



# Annual Wellness Visit (AWV): The Big Picture

The Why, What, Who & How

PRACTICE CHANGE PACKAGE



Quality  
Insights

## TABLE OF CONTENTS

THE ANNUAL WELLNESS VISIT: WHY? .....	1
THE ANNUAL WELLNESS VISIT: WHAT? .....	1
THE ANNUAL WELLNESS VISIT: WHO? .....	2
THE ANNUAL WELLNESS VISIT: HOW? .....	2
PREPARING FOR THE VISIT .....	2
PREPARING THE PATIENT FOR THE VISIT .....	3
VISIT ASSESSMENTS .....	3
HOW TO BILL.....	6
BILLING TIPS .....	8
ACKNOWLEDGEMENTS .....	10

This material was prepared by Quality Insights, the Medicare Quality Innovation Network-Quality Improvement Organization for West Virginia, Pennsylvania, Delaware, New Jersey and Louisiana under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number QI-AWV-031218

## THE ANNUAL WELLNESS VISIT: WHY?

One component of the ongoing transformation of the U.S. health care system is evolution from a curative medical model to wellness and preventive care. Clinical preventive services—which include immunizations, screening tests and counseling to prevent the onset or progression of disease and disability—are important tools to maintain the health of older adults. They help prevent or delay the onset of chronic disease, reduce associated complications, lower functional limitations, and help lower the risks and costs of treating chronic disease. Older adults who obtain clinical preventive services and practice healthy behaviors are more likely to remain healthy and functionally independent. In spite of this, fewer than half of adults age 65 years or older are up-to-date with core preventive services despite regular checkups. By 2030, the numbers of U.S. adults age 65 or older will more than double to about 72 million. This rapid increase in the number of older adults will put pressure on public health and health care systems, and the aging services network, making the role of clinical preventive services even more important. Recognizing this, the Congress has expanded preventive benefits in the Medicare program over time, increasing the number of services covered and decreasing their cost to beneficiaries through elimination of co-pays and deductibles. With the passage of the Patient Protection and Affordable Care Act (ACA), the cost barrier was largely eliminated. The ACA expands Medicare coverage for preventive services recommended by the U.S. Preventive Services Task Force (USPSTF) and removes out-of-pocket costs for most clinical preventive services provided under Medicare. Beneficiaries have access to Medicare-covered preventive services without paying a copayment or deductible. The benefit specifically includes an Annual Wellness Visit.

## THE ANNUAL WELLNESS VISIT: WHAT?

The AWW is similar to the Welcome to Medicare Visit (WMV) that is conducted in the first 12 months of enrollment in Part B Medicare coverage. The AWW is an ongoing yearly benefit starting after 12 months of enrollment in Part B Medicare coverage. The AWW is designed to provide clinical preventive services across all three stages of disease development: 1) before disease occurs, 2) before disease is clinically evident, and 3) before established disease has made its maximal impact. The information from the AWW is used to develop or update a plan to prevent disease and disability based on the beneficiary's current health status and risk factors. The AWW involves filling out a Health Risk Assessment as part of the visit. The AWW includes:

- A review of the medical history
- Developing or updating a list of current providers and prescriptions

- Height, weight, blood pressure and other routine measurements such as body mass index
- Detection of any cognitive impairment
- Personalized health advice
- Developing a list of risk factors and treatment options
- Utilizing a screening schedule checklist for appropriate preventive services.

## THE ANNUAL WELLNESS VISIT: WHO?

Nearly 90 percent of Medicare beneficiaries visit a physician at least once a year, making an average of six visits during the year. In spite of this, the Centers for Disease Control and Prevention has reported that only 33% of women and 40% of men aged 65 and over receive the full range of recommended age specific preventive services. The Affordable Care Act addressed this gap by expanding coverage for preventive services in seniors. On January 1, 2011, Medicare began paying for Annual Wellness Visits (AWV) designed to prevent disease and/or disability and to slow the progression of chronic disease. Following the coverage expansion, use of the AWV has been low. In 2014, CMS reported that only 14.5% of eligible Part B fee for service beneficiaries had taken advantage of the service, a proportion that had scarcely budged a year later.

## THE ANNUAL WELLNESS VISIT: HOW?

The following tools can help your team implement the AWV into your practice. This comprehensive list is categorized by topic for ease of use. These items are all available online.

