

Annual Wellness Visit Provider Form

MEMBER NAME: _____ DOB: _____

PROVIDER SIGNATURE _____ Date of service: ____/____/____

Services provided

- ___ **Initial Preventive Physical Exam (IPPE) G0402** *(During first 12 months of Medicare enrollment)*
- ___ **Initial Annual Wellness Visit with a personalized prevention plan of service (AWV with PPS) G0438**
(after 12 months and has not received an IPPE or AWV within the past 12 months)
- ___ **Subsequent AWV with a personalized prevention plan of service (Subsequent AWV with a PPS) G0439**
(has not received an Initial Preventive Physical Examination (IPPE) or AWV within the past 12 months)

Optional Element of AWV

- ___ **Advanced Care Planning CPT-99497** *(To include the explanation and discussion of advanced directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional: **first 30 minutes**, face to face with patient, family members(s) and /or surrogate. **(A diagnosis code is required and should be consistent with a beneficiaries exam)**)*
- ___ **Advanced care planning CPT-99498** - same requirements as above for each **additional 30 minutes** *(List separately in addition to code for primary procedure)*

Please Complete form (4 pages) and attach office visit note:

Fax to 1-860-907-3724

OR

Upload to the provider portal to HEDIS Record Submission category

SAVE COPY IN MEMBERS CHART

Acquire / Update Member Information

(Acquire / Update patient's medical and social history)

1. Administer HRA *(Initial AWV and Subsequent AWV with PPS)*

Collect self-reported information from member: **at a minimum address the following topics:**

- ___ Demographic data
- ___ Self-assessment of health status
- ___ Psychosocial risks
- ___ Behavioral risks
- ___ Activities of Daily Living including, but not limited to dressing, bathing and walking
- ___ Instrumental ADL's, including but not limited to: shopping, housekeeping, managing own medications and handling finances

2. Establish/ Update a list of current providers and suppliers:

- Current providers
- Suppliers
- Pharmacy
- Any providers involved in providing medical care

3. Establish /Update Members Medical/Social History and Family History

- Past Medical History: illnesses, hospital stays, injuries, treatments
- Past Surgical History: operations
- Current Medications/Supplements/Vitamins/Allergies
- Family history: Medical events of parents, siblings and children: diseases that may be hereditary or place member at risk
- History of Alcohol/ Tobacco/ Illicit Drugs
- Physical Activity
- Pain Assessment

4. Review members potential risk factors for depression including current or past experiences with depression or other mood disorder

- Depression screening (*Initial AWW only*)

5. Review /Update members functional ability and level of safety

- Hearing Impairment
- Ability to successfully preform ADL/IADL (*initial and subsequent*)
- Fall risk
- Home safety

Begin Assessment and Discussion
(*Physical Exam and Discussion*)

1. Exam

- Height
- Weight
- Body Mass Index
- Blood Pressure
- Visual acuity
- Other factors deemed appropriate based upon the members medical and social history and current clinical standards

2. Establish / Update / Detect any cognitive impairment member may have

- Direct observation
- Obtained by family, friends, caretakers or others

Counsel Member

1. Establish/Update a written screening schedule for member, checklist for next 5-10 years as Appropriate

Scheduled date for appropriate screenings and other preventative services:

- DATE: _____ Abdominal Aortic Aneurysm Screening ultrasound
- DATE: _____ Alcohol Misuse Screening and Counseling
- DATE: _____ Bone Mass Measurement (Bone Density Test)
- DATE: _____ Cardiovascular Disease (Behavioral Therapy) CVD risk reduction visit
- DATE: _____ Cervical Cancer screening with Human Papillomavirus test (HPV)
- DATE: _____ Cardiovascular Screenings (cholesterol, lipids, triglycerides)
- DATE: _____ Colorectal Cancer Screening: **(Please fill in completion date below)**
- DATE: _____ FOBT/FIT
- DATE: _____ FIT DNA
- DATE: _____ Colonoscopy
- DATE: _____ Sigmoidoscopy
- DATE: _____ Colonography
- DATE: _____ Depression Screening
- DATE: _____ Diabetes Screening: A1C, nephropathy, eye exam
- DATE: _____ Diabetes Self-Management Training
- DATE: _____ Influenza Virus Vaccine and administration
- DATE: _____ Glaucoma Test
- DATE: _____ Hepatitis B Virus Vaccine and administration
- DATE: _____ Hepatitis C Screening
- DATE: _____ HIV Screening
- DATE: _____ Lung Cancer Screening counseling and Low dose computed Tomography (LDCT)
- DATE: _____ Mammogram screening
- DATE: _____ Medical Nutrition Therapy Services
- DATE: _____ Obesity Screening and Counseling
- DATE: _____ Pap test and Pelvic exam (included breast exam)
- DATE: _____ Pneumococcal Vaccine and administration
- DATE: _____ Prostate Cancer screening
- DATE: _____ Sexually Transmitted Infections Screenings and High intensity counseling to prevent STIs
- DATE: _____ Tobacco use cessation (counseling to stop smoking)
- DATE: _____ * **Once in lifetime screening EKG/ECG as appropriate***

2. Establish /Update a list of risk factors and conditions for which the primary, secondary, or tertiary interventions are recommended or underway for member

- _____ Any mental health conditions or risk factors or conditions identified through and IPPE
- _____ A list of treatment options and their associated risks and benefits

3. _____ Educate, Counsel and refer based on previous components and other preventative services when appropriate

4. _____ Furnish personalized health advice to member and a referral as appropriate to health education or preventive counseling services or programs

DATE: _____ Community based lifestyle interventions to reduce health risks and promote Self-management and wellness

DATE: _____ Fall prevention

DATE: _____ Nutrition

DATE: _____ Physical activity

DATE: _____ Tobacco-use cessation

DATE: _____ Weight loss

5 End of life planning, Advanced Directives

Examples: *Living will, health care power of attorney, health care proxy, physician Orders for Life sustaining treatment, five wishes, written document designating a surrogate decision maker, documentation of a conversation with relatives/friend about life sustaining treatment and end of life care)*

___ Discussion of Advanced Directives

___ Verbal or written information provided to member if no plan is noted

___ Are you willing to follow member's wishes as expressed in advanced directive?

Generally, you may provide other medically necessary services on the same date of service as an AWV. The deductible and coinsurance/copayment apply for these other medically necessary services.

When you provide a significant, separately identifiable, medically necessary Evaluation and Management (E/M) service in addition to the AWV, Medicare may pay for the additional service. Report the Current Procedural Terminology (CPT) code with modifier -25. That portion of the visit must be medically necessary to treat the beneficiary's illness or injury or to improve the functioning of a malformed body member.

The AWV does not include any clinical laboratory tests, but you may make referrals for such tests as part of the AWV, if appropriate.

You must report a diagnosis code when submitting a claim for Advanced Care Planning as an optional element of AWV. Since you are not required to document a specific diagnosis code for ACP as an optional element AWV, you may choose any diagnosis code consistent with a beneficiary's exam.

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