Annual Wellness Visit sooner than 11 months following Initial (IPPE) Policy

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In a conflict, federal and state guidelines, as applicable, and the member's benefit plan document supersede the information in this policy. Also, to the extent of conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval. If there is a state exception, please refer to the state exception table listed below.

Policy Overview

Initial Preventative Physical Examination (IPPE) Claims (HCPCS: G0402)

- IPPE claims must be billed within 12 months after the start of the patient's first part B coverage.
- Each patient is eligible for only one IPPE claim in their lifetime.

Initial Annual Wellness Visit (AWV) Claims (HCPCS: G0438)

- The initial AWV includes a Personalized Prevention Plan Service (PPPS).
- An initial AWV claim cannot be submitted within 12 months of an IPPE (G0402) for the same patient.

Subsequent Annual Wellness Visit (AWV) Claims (HCPCS: G0439)

- Subsequent AWV claims are not permitted within 12 months of an initial AWV (G0438).
- A subsequent AWV cannot be billed within 12 months of an IPPE (G0402).

Please note that an Annual Wellness Visit (AWV) is different from an annual physical exam.

Reimbursement Guidelines

Molina Healthcare mandates thorough documentation of medical necessity and accurate diagnosis codes for the reimbursement of specific procedures. Claims lacking supporting evidence of medical necessity or correct diagnosis codes will not contribute to the final claim payment calculation.

To comprehend coverage guidelines, limitations, and medical necessity criteria, please consult the reference document: Medicare Wellness Visit

For successful reimbursement, you must pair the following procedure codes with one of the diagnosis codes listed in Section 2 of the referenced document: Chapter 12 Medicare Claims Processing Manual

Incorrectly billed claims may face denial or potential recovery. Rates are set based on the applicable fee schedule or the provider contract agreement.

Molina Healthcare retains the right to audit all claim payments and recover any overpaid amount

identified, based on contractual rates.

Supplemental Information

Definitions

Term	Definition
AWV	Annual Wellness Visit
CMS	Center for Medicare and Medicaid
HCPCS	Healthcare Common Procedure Coding System
IPPE	Initial Preventative Physical Examination

State Exceptions

State	Exception
TX	Adhere to Texas Health Steps Periodicity Schedule for guidelines and exemptions for wellness visits.

Documentation History

Type	Date	Action
Initial Creation Date	10/23/2023	New Policy
Revised Date	12/12/2024	Reviewed Links
Revised Date	7/30/2025	Updated Template

References

This policy was developed using:

• CMS
• State Medicaid Regulatory Guidance
• State Contracts

Reference	Link
CMS	MLN6775421 – Medicare Wellness Visits
CMS	Ch 12 Medicare Claims Processing Manual
CMS	CH 15 Medicare Policy Manual - Section 280.5
CMS	Ch 18 Medicare Claims Processing Manual
TX	Texas Health Steps Medical Checkup Periodicity Schedule for Infants, Children, and Adolescents
TX	Texas Health Steps Quick Reference Guide

***CODING DISCLAIMER**. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is*

included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.