Medicare Wellness Visits (https://www.cms.gov/training-education/medicare-learning-network/resources-training)

> 🧑‍🤝‍🧑 **Early detection saves lives. Encourage patients to get their other preventive services** (https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html). 💚

What's Changed?

- Added information about monthly chronic pain management and treatment services
- Added information about checking for cognitive impairment during annual wellness visits
- Added information about Social Determinants of Health Risk Assessments as an optional element of annual wellness visits

Substantive content changes are in dark red.

Quick Start

The Annual Wellness Visits video (https://www.youtube.com/watch?v=r7yOUaMJyJU) helps you understand these exams, as well as their purpose and claim submission requirements.

Medicare Physical Exam Coverage

Initial Preventive Physical Exam (IPPE) (#IPPE)

Review of medical and social health history and preventive services education.

✓ New Medicare patients within 12 months of starting Part B coverage

✓ Patients pay nothing (if provider accepts assignment)

Annual Wellness Visit (AWV) (#AWV)

Visit to develop or update a personalized prevention plan and perform a health risk assessment.

✓ Covered once every 12 months

✓ Patients pay nothing (if provider accepts assignment)

Routine Physical Exam (#Know-Differences)

Exam performed without relationship to treatment or diagnosis of a specific illness, symptom, complaint, or injury.

✗ Medicare doesn't cover a routine physical

✗ Patients pay 100% out-of-pocket

Together we can advance health equity and help eliminate health disparities for all minority and underserved groups. Find resources and more from the [CMS Office of Minority Health](https://www.cms.gov/priorities/health-equity/minority-health) (https://www.cms.gov/priorities/health-equity/minority-health):

- [Health Equity Technical Assistance Program](https://www.cms.gov/priorities/health-equity/minority-health/equity-programs/technical-assistance) (https://www.cms.gov/priorities/health-equity/minority-health/equity-programs/technical-assistance)
- [Disparities Impact Statement](https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Disparities-Impact-Statement-508-rev102018.pdf) (https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Disparities-Impact-Statement-508-rev102018.pdf)

Communication Avoids Confusion

As a health care provider, you may recommend that patients get services more often than we cover or that we don't cover. If this happens, help patients understand they may have to pay some or all costs. Communication is key to ensuring patients understand why you're recommending certain services and whether we cover them.

Initial Preventive Physical Exam

The initial preventive physical exam (IPPE), also known as the "Welcome to Medicare" preventive visit, promotes good health through disease prevention and detection. We pay for 1 IPPE per lifetime if it's provided within the first 12 months after the patient's Part B coverage starts.

IPPE Components

1. Review the patient's medical and social history

At a minimum, collect this information:

- Past medical and surgical history (illnesses, hospital stays, operations, allergies, injuries, and treatments)
- Current medications, supplements, and other substances the person may be using
- Family history (review the patient's family and medical events, including hereditary conditions that place them at increased risk)
- Diet
- Physical activities
- Social activities and engagement
- Alcohol, tobacco, and illegal drug use history

Learn information about Medicare's [substance use disorder (SUD) services coverage](https://www.medicare.gov/coverage/mental-health-substance-use-disorder-services) (https://www.medicare.gov/coverage/mental-health-substance-use-disorder-services).

2. Review the patient's potential depression risk factors

Depression risk factors include:

- Current or past experiences with depression
- Other mood disorders

Select from various standardized screening tools designed for this purpose and recognized by national professional medical organizations. APA's Depression Assessment Instruments (https://www.apa.org/depression-guideline/assessment) has more information.

3. Review the patient's functional ability and safety level

Use direct patient observation, appropriate screening questions, or standardized questionnaires recognized by national professional medical organizations to review, at a minimum, the patient's:

- Ability to perform activities of daily living (ADLs)
- Fall risk
- Hearing impairment
- Home and community safety, including driving when appropriate

Medicare offers cognitive assessment and care plan services (https://www.cms.gov/medicare/payment/fee-schedules/physician/cognitive-assessment) for patients who show signs of impairment.

