

Going Beyond the Routine Physical: Your Guide to Annual Wellness Visits and Reimbursement

The days of the routine physical as the standard for preventive care are behind us.

A routine physical, when deployed properly, ensures that patients hit certain benchmarks, and it can uncover important health issues that need to be addressed. But as patients age and develop chronic conditions that require more aggressive responses from their care team, a different type of plan must be established, one that takes into account the heightened likelihood of complicating factors and disease development.

That's where the concept of the Annual Wellness Visit (AWV) comes in. This is not, by any stretch of the imagination, a routine physical. The AWV provides patients with a patient-centric, comprehensive annual review of their health status. Designed to identify chronic medical conditions and the prospective development of the same, the AWV includes preventive services and strategic medical planning that can stave off some of the worst complications patients may encounter.

The following White Paper serves as a Guide to the establishment of an appropriate Annual Wellness Visit program, helping you ensure that your covered Medicare Part B patients are being enrolled in the program and that you're performing the services necessary to get those patients the care they require and attain the applicable reimbursement.

Continue reading for more information on how to develop this program and benefit your patients and your facility.

The Basics

The Centers for Medicare and Medicaid Services (CMS) have done an exceptional job [laying out the basics of the program itself](#), which can only be implemented by Medicare Fee-For-Service Providers.

In the hyperlinked PDF document, CMS establishes the components inherent to any initial AWV for the patients as well as the components that need to be included in all subsequent visits. These differ slightly, as the patient who's never undergone the intensive health assessment of the initial appointment has differing needs than a patient who has been enmeshed within the system for years.

You'll also need to be aware of the five CPT codes to keep in mind depending on the distinct type of AWV provided and care received. G0438 and G0439, for instance, are the primary codes you'll be using for initial and subsequent visits, respectively. There is a third code for federally qualifying institutions that choose to bundle multiple Medicare services, such as the annual physical and any attendant tests said physical might typically entail.

Two additional codes can be submitted if your facility chooses to offer advance care planning in connection with the AWV (delving into directives and patient wishes in the event of some form of incapacitation). The only difference in these particular codes lies in the whether or not the face-to-face appointment takes 30 minutes, which will entail an initial code, or longer, which necessitates an additional code being appended to the first one.



The CMS document also lists some Frequently Asked Questions you may find worthwhile.

The following guide is not intended as an ad nauseum retread of what CMS has already established. What we're more concerned with, based on conversations with our own Medicare fee-for-service provider clients, is the minutiae of actually developing a program.

There's a reason not every healthcare organization implements AWVs with their patients. Actually establishing the parameters of the program can be difficult, requiring an in-depth analysis of the patient population, brainstorming the appropriate means of putting a program in place, hiring personnel to oversee and implement the AWV according to schedule, and more.

The remainder of this guide, therefore, will highlight eight areas of concern you'll need to address when managing the care of your patients according to AWV specifications. With a better understanding of these categories and the challenges they pose, you'll have a better idea of where you are in terms of timeline for your facility.

Patient Stratification

The first step of any Annual Wellness Visit program is to determine those within the patient population who actually qualify for and would benefit from administration of these procedures.

The first metric is straightforward: Medicare Part B patients are the only persons you're getting reimbursed for, thus your first step will be categorizing these persons into their own group. It's highly likely that you already have this information readily available.

The next step is where things may get a little complicated. You'll want to work with your key stakeholders to identify the persons who are most in the need of the AWV service. For instance, those who already suffer from certain chronic conditions and are at risk for readmission should be your initial rollout.



It will be up to you to identify the specific conditions and patient populations you want to target first. After all, when embarking upon an AWV strategy, you're going to want to start relatively small and slowly scale your way up to your entire qualifying patient population. How you go about that will depend on multiple factors, including your available resources, the varying levels of risk of your population, and more.

Our recommendation is to start with specific chronic conditions and then branch out from there. These are the patients whom could increase your administrative burden over the course of time, and thus their level of risk positions them well for the positive benefits of your AWV program.

Outreach and Explanation

Once you've targeted the applicable portion of your patient population and you have the resources in place to administer an AWV program, you then need to actually get in contact with these persons to gauge their interest.

How you phrase their participation is crucial. You can't force your patients to submit to an Annual Wellness Visit, so showing that it's in their best interest, both economically and for their wellbeing, is critical.

Determine those staff members who will be responsible for this outreach (social workers, case managers, support staff, etc.), the format in which they'll attempt to approach patients (EHR messaging, phone call, email), and devise a sample script these persons can use to broach the idea of the AWV program. It's important to maintain excitement and relate it as an opportunity. Emphasize the potential health benefits and speak to the ongoing importance of chronic condition management (or, in the case of persons who do not currently have a chronic condition, preventing those conditions or identifying them at the earliest possible juncture).

Most importantly, be sure to reassure the patient that the service is completely covered under Medicare. This will be the primary concern for many patients, so making note of this from the beginning is crucial for their ongoing participation.

