CHPA | COMMUNITY HEALTH PROVIDER ALLIANCE

ANNUAL WELLNESS VISIT (AWV) PLAYBOOK

A comprehensive guide for Community Health Centers to enhance patient engagement through proactive preventive care.

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CHPA COMMUNITY HEALTH PROVIDER ALLIANCE
LEADERS IN INTEGRATED PRIMARY CARE

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The Why: Intro to the Annual Wellness Visit (AWV)

The Annual Wellness Visit (AWV) was introduced in January 2011 as a part of the Affordable Care Act (ACA) and is offered to all eligible Medicare beneficiaries at no cost. It aims to give both the patient and primary care provider a comprehensive understanding of the patient's health risk and goals. During the AWV, the patient, primary care provider, and care-team work towards creating a personalized, preventive health plan that helps patients understand their risk factors and how to prevent disease.

The AWV encourages patients to take an active role in their health and focus on proactive, preventive care; not reactive, sick care. Patients are encouraged to discuss topics relevant to older adults such as ability to care for oneself, household safety, advance care planning, and changes in cognition. For providers, the AWV presents an opportunity to fully address preventive screenings, identify patients in need of additional support (such as care management services), capture clinical quality measures, close care gaps, document and assess chronic conditions, and most importantly, strengthen the provider-patient relationship by increasing patient engagement through collaboration and education.

The What: Types of AWVs

The Centers for Medicare and Medicaid Services (CMS) allows for three distinct types of AWVs. The Initial Preventive Physical Exam (IPPE) is a one-time benefit for new Medicare enrollees. This AWV is often referred to as the "Welcome to Medicare Visit." CMS requires this visit to be completed within the first 12 months of Part B coverage. After the first 12 months of Part B coverage has ended, patients are then eligible for an Initial AWV. Just like an IPPE, the Initial AWV is a one-time benefit. When scheduling an Initial AWV, it is important to ensure a patient has not had an IPPE in the previous 12 months of Part B coverage. Of note, a patient is not required to have an IPPE prior to having an Initial AWV. Subsequent AWVs are offered to patients annually after their initial 12 months of Part B coverage and after they have had an Initial AWV.

Initial Preventive Physical Exam (IPPE) G0468 + G0402	Initial Annual Wellness Vist (AWV) G0468 + G0438	Subsequent Annual Wellness Visit (AWV) G0468 + G4039
• Also known as the "Welcome to Medicare Visit". • One-time benefit for new Medicare enrollees. • Completed in the first 12 months of Part B coverage.	• First AWV received by a beneficiary, one per lifetime. • Completed after 12 months of Part B coverage. • No IPPE or AWV can be billed in previous 12 months.	• Applicable for all AWVs after the Initial AWV. • No IPPE in previous 12 months. • Can be completed annually each calendar year.

Medicare Advantage: Separate reimbursement is allowed for an IPPE/AWV and an Annual Preventive Physical Exam when performed on the same day by the same provider. Code: G0466 + 99385-99387 (new patient) or G0466 + 99395-99397 (established patient) using modifier 59.

AWVs: Traditional Medicare vs. Medicare Advantage Plans

Patients who qualify for Medicare may choose between Traditional Medicare or one of many Medicare Advantage plans. There are a few differences between traditional Medicare and Medicare Advantage plans when it comes to types of covered visits and when those visits are covered. The table below highlights these differences. Later in this document, we will also highlight differences between billing the two coverage types.

Visit Type	Scheduling Rules	Completed by	Covered by Traditional Medicare	Covered by Medicare Advantage
Initial Preventive Physical Exam (IPPE)	Once in a lifetime within the first 12 months of Medicare B Coverage.	Community Health Center	✓	✓
Initial Annual Wellness Visit (AWV)	Once in a lifetime within the first 12 months of Medicare B Coverage.	Community Health Center	✓	✓
Subsequent Annual Wellness Visit (AWV)	*See details.*	Community Health Center	✓ Once a year. Must be scheduled in the same month, or subsequent months, as it was completed the year prior.	✓ Once a calendar year. Can be scheduled anytime in the calendar year regardless of when it was scheduled the previous year.
In-home Health and Well-being Assessment (IHWA)	Once a calendar year. Can be scheduled anytime in the calendar year regardless of when it was scheduled the previous year.	Payer		✓
Annual Physical Exam	Once a calendar year. Can be scheduled anytime in the calendar year regardless of when it was scheduled the previous year.	Community Health Center		✓

In-home Health and Well-being Assessments (IHWA) VS. Annual Wellness Visits (AWVs)

Our payer partners recognize licensed Advanced Practice Clinicians (APCs), which include Adult Nurse Practitioners (NPs), Clinical Nurse Specialists (CNS), Family NPs, Gerontology NPs, Board-Certified Physicians, and Physician Assistants.

Why Are Both Assessments/Visits Important?

Both visits give a comprehensive view of the patient's health to ensure they get the best possible care by addressing both medical needs and social factors.

How are They Different?

In-home Health & Well-being Assessment (IHWA)	Annual Wellness Visit (AWV)
An IHWA is a service provided by the patient's insurance company to assess their health and living conditions. During an IHWA, a licensed clinician (APC) will either visit the patient's home or conduct a video call to evaluate their overall health and understand their living environment.	An AWV is a free, yearly health check-up provided by the patient's insurance plan. It takes place at either their healthcare provider's office or sister clinic and focuses on preventive care and personalized health planning.
LOCATION AND PROVIDER	
Conducted by an APC at home.	Conducted by the PCP and/or care team in the office.
FOCUS	
• In-depth evaluation of patient's health and social circumstances. • Addresses medical and non-medical needs, with emphasis on how their home impacts their health. • Identifies health risks and provides personalized education and resources.	• Create or update a personalized prevention plan based on evidence-based data regarding current health and risks. • Comprehensive preventive care: screenings, immunizations, and health risk assessments. • Discuss lifestyle and health management strategies, including diet, exercise, and smoking cessation.
COMPONENTS	
• hands-on assessments • detailed health history and physical examination • review and reconciliation of medications • assessment of social factors like food insecurity and transportation • education on managing health and connecting to community resources • conducts diabetes and peripheral artery disease testing and colorectal cancer screenings	• hands-off assessments • comprehensive review of medical and family history • assessment of cognitive function and depression risk • review and update personalized health advice and preventive care planning • coordination of referrals for additional preventive services or tests

Important: IHWA visits do not replace AWVs.

What types of tests or screenings occur during an IHWA vs an AWV?

IHWA	AWV
The APC conducts health screenings and tests as appropriate, including but not limited to: • diabetes blood sugar testing • peripheral artery disease testing • colorectal cancer screening (iFBOT) • social determinants of health (SDOH) screening	AWVs are hands-off visits. • depression screening • fall risk • cognitive impairment testing • SDOH screening • substance use disorder (SUD) • functional ability – activities of daily living (ADLs) and instrumental activities of daily living (IADLs)

Important:

- Breast Cancer Screenings and alternative Colorectal Cancer screenings are not conducted during IHWAs.
- It is important to have the patient follow-up with your office after their in-home visit for continuity of care.

Best Practice Workflow

It is considered best practice to actively encourage eligible patients to participate in an IHWA.

Recommended Verbiage: *Following the assessment, we recommend scheduling a follow-up appointment or Annual Wellness Visit at our office. This approach ensures comprehensive care and personalized health planning tailored to the individual's needs and conditions identified during the IHWA.*

What Happens After the Visit?

- The APC will give your patient a report to bring to their PCP called an “Ask your PCP Form” (UHC).
- The APC will send a detailed health report to your office via mail.