4. Exam

Measure:

- Height, weight, body mass index (BMI) (or waist circumference, if appropriate), blood pressure, balance, and gait
- Visual acuity screen
- Other factors deemed appropriate based on medical and social history and current clinical standards

5. End-of-life planning, upon patient agreement

End-of-life planning is verbal or written information you (their physician or practitioner) can offer the patient about:

- Their ability to prepare an advance directive in case an injury or illness prevents them from making their own health care decisions
- If you agree to follow their advance directive
- This includes psychiatric advance directives (https://www.samhsa.gov/sites/default/files/a_practical_guide_to_psychiatric_advance_directives.pdf)

6. Review current opioid prescriptions	For a patient with a current opioid (https://www.cms.gov/medicare/payment/opioid-treatment-program) prescription:
	• Review any potential opioid use disorder (OUD) risk factors
	• Evaluate their pain severity and current treatment plan
	• Provide information about non-opiod treatment options
	• Refer to a specialist, as appropriate
	The HHS Pain Management Best Practices Inter-Agency Task Force Report (https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf) has more information. Medicare now covers monthly chronic pain management and treatment services (https://www.medicare.gov/coverage/chronic-pain-management-treatment-services).

| **7. Screen for potential SUDs** | Review the patient's potential SUD risk factors, and as appropriate, refer them to treatment. You can use a screening tool, but it's not required. The National Institute on Drug Abuse (https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools) has screening and assessment tools. Implementing Drug and Alcohol Screening in Primary Care (https://alcoholdrugscreening.simmersion.com/) is a helpful resource (https://nida.nih.gov/sites/default/files/nida_ctn_ehr_screen_tool_factsheet_508.pdf). |

| **8. Educate, counsel, and refer based on previous components** | Based on the results of the review and evaluation services from the previous components, provide the patient with appropriate education, counseling, and referrals. |

9. Educate, counsel, and refer for other preventive services	Include a brief written plan, like a checklist, for the patient to get:
	• A once-in-a-lifetime screening electrocardiogram (ECG), as appropriate
	• Appropriate screenings and other covered preventive services (https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html)

> ## IPPE Coding, Diagnosis, & Billing

Coding

Use these HCPCS codes to file IPPE and ECG screening claims:

G0402	Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of medicare enrollment
G0403	Electrocardiogram, routine ecg with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report
G0404	Electrocardiogram, routine ecg with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination
G0405	Electrocardiogram, routine ecg with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination
G0468*	Federally qualified health center (fqhc) visit, ippe or awv; a fqhc visit that includes an initial preventive physical examination (ippe) or annual wellness visit (awv) and includes a typical bundle of medicare-covered services that would be furnished per diem to a patient receiving an ippe or awv

* Section 60.2 of the [Medicare Claims Processing Manual, Chapter 9](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf#page=15) has more information on how to bill HCPCS code G0468.

Diagnosis

Report a diagnosis code when submitting IPPE claims. We don't require you to use a specific IPPE diagnosis code, so you may choose any diagnosis code consistent with the patient's exam.

Billing

Part B covers an IPPE when performed by a:
- Physician (doctor of medicine or osteopathy)
- Qualified non-physician practitioner (physician assistant, nurse practitioner, or certified clinical nurse specialist)

When you provide an IPPE and a significant, separately identifiable, medically necessary evaluation and management (E/M) service, we may pay for the additional service. Report the additional CPT code (99202–99205, 99211–99215) with modifier 25. That portion of the visit must be medically necessary and reasonable to treat the patient's illness or injury or to improve the functioning of a malformed body part.

IPPE Resources

- [42 CFR 410.16](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-410#410.16)

IPPE FAQs

Is the IPPE the same as a patient's yearly physical?

No. The IPPE isn't a routine physical that some patients may get periodically from their physician or other qualified non-physician practitioner (NPP). The IPPE is an introduction to Medicare and covered benefits, and it focuses on health promotion, disease prevention, and detection to help patients stay well. We encourage providers to inform patients about the AWV during their IPPE. **The Social Security Act (https://www.ssa.gov/OP_Home/ssact/title18/1862.htm) explicitly prohibits Medicare coverage of routine physical exams.**

Are clinical lab tests part of the IPPE or AWV?

No. The IPPE and AWV don't include clinical lab tests, but you may make appropriate referrals for these tests as part of the IPPE or AWV.

Does the deductible, coinsurance, or copayment apply for the IPPE?

No. We waive the coinsurance, copayment, and Part B deductible for the IPPE (HCPCS code G0402). Neither is waived for the screening electrocardiogram (ECG) (HCPCS codes G0403, G0404, or G0405).

