Annual care visits

Documentation and coding: Individual & Family Plans

December 2025

For coding education questions, email CignaHealthcareHCPEducation@CignaHealthcare.com.

It's important to accurately document and code diagnoses when submitting claims for your patients with Cigna Healthcare®-administered coverage. This helps ensure your diagnosis and coding practices comply with all applicable legal requirements,[1] while enabling us to provide our customers with the benefits and resources they need. For additional information and resources, visit the Cigna Healthcare Individual & Family Plans page at CignaforHCP.com/IFP.

The information that follows is designed to provide guidance for the documentation and coding of claims for your patients' annual care visits. It is not meant to replace your judgment when caring for your patients.

Overview

The annual care visit (ACV) is a key opportunity to assess health needs, initiate preventive care, manage chronic conditions, and ensure the proper documentation and coding of a patient's health history. Proper ACV documentation and coding support patient care and improve your practice's risk-adjustment accuracy under the U.S Department of Health and Human Services Affordable Care Act (HHS ACA) risk-adjustment program.

What is an annual care visit?

An ACV is a visit that is focused on prevention and long-term care planning, *not treatment of acute conditions*. For the HHS ACA program, the framework includes:

- Comprehensive history and physical examination.
- Review of current and chronic conditions.
- Medication and problem list reconciliation.
- Preventative screening and care planning.
- A visit once every calendar year. (e.g., Patient can have an ACV in December 2024 and again in January 2025.)

Tips for patient ACV outreach

- Use clear, patient-friendly language when describing the purpose of the ACV (e.g., "This is your free yearly health check-up focused on prevention and long-term wellness.")
- Leverage multiple communication platforms – phone calls, texts, email, and traditional mail.
- Offer flexible scheduling.
- Encourage the front desk to mention ACVs during routine calls.

Documentation and coding

- Use thorough pre-visit planning prior to the encounter.
- Ensure documentation supports each reported diagnosis with clinical evidence.
- Address and document chronic conditions annually – even if stable.
- Reconcile conditions from problem list during current encounter.
- Link diagnosis to treatment plans, when applicable.

ICD-10-CM coding

- Submit International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) codes to capture chronic and active conditions addressed during the visit.
- Do not code conditions that are historical, suspected, or not addressed during the encounter.
- Avoid unspecified or vague codes when a more specific code is available.

1 Diagnosis inaccuracies that are not addressed can result in administrative sanctions and potential financial penalties.

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Annual care visit

Submit the appropriate evaluation and management (E/M) code or preventative code based on the visit type. Choose a Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) code from the list below.

CPT code, new patient	Description
99381	Initial comprehensive preventive medicine E/M of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)
99382	Initial comprehensive preventive medicine E/M of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age 1–4 years)
99383	Initial comprehensive preventive medicine E/M of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age 5–11 years)
99384	Initial comprehensive preventive medicine E/M of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age 12–17 years)
99385	Initial comprehensive preventive medicine E/M of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age 18–39 years)
99386	Initial comprehensive preventive medicine E/M of an individual including an age and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age 40–64 years)
99387	Initial comprehensive preventive medicine E/M of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age 65+ years)

CPT code, established patient	Description
99391	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year)
99392	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1–4 years)
99393	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5–11 years)
99394	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent (age 12–17 years)
99395	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient (age 18–39 years)
99396	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient (age 40–64 years)
99397	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient (age 65+ years)

HCPCS code, initial visit Medicare	Description
G0438	Initial Medicare annual wellness visit
G0439	Subsequent Medicare annual wellness visit

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