

# Primary prevention recommendations to reduce the risk of cognitive decline



## Neurovascular Risk Management

### RECOMMENDATION

For adults (ages 45+) with established hypertension or Type II diabetes, clinicians should manage their conditions according to guidelines with appropriate medications to help reduce the risk of cognitive decline, and clinicians should encourage optimal brain health in the same way they encourage cardiovascular health through other modifiable risk factors (or lifestyle interventions) such as physical activity, diet, and sleep to reduce the risk of cognitive decline.

### CONSIDERATIONS FOR IMPLEMENTATION

- Follow USPSTF recommendations to screen for high blood pressure in adults aged 18 years or older (Grade: A) (USPSTF, 2015); for statin use for primary prevention of cardiovascular disease (Grade: B) (USPSTF, 2016); and for screening for abnormal blood glucose and Type II diabetes (Grade: B) (USPSTF, 2015)
- Follow ACC/AHA hypertension guidelines for a target systolic blood pressure < 130 (Flack & Adekola, 2020; ACC/AHA, 2018)
- If just beginning to have these conversations with your patients, consider handouts like this to help them remember that brain health equals heart health:  
→ [English](#) | [Spanish](#) | [French](#) | [Arabic](#) | [Chinese](#)
- [AHA's "Life's Simple 7"](#) tools highlight key areas for optimal brain health related cardiovascular care (AHA/ASA, 2017). Sharing patient facing tools might help them achieve desired goals
- Be extra vigilant to look for neurovascular risk factors in women and persons from race and ethnicity groups who are at greater risk for developing ADRD  
→ [Targetbp.org](#) includes tools and resources designed to help improve blood pressure control in clinical care settings with a focus on accurate blood pressure measurement to achieve blood pressure control.

### POSSIBLE BILLING CODES

- When provided as part of comprehensive preventive care visit for which the purpose/focus of the visit is not the established condition, use [comprehensive preventive medicine service codes](#) 99386, 99387, 99396, 99397 (non-Medicare)
- When provided as part of a Medicare initial preventive physical exam or annual wellness visit, use [Medicare wellness visit codes](#) G0402, G0438, G0439 (Medicare only)
- For encounters separate from preventive/wellness visits (when the purpose of the visit is not tied to the established medical condition/patient is asymptomatic) use [counseling, risk factor reduction, and behavior change intervention codes](#) 99401-99404, 99411, 99412
- If the focus or purpose of the visit is tied to the patient's diagnosed condition, use [problem-oriented evaluation & management \(E/M\) codes](#) 99202-99215
- Depending on payer and specific services provided, providers may also be able to use the following codes:
  - G0446 for [behavioral counseling for cardiovascular disease](#) (Medicare only)
  - 82947, 82950, 82951 ([diabetes screening codes](#))

# Physical Activity



## RECOMMENDATION 1

Clinicians should conduct a physical activity assessment, at least annually, using a practical and validated tool(s) to identify adults (age 45+) who are sedentary or not meeting recommended levels of physical activity (ACC/AHA, 2019)(150 minutes [2 ½ hours] per week of moderate intensity) (HHS, 2018) and who can decrease their risk of cognitive decline or worsening health.

## RECOMMENDATION 2

For individuals not meeting recommended levels of physical activity, develop a plan using a safe, gradual approach that starts with moderate-intensity physical activity<sup>1</sup> that fits within a person's lifestyle (e.g., walking, gardening, dancing, calisthenics) and is culturally acceptable.

## RECOMMENDATION 1

### CONSIDERATIONS FOR IMPLEMENTATION

- Examples of validated physical assessment tools to evaluate an individual's level of physical activity (AHA, 2018):
  - Rapid Assessment of Physical Activity
  - Physical Activity Vital Sign (PAVS)
  - Exercise Vital Sign (EVS)
  - Speedy Nutrition and Physical Activity Assessment (SNAP)
  - General Practice Physical Activity Questionnaire (GPPAQ)
  - Stanford Brief Activity Survey (SBAS)
  - Additional tools can be found at:  
<https://www.ahajournals.org/doi/epub/10.1161/CIR.0000000000000559>

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- Depending on payer, [non-physician health and wellbeing coaches](#) may be able to use 0591T, 0592T, 0593T (health and wellbeing coaching)
- For more information on billing codes applicable to physical activity related patient assessments, management, and follow up care, see "[Physical Activity Related Current Procedural Terminology \(CPT®\) Codes](#)"

<sup>1</sup> Moderate-intensity physical activity is defined as activity that requires 3.0 to less than 6.0 metabolic equivalents (METs); such as walking briskly or with purpose (3 to 4 mph), mopping, vacuuming, or raking a yard. Levels of "moderate" or "vigorous" activity are different for every individual depending on their fitness level, which is why elevated heart rate is a good indicator of optimal activity.

