Medicare Annual Wellness Visit (AWV)

Streamline Workflow to Perform a Thorough AWV

How Will This Module Help Me?

1. Describe the Centers for Medicare and Medicaid Services requirements for the Medicare Annual Wellness Visit
2. Assist with setting appropriate patient expectations for the Annual Wellness Visit
3. Provide an example of an efficient Annual Wellness Visit workflow for care team members
Introduction

Since the passage of the Affordable Care Act, the Centers for Medicare and Medicaid Services (CMS) has made a concerted effort to reform the payment schedule to promote preventive care and improve care coordination and chronic disease management for patients under Medicare. The Annual Medicare Wellness Visit (AWV) was the first of these changes to be introduced, followed by codes to reimburse physicians for transitional care management, chronic care management, advance care planning, and cognitive assessment. These reforms support the evolution of advanced primary care practices consistent with the idea of the patient-centered medical home. However, certain changes in day-to-day operations are required for primary care physicians to adapt to these changes.

The AWV is a type of office visit in primary care that involves preventive care, advanced care planning, and depression and dementia screening. It is an opportunity for physicians to update important information in a patient's chart such as the problem list or medication list, as well as to create and maintain a personalized screening and prevention plan. The AWV also identifies factors that, if not attended to, can negatively impact an older individual's health status (eg, mental health concerns, cognitive impairments). Accomplishing these tasks often involves in-depth conversations and non-face-to-face work, which is important and different from the focus of more traditional medical visits. The important tasks embodied within the AWV simply cannot be addressed adequately in a regular problem-based office visit. Incorporating a separate AWV not only removes the time constraint in accomplishing this critical work, but also provides a way for physicians to be reimbursed for it. As a result, these tasks are no longer viewed as an extraneous burden to tack onto a regular office visit, but appropriately as meaningful work. Ultimately, this feeling of accomplishing meaningful work that directly improves patient care is one of the drivers of joy in practice.

Three STEPS to Optimize the Annual Wellness Visit in Your Practice

1. Understand the Annual Wellness Visit (AWV)

2. Communicate with Patients to Set Expectations for the Annual Wellness Visit (AWV)

3. Map Out an Annual Wellness Visit (AWV) Workflow

Understand the Annual Wellness Visit (AWV)

CMS covers two types of annual wellness visits, an initial visit (G0438) and a subsequent visit (G0439). The initial visit is the first time a patient under Medicare receives an AWV, and subsequent visits include all subsequent AWVs. These are both different from the Initial Preventive Physical Examination (IPPE), which is a one-time visit for a patient within 12 months of enrollment in Medicare Part B. AWVs are for patients no longer within 12 months of enrollment and are covered once every 12 months. Detailed information about each of these visits can be found on the CMS website; bullet points of main topics are listed below. Answers to frequently asked questions (FAQs) about the AWV from the American Academy of Family Physicians (AAFP) can be found here.

The components of an initial AWV:

- Perform a Health Risk Assessment (HRA).
- Establish medical and family history
- Establish a list of current health care providers and suppliers
• Measure vitals
• Screen for cognitive impairment
• Review potential risk factors for depression
• Review functional ability and level of safety
• Establish an appropriate written screening schedule for the next 5 to 10 years
• Furnish personalized health advice and appropriate referrals to health education or preventive counseling services or programs
• Establish a list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or underway
• Discuss optional advance care planning services

A subsequent AWV contains essentially all the same components as an initial AWV, except the goal is to review and update each of the components rather than establish them de novo.

Many physicians choose not to perform an AWV because they perceive it to be too onerous. Adoption and routine use of the AWV across the country remains low to modest at best. However, most of the components of the AWV can (and should) be performed by the non-physician care team, including medical assistants (MAs). Their job should be to collect the data; your job is to synthesize the findings and provide recommendations. In short, you don’t have to do it all.

Medicare covers the AWV if it is furnished by a:
• Physician (Doctor of Medicine or Osteopathic Medicine)
• Physician assistant
• Nurse practitioner
• Clinical nurse specialist
• Medical professional or team of professionals (eg, health educator, registered dietitian, nutrition professional, or other licensed practitioner, such as a medical assistant) working under the direct supervision of a physician. Direct supervision is defined as being physically present in the office suite to render assistance, if necessary.

The AWV is well-reimbursed by Medicare, as illustrated in the table below.

