2024 Medicare Advantage preventive screening guidelines

Coding procedures

The following coding procedures for UnitedHealthcare® Medicare Advantage plans in 2024 can help you determine the appropriate submission codes for covered preventive services. For more information about the Centers for Medicare & Medicaid Services (CMS) policies that define the procedures, and to determine if a service is covered by Medicare, please click on the appropriate link in the following list:

- **Medicare Physician Fee Schedule**
- **CMS Internet-Only Manuals (IOM)**
- **CMS National Correct Coding Initiative (NCCI)**
- **CMS Medicare Coverage Database (NCD/LCD Lookup)**
- **CMS Preventive Services Guide**

A note about cost-sharing

All references to cost-sharing for out-of-network care providers apply only to UnitedHealthcare Medicare Advantage PPO, RPPO and POS plans with out-of-network coverage. UnitedHealthcare Medicare Advantage Private Fee-For-Service plans don't have provider networks. For these plans, the in-network cost-sharing is shown in the following table.

Wellness visits/routine physicals

Service	Covered by	Copayment	Visit frequency	Submission codes
Welcome to Medicare visit Initial preventive physical exam (IPPE)	• Original Medicare • UnitedHealthcare Medicare Advantage plans when performed by the member's primary care provider (PCP)	• $0 in network • A copay or coinsurance may apply if a member uses an out-of-network benefit, if available	Within the first 12 months of Medicare Part B (once per lifetime benefit)	• G0402*
Annual wellness visit Personalized prevention plan services (PPPS)	• Original Medicare • UnitedHealthcare Medicare Advantage plans when performed by the member's PCP	• $0 in network • A copay or coinsurance may apply if a member uses an out-of-network benefit, if available	Every calendar year (visits do not need to be 12 months apart)	• G0438* (first visit) • G0439* (subsequent visit)
Annual routine physical exam	• UnitedHealthcare Medicare Advantage plans when performed by the member's PCP • Not covered by Original Medicare	• $0 in network • A copay or coinsurance may apply if a member uses an out-of-network benefit, if available	Every calendar year (visits do not need to be 12 months apart)	• 99385, 99386, 99387 • 99395, 99396, 99397

***FQHC:** A Welcome to Medicare visit or an annual wellness visit performed in a Federally Qualified Health Center (FQHC) is payable under the FQHC prospective payment system (PPS). Code G0468 must be accompanied by qualifying visit code G0402, G0438 or G0439. Note that not all FQHCs are contracted as an FQHC with UnitedHealthcare. Please check your UnitedHealthcare contract to determine if this pertains to your facility.

Notes

- See the **Types of office visits** section for specific services to be provided during each type of visit
- Annual routine physical exam coverage: If you bill the 99XXX codes for these services, you must provide a head-to-toe exam and can't bill for a separate breast and pelvic exam, digital rectal exam or counseling to promote healthy behavior. See the "Types of office visits" section for a list of the specific components included in the visit.
- The annual wellness visit (AWV) is a yearly appointment with a Medicare beneficiary's PCP to create or update a PPPS. This plan may help prevent illness based on current health and risk factors. An AWV is not a physical exam. Therefore, it is incorrect to report a Z00.0- code with an AWV.
- Members may receive either the Welcome to Medicare Visit or AWV, along with the annual routine physical exam, on the same day from the same PCP, as long as all components of both services are provided and fully documented in the medical record. Please don't submit either of these 2 visits with a -25 modifier.
- When you perform a separately identifiable, medically necessary Evaluation and Management (E/M) service, in addition to the IPPE, annual routine physical exam or AWV, you may also bill CPT® codes 99202–99215 reported with modifier -25. When medically indicated, this additional E/M service is subject to the applicable copayment for an office visit. Any additional services provided are subject to applicable cost-sharing. See **CMS National Correct Coding Initiative (NCCI).**
- Coverage for an annual routine physical exam under Medicare Advantage employer group plans may vary.

Additional services

Only the codes listed on the "wellness visits/routine physicals" chart above are included in the $0 copayment for wellness visits. If you also bill other services with the visit, and those services are normally subject to a copayment or coinsurance, that copayment or coinsurance applies, even if the primary reason for the visit was for a wellness visit or routine physical exam.

