

# Annual Wellness Visit (AWV)



# Overview

AWV is scheduled with primary care provider and consist of completing Health Risk Assessment (HRA) once a year and does not require a physical exam.

Visit may include:

- Measuring height, weight, BMI, and blood pressure and other routine measurements are checked
- Reviewing family and medical history
- Ordering of recommended tests and immunizations
- Conducting a health risk assessment
- Reviewing functional ability, level of safety, and risks for disease
- Checking for cognitive impairment (if applicable)
- Self-assessment of health status, psychosocial and behavioral risks, and activities of daily living (ADLs), instrumental ADLs including but not limited to shopping, housekeeping, managing own medications, and handling finances
- Reviewing preventative care needs, identifying risks or conditions, and providing education and resources
- Completing the Advanced care planning worksheet

\*excludes specific treatment for acute or chronic condition\*

# Annual Wellness Visit

## WHY IS IT IMPORTANT

- It allows practices to gain information about the patient and review the patient's wellness
- Primary care provider (PCP) can develop a personalized prevention plan and update it as needed to help prevent disease or disability based on current health and risk factors
- The AWW provides an opportunity for PCP to improve the quality of care, assist in patient engagement, and optimize payment opportunities
- This service is used to document diagnoses and conditions to accurately reflect patient severity of illness (hierarchical condition category [HCC] coding) and risk of high-cost care

<https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/annual-wellness-visits.html>

# Understanding the Measure

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### Annual Wellness Visit:

- Identifies star measures care gaps opportunities
- Assess all active conditions
- Review & reconcile medication list
- Order all applicable lab panels for screening
- Preventive health screenings for BCS, COL, Diabetes screening tests
- Use Appointment Agenda as a guide when completing AWV – all diagnosis must be answered as active or not active

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## TALKING POINTS WITH PROVIDER GROUPS

- Discuss with provider groups that this visit:
- Is an opportunity to identify care gaps and preventive services needed
- Provides an opportunity to deliver, document and bill for the service
- Allows provider groups to invest in patient-centered, team-based care while promoting quality and cost-effective care
- Is an opportunity to improve health outcomes by identifying and addressing social needs  
Examples: Problems related to unemployment, housing, support group, education and literacy
- Can be used to complete Appointment Agenda
- Talk about Continuity of Care (COC) program using the flyer to explain how this program works in conjunction with completing Appointment Agendas

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## PROVIDER GROUP'S KEY TO SUCCESS

Remind provider groups the following:

- Use this service to risk stratify your patient population
- Use this time to document any applicable social determinants of health
- For CoC Bonus Program, use this service to document diagnoses and conditions to accurately reflect patient severity of illness (hierarchical condition category [HCC] coding) and risk of high-cost care
  - Must complete all the diagnosis listed on the Appointment Agendas as active or not active
    - Can be completed and signed by other than primary care provider
    - Can be completed in the provider analytics, if provider group has Medicaid and or Marketplace and or Medicare
    - Can be completed in the Wellcare provider portal or RxEffect portal for provider groups who only has Medicare *line of business*

# Resources

- [Adult Pocket Guide](#)
- [CPT II Codes Flyer](#)