### Preparing for the Visit:

- [Building the Annual Wellness Visit Delivery: Seven Strategies](#)
- [The ABCs of the Annual Wellness Visit](#)
- [Process Map for Annual Wellness Visit](#)
- [Telephone Scripts for Visits](#)
- [Diagram of a Suggested Work Flow](#)
- [Novitas Solutions Medicare Administrative Contracts](#) – check Annual Wellness Visit services for individual patients, ensuring it has not already been captured by another provider for the service period



Create an Annual Wellness Visit template and/or electronic Health Risk Assessment in your practice's EHR or assess your current templates and Health Risk Assessment for compliance. Contact your EHR vendor for technical assistance with building templates.

## Preparing the Patient for the Visit:

- [Patient Fact Sheet](#)
- [Visit Checklist](#) – list of items to review & verify as well as screen & assess during the visit
- [Annual Care Checklist](#) – this checklist is to be completed by the beneficiary prior to the Annual Wellness Visit

## Patient Letters

- [Annual Wellness Visit Letter to Patients with Medicare](#) – this letter introduces the beneficiary to the Annual Wellness Visit
- [Patient Letter](#) – this detailed letter explains the difference between the Welcome to Medicare Visit, the initial Annual Wellness Visit and subsequent Annual Wellness Visits



## Health Risk Assessments

- [Health Risk Assessment](#) (large font)
- [Health Risk Assessment](#)
- [Home Safety Checklist](#) – this two-page checklist offers suggested remedies to fix potential hazards
- [Action Plan](#) – this one-page flyer encourages the beneficiary to choose and document one goal to improve his/her health as a result of the Annual Wellness Visit

## Visit Assessments:

- [Alcoholism Screening](#)
- [Alcohol Screening \(SMAST-G\)](#)
- [Alcohol Use Among Older Adults](#)
- [Body Mass Index Table](#)

## Anxiety:

- [Generalized Anxiety Disorder Screener \(GAD-2\)](#)
- [Generalized Anxiety Disorder Screener \(GAD-7\)](#)



## Depression:

- [Patient Health Questionnaire \(PHQ-2\)](#)
- [Patient Health Questionnaire \(PHQ-9\)](#)
- [Alternate Geriatric Depression Scale](#)

### Mobility Assessment:

- [Stopping Elderly Accidents, Deaths & Injuries \(STEADI\)](#)
- [Stay Independent Brochure](#)
- [The Timed Up and Go \(TUG\) Test](#)
- [The 30-Second Chair Stand Test](#)
- [The 4-Stage Balance Test](#)
- [Stop Falls Website](#)
- [Algorithm for Fall Risk Assessment & Interventions](#)



### Memory Assessment:

- [Algorithm for Assessment of Cognition](#)
- [Mini Cog™ Screening for Cognitive Impairment in Older Adults](#)
- [Montreal Cognitive Assessment \(MoCA\) Form](#)
- [Montreal Cognitive Assessment \(MoCA\) Administration and Scoring Instructions](#)

### Medication:

- [AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults](#)
- [High-Risk Medications in the Elderly](#)
- [Annual Visit and Medication Planner](#)
- [Medication Reconciliation](#)
- [Medication Adherence](#)
- [State-Specific Medication Storage and Disposal Programs](#)

### End of Life Care:

- [Palliative Hospice Care Brochure](#)
- [West Virginia Center for End-of-Life Care](#)
- [New Jersey Department of Health Advance Directive](#)
- [Delaware's Advance Health Care Directive Form](#)
- [Pennsylvania Orders for Life-Sustaining Treatment \(POLST\)](#)
- [Louisiana Physician Orders for Scope of Treatment \(LaPOST\)](#)



### Honoring Care Decisions:

- [Talking to Patients About Care Planning](#)
- [Honoring Decisions For End-Of-Life-Care](#)
- [When Decisions Matter Most](#)

### Preventative Plans:

- [Men's Preventive Plan](#)
- [Women's Preventive Plan](#)
- [Preventive Services for Medicare Beneficiaries](#)
- [Medicare Preventive Services](#)



### \*Billing:

- [How to Bill Medicare's Annual Wellness Visit](#)
- [Annual Wellness Visit ICD-10 Codes](#)
- [Coding Medicare Annual vs. Regular Physicals \(Part 1\)](#)
- [Coding Medicare Annual vs. Regular Physicals \(Part 2\)](#)
- [Chronic Care Management Services Changes for 2017](#)
- [Medicare Preventive Services Quick Reference Chart](#)

\*Quality Insights has compiled this coding information for your convenience. This information is gathered from third party sources and is subject to change without notice. This information is presented for illustrative purposes only and does not constitute reimbursement or legal advice. It is always the provider's responsibility to determine medical necessity and submit appropriate codes, modifiers, and charges for services rendered. Please contact your local carrier/payer for interpretation of coding and coverage.