If a patient enrolls in Medicare in 2023, can they get the IPPE in 2024 if it wasn't performed in 2023?

A patient who hasn't had an IPPE and whose Part B enrollment began in 2023 can get an IPPE in 2024 if it's within 12 months of the patient's Part B enrollment effective date.

We suggest providers check with their MAC for available options to verify patient eligibility. If you have questions, find your MAC's website (https://www.cms.gov/MAC-info).

Annual Wellness Visit Health Risk Assessment

The annual wellness visit (AWV) includes a health risk assessment (HRA). View the HRA minimum elements summary below. [A Framework for Patient-Centered Health Risk Assessments](https://www.cdc.gov/policy/paeo/hra/frameworkforhra.pdf) (https://www.cdc.gov/policy/paeo/hra/frameworkforhra.pdf) has more information, including a sample HRA.

First Annual Wellness Visit Components

Perform an HRA

- Get patient self-reported information
  - You or the patient can update the HRA before or during the AWV
- Consider the best way to communicate with underserved populations, people who speak different languages, people with varying health literacy, and people with disabilities
- At a minimum, collect this information:
  - Demographic data
  - Health status self-assessment
  - Psychosocial risks, including, but not limited to, depression, life satisfaction, stress, anger, loneliness or social isolation, pain, suicidality, and fatigue
  - Behavioral risks, including, but not limited to, tobacco use, physical activity, nutrition and oral health, alcohol consumption, sexual health, motor vehicle safety (for example, seat belt use), and home safety
  - Activities of daily living (ADLs), including dressing, feeding, toileting, and grooming; physical ambulation, including balance or fall risks and bathing; and instrumental ADLs (IADLs), including using the phone, housekeeping, laundry, transportation, shopping, managing medications, and handling finances

1. Establish the patient's medical and family history

At a minimum, document:

- Medical events of the patient's parents, siblings, and children, including hereditary conditions that place them at increased risk
- Past medical and surgical history (illnesses, hospital stays, operations, allergies, injuries, and treatments)
- Use of, or exposure to, medications, supplements, and other substances the person may be using

2. Establish a current providers

Include current patient providers and suppliers that regularly provide medical care, including behavioral

and suppliers list	health care.
3. Measure	Measure: • Height, weight, body mass index (BMI) (or waist circumference, if appropriate), and blood pressure • Other routine measurements deemed appropriate based on medical and family history
4. Detect any cognitive impairments the patient may have	Check for cognitive impairment (https://www.cms.gov/medicare/payment/fee-schedules/physician/cognitive-assessment) as part of the first AWV. Assess cognitive function by direct observation or reported observations from the patient, family, friends, caregivers, and others. Consider using brief cognitive tests, health disparities, chronic conditions, and other factors that contribute to increased cognitive impairment risk. Alzheimer's and Related Dementia Resources for Professionals (https://www.nia.nih.gov/health/health-care-professionals-information/alzheimers-and-related-dementias-resources) has more information.
5. Review the patient's potential depression risk factors	Depression risk factors include: • Current or past experiences with depression • Other mood disorders Select from various standardized screening tools designed for this purpose and recognized by national professional medical organizations. APA's Depression Assessment Instruments (https://www.apa.org/depression-guideline/assessment) has more information.
6. Review the patient's functional ability and level of safety	Use direct patient observation, appropriate screening questions, or standardized questionnaires recognized by national professional medical organizations to review, at a minimum, the patient's: • Ability to perform ADLs • Fall risk • Hearing impairment • Home and community safety, including driving when appropriate Medicare offers cognitive assessment and care plan services (https://www.cms.gov/medicare/payment/fee-schedules/physician/cognitive-assessment) for patients who show signs of impairment.
7. Establish an appropriate patient written screening	Base the written screening schedule on the: • Checklist for the next 5–10 years

schedule

- Checklist for the next 5–10 years
- [United States Preventive Services Task Force](https://www.uspreventiveservicestaskforce.org/uspstf) (https://www.uspreventiveservicestaskforce.org/uspstf) and [Advisory Committee on Immunization Practices (ACIP)](https://www.cdc.gov/vaccines/acip) (https://www.cdc.gov/vaccines/acip) recommendations
- Patient's HRA, health status and screening history, and age-appropriate [preventive services](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html) (https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html) we cover

