Medicare Coding Opportunities

Code	G0402	G0438	G0439
Description	**Welcome to Medicare Visit**	**Initial Annual Wellness Visit**	**Subsequent Annual Wellness Visit**
Telehealth?	**No**	**Yes**	
Elements	Initial Preventive Physicial Examination (this is not a comprehensive physical exam) Elements of the IPPE 1. Review of medical and social history 2. Review of potential risk factors for depression and other mood disorders. 3. Review of functional ability and level of safety. 4. Obtain height, weight and BP; visual acuity screen; BMI; and other factors deemed appropriate. 5. End-of-life planning. 6. Education, counseling, and referral based on 1-5. 7. Education, counseling, and referral for other preventive services	1. Establishment of medical and family history 2. Review of potential risk factors for depression, including current or past experiences with depression or other mood disorders. 3. Review of functional ability and level of safety 4. Obtain height, weight, BMI (or waist circumference, if appropriate), BP, and other routine measurements as deemed appropriate 5. Establishment of a list of current providers and suppliers 6. Detection of any cognitive impairment. 7. Establishment of a written screening schedule, such as a checklist for the next 5-10 years, as appropriate. 8. Establishment of a list of risk factors and conditions of which the primary, secondary, or tertiary interventions are recommended or underway. 9. Furnishing of personalized health advice to the beneficiary and a referral as appropriate to health education or prevention counseling services	**Elements of the Subsequent AWV** 1. Update of medical and family history 2. Obtain weight (or waist circumference, if appropriate), BP, and other routine measurements as deemed appropriate. 3. Update of the list of current providers and suppliers developed at the first AWV. 4. Detection of any cognitive impairment. 5. Update to the written screening schedule developed at the first AWV. 6. Update to the list of risk factors and conditions of which the primary, secondary or tertiary interventions are recommended or underway as was developed at the first AWV. 7. Furnishing of personalized health advice to the beneficiary and a referral as appropriate.
Frequency	1 per lifetime	Second year patient is eligible only one AWV per lifetime	One year after the patient's initial AWV. Once every 12 months. Use technology to remind patients to schedule.
Can I also bill an E&M?	Yes -- Add medically necessary E&M code with Modifier 25		
Medicare Reimbursement	**$163.05**	**$167.15**	**$113.11**

Medicare Coding Opportunities

Code	99497	99498	G0444
Description	**Advanced Care Planning**	**Advanced Care Planning** ***(Addl 30 Min)***	**Annual depression screening** ***(15 minutes)***
Telehealth?	**Yes**		**Yes**
Elements	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed-**does not require form completion**), by the physician or other qualified health care professional; first **30 minutes**, face-to-face with the patient, family member(s), and/or surrogate- (approved via telehealth during COVID19)	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) (approved via telehealth during COVID19)	Annual depression screening services are used to identify depression in patients. There should be staff in place to ensure accurate diagnosis, effective treatment, follow-up, and coordinate referrals. There are various tools that can be used to determine the screening. Depression screening services do not include treatment options for depression or any diseases, complications, or chronic conditions that the patient may have due to the depression. It also doesn't include any therapeutic interventions, such as medication therapy, or a combination of drug and counseling to treat the depression.
Frequency	No limits but document why billed multiple times (change in health status or end of life care)		Can only bill once per 365 days (not calendar year/exact year)
Can I also bill an E&M?	Yes -- Add medically necessary E&M code, add modifier 33 with AWV (Coinsurance will not apply when on same day with AWV)		Yes -- Use Modifier 25 on E/M Code
Medicare Reimbursement	**$84.40**	**$73.96**	**$17.68**