Service	Covered by	Copayment	Visit frequency
Abdominal aortic aneurysm screening	• Original Medicare • UnitedHealthcare Medicare Advantage plans	• $0 in network • A copay or coinsurance may apply if a member uses an out-of-network benefit, if available	One time only for at-risk members when a referral for the screening is received as a result of the wellness visit
Advanced care planning	• Original Medicare • UnitedHealthcare Medicare Advantage plans	• $0 in network • A copay or coinsurance may apply if a member uses an out-of-network benefit, if available	Can be performed at the time of the wellness visit or outside of the annual wellness visit, as necessary
Electrocardiogram screening	• Original Medicare • UnitedHealthcare Medicare Advantage plans	Subject to member cost-sharing in most plans	One time only when provided during the Welcome to Medicare visit
Any clinical laboratory tests or other diagnostic services CMS recognizes and defines as medically necessary rather than preventive	• Original Medicare • UnitedHealthcare Medicare Advantage plans	Subject to member cost-sharing in most plans	As medically necessary

Service	Covered by	Copayment	Visit frequency	Submission codes
Pap/pelvic exam including pelvic exam and/or Pap collection	• Original Medicare • UnitedHealthcare Medicare Advantage plans	• $0 in network • A copay or coinsurance may apply if a member uses an out-of-network benefit, if available	• Every calendar year for those at high risk (visits do not need to be 12 months apart) • Every 2 calendar years for women not considered high risk (visits do not need to be 24 months apart)	• Exam: G0101 • You may bill a separate E/M code only if you provided a separately identifiable E/M service • When a member sees an obstetrician or gynecologist who isn't their assigned PCP for a routine Pap/pelvic exam, only the Medicare-covered annual Pap/pelvic service should be performed and billed. Please refer members to their assigned PCP if a more comprehensive preventive service is needed.

Types of office visits

Welcome to Medicare visit

A one-time preventive E/M service that includes the following:

1. Review of a patient's medical and social history, including past medical and surgical history, current medications and supplements, family history, diet, physical activities and history of substance use
2. Review of a patient's potential risk factors for depression
3. Review of a patient's functional ability and safety level, including hearing impairment, activities of daily living (ADLs), fall risk and home safety
4. An exam with height, weight, body mass index, blood pressure, visual acuity and other measurements
5. End-of-life planning assistance, such as an advance directive, with a patient's consent
6. Review current opioid prescriptions
7. Screen for potential substance use disorders (SUDs)
8. Education, counseling and referral, based on the results of numbers 1–7 in this list
9. Education, counseling and referral, including a brief written plan for obtaining a screening EKG, as appropriate, and other appropriate screenings and/or Medicare Part B preventive services

Annual wellness visit

Allows the physician and patient to develop or update a personalized prevention plan. During the visit, the provider will:

1. Perform or review patient Health Risk Assessment (HRA), including demographic data, health status self-assessment, psychosocial and behavioral risks, ADLs and instrumental ADLs (IADLs).
2. Establish or update record of patient's medical and family history, including medical events of patient's family that pose increased risk, past medical and surgical history, and use of medications and supplements
3. Establish or update list of patient's current medical care providers and suppliers
4. Measure height, weight, body mass index (BMI), blood pressure and other routine measurements
5. Detect any cognitive impairment
6. Review potential depression risk factors, including current or past experiences with depression or other mood disorders (not included in subsequent AWV; can be provided and billed separately)
7. Review functional ability and level of safety

8. Establish or update screening schedule for the next 5–10 years, as appropriate
9. Establish or update list of patient's risk factors and conditions where primary, secondary or tertiary interventions are recommended or underway, including mental health conditions such as depression, SUD(s) and cognitive impairment
10. Provide or update personalized health advice and appropriate referrals to health education or preventive counseling services or programs to reduce health risks and promote self-management and wellness, including fall prevention, nutrition, physical activity, tobacco-use cessation, weight loss and cognition
11. Provide Advance Care Planning (ACP) services, such as advance directive preparation, at patient's discretion (Note: This is an optional component)
12. Review current opioid prescriptions
13. Screen for potential SUDs

Pap/pelvic exam

Well-woman exams with or without specimen collection for smears and cultures should include at least 7 of the following:

1. Inspection and palpation of breasts for masses or lumps, tenderness, symmetry or nipple discharge
2. Digital rectal examination, including sphincter tone and presence of hemorrhoids or rectal masses
3. Examination of external genitalia – For example, general appearance, hair distribution or lesions
4. Examination of urethral meatus – For example, size, location, lesions or prolapse
5. Examination of urethra – For example, masses, tenderness or scarring
6. Examination of bladder – For example, fullness, masses or tenderness
7. Examination of vagina – For example, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele or rectocele
8. Examination of cervix – For example, general appearance, lesions or discharge
9. Examination of uterus – For example, size, contour, position, mobility, tenderness, consistency, descent or support
10. Examination of adnexa/parametria – For example, masses, tenderness, organomegaly or nodularity
11. Examination of anus and perineum

Annual routine physical exam

This comprehensive physical examination screens for disease, promotes a healthy lifestyle and assesses a patient's potential risk factors for future medical problems. It includes the components listed below. Any clinical laboratory tests or other diagnostic services performed at the time of the wellness visit may be subject to a copay or coinsurance.

