Priority Health	BILLING POLICY No. 064
MEDICARE ANNUAL WELLNESS VISIT / PREVENTIVE CARE VISITS	
Date of origin: Dec. 26, 2024	**Review dates: 2/2025, 5/2025, 5/2026, 07/2026**

DEFINITION

Priority Health plan members have no member cost-sharing for preventive services rendered by in-network providers. Members may be required to pay a copayment, deductible, or coinsurance for non-preventive services received in conjunction with a preventive service visit.

POLICY SPECIFIC INFORMATION

Welcome to Medicare visit / Initial preventive physical exam (IPPE)

Physicals performed when the member is new to Medicare, in addition to annual physical exams.

Limit:

- Once per lifetime
- Must be used within 12 months of Medicare effective date

Codes:

- G0402* – Welcome to Medicare visit (initial visit)
- G0403 – EKG with Welcome to Medicare visit
- G0404 – EKG tracing for Welcome to Medicare visit
- G0405 – EKG interpretations & report for Welcome to Medicare visit

*Note: Priority Health doesn't reimburse for a Welcome to Medicare visit (G0402) when performed on the same date as other preventive medicine exams and services.

Annual wellness visit (AWV)

Yearly appointment for members who have not already received a Welcome to Medicare or annual wellness visit in the previous calendar year.

Limit:

- G0438 – Once per lifetime
- G0439 – Once per calendar year

Codes:

- G0438 – Initial annual wellness visit
- G0439 – Subsequent annual wellness visit

"Free to talk" annual preventive physical exams

Supplemental benefit offered by Priority Health Medicare. This preventive physical exam may be performed in conjunction with an annual wellness exam. The member will pay $0 for both visits if done on the same day.

Limit:

- Once per calendar year

Codes:

- Preventive medicine codes
  - 99381-99387: new patient
  - 99391-99397: established patient
- Any labs/tests/etc. ordered as a result of this visit will follow the normal copay structure.

Note: Verify members haven't already had an annual wellness or preventive physical exam from their primary care physician to avoid duplicate, non-medically necessary services.

Modifier:

- Modifier 52: Use modifier 52 to report a preventive physical exam given on the same day as an annual wellness exam.

Advanced care planning
See our Advance care planning billing policy.

Place of service

- Primary care setting

Related denial language
Prism explanation code: **pf1 – Code previously billed/paid on fac claim**

RESOURCES
See the Medicare Learning Article, *Medicare Wellness Visits*, for further billing guidelines.

DISCLAIMER
CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 14, 2025	Added "Disclaimer" section
May 13, 2025	Added "Related denial language" section and included prism explanation code pf1 – Code previously billed/paid on fac claim
May 11, 2026	G0439 was updated to "once in a 12-month period" from "once in a calendar year"
July 8, 2026	G0439 was updated to "Once per calendar year" from "Once in a 12-month period"