# Physical Activity



## RECOMMENDATION 2

### CONSIDERATIONS FOR IMPLEMENTATION

- If a completed assessment identifies someone who is not meeting recommended levels of physical activity, help individuals choose smaller goals to start
  - The ultimate goal should be to reach 150 minutes of aerobic, moderate-intensity physical activity per week (or 30 minutes on most days of the week) (HHS, 2018).
  - When patients cannot do the recommended amounts of physical activity due to disability or chronic health conditions, they should be as physically active as their abilities and conditions allow.
- Goals should be updated or revised based on an individual's progress (or lack of progress)
- The benefits of physical activity communicated to patients should include its effects on memory/brain health
- Suggesting physical activities that can be done with family, friends, or peers is often more successful
- Refer to any local/community resources that offer free, low-cost physical activity programs when possible
- When available, connect individuals with a resource to be a support in between or during visits
- [Resources to share with older adults](#)
- If an individual is comfortable using digital devices, consider recommending a digital device (e.g., Apple watch, Fitbit) or free app to motivate or help them monitor their activity
- For individuals meeting physical activity recommendations, continued encouragement and recognition or praise should be given for maintenance.

### POSSIBLE BILLING CODES

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- Depending on payer, [non-physician health and wellbeing coaches](#) may be able to use 0591T, 0592T, 0593T
- If patient is enrolled in a Medicare Advantage plan, check with plan regarding possible supplemental benefits tied to physical activity (e.g., silver sneakers membership)
- For more information on billing codes applicable to physical activity related patient assessments, management, and follow up care, see "[Physical Activity Related Current Procedural Terminology \(CPT®\) Codes](#)"



# Sleep

## RECOMMENDATION 1

Clinicians should routinely (if possible, at each visit) assess sleep quantity and quality in patients 45 years old and older using a validated tool and whether they take any medications to sleep.

## RECOMMENDATION 2

For individuals getting insufficient or poor-quality sleep, clinicians should encourage getting 7-8 hours of sleep in a 24-hour period, including naps. Those with severe sleep complaints which may indicate sleep apnea (e.g., snoring with stops of breathing or excessive daytime sleepiness), should be referred to a sleep clinic for diagnosis and treatment.

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## RECOMMENDATION 1

### CONSIDERATIONS FOR IMPLEMENTATION

- Example of a validated tool to assess sleep quality:
  - [Pittsburgh Sleep Questionnaire](#)
- An individual may have a sleep disorder if they experience one or more of the following (AARP, 2017):
  - trouble falling or staying asleep three times a week for at least three months
  - frequent snoring
  - persistent daytime sleepiness
  - leg discomfort before sleep
  - acting out your dreams during sleep
  - grinding your teeth or waking with a headache or aching jaws

### POSSIBLE BILLING CODES

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- If the focus or purpose of the visit is tied to the patient's diagnosed condition, use [problem-oriented evaluation & management \(E/M\) codes](#) 99202-99215



# Sleep

## RECOMMENDATION 2

### CONSIDERATIONS FOR IMPLEMENTATION

- [Share tips and information on napping for those who need additional sleep](#)
- Share tips for optimal sleep environments, such as:
  - Make the room as dark and quiet as possible
  - Avoid using your bed for work
  - Don't text in bed. Keep electronic media out of the bedroom
  - Keep your room on the cooler side
  - Stop watching TV at least an hour before bedtime
  - Make the room as soothing to senses as possible with colors and scents
  - Buy a comfortable mattress with sufficient back support—the firmer the better for most people
  - Use a hypoallergenic pillow and wash bedclothes frequently enough to eliminate dust
- Ask patients about their medications and if they may be affecting nighttime sleep or contributing to daytime sleepiness
  - Consider changing the timing of when medications are taken to minimize their impact on sleep quality

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- If the focus or purpose of the visit is tied to the patient's diagnosed condition, use [problem-oriented evaluation & management \(E/M\) codes](#) 99202-99215
- Depending on payer, [non-physician health and wellbeing coaches](#) may be able to use 0591T, 0592T, 0593T

# Nutrition



## RECOMMENDATION 1

Clinicians should assess dietary eating patterns and habits, at least annually with patients age 45+.

## RECOMMENDATION 2

For individuals who indicate a less than optimal diet, clinicians should counsel patients about the value of a healthy diet, and should broach the topic of culturally acceptable dietary interventions that directly and indirectly impact brain health at each annual encounter to suggest beneficial nutritional modifications.

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## RECOMMENDATION 1

### CONSIDERATIONS FOR IMPLEMENTATION

- Helpful question to assess the quality of one's diet include:
  - Are you concerned about your diet?
  - Do you think you get enough fruits and vegetables in your diet? How many servings do have per day?
  - How many times per week do you eat butter, cheese, red meat, or fried foods? In what quantities?
  - How many meals per day (or per week) are processed food?

