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Medicare Wellness Visits

Early detection saves lives. Encourage patients to get their preventive services.

What's Changed?

Note: No substantive content updates.

Quick Start

The Annual Wellness Visits video (https://www.youtube.com/watch?v=r7yOUaMJyJU&feature=youtu.be) helps health care professionals understand these exams and their purpose, and the requirements when submitting claims for them.

Medicare Physical Exams Coverage

Initial Preventive Physical Exam (IPPE) (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-410#410.16)

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

✓ New Medicare patients within 12 months of first Part B coverage period

✓ Patients pay nothing (if provider accepts assignment)

Annual Wellness Visit (AWV) (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-410/subpart-B/section-410.15)

Visit to develop or update a Personalized Prevention Plan (PPP) and perform a Health Risk Assessment (HRA).

✓ Covered once every 12 months

✓ Patients pay nothing (if provider accepts assignment)

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

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

✗ Medicare doesn't cover a routine physical (it's prohibited by statute (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-411)), but the IPPE, AWV, or other Medicare benefits cover certain routine physical elements

✗ 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/About-CMS/Agency-Information/OMH):

- Health Equity Technical Assistance Program (https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/Health-Equity-Technical-Assistance)
- Disparities Impact Statement (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 patients get services more often than we cover, including the AWV, or you may recommend services we don't cover. If this happens, help patients understand they may pay some or all costs. Communication is key to ensuring patients understand why you're recommending certain services, and whether we pay for 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 patient IPPE per lifetime **no later than the first 12 months after the patient's Part B benefits eligibility date.**

IPPE Components	
1. Review patient's medical and social history	At a minimum, collect this information: • Past medical and surgical history (illness experiences, hospital stays, operations, allergies, injuries, and treatments) • Current medications and supplements (including calcium and vitamins) • Family history (review patient's family and medical events, including hereditary conditions that place them at increased risk) • Diet • Physical activities • Alcohol, tobacco, and illegal drug use history SBIRT Services (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/SBIRT_Factsheet_ICN904084.pdf) booklet has more information about Medicare substance use disorder (SUD) services coverage.
2. Review patient's potential depression risk factors, including current or past experiences with depression or other mood disorders	Select from various standardized screening tools designed for this purpose and recognized by national professional medical organizations. Depression Assessment Instruments (https://www.apa.org/depression-guideline/assessment) webpage has more information.

3. Review patient's functional ability and safety level	Use direct patient observation, or appropriate screening questions or standardized questionnaires recognized by national professional medical organizations, to review, at a minimum, these areas: • Ability to perform activities of daily living (ADLs) • Fall risk • Hearing impairment • Home safety
4. Exam	Measure: • Height, weight, body mass index (BMI) (or waist circumference, if appropriate), and blood pressure • Visual acuity screen • Other factors deemed appropriate based on medical and social history and current clinical standards
5. End-of-life planning, on patient agreement	End-of-life planning is verbal or written information offered to the patient about: • Their ability to prepare an advance directive in case an injury or illness prevents them from making health care decisions • If you (their physician or practitioner) agree to follow their advance directive
6. Review current opioid prescriptions	For a patient with a current opioid prescription: • Review any potential opioid use disorder (OUD) risk factors • Evaluate their pain severity and current treatment plan • Provide non-opioid treatment options information • Refer to a specialist, as appropriate 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.
7. Screen for potential substance use disorders (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. National Institute on Drug Abuse Screening and Assessment Tools Chart (https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools) has screening and assessment tools.
8. Educate, counsel, and refer based on previous components	Based on the review and evaluation services results in the previous components, provide 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: • Once-in-a-lifetime screening electrocardiogram (ECG), as appropriate • Appropriate screenings and other preventive services we cover

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 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

You must 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 (NPP) (physician assistant [PA], nurse practitioner [NP], or certified clinical nurse specialist [CCNS])

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 (99201–99215) 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.

Annual Wellness Visit Health Risk Assessment

The Annual Wellness Visit (AWV) includes a Health Risk Assessment (HRA). See the HRA minimum elements summary below. A Framework for Patient-Centered Health Risk Assessments (https://www.cdc.gov/policy/hst/HRA/FrameworkForHRA.pdf) booklet has more information, including a sample HRA.