Figure 1.
Medicare Reimbursement Coding for the AWV

<table>
<thead>
<tr>
<th>CODE</th>
<th>WORK RVU</th>
<th>TOTAL NONFACILITY RVU</th>
<th>MEDICARE PAYMENT (NONFACILITY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0438</td>
<td>2.43</td>
<td>4.84</td>
<td>$174.43</td>
</tr>
<tr>
<td>G0439</td>
<td>1.50</td>
<td>3.28</td>
<td>$118.21</td>
</tr>
<tr>
<td>99204</td>
<td>2.43</td>
<td>4.63</td>
<td>$166.86</td>
</tr>
<tr>
<td>99214</td>
<td>1.50</td>
<td>3.06</td>
<td>$110.28</td>
</tr>
<tr>
<td>99213</td>
<td>0.97</td>
<td>2.09</td>
<td>$75.32</td>
</tr>
</tbody>
</table>

Work Relative Value Units (RVUs) represent RVUs for activities performed personally by the physician. Work RVUs are the basis for many productivity-based physician contracts. Total RVU represents the sum of work RVUs plus RVUs for practice expense (eg, non-physician care team, equipment, and supplies) and malpractice expense. When the physician practice bears the cost of work RVUs, practice expense, and malpractice expense, total RVU is the...
basis of payment. This is true for the nonfacility setting, typically a private practice. Many hospital clinics are also paid this way.

Sometimes a hospital claims facility status. In that case, the hospital is paid for practice expense through the Hospital Outpatient Prospective Payment System. Payment for practice expense through the Physician Fee Schedule is therefore reduced, so that the total facility RVU will be less than the total nonfacility RVU. Work RVU is the same whether claiming facility or nonfacility status.

Communicate With Patients to Set Expectations for the Annual Wellness Visit (AWV)

The AWV is not the same as an annual physical (CPT codes: 99381-99397), and does not include a physical exam. Unlike with commercial insurers, there is no such thing as an “annual head-to-toe physical” when it comes to Medicare. What Medicare does cover are 1) problem-based visits that may involve some directed physical exam and diagnostic work up (an Evaluation and Management, or E&M, visit), and 2) the AWV. There are exceptions, however, as some Medicare Advantage plans provided via commercial insurers do cover an annual physical exam. Alternatively, some practices do perform an “annual exam” and charge patients directly (this should not be billed to Medicare).

Figure 2.
Components and Coverage of the AWV

<table>
<thead>
<tr>
<th>INITIAL PREVENTIVE EXAMINATION</th>
<th>ANNUAL WELLNESS VISIT</th>
<th>ROUTINE PHYSICAL EXAMINATION</th>
<th>ANNUAL WELLNESS VISIT/EVALUATION AND MANAGEMENT CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review medical history, and provide preventive wellness education</td>
<td>Patient visit to create or renew a personal preventive plan, and perform a health risk assessment</td>
<td>Exam conducted without relationship to treatment or diagnosis for specific illness, symptom, complaint or injury</td>
<td>Patient visit to create or renew a personal preventive plan, perform a health risk assessment, and a problem based visit for patients acute and chronic medical problems</td>
</tr>
<tr>
<td>Covered by Medicare only once within 12 months of Part B enrollment</td>
<td>Covered by Medicare once every 12 months</td>
<td>Not covered by Medicare</td>
<td>Covered by Medicare</td>
</tr>
<tr>
<td>Patient does not pay (if provider accepts assignment)</td>
<td>Patient does not pay (if provider accepts assignment)</td>
<td>Patient pays 100% of the out of pocket cost</td>
<td>Patient may pay a co-pay</td>
</tr>
</tbody>
</table>

It is essential to explain this to patients prior to their visit either with a phone call, handout, or FAQ letter.

