CME

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## E/M services during a Medicare AWV

**Q Reviewing a patient's medications is required during a Medicare annual wellness visit (AWV) but assessing chronic conditions such as hypertension and hyperlipidemia is not, even though these tasks are inter-related. Is the latter separately billable when performed in the context of an AWV?**

A You may report a significant, separately identifiable, problem-oriented E/M service in addition to a Medicare AWV. You should append modifier 25 to the problem-oriented E/M code to facilitate payment.

Payment depends on whether the components of the problem-oriented service were significant and separately identifiable in the documentation. Medical necessity should also be supported. You should also take into account the elements of history and examination included in the AWV and make sure this work is not used to support the level of code you select for the problem-oriented service. These AWV elements include the following:

- An update of the individual's medical/family history and the list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or underway for the individual,
- Weight (or waist circumference), blood pressure, and other routine measurements as deemed appropriate, based on the medical and family history.

Medication review is part of the AWV, but *renewing* a prescription affects the risk portion of the medical decision-making component of the E/M service. Maintaining the same prescription is generally considered to share the same level of risk as changing or discontinuing a prescription. Documentation should make it clear that medications and dosages were evaluated. Note that prescription drug management is associated with moderate risk, but so is the presence of two or more stable chronic illnesses or a mild exacerbation or side effects of a chronic illness.

**About the Author**

Cindy Hughes is an independent consulting editor. Author disclosure: no relevant financial affiliations disclosed. These answers were reviewed by members of the *FPM* Coding & Documentation Review Panel, including Kenneth D. Beckman, MD, MBA, CPE, CPC; Robert H. Bösl, MD, FAAFP; Marie Felger, CPC, CCS-P; Thomas A. Felger, MD, DABFP, CMCM; Emily Hill, PA-C; Joy Newby, LPN, CPC; and Susan Welsh, CPC, MHA.

## When patients provide B12 for injections

**Q How should I bill for a B12 injection when the patient provides the medication?**

A Code 96372 is appropriate for reporting subcutaneous or intramuscular injection. Because the practice bears no expense for it in this case, the drug should not be reported. However, a payer may require that the claim list the substance so the payer can determine if administration is covered. You can reference the substance in the notes field or report the drug code with a zero dollar charge.

## Cardiovascular risk-reduction counseling

**Q Medicare allows us to bill once a year for cardiovascular disease risk-reduction counseling. What is a diagnosis code to support that service?**

A Intensive behavioral therapy for cardiovascular disease is billed to Medicare with HCPCS code G0446. Unless specified by your Medicare Administrative Contractor (MAC), no specific diagnosis code is required. You might consider diagnosis code V65.49 for counseling followed by any applicable codes for known cardiovascular risk factors.

If you are receiving denials, consider the following:

- The service must be provided and reported by a primary care physician or other qualified health care professional in a primary care setting,
- The place of service code must be 11 (office), 22 (outpatient), 49 (independent clinic), or 72 (rural health clinic),
- The National Correct Coding Initiative (NCCI) edits require using modifier 25 to designate that this service was separately identifiable from other E/M services provided on the same date, so the modifier must be applied to the code found in column two of the NCCI edits file,
- A new visit is covered after 11 full months have passed.

If you cannot identify the reason for denial, contact your MAC for an explanation. FPM

*Editor's note:* Some payers may not agree with the advice given. Refer to current coding manuals and payer policies.

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