



How to Bill Medicare's Annual Wellness Visit

Diagnosis code	V70.0
Initial Annual Wellness Visit	G0438
Subsequent Annual Wellness Visit	G0439

Medicare will pay a physician for an AWW service and a medically necessary service, e.g. a mid-level established office visit, Current Procedural Terminology (CPT) code 99213, furnished during a single beneficiary encounter. It is important that the elements of the AWW not be replicated in the medically necessary service. Physicians must append **modifier -25 (significant, separately identifiable service)** to the medically necessary E/M service, e.g. 99213-25, to be paid for both services. For example, for the patient who comes in for his Annual Wellness Visit and complains of tendonitis, here's how you would bill it:

<u>CPT</u>	<u>ICD9</u>
G0438	V70.0
99212-25	726.90 (tendonitis)

Until Medicare publishes documentation guidelines, practices should check with their local carrier for further information. Otherwise it is recommended that practices use ACP resources provided, including the Practice Checklist, Patient Explanation Letter, and the Patient Annual Wellness Visit Report of risk factors, referrals, and screening schedule.