The Annual Wellness Visit for Medicare Beneficiaries/PCP and Care Transitions

Optimizing Benefit for Patient and Physician

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Objectives

- Audience will
  - Learn how to optimize reimbursement for the Medicare annual wellness visit
  - acknowledge appropriate screening for cognitive impairment in the older adult
  - recognize how to make advanced care planning as part of the annual wellness visit
  - Learn billing for care transitions.
Disclosures

- I have nothing to disclose
Goals - The Annual Wellness Visit

Improve care of older adults
More value per visit
Increase cognitive screening
Maintain continuity of care
78 y/o female with PMH HTN, Hypercholesterolemia, HOTH, OA hospitalized for UTI with sepsis.

Meds - Acetaminophen, Lisinopril, Amlodipine, Levothyroxine, Pravastatin

Saw PCP on week after discharge from hospital, husband reported some increased agitation, memory loss and pt not sleeping. Referred for geriatric assessment for dementia. “Brown bag” - all medications patient taking brought to geriatric office 2 weeks later

Patient HR 128, restless, confused
Primary Care Physician Role in Care Transitions

- Best practices in transitions of care
  - Comprehensive discharge planning (including psychosocial/financial and caregiving needs)
    - First fill
  - Medication reconciliation
  - Patient/caregiver “teachback”
  - Open communication between providers
  - Prompt follow up with outpatient provider

**MAKE YOUR PRACTICE OPEN TO APPOINTMENTS POST DISCHARGE**

- University of Michigan - Center for Healthcare Research & Transformation.
Primary Care Physician Role in Care Transitions

- **JCAHO recommendations.**
  - Multidisciplinary communication
  - Clinician involvement in all points of transition
  - Comprehensive planning and risk assessment throughout hospital stay
  - Standardized transition plans, procedures and forms
  - Standardized training
  - Timely follow up and coordination of care.
Primary Care Physician Role in Care Transitions

- Transitions of care: optimizing the handoff from hospital-based teams to PCP
  - Kim, MD, Coffey, MD American Family Physician 2014 May 1 706-707
- For PCP not following in hospital
- Programs that focus on whole patient rather than specific diagnosis are more successful in reducing readmit
- PCP should be involved 3 points in patient hospitalization - on admit, immediately at time discharge, post discharge follow up visit
  - Admit - discuss care plan, meds, history, social/family dynamics, estimated date DC
  - Immediately at DC /within 24-72 hours (contact pt) - pt continued symptoms, med changes, after care services
  - Follow up visit - discuss self care plan, med reconciliation, test results and tests to be done
Already Busy Practice

- CPT codes 99495 and 99496 for transitional care management services
- Try to get some added reimbursement for added time spent
- Established patient
- Transition from hospital stay, LTACH, SNF to home setting (home, AL, etc)
- Commences date of discharge for 29 days
- One face to face visit combined with non face to face services provided by clinical staff
  - Communication (patient/family, community services)
  - Education / Identify community and health resources
  - Assessment and support for treatment regimen, compliance / facilitate access to care
Already Busy Practice

- One face to face visit combined with non face to face services provided by physician/provider
  - Review discharge information
  - Review need for follow up diagnostic tests
  - Interaction with qualified health professionals
  - Education
  - Establishment referrals/arranging services
  - Assist scheduling appts
- First face to face included in TCM, others reported separately
- Requires contact with patient within 2 business days of discharge - any member of team, 2 reasonable failed attempts, ok to still bill
- Med rec no later than date of face to face visit.
Billing Transitions of Care Management

- CPT codes 99495 and 99496 for transitional care management services
- Determined by time of face to face visit and medical decision making
- Medical decision making
  - Moderate /within 7 or 8-14 days 99495
  - High/ within 7 days - 99496, within 8-14 days 99495
- Only one provider bill within 30 days
The Annual Wellness Visit

- Annual preventive health screening
- Begins 12 months after enrolling in Medicare
  - Welcome to Medicare Visit
  - Initial Annual Wellness Visit (one per lifetime)
  - Subsequent Annual Wellness Visits (annually)
- Must be provided by a health professional
  - Physician, NP, PA or other licensed practitioner working under direct supervision of a physician
- Cannot do in the same year as the welcome to Medicare exam
Coverage and Benefits

- No co-payments or deductibles for patients
- Limited scope visit (no physical exam)
- Problem-based visit can be added on same day
  - Add a -25 coding modifier - patient charged usual office visit copay
- Advanced care planning (ACP) can be added without a copay on the same day
  - Add a -33 preventative health coding modifier
- Next Gen ACOs - CMS provides a $25 payment to patients attributed to the ACO who have an AWV
Elements of the Annual Wellness Visit

- Provides a PPPS (Personalized Prevention Plan Services)
- Documentation of medical/ family history
- List of current providers regularly involved in patient care
- Review of Health Risk Assessment (HRA)
- Obtain full patient history
- List of current providers/suppliers
- Meds/allergies
- Patient assessment
  - Height, weight, BMI, BP
  - Does not require physical exam
Elements of the Annual Wellness Visit

