

Documentation Guidance for a Comprehensive Annual Wellness Visit (AWV) and Initial Health Appointment (IHA) Progress Notes

AWV: Discussion-focused, prevention-oriented, no physical exam

Physical Exam (PE): Problem-focused, includes tests, physical exam head to toe

Initial Preventive Physical Exam (IPPE): One-time, history/risk-focused, a Welcome to Medicare, no physical exam
The AWV and physical exam, or IHA with chronic conditions management visits, can be completed during one or multiple encounter visits within the current calendar year.

HCCPCS code	Medicare (OneCare) AWV and IPPE
G0402	IPPE, also known as Welcome to Medicare, once in a lifetime service within the first 12 months after the patient's starts Part B coverage.
G0438	AWV; includes a personalized prevention plan of service (PPS), initial visit
G0439	AWV, includes a PPS, subsequent visit
G0468	Federally Qualified Health Center (FQHC) visit, IPPE or AWV; an FQHC visit that includes an IPPE or AWV and includes a typical bundle of Medicare services.

Additional information on IHA can be found on our website at [Manuals, Policies and Guides](#) under the IHA Reference Guide for PCPs

CPT Codes	Department of Health Care Services (DHCS) Requirements for Medi-Cal IHA
Initial IHA/Preventive Visit (New) Within the First 120 days of Medi-Cal Member Enrollment	
99386	40–64 years old (Current Procedural Terminology [CPT] description) (Medi-Cal IHA/AWV Program for members 45 years old and over)
99387	65 years and over
Subsequent IHA/Preventive Visit (Established) After the First 120 days of Medi-Cal Member Enrollment	
99396	40–64 years old (CPT description) (Medi-Cal IHA/AWV Program for members 45 years old and over)
99397	65 years old and over

Documentation Guidelines, Compliance and Best Practices

- **Narrative and Rationale:** Provide a complete patient story and clinical rationale for treatments, ensuring medical necessity and evidence are clearly linked.
- **Standardization:** Use standardized terminology (electronic health records [EHR] Intelligent Medical Objects (IMO) and Systematized Nomenclature of Medicine-Clinical Terms (SNOMED-CT) to maintain consistency and avoid misinterpretation.
- **Avoid Cloning:** Ensure each entry reflects the patient's status and the provider's latest decisions. Elaborate on event timelines.
- **Avoid Abbreviations:** Use full terms (e.g., hypertension, not HTN; diabetes mellitus, not DM; shortness of breath, not SOB).
- **History Versus Active Conditions:**
 - History conditions are resolved or stable and not the immediate focus (e.g., history of small bowel resection in 2024).
 - Active conditions need current evaluation or management (e.g., active diagnosis of hypertension, managed with lisinopril).
- **Amendments of Medical Records (in a timely manner):**
 - **Addendum:** Provides missing information with the current date and reason, signed by the person adding it (e.g., the chest X-ray report showed an enlarged cardiac silhouette. John Doe, MD 11/20/25).
 - **Corrections:** Track original and corrected entries with the current date, time, reason for change and initials of the person making the correction.

- **Evidence-Based Approach:**
 - Justify with evidence to support treatment decisions by referencing guidelines, research or evidence that proves medical necessity.
 - Record outcomes of the patient's response to interventions and behavioral trends to demonstrate effectiveness.
- **Document the Diagnosis, Status, and Plan (DSP)**
 - **Diagnosis (D):** Clearly state the final diagnosis
 - **Status (S):** Document current complaints, physical exam findings
 - **Plan (P):** What will happen next for each diagnosis

