

## Comparative Billing Report



Comparative Billing Report Program  
7127 Ambassador Rd., Suite 150  
Baltimore, MD 21244

August 14, 2017

CBR#: CBR201707  
Topic: IPPE/AWV  
NPI#:1111111111  
Fax#: (888)555-5555

ORGANIZATION NAME  
FULL NAME  
123 STREET LANE  
SUITE 4000  
ANYTOWN, XX 55555-4444

**Questions:** Contact CBR Support  
[www.cbrinfo.net](http://www.cbrinfo.net)  
(800) 771-4430 / M-F 9 am – 5 pm ET  
[cbrsupport@eglobaltech.com](mailto:cbrsupport@eglobaltech.com)  
Write to the return address above

Dear Medicare Provider:

The Centers for Medicare & Medicaid Services (CMS) strives to protect the Medicare Trust Fund and effectively manage Medicare resources. To support these goals, CMS has contracted with eGlobalTech, a professional services firm, to develop Comparative Billing Reports (CBRs).

### ***What is a CBR?***

- A CBR is an educational tool that reflects your billing patterns compared to peer patterns for the same services in your state and nationwide.

### ***Why did I get a CBR?***

- You received this CBR because your billing patterns differ from your peers in your state or across the nation. Receiving this CBR is not an indication or precursor to an audit.

### ***What should I do with this CBR?***

- Read the report in its entirety. We hope the report assists you in identifying opportunities for improvement, or helps you validate your current billing patterns.
- Contact your Medicare Administrative Contractor for specific billing or coding questions, and to ensure you are meeting Medicare standards for your jurisdiction.

### ***Do I need to reply to explain my utilization?***

- No reply is necessary, as this report is for educational purposes.

REMINDER: If you have changed your mailing address or contact information, please take time to review and update the appropriate Medicare provider enrollment system.

Sincerely,

A handwritten signature in black ink, appearing to read "Frank Gorton".

Frank Gorton  
CBR-Program Director  
eGlobalTech

Enclosure

This page is left blank intentionally

This page is left blank intentionally

---

**Comparative Billing Report (CBR): NPI 1111111111**  
**Initial Preventive Physical Examination / Annual Wellness Visits**

## **Introduction**

CBR201707 focuses on providers who submitted claims for Initial Preventive Physical Examinations (IPPEs) and Annual Wellness Visits (AWVs) using Healthcare Common Procedure Coding System (HCPCS) codes G0402, G0438 and G0439. These are preventive services; therefore, the deductible and co-insurance are waived.

In 2010, the Patient Protection and Affordable Care Act (ACA) mandated that some preventive services be provided free of charge. Medicare developed HCPCS codes for IPPEs and AWVs and these codes were put into place January 1, 2011 in order to be in compliance with the ACA. During their IPPEs and AWVs, many beneficiaries mentioned ailments that were not covered and as a result, incurred charges for additional evaluation and management (E/M) services.

Table 1 lists each of the HCPCS codes and an abbreviated description for each of the codes covered in this CBR.

**Table 1: HCPCS Codes with Abbreviated Descriptions**

<b>HCPCS Code</b>	<b>Abbreviated Description</b>
G0402	Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment
G0438	Annual wellness visit; includes a personalized prevention plan of service (ppps), initial visit
G0439	Annual wellness visit; includes a personal plan of service (ppps), subsequent visit

Level II HCPCS codes are maintained and distributed by the Centers for Medicare & Medicaid Services (CMS)

The metrics included in this report are:

- The percentage of services submitted with E/M by HCPCS code
- The average allowed charges for all Medicare Part B services per beneficiary submitted with IPPE/AWV

---

## Coverage and Documentation Overview

This portion of the CBR offers a broad look at the coverage and documentation requirements to ensure compliance with Medicare guidelines. **The information provided does not supersede or alter the coverage and documentation policies, as outlined by the Medicare Administrative Contractors' (MACs) Local Coverage Determinations (LCDs) and Local Coverage Articles (LCAs).** Please refer any specific questions you may have to the MAC for your region.

According to Chapter 18 of the *Medicare Claims Processing Manual*, the IPPE can be performed by a physician or a nonphysician practitioner (NPP) such as physician assistant, nurse practitioner or clinical nurse specialist. A beneficiary's examination must be provided no later than 12 months after the date Medicare Part B coverage began. The goals are health promotion, disease prevention, and detection. Per the *Medicare Claims Processing Manual*, "The IPPE includes:

- (1) Review of the individual's medical and social history with attention to modifiable risk factors for disease detection
- (2) Review of the individual's potential (risk factors) for depression or other mood disorders,
- (3) Review of the individual's functional ability and level of safety
- (4) An examination to include measurement of the individual's height, weight, body mass index, blood pressure, a visual acuity screen, and other factors as deemed appropriate, based on the beneficiary's medical and social history
- (5) End-of-life planning, upon agreement of the individual
- (6) Education, counseling, and referral, as deemed appropriate, based on the results of the review and evaluation services described in the previous 5 elements, and
- (7) Education, counseling, and referral including a brief written plan (e.g., a checklist or alternative) provided to the individual for obtaining appropriate screening and other preventive services, which are separately covered under Medicare Part B.