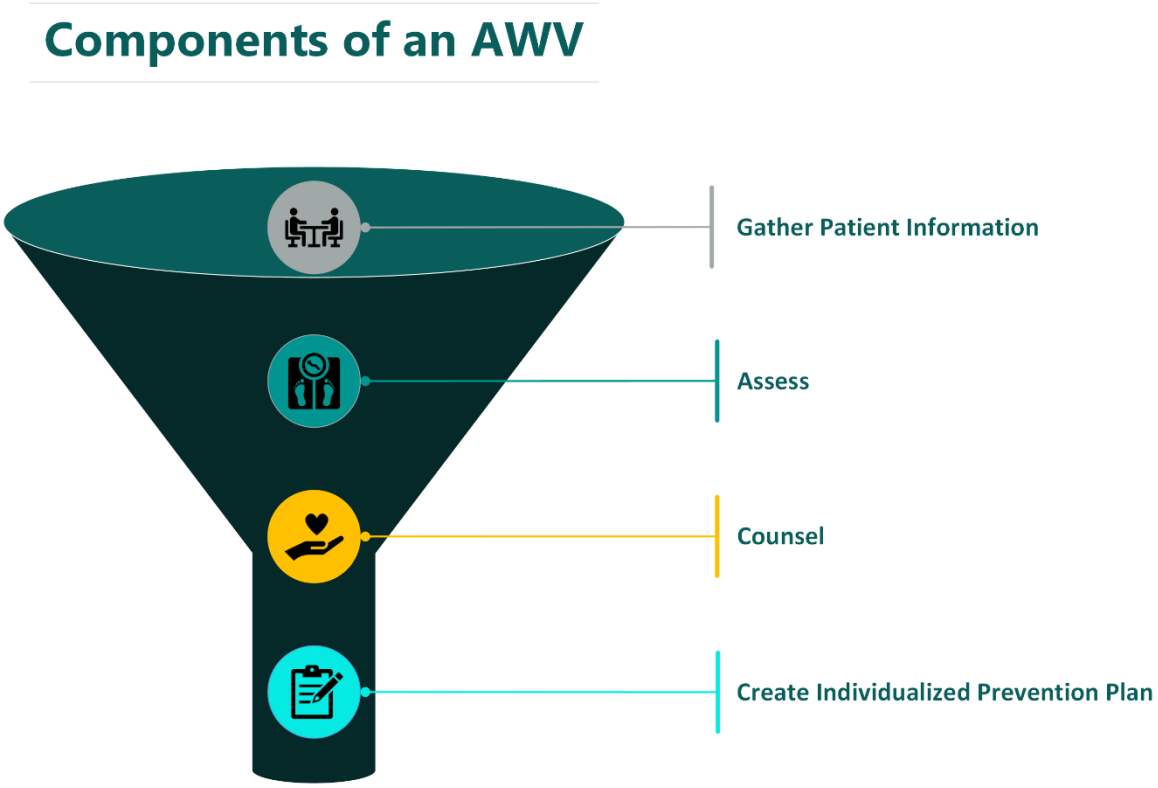
Patient Recommendations

- Encourage them to schedule a follow-up visit with their PCP as soon as possible. **If they have not had an AWV completed this is a great time to schedule it and address their IHWA findings at the same time!**
- Instruct them to bring any documentation or information that was provided by the APC.

Components of the AWV

CMS has identified specific components that must be addressed at an IPPE and Initial/Subsequent AWV. These minimum requirements ensure that providers and care teams address topics that are pertinent to older adults, keep the focus on disease prevention, and assist patients in future planning related to their health status.

The AWV starts with the **gathering of patient information**, followed by an **assessment**, and finishes with **counseling**. Each component builds on the previous one, culminating in a collaborative **personalized prevention plan**. Patients, providers, and the healthcare teams use the personalized plan to inform care decisions over the next year.



Step One:
Gather Patient Information

The first component of an AWV is gathering patient information. During this step, members of the care team partner with the patient to obtain a health status self-assessment, typically referred to as a health risk assessment (HRA). Although family and staff may support patients in completing the HRA, it needs to reflect the patient's perspective. Often, the HRA is administered as a document created by an organization to capture patient information. It may be completed prior to or at the time of the AWV.

Barriers to communication and comprehension can impede obtaining an accurate picture of a patient's health status. Consider the barriers and solutions below before gathering patient information:

- Language - allow patients to communicate in their preferred language
- Hard of Hearing - encourage patients to bring their hearing aids
- Low Vision - encourage patients to bring their vision aids
- Cognitive Impairment - encourage patients to invite a caregiver to attend the AWV with them
- Health Literacy - consider patients' health literacy and communicate on a level that supports comprehension

Sample HRA

Courtesy of: Tepeyac Community Health Center

ANNUAL WELLNESS VISIT - HEALTH RISK ASSESSMENT (HRA)

Name:_____DOB:___/___/____

MRN: _____

Hello,

Your Appointment for the *Welcome to Medicare Visit* OR *Annual Wellness Visit* is
On_____at_____

This is a free benefit through Medicare.

During this visit we will work with you to plan for how to stay well.

What is the Annual Wellness Visit?
- This visit is for talking with your care team about your medical history, your risk for certain medical problems, the current state of your health and your plan for staying well.
- We will measure your height, weight, and blood pressure.
- We might refer you for preventive screenings or services outside of the appointment.

How is the Annual Wellness Visit different from other visits?
- This is not the same as a yearly physical exam.
- We will not listen to your heart and lungs or check other parts of your body.
- You probably will not get screenings or blood tests during this visit.
- We would want to schedule another appointment if you are not feeling well or are concerned about a medical problem.

Who pays for it?
- Medicare will pay for the Annual Wellness Visit so you will have no out of pocket expense.
- You might have a co-pay for some follow-up screening services and visits.
- If you receive additional tests or services during the same visit that aren't covered under these preventive benefits, you may have a co-pay and the Part B deductible may apply.

Things to bring to your Annual Wellness Visit:
- Please complete the Health Risk Assessment on the following pages and bring it to your visit.
- A copy of your Advance Directive, if you have one, and your insurance card.
- **Please bring a bag with all the medicines you take including over-the-counter drugs, vitamins, and herbals.**

We look forward to seeing you soon!

Your Tepeyac Community Health Center Team

General Health

(Please circle or write your answer below)

Form completed by:	Self	Family/ Friend	Clinic staff	Other	
How do you rate your overall health?	Excellent	Very good	Good	Fair	Poor
Do you have a dentist you see regularly?	Yes	No			
How many times in the last 12 months have you been to the emergency room?	0	1-2	3-4	5+	**Reason:**
How many times in the last 12 months have you been admitted to the hospital?	0	1-2	3-4	5+	**Reason:**
How confident do you feel in your ability to manage your health & meet your health goals?	Very Confident	Confident	Somewhat Confident	Not Confident	

Medical History

Have you or any of your family members been diagnosed with any of the following conditions?

	Myself	Father	Mother	Siblings	Children	Grandparents
Heart disease or stroke						
High blood pressure						
High cholesterol						
Cancer						
Diabetes						
Kidney disease						
COPD (lung disease)						
Substance use						
Depression or anxiety						
Other:						

Have you had any surgeries or major hospitalizations?	Yes	NO
Explain the reason(s) for each surgery or hospitalization	**Year of surgery or hospitalizati**	**on**

Medications

Do you take any non-prescription medications including vitamins or herbs?	Yes	No	**If yes, which ones?**
Do you have any allergies to medications?	Yes	No	**If yes, which ones?**
Do you have enough money to pay for medications, supplies and medical visits?	Yes		No
Do you take all your medications as prescribed?	Always	Sometimes	Almost never / N/A
In the past 12 months, have you used illegal drugs or used a prescription medication for non-medical reasons?	Often	Sometimes	Rarely / Never

Tobacco Use

Do you use tobacco or nicotine products?	Yes	In the Past	Never
If yes to current or past use:	How many per day?	For how many years?	
Are you interested in quitting?	Yes	No	N/A
Have you had a lung cancer screening?	Yes	No	N/A

Alcohol and Substance Use

How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4 times or more per week
How many drinks containing alcohol do you have on a typical day you drink?	1-2	3-4	5-6	7-9	10 or more
How often do you have 6 or more drinks on one occasion?	Never	Monthly or less	Monthly	Weekly	Daily or almost daily

Nutrition

How many days per week do you eat at least 3 servings or fruit and vegetables?	0	1-2	3-4	5+
How many days per week do you eat fast food?	0	1-2	3-4	5+
How many days per week do you eat smaller meals or skip meals because you do not have enough money, or enough help to shop or cook?	0	1-2	3-4	5+

How often does anyone (including family/friends) insult, threaten, physically hurt, or mistreat you financially?	Often	Sometimes	Almost never	Never
In the past year have you had to go without health care because you did not have transportation?	Yes	No		
In the past year have you had to go without health care because of the cost?	Yes	No		
Do you need help reading materials given to you about your health care?	Yes	No		

Activities of Daily Living

Which of the following can you do on your own without help? *Please mark the ones that apply from the list on the right.*	☐ Eat ☐ Bathe ☐ Dress ☐ Walk ☐ Stand ☐ Use stairs ☐ Use Toilet	☐ Cleaning ☐ Cooking ☐ Shopping ☐ Driving/using public transport ☐ Use the telephone ☐ Take medicine

Do you need an assistive device to move around?	Yes	**If yes:** Cane Walker Wheelchair Other:	No	
In the past year have you experienced leaking of urine?	Often	Sometimes	Almost never	Never

How many days per week do you have physical pain that affects your activities?	0	1-2	3-4	5+
Do you or people around you have concerns about your memory?	Yes	No		

Home Safety/Fall Risk

What is your living situation? *Please mark the ones that apply from the list on the right.*	☐ Lives by self ☐ With spouse/family ☐ With friend/roommate ☐ Nursing home ☐ Assisted living ☐ I don't have a place to live ☐ Other: _____	
Are you worried that the next 2 months you may not have stable housing?	Yes	No
In the past year has your water or electric service been shut off for not paying your bill?	Yes	No
Does your home have: *Please mark the ones that apply from the list on the right.*	☐ Stairs ☐ Handrails on stairs ☐ Smoke alarm ☐ Carbon monoxide ☐ Doors and windows with locks	☐ Rugs ☐ Slippery bathtub ☐ Handrails in bathtub ☐ Phone within reach
Do you feel unsteady navigating through your home?	Yes	No
Have you fallen in the last year?	Yes	No

Step Two:
Assessment & Screening

During the assessment component, care team members will collect patient measurements which at a minimum include height, weight, BMI, and blood pressure. At this time care team members will also assess cognitive impairment, depression risk factors, substance use disorders, and fall risk factors through direct observations, reported observations from the patient, family, friends, and caregivers, or with standardized assessments. Care team members should be mindful of scope of practice and choose the assessment method that aligns with their scope. A standardized tool to assess social determinants of health (SDOH) should also be utilized. Functional ability is assessed through questions related to activities of daily living (ADLs) **and** instrumental activities of daily living (IADLs).