8. Establish the patient's list of risk factors and conditions

Include:

- A recommendation for primary, secondary, or tertiary interventions or report whether they're underway
- Mental health conditions, including depression, [substance use disorders](https://www.samhsa.gov/find-help/disorders) (https://www.samhsa.gov/find-help/disorders), suicidality, and cognitive impairments
- IPPE risk factors or identified conditions
- Treatment options and associated risks and benefits

9. Provide personalized patient health advice and appropriate referrals to health education or preventive counseling services or programs

Include referrals to educational and counseling services or programs aimed at:

- Community-based lifestyle interventions to reduce health risks and promote self-management and

  - Fall prevention
  - Nutrition
  - Physical activity
  - Tobacco-use cessation
  - Social engagement
  - Weight loss
- wellness, including:
  - Cognition

10. Provide advance care planning (ACP) services at the patient's discretion

ACP is a discussion between you and the patient about:

- Preparing an advance directive in case an injury or illness prevents them from making their own health care decisions
- Future care decisions they might need or want to make
- How they can let others know about their care preferences
- Caregiver identification
- Advance directive elements, which may involve completing standard forms

Advance directive is a general term that refers to various documents, like a living will, instruction directive, health care proxy, psychiatric advance directive, or health care power of attorney. It's a

document that appoints an agent or records a person's wishes about their medical treatment at a future time when the individual can't communicate for themselves. The Advance Care Planning (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf) fact sheet has more information.

We don't limit how many times the patient can revisit the ACP during the year, but cost sharing applies outside the AWV.

11. Review current opioid prescriptions

For a patient with a current opioid (https://www.cms.gov/priorities/key-initiatives/opioids) prescription:

- Review any potential OUD risk factors
- Evaluate their pain severity and current treatment plan
- Provide information about non-opioid treatment options
- Refer to a specialist, as appropriate

The HHS Pain Management Best Practices Inter-Agency Task Force Report (https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf) has more information. Medicare now covers monthly chronic pain management and treatment services (https://www.medicare.gov/coverage/chronic-pain-management-treatment-services).

12. Screen for potential SUDs

Review the patient's potential SUD risk factors, and as appropriate, refer them for treatment. You can use a screening tool, but it's not required. The National Institute on Drug Abuse (https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools) has screening and assessment tools. Implementing Drug and Alcohol Screening in Primary Care (https://alcoholdrugscreening.simmersion.com/) is a helpful resource (https://nida.nih.gov/sites/default/files/nida_ctn_ehr_screen_tool_factsheet_508.pdf).

13. Social Determinants of Health (SDOH) Risk Assessment

Starting in 2024, Medicare includes an optional SDOH Risk Assessment (https://www.federalregister.gov/documents/2023/11/16/2023-24184/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other#h-512) as part of the AWV. This assessment must follow standardized, evidence-based practices and ensure communication aligns with the patient's educational, developmental, and health literacy level, as well as being culturally and linguistically appropriate.

Subsequent AWV Components

1. Review and update the HRA

- Get patient self-reported information
  - You or the patient can update the HRA before or during the AWV
- At a minimum, collect this information:
  - Demographic data
  - Health status self-assessment
  - Psychosocial risks, including, but not limited to, depression, life satisfaction, stress, anger, loneliness or social isolation, pain, suicidality, and fatigue
  - Behavioral risks, including, but not limited to, tobacco use, physical activity, nutrition and oral health, alcohol consumption, sexual health, motor vehicle safety (for example, seat belt use), and home safety
  - Activities of daily living (ADLs), including dressing, feeding, toileting, and grooming; physical ambulation, including balance or fall risks and bathing; and instrumental ADLs (IADLs), including using the phone, housekeeping, laundry, transportation, shopping, managing medications, and handling finances

2. Update the patient's medical and family history

At a minimum, document updates to:
- Medical events of the patient's parents, siblings, and children, including hereditary conditions that place them at increased risk
- Past medical and surgical history (illnesses, hospital stays, operations, allergies, injuries, and treatments)
- Use of, or exposure to, medications, supplements, and other substances the person may be using

3. Update current providers and suppliers list

Include current patient providers and suppliers that regularly provide medical care, including those added because of the first AWV personalized prevention plan services (PPPS), and any behavioral health providers.

