CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 134	**Date: DECEMBER 3, 2010**
	Change Request 7079

This transmittal is being re-issued on December 14, 2010 to insert the Revision number, date issued, effective and implementation dates in the manual instruction, which were erroneously omitted during the original communication. The transmittal number, date issued and all other information remains the same.

SUBJECT: Annual Wellness Visit (AWV), Including Personalized Prevention Plan Services (PPPS)

I. SUMMARY OF CHANGES: Pursuant to section 4103 of the Affordable Care Act of 2010 (ACA), the Centers for Medicare and Medicaid Services (CMS) amended sections 411.15(a)(1) and 411.15 (k)(15) of 42 CFR (list of examples of routine physical examinations excluded from coverage) effective for services furnished on or after January 1, 2011. This expanded coverage is subject to certain eligibility and other limitations that allow payment for an annual wellness visit (AWV), including personalized prevention plan services (PPPS), for an individual who is no longer within 12 months after the effective date of his or her first Medicare Part B coverage period, and has not received either an initial preventive physical examination (IPPE) or an AWV providing PPPS within the past 12 months. Medicare coinsurance and Part B deductibles do not apply.

EFFECTIVE DATE: January 1, 2011
IMPLEMENTATION DATE: April 4, 2011

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15/Table of Contents
N	15/280.5/Annual Wellness Visit (AWV) Including Personalized Prevention Plan Services (PPPS)

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-02	Transmittal:134	Date: December 3, 2010	Change Request: 7079

This transmittal is being re-issued on December 14, 2010 to insert the Revision number, date issued, effective and implementation dates in the manual instruction, which were erroneously omitted during the original communication. The transmittal number, date issued and all other information remains the same.

SUBJECT: Annual Wellness Visit (AWV), Including Personalized Prevention Plan Services (PPPS)

Effective Date: January 1, 2011
Implementation Date: April 4, 2011

I. GENERAL INFORMATION

A. Background: Pursuant to section 4103 of the Affordable Care Act of 2010 (ACA), the Centers for Medicare & Medicaid Services (CMS) amended sections 411.15(a) (1) and 411.15 (k) (15) of 42 CFR (list of examples of routine physical examinations excluded from coverage) effective for services furnished on or after January 1, 2011. This expanded coverage is subject to certain eligibility and other limitations that allow payment for an annual wellness visit (AWV), including personalized prevention plan services (PPPS), for an individual who is no longer within 12 months of the effective date of his or her first Medicare Part B coverage period, and has not received either an initial preventive physical examination (IPPE) or an AWV within the past 12 months. Medicare coinsurance and Part B deductibles do not apply.

B. Policy: This AWV will include the establishment of, or update to, the individual's medical and family history, measurement of his or her height, weight, body-mass index or waist circumference, and blood pressure with the goal of health promotion and disease detection and fostering the coordination of the screening and preventive services that may already be covered and paid for under Medicare Part B. Coverage is available for an AWV that meets the following requirements:

1. It is performed by a health professional;

2. It is furnished to an eligible beneficiary who is no longer within 12 months after the effective date of his/her first Medicare Part B coverage period, and he/she has not received either an IPPE or an AWV providing a PPPS within the past 12 months.

See Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 280.5, for coverage benefit questions, and Pub. 100-04, Claims Processing Manual, chapter 12, sections 30.6.1.1 and 100.1.1, and chapter 18, section 140, for detailed claims processing information regarding the AWV, including definitions of: (1) detection of cognitive impairment, (2) eligible beneficiary, (3) establishment of, or an update to, an individual's medical/family history, (4&5) first and subsequent AWVs providing PPPS, (6) health professional, (7) review of an individual's functional ability/level of safety, and, (8) voluntary advance care planning.

NOTE: This change request (CR) does not impact claims for supplemental payments to Federally Qualified Health Centers (FQHCs) under contract with Medicare Advantage Plans.