First Annual Wellness Visit Components

Perform Health Risk Assessment (HRA)

- Get patient self-reported information
  - You or the patient can update the HRA before or during the AWV; it shouldn't take more than 20 minutes
- Consider the best way to communicate with underserved populations, people with limited English proficiency, health literacy needs, 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, 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, grooming; physical ambulation, including balance or fall risks and bathing; and instrumental ADLs (IADLs), including using the phone, housekeeping, laundry, mode of transportation, shopping, managing medications, and handling finances

1. Establish 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 (illness experiences, hospital stays, operations, allergies, injuries, and treatments)
- Use of, or exposure to, medications and supplements, including calcium and vitamins

2. Establish current providers and suppliers list

Include current patient providers and suppliers that regularly provide medical care, including behavioral 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 impairment patients may have

Assess cognitive function by direct observation, considering information from the patient, family, friends, caregivers, and others. Consider using a brief cognitive test, 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/alzheimers-dementia-resources-for-professionals) webpage has more information.

5. Review patient's potential depression risk factors, including current or past experiences with depression or other mood disorders

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

6. Review patient's functional ability and level of safety

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

- Ability to perform ADLs
- Fall risk
- Hearing impairment
- Home safety

7. Establish an appropriate patient written screening schedule, like a checklist for the next 5–10 years

Base written screening schedule on the:

- United States Preventive Services Task Force (https://www.uspreventiveservicestaskforce.org) 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 we cover

8. Establish patient's list of risk factors and conditions where you recommend primary, secondary, or tertiary interventions or report whether they're underway

Include:

- Mental health conditions, including depression, substance use disorder(s) (https://www.samhsa.gov/find-help/disorders), and cognitive impairment
- 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
  - Weight loss

  wellness, including:
  - Cognition

10. Provide Advance Care Planning (ACP) services at patient's discretion

ACP is a discussion between you and the patient about:

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

Advance directive is a general term referring 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. Advance Care Planning (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf) fact sheet has more information.

11. Review current opioid prescriptions

For a patient with a current opioid prescription:

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

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.

12. Screen for potential substance use disorders (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. National Institute on Drug Abuse Screening and Assessment Tools Chart (https://nida.nih.gov/nidamed-medical-health-professionals/screening-too

ls-resources/chart-screening-tools) has screening and assessment tools.

Subsequent Annual Wellness Visit Components

1. Review and update Health Risk Assessment (HRA)

- Get patient self-reported information
  - You or the patient can update the HRA before or during the AWV; it shouldn't take more than 20 minutes
- 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, 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, grooming; physical ambulation, including balance or fall risks and bathing; and instrumental ADLs (IADLs), including using the phone, housekeeping, laundry, mode of transportation, shopping, managing medications, and handling finances

2. Update patient's medical and family history

At a minimum, update and 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 (illness experiences, hospital stays, operations, allergies, injuries, and treatments)
- Use of, or exposure to, medications and supplements (including calcium and vitamins)

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) and blood pressure
- Other routine measurements deemed appropriate based on medical and family history

5. Detect any cognitive impairment patients may have

Assess cognitive function by direct observation, considering information from the patient, family, friends, caregivers, and others. Consider using a brief cognitive test, 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/alzheimers-dementia-resources-for-professionals) webpage has more information.

6. Update patient's written screening schedule

Base written screening schedule on the:

- United States Preventive Services Task Force (https://www.uspreventiveservicestaskforce.org/) 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 we cover

7. Update patient's list of risk factors and conditions where you recommend primary, secondary, or tertiary interventions or report whether they're underway

Include:

- Mental health conditions, including depression, substance use disorder(s) (https://www.samhsa.gov/find-help/disorders), and cognitive impairment
- 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 health risks and promote self-management and
  - Fall prevention
  - Nutrition
  - Physical activity
  - Tobacco-use cessation
  - Weight loss
- wellness, including:
  - Cognition

9. Provide Advance Care Planning (ACP) services at patient's discretion

ACP is a discussion between you and the patient about:

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

Advance directive is a general term referring 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. Advance Care Planning (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf) fact sheet has more information.

10. Review current opioid prescriptions

For a patient with a current opioid prescription:

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

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.

11. Screen for potential substance use disorders (SUDs)

Review the patient's potential SUD risk factors and, as appropriate, refer them to treatment. You may use a screening tool, but it's not required. National Institute on Drug Abuse Screening and Assessment Tools Chart (https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools) has screening and assessment tools.

Preparing Eligible Patients for the Annual Wellness Visit

Providers can 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 (pps), subsequent visit
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 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

You must 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 (NPP) (physician assistant [PA], nurse practitioner [NP], or certified clinical nurse specialist [CCNS])
- Medical professional (including health educator, registered dietitian, nutrition professional, or other licensed practitioner), or a team of medical professionals that a physician directly supervises

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 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. Remember, you must not bill G0438 or G0439 within 12 months of a previous G0402 (IPPE) billing for the same patient. We deny these claims with messages of, "Benefit maximum for this time period or occurrence has been reached" and "Consult plan benefit documents/guidelines for information about restrictions for this service."