Depression

- Patient Health Questionaire - 2
- Patient Health Questionaire - 9 (PHQ-9)

Fall Risk

- Timed Up & Go (TUG)
- Stopping Elderly Accidents, Deaths & Injuries (STEADI) Algorithm for Fall Risk Screening, Assessment, and Intervention

Cognitive Impairment

- Mini-Cog
- Mini-Mental State Examination (MMSE)
- AD8 Dementia Screening Interview
- St. Louis University Mental Status Examination (SLUMS)

Social Determinants of Helath (SDOH)

- PRAPARE Screening Tool
- Accountable Health Communities Health Related Social Needs (HRSN) Screening Tool

Substance Use Disorder (SUD)

- Alcohol Use Disorders Identification Test (AUDIT)
- Cut down, Annoyed, Guilty, Eye-opener (CAGE) Assessment

Functional Ability

- Katz Index of Independence in Activities of Daily Living (ADLs)
- Lawton-Brody Instrumental Activities of Daily Living (IADLs) Scale

Step Three: Counsel and Refer

After gathering patient information, measurements, and completing assessments, care team members will then counsel patients on the next steps. During this component, patients receive appropriate education to positively impact their health status, counseling on identified risk factors, recommendations on preventive services, and referrals to organizations or providers to mitigate these risks. End-of-life planning is also discussed during this step if the patient is agreeable. Care team members will discuss interventions with patients to reduce health risks and promote self-management and wellness.

An AWV presents an ideal opportunity to engage patients in shared decision making regarding recommended preventive services. Best practice involved reviewing preventive services that the patient is due for in the next five to ten years and discussing these services, along with all potential options, with the patient. Types of preventive services include chronic condition screenings, cancer screenings, STI screenings, and immunizations. It is important to consider any barriers to communication and comprehension that the patient may have while discussing recommended preventive services.

The SHARE Approach to Shared Decision Making

S – seek your patient's participation
H – help your patient explore and compare treatment options
A – assess your patient's values and preferences
R – reach a decision with your patient
E – evaluate your patient's decision

Source: Agency for Healthcare Research and Quality: Home

CHPA Recommended Tools

- Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network (MLN): Medicare Preventive Services
- U.S. Preventive Services Task Force (USPTSF)
    - Prevention TaskForce App
    - Preventive TaskForce Web Tool

Step Four:
Personalized Prevention Plan

The final component of an AWV is the personalized prevention plan. At this point, care team members have reviewed the HRA with patients, gathered patient information, completed appropriate assessments and screenings, and collaborated with the patient to identify appropriate preventive services due in the next five to ten years. Think of this information as ingredients for a compounded medication. The medical provider will now take all these ingredients and devise a patient-specific prescription (personalized prevention plan) for total health maintenance.

Key Personalized Prevention Plan Components

- interventions for identified concerns from HRA
- review of current health status to include:
  - risk factors
  - conditions
  - treatment options
- recommended screenings
- referrals
  - specialists
  - health education
  - preventive counseling services or programs
  - community based lifestyle interventions

Sample Personalized Prevention Plan

[CLINIC LOGO]

Patient Name_____ Appt Date: _____

Personalized Health Plan

Prevention Screening Schedule	Date completed	Due now or in the next 12 months	Plan for Completion	Referral
Bone Mass Measurement (Bone Density Test)		Yes No		
Breast Cancer Screening		Yes No		
Cardiovascular Screenings (cholesterol, lipids, triglycerides)		Yes No		
Colorectal Cancer Screenings		Yes No		
Diabetes Screening		Yes No		
Hepatitis B Screening		Yes No		
Hepatitis C Screening		Yes No		
Lung Cancer Screening		Yes No		
Pap Test and Pelvic Exam		Yes No		
Prostate Cancer Screening		Yes No		
Sexually Transmitted Infection Screening and Counseling		Yes No		

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Patient Name_____ Appt Date: _____

Personalized Health Plan

Immunizations	Date completed	Due now or in the next 12 months	Plan for Completion	Referral
Flu Shot		Yes No		
Pneumococcal Shots		Yes No		
Shingles		Yes No		
COVID 19		Yes No		

Health Risks	Current Concern	Plan to manage risk	Referral
Activities of Daily Living	Yes No		
Cognition	Yes No		
Falls	Yes No		
Physical Activity	Yes No		
Mood/Alcohol/Substance Use	Yes No		
Tobacco Use	Yes No		
Weight	Yes No		

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[CLINIC LOGO]

Patient Name_____ Appt Date: _____

Personalized Health Plan

Additional Health Advice

If you have any questions or problems with referrals, please contact your Annual Wellness Care Team Support Member by sending a message using the portal or calling _____.

Thank you for partnering with us to keep you as healthy as possible. We look forward to your next Wellness visit in a year.

_____ _____

Patient Signature Primary Care Provider Signature

_____ _____

Patient Support Team Member Annual Wellness Care Team Support Member

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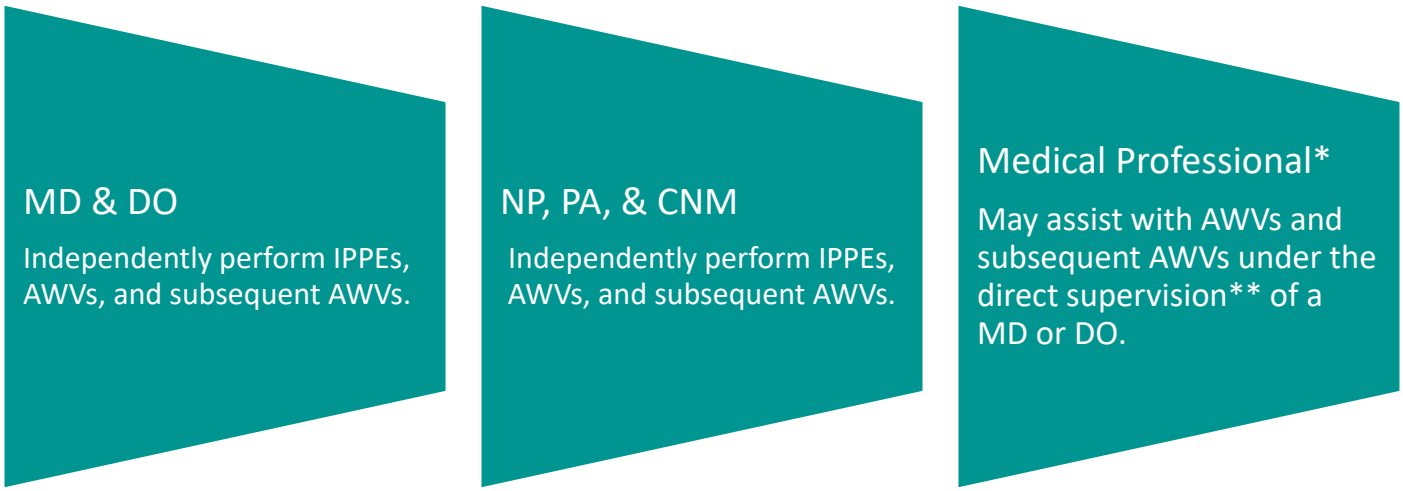
AWV Program Implementation

Now that we understand **why** AWVs are important and **what** they entail, we will move on to implementing a successful AWV program. There are many unique options for implementation, but keep in mind that AWVs are resource dependent, and the availability of these resources is always changing. Flexibility in utilizing resources is key. Your current state is only a starting point; what works now may not work in the future. It's essential to prepare with a mindset focused on continuous improvement. As we review these options, remember that the most successful program will be the one that your organization can commit to with its current resources and adapt as needed.

Who May Perform/Assist with IPPEs, AWVs, and Subsequent AWVs



***Medical professional** includes a health educator, registered dietitian, nutrition professional, or other licensed practitioner working within their scope.

****Direct Supervision** does not require the physician to be in the same room while the medical professional is performing AWV-related tasks, but it does require the physician to be onsite and readily available. The physician must see the patient face-to face for part of the visit to be eligible for reimbursement.

Which staff members do we have who are eligible to perform IPPEs, AWVs and subsequent AWVs?