## How to Bill: Examples of Medicare AWV Claims Data

CPT Code	Description	Modifier	Diagnosis Code
G0439	Medicare Subsequent Physical	25	V70.0
93000	EKG		V70.0, 401.9
G0442	Annual Alcohol Screening		V70.0
G0444	Annual Depression Screening		V70.0
99214	Office Visit, Est. Pt., Level 4	25	401.9, 272.0, 241.0, 785.2
G0008	Admin Flu	59	V04.81
Q2037	Fluvirin Vaccine	59	V04.81
36415	Venipuncture, Routine		V70.0

CPT Code	Description	Modifier	Diagnosis Code
G0438	Medicare Annual Wellness 1 <sup>st</sup> Visit	25	V70.0
G0008	Admin Flu Vaccine	59	V04.81
Q2037	Fluvirin Vaccine	59	V04.81
36415	Venipuncture, Routine	N/A	V70.0
93000	EKG	N/A	250.00, 272.0, 401.9
G0442	Annual Alcohol Screening	N/A	V70.0
G0444	Annual Depression Screening	N/A	V70.0
99214	Office Visit, Est. Pt.	25	250.00, 272.0, 401.9

## Chronic Care Management

On November 13, 2014, the Centers for Medicare & Medicaid Services (CMS) issued the Medicare Physician Fee Schedule final rule, including a new code and guidance for billing for chronic care management services (CCM), effective January 1, 2015.

### Chronic Care Management *(Good news: we've been doing this all along)*

- ✓ Medication reconciliation
- ✓ Medication management (refills, prior-authorizations, etc.)
- ✓ Forms (DME, DMV, etc.)
- ✓ Coordination of care (referrals- consultants/home health/PT/OT)
- ✓ Transitions across care domains (Hospital <-> ER <-> Office <-> Home)
- ✓ Health maintenance and its coordination
- ✓ Out of office patient care



You're probably already doing the work – participation in current and previous quality initiatives sets your practice up for quality measure reporting.



### Overall Benefits of Chronic Care Management

- ✓ Patients will receive improved care
  - Increased touches with patients (patient better educated/more satisfied)
  - Identifying patient needs before known
    - Refilling meds just before needed (less calls to office)
    - Patient referred to services prior to ER/Hospital (decrease in ER visits)
    - Decrease high cost service utilization (as a result of pre-emptive care)
- ✓ Staff satisfaction (more involved with direct care and patient outcomes)
  - Receiving credit for work performed
  - Facilitate team-based care and office unity
- ✓ Improved performance with quality measures (PQRS, MU, CQM, CPC, MSSP)

### Guidance from *Chronic Care Management Services Changes for 2017*

TABLE 1. SUMMARY OF 2017 CCM CODING CHANGES

BILLING CODE	PAYMENT (NON-FACILITY RATE)	CLINICAL STAFF TIME	CARE PLANNING	BILLING PRACTITIONER WORK
CCM (CPT 99490)	\$43	20 minutes or more of clinical staff time in qualifying services	Established, implemented, revised, or monitored	Ongoing oversight, direction, and management Assumes 15 minutes of work
Complex CCM (CPT 99487)	\$94	60 minutes	Established or substantially revised	Ongoing oversight, direction, and management + Medical decision-making of moderate-high complexity Assumes 26 minutes of work
Complex CCM Add-On (CPT 99489, use with 99487)	\$47	Each additional 30 minutes of clinical staff time	Established or substantially revised	Ongoing oversight, direction, and management + Medical decision-making of moderate-high complexity Assumes 13 minutes of work
CCM Initiating Visit*	\$44-\$209	--	--	Usual face-to-face work required by the billed initiating visit code
Add-On to CCM Initiating Visit (G0506)	\$64	N/A	Established	Personally performs extensive assessment and CCM care planning beyond the usual effort described by the separately billable CCM initiating visit

\*(Annual Wellness Visit [AWV], Initial Preventive Physical Examination [IPPE], Transitional Care Management [TCM], or Other Qualifying Face-to-Face Evaluation and Management [E/M])

Note: See the appendix for the complete document, *Chronic Care Management Services Changes for 2017*