Patient Full Name: _____		DOB: _____	DOS: 10/30/2025
Each page must contain two patient identifiers.			
Allergies: NKA Problem List: Type 2 diabetes with neuropathy (E11.40) Hypertension (I10) COPD/centrilobular emphysema on 2L oxygen via nasal cannula (J44.1), former smoker (Z87.891), obesity, class 3 (E66.813) Hospitalizations: UCI Medical Center 3/2020 Discharge Dx: Hypertensive urgency Past Surgical History: Cataract: right eye 10/2023; left eye 12/2023 Family History: Mother: Diabetes, HLD Father: hypertension, dementia Social History: Marital status: Married Pregnancy: G4P3 Lives at home with spouse Three children (ages 45, 42, 38) and one miscarriage Occupation: Retired Education completed: High school Former smoker (tobacco), 25 pack-year history No EtOH and substance use history	Reason for Visit/Chief Complaint (CC): (Check the box with the applicable rendering services) ☐ IPPE ☐ Initial AWW ☐ Subsequent AWW ☐ IHA Patient reports depression, fatigue, insomnia and difficulty concentrating over the last few weeks. Denies fever, cough, chest pain or shortness of breath (SOB). Reports adhering to medication regimen as prescribed.		
	Patient's clinical care team involved in care management (reviewed and updated 10/30/25):		
	PCP: John J. Doe, MD		Pulmonologist: John Smith, MD
	Podiatrist: Jane Smith, DPM		Dietician: Jane Doe
	Medication list (reviewed and updated 10/30/25): Metformin 500 mg tablet; one tablet by mouth daily; for diabetes Gabapentin 600 mg tablet; two times per day for diabetic neuropathy Novolog is given on a sliding scale two times per day to control blood sugar Symbicort inhaler 160/4.5 mcg; two puffs twice a day for chronic obstructive pulmonary disorder (COPD) Lotensin 5 mg tablet; one tablet by mouth daily; Qty: 90; Refills: two, for hypertension Note: Medications must be linked to a diagnosis to support medical necessity.		
	Subjective/History of Present Illness (HPI): A 68-year-old female patient presents for her AWW. Her home blood sugar readings log reviewed. Blood sugars have been between low l00s and 120s before meals, 120s and 160s postprandial, and 80s and 140s at bedtime. Her last A1C in 10/2025 has decreased to 7.5 from 8.6 in 5/2025. She has lost 12 pounds since her last visit on 6/2025. Congratulated her for her improvements towards her goals. BP reading log reviewed and BP at goal.		
	Activities of daily living (ADLs) (Dressing, feeding, toileting, grooming, physical ambulation, bathing): Independent Independent ADLs (Using the phone, housekeeping, laundry, transportation, shopping, managing medications and handling finances): Independent Gait: Normal. Fall risk: No. Pain assessment: 0/10 *Mini-Cog score: 2. (Completed 10/30/25) *PHQ-9 score: 6. No suicidal or homicidal ideation (Completed 10/30/25) *GAD score: 0 (Completed 10/30/25) Advance directives: Copy on file Exam: Describing in detail any pertinent positive findings that affect the care and treatment of the patient.		

Diagnostics tests/procedures: CT chest 8/2025: Centrilobular emphysema CT brain 8/2025 (UCI Medical Center): Microvascular disease, Brain atrophy	
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Vitals:	T: 97.8; BP: 128/82 (left arm); HR: 82; RR: 14; SpO2: 98% on 2 L O2 via nasal cannula;
Objective:	HT: 63"; WT: 228 lbs.; BMI: 40.4
Physical exam: Constitution:	Well-developed. Severely obese. Well-groomed. NAD.
HEENT	Head: Normocephalic. Eyes: Pupils Equal, Round, Reactive to Light and Accommodation (PERRLA) Sclera - white and clear; conjunctiva - pink and moist, no lesions or discharge. Ears: Cerumen right ear and left ear clear. TMs — Translucent and pearly gray, no redness, fluid or perforation. Nose: External — normal. Internal mucosa — pink and moist, no swelling, polyps or discharge. Nasal septum/turbinate normal. Throat: Lips/buccal mucosa pink and moist, no lesions. Teeth/gums — pink, no swelling or inflammation. Tongue moist, no lesions or tremors. Pharynx clear, no erythema, exudate or swelling. Trachea midline, no deviation. Thyroid normal, no masses. No lymphadenopathy (LAD) in cervical or supraclavicular areas. Neck — Supple, normal ROM.
Cardiac:	Patient alert, oriented to person, place and time. Clear to auscultation on S1 and S2. No murmurs, clicks or gallops.
Pulmonary:	Lungs are clear to percussion and auscultation.
GI:	Bowel sounds normal. No tenderness, swelling or masses.
Musculoskeletal:	No pain, tenderness or swelling. Posture is upright and aligned. All joints full range of motion (ROM). Strength is 5/5 in all extremities. No crepitus or instability noted.
Neurological:	A&Ox4. Gait normal. Slightly decreased touch sensory of lower extremities, feet and toes
Vascular system:	No carotid bruits. No abdominal bruits. No pain, no pallor, no cyanosis or redness. Capillary refills less than two seconds. Radial, ulnar and brachial pulses normal. Right leg: No pallor, no cyanosis, no redness. Cool, shiny and hairless skin. Femoral, popliteal, posterior tibial and dorsalis pedis pulses: +2 Left leg: No pallor, no cyanosis, no redness. Skin warm to the touch. Femoral, popliteal, posterior tibial pulses +2. Dorsalis pedis pulses: +1