AWV Workflows

After identifying staff members who may perform and assist with AWVs, the next step in developing your program is to determine the best workflow. Will you rely on your physicians, nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists (CNSs), or will you leverage another medical professional to perform the majority of an AWV visit? There are benefits and challenges to each option. A physician and non-physician medical practitioner program leverage the patient-physician relationship, while a medical professional program leverages team-based care and maximizes access on physician schedules. However, it still requires face-to-face time with a physician or non-physician medical practitioner.

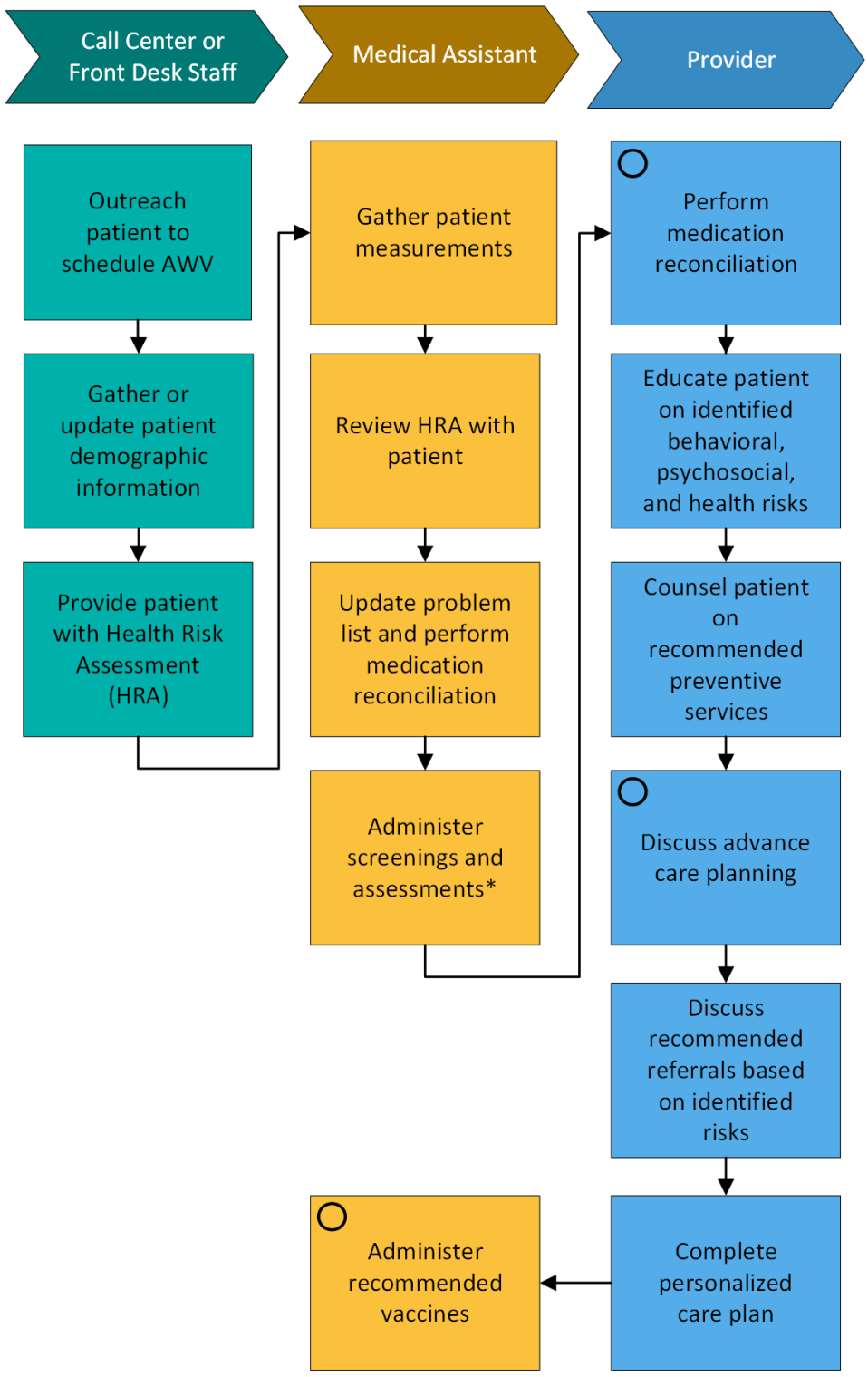
This section features three distinct sample workflows: a provider-led workflow, a medical professional-led workflow, and a telehealth workflow. When reviewing each sample workflow, we encourage you to start thinking about which one will suit your organization best. Also, keep in mind these are "samples" and can be adjusted to fit the needs of your organization.

Federally Qualified Health Center (FQHC) Specific Requirements

- face-to-face visit requirement – requires a face-to-face visit with a physician or a non-physician medical practitioner for the IPPE, AWV, and subsequent AWV in order to be reimbursed.
- direct supervision requirement – billing physician or non-physician practitioner must be present in the building and readily available should assistance be needed.

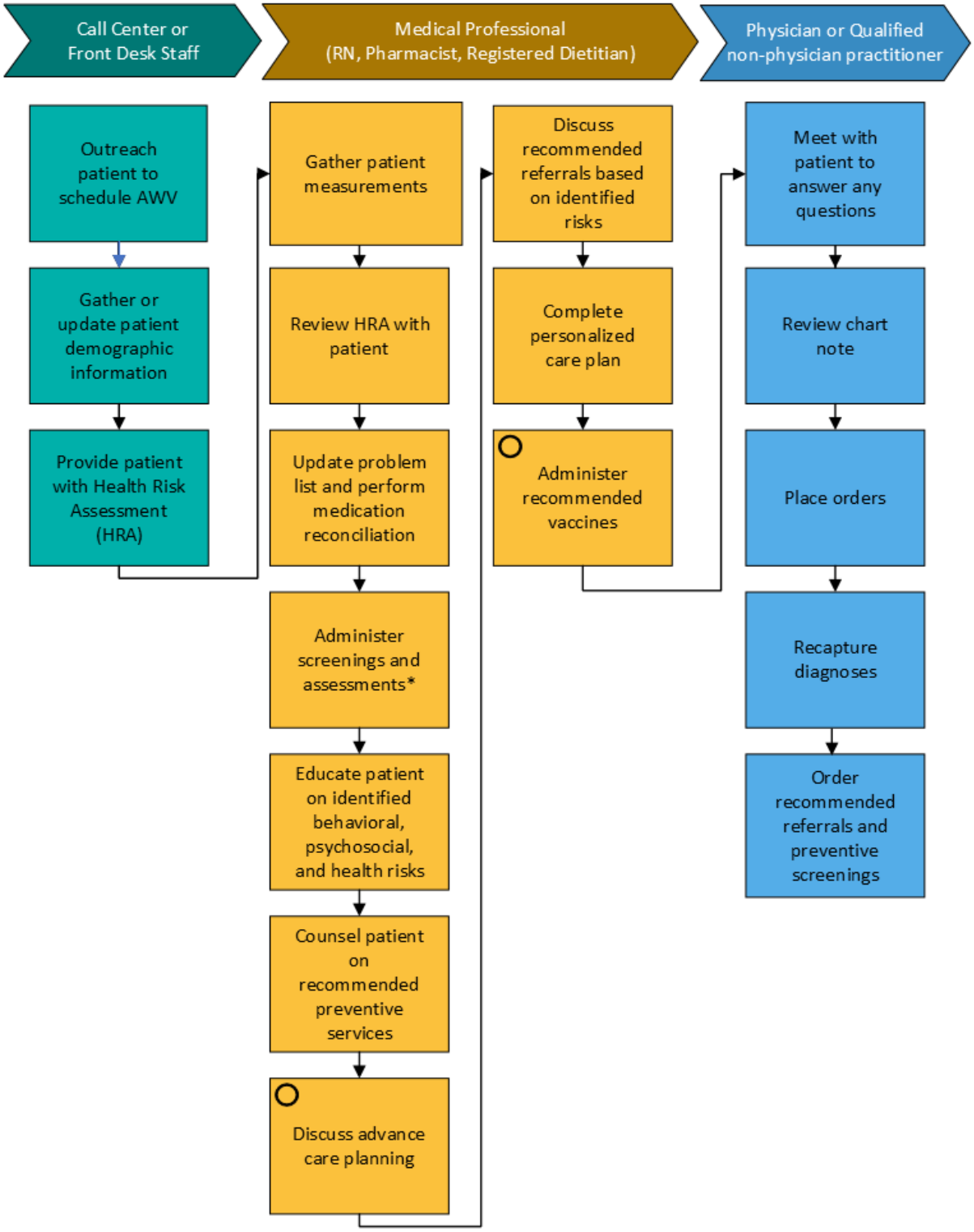
[see the three following pages for workflow diagrams]

Provider-Led AWV with MA only



◯ = Not an AWV requirement, but highly recommended

Medical Professional-Led AWV



◯ = Not an AWV requirement, but highly recommended

Which AWV Workflow Model Suits Your Organization?