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# Nutrition



## RECOMMENDATION 2

### CONSIDERATIONS FOR IMPLEMENTATION

- Modifications through shared decision-making and collaborative health care should focus on decreasing the intake of high-fat dairy products (e.g., butter, cheese), red meat, fried foods, and processed foods or sweets.
- Equally great effort should be made to motivate patients to increase relative intake of leafy green and cruciferous vegetables, berries, beans, high-fiber nuts and whole grains, and non-red meats like fish or chicken.
- Note for patients that diet changes may be accompanied by temporary abdominal discomfort that could occur for up to a month due to “your body changing to process the new foods”; this can be minimized by introducing incremental changes to the diet.
- The following resources for brain-healthy diets can be shared with patients to help them introduce diet modifications:
  - [MIND diet handout](#) | [DASH diet info.](#) | [Mediterranean diet info.](#)
- Determining underlying motivations as well as potential barriers to diet change is important and should be addressed to prevent “relapse.”
- Access to healthy foods should be discussed with patients.
- Objective measures (including vitals like heart rate and blood pressure), physical measures (like waist circumference and BMI), and lab values (specifically, lipid panel and hemoglobin A1C) should be tracked from recorded patient data to help ensure individuals maintain healthy weight.
  - Additional trending for CMP and CBC-ions, minerals, and H&H can also be considered
- If you have prescribed supplements to your patients, they should continue taking them. But you should relay to your patients that foods provide a much more diverse nutrient and bioactive profile than supplements and should be prioritized.
- Correct nutrient or ion abnormalities as needed
- Monitor for unplanned or unexpected weight loss, which often precedes dementia
- Patients might benefit from referral to a dietitian, particularly if patient nutritional needs are complicated

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- Depending on payer, provider type, patient conditions or diagnoses, other factors, clinicians may be able to use additional codes:
  - [Medical nutrition therapy service codes](#) 97802-97804
  - 99078 for [group physician education services](#)
  - G0447 for [behavioral counseling for obesity](#) (Medicare-only)
  - S9452 for [nutrition classes](#) (non-Medicare only)
  - S9470 for [nutrition counseling](#) (non-Medicare only)
- If making referrals or coordinating with other providers, clinicians may be able to use [chronic care management codes](#) 99490, 99439, 99487, 99489, 99491 or [principal care management codes](#) 99424, 99435, 99426
- If the patient is enrolled in a Medicare Advantage plan, check with plan regarding possible supplemental benefits tied to groceries, meals, or nutrition services.

# Social Activity



## RECOMMENDATION 1

Clinicians should annually, or after major life events (e.g., death of loved one, changed living arrangements), perform an assessment using one or more validated tool(s) (e.g., the UCLA Loneliness Scale for assessing loneliness, or the Berkman-Syme Social Network Index for assessing social isolation) to identify adults 45+ years experiencing loneliness<sup>2</sup> or social isolation.<sup>3</sup>

## RECOMMENDATION 2

For those identified with elevated risk of social isolation or loneliness, clinicians should suggest strategies for enhancing their social connection<sup>4</sup> and activity and check-in with them via phone or virtual meeting every few months to offer guidance or additional resources, as needed, to help prevent further declines in social activity.

## RECOMMENDATION 1

### CONSIDERATIONS FOR IMPLEMENTATION

- Don't assume you know who is or is not lonely; Think about how and why someone may be lonely or isolated and focus your advice on the mechanism.
- Examples of validated tools to assess social activity:
  - UCLA Loneliness Scale for assessing loneliness
  - Berkman-Syme Social Network Index for assessing social isolation, grinding your teeth or waking with a headache or aching jaws

2 *Loneliness*: the perception of social isolation or the subjective feeling of being lonely (National Academies of Sciences, 2020).

3 *Social isolation*: the objective lack of (or limited) social contact with others (National Academies of Sciences, 2020).

4 *Social connection* is related to *social support*, which is having people who can provide help and assistance in times of need. There are many types of social connection, ranging from intimate relationships (in which a person can share deep concerns and aspirations) with a romantic partner, close family member, or best friend, to casual encounters with grocery store clerks or online friends – and all forms serve as a protective factor to brain health. There are also different types of social support (National Academies of Sciences, 2020):

- *Emotional support*, in which people offer a shoulder to cry on
- *Instrumental support*, in which people offer concrete help such as babysitting one's children or cooking a meal for a sick person, and
- *Informational support*, in which people offer useful information, such as legal help or therapy

### POSSIBLE BILLING CODES

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- Depending on payer, provider type, patient conditions or diagnoses, other factors, clinicians may be able to use additional codes:
  - 96127 for [brief emotional assessment](#)
  - G0444 for [Medicare annual depression screening](#) (in conjunction with Medicare AWW only)