CMS Advanced Care Planning Resource

Medicare Coding Opportunities

Code	G0447	97802	97803	97804
Description	**Face-to-face behavioral counseling for obesity** ***(15 minutes)***	**Medical nutrition therapy: Initial assessment and intervention, individual, face-to-face with the patient** ***(Each 15 minutes)***	**Medical nutrition therapy: Re-assessment and intervention, individual, face-to-face with the patient** ***(Each 15 minutes)***	**Medical nutrition therapy; group (2 or more individual(s))** ***(Each 30 minutes)***
Telehealth?	**Yes**	**Yes**	**Yes**	**Yes**
Elements	Behavioral counseling for obesity is reported with this code. The United States Preventive Services Task Force (USPSTF) considers BMI a good indication of morbidity and mortality as a result of being overweight or obesity. Behavioral counseling and behavior modification can be an effective combination to produce moderate, sustainable weight loss. The patients should have the following services: screening for obesity using BMI, assessment of food and nutritional intake, and counseling to include diet and exercise. Behavioral counseling interventions should include the following Five A's approach that has been developed by the USPSTF: Assess: Ask about/assess behavioral health risk(s) and factors affecting choice of behavior and change goals/methods; Advise: Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits; Agree: collaboratively select appropriate treatment goals and methods based on the patient's interest in and willingness to change the behavior; Assist: Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate; Arrange: Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.	A dietetic professional provides medical nutrition therapy assessment or re-assessment and intervention in a face-to-face or group patient setting. After nutritional screening identifies patients at risk, preventive or therapeutic dietary therapy is initiated to induce a positive result in the role nutrition plays in improving health outcomes. Report 97802 for the initial assessment and intervention face-to-face with an individual patient for each 15 minutes of medical nutrition therapy.	A dietetic professional provides medical nutrition therapy assessment or re-assessment and intervention in a face-to-face or group patient setting. After nutritional screening identifies patients at risk, preventive or therapeutic dietary therapy is initiated to induce a positive result in the role nutrition plays in improving health outcomes.Report 97803 for re-assessment and intervention with an individual patient for each 15 minutes of medical nutrition therapy.	A dietetic professional provides medical nutrition therapy assessment or re-assessment and intervention in a face-to-face or group patient setting. After nutritional screening identifies patients at risk, preventive or therapeutic dietary therapy is initiated to induce a positive result in the role nutrition plays in improving health outcomes. Report 97804 for group medical nutrition therapy provided for two or more individuals, each 30 minutes.
Frequency	1 visit/week = Month 1 ; 1 visit/biweekly = Months 2-6 ; 1 visit/month = Months 7-12 (**APPROVED DX: Z68.30-Z68.39 / Z68.41-Z68.45)**	1 TIME PER YEAR (INITIAL VISIT ONLY)	**3 HOURS First Calendar Year** (January - December) / **2 HOURS Subsequent Calendar Years** (Hours cannot be carried over to next year) / To Request additional hours a referral is needed	
Can I also bill an E&M?	**NO**	**NO**	**NO**	**NO**
Medicare Reimbursement	**$25.87**	**$37.06**	**$32.12**	**$16.79**

CMS Medical Nutrition Therapy Services for Beneficiaries With Diabetes or Renal Disease

Medicare Coding Opportunities

Code	99495	99496
Description	**Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of at least moderate complexity during the service period Face-to-face visit *(within 14 calendar days of discharge)***	**Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of high complexity during the service period Face-to-face visit *(within 7 calendar days of discharge)***
Telehealth?	**Yes**	**Yes**
Elements	Transitional care management services are reported for patients requiring moderate to high complex medical decision making who are transitioning from an inpatient facility to a home or community type setting, such as a domiciliary or assisted living facility. The start date is the day of discharge from the inpatient setting and lasts through the following 29 days. These services include one face-to-face encounter in addition to other services performed within the specific timeframe by licensed clinical staff. These services are provided under direct qualified clinician supervision and may include communication with family and care givers, evaluation of treatment and medication, education on resources with assistance to available care, and review of discharge information, follow-up appointments, and interaction with other qualified health care professionals. To report these services, the initial direct contact (includes telephone/electronic) **must occur within two days of discharge with review of medication regimen by the date of the initial face-to-face encounter.** The date of the direct contact and medical decision making drives the code selection. **Report 99495 when MDM is at least moderate complexity in addition to the face-to-face encounter within 14 days of hospital discharge.**	Transitional care management services are reported for patients requiring moderate to high complex medical decision making who are transitioning from an inpatient facility to a home or community type setting, such as a domiciliary or assisted living facility. The start date is the day of discharge from the inpatient setting and lasts through the following 29 days. These services include one face-to-face encounter in addition to other services performed within the specific timeframe by licensed clinical staff. These services are provided under direct qualified clinician supervision and **may include communication with family and care givers, evaluation of treatment and medication**, education on resources with assistance to available care, and review of discharge information, follow-up appointments, and interaction with other qualified health care professionals. To report these services, the initial direct contact (includes telephone/electronic) must occur within two days of discharge with review of medication regimen by the date of the initial face-to-face encounter. **The date of the direct contact and medical decision making drives the code selection. Report 99496 when MDM is high complexity in addition to the face-to-face encounter within seven days of hospital discharge.**
Frequency	Once per Discharge / **If patient is re-admitted the TCM code becomes an E/M code and the 30 days will start again once discharged**	Once per Discharge / **If patient is re-admitted the TCM code becomes an E/M code and the 30 days will start again once discharged**
Can I also bill an E&M?	**NO**	**NO**
Medicare Reimbursement	**$181.03**	**$238.96**

AAFP FAQs about Transitional Care Management