Provider-Led AWV		Medical Professional-Led AWV	
Pros	Cons	Pros	Cons

Questions to help focus Pros and Cons:

1. Which staff members are available to lead AWVs?

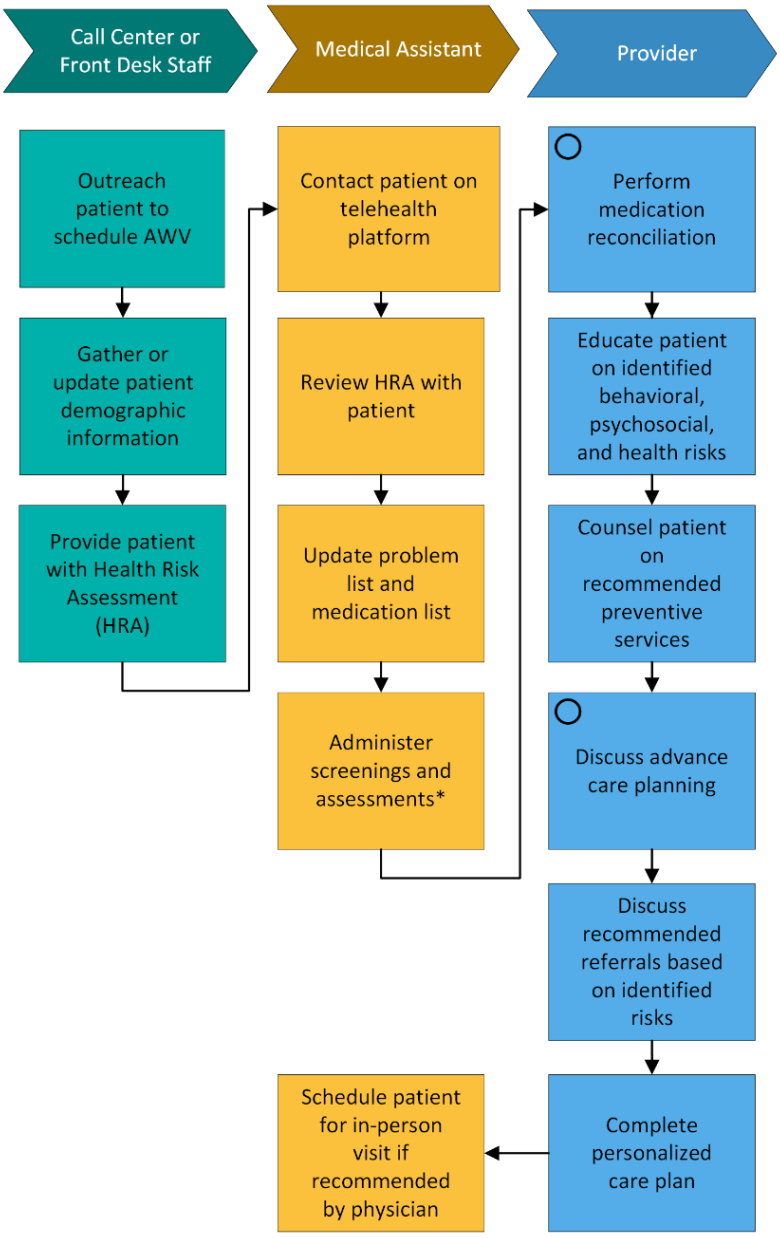
2. How much time can our medical providers devote to AWV completion?

3. Is our Medicare patient population agreeable to seeing providers other than their PCP?

A Third Option: Telehealth

During the public health emergency related to COVID-19, Medicare approved using telehealth visits to complete AWVs. This approval was extended through December 2024. At this time, it is uncertain whether this will be extended again. However, during the COVID-19 pandemic, telehealth became a viable option for patients who have barriers to in-person visits. It is important to note that the reimbursable rate for an AWV completed via telehealth is significantly lower than an AWV completed in the office.

See below for a sample workflow for telehealth AWVs as a resource for organizations who would like to add them to their traditional in-person AWV program.



*Some screenings and assessments will need to be adapted for telehealth visits. Physicians and non-physician medical professionals should direct support staff on how to adapt them.

◯ = Not an AWV requirement, but highly recommended

Creating Value with Patient Education & Outreach

Now that you have determined your overarching AWV program workflow, let's talk about creating value with patient outreach. Often, a patient's first introduction to an AWV comes through a phone call from support staff. If your support staff is not well-versed in the details of an AWV, your biggest challenge in implementing the program may be convincing patients to schedule the appointment. You'll likely get responses from your patients like "what's the point of this visit?" or "why would I come in if my doctor isn't going to listen to my heart or lungs?" After putting in so much effort to develop your workflow, this challenge can seem insurmountable, but there are a few key things you can do to set yourself up for success. We'll talk about those in this section.

Keys to Success in Scheduling AWVs

- Educate physicians, non-physician medical practitioners, care team members, billers, coders, and outreach staff on the in's and out's of AWVs.
- Physicians and non-physician medical practitioners as AWV champions.
- Create an AWV script for outreach staff.

Educating Staff on the Ins and Outs of AWVs

If you're going to be successful in scheduling AWVs, your entire care team, including outreach staff, need to understand and have the ability to convey the value of AWVs. This starts with education. CMS has provided a great starting point in their educational tools Medicare Wellness Visits PDF and Annual Wellness Visits video. You may need to target education to specific groups of staff members based on the role they play in completing AWVs.

Physicians and Non-Physician Medical Practitioners as AWV Champions

Physicians and non-physician medical practitioners are often the source of influence for care teams. As such, they play a large role in creating the culture surrounding AWVs. If your physicians and non-physician medical practitioners see the value of AWVs, they can then convey that value to the rest of the care team and to patients.

Create an AWV Patient Outreach Script

Empower your outreach staff by providing them with the knowledge to convey the value of an AWV to the patients they are outreaching by developing a brief script. Scripting allows for consistent messaging across all members of the care team, including outreach staff.

[see the following two pages for sample scripts]

Phone Scripts for Annual Wellness Visit Patient Outreach

Annual Wellness Visit Patient Outreach

Scheduler: *Hello Mr./Mrs./Ms. [PATIENT NAME], I am [YOUR NAME], calling from Dr. [PROVIDER NAME]'s office. We are contacting all of our eligible patients to schedule your Annual Wellness Visit.*

First, I would like to share with you a little bit about the Annual Wellness Visit and how important it is for you to use this benefit that Medicare provides.

As Medicare consumer, you are allowed a comprehensive Annual Wellness Visit every 12 months. This examination will help your doctor identify any health risks you may have and allow us to work with you to develop a plan to address your health care needs. Our goal is to help you reach your goals in getting or staying healthy. Medicare pays 100% of the cost for this exam with no out-of-pocket expense to you.

At this visit, if we need to address other medical concerns (like a sore knee or other medical conditions}, we want you to know you may have a deductible or copay.

What would be a good day to get your Annual Wellness Visit scheduled for you?

To prepare for this visit, please bring all medications (including inhalers and injectables) you take including over-the counter vitamins, supplements, and topical creams so we can update your records. In addition, we will be mailing/sending via portal you a 'Health Risk Assessment' form that we ask you complete prior to the appointment to assist us in developing a personalized prevention plan for you to stay healthy.

Annual Wellness Visit Patient Outreach – No Answer

Scheduler: *Hello, this is [YOUR NAME] from Dr. [PROVDER NAME]'s office. We are contacting all our eligible patients to schedule your Annual Wellness Visit. Please call our office at [PHONE NUMBER] so we can assist you in scheduling this very important visit.*

Note**:** Define how many calls will be made before sending the Annual Wellness Visit reminder letter to the patient. Best practice would be to document in the EMR each attempt to outreach along with any pertinent information for additional team members.

Annual Wellness Visit - Incoming Patient Call

Caller: *I am calling to schedule a physical with my doctor.*

Note: The patient may be returning your call or responding to the letter sent by the provider's office.

Scheduler: *Are you calling to schedule an Annual Wellness Visit that is covered by Medicare?*

The Annual Wellness Visit includes a Health Risk Assessment and other assessments allowing the clinic and member to update their records, define a screening schedule, address risk factors, and provide personalized health advice to the beneficiary - such as health education, counseling services, or programs.

Note: Determine if the patient is eligible for the Annual Wellness Visit. (12 months from previous routine physical exam or the Welcome to Medicare visit and patient has had Medicare Part B for at least 12 months) It is not required to have a Welcome to Medicare Visit to be covered for an Annual Wellness Visit after that patient has had Part B for 12 months.

If the patient expresses concern about their eligibility for this benefit, you may want to check eligibility prior to making the appointment.