# Social Activity



## RECOMMENDATION 2

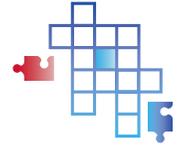
### CONSIDERATIONS FOR IMPLEMENTATION

- Ask the patient what he or she thinks would be a solution to their loneliness or social isolation and familiarize yourself with some of the community programs and resources in your area. For older adults, the Area Agencies on Aging and the AARP Connect 2 Affect are good places to start.
- Examples to suggest may include:
  - Meeting new people by joining clubs or organizations, such as a book club, a local sports team, a civic organization, or a political or religious group.
  - Volunteering, for instance, at a pet shelter, the library, hospital, school, or senior center.
  - Staying connected to family and friends (even during times of social distancing) by phone and video conferencing should be encouraged, recognizing that limited mobile/internet access may impact some individual's ability to maintain virtual social connections
- Explain to patients that all forms of relationships and support can be meaningful in building a sense of connection and serve as a protective factor to brain health. The more supported and connected a person feels, the better they can handle stress and build stress resilience.
- Use Dr. Carson's support mapping exercise as an awareness activity
- Try to document results of loneliness and social isolation screenings in your electronic health records

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- For patients who are assessed to have social activity or loneliness needs, clinicians may wish to document those in the patient's medical record using International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis and other types of medical codes, particularly the "z-codes" (Z55-Z65). For more information, see "[Loneliness and Social Isolation Social Determinants of Health Issue Brief](#)"

# Cognitive Stimulation



## RECOMMENDATION 1

During each scheduled visit, but at least annually, clinicians should ask patients (aged 45+) about their level of cognitive stimulation or activity,<sup>5</sup> which may include learning new skills or other stimulating activities they practice.

## RECOMMENDATION 2

For individuals who indicate low levels of cognitive stimulation or activity, suggestions for cognitive stimulation should be made.

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## RECOMMENDATION 1

### CONSIDERATIONS FOR IMPLEMENTATION

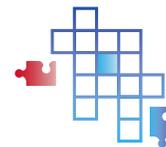
- When assessing for levels of cognitive activity or stimulation, clinicians could inquire about:
    - New skills being learned (e.g., cooking, dancing, language, crafting)
    - What or how frequently they read (non-fiction vs fiction)
    - Whether they watch documentaries or news
    - Making music or art
    - Playing strategy games (e.g., chess or dominoes)
    - Practicing mindfulness or being exposed to nature
- UCLA Loneliness Scale for assessing loneliness

### POSSIBLE BILLING CODES

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<sup>5</sup> Cognitive stimulation therapy refers to "participation in a range of activities aimed at improving cognitive and social functioning", while cognitive training refers to "guided practice of specific standardized tasks designed to enhance particular cognitive functions" (WHO, 2019), primarily as an intervention to prevent or delay cognitive decline or dementia (AHRQ, 2017); Cognitive activity is described as "mentally stimulating activities... such as reading, playing chess, etc." (Yu et al., 2020)

# Cognitive Stimulation



## RECOMMENDATION 2

### CONSIDERATIONS FOR IMPLEMENTATION

- Include non-judgmental communications and not “blaming” individuals for being cognitively inactive
- Consider individual and cultural preferences when suggesting activities and discuss different options with each individual to encourage a variety of activities
- [Share this handout with patients](#) for tips regarding best stimulation activities to target
- For those who may benefit, consider cognitive training programs (e.g., CogniFit, BrainHQ) (Sikkes et al., 2020; Medicare.org, 2020; Strenziok et al., 2014)
- For patients that engage in regular cognitive stimulation or activities, continued encouragement and recognition or praise should be given for maintenance.

### POSSIBLE BILLING CODES

- When provided as part of comprehensive preventive care visit for which the purpose/focus of the visit is not the established condition, use [comprehensive preventive medicine service codes](#) 99386, 99387, 99396, 99397 (non-Medicare)
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- If the patient is enrolled in a Medicare Advantage plan, check the with the plan to see if cognitive training programs are covered as supplemental benefits (e.g., BrainHQ)

## Billing Codes

CPT CODE	DESCRIPTION	CODE-SPECIFIC INFORMATION	PROVIDER RESTRICTIONS	PAYER RESTRICTIONS
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### COMPREHENSIVE PREVENTIVE MEDICINE SERVICES

Comprehensive medicine services (i.e., well visits) are evaluation and management (E/M) services provided to asymptomatic patients when the purpose of the visit is to evaluate the patient’s overall health, and to identify potential health problems. To use these codes, the provider must document a comprehensive evaluation that includes an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/ diagnostic procedures.

These codes are not covered by Medicare (see G0438, G0439, G0402). Other payers may also have restrictions or limitations on these codes.