Medicare will pay for only one IPPE per beneficiary per lifetime...The IPPE does not include other preventive services that are currently separately covered and paid under Medicare Part B."

On January 1, 2011, Medicare added AWVs. This visit includes personalized prevention plan services (PPPS) for a beneficiary enrolled in Medicare Part B for over 12 months and has not had either an IPPE or AWV in the past 12 months. The AWV includes a Health Risk Assessment (HRA) that is completed by the beneficiary or provider. The initial AWV establishes beneficiary's:

---

- (1) Medical/family history
- (2) Measurement of height, weight, body mass index (BMI) or waist circumference and blood pressure
- (3) Assessment for cognitive impairment
- (4) Other measurements based on the history

A written screening schedule for the beneficiary should be established for the next 5 - 10 years. It should be based on covered Medicare preventive services, the beneficiary's HRA, health status and screening history. Recommendations from the United States Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunization Practices (ACIP) should be utilized.

A list of risk factors and conditions should also be established with recommended or ongoing interventions. This should include mental health conditions or medical problems that have been identified. The list should also include treatment options with risks and benefits. Personalized health advice should then be provided as well as referrals for health education and preventive counseling services. Referrals should include programs aimed at nutrition, physical activity, weight loss and tobacco-use cessation.

The subsequent AWV can be performed no earlier than 11 full months after the initial AWV. This begins with updating the HRA, list of providers, suppliers, and medical and family history. After updating the HRA, the components are the same as the initial AWV.

The IPPE and AWV are not routine physical checkups. Medicare does not cover routine physical examinations. Clinical laboratory tests are also not included; however, providers can make referrals for these tests.

An additional E/M service may also be billed if a significant, separately identifiable medically necessary problem is addressed. The Current Procedural Terminology (CPT<sup>®</sup>) code (99201 – 99215) should be reported along with modifier 25. The service must be medically necessary to treat the beneficiary's illness or injury, or to improve the functioning of a malformed body member. None of the information and work done to perform the IPPE or AWV may be counted towards the E/M service. Therefore, it would be unlikely that the higher level CPT<sup>®</sup> codes would be billed.

---

## Methods & Results

This report is an analysis of providers submitted as the “Rendering NPI” on Medicare Part B claims extracted from the Integrated Data Repository (IDR) based on the latest version of claims as of July 6, 2017. The analysis includes claims with dates of service from April 1, 2016 to March 31, 2017.

There are over 128,000 providers nationwide with allowed charges for the HCPCS codes included in this study. Those who received the CBR were significantly higher than one of their peer groups on at least one of the measurements studied and also were near or above the 85<sup>th</sup> percentile in allowed charges (\$15,000), with at least 80 beneficiaries during this one-year period.

Table 2 provides a summary of your utilization of the procedure codes included in this CBR. The total allowed charges, allowed services, and distinct beneficiary counts are included for each HCPCS code. In addition, an overall “Total” row is included. Your percentages and averages, denoted in Tables 3 and 4, are calculated from your utilization of the procedure codes summarized in Table 2, using the formulas that follow.

**Table 2: Summary of Your Utilization of IPPE/AWV**  
**Dates of Service: April 1, 2016 – March 31, 2017**

HCPCS Code	Allowed Charges	Allowed Services	Beneficiary Count
G0402	\$1,079	6	6
G0438	\$18,066	96	96
G0439	\$391	3	3
<b>Total</b>	<b>\$19,536</b>	<b>105</b>	<b>105</b>

Please note that the totals may not be equal to the sum of the rows due to rounding. Also, the beneficiary count is an unduplicated count for each row and the total. For example, a beneficiary receiving multiple HCPCS codes within this time period would be counted in the beneficiary count in each applicable row; however, this beneficiary would be counted only once in the total row.