Caller: *I understand and would like to schedule an Annual Wellness Visit with my physician.*

The visit is scheduled

Scheduler: *For the visit, please bring all medications (including inhalers and injectables) you take including over-the counter vitamins, supplements, and topical creams so we can update your records. In addition, we will be mailing/sending via portal you a 'Health Risk Assessment' form we ask you complete prior to the appointment to assist us in developing a personalized prevention plan for you to stay healthy.*

Missed Annual Wellness Visit Appointment

Scheduler: *Hello Mr./Mrs./Ms. [PATIENT NAME] I am [YOUR NAME] calling from Dr. [PROVIDER NAME] 's office.*

I see you missed your Annual Wellness Visit appointment. I am calling to help you reschedule your appointment. Dr. [PROVIDER NAME] feels this type of visit is very important to identifying any health risks you may have and allow us to work with you to develop a plan to address your healthcare needs.

What would be a good day to get this rescheduled for you?

To prepare for this visit, please bring all medications (including inhalers and injectables) you take including over-the counter vitamins, supplements, and topical creams so we can update your records. In addition, we will be mailing/sending via portal you a 'Health Risk Assessment' form we ask you complete prior to the appointment to assist us in developing a personalized prevention plan for you to stay healthy.

Pre-Visit Planning (PVP): Work Smarter, Not Harder

What is CHPA Pre-visit Planning?

Pre-visit planning (PVP) is a service that CHPA provides to members to aid your providers in conducting visits more effectively. CHPA's dedicated value-based coding advisors (VBCAs) do this by gathering and organizing clinical data found within the medical record, and recapture information from the payer portal prior to a patient's appointment. By accessing this aggregation of health information before the patient comes in, the provider has more time to devote their attention to the patient during the visit, and the administrative burden on the care team is reduced. With over 40 years of cumulative coding expertise within the Risk Adjustment & Quality Department, CHPA provides coding education and resources to give the provider much-needed time, guidance, and peace of mind as your trusted coding partners!

Why is Pre-Visit Planning Important?

PVP is a team-based approach to healthcare, where your care team and CHPA VBCAs work together to plan for a patient's appointment and ensure the patient is getting the best care possible. As a result of working as a team, the patient's acuity is accurately captured based on their coded health conditions that map to an HCC (hierarchical condition category). By providing diagnoses to the payer, so that they may recognize the complexity of the patient, this ensures that the payer is allocating funding appropriately and the care team can provide high-quality care. When PVP is performed, it ensures that shared savings benchmarks and stars ratings are being met. With PVP, you will be up to date on the patient's chronic conditions, changes in diagnoses from specialists, open quality care gap opportunities, and whether the patient has had an AWV in the current calendar year. **PVP saves clinical time, improves the quality of care for the patient, and strengthens care team satisfaction!**

Who is the target of Pre-Visit Planning?

CHPA conducts PVP for value-based contracts that your Community Health Center (CHC) is engaged in and assists in helping your CHC work towards shared savings. These contracts are for Medicare and Medicare Advantage populations, with a goal to move into Medicaid contracts in the near future.

What does a CHPA Value-Based Coding Advisor do for me?

The VBCA working with your CHC is responsible for looking at the provider's appointment schedule on a weekly basis before patients come in for their appointment. They review clinical documentation, recommend diagnoses that need to be recaptured, give feedback on diagnosis codes that are omitted from the medical record, and notify the provider of open quality care gaps (i.e., colorectal cancer screening, mammograms, etc.). The advisor will send a message providing all the information needing to be addressed at the visit, if clinically appropriate for the date of service. At the point of care, you can verify the diagnoses and improve the accuracy of the HCC score of the patient, and over time, the HCC goals of the CHC as a whole.

What does a PVP message look like?

Every electronic medical record (EMR) is different, and messages may be sent in various ways depending on your CHC's preference. In general, this is what you can expect when receiving a PVP message:

> Pt has 1 HCC code that has not been assessed and billed (recaptured) for 2024 yet' if appropriate please consider: I27.20 – Pulm HTN
>
> Pt is due for both an EGFR (BMP/CMP) for a microalbumin & A1C.
> Pt is due for colon cancer screening.
>
> Thank you for your time!
>
> Christine Smidt, CPC, CRC
> CHPA

> Next appointment is 7-22-24
>
> Listed below are all the HCC diagnosis that have been previously addressed/billed in 2023/2024, either by your clinic or another POS. If you agree that these are active conditions, can you please address them at the upcoming appointment, if you have time. If not, please consider addressing them in the future.
>
> J449 Chronic obstructive pulmonary disease, unspecified, last addressed on 12-1-23
>
> Patient is due for a colonoscopy, breast cancer screening, and AWV.
>
> If any of these are not current/active, please let me know and I'll make note of it, ensuring no future messages for those dx.
>
> All active HCC dx need to be billed at least once a year.
>
> Richelle Griffiths, RHIT, CCS, CRC
> CHPA

How can I interact with my risk adjustment specialist?

Responding to PVP messages is not required but can be helpful at times to give the coding advisor feedback. If a patient does not have a condition that their insurance is suspecting them to have, letting us know can help us document and report that information to our payer partners.

How to Code and Bill an AWV

Billing an AWV appropriately can be tricky, especially with different rules depending on the type of insurance and the specifics of the encounter. As such, we will break down how to bill an AWV for both Medicare and Medicare Advantage (MA) plans.

Specific Payment Codes

To begin, the first step in understanding how to bill an AWV for a patient is to understand the contract your CHC has with the payer. Specific payment codes are used for Federally Qualified Health Centers (FQHCs) when submitting claims to Medicare and MA plans under the FQHC prospective payment system (PPS) rate. To qualify as an FQHC visit, the encounter must be a "qualifying visit" type. For AWVs being billed with the PPS rate, first code **G0468**, followed by the AWV code **G0438/9** on the CMS-1450 (UB-04) form. For fee-for-service (FFS) contracts, the FQHC code is omitted, and the G0438/9 AWV code is billed on the CMS-1500 form. The CMS-1500 form (Medicare Part B) is used by individual healthcare providers, such as physicians and therapists, while the UB-04 (Medicare part A) form is usually used by institutional healthcare providers, such as hospitals, nursing homes, and rehabilitation centers. Most payers accept both forms depending on the encounter/procedure, and how the CHC is contracted (see contract for more guidance).

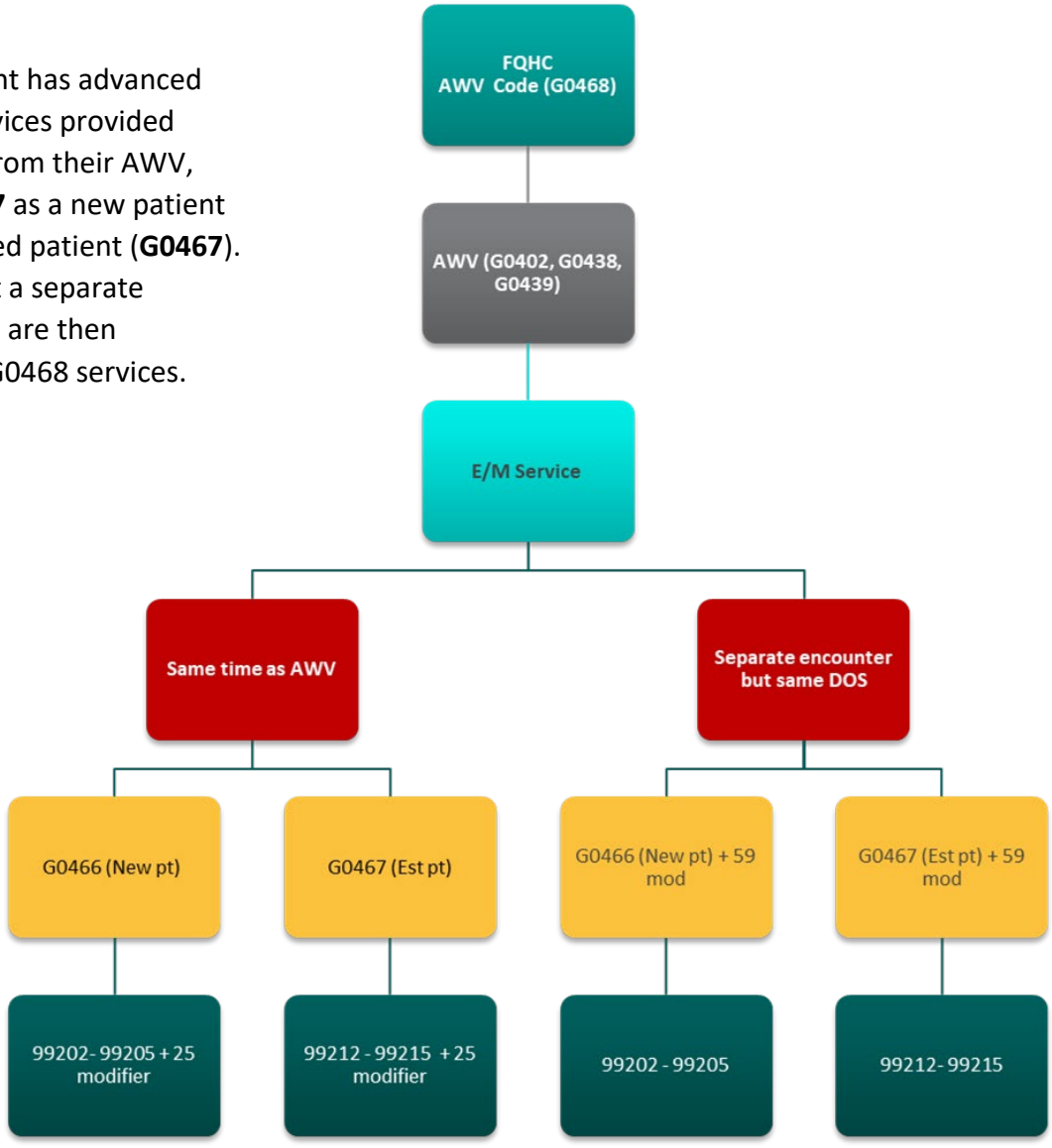
Specific Payment Code	Description
G0466	FQHC visit, new patient.
G0467	FQHC visit, established patient.
G0468	FQHC visit, IPPE or AWV.