Medicare telehealth includes HCPCS codes G0438 and G0439. List of Telehealth Services (https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes) webpage has more information.

Advance Care Planning as an Optional Annual Wellness Visit Element

Advance Care Planning (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

You must 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:

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

IPPE, AWV, & Routine Physical: Know the Differences

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

- The IPPE, also known as the **Welcome to Medicare Preventive Visit**, promotes good health through disease prevention and detection
- We pay for 1 patient IPPE per lifetime no later than the first 12 months after the patient's Part B benefits eligibility date
- We pay IPPE costs if the provider accepts assignment

AWV (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-410/subpart-B/section-410.15)

We cover an AWV that delivers Personalized Prevention Plan Services (PPPS) for patients who:

- Aren't within 12 months after the patient's first Part B benefits eligibility date
- Didn't get an IPPE or AWV within the past 12 months
- 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)

- Exam performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury
- We don't cover a routine physical (it's prohibited by statute (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-411)), but the IPPE, AWV, or other Medicare benefits cover some routine physical elements
- Patient pays 100% out-of-pocket

FAQs

What are other Medicare Part B preventive services?

- Advance Care Planning (ACP) as an Optional AWV Element
- Alcohol Misuse Screening & Counseling
- Bone Mass Measurements
- Cardiovascular Disease Screening Tests
- Cervical Cancer Screening
- Colorectal Cancer Screening
- Counseling to Prevent Tobacco Use
- Depression Screening
- Diabetes Screening
- Diabetes Self-Management Training
- Flu, Pneumococcal, & Hepatitis B Shots and their Administration
- Glaucoma Screening
- Hepatitis B Screening
- Hepatitis C Screening
- HIV Screening
- Intensive Behavioral Therapy (IBT) for Cardiovascular Disease
- IBT for Obesity
- Lung Cancer Screening
- Mammography Screening
- Medical Nutrition Therapy
- Medicare Diabetes Prevention Program
- Pap Tests Screening
- Prolonged Preventive Services
- Prostate Cancer Screening
- Sexually Transmitted Infections (STIs) Screening & High Intensity Behavioral Counseling (HIBC) to Prevent STIs
- Screening Pelvic Exam
- Ultrasound Abdominal Aortic Aneurysm (AAA) Screening

Medicare Preventive Services (https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html) educational tool has more information.

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

No. The IPPE isn't a routine physical that some older adults may get periodically from their physician or other qualified non-physician practitioner (NPP). The IPPE is an introduction to Medicare and covered benefits, and focuses on health promotion, disease prevention, and detection to help patients stay well. We encourage providers to inform patients about the AWV and perform such visits. **The Social Security Act explicitly prohibits Medicare coverage of routine physical exams.**

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

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

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

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

If a patient enrolls in Medicare in 2022, can they get the IPPE in 2023 if it wasn't performed in 2022?

An eligible 2022 patient who hasn't had an IPPE and whose initial enrollment in Part B began in 2022, can get an IPPE in 2023 if it's within 12 months of the patient's first 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).

Who's eligible for the AWV?

We cover an AWV for all patients who aren't within 12 months after the eligibility date for their first Part B benefit period and who didn't have an IPPE or an AWV within the past 12 months. **We pay for only 1 IPPE per patient per lifetime and 1 additional AWV per year thereafter.**

Can I bill an electrocardiogram (ECG) and the AWV 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 (https://www.medicare.gov/basics/costs/medicare-costs) or copayment apply 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. Get the information through the Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS) (https://www.cms.gov/research-statistics-data-and-systems/cms-information-technology/hetshelp) or the provider call center interactive voice responses (IVRs). Checking Medicare Eligibility (https://www.cms.gov/files/document/checking-medicare-eligibility.pdf) fact sheet has more information. Find your MAC's website (https://www.cms.gov/MAC-info) if you have specific patient eligibility questions.

Resources

- AWV: Section 280.5 of Medicare Benefit Policy Manual, Chapter 15 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf#page=260)
- AWV: Section 140 of Medicare Claims Processing Manual, Chapter 18 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf#page=148)
- AWV & IPPE: Medicare Claims Processing Manual, Chapter 12 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf#page=31)
- AWV & IPPE: Medicare Diabetes Prevention Program Expanded Model (https://innovation.cms.gov/innovation-models/medicare-diabetes-prevention-program)
- CMS Opioid Resources (https://www.cms.gov/About-CMS/Agency-Information/OMH/resource-center/hcps-and-researchers/Opioid-Resources-Page)
- IPPE: Section 80 of Medicare Claims Processing Manual, Chapter 18 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf#page=123)