NOTE: In addition, effective for services furnished on or after January 1, 2011, sections 4103 and 4104 of the ACA provide for a waiver of the Medicare coinsurance and Part B deductible requirements for the AWV. See CR 7012, Transmittal 739, dated July 30, 2010, for information related to the waiver that applies to preventive services, as well as the AWV.

NOTE: Two new HCPCS codes, G0438 - Annual wellness visit, includes personalized prevention plan of service (PPPS), first visit, (Short descriptor – Annual wellness first) and G0439 - Annual wellness visit, includes PPPS, subsequent visit, (Short descriptor – Annual wellness subseq) will be implemented January 1, 2011, through the Medicare Physician Fee Schedule Database (MPFSDB) and Integrated Outpatient Code Editor (IOCE).

II. BUSINESS REQUIREMENTS

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7079-02.1	Effective for dates of service on and after January 1, 2011, contractors shall pay claims containing HCPCS codes G0438 and G0439 when billed for an AWV as described in Pub. 100-02, chapter 15, section 280.5, and Pub. 100-04, chapter 12, section 30.6.1.1 and 100.1.1 and chapter 18, sections 140-140.7.	X		X	X		X	X			

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7079-02.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X	X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
	NA

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Coverage: Bill Larson, William.Larson@cms.hhs.gov, 410-786-4639; Pat Brocato-Simons, patricia.brocatosimons@cms.hhs.gov, 410-786-0261, Part A Claims Processing: Bill Ruiz, William.Ruiz@cms.hhs.gov, 410-786-9283, Part B Claims Processing: Thomas.Dorsey, Thomas.Dorsey@cms.hhs.gov, 410-786-2033

Post-Implementation Contact(s): Appropriate CMS Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Intermediaries (RHHIs):*
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs:*
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Benefit Policy Manual
Chapter 15 – Covered Medical and Other Health Services

Table of Contents
(Rev. 134, Issued: 12-03-10)

280.5 – Annual Wellness Visit (AWV) Including Personalized Prevention Plan Services (PPPS)

280.5 – Annual Wellness Visit (AWV) Including Personalized Prevention Plan Services (PPPS)

(Rev. 134, Issued: 12-03-10, Effective: 01-01-11, Implementation: 04-04-11)

A. General

Pursuant to section 4103 of the Affordable Care Act of 2010 (the ACA), the Centers for Medicare & Medicaid Services (CMS) amended section 411.15(a)(1) and 411.15(k)(15) of the Code of Federal Regulations (CFR)(list of examples of routine physical examinations excluded from coverage), effective for services furnished on or after January 1, 2011. This expanded coverage, as established at 42 CFR 410.15, is subject to certain eligibility and other limitations that allow payment for an annual wellness visit (AWV), including personalized prevention plan services (PPPS), when performed by qualified health professionals, for an individual who is no longer within 12 months after the effective date of his/her first Medicare Part B coverage period, and has not received either an initial preventive physical examination (IPPE) or an AWV within the past 12 months. Medicare coinsurance and Part B deductibles do not apply.

The AWV will include the establishment of, or update to, the individual's medical/family history, measurement of his/her height, weight, body-mass index (BMI) or waist circumference, and blood pressure (BP), with the goal of health promotion and disease detection and encouraging patients to obtain the screening and preventive services that may already be covered and paid for under Medicare Part B. Definitions relative to the AWV are included below.

Coverage is available for an AWV that meets the following requirements:

1. It is performed by a health professional; and,

2. It is furnished to an eligible beneficiary who is no longer within 12 months after the effective date of his/her first Medicare Part B coverage period, and he/she has not received either an IPPE or an AWV providing PPPS within the past 12 months.

Sections 4103 and 4104 of the ACA also provide for a waiver of the Medicare coinsurance and Part B deductible requirements for an AWV effective for services furnished on or after January 1, 2011.