- Screening and detection of:
  - Cognitive impairment
  - Depression including potential risk factors
  - Functional ability and safety, including
    - Hearing impairment
    - Ability to perform ADLs and IADLs
    - Fall risk
    - Home safety
- can be done by direct observation or screening questions
Elements of the Annual Wellness Visit

- Establishment of a written screening schedule
  - given to patient
- Checklist for the next 5-10 years
  - for healthcare maintenance
“assessment of an individual’s cognitive function by direct observation, with due consideration of information obtained by way of patient report, concerns raised by family members, friends, caretakers, or others”
Mini-Cog Scoring Algorithm

The Mini-Cog scoring algorithm. The Mini-Cog uses a three-item recall test for memory and the intuitive clock-drawing test. The latter serves as an “informative distractor,” helping to clarify scores when the memory recall score is intermediate.
AWV final steps

- Provide to the patient
  - Written screening schedule - appropriate USPSTF preventative health services
  - Risk factors and conditions being addressed or followed up after the AWV
  - Personalized health advice for health education or lifestyle changes
    - Often includes community services
Tips for optimizing AWV

- Can be nurse led
- 15-20min min appointments- >amount if add in ACP
- Can integrate within PCP visit
- Use EMR tool
  - Depression screen (PHQ2/9)
  - Falls screening
  - IADL/ADLs
  - ETOH screening
  - Health care screening- refer direct to order
- Send letter/advertise for patients to schedule
A word to our patients about
MEDICARE ANNUAL WELLNESS VISITS

- Medicare pays for a single wellness months a year to identify health risks and help you to reduce them

- We believe that the annual wellness visit is part of the ongoing relationship between you and our practice. This allows us to provide you with continuity of care.
Tips for optimizing AWV

Built in clinical guidelines
- Breast cancer screening
  - mammogram
- Colorectal Cancer Screening
  - Stool occult blood
  - Referral GI/colonoscopy
- Osteoporosis screening
  - Dexa scan
- Cervical cancer screening
  - Referral gynecology
- Hep C screening
  - Hep C virus antibody
Health Risk Assessment Should Include

- Demographic data: age, gender, race, ethnicity
- Self-assessment of health status, frailty, physical functioning
- Psychosocial risks: depression, stress, anger, loneliness or social isolation, pain or fatigue
- Behavioral risks: smoking, physical activity, nutrition/oral health, alcohol use, sexual health, seat belt use, home safety
Health Risk Assessment

- Fall risk screening
  - Have you fallen in the past year?
  - Do you feel unsteady when standing or walking?
  - Do you worry about falling?
- Safety issues - smoke detectors, seatbelt
- Provide handouts on fall risk reduction and home safety modifications
- AARP online home safety checklist for patients or caregivers:
Health Risk Assessment (HRA) form

- Publicly available online versions
  - https://medicarehealthassess.org
Screening Tools - Examples

- Fall risk screening
  - timed up- and go test
- Depression screening
  - PHQ-2
- Functional screening
  - ADLs - dressing, feeding, toileting, grooming, bathing, ambulation
  - IADLs - shopping, food preparation, telephone, housekeeping, laundry, transportation, medications, finances
Workflow

- Patient completes questionnaire (HRA) while waiting or in exam room with MA.
- MA enters data into EMR.
  - If patient screens positive for fall risk or cognitive impairment, MA can perform Timed Up and Go or Mini-Cog.
  - Can assist with placing orders for preventative care.
- Provider uses EMR AMW template to create note, review positive screens and discuss.
- ACP per provider.
Challenges to optimal implementation

- Managing positive findings
  - Dementia
  - Falls
- Customize questions to match available resources
- Prioritize questions
  - Home safety questions
  - Home equipment and supportive devices
Billing for Annual Wellness Visit

- **Initial AWV G0438** (average reimbursement $172)
  Payable: only once per lifetime

- **Subsequent AWV G0439** (average reimbursement $111)
  Payable: every 12 months

V70.0 is the diagnosis to use

E/M services are reported in addition to the AWV using CPT codes 99201-99215. Practices should consider append modifier 25 to the E/M service code if appropriate.

No Copay or deductible for patient

Can charge more if add in E&M service or advanced care planning
Sample Patient

- 80-year-old female who has been your office patient for 4 years
- multiple past medical history including Alzheimer’s dementia, hypertension, glaucoma
- presents to office with her daughter with whom she lives and is her primary caregiver

HOW TO OPTIMIZE THE ANNUAL WELLNESS VISIT
References

- Annual Health Wellness checkup for persons >65 years old. https://medicarehealthassess.org
- Alzheimer’s Association Recommendations for operationalizing the detection of cognitive impairment during Medicare annual Wellness visit in primary care setting -Elsevier 2013