<b>99386</b>	Initial comprehensive preventive medicine service	For new patient age 65+	Qualified physicians or other qualified professional (e.g., nurse practitioner (NP), physicians assistant (PA)).	Medicare does not cover (see G0438, G0439, G0402)
<b>99387</b>	Initial comprehensive preventive medicine service	For new patient age 65+	Qualified physicians or other qualified professional (e.g., NP, PA).	Medicare does not cover (see G0438, G0439, G0402)
<b>99396</b>	Periodic comprehensive preventive medicine service	For established patient age 40-64	Qualified physicians or other qualified professional (e.g., NP, PA).	Medicare does not cover (see G0439)
<b>99397</b>	Periodic comprehensive preventive medicine service	For established patient age 65+	Qualified physicians or other qualified professional (e.g., NP, PA).	Medicare does not cover (see G0439)

CPT CODE	DESCRIPTION	CODE-SPECIFIC INFORMATION	PROVIDER RESTRICTIONS	PAYER RESTRICTIONS
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**MEDICARE WELLNESS VISITS**

Medicare does not provide coverage of comprehensive preventive medicine services (i.e., annual physicals) but covers similar services through the initial preventive physical exam (IPPE) and annual wellness visits (AWVs). These visits require several specific components which are detailed at [CMS.gov](https://www.cms.gov).

These codes can often be combined with separately identifiable problem-oriented E/M services that are medically necessary and reasonable to treat a patient’s illness or injury (see below) by reporting both the relevant wellness visit code and E/M code with modifier -25.

<b>G0402</b>	Initial preventive physical examination (IPPE); face-to-face visit.	Also referred to as “Welcome to Medicare” visit. Services limited to new beneficiary during the first 12 months of Medicare enrollment.	Physician or qualified Non-Physician Practitioner (NPP) (i.e., a Physician Assistant (PA), Nurse Practitioner (NP), or Certified Clinical Nurse Specialist (CCNS).	Unique to Medicare
<b>G0438</b>	Annual wellness visit, includes a personalized prevention plan of service (PPPS), first visit.	Can only be used for a Medicare beneficiary who is no longer within the first 12 months after the effective date of their Part B coverage and who has not had an IPPE or annual wellness visit within the past 12 months.	Physician or qualified NPP (i.e., PA, NP, or CCNS) or medical professional including a health educator, registered dietitian, nutrition professional, or other licensed practitioner), or a team of medical professionals directly supervised by a physician.	Unique to Medicare
<b>G0439</b>	Annual wellness visit, includes a personalized prevention plan of service (PPPS) subsequent visit.	For subsequent visits – can be billed once every 12 months.	Physician or qualified NPP (i.e., PA, NP, or CCNS) or medical professional including a health educator, registered dietitian, nutrition professional, or other licensed practitioner), or a team of medical professionals directly supervised by a physician.	Unique to Medicare

CPT CODE	DESCRIPTION	CODE-SPECIFIC INFORMATION	PROVIDER RESTRICTIONS	PAYER RESTRICTIONS
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**COUNSELING, RISK FACTOR REDUCTION, AND BEHAVIOR CHANGE INTERVENTION CODES**

These codes are used for the purpose of promoting health and preventing illness or injury at encounters separate from the preventive medicine service (see above). They are used for counseling or interventions for patients without a specific illness for which the counseling might otherwise be used as part of treatment. They are not reported when counseling is related to an established condition, disease, or treatment (for those, see 99202-99215). These are time-based codes that typically require medical record documentation of the total time spent in counseling and a summary of the issues discussed.

These codes can often be combined with separately identifiable problem-oriented E/M services that are medically necessary and reasonable to treat a patient’s illness or injury (see below) by reporting both the relevant wellness visit code and E/M code with modifier -25.

Different payers may have limitations or restrictions on when and for whom these codes can be used (e.g., may require them to be combined with certain diagnoses codes).

<b>99401</b>	Preventive medicine counseling or risk factor reduction intervention(s) provided to an individual	Approximately 15 minutes	Qualified physicians or other qualified professional (e.g., NP, PA).	Varies by payer
<b>99402</b>	Preventive medicine counseling or risk factor reduction intervention(s) provided to an individual	Approximately 30 minutes	Qualified physicians or other qualified professional (e.g., NP, PA).	Varies by payer
<b>99403</b>	Preventive medicine counseling or risk factor reduction intervention(s) provided to an individual	Approximately 45 minutes	Qualified physicians or other qualified professional (e.g., NP, PA).	Varies by payer
<b>99404</b>	Preventive medicine counseling or risk factor reduction intervention(s) provided to an individual	Approximately 60 minutes	Qualified physicians or other qualified professional (e.g., NP, PA).	Varies by payer
<b>99411</b>	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting	Approximately 30 minutes	Qualified physicians or other qualified professional (e.g., NP, PA).	Varies by payer
<b>99412</b>	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting	Approximately 60 minutes	Qualified physicians or other qualified professional (e.g., NP, PA).	Varies by payer