The AWV can be performed on the same day as a routine E&M visit (to address problem-based concerns), or it can be separated into its own visit. There are pros and cons for each strategy, as described in the table below.
Figure 3.
Comparison of the Combined and Individual AWV and E&M Visits

<table>
<thead>
<tr>
<th></th>
<th>PROS</th>
<th>CONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combined visit</td>
<td>• One visit for the patient, more patient-centered</td>
<td>• Longer visit for patient and provider</td>
</tr>
<tr>
<td>(AWV + E&amp;M)</td>
<td>• Able to bill both AWV and E&amp;M (with 25 modifier) in one visit</td>
<td>• Patient may have a copay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Additional documentation required</td>
</tr>
<tr>
<td>Separate visits</td>
<td>• Cleaner separation between preventative wellness visit vs problem-based visit</td>
<td>• Two visits are required (care may seem fragmented; difficult for patients who have transportation issues)</td>
</tr>
<tr>
<td></td>
<td>• Less chance of information overload for patient</td>
<td>• Access may be difficult if provider availability is limited (2 visits required)</td>
</tr>
<tr>
<td></td>
<td>• No copay for the AWV portion</td>
<td></td>
</tr>
</tbody>
</table>

Q&A

What is the cost of an AWV for the patient?

While the AWV is 100% covered by Medicare, any E&M work done during the visit is subject to copays, deductibles, and coinsurance. If an AWV without E&M is done, there is no copay, deductible, or coinsurance owed by the patient. A patient is eligible for a yearly AWV after the first 12 months of Medicare Part B enrollment. However, an AWV is only covered once every 12 months; if a patient has already had an AWV elsewhere, they are not eligible for another one.

Map Out an AWV Workflow

After you decide whether to use a combined or separate visit approach for the AWV and problem-based visits, your office workflow can be established. Refer to the sample process map of the AWV workflow below for guidance on how to map out each step.
Q&A

What is an example of an AWV with E&M workflow?

1. Patient calls clinic to schedule an AWV. Alternatively, the Electronic Health Record (EHR) can send a list of patients eligible for an AWV, and care team members can contact these patients to schedule an appointment.
2. Send patient the pre-visit HRA. Ideally, the EHR allows the patient to load data from the HRA directly into their record.
3. During routine pre-visit planning, order appropriate preventive tests.
4. Patient arrives for their visit. If the HRA has not been completed, provide a copy is to the patient to fill out prior to rooming.
5. Perform usual rooming tasks and load data into the EHR. Clarify any ambiguities on the HRA.
6. Review positive findings from HRA and provide resources for positive findings. Resources should be available on the after-visit summary (AVS).
7. Continue with the problem-based visit to address any acute or chronic medical concerns, perform a necessary physical exam, and order necessary labs.
8. Review any questions that the patient may have about the content of the visit.
9. Document the visit using both AWV and E&M templates.

Conclusion

CMS now recognizes the important work done by primary care physicians that is different from the traditional “sick visit” model. By focusing the AWV on preventive screening, safety issues (eg, falls), and social needs (eg, food insecurity, transportation), patients’ qualities of life can be enhanced. Setting up a system within your practice that involves contributions from all members of the care...
team will maximize both patient benefit and practice reimbursement for this important work.

AMA Pearls

- Involve all members of the care team in the AWV; most of the tasks can be performed by the non-physician care team
- Communicate clearly with patients about what to expect and what is covered with an AWV
- Standardize your practice's AWV workflow and documentation templates

Learning Objectives
1. Identify the Centers for Medicare & Medicaid Services (CMS) requirements for the AWV
2. Outline an AWV workflow for care team members to ensure a thorough and efficient visit

Article Information

AMA CME Accreditation Information

Credit Designation Statement: The American Medical Association designates this enduring material activity for a maximum of 0.50 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Disclosure Statement: Unless noted, all individuals in control of content reported no relevant financial relationships.

ABP MOC Statement: Successful completion of this CME activity, which includes participation in the activity and individual assessment of and feedback to the learner, enables the learner to earn up to 0.50 MOC points in the American Board of Pediatrics' (ABP) Maintenance of Certification (MOC) program. It is the CME activity provider's responsibility to submit learner completion information to ACCME for the purpose of granting ABP MOC credit.

ABIM MOC Statement: Successful completion of this CME activity, which includes participation in the evaluation component, enables the participant to earn up to 0.50 Medical Knowledge MOC points the American Board of Internal Medicine's (ABIM) Maintenance of Certification (MOC) program. Participants will earn MOC points equivalent to the amount of CME credits claimed for the activity. It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of granting ABIM MOC credit.

ABONHS MOC Statement: Successful completion of this CME activity, which includes participation in the evaluation component, enables the participant to meet the expectations of the American Board of Otolaryngology's Maintenance of Certification (MOC) program. It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of recognizing participation.
References