Appointment Scheduling and Reminders

The initial outreach is also when many providers will likely want to start the process of scheduling appointments. After all, once you've told the patient about the situation, you'll increase your participation numbers if you can get them enrolled in the AWV program as quickly as possible.

Be ready to answer questions and then schedule the necessary in-person visit to get the patient into the new system. If the patient isn't ready to schedule the appointment right then or will need to look at their schedule, make sure to set follow-up phone calls or email reminders as necessary.

With the visit scheduled, you'll want to set up reminders one week, 24 hours and probably even one hour in advance to increase the overall chances that the patient keeps the appointment. You might even take it upon yourself to coordinate the patient's transportation to the facility. For those patients who struggle to find necessary transportation on a regular basis, apps like Lyft and Uber have been a boon to wellbeing, and you can further your own bond with the patient by setting up the ride for them, thus further reducing the chance of a missed appointment.

Medication and Medical History Reviews

It's also a good idea to use the time prior to the appointment as an opportunity to verify medications, supply of prescriptions and any other medical history questions you have. Getting as much information in ahead of time streamlines the process for the eventual AWV, even if you briefly review that same information when the individual comes for their in-person visit.

Health Risk Assessment

This is the cornerstone of any Annual Wellness Visit program.

CMS is explicit in the needs of a standard Health Risk Assessment, providing mandated information that must be included within the initial visit and in subsequent visits. Documenting these details and your adherence to the necessary processes is critical. The entire purpose of the Annual Wellness Visit is to properly identify the patient's degree of risk for a variety of conditions common to their demographic. Thus, properly completing this assessment is essential to the ongoing success of your program and the continued wellbeing of your patients.

Create a proper questionnaire and train staff to acquire the necessary information about daily activity, medical history, family history, social determinants of health, and anything else that could have an impact on their wellbeing. This survey will go hand in hand with any measurements that the patient's care team acquires in order to supplement the relevant history with actionable, quantifiable data about the patient.

Please note that much of this patient's history and current health picture can be attained during a pre-screening questionnaire. Members of the care team are encouraged to verify as many details as possible prior to the appointment itself. However, CMS requires the patient to come in for an in-person meeting with their physician, non-physician practitioner (PAs, NPs, or CNSs) or other medical professionals under direct physician supervision, so there will always be some kind of in-person component.

For those interested in the additional revenue and patient wellbeing opportunity offered by advance care planning services, the health risk assessment stage is also where those conversations can and should take place, with literature and forms taking into account the patient's requests for care and their beneficiary information.

Preventive Services Flagging

Once you have the information necessary to gain an accurate picture of the patient's health and assorted risk factors, you can analyze this information to understand the types of preventive services that can minimize risk and keep the individual's health on track.

Please note that this is really only step one in the journey. The Health Risk Assessment may be complete, but your care management efforts have only just begun. From here, you can



begin to work with the patient to address high-risk situations and maintain a certain baseline of health.

Keeping lines of communication open with your patients is an important step at this juncture. You need to let patients know the steps they can expect in the months and years to follow, appointments that will need to be made and kept, therapies that will be pursued, vital signs that will be tracked, changes to diet or daily activities, etc. By bringing the patient in as a partner to their own health, preventive services have a greater chance of success. And communication is key to that.

Documentation Within EHR

Once you have the patient's statistics on file and a plan of action for preventing chronic conditions and other health dangers, you need to add this information into an EHR accessible to every member of the care team and, ideally, to the patient.

In this way, the physician, the patients, the nurses, the technologists, the specialists, and anyone else who will conceivably play a role in that patient's ongoing wellness will be on the same page. Everyone sees the role they have to play within the system drawn up by the physician or practitioner.

This record will, out of necessity, be updated yearly or even sooner as changes take place in order to ensure the plan reflects the current reality of the patient's health situation.

Billing and Reimbursement

Finally, what begat this entire guide in the first place: billing and reimbursement. After following the steps listed above and establishing your AWV program, you're now in a position to bill Medicare for the procedure.

Because you've been diligent about documenting the relevant information within the patient's EHR and your own processes for coordinating your AWV program, you should have no problem filing the appropriate CPT codes and getting reimbursed for the same.

Using [CMS's Physician Fee Schedule](#), here are the 2018 reimbursement rates:

Type of Visit	Code	Reimbursement Rate
Initial Annual Wellness Visit	G0438	\$175.32
Subsequent Annual Wellness Visit	G0439	\$119.16
Advance Care Planning (first 30 minutes)	99497	\$80.64 - \$86.04
Advance Care Planning (subsequent 30 minute increments; stacks with initial 30 minute block)	99498	\$75.60 - \$75.96

Those reimbursements can be substantial, particularly once you scale your program to reflect the majority of your eligible patient population.

Getting Started

Annual Wellness Visits have the potential to keep patients healthy and limit the strain that your most at-risk patients can put on your resources.

Establishing an AWV program is the next big step for forward-thinking healthcare institutions. By directing resources toward the AWV screening process, you have the potential to transform care management for the better, as well as create an extensive new revenue opportunity for your facility.

 [Contact Ensocare for more information on developing an AWV program at your organization.](#)

