2014 Coding Procedures Update for Medicare Advantage

The following Medicare Advantage plans have updated coding procedures for 2014:
- AARP® MedicareComplete®
- UnitedHealthcare® MedicareComplete®
- UnitedHealthcare® Dual Complete™
- UnitedHealthcare MedicareDirect™

Medicare Part B covers the following types of wellness exams:
- Welcome to Medicare Visit (Initial Preventive Physical Exam (IPPE))
- Annual Wellness Visit (Personalized Prevention Plan Services (PPPS))

Medicare members are entitled to receive a Welcome to Medicare Visit within the first 12 months of Medicare Part B coverage for a $0 copayment. Medicare members are also entitled to receive an Annual Wellness Visit every calendar year thereafter for a $0 copayment. Please see the Details section (Page 4) for specific services to be provided during each type of visit.

All Medicare Advantage plans insured by UnitedHealthcare (HMO, PPO, POS, PFFS and SNP) also cover the Welcome to Medicare and Annual Wellness Visits for a $0 copayment in-network (or out-of-network for PFFS members).

Wellness Visit Submission Codes
Providers may submit the following code for the one-time Welcome to Medicare Visit:
- G0402

Providers may submit one of the following codes for the Annual Wellness Visit:
- G0438 (first visit)
- G0439 (subsequent visit)

In 2014 our plans also cover an Annual Routine Physical Examination performed by the member’s Primary Care Physician (PCP), in addition to the Medicare-covered services billed using the following codes:
- 99385-99387
- 99395-99397

Notes on Annual Routine Physical Examination coverage:
- If you bill these 99XXX codes, you must provide a head-to-toe exam and cannot bill for a separate breast and pelvic exam, a Digital Rectal Exam (DRE), or counseling to promote healthy behavior. See the Definitions section for details on the specific components included in the visit.

All Medicare Advantage plans insured by UnitedHealthcare offered to individuals cover this benefit in 2014, except H0543-153 AARP Medicare Complete SecureHorizons Plan 3 offered in Los Angeles, Orange, Riverside and San Bernardino counties in California. Coverage on employer group Medicare Advantage plans may vary.

Additionally, all plans offer a Pap/Pelvic Exam (including pelvic exam and the pap collection with coverage periodicity following Medicare guidelines: covered annually for those at high risk and every 2 years for all other women) for a $0 copay. A separate Evaluation and Management (E/M) code may be billed only if a separately identifiable E/M service was provided. The following code is accepted:
- Exam: G0101
When members see an obstetrician or gynecologist who is not their assigned PCP for a routine pap/pelvic exam, only the Medicare-covered annual pap/pelvic service should be performed and billed. Members should be referred to their assigned PCP if a more comprehensive preventive service is warranted.

**Note:** All codes are subject to change. Please review coding prior to claims submission through the Centers for Medicare & Medicaid Services (CMS) website at [cms.gov](http://cms.gov).

### Helpful Tip

Subscribe to MLN Matters to stay informed of current CMS Program information and changes. See footnote on Page 3 if you are unfamiliar with the most frequently impacted CMS Policy resources, i.e., CMS NPFS, IOM, NCD/LCD lookup, National Correct Coding Initiative (NCCI) Policy.

### Additional Services Provided with the Wellness Visit

Only the codes listed on the first page are included in the $0 copayment for wellness visits. If you also bill other services with the visit, and those services are normally subject to a copayment or coinsurance, that copayment or coinsurance will still apply even if the primary reason was for a wellness exam.

Medicare covers a one-time only **Abdominal Aortic Aneurysm (AAA) Screening** for at-risk members when a referral for the screening is received as a result of the wellness exam. In 2014, this service is subject to member cost-sharing in most plans.

Medicare covers a one-time only **Electrocardiogram (EKG) Screening** for Medicare members. In 2014, this service is subject to member cost-sharing in most plans.

Any **clinical laboratory tests or other diagnostic services** that CMS recognizes and defines as medically necessary (as opposed to preventive) performed at the time of the wellness visit may be subject to a copayment or coinsurance. Refer to the CMS Policy that defines these guidelines, e.g., refer to the Medicare Physician Fee Schedule to determine if a service is covered by Medicare. A Status Indicator of ‘N’ reflects non-coverage. Therefore, the member is required to sign the Advanced Notice of Non Coverage (ANN) form prior to the service being provided by a contracting lab. Other reference sources in addition to Medicare Physician Fee Schedule include: National Coverage Determinations, Local Coverage Determinations, and NCCI Policy.

In general, screening lab work is not covered by Medicare (with a few exceptions as outlined in the list of covered preventive services below) and therefore not covered by our plan.

### Common Preventive Services and Screenings

Physicians and other health care professionals may also provide and bill separately for screenings and other preventive services. All Medicare Advantage plans insured by UnitedHealthcare cover the following Medicare-covered preventive services at the same frequency as covered by original Medicare, except where otherwise noted, for a $0 copayment:

- Alcohol misuse screening and counseling
- Bone mass measurement
- Breast cancer screening (mammograms)
- Cardiovascular screening
- Hepatitis B immunization
- HIV screening
- Intensive behavioral therapy to reduce cardiovascular disease risk
**Common Preventive Services and Screenings continued**

- Cervical and vaginal cancer screening (Pap test and pelvic exam)\(^2\)
- Colorectal cancer screening\(^3\)
- Depression screening
- Diabetes screening
- Flu shot
- Glaucoma tests (for those at high risk)
- Medical nutrition therapy services
- Obesity screening and counseling\(^1\)
- Pneumococcal shot
- Prostate-specific antigen (PSA) test\(^4\)
- Tobacco use cessation counseling
- Sexually transmitted infections screening and counseling

1. In accordance with Medicare guidelines, covered only in the primary care setting.
2. In 2014, coverage periodicity follows Medicare guidelines: covered annually for those at high risk and every two years for all other women.
3. For all Medicare Advantage plans insured by UnitedHealthcare, a colonoscopy that begins as a Medicare-covered screening service is subject to the $0 screening cost-share regardless of whether a polyp is found and/or removed during the procedure.
4. A DRE is subject to cost-sharing.