## Billing Tips

CPT Code	Description	Frequency	Avg. Medicare Fee
<b>G0402</b>	Welcome to Medicare Visit (First year only)	New to Medicare 1x	\$172.33
<b>G0438</b>	Initial well visit no longer in 1 <sup>st</sup> year of Medicare	1 per lifetime	\$157.26
<b>G0439</b>	Annual wellness who have utilized previous services	Every 365	\$105.26
<b>G0403</b>	Welcome to Medicare EKG	1 per lifetime	\$21.23
<b>99406/99407</b>	Symptomatic tobacco users 3min/10min	See below*	\$30.34
<b>G0436/G0437</b>	Asymptomatic tobacco users 3min/10min	See below*	\$15.64
<b>G0444 allowed only with G0439</b>	Annual depression screening	Annually	\$40.81
<b>G0442</b>	15 min Annual alcohol misuse screening	Annually	\$22.78
<b>G0443</b>	Brief counseling for alcohol misuse	4x year	\$29.67
<b>G0446</b>	Behavioral therapy for CVD	Bi-Annually	\$29.67
<b>G0447</b>	15 face-to-face behavioral counseling for obesity	See below*	\$29.67
<b>99401 (Commercial Insurance)</b>	15 min prev medicine/obesity screening/counseling	See below*	Based on commercial ins.
<b>99402 (Commercial Insurance)</b>	30 min prev medicine/obesity screening/counseling	See below*	Based on commercial ins.
<b>99496</b>	Transition in care 7 day	See below*	\$259.37
<b>99495</b>	Transition in care 14 day	See below*	\$184.37
<b>99490</b>	Chronic Care Management	Monthly	\$45.01
<b>99497</b>	Advanced Care Planning (16-30min)	No Limit*	\$85.99
<b>99498</b>	Advanced Care Planning (46-60min)	No Limit*	\$74.88

**\*G0447**

- Medicare covers screening for beneficiaries with obesity, defined as Body Mass Index (BMI) equal to or greater than 30 kg/m<sup>2</sup>
- One face-to-face visit every week for the first month
- One face-to-face visit every other week for months 2-6
- One face-to-face visit every month for months 7-12, if the beneficiary meets the 3kg (6.6 lbs.) weight loss requirement

**\*99401/99402**

- Will align reimbursement with Medicare including:
  - One face-to-face visit every week for the first month
  - One face-to-face visit every other week for months 2-6
  - One face-to-face visit every month for months 7-12 [if the member meets the 3kg (6.6 lbs.) weight loss requirement during the first 6 months]
- For members who do not achieve a weight loss of at least 3 kg (6.6 pounds) during the first 6 months of intensive therapy, a reassessment of their readiness to change and BMI is appropriate after an additional 6-month period

**\*99406/99407 and G0436/G0437**

- If the patient has symptoms related to their tobacco use, practitioners should continue to submit payment using the CPT® codes 99406 (intermediate) and 99407 (intensive) for their counseling efforts
- For asymptomatic tobacco using individuals, two new codes G codes have been introduced. Starting in January 1st, 2011, the Accountable Care Act (ACA) provided for a waiver of Medicare coinsurance and Part B deductible requirements for these two G codes only
- G0436 for greater than 3 minutes up to 10 minutes of counseling (intermediate)
- G0437 for greater than 10 minutes of smoking cessation counseling (intensive)
  - According to the CMS rule, Medicare will allow two individual tobacco cessation counseling attempts per year during which each attempt can include up to four intermediate or intensive sessions, for a maximum benefit of up to 8 sessions per year

**\*99497/99498**

- If performed during an AWW it is separately payable when utilizing a 33 modifier without being applied to the deductible or coinsurance. If performed with an E/M Medicare deductible and coinsurance apply.

## ACKNOWLEDGEMENTS

Thanks to the following organizations and individuals that allowed their materials to be included in this change package.

- Alzheimer's Association
- Anthem, Inc. (Empire Blue)
- Banner Health Network
- Dr. Ziad Nasreddine, Neurologist, MoCA© Copyright Owner
- Geriatric Workforce Enhancement Program
- MaineHealth
- New Hampshire Falls Risk Reduction Task Force
- Orange County Aging Services Collaborative (OCASC)
- Orange County Healthy Aging Initiative (OCHAI)
- Pennsylvania Medical Society
- Soo Borson, MD, Professor Emerita, University of Washington School of Medicine and Affiliate Professor, School of Nursing