



Medicare Annual Wellness Visit

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In 2011, the Centers for Medicare and Medicaid Services (CMS) introduced Annual Wellness Visit (AWV) fee-for-service billing codes in order to encourage healthcare providers to place increased focus on preventive care. The AWV is offered free of charge to Medicare beneficiaries with the stated purpose to “develop or update a personalized prevention plan, and perform a health risk assessment.”¹ The percentage of Medicare beneficiaries receiving AWVs increased from 7.5% in 2011 to 15.6% in 2014.² Early analyses suggest that, as intended, patients who receive AWVs are more likely to receive preventive services than patients who don’t receive AWVs.^{3,4} AWVs may also reduce total costs of care for some patients in accountable care organizations.⁵

Conducting AWVs

Ambulatory clinicians must determine a patient’s Medicare Part B eligibility and whether an initial AWV was previously performed for their patient by any provider (Figure 1).¹

Figure 1. Billing for AWVs*

Patient eligible for Medicare Part B for < 12 months →

Initial Preventive Physical Examination (CPT G0402)

Patient eligible for Medicare Part B for >12 months and has never had an AWV →

Initial AWV (CPT G0438)

Patient has had a prior AWV (regardless of who billed the initial AWV) →

Subsequent AWV (CPT G0439)

*CPT codes are for non-federally qualified health centers (FQHCs). A similar code for FQHCs is G0468; see <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf> for details. CPT is a registered trademark of the American Medical Association, and CPT codes, descriptions and related data are copyright American Medical Association, all rights reserved.

Clinicians must meet specific requirements of AWVs, including a review of the patient’s medical history as well as referrals to appropriate “health education or preventive counseling services or programs,”¹ outlined in Table 1.

Initial AWW	<ul style="list-style-type: none"> • Perform health risk assessment • Review medical and family history • Create list of current healthcare providers and suppliers • Measure height, weight, BMI (or waist circumference) and blood pressure • Assess for cognitive impairment • Review risk factors for and/or history of depression • Review functional ability and level of safety • Create preventive screening plan for the next 5-10 years • Create a list of risk factors and medical problems for which patients are receiving treatment • Provide advice and refer to appropriate health education, preventive counseling services • If desired by the patient, perform advanced care planning services
Subsequent AWW	<ul style="list-style-type: none"> • Review and update health risk assessment • Update medical and family history • Update list of current health care providers and suppliers • Measure weight (or waist circumference) and blood pressure • Assess patient for cognitive impairment • Update preventive screening plan • Update risk factors and medical problems for which patients are receiving treatment • Update advice and referrals to appropriate health education, preventive counseling services • If desired by the patient, perform advanced care planning services

Of note, the AWW can be performed by a range of clinicians, including physicians, nurse practitioners, physician assistants, and (directly supervised) health educators and registered dietitians, or other licensed practitioners.

Other Considerations

Table 2 reviews reimbursement rates for AWWs and standard outpatient office visits (CPT 99213, 99214) in 2019. Performing an AWW may have greater financial benefit to a clinic than the values noted below if the visit is used to update hierarchical condition category codes, which in turn can increase reimbursement for providers engaged in value-based payment models.

Code	Work RVUs	Reimbursement for Work RVUs*
99213	0.97	\$34.96
99214	1.5	\$54.06
G0438	2.43	\$87.58
G0439	1.5	\$54.06

Notes: *2019 conversion factor = \$36.04⁷

Future Directions

More research is needed to elucidate a number of issues related to AWWs, including longer-term trends in AWW use, the rate at which AWW claims are denied, common

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reasons for why AWW claims are denied, types of healthcare providers performing AWWs, barriers to AWW use, and most importantly, how AWWs affect patient outcomes.

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References

- ¹ Centers for Medicare and Medicaid Services. Annual Wellness Visit. Medicare Learning Network. Published August 2018. Accessed 17 Nov 2019 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AWW_Chart_ICN905706.pdf
- ² Ganguli I, Souza J, McWilliams JM, Mehrotra A. Trends in use of the US Medicare Annual Wellness Visit, 2011-2014. *JAMA*. 2017;317(21):2233-2235. doi: 10.1001/jama.2017.4342.
- ³ Jiang et al. The effect of Medicare's Annual Wellness Visit on preventive care for the elderly. *Prev Med*. 2018 Nov;116:126-133. doi: 10.1016/j.ypmed.2018.08.035.
- ⁴ Chung et al. Medicare annual preventive care visits: use increased among fee-for-service patients, but many do not participate. *Health Aff (Millwood)*. 2015 Jan;34(1):11-20. doi: 10.1377/hlthaff.2014.0483.
- ⁵ Beckman et al. Medicare Annual Wellness Visit association with healthcare quality and costs. *Am J Manag Care*. 2019 Mar 1;25(3):e76-e82.
- ⁶ Centers for Medicare and Medicaid Services. Physician Fee Schedule Search. 4 Oct 2019. Accessed 18 Nov 2019 at <https://www.cms.gov/apps/physician-fee-schedule>.
- ⁷ Centers for Medicare and Medicaid Services. Final Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2019. 1 Nov 2018. Accessed 18 Nov 2019 at <https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year>.

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