.

Voluntary Advance Care Planning (ACP) means the face-to-face service between a physician (or other qualified health care professional) and the patient discussing advance directives, with or without completing relevant legal forms. An advance directive is a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time.

IPPE (G0402) includes:
1. Review of medical and social history
2. Review of potential (risk factors) for depression
3. Review of functional ability and level of safety
4. Measurement of height, weight, body mass index, blood pressure, visual acuity screen, and other factors deemed appropriate
5. Discussion of end-of-life planning, upon agreement of the individual
6. Education, counseling and referrals based on results of review and evaluation services performed during the visit, including a brief written plan such as a checklist, and if appropriate, education, counseling and referral for obtaining an electrocardiogram (EKG, ECG)

IPPE-Related Screenings:
- The screening EKG (G0403, G0404, G0405), when done as a referral from an IPPE, is optional and only covered once during a beneficiary’s lifetime.
- CPT code 76706 is a one-time only ultrasound screening for an Abdominal Aortic Aneurysm (AAA) and can be done as the result of a referral from an IPPE for Medicare beneficiaries with certain risk factors.

First AWV (G0438) includes:
1. Medical/family history
2. List of current providers/suppliers
4. Detection of any cognitive impairment
5. Review potential (risk factors) for depression, functional ability, and level of safety.
6. Establishment of:
   • Written screening schedule (such as a checklist) for next 5-10 years.
   • List of risk factors and conditions where interventions recommended.
7. Personalized health advice and referrals for health education and preventive counseling
Subsequent AWV’s (G0439) include:
1. Update of medical/family history
2. Update of list of current providers/suppliers
3. Measurement of weight, blood pressure, and other routine measurements
4. Detection of any cognitive impairment
5. Update to:
   - Written screening schedule
   - List of risk factors and conditions where interventions recommended.
6. Personalized health advice and referrals for health education and preventive counseling

IPPE and AWV:
- Are preventive wellness visits and not routine physical examinations. Medicare does not provide coverage for routine physical exams.
- A Physician, Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist can provide an IPPE or AWV. 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 can provide only an AWV.
- Although a diagnosis code must be reported on the claim, there are no specific diagnosis codes that are required.
- The various components as described above must be provided and documented in a beneficiary’s medical record during the visit, along with an appropriate diagnosis code(s).

POLICY

“Welcome to Medicare” Preventative Physical Exam, Annual Wellness Visit, and Advance Care Planning do not require prior authorization for Elite. This policy only refers to Elite members.

Beginning January 1, 2014, Paramount will follow Medicare guidelines and will no longer cover preventive services identified in the CPT code range 99381-99397 for Paramount Elite members. Medicare discontinued coverage of the above mentioned codes January 1, 2011 and offered alternative G-codes.

If providing an Evaluation and Management (E/M) Service in addition to IPPE/AWV use CPT Modifier 25:
- Appended to claims denoting a separate E/M service furnished with an IPPE/AWV.
- Cost sharing (coinsurance, copayment and deductible) applies to the additional (E/M) service.
- CPT codes 99201–99215 may be reported depending on the clinical appropriateness of the circumstances.

NOTE: Some of the components of a medically necessary E/M service may have been part of the IPPE/AWV and should not be included when determining the most appropriate level of E/M service to be billed for the medically necessary, separately identifiable, E/M service.

Effective January 1, 2016, Paramount will follow Medicare guidelines and Advance Care Planning (ACP) (99497, 99498) services furnished on the same day and by the same provider as an AWV will be considered a preventive service. Therefore when voluntary ACP services are furnished as a part of an AWV, the coinsurance and deductible would not be applied for ACP. Under that circumstance, both the ACP and AWV must also be billed together on the same claim. In order to have the deductible and coinsurance waived for ACP when performed with an AWV, the ACP code(s) must be billed with modifier 33 (Preventive Services). Since payment for an AWV is limited to only once a year, the deductible and coinsurance for ACP billed with an AWV can only be waived once a year. The deductible and coinsurance does apply when ACP is not furnished as part of a covered AWV.