CPT CODE	DESCRIPTION	CODE-SPECIFIC INFORMATION	PROVIDER RESTRICTIONS	PAYER RESTRICTIONS
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**PROBLEM-ORIENTED E/M SERVICES CODES**

These codes are for office or other outpatient visit for the evaluation and management of a new or established patient who presents with a problem (symptoms, established illness or injury). Choosing the appropriate level of E/M service is based on either time (face-to-face and non-face-to-face time) or level of medical decision making (MDM) for the services rendered. In order to use time as the basis, documentation must show that more than 50% of the face-to-face time is spent providing counseling or coordination of care.

Problem-oriented E/M service codes can often be combined with preventive/wellness visit codes (G0402, G0438, G0439, 99401-99404, 99411, 99412, 99386, 99387, 99396, 99387) if the services are separately identifiable and medically necessary and reasonable to treat a patient’s illness or injury by reporting both the relevant wellness visit code and E/M code with modifier -25.

Different payers may have limitations or restrictions on when and for whom these codes can be used (e.g., may require them to be combined with certain diagnoses codes).

<b>99202</b>	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward MDM. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.	Straightforward MDM or 15-29 minutes. Usually, the presenting problem(s) are of low to moderate severity	Qualified physicians or other qualified professional (e.g., NP, PA).	Varies by payer
<b>99203</b>	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed examination; and MDM of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.	MDM of low complexity or 30-44 minutes. Usually, the presenting problem(s) are of moderate severity	Qualified physicians or other qualified professional (e.g., NP, PA).	Varies by payer

CPT CODE	DESCRIPTION	CODE-SPECIFIC INFORMATION	PROVIDER RESTRICTIONS	PAYER RESTRICTIONS
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and MDM of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.	MDM of moderate complexity or 44-59 minutes. Usually, the presenting problem(s) are of moderate to high severity.	Qualified physicians or other qualified professional (e.g., NP, PA).	Varies by payer
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and MDM of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.	MDM of high complexity or 60-74 minutes. Usually, the presenting problem(s) are of moderate to high severity.	Qualified physicians or other qualified professional (e.g., NP, PA).	Varies by payer
99212	For established patients. Requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; straightforward MDM. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.	Straightforward MDM or 10-19 minutes; Usually, the presenting problem(s) are self limited or minor.	Qualified physicians or other qualified professional (e.g., NP, PA).	Varies by payer
99213	For established patients. Requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; MDM of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.	MDM of low complexity or 20-29 minutes. Usually, the presenting problem(s) are of low to moderate severity	Qualified physicians or other qualified professional (e.g., NP, PA).	Varies by payer

CPT CODE	DESCRIPTION	CODE-SPECIFIC INFORMATION	PROVIDER RESTRICTIONS	PAYER RESTRICTIONS
99214	For established patients. Requires at least 2 of these 3 key components: A detailed history; A detailed examination; MDM of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity.	MDM of moderate complexity or 30-39 minutes, Usually, the presenting problem(s) are of moderate to high severity.	Qualified physicians or other qualified professional (e.g., NP, PA).	Varies by payer
99215	For established patients. Requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; MDM of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity	MDM of high complexity or 40-54 minutes. Usually the presenting problem(s) are of moderate to high severity	Qualified physicians or other qualified professional (e.g., NP, PA).	Varies by payer
99417	Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes	Can only be used in addition to codes 99205, 99215 for office or other outpatient E/M services.	Qualified physicians or other qualified professional (e.g., NP, PA).	Not recognized by Medicare (use G2212)
G2212	Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes.	Can only be used in addition to codes 99205, 99215 for office or other outpatient E/M services.	Qualified physicians or other qualified professional (e.g., NP, PA).	Medicare only

CPT CODE	DESCRIPTION	CODE-SPECIFIC INFORMATION	PROVIDER RESTRICTIONS	PAYER RESTRICTIONS
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**OTHER SPECIFIC SERVICE CODES**

Depending on payer, provider type, patient diagnosis, and the specific services provided, providers may also be able to use these codes for prevention services to help reduce the risk of cognitive decline. Different payers may have limitations or restrictions on when and for whom these codes can be used (e.g., may require them to be combined with certain diagnoses codes, may have limits for how many times they can be billed per year).