Procedure Codes	Service Requirements	FQHC PPS
G0402	Initial Preventive Physical Exam for new beneficiaries during first 12 months of Medicare Part B enrollment	G0468
G0438	Initial AWV	
G0439	Subsequent AWV	

Straight Medicare

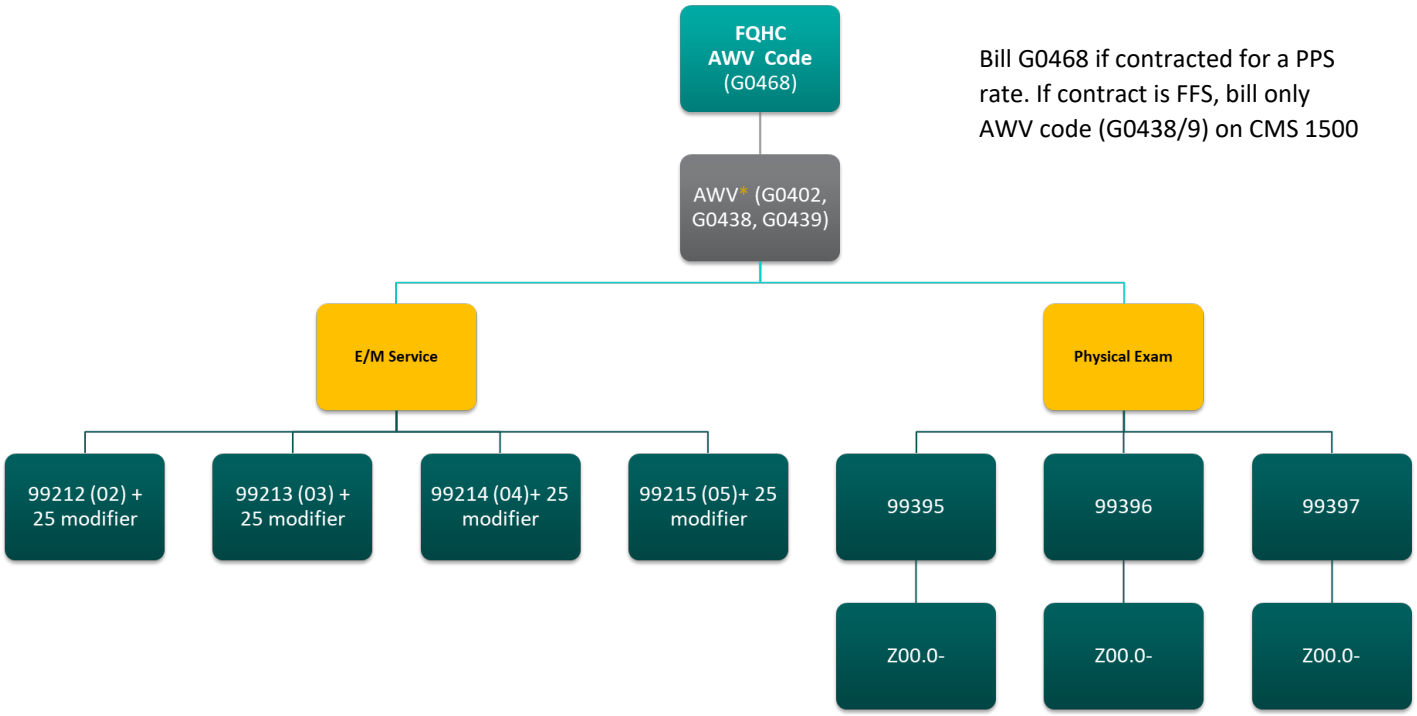
Medicare is more stringent yet straightforward than their Advantage plan counterparts regarding billing an AWV. FQHCs are reimbursed for an AWV as a standalone visit when all requirements in documentation and screenings are met, and no other AWVs have been performed within 12 months of their last AWV. To provide a separately identifiable service with an AWV, such as an evaluation and management (E/M) service, a separate Subjective, Objective, Assessment and Plan (SOAP) note should be written to support the additional billing of the service. When billing the AWV and the E/M, a **-25** modifier should be attached to the E/M service. When a patient has an AWV and a subsequent unrelated service on the same date of service, **modifier 59** is used. Modifier 59 is the FQHC's attestation that the patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day. For claims subject to the FQHC PPS, modifier 59 is only valid with FQHC payment code **G0467**.

When a Medicare Patient has advanced care planning (ACP) services provided during a separate visit from their AWV, FQHCs can bill for **99497** as a new patient (**G0466**) or an established patient (**G0467**). If the ACP is not done at a separate encounter, ACP services are then considered part of the G0468 services.



Medicare Advantage Plans

Medicare Advantage plans have many similarities to straight Medicare in documentation requirements, but when it comes to the timing and billing of the AWV, the MA plans differ greatly. To start, an AWV can be performed any time throughout the calendar year, unlike straight Medicare, which requires a patient to wait 12 calendar months before an AWV can be conducted and billed again. That means if a patient had an AWV performed in December of the previous calendar year, that patient can be brought back in January of the current calendar year, despite having one just a month prior. AWVs for MA plans must be completed by an acceptable provider type, and the provider must be face-to-face with the patient. If the visit is telehealth, the medical record should state that the encounter was completed with both audio and visual components. If the medical record does not state that the encounter was audio and visual, it is assumed to be the case. To bill an AWV, the codes are the same for **G0402**, **G0438**, and **G0439**, with the corresponding PPS **G0468** code if contracted as PPS. However, MA plans allow billing for an AWV and a physical exam at the same encounter when performed by the same provider for a reduced rate. To perform an AWV with a physical exam at the same encounter, all elements of both visit types must be covered during the joint encounter. The same goes for billing an AWV with an E/M service, except the -25 modifiers for a separately identifiable service will be placed with the E/M code. The patient will be charged a copay for the combined services, so be sure to inform the patient of the extra charge before performing the additional service.



ICD-10-CM Coding for AWVs

On January 1st of every calendar year, each Medicare and MA patient is assigned a Risk Adjustment Factor (RAF) number of **1.0**. This RAF score of 1.0 indicates a patient is of average health. Anything **over** 1.0 indicates a patient requires more care and is sicker than the average patient, while anything **below** 1.0 is considered healthier than the average patient.

Diagnoses that map back to a Hierarchical Condition Category (HCC) are captured (billed and paid on a claim by an acceptable provider type) over the span of a year by documenting and billing a patient's ICD-10 conditions. Conditions that map to an HCC increase the RAF score and determine reimbursement and allotment of funds in value-based care programs. After applying demographic data, the risk adjustment model (RAF scores) uses the year's reported conditions to predict the total cost of care for the next year. Each diagnosis must be re-evaluated, documented, and billed out on a claim annually – so patients must be seen at least once a calendar year. These conditions can be recaptured anytime within the calendar year. However, an **AWV is truly the best time to recapture these diagnoses**, as the wealth of documentation makes it easy to validate the diagnoses on the claim.