4. Measure

Measure:

- Weight (or waist circumference, if appropriate)

- Weight (or waist circumference, if appropriate) and blood pressure
- Other routine measurements deemed appropriate based on medical and family history

5. Detect any cognitive impairments patients may have

Check for cognitive impairment (https://www.cms.gov/medicare/payment/fee-schedules/physician/cognitive-assessment) as part of the subsequent AWV.

Assess cognitive function by direct observation or reported observations from the patient, family, friends, caregivers, and others. Consider using brief cognitive tests, health disparities, chronic conditions, and other factors that contribute to increased cognitive impairment risk. Alzheimer's and Related Dementia Resources for Professionals (https://www.nia.nih.gov/health/health-care-professionals-information/alzheimers-and-related-dementias-resources) has more information.

6. Update the patient's written screening schedule

Base written screening schedule on the:

- United States Preventive Services Task Force (https://www.uspreventiveservicestaskforce.org/uspstf) and Advisory Committee on Immunization Practices (ACIP) (https://www.cdc.gov/vaccines/acip) recommendations
- Patient's HRA, health status and screening history, and age-appropriate preventive services (https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html) we cover

7. Update the patient's list of risk factors and conditions

Include:

- A recommendation for primary, secondary, or tertiary interventions or report whether they're underway
- Mental health conditions, including depression, substance use disorders (https://www.samhsa.gov/find-help/disorders), and cognitive impairments
- Risk factors or identified conditions
- Treatment options and associated risks and benefits

8. As necessary, provide and update patient PPPS, including personalized health advice and appropriate referrals to health education or preventive counseling services or programs

Include referrals to educational and counseling services or programs aimed at:

- Community-based lifestyle interventions to reduce

- Community-based lifestyle interventions to reduce health risks and promote self-management and
  - Fall prevention
  - Nutrition
  - Physical activity
  - Tobacco-use cessation
  - Social engagement
  - Weight loss
  wellness, including:
  - Cognition

9. Provide advance care planning (ACP) services at the patient's discretion

ACP is a discussion between you and the patient about:

- Preparing an advance directive in case an injury or illness prevents them from making their own health care decisions
- Future care decisions they might need or want to make
- How they can let others know about their care preferences
- Caregiver identification
- Advance directive elements, which may involve completing standard forms

Advance directive is a general term that refers to various documents, like a living will, instruction directive, health care proxy, psychiatric advance directive, or health care power of attorney. It's a document that appoints an agent or records a person's wishes about their medical treatment at a future time when the individual can't communicate for themselves. The Advance Care Planning (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf) fact sheet has more information.

We don't limit how many times the patient can revisit the ACP during the year, but cost sharing applies outside the AWV.

10. Review current opioid prescriptions

For a patient with a current opioid (https://www.cms.gov/priorities/key-initiatives/opioids) prescription:

- Review any potential OUD risk factors
- Evaluate their pain severity and current treatment plan
- Provide information about non-opioid treatment options
- Refer to a specialist, as appropriate

The HHS Pain Management Best Practices Inter-Agency Task Force Report (https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf) has more information. Medicare now covers monthly chronic pain management and treatment services (https://www.

11. Screen for potential substance use disorders (SUDs)

Review the patient's potential SUD risk factors, and as appropriate, refer them for treatment. You can use a screening tool, but it's not required. The National Institute on Drug Abuse (https://nida.nih.gov/nida med-medical-health-professionals/screening-tools-resources/char t-screening-tools) has screening and assessment tools. Implementing Drug and Alcohol Screening in Primary Care (https://alcoholdrugscreening.simmersion.com/) is a helpful resource (https://nida.nih.gov/sites/default/files/ni da_ctn_ehr_screen_tool_factsheet_508.pdf).

12. Social Determinants of Health (SDOH) Risk Assessment

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Preparing Eligible Patients for their AWV

Help eligible patients prepare for their AWV by encouraging them to bring this information to their appointment:

- Medical records, including immunization records
- Detailed family health history
- Full list of medications and supplements, including calcium and vitamins, and how often and how much of each they take
- Full list of current providers and suppliers involved in their care, including community-based providers (for example, personal care, adult day care, and home-delivered meals), and behavioral health specialists

AWV Coding, Diagnosis, & Billing

Coding

Use these HCPCS codes to file AWV claims:

G0438 Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit

G0439 Annual wellness visit, includes a personalized prevention plan of service

G0468*   Federally qualified health center (fqhc) visit, ippe or awv; a fqhc visit that includes an initial preventive physical examination (ippe) or annual wellness visit (awv) and includes a typical bundle of medicare-covered services that would be furnished per diem to a patient receiving an ippe or awv

* Section 60.2 of the [Medicare Claims Processing Manual, Chapter 9 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf#page=15)](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf#page=15) has more information on how to bill HCPCS code G0468.