1. Health history
2. Vital signs
3. General appearance
4. Heart exam
5. Lung exam
6. Head and neck exam
7. Abdominal exam
8. Neurological exam
9. Dermatological exam
10. Extremities exam
11. Male physical exam (if deferred, document reason) a. Testicular, hernia, penis and prostate exams
12. Female physical exam (if deferred, document reason) a. Breast and pelvic exams
13. Counseling to include healthy behaviors and screening services

You may not bill separate codes for components with 99385, 99386, 99387, 99395, 99396 or 99397. Payment for these codes includes reimbursement for all services listed.

Common preventive services and screenings

All UnitedHealthcare Medicare Advantage plans cover the following Medicare-covered preventive services at the same frequency as covered by Original Medicare, except where otherwise noted, for a $0 copay with a network provider. All preventive services can be provided any time during the calendar year in which the member is eligible to receive the service. In general, screening lab work isn't covered by Medicare and therefore not covered by UnitedHealthcare Medicare Advantage plans. The exceptions are listed in the following list of commonly covered preventive services and screenings.

- Alcohol misuse screening and counseling
- Bone mass measurement for those at high risk
- Cardiovascular disease screening tests
- Colorectal cancer screening[1]
- Counseling to prevent tobacco use
- Depression screening
- Diabetes screening
- Diabetes self-management training
- Glaucoma screening for those at high risk[2]
- Hepatitis B virus screening
- Hepatitis B virus vaccine and administration
- Hepatitis C virus screening
- HIV screening
- Human papillomavirus (HPV) test
- Influenza virus vaccine and administration (flu shot)[3]
- Intensive behavioral therapy for cardiovascular disease
- Intensive behavioral therapy for obesity
- Lung cancer screening with low-dose computed tomography
- Medical nutrition therapy
- Medicare Diabetes Prevention Program (MDPP)
- Pneumococcal vaccine and administration[3]
- Prostate cancer screening (prostate-specific antigen [PSA] test)[4]
- Screening for sexually transmitted infections (STIs) and high-intensity behavioral counseling to prevent STIs
- Screening mammography (2D and 3D mammograms)[5]
- Screening Pap tests and pelvic examinations

These additional preventive services and screenings can be provided and billed separately, in addition to the subsequent annual wellness visit (G0439), as long as Medicare guidelines are met. This doesn't apply to the Welcome to Medicare visit (G0402) or the first annual wellness visit (G0438).

Resources

To stay up-to-date on current CMS program information and changes, you can subscribe to **Medicare Learning Network® MLN Matters®.** If you have questions, please call the Customer Service number listed on the plan member's ID card.

We're here to help

For more information about how our programs can help support your patients who are UnitedHealthcare Medicare Advantage plan members, please contact your UnitedHealthcare representative. Thank you.

[1] A colonoscopy that begins as a Medicare-covered screening service is subject to the $0 screening cost share, regardless of whether a polyp is found and/or removed during the procedure. In 2024, all UnitedHealthcare Medicare Advantage plans have a $0 copayment for in-network diagnostic colonoscopies and therapeutic colonoscopies and sigmoidoscopies. (Exception: Employer group plans may apply outpatient surgery cost-sharing.)

[2] Glaucoma screening is $0 for most non-special needs and some employer group plans. Some Institutional Special Needs Plans may apply the same cost-sharing as Original Medicare.

[3] Flu and pneumonia shots are covered for a $0 copay with both in-network and out-of-network providers.

[4] A digital rectal exam (DRE) may be subject to cost-sharing, depending on the plan. (Note: Most non-SNPs have a $0 copayment for this service.)

[5] In 2024, many UnitedHealthcare Medicare Advantage plans have a $0 copayment for in-network diagnostic mammograms. (Exception: Institutional Special Needs Plans and employer group plans may apply radiologic diagnostic cost-sharing.)

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