

Proposed in-office visit workflow

Pre-visit planning:

1. Verify Medicare eligibility. Confirm the patient has had Medicare Part B for at least 12 months.
 - Patients are only eligible for a Welcome to Medicare visit (G0402/IPPE) during the first 12 months of Medicare Part B eligibility.
 - If a patient receives a G0402/IPPE, they are not eligible for an Initial Annual Wellness Visit (G0438) until 12 months have passed since the IPPE.
 - If a patient does not receive a G0402/IPPE during their first 12 months of Medicare Part B eligibility, an Initial AWV (G0438) may be performed once the patient has been enrolled in Part B for more than 12 months.
2. Send the Health Risk Assessment (HRA) questionnaire via patient portal or email to be completed prior to the visit to identify care gaps and required screenings (e.g., fall risk, depression).
3. Remind patient to bring list of current medical providers, prescribed and over-the-counter medications, vitamins and supplements with dosages.

Patient:

1. Update medical and family history, current medical problems and surgeries
2. Bring a list of current medical providers
3. Bring a list of all prescribed and over-the-counter medications, vitamins and supplements with dosages

4. Bring HRA survey or fill out in office prior to the appointment

Rooming (nurse)

1. Measure height, weight, BMI, and blood pressure.
 - If first BP is non-compliant it should be documented.
 - Repeat blood pressure at end of visit and document results.
2. Confirm medication list and provider list.
 - Review each medication name/dose/frequency
 - Document other providers involved in patient's care
 - Document medication reconciliation was completed in medical record
3. Review HRA responses with the patient.
 - Demographic data
 - Health status self-assessment
 - Psychosocial risks, including, but not limited to, depression, life satisfaction, stress, anger, loneliness or social isolation, pain, and fatigue
 - Behavioral risks, including, but not limited to, tobacco use, physical activity, nutrition and oral health, alcohol consumption, sexual health, motor vehicle safety (for example, seat belt use), and home safety
 - Document all responses in appropriate medical record locations
 - Activities of daily living (ADLs), including, but not limited to, dressing, feeding, toileting, grooming, physical ambulation (including balance or fall risks), and bathing

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- Instrumental ADLs (IADLs), including, but not limited to, using the phone, food preparation, housekeeping, laundry, transportation, shopping, managing medications, and handling finances
 - Medical events of the patient's parents, siblings, and children, including hereditary conditions that place them at increased risk
 - Past medical and surgical history (illnesses, hospital stays, operations, allergies, injuries, and treatments)
 - Use of, or exposure to, medications, supplements, and other substances
4. Assess Cognitive Impairment by direct observation or reported observations from patient, family, caregivers.
 5. Complete depression screening
 - Document appropriate codes for completing screening
 - If positive screening, document follow-up plan
 6. Assess for urinary incontinence
 - Document assessment findings
 7. Assess patient's functional ability to perform ADLs
 - Complete fall risk assessment (document coding appropriately)
 - Hearing impairment assessment
 - Home and community safety
 - Document findings
 8. Assess for age-appropriate preventive screening needs
 - Assist with scheduling for patient
 9. Flag concerns/questions for the provider

Visit encounter (provider):

1. Review HRA and address positive findings.
2. Perform cognitive, depression, and functional impairment screenings.
3. Update medical/family history.
4. Formulate the Personalized Prevention Plan (PPP).
5. Provide education and referrals, counseling services, or programs based on assessment findings, considering the below:
 - Fall prevention
 - Nutrition
 - Physical Activity
 - Tobacco use-cessation
 - Weight loss
 - Cognition
 - Urinary incontinence
6. Discuss Advance Care Planning for the below items:
 - Preparing an advance directive in case an injury or illness prevents them from making their own health care decisions
 - Future care decisions they might need or want to make
 - How they can let others know about their care preferences
 - Caregiver identification
 - Advance directive elements, which may involve completing standard forms
7. HCC Documentation & Coding
 - Assess and document all active chronic conditions.
 - Capture and code all applicable HCC diagnoses.
 - Support diagnoses with appropriate documentation and specificity.
 - Document follow-up care and management plans.

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Post-visit (provider/admin):

1. Document the visit ensuring all required elements are met.
2. Provide the patient with a written plan and summary.
3. Schedule the next appointment. Consider scheduling around the patient's birthday.

Billing

Note: Submit appropriate CPT II codes based on assessments completed and findings.

1. Initial Wellness Visit G0438 (Dx. V70.0)
2. Subsequent Annual Wellness Visit G0439
3. Welcome to Medicare visit G0402

Referral

1. Care Management call – Provider Services (list numbers for each LOB)
2. Chronic Disease Management call **1-866-243-0937**

Coding: AWW vs. Tele-AWW Quality Coding Documentation

Measure / Assessment	In-Person AWW Documentation	Tele-AWW Documentation
Depression Screening 3725F: Depression screening performed G8510: Negative screen G8431: Positive screen with follow-up plan	PHQ-2 / PHQ-9 completed on paper or verbally. Result and follow-up plan documented, if applicable.	PHQ-2 / PHQ-9 completed verbally or electronically. Document method used and result.
Fall Risk Assessment 1101F: Fall risk assessment completed 1100F: Patient not at risk 3288F: Fall risk documented	May include observation, balance/gait assessment, and/or patient report.	Based on patient-reported history, including falls, dizziness, unsteadiness, or safety concerns.
Functional Status / ADLs / IADLs 1170F: Functional status assessed	Observed and/or patient-reported functional ability.	Patient-reported functional ability. Document language such as "Patient reports independence with..."
Medication Review 1159F: Medication list reviewed 1160F: Medications	Medication list reviewed. Bottles may be reviewed if available.	Medication reconciliation completed verbally. Document that meds were reviewed with patient/caregiver.
Advance Care Planning 1123F: ACP discussed 1124F: ACP declined 1157F: Advance directive documented 1158F: ACP documented in record	Discussion completed face-to-face. Document discussion, patient preference, or decline.	Discussion completed via telehealth. Document patient consent, modality, and discussion or decline.
Other Preventive Screenings 1125F/1126F: Pain assessment 3016F: Alcohol screening 1036F: Tobacco non-user 96127: Brief emotional/behavioral assessment	Pain, alcohol, tobacco, behavioral health, and other screenings completed by questionnaire, verbal assessment, or observation.	Screenings completed verbally or electronically. Document method and patient responses.

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Code	Description
G0402	Welcome to Medicare Visit (IPPE). One-time benefit available during the first 12 months of Medicare Part B enrollment. Must be performed in person; telehealth is not permitted.
G0438	Initial Annual Wellness Visit
G0439	Subsequent Annual Wellness Visit
Modifier 25	Separate E/M service performed in addition to the AWV
Modifier 33	Advance Care Planning (99497/99498) provided with an AWV

Recommend the following Sentara Health Plan benefits and services:

- AWV benefit \$0 copay, APE \$0 copay. Both exams are fully covered by Sentara Medicare, even if completed on the same day.
- Healthy Rewards – Earn a \$100 healthy reward by completing the AWV. Earn an additional \$20 if the APE is also completed at the same visit.
- Essential Benefits – Use a quarterly allowance to purchase digital blood pressure cuff, scales, incontinence supplies.
- Bathroom Safety Devices – Get two safety devices per year to help prevent falls in the bathroom.
- Transportation services - Members have access to a transportation service where they can get rides to and from medical appointments. Help remind patients they may have access to extra benefits that can help them make it to medical appointments.
- Home Delivery for Prescriptions - Help members save time for other things with fewer trips to the pharmacy.