Diagnosis

Report a diagnosis code when submitting AWV claims. We don't require you to use a specific AWV diagnosis code, so you may choose any diagnosis code consistent with the patient's exam.

Billing

Part B covers an AWV if performed by a:

- Physician (doctor of medicine or osteopathy)
- Qualified non-physician practitioner (physician assistant, nurse practitioner, or certified clinical nurse specialist)
- Medical professional (including health educator, registered dietitian, nutrition professional, or other licensed practitioner) or a team of medical professionals directly supervised by a physician

When you provide an AWV and a significant, separately identifiable, medically necessary evaluation and management (E/M) service, we may pay for the additional service. Report the additional CPT code (99202–99205, 99211–99215) with modifier 25. That portion of the visit must be medically necessary and reasonable to treat the patient's illness or injury or to improve the functioning of a malformed body part.

You can only bill G0438 or G0439 once in a 12-month period. G0438 is for the first AWV, and G0439 is for subsequent AWVs. Don't bill G0438 or G0439 within 12 months of a previous G0402 (IPPE) billing for the same patient. We deny these claims with messages indicating the patient reached the benefit maximum for the time period.

Medicare [telehealth (https://www.cms.gov/medicare/coverage/telehealth/list-services)](https://www.cms.gov/medicare/coverage/telehealth/list-services) includes HCPCS codes G0438 and G0439.

> **Advance Care Planning as an Optional Annual Wellness Visit Element**

ACP is the face-to-face conversation between a physician (or other qualified health care professional) and a patient to discuss their health care wishes and medical treatment preferences if they become unable to communicate or make decisions about their care. At the patient's discretion, you can provide the ACP during the AWV.

Coding

Use these CPT codes to file ACP claims as an optional AWV element:

99497   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; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

99498   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)

Diagnosis

Report a diagnosis code when submitting an ACP claim as an optional AWV element. We don't require you to use a specific ACP diagnosis code as an optional AWV element, so you may choose any diagnosis code consistent with a patient's exam.

Billing

We waive both the Part B ACP coinsurance and deductible when it's:
- Provided on the same day as the covered AWV
- Provided by the same provider as the covered AWV
- Billed with modifier 33 (Preventive Service)
- Billed on the same claim as the AWV

We waive the ACP deductible and coinsurance once per year when billed with the AWV. If we deny the AWV billed with ACP for exceeding the once-per-year limit, we'll apply the ACP deductible and coinsurance (https://www.medicare.gov/basics/costs/medicare-costs).

We apply the deductible and coinsurance when you deliver the ACP outside the covered AWV. There are no limits on the number of times you can report ACP for a certain patient in a certain period. When billing this service multiple times, document changes in the patient's health status or wishes about their end-of-life care.

Social Determinants of Health Risk Assessment as an Optional Annual Wellness Visit Element

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SDOH is important in assessing patient histories; in assessing patient risk; and in guiding medical decision making, prevention, diagnosis, care, and treatment. In the CY 2024 Medicare Physician Fee Schedule final rule (https://www.federalregister.gov/documents/2023/11/16/2023-24184/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other#h-512), we added a new SDOH Risk Assessment as an optional, additional element of the AWV. At both yours and the patient's discretion, you may conduct the SDOH Risk Assessment during the AWV.

Coding

Use this HCPCS code to file SDOH Risk Assessment claims as an optional AWV element:

G0136   Administration of a standardized, evidence-based social determinants of health risk assessment tool, 5-15 minutes

Diagnosis

Report a diagnosis code when submitting an SDOH Risk Assessment claim as an optional AWV element. We don't require you to use a specific SDOH Risk Assessment diagnosis code as an optional AWV element, so you may choose any diagnosis code consistent with a patient's exam.