<b>G0444</b>	Annual depression screening, 15 minutes	Screening available to all Medicare beneficiaries once annually. Must be done in a primary care setting with "staff-assisted depression care supports in place." Use for patients who do not have symptoms of depression. Can be reported with subsequent Medicare AWV G0439.	Qualified physicians or other qualified professional (e.g., NP, PA)	Medicare-specific
<b>G0446</b>	Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes	Face-to-face risk reduction available to all Medicare beneficiaries once annually. Requires certain components: (1) encourage aspirin use when the benefits outweigh the risks for men age 45-79 and women 55-79. (2) screen for high blood pressure (everyone over age 18). (3) intensive behavioral counseling to promote a healthy diet for adults who already have hyperlipidemia, hypertension, advancing age, and other known risk factors for cardiovascular and diet related chronic diseases. In general this cannot be billed on the same day as another encounter visit (except the IPPE or claims with diabetes self-management training/medical nutrition services.	Qualified physicians or other qualified professional (e.g., NP, PA).	Medicare-specific
<b>G0447</b>	Behavioral counseling for obesity, 15 minutes	Ongoing face-to-face behavioral counseling for patients with a BMI of $\geq 30$ . Service consists of screening for obesity, dietary assessment and intensive behavioral counseling and behavioral therapy, for eligible patients.	Qualified physicians or other qualified professional (e.g., NP, PA) as well as medical practice staff incident to the services of a physician or an NPP.	Medicare-specific

CPT CODE	DESCRIPTION	CODE-SPECIFIC INFORMATION	PROVIDER RESTRICTIONS	PAYER RESTRICTIONS	
82947	Glucose; quantitative, blood (except reagent strip)	Diabetes Screening (Blood Glucose Testing) for patients with certain risk factors for diabetes (e.g., hypertension) or diagnosed with pre-diabetes. Should not be used for patients with established diabetes. Different payers may have different requirements (e.g., for which patients qualify, frequency limits).	Qualified physicians or other qualified professional (e.g., NP, PA)	Varies by payer	
82950	Glucose; post glucose dose (includes glucose)		Qualified physicians or other qualified professional (e.g., NP, PA)	Varies by payer	
82951	Glucose; tolerance test (GTT), 3 specimens (includes glucose)		Qualified physicians or other qualified professional (e.g., NP, PA)	Varies by payer	
96127	Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument		Generic mental health screening code that should be used to report a brief assessment for ADHD, depression, suicidal risk, anxiety, somatic symptom disorder and substance abuse and can be billed up to 4 times per year. <i>Note: Requires use of standardized instruments, payers may vary in which tools can be used (e.g., whether loneliness scales listed may qualify)</i>	Qualified physicians or other qualified professional (e.g., NP, PA)	Varies by payer
99078	Physician educational services in a group		The provider conducts group instruction as patient education, such as a diabetic teaching	Qualified physicians or other qualified professional (e.g., NP, PA)	Varies by payer

CPT CODE	DESCRIPTION	CODE-SPECIFIC INFORMATION	PROVIDER RESTRICTIONS	PAYER RESTRICTIONS
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**CHRONIC CARE MANAGEMENT CODES**

Although the recommendations are intended to provide guidance on primary prevention recommendations to reduce the risk of cognitive decline, some patients with chronic conditions may benefit from these recommendations as part of chronic care management. For Medicare patients, chronic care management (CCM) services are generally non-face-to-face services provided to Medicare beneficiaries who have multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. These are Medicare-specific codes which may or may not be covered by other payers.

<b>99490</b>	Non-complex CCM provided by clinical staff to coordinate care across providers and support patient accountability; comprehensive care plan established, implemented, revised, or monitored	At least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.	Clinical staff (directed by qualified physician or other qualified professional (e.g., NP, PA))	Medicare-specific code, other payers may cover differently
<b>99439</b>	Each additional 20 minutes of clinical staff time spent providing non-complex CCM directed by a physician or other qualified health care professional	Billed in conjunction with CPT code 99490	Clinical staff (directed by qualified physician or other qualified professional (e.g., NP, PA))	Medicare-specific code, other payers may cover differently
<b>99487</b>	Complex CCM provided by clinical staff involving establishment or substantial revision of a comprehensive care plan, moderate or high complexity medical decision making	60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month	Clinical staff (directed by qualified physician or other qualified professional (e.g., NP, PA))	Medicare-specific code, other payers may cover differently
<b>99489</b>	Each additional 20 minutes of clinical staff time spent providing non-complex CCM directed by a physician or other qualified health care professional	Billed in conjunction with CPT code 99487	Clinical staff (directed by qualified physician or other qualified professional (e.g., NP, PA))	Medicare-specific code, other payers may cover differently
<b>99491</b>	Complex CCM services provided personally by a physician or other qualified health care professional; comprehensive care plan established, implemented, revised, or monitored	At least 30 minutes of physician or other qualified health care professional time, per calendar month. Includes only time that is spent personally by the billing practitioner. Clinical staff time is not counted towards the required time threshold for reporting this code.	Qualified physician or other qualified professional (e.g., NP, PA)	Medicare-specific code, other payers may cover differently

