CalOptima Health's
Medi-Cal Annual Wellness Visit (AWV) Program FAQ

1. Where can I find my assigned members?

CalOptima Health will provide the attestation forms and medical records submission instruction documents for each of your assigned members via the CalOptima Health Provider Portal.

Providers can access the provider portal at providers.caloptima.org/#/login. To obtain access, providers are required to complete, sign and submit the Provider Portal Access Agreement to providerservicesinbox@caloptima.org (one access agreement per provider office).

Note: Health networks cannot view members due for an AWV. Only providers can view the detailed information of their assigned members.

2. How do I bill for the AWV?

The codes in the table below are designed specifically for billing for the AWV program. To qualify for the appropriate program reimbursement, the appropriate Current Procedural Terminology (CPT) service code must be present in the claim. Claims can be billed through the standard electronic data interchange (EDI) clearinghouse or through a paper claim submission.

Health Network: Health networks are responsible for claims for their delegated populations (fee-for-service [FFS] or capitated) effective July 1, 2024.

Applicable to CHCN-eligible providers: AWV claims should be billed under the age-banded, preventive visit Initial Health Appointment (IHA) CPT codes.

Initial Preventative Visit (New) within the first 120 days of Medi-Cal member enrollment		
CPT Code	**Age Band**	**Rate (as of January 1, 2024)**
99386	**40–64 years old**	**$135.01**
99387	**65+ years old**	**$146.75**

Periodic Preventative Visit (Established) after 120 days of Medi-Cal member enrollment		
CPT Code	**Age Band**	**Rate (as of January 1, 2024)**
99396	**40–64 years old**	**$112.20**
99397	**65+ years old**	**$121.16**

Qualified providers can receive a supplemental payment of $150 per assigned member per year for each completed, submitted and verified AWV attestation form, billed using the appropriate

AWV/IHA CPT service code.

A qualified provider for the purposes of this program is a contracted primary care provider (PCP) or another affiliated PCP, nurse practitioner or physician assistant operating within the provider group. See CalOptima Health Policy GG.1132 Medi-Cal Annual Wellness Visit Program.

3. Does the AWV have to be completed in person?

A comprehensive AWV must be completed in a face-to-face setting, including, but not limited to, in-person visits and/or telehealth utilizing a real-time synchronous audio and video platform. Appropriate modifiers and place of service codes should be utilized when billing telehealth services.

Place of Service (POS)	Description
02	**Telehealth is provided in a location other than in patient's home.** The location where you provide health services and health-related services through telecommunication technology. The patient isn't located in their home when receiving health services or health-related services through telecommunication technology.
10	**Telehealth is provided in patient's home.** The location where you provide health services and health-related services through telecommunication technology. The patient is in their home (which is a location other than a hospital or other facility where the patient gets care in a private residence) when receiving health services or health-related services through telecommunication technology.
11	**Telehealth is provided in an office location**, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis.

Reference: www.cms.gov/files/document/mln901705-telehealth-remote-patient-monitoring.pdf

Modifier	Description
95	Synchronous telemedicine service is rendered via a real-time interactive **audio and video** telecommunications system.

Reference: med.noridianmedicare.com/web/jeb/topics/modifiers/95

4. What documentation do I need to submit?

Submit the verified attestation form, supporting medical records and Social Determinants of Health (SDOH) Assessment to the CalOptima Health Auditing and Coding team via the provider portal, within the submission period but no later than January 31 following the service year.

The qualified provider must appropriately document all the required elements in the attestation form, with supporting medical records, including, but not limited to:

1. Member's full name, date of birth and client index number (CIN) number
2. Document number
3. Date of service
4. Preventive Health Screening section
5. Year-Over-Year Chronic and Non-Chronic Conditions sections
6. SDOH Assessment
7. Date of authentication

Note: Existing and/or new condition diagnosis descriptions must be clearly documented to the highest level of specificity, severity and complexity, if known, at the time of service, to reflect the member's complete clinical representation and development of the member's risk profile during each episode of care, which are codified to the appropriate ICD-10-Clinical Modification (CM) Guidelines for Coding and Reporting.

5. When will I receive the supplemental payment?

CalOptima Health will make a supplemental payment of $150 per completed and verified attestation form, with supporting medical records, per member per qualified provider per year, based on our Auditing and Coding team's review, within 45 calendar days from the end of the submission month.

6. When will I be notified if the attestation form is not approved?

CalOptima Health's Auditing and Coding team will send provider groups their monthly attestation status and attestation payment status reports. Statuses include approved for payment, paid, returned, pending and/or denied.

