HCCIntelligence™ PREMIER

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Annual Wellness Visit Template Guidelines

Purpose

This resource is intended for home-based primary care (HBPC) providers and practice staff and assists with the creation of an Annual Wellness Visit (AWV) template by outlining the required documentation elements necessary to bill Medicare for this service. This resource was developed utilizing Centers for Medicare & Medicaid Services (CMS) guidelines and requirements and can be referenced for further details.

- Health Risk Assessment (HRA)
  A Health Risk Assessment of choice may be completed by the patient prior to the visit or with assistance during the visit. For a complete sample HRA, please refer to the Centers of Disease Control (CDC).

  At a minimum, the HRA must assess or review:

  - Patient demographics
  - Patient self-assessment of health status, frailty, or physical/mental functionality
  - Biometric measures (height; weight; obesity; BMI; blood pressure reading from the past year; blood lipids including HDL, LDL, total cholesterol, and triglycerides; blood glucose, including blood sugar and hemoglobin A1C levels)
  - Psychosocial risks such as depression, life satisfaction, stress/anger, loneliness/social isolation, and pain/fatigue
  - Behavioral risks such as tobacco use, inadequate physical activity, poor nutrition or diet, excessive alcohol consumption, prescription drug use for non-medical reasons, and motor vehicle safety
  - Activities of Daily Living (ADLs) such as dressing, bathing, and walking
  - Instrumental ADLs (IADLs) including, but not limited to, using the phone, transportation, food preparation, shopping, housekeeping, managing own medications, and handling finances
  - Compliance with current screenings and immunizations
- Medical History Review

  The Annual Wellness Visit requires a review and update as appropriate, of:

  - Past medical history, Family & Social History (PFSH)
  - Hospitalizations & Surgical history (required)
  - Allergies
  - Medication list (including vitamins, minerals, and other supplements)

- Lifestyle and Preventive Care:
  - Exercise and physical activity
  - Diet and nutrition
  - Written screening and immunization schedule, e.g., 1-5-year checklist as appropriate for the patient
  - List of current providers and supplies, e.g., home health; specialists; Durable Medical Equipment (DME) such as a wheelchair, shower grab bars, etc.
  - Review of potential for depression and other mood disorders, e.g., PHQ-2 and PHQ-9 if indicated
- Review of functional ability and level of safety:
  - Hearing difficulty? (Yes or No)
  - Vision difficulty? (Yes or No)
  - Has the patient received an eye exam by an optometrist or ophthalmologist in the past two years? (Yes or No)
  - Basic and instrumental activities of daily living
  - Physical activities the patient may be unable to perform or has difficulty with, e.g., kneeling, bending or stooping, performing housework, lifting arms above the shoulder, lifting or carrying 10 pounds, walking short distances, writing or handling small objects
- Self-described overall health (Excellent/ Good/ Fair/ Poor)
  - Consider Vulnerable Elders Survey Scale Scoring (VES-13)
- Has the patient fallen in the past 12 months? (Yes or No)
  - Difficulty with walking or keeping your balance? (Yes or No)
  - Anything about living at home that makes you feel unsafe? (Yes or No)
- Physical examination: The AWV does not include a comprehensive physical exam. Documentation is limited to:
  - Hearing difficulty? (Yes or No)
  - Vision difficulty? (Yes or No)
- Mini-Cog test
  - Ask the patient to repeat three unrelated words, draw a clock, then ask them to recall the three unrelated words
  - Record number of words recalled and if the clock drawing was normal or abnormal
- List of risk factors or conditions from the patient's problem list for which interventions or current treatment is needed as well as an ongoing management plan
- Document any personalized health advice provided and referrals placed based on patient assessment
- Advance Care Planning (ACP)
  - Obtain patient consent for end-of-life planning discussion
  - Document summary of the discussion
  - If specific advance directive documents were discussed and/or completed
  - Document if counseling was provided and the exact amount of time spent
  - If at least 16 minutes face-to-face is spent on the ACP discussion, this is an additional billing opportunity to report using code 99497. Note, when ACP is conducted in conjunction with an annual wellness visit, the copay is waived.
- Social Determinants of Health (SDOH) Risk Assessment (NEW)
  - SDOH Risk assessment is optional and may be conducted during the AWV
  - CMS allows separate reporting of SDOH risk assessment using HCPCS code G0136 when performed with a standardized, evidence-based tool. (See Medicare Claims Processing Manual, Chapter 18)

- Assess social needs that may interfere with diagnosis or treatment
- Common domains include housing, food insecurity, transportation, utilities, safety, and financial strain.
- May be billed with AWV when separately documented and using the correct diagnosis (ICD 10) to support SDOH.

To determine the correct AWV HCPCS Code, you must verify if the patient is in their first 12 months of Medicare Part B enrollment, if they've ever had an initial annual wellness visit, or if it's a subsequent annual wellness visit that has not been conducted in the past 12 calendar months. You can verify eligibility through real-time eligibility within your EHR, an online verification tool, CMS's HIPAA Eligibility Tracking System HETS and/or by calling the Medicare toll-free provider number at 1-800-633-4227.

AWV HCPCS Code	Billing Code Description
G0438	Annual Wellness Visit; includes personalized prevention plan of service (PPS), initial visit (applies the first-time patient receives an AWV)
G0439	Subsequent Annual Wellness Visit includes a PPS. This code applies after initial AWV has been performed.
G0468	Federally Qualified Health Center (FQHC), IPPE, or AWV. Please visit the Medicare Claims Processing Manual for more information as specifics are not covered in this resource.
G0136	Social Determinants of Health (SDOH) Risk Assessment. Separately billable when a standardized, evidence-based SDOH screening tool is used. May be billed once every 6 months; no time requirement.

The John A. Hartford Foundation

HCCIntelligence™ is funded in part by a grant from The John A. Hartford Foundation.

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