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All conditions must be linked to a treatment plan (DSP)			
Assessment:		Plan:	
1. Encounter for general adult medication examination with abnormal findings (Z00.01)		1. Health maintenance, risk assessments, current medications, medical history and advanced care planning were all reviewed/addressed with patient and updated today.	
2. Centrilobular emphysema (J43.2)		2. I reviewed pulmonologist consult notes and CT chest scan from 07/2025, which noted centrilobular emphysema. Stable on current O2 flow. Continue current Symbicort inhaler dosage and continue care with pulmonologist, appointment with Dr. John Smith next week.	
3. Personal history of nicotine dependence (Z87.891)		3. Low-dose CT chest scan completed 8/2025, no evidence of lung cancer. Continue care with pulmonologist.	
4. Dependence on supplemental oxygen (Z99.81)		4. Continue care with pulmonologist.	
5. Personal history of nicotine dependence (Z87.891)		5. Continue care with pulmonologist.	
6. Type 2 diabetes with diabetic neuropathy, unspecified (E11.40)		6. HbA1C has improved with weight loss. Continue home glucose monitoring. Neuropathy stable on gabapentin. Continue nutritional goals with dietician. HbA1C in two months with follow-up visit.	
7. Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene (E11.51)		7. Arterial duplex of bilateral lower extremity ordered. Patient will schedule her follow-up with podiatrist, Dr. Jane Smith.	
8. Long-term (current) use of oral hypoglycemic drugs (Z79.84)		8. Continue Monday, Tuesday, and Friday.	
9. Long-term (current) use of insulin (Z79.4)		9. Continue insulin sliding scale.	
10. Essential (primary) hypertension (I10)		10. Continue Lotensin and home BP daily log.	
11. Obesity, class 3 (E66.813)		11. Continue daily activities and nutrition with dietitian to improve weight loss, which also helps to improve blood sugar levels and BP goals.	
12. Body mass index (BMI) 40.0-44.9 adult (Z68.41)		12. Congratulated patient on BP and weight loss towards goal. Continue exercise and nutrition with dietitian.	
13. Major depression disorder, single episode, mild (F32.0)		13. PHQ-9 score: 6. Referral to behavioral health.	
14. Mild cognitive impairment of uncertain or unknown etiology (G31.84)		14. Mini-Cog score: 2. Referral to neurologist. Send a copy of CT brain report 8/2025.	

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Return to clinic in two months for diabetes and weight management. (Continuity of care follow up on work-up conditions from specialists)		
Electronically signed by: John J. Doe MD, 10/31/2025		
Health Maintenance		
Preventive services:	Date last completed with results:	Date next due:
Annual Wellness Visit (AWV)	10/16/2024	2025
Diabetic comprehensive exam: ➤ HbA1C ➤ Estimated glomerular filtration rate (eGFR) and urine albumin creatinine ratio (UACR): ➤ Retinal eye exam ➤ Dental/oral exam ➤ Diabetic foot exam	5/10/2025 Result: 8.6% 10/16/2024 Result: 59 10/16/2024 Result: 29 07/08/2025 Result: No diabetic retinopathy 08/02/2025	8/10/2025 2025 2025 07/08/2026 Under the care of podiatrist, Dr. Jane Smith
Mammogram:	08/01/2025 Result: BI-RADS 2 (Benign)	08/01/2026
Colonoscopy:	2020 Result: Normal	2030 (10 years)
Dexa scan	06/2023 Result: Normal	2028–2033 (five to 10 years)
Low-Dose Chest CT Scan	6/2025 Centrilobular emphysema	Pulmonologist – Dr. John Smith
Advance Care Planning	8/2025	Copy in patient chart
Immunizations: Influenza Pneumococcal (PVC20) Shingrix, 2 series) Tdap	10/2024 08/2023 03/2017 05/2020	2025 Not applicable 2028 05/2030

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