

ANNUAL WELLNESS VISIT (AWV)

1. Information here pertains to Medicare only. Medicaid and private payer guidelines and codes may vary.
2. Medicare Advantage Plan patients are entitled to the same benefits, but may be required to stay in a MAP provider network to prevent or keep low copays or payments on deductibles.

Minimum Content – (Initial AWV establishes this info, Subsequent AWVs update it all.)

Current and past family & medical hx, including meds & supplements, mental, functional and safety assessment **including Pt's own health risk assessment done before or during visit.** List current health care team members, Set a screening schedule, List risk factors that are being or can be addressed through interventions, list treatment options. Provide personalized health advice and refer to health education and preventive services as appropriate. For more detail, see *The ABCs of the Annual Wellness Visit.* *

ICD-10 Codes	Any appropriate billable code is accepted. See the ICD-10-CM Tabular List of Diseases and Injuries in the latest ICD-10-CM Official Codes book as there are many notes to be adhered to for choosing a billable code. See also Chap 21 (Z00-Z99). Z00-Z99 are reasons for encounters that are not diagnoses or problems as listed in codes like A00-Y89. For further guidance, check with your *MAC
*MAC = Medicare Administrative Contractor	
HHPCPS/CPT Codes	Initial and Annual Medicare Wellness Exam Codes (G0402,G0438,G0439) <ul style="list-style-type: none"> • Cannot be billed within first 12 months after patient's effective date of Part B coverage • Cannot be billed within 12 months of previous billing of G0402, G0438, G0439 for same patient • If necessary E/M service (to treat illness or injury, or to improve function of malformed body part) done in same visit, 99201-99215 with -25 modifier may also be billed, & E/M service applies to deductible & coinsurance
Eligible Providers	Physician (MD or DO), PA, NP, CNS, or medical professional (such as registered dietitian, health educator, social worker, pharmacist) or team of such medical professionals working under the direct supervision/coordination of an MD or DO. All billing is done under supervising physician
Locations	Primary care, telehealth for CMS rural areas
Beneficiary Eligibility Criteria	Beneficiary who: <ul style="list-style-type: none"> • Is not in the first 12 months of his/her first Part B coverage period and • Has not received the Initial Preventive Physical Exam (IPPE) or AWV within the past 12 months
Frequency	Initial is once per lifetime. Subsequent is annually
Restrictions or Exceptions	Use validated Health Risk Assessments (HRAs) as provider deems appropriate
Beneficiary Pays	No copay and not applied to deductible

REFERENCE:

The ABCs of the Annual Wellness Visit, Medicare Learning Network, ICN 905706, January 2015.