**Please follow original Medicare-covered indications and coding rules when billing Medicare-covered preventive services. Refer to CMS Policies for guidance (NCCI Policy, IOM Claims Processing Manual, etc.) see CMS Resources on Page 5.**

**Coding Tip**
When a provider performs a separately identifiable medically necessary E/M service in addition to the IPPE, CPT codes 99201-99215 reported with modifier -25 may also be billed. When medically indicated, this additional E/M service would be subject to the applicable copayment for office visits. See CMS NCCI policy on Page 5 under CMS Resources.

**Colonoscopy Screenings and Related Subsequent Diagnostic Procedures**
Currently, in all UnitedHealthcare Medicare Advantage plans, a colonoscopy that begins as an in-network screening service is subject to the $0 screening cost-share regardless of whether a polyp is found and/or removed during the procedure.

**Coding:**
- Endoscopy codes G0104, G0121 or G0105 are used for screening colonoscopies. These continue to assess a $0 in-network cost-share per the Medicare preventive services coverage guidelines.
- CPT Code 45330 (and family codes) and CPT Code 45378 (and family codes) billed with modifier PT are used if a screening turns into a diagnostic procedure. These codes, when billed with the PT modifier, will assess the $0 in-network cost-share. If the colonoscopy service is billed without the PT modifier, the claim will be processed as a surgery and the applicable cost-share will apply.
- Providers may not bill both the screening and the diagnostic services when a screening colonoscopy turns into a diagnostic procedure. Only the diagnostic code with the PT modifier may be billed in these circumstances.
- If the screening service and subsequent diagnostic procedure is performed at an out-of-network facility, applicable cost-shares will be assessed.
Details
The Welcome to Medicare Visit is a one-time preventive evaluation and management service that includes the following services:

1. Review of the member’s medical and social history.
2. Review of the member’s potential risk factors for depression.
3. Review of the member’s functional ability and level of safety, including hearing impairment, daily living activities, fall risk and home safety.
4. An exam to include height, weight, body mass index, blood pressure, visual acuity and other measurements.
5. End-of-life planning assistance such as an advance directive or health care proxy, with the member’s consent.
6. Education, counseling and referral based on the results of numbers 1-5 in this list.
7. Education, counseling and referral, including a brief written plan for obtaining a screening EKG, as appropriate, and other appropriate screenings and/or Medicare Part B preventive services.

The Annual Wellness Visit allows the physician and member to develop a personalized prevention plan that considers age-appropriate preventive services plus additional services based on the patient’s health status. The visit may include at least the following services:

1. Establish or update the member’s medical and family history.
2. Review the member’s potential risk factors for depression.
3. Review the member’s functional ability and level of safety, including hearing impairment, daily living activities, fall risk and home safety.
4. An exam to include height, weight, body mass index, blood pressure and other routine measurements.
5. List or update the list of the member’s medical providers and suppliers.
6. Detect any cognitive impairment the member may have.
7. Establish or update a screening schedule for the next five to 10 years, as appropriate.
8. Establish or update the member’s list of risk factors.
9. Personalized health advice and appropriate referrals to health education or preventive services.

The Pap/Pelvic Exam (also known as the Well Woman Exam) should include at least seven of the following elements:

1. Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge
2. Digital rectal examination including sphincter tone and presence of hemorrhoids or rectal masses
3. Examination of external genitalia (for example, general appearance, hair distribution, or lesions)
4. Examination of urethral meatus (for example, size, location, lesions, or prolapse)
5. Examination of urethra (for example, masses, tenderness, or scarring)
6. Examination of bladder (for example, fullness, masses, or tenderness)
7. Examination of vagina (for example, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, or rectocele)
8. Examination of cervix (for example, general appearance, lesions, or discharge)
9. Specimen collection for pap smears and cultures.
The purpose of the *Annual Routine Physical Exam* is to provide a comprehensive physical examination in order to screen for disease, promote a healthy lifestyle, and assess a member’s potential risk factors for future medical problems. Any clinical laboratory tests or other diagnostic services performed at the time of the wellness visit may be subject to a copayment or coinsurance.

This exam includes performance of all of the following components as well as the gender-specific examination:

1. History
2. Vital signs
3. General appearance
4. Heart exam
5. Lung exam
6. Head and neck exam
7. Abdominal exam
8. Neurological exam
9. Dermatological exam
10. Extremities exam
11. Male physical exam
   - Testicular, hernia, penis, and prostate exams
12. Female physical exam
   - Breast and pelvic exams
13. Counseling to include healthy behaviors and screening services

Separate codes for these components may not be billed in conjunction with 99385-99387 or 99395-99399. Payment for these codes includes reimbursement for all services listed above.

**CMS Resources**

Medicare Physician Fee Schedule - [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html)


If you have any questions, please contact Customer Service at the number listed on the back of the member’s ID card. Thank you.