7. What is the process of resubmitting a declined attestation form?

Providers can correct or dispute the findings within 30 calendar days and resubmit the completed attestation form, with supporting documentation and/or medical records. You can submit up to five supplemental documentation materials in the provider portal.

8. Is there a member health reward for completing an AWV?

Once per service year, CalOptima Health will distribute a $50 gift card to eligible Medi-Cal members who are 45 years or older as of December 31 of the date of service (DOS) year and who complete an AWV.

Resources:

Attestation Sample
SDOH Assessment
HEDIS My 2025 Quick Reference

Guide
Policy GG.1132 Medi-Cal
AWV
Policy GG.1613 IHA (Medi-Cal)
Provider Portal Access Agreement

The steps below outline the process for qualified providers to complete the Medi-Cal AWV Program.

Step-by-Step Process		
Responsible Party	**Process**	**Information Needed**
Step 1 Qualified provider	Obtain an attestation form and medical records submission instruction documents for **each** of your assigned members via the **provider portal.**	provider.caloptima.org/#/login Provider Portal Release Note
Step 2 Qualified provider	Complete face-to-face AWV, preventive care services and chronic disease management for each of your assigned members. Complete all AWVs during the service year (January 1–December 31) at a minimum of six months apart from member's previous AWV.	Medi-Cal AWV Program overview Medi-Cal IHA Policy GG.1613
Step 3 Qualified provider in conjunction with CalOptima Health Auditing and Coding team	Submit the verified attestation form, SDOH assessment, as well as supporting medical records for **each** completed AWV to the CalOptima Health Auditing and Coding team via the **provider portal** within the submission period but no later than January 31 following the service year.	• Verifies attestation form is accurately completed • SDOH Assessment • Medical record of face-to-face (single or multiple pertinent encounter notes) ▪ AWV ▪ Preventive care/Initial Health Appointment (IHA) services ▪ Chronic conditions management visits
Step 4 CalOptima Health Quality Improvement department, in conjunction with Auditing and Coding team	Within 30 calendar days from the end of the submission period, the Auditing and Coding will review the qualified provider's attestation form and supporting medical records to ensure each condition diagnosis code submitted by the qualified provider has appropriate clinical documentation. Verifies the qualified provider has met the conditions as specified.	• Verifies attestation form is accurately completed • SDOH Assessment • Medical record of face-to-face (single or multiple pertinent encounter notes) ▪ AWV ▪ Preventive care services ▪ Chronic conditions management visits

Step 5a CalOptima Health Quality Improvement department, in conjunction with Auditing and Coding team	Based on Auditing and Coding team's review, makes a supplemental payment of $150 per completed and verified attestation form with supporting medical records, per member per qualified provider per year.	• CalOptima Health will make monthly supplemental payments to the qualified provider based on the Auditing and Coding team's review. • CalOptima Health will make supplemental payment 45 days from the end of the submission month based on Auditing and Coding team's review.
Step 5b CalOptima Health Quality Improvement department, in conjunction with Auditing and Coding team	If CalOptima Health determines the attestation form or supporting medical records are incomplete or lack clinical justification, or the condition diagnosis codes/SDOH factors are not reported on a claim or encounter file that reflects the codes documented on the attestation form, staff will deny the attestation submission and provide a written notification.	• CalOptima Health will provide written notification within 30 calendar days to the qualified provider of the determination and rationale for the rejection.
Step 6 Qualified provider	Upon receipt of CalOptima Health's notification of incomplete medical records, the qualified provider may correct or dispute the findings within **30 calendar days.**	• An addendum, when appropriate, is used to provide information that was not available at the time of the original entry. The addendum should also be timely, and bear the current date, the provider's full name, credentials, original signature date, and reason for the addition or clarification of information being added to the medical record and be signed by the person making the addendum. • Noridian Documentation Guidelines for Amended Medical Records • Resubmit the attestation form with the addendum and documentation requirements. • Addendums will be accepted no later than 90 days from the date of service and/or additional medical records within the current calendar year can be submitted via the provider portal.

Step 7 AWV CPT Codes for Billing	Attestation form **AWV claims:** **Health Network:** Health networks will now be responsible for claims for their delegated populations (FFS or capitated) (effective July 1, 2024) ****Applicable to CHCN-eligible providers** **CHCN:** CalOptima Health will pay claims for CHCN members.	• AWV claims should be billed under age-banded, preventive visit IHA CPT codes • AWV • Preventive care services • SDOH Assessment • Medical record Affirm, reject or provide additional information, as appropriate, regarding the individualized Healthcare Effectiveness Data and Information Set (HEDIS) preventive care measures, SDOH diagnosis codes and health conditions on the attestation form