Annual Wellness Visit (AWV)

wellcare By allwell.

The Annual Wellness Visit (AWV) is a yearly appointment with a primary care provider (PCP) to create or update a personalized prevention plan and perform a Health Risk Assessment (HRA). This plan may help prevent illness based on a member's current health and risk factors.

During COVID-19, many AWV services can be completed via a telehealth visit. Please refer to the NCQA & CMS sites for up to date guidelines:

https://www.ncqa.org/covid/?utm_source=sf&utm_medium=email&utm_campaign=hedis-update-nov2020

https://www.cms.gov/files/document/general-telemedicine-toolkit.pdf

During an Annual Wellness Visit, the PCP develops a personalized prevention plan for the member, which includes the following actions:

- ✓ Check height, weight, blood pressure, BMI value and other routine measurements
- ✓ Give member a health risk assessment
- ✓ Review functional ability and level of safety
- ✓ Learn about medical and family history
- ✓ Review lists of current providers, durable medical equipment (DME) suppliers, and medications
- ✓ Create a written 5-10 year screening schedule or check-list
- ✓ Screen for cognitive impairment, including diseases such as Alzheimer's and other forms of dementia
- ✓ Screen for depression
- ✓ Provide health advice and referrals to health education and/or preventive counseling services

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When evaluating members and establishing the presence of a diagnosis, remember to put the M.E.A.T. (Monitoring, Evaluating, Assessing/Addressing, & Treating) in your documentation.

Monitoring	Evaluating	Assessing/Addressing	Treating
• Signs • Symptoms • Disease Progression • Disease regression	• Test Results • Medication Effectiveness • Response to Treatment	• Ordering Tests • Discussion • Review Records • Counseling • Planning	• Medications • Therapies • Other Modalities • Referrals to Specialists • Disease Management Programs • Testing

Care of the Older Adult

The Care of the Old Adult (COA) measures can also be incorporated into the annual wellness visit.

COA includes members 66 years of age and older who had each of the following at least once during the measurement year:

- ✓ Advance Care Planning
- ✓ Medication Review
- ✓ Functional Status Assessment
- ✓ Pain Assessment

Services rendered during a telephone visit, e-visit or virtual check-in meet criteria for the Advance Care Planning, Functional Status Assessment, Pain Assessment indicators and Medication review.

Advance Care Planning

Requires evidence of advance care planning that took place during the measurement year.

CPT	CPT CATEGORY II	HCPCS	ICD10
99497, 99483	1123F, 1124F, 1157F, 1158F	S0257	Z66

To improve HEDIS scores:

- ✓ Document discussion of advance care planning on an annual basis.
- ✓ Ensure that at least one of the following is documented in the medical record:
  - Presence of an advance care plan in the medical record- advance directive, actionable medical orders, living will, surrogate decision maker.
  - Advance care planning discussion and date (during the current measurement year); oral statements documented from family members or friends is acceptable.
  - Notation that a previous executed advance care plan was completed (must be dated on or before December 31 of the measurement year)

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Medication Review

Requires at least one medication review during the measurement year **and the presence of a medication list in the medical record or transitional care management services.**

	CPT	CPT CATEGORY II	HCPCS
Medication Review	90863, 99605, 99606, 99483	1160F	
Medication List		1159F	G8427

To improve HEDIS scores:

- ✓ Include the medication list in the record (add CPT II 1159F or HCPCS G8427) and at least one time, documentation of review of the medications by a physician or pharmacist (add CPT 90863, 99605, 99606, 99483 or 1160F).

Medication review does not require the member to be present.

Functional Status Assessment

Requires at least one functional status assessment completed and dated during the measurement year.

CPT	CPT CATEGORY II	HCPCS
99483	1170F	G0438, G0439

To improve HEDIS scores:

Use of a standardized functional status assessment tool, documentation of assessment of activities of daily living (ADL) or instrumental activities of daily living (IADL) should be completed.

- ✓ Activities of Daily Living (ADL): Bathing, dressing, eating, transferring [from chair or bed], using toilet, and walking.
- ✓ Instrumental Activities of Daily Living (IADL): Shopping for groceries, driving and using public transportation, using telephone, meal preparation, housework, home repair, laundry, taking medications, and handling finances.

A functional status assessment limited to an acute or single condition, event or body system does not meet criteria for a comprehensive functional status assessment.

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Pain Assessment

Requires at least one pain assessment documented during the measurement year

CPT CATEGORY II
1125F, 1126F

To improve HEDIS scores:

Ensure that the member is assessed for pain routinely and at least one of the following is documented in the medical record:

- ✓ Negative or positive findings for pain.
- ✓ Acute or chronic findings for pain.
- ✓ Standardized pain assessment tools, i.e. numeric rating scales, FLACC scale, Faces Pain Scale, etc.

**** Documentation of chest pain, pain specific to an injury or condition does not meet this criteria.***
**** Pain management plans or pain treatment plans alone do not meet this criteria.***