CPT CODE	DESCRIPTION	CODE-SPECIFIC INFORMATION	PROVIDER RESTRICTIONS	PAYER RESTRICTIONS
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**PRINCIPAL CARE MANAGEMENT CODES**

Although the recommendations are intended to provide guidance on primary prevention recommendations to reduce the risk of cognitive decline, some patients with chronic conditions may benefit from these recommendations as part of chronic care management. For Medicare patients, principal care management (PCM) services are generally non-face-to-face services provided to Medicare beneficiaries who one complex chronic condition expected to last at least 3 months, and that places the patient at significant of hospitalization, acute exacerbation decompensation, functional decline, or death. The condition must require frequent adjustments in medication regimen and/or regimen and/or the management of the condition is usually complex due to comorbidities. These are Medicare-specific codes which may or may not be covered by other payers.

<b>99424</b>	PCM services for a single high-risk disease first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month.	First 30-minutes provided personally by a physician	Qualified physician or other qualified professional (e.g., NP, PA)	Medicare-specific code, other payers may cover differently
<b>99425</b>	PCM services for a single high-risk disease each additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month	Each additional 30 minutes	Qualified physician or other qualified professional (e.g., NP, PA)	Medicare-specific code, other payers may cover differently
<b>99426</b>	PCM, for a single high-risk disease first 30 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month	First 30 minutes of clinical staff time	Clinical staff (directed by qualified physician or other qualified professional (e.g., NP, PA)	Medicare-specific code, other payers may cover differently
<b>99427</b>	CM services, for a single high-risk disease each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month	Each additional 30 minutes	Clinical staff (directed by qualified physician or other qualified professional (e.g., NP, PA)	Medicare-specific code, other payers may cover differently

CPT CODE	DESCRIPTION	CODE-SPECIFIC INFORMATION	PROVIDER RESTRICTIONS	PAYER RESTRICTIONS	
<b>CODES FOR NON-PHYSICIAN PROVIDERS</b>					
These codes likely cannot be billed by primary care providers, but may be used for services provided by other provider types that could be helpful in preventing cognitive decline.					
<b>0591T</b>	Health and well-being coaching face-to-face; individual, initial assessment	Coaches work with individuals and groups in a client-centered process to facilitate and empower the client to achieve self-determined goals related to health and wellness. Coverage and specific rules for coverage and billing may be limited and vary by payer.	Health and wellbeing professionals (non-physicians) certified by Professionals certified by NBHWC or NCHEC (The National Commission for Health Education Credentialing, Inc.) can use the new codes.	Varies by payer	
<b>0592T</b>	Health and well-being coaching face-to-face; individual, follow-up session, at least 30 minutes			Varies by payer	
<b>0593T</b>	Health and well-being coaching face-to-face; group (2 or more individuals), at least 30 minutes			Varies by payer	
<b>97802</b>	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	These codes are used for Medical nutrition therapy (MNT services) which can include nutrition and lifestyle assessments, individual or group nutritional therapy services, lifestyle management techniques, and follow-up visits. These codes usually require that the patient has certain diagnosed conditions (i.e., used alongside certain diagnosis codes) which vary by payer. For example, Medicare covers MNT) services for patients with diabetes or kidney disease or recent kidney transplants, while private payers may cover MNT for a wider range of patients.	Registered Dietitian or nutrition professional	Varies by payer	
<b>97803</b>	Re-assessment and intervention, individual, face-to-face with patient, each 15 minutes [Medical nutrition therapy]			Registered Dietitian or nutrition professional	Varies by payer
<b>97804</b>	Group (2 or more individuals) [Medical nutrition therapy]			Registered Dietitian or nutrition professional	Varies by payer
<b>S9452</b>	Nutrition classes, non-physician provider, per session	Nutrition classes	Non-physician providers	Varies by payer	
<b>S9470</b>	Nutritional counseling, dietitian visit (initial, individual visit)	Nutritional counseling that is less comprehensive than MNT and does not include assessment or reassessment.	Registered Dietitian or nutrition professional	Non-Medicare only	

**Notes.** Qualified nonphysician health care professionals are professionals who have demonstrated skills, education, and regulatory requirements, to obtain licensure with their respective licensing board. Unless otherwise noted, in this table, qualified health care professional refers professionals who are authorized to perform such services within their scope of practice (varies by state, training, and licensure).

The information in this recommendations summary is provided “as is” without any express or implied guarantee or fitness for the use or billing of any of the CPT codes referenced. The information here includes possible CPT code options for discussion only. It is the responsibility of the medical provider performing services to determine what CPT/ICD-10 codes are appropriate for billing based on service performed, supporting documentation, and payor guidelines.