Billing

The implementation date for SDOH Risk Assessment claims is July 1, 2024. We waive both the Part B SDOH Risk Assessment coinsurance and deductible when it's:

- Provided on the same day as the covered AWV
- Provided by the same provider as the covered AWV
- Billed with modifier 33 (Preventive Service)
- Billed on the same claim as the AWV

We waive the SDOH Risk Assessment [deductible and coinsurance (https://www.medicare.gov/basics/costs/medicare-costs)](https://www.medicare.gov/basics/costs/medicare-costs) once per year when billed with the AWV.

If we deny the AWV billed with SDOH Risk Assessment for exceeding the once-per-year limit, we'll apply the deductible and coinsurance. We also apply the deductible and coinsurance when you deliver the SDOH Risk Assessment outside the covered AWV.

AWV Resources

- [42 CFR 410.15 (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-410/subpart-B/section-410.15)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-410/subpart-B/section-410.15)
- [Section 30.6.1.1 of the Medicare Claims Processing Manual, Chapter 12 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf#page=30)](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf#page=30)
- [Section 140 of the Medicare Claims Processing Manual, Chapter 18 (https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c18pdf.pdf#page=161)](https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c18pdf.pdf#page=161)
- [U.S. Preventive Services Task Force Recommendations (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations)](https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations)

AWV FAQs

> **Is the AWV the same as a patient's yearly physical?**

No. The AWV isn't a routine physical some patients may get periodically from their physician or other qualified NPP. **We don't cover routine physical exams.**

> **Does the deductible, coinsurance, or copayment apply for the AWV?**

No. We waive the coinsurance, copayment, and Part B deductible for the AWV.

> **Who's eligible for the AWV?**

We cover an AWV for all patients who've had Medicare coverage for longer than 12 months after their first Part B eligibility date and who didn't have an IPPE or AWV within those past 12 months. **We cover only 1 IPPE per patient per lifetime and 1 additional AWV every 12 months after the date of the patient's last AWV (or IPPE).** [Check eligibility (https://www.cms.gov/files/document/mln8816413-checking-medicare-eligibility.pdf)](https://www.cms.gov/files/document/mln8816413-checking-medicare-eligibility.pdf) to find when a patient is eligible for their next preventive service.

> **Are clinical lab tests part of the IPPE or AWV?**

No. The IPPE and AWV don't include clinical lab tests, but you may make appropriate referrals for these tests as part of the IPPE or AWV.

> **Can I bill an AWV and an electrocardiogram on the same date of service?**

Generally, you may provide other medically necessary services on the same date as an AWV. The [deductible and coinsurance or copayment (https://www.medicare.gov/basics/costs/medicare-costs)](https://www.medicare.gov/basics/costs/medicare-costs) applies for these other medically necessary and reasonable services.

> **How do I know if a patient already got their first AWV from another provider and whether to bill for a subsequent AWV even though this is the first AWV I provided to this patient?**

You have different options for accessing AWV eligibility information depending on where you practice. [Check eligibility (https://www.cms.gov/files/document/mln8816413-checking-medicare-eligibility.pdf)](https://www.cms.gov/files/document/mln8816413-checking-medicare-eligibility.pdf) to find when a patient is eligible for their next preventive service. Find your [MAC's website (https://www.cms.gov/MAC-info)](https://www.cms.gov/MAC-info) if you have specific patient eligibility questions.

Know the Differences

[IPPE (#IPPE)](#IPPE)

An IPPE is a review of a patient's medical and social health history and includes education about other [preventive services (https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html)](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html).

- We cover 1 IPPE per lifetime for patients within the first 12 months after their Part B benefits eligibility date
- We pay IPPE costs if the provider accepts assignment

[AWV (#AWV)](#AWV)

An AWV is a review of a patient's personalized prevention plan of services and includes a health risk assessment.

- We cover an annual AWV for patients who aren't within the first 12 months after their Part B benefits eligibility date
- We cover an annual AWV 12 months after the last AWV's (or IPPE's) date of service
- We pay AWV costs if the provider accepts assignment

[Routine Physical Exam (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c16.pdf#page=26)](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c16.pdf#page=26)

A routine physical is an exam performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.

- We don't cover routine physical exams, but the IPPE, AWV, or other Medicare benefits cover some routine

- We don't cover routine physical exams, but the IPPE, AWV, or other Medicare benefits cover some routine physical elements
- Patients pay 100% out of pocket

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