Elite
Deductible and Copayment/Coinsurance waived:
- IPPE (G0402)
- AWV (G0438, G0439)
- AAA ultrasound screening (76706)
- ACP (99497, 99498) services must be billed with modifier 33 (Preventive Services)

Deductible and Copayment/Coinsurance NOT waived:
- Screening EKG (G0403, G0404, G0405)
CODING/BILLING INFORMATION

The appearance of a code in this section does not necessarily indicate coverage. Codes that are covered may have selection criteria that must be met. Payment for supplies may be included in payment for other services rendered.

CPT CODES

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>76706</td>
<td>Ultrasound, abdominal aortic, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)</td>
</tr>
<tr>
<td>99201</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient; history, exam, straightforward decision-making; 10 minutes</td>
</tr>
<tr>
<td>99202</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient; expanded history, exam, straightforward decision-making; 20 minutes</td>
</tr>
<tr>
<td>99203</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient; detailed history, exam, straightforward decision-making; 30 minutes</td>
</tr>
<tr>
<td>99204</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient; comprehensive history, exam, moderate complexity decision-making; 45 minutes</td>
</tr>
<tr>
<td>99205</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient; comprehensive history, exam, high complexity decision-making; 60 minutes</td>
</tr>
<tr>
<td>99211</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient; evaluation and management, may not require presence of physician; 5 minutes</td>
</tr>
<tr>
<td>99212</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient; history, exam, straightforward decision-making; 10 minutes</td>
</tr>
<tr>
<td>99213</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient; expanded history, exam, straightforward decision-making; 15 minutes</td>
</tr>
<tr>
<td>99214</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient; office visit (25 minutes face to face)</td>
</tr>
<tr>
<td>99215</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient; office visit (25 minutes face to face)</td>
</tr>
<tr>
<td>99497</td>
<td>Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate</td>
</tr>
<tr>
<td>99498</td>
<td>Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)</td>
</tr>
</tbody>
</table>

HCPCS CODES

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0402</td>
<td>Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment</td>
</tr>
<tr>
<td>G0403</td>
<td>Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report</td>
</tr>
<tr>
<td>G0404</td>
<td>Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination</td>
</tr>
<tr>
<td>G0405</td>
<td>Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination</td>
</tr>
<tr>
<td>G0438</td>
<td>Annual wellness visit, including Personalized Prevention Plan Service, first visit</td>
</tr>
<tr>
<td>G0439</td>
<td>Annual wellness visit, including Personalized Prevention Plan Service, subsequent visit</td>
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</tbody>
</table>

MODIFIER

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>25</td>
<td>Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service. It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed.</td>
</tr>
<tr>
<td>33</td>
<td>Preventive Services. When the primary purpose of the service is the delivery of an evidence based service in accordance with the US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (Legislative or regulatory), the service may be identified by adding 33 to the procedure.</td>
</tr>
</tbody>
</table>

REVISION HISTORY EXPLANATION

02/01/06: No change
01/01/07: No change
01/01/08: No change
02/01/09: Deleted/added codes
02/01/10: Updated
12/10/13: CPT/HCPCS codes added 99201-99215, G0403, G0404, G0405, G0438, G0439, G0389 and Modifier 25 (as a result of the Affordable Care Act that made changes to Medicare-covered preventive services). Deleted CPT code G0344 as it was deleted in 2009 and does not need to be referenced anymore. Policy reviewed and updated to reflect most current clinical evidence. Approved by Medical Policy Steering Committee as revised.
02/09/16: Added codes 99497 & 99498 and modifier 33. Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee.
01/10/17: Added effective 01/01/17 new code 76706. Removed effective 01/01/17 deleted HCPCS code G0389. Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee.
07/25/18: Edits made per administrative review/direction.

REFERENCES/RESOURCES
Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services
Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
Industry Standard Review