---

Metrics were calculated from your utilization and for each of the following peer groups:

- The **state** peer group is defined as all rendering Medicare providers practicing in the individual provider's state with allowed charges for the procedure codes included in this study
- The **national** peer group is defined as all rendering Medicare providers in the nation with allowed charges for the procedure codes included in this study

Your metrics were compared to your state (AK) and the nation using statistical analysis. There are four possible outcomes for the comparisons between the provider and the peer groups:

- Significantly Higher - Provider's value is higher than the peer value and the statistical test confirms significance
- Higher - Provider's value is higher than the peer value, but the statistical test does not confirm significance
- Does Not Exceed - Provider's value is not higher than the peer value
- N/A - Provider does not have sufficient data for comparison

It is important to note that significance is based on the total number of charges, services, or beneficiaries and the variability of those values.

### **Percentage of Services Submitted with E/M, by HCPCS Code**

An E/M service may be billed with the IPPE/AWV code only if a significant, separately identifiable, medically necessary problem is addressed during the visit. The percentage of services submitted with an E/M is calculated as follows for each HCPCS code:

$$\left( \frac{\text{Number of Services Submitted with E/M}}{\text{Number of Services}} \right) \times 100$$

Table 3 provides a statistical analysis of the percentage of services submitted with an E/M, by HCPCS code. Your percentage is compared to that of your state and the nation.

**Table 3: Percentage of Services Submitted with E/M, by HCPCS Code**  
**Dates of Service: April 1, 2016 – March 31, 2017**

HCPCS Code	Number of Services with E/M	Total Number of Services	Your Percent	Your State's Percent	Comparison with Your State	National Percent	Comparison with National Percent
G0402	6	6	100%	30%	Higher	36%	Higher
G0438	93	96	97%	32%	Significantly Higher	41%	Significantly Higher
G0439	3	3	100%	36%	Higher	46%	Higher

A chi-square test was used in this analysis, alpha = 0.05.

**Average Allowed Charges of All Medicare Part B Services per Beneficiary Submitted with each HCPCS Code**

The goals of the IPPE/AWV are health promotion, disease prevention, and detection. While the HCPCS codes in the study cover various elements of the exam, the provider may perform additional screenings or preventative services that would be billed separately. The average allowed charges of all Medicare Part B services per beneficiary submitted by the same provider on the same date of service with each HCPCS code studied is calculated as follows:

$$\frac{\text{Total Charges Allowed For All Part B Services at IPPE/AWV}}{\text{Total Number of Beneficiaries}}$$

Table 4 provides a statistical analysis of the average allowed charges of all Medicare Part B services per beneficiary submitted with each HCPCS code. Your average is compared to that of your state and the nation.

**Table 4: Average Allowed Charges of All Medicare Part B Services per Beneficiary Submitted with each HCPCS Code**  
**Dates of Service: April 1, 2016 – March 31, 2017**

HCPCS Code	Total Allowed Charges	Total Number of Beneficiaries	Your Average	Your State's Average	Comparison with Your State	National Average	Comparison with National Average
G0402	\$1,952.82	6	\$325.47	\$326.92	Does Not Exceed	\$276.66	Higher
G0438	\$31,718.82	96	\$330.40	\$303.67	Significantly Higher	\$258.54	Significantly Higher
G0439	\$868.32	3	\$289.44	\$229.39	Higher	\$210.25	Higher

A t-test was used in this analysis, alpha = 0.05.

## References & Resources

The coverage and documentation guidelines for IPPE/AWV are listed below. Please follow the guidelines pertinent to your region. A complete list of web links is located at <http://www.cbrinfo.net/cbr201707-recommended-links>.

### Public Law 111 – 148:

- Affordable Care Act

### Medicare Manuals:

- *Claims Processing Manual*, Chapter 18

### Medicare Learning Network® (MLN):

- The ABCs of the Annual Wellness Visit (AWV)
- The ABCs of the Initial Preventive Physical Examination (IPPE)

### University of Connecticut

- For background on the statistical tests used in this CBR, the University of Connecticut provides resources for the t-test and the chi-square test at: <http://researchbasics.education.uconn.edu/>

---

## The Next Steps

We encourage you to check with your MAC to ensure that you are meeting the Medicare standards for your jurisdiction. Please use the above references and resources as a guide.

You are invited to join us for the CBR201707 webinar on September 13, 2017 from 3:00-4:00 PM ET. Space is limited, so please register early. Register online at <http://www.cbrinfo.net/cbr201707-webinar>.

If you are unable to attend, you may access a recording of the CBR201707 webinar five business days following the event at <http://www.cbrinfo.net/cbr201707-webinar>.

If you have any questions or suggestions related to this CBR, please contact the CBR Support Help Desk via email at [CBRsupport@eglobaltech.com](mailto:CBRsupport@eglobaltech.com) or via telephone at (800) 771-4430.

For written correspondence, postal mail can be sent to the following address:

CBR Program  
eGlobalTech  
7127 Ambassador Road, Suite 150  
Baltimore, MD 21244