B. Definitions Relative to the AWV:

Detection of any cognitive impairment: *The assessment of an individual's cognitive function by direct observation, with due consideration of information obtained by way of patient reports, concerns raised by family members, friends, caretakers, or others.*

Eligible beneficiary: *An individual who is no longer within 12 months after the effective date of his/her first Medicare Part B coverage period and who has not received either an IPPE or an AWV providing PPPS within the past 12 months.*

Establishment of, or an update to, the individual's medical/family history: *At a minimum, the collection and documentation of the following:*

a. *Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments.*

b. *Use or exposure to medications and supplements, including calcium and vitamins.*

c. *Medical events in the beneficiary's parents and any siblings and children, including diseases that may be hereditary or place the individual at increased risk.*

First AWV providing PPPS: *The provision of the following services to an eligible beneficiary by a health professional as those terms are defined in this section:*

a. *Establishment of an individual's medical/family history.*

b. *Establishment of a list of current providers and suppliers that are regularly involved in providing medical care to the individual.*

c. *Measurement of an individual's height, weight, BMI (or waist circumference, if appropriate), BP, and other routine measurements as deemed appropriate, based on the beneficiary's medical/family history.*

d. *Detection of any cognitive impairment that the individual may have as defined in this section.*

e. *Review of the individual'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 medical professional organizations.*

f. *Review of the individual's functional ability and level of safety based on direct observation, or the use of 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.*

g. *Establishment of the following:*

   (1) *A written screening schedule for the individual, such as a checklist for the next 5 to 10 years, as appropriate, based on recommendations of the United States Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunization Practices (ACIP), as well as the individual's health status, screening history, and age-appropriate preventive services covered by Medicare.*

(2) A list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are underway for the individual, including any mental health conditions or any such risk factors or conditions that have been identified through an IPPE, and a list of treatment options and their associated risks and benefits.

h. Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management, or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition.

i. Voluntary advance care planning (as defined in this section) upon agreement with the individual.

j. Any other element determined appropriate through the National Coverage Determination (NCD) process.

Health professional:

a. A physician who is a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Social Security Act (the Act); or,

b. A physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5) of the Act); or,

c. A medical professional (including a health educator, registered dietitian, or nutrition professional or other licensed practitioner) or a team of such medical professionals, working under the direct supervision (as defined in CFR 410.32(b)(3)(ii)) of a physician as defined in this section.

***Review of the individual's functional ability and level of safety**: At a minimum, includes assessment of the following topics:*

a. Hearing impairment,

b. Ability to successfully perform activities of daily living,

c. Fall risk, and,

d. Home safety.

***Subsequent AWV providing PPPS:** The provision of the following services to an eligible beneficiary by a health professional as those terms are defined in this section:*

a. An update of the individual's medical/family history.

b. An update of the list of current providers and suppliers that are regularly involved in providing medical care to the individual, as that list was developed for the first AWV providing PPPS.

c. Measurement of an individual's weight (or waist circumference), BP, and other routine measurements as deemed appropriate, based on the individual's medical/family history.

d. Detection of any cognitive impairment that the individual may have as defined in this section.

e. An update to the following:

(1) The written screening schedule for the individual as that schedule is defined in this section, that was developed at the first AWV providing PPPS, and,

(2) The list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are under way for the individual, as that list was developed at the first AWV providing PPPS.

f. Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs as that advice and related services are defined for the first AWV providing PPPS.

g. Voluntary advance care planning (as defined in this section) upon agreement with the individual.

h. Any other element determined appropriate by the Secretary through the NCD process.

Voluntary Advance Care Planning means verbal or written information regarding the following areas:

a. An individual's ability to prepare an advance directive in the case where an injury or illness causes the individual to be unable to make health care decisions.

b. Whether or not the physician is willing to follow the individual's wishes as expressed in an advance directive.

See Pub. 100-04, Medicare Claims Processing Manual, chapter 18, section 140, for detailed claims processing and billing instructions.