Impact of Appropriate HCC Coding on Payment

Female, age 76. Not: originally disables, Medicaid, ERSD, or institutionalized.
Demographic RAF score: .448

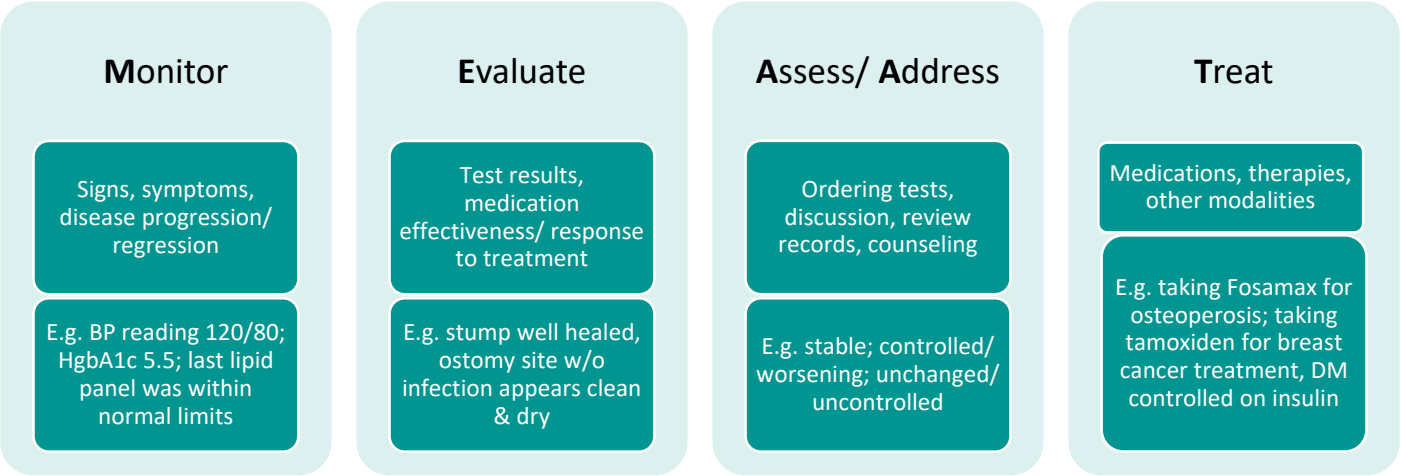
Option 1	HCC Risk Score
Obesity	0
Type 2 diabetes, Exudative retinopathy	.104, 0
Major depressive disorder, single episode, unspecified	0
CHF	.323
Asthma	0
Pressure ulcer of right heel, unspecified	0
CHF*DM	.154

RAF score: 1.029
Sample Medicare Advantage member payment, annual: $9K

Option 2	HCC Risk Score
Morbid obesity, BMI 42	.273
Type 2 diabetes w/ diabetic retinopathy	.318
Major depressive disorder, single episode, mild	.395
CHF, class 3	.323
COPD	.328
Pressure ulcer of right heel, stage 3	1.204
CHF*DM; CHF*COPD	.154, .19

RAF score: 3.633
Sample Medicare Advantage member payment, annual: $32K

Think of MEAT as You Chart



Complete but concise documentation in the medical record is the key to appropriate code selection! Specificity in documentation is extremely important in HCC coding, as some conditions do not carry a RAF if they are unspecified or uncomplicated. To document a condition effectively, a provider should thoroughly record the patient's active conditions to the highest specificity during an office visit, including how comorbidities are affecting the patient's health, what medications the patient is taking, whether the condition is stable, and the treatment plan for the condition. **Even if an outside provider or specialist is managing a comorbidity, it is up to the primary care provider to document and code all known conditions, as well as monitor and coordinate care for all diagnoses.** The level of complexity or presence of comorbidities can determine if the diagnosis is an HCC or not.

Documentation Examples

Example 1 Type 2 Diabetes with CKD stage 2- E11.22, N18.2

Assessment and plan (A&P): "Patient compliant with metformin and is stable. No current complaints or symptoms. Last A1c from 01/21/24 was 6.1. Patient has follow-up with Nephrology 5/1/24 to renew labs. Patient will come back in 3 months for f/u."

Example 2 Hypertensive Heart Disease with Heart Failure- I11.0, I50.9

A&P: Patient is compliant with Losartan and has no complaints or concerns. BP today 120/70. Patient maintains BP log at home and has had stable readings for the past 3 months. Will continue with current regimen. Patient has routine f/u with Cardiology 7/23/24."

Example 3 Type 2 Diabetes with Neuropathy with Insulin- E11.40, Z79.4

A&P: "Patient is non-compliant with at home glucose monitoring. Continues to drink sugary sodas and teas. Patient complains of numbness and tingling in lower extremities and feet. Referral sent to podiatry for diabetic foot exam. Patient given counseling on healthy eating, and encouraged to log blood sugars for next visit. Prescribed Novolog to be taken before meal times for glucose maintenance. Will follow-up in 3 weeks for repeat A1c labs."

All this documentation is more than enough to validate the ICD-10 codes and to help coders select the appropriate code to put on the claim. Notice that documenting the treatment plan and medication regimen is valid documentation and does not change the spirit of the "no touch" visit. Treat the medical record as if a first-time reader is reviewing the note. Provide a synopsis of the treatment plan and explain how you have taken care of the patient thus far (even if the condition is stable), as it helps a new reader understand the patient's situation. The record should be able to stand alone, and you should be able to understand the patient's medical needs by reading just one encounter. Even if you are not providing active treatment at an AWV, since it is a "no touch" visit, describing the status of their conditions, how you are monitoring them, and the treatment plan is sufficient.

CPT II Reporting Codes for Quality

CPT II codes are tracked for certain performance measures, including Healthcare Effectiveness Data and Information Set (HEDIS®) measures from the National Committee for Quality Assurance (NCQA). While some payers (e.g., Humana, UHC) accept supplemental data and records to close care gaps, payers have become more reliant on billing reporting codes rather than EMR data. CPT II coding reduces the administrative burden of uploading care records to the payers, allowing your CHCs quality scores to reflect the good care provided to the patient population.

Straight Medicare does not accept CPT II codes on the UB-04 form. To submit CPT II codes, bill on the CMS-1500 form. Medicare Advantage plans are more accepting of CPT II codes but **be sure to submit CPT II codes with a $0.01 charge.**

Common CPT II Reporting Codes for AWVs

HEDIS Measure	Helpful Tips	CPT II Code	Code Description
Controlling Blood Pressure	If two readings are taken at an encounter, blend the lowest systolic and the lowest diastolic readings for reporting.	3074F	Most recent **systolic** blood pressure less than 130mm Hg
		3075F	Most recent **systolic** blood pressure 130- 139 mm Hg
		3077F	Most recent **systolic** blood pressure greater than or equal to 140 mm Hg
		3078F	Most recent **diastolic** blood pressure less than 80 mm Hg
		3079F	Most recent **diastolic** blood pressure 80-89 mm Hg
		3080F	Most recent **diastolic** blood pressure greater than or equal to 90 mm Hg
Care of Older Adults (three elements)	**Functional Status Assessment** Notation of ADL's (bathing, dressing, etc.) or IADL's (grocery shopping, driving, etc.) were assessed and documented. **Medication Review** Medication list was reviewed and reconciled by a prescribing practitioner/clinical pharmacist, including date when performed or notation of patient not taking medication and date when noted. **Pain Assessment** Medical record with documentation of result of assessment using a standardized pain assessment tool, or notation of "no pain" within the encounter. *Note: **both** 1159F and 1160F must be reported to satisfy the medication review component of COA measure.*	1125F	Pain severity quantified; pain present
		1126F	Pain severity quantified; no pain present
		1159F	Medication list documented in medical record.
		1160F	Review of all medications by a prescribing provider/practitioner/clinical pharmacist documented in the medical record.
		1170F	Functional status assessed.
Advanced Care Planning	The medical record should include discussions of the patient's healthcare wishes if they become unable to make decisions about their care with or without legal forms. Includes living wills, instruction directives, health care proxy, health care power of attorney.	1123F	Advanced Care planning discussed and documented advanced care plan or surrogate decision maker documented in the medical record
		1124F	Advanced Care Planning discussed and documented in the medical record, patient did not wish or was not able to name a surrogate decision maker or provide an advanced care plan
		1157F	Advanced care plan or similar legal document present in the medical record
		1158F	Advanced care planning discussion documented in the medical record

Advanced Care Planning

For straight Medicare, FQHCs can bill for **99497** as a new patient (**G0466**) or an established patient (**G0467**) for ACP services provided during a separate visit from their AWV. If the ACP is not performed at a separate encounter, ACP services are considered part of the G0468 services and will not be separately reimbursed. ACP is an optional component of an AWV.

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6. Annual Wellness Visits video: https://www.youtube.com/watch?v=r7yOUaMJyJU

Assessment & Screening Tools (Page 10)

1. Patient Health Questionnaire - 9 (PHQ-9): https://www.apa.org/depression-guideline/patient-health-questionnaire.pdf
2. Stopping Elderly Accidents, Deaths & Injuries (STEADI) Algorithm for Fall Risk Screening, Assessment, and Intervention: https://www.cdc.gov/steadi/media/pdfs/STEADI-Algorithm-508.pdf
3. Mini-Cog: https://www.slu.edu/medicine/internal-medicine/geriatric-medicine/aging-successfully/pdfs/slums_form.pdf
4. AD8 Dementia Screening Interview: https://www.slu.edu/medicine/internal-medicine/geriatric-medicine/aging-successfully/pdfs/slums_form.pdf
5. St. Louis University Mental Status Examination (SLUMS): https://www.slu.edu/medicine/internal-medicine/geriatric-medicine/aging-successfully/pdfs/slums_form.pdf
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