## Annual Wellness Visit (AWV) Practice Checklist

| <b>Initial</b> Annual Wellnes | s Visit                                 | G0438             | Dx V70.0)                            |  |  |  |
|-------------------------------|---|-------------------|--------------------------------------|--|--|--|
| <b>Subsequent</b> Annual W    | ellness Visit                           | G0439             |                                      |  |  |  |
| Before the visit:             |   |                   |                                      |  |  |  |
| ☐ Verify eligibilit           | [ ] Not eligib                          |                   | e to Medicare Visit<br>e initial AWV |  |  |  |
| ☐ Explain the Ani             | nual Wellness Visit to                  | the patient       |                                      |  |  |  |
| ☐ Is the problem l            | ist complete?                           |                   |                                      |  |  |  |
| ☐ Is the medication           | n list complete?                        |                   |                                      |  |  |  |
| ☐ Is the family his           | Is the family history complete?         |                   |                                      |  |  |  |
| Do we have a li               | st of the patient's oth                 | er physicians?    |                                      |  |  |  |
| During the visit:             |   |                   |                                      |  |  |  |
| ☐ Have the patien             | t complete a depressi                   | on screen         |                                      |  |  |  |
| ☐ Have the patien             | t complete <u>functional</u>            | assessment (in    | itial and subsequent)                |  |  |  |
| ☐ Measure BP, he              | ight, weight, BMI an                    | d/or waist meas   | surement                             |  |  |  |
| Complete list or              | risk factors.                           |                   |                                      |  |  |  |
| Update immuni                 | zation record and ord                   | er immunizatio    | ons.                                 |  |  |  |
| Update prevent                | ve checklist.                           |                   |                                      |  |  |  |
| ☐ Make new sche               | dule of preventive an                   | d early detection | on interventions.                    |  |  |  |
| ☐ Discuss advanc              | e directive.                            |                   |                                      |  |  |  |
| [ ] Treatm<br>[ ] Fall pr     | onal interventions<br>ent of depression |                   |                                      |  |  |  |

**To:** Our Medicare Patients:

**Subject:** Medicare Annual Wellness and Other Preventive Visits

Beginning January 1, 2011, Medicare covers an "Annual Wellness Visit" in addition to the one-time "Welcome to Medicare" exam. The "Welcome to Medicare" exam occurs only once during your first twelve months as a Medicare patient. You may receive your Annual Wellness Visit after you have been with Medicare for more than one year, or it has been at least one year since your "Welcome to Medicare" exam.

| Initial Preventive Physical    | "Welcome to Medicare" is only for <i>new</i> Medicare patients. This                   |
|--------------------------------|--|
| Exam (IPPE)                    | must be done in the 1 <sup>st</sup> year as a Medicare patient.                        |
| Annual Wellness Visit, Initial | At least 1 yr after the "Welcome to Medicare" exam.                                    |
| Annual Wellness Visit,         | Once a year (more than $1 \text{ yr} + 1 \text{ day after the last Wellness Visit)}$ . |
| Subsequent                     |  |

The Annual Wellness Visit is not the same thing as what many people often refer to as their yearly physical exam. Medicare is very specific about what the "Annual Wellness Visit" includes and excludes.

At the Annual Wellness Visit, your doctor will talk to you about your medical history, review your risk factors, and make a personalized prevention plan to keep you healthy. The visit does *not* include a hands-on exam or any testing that your doctor may recommend, nor does it include any discussion about any new or current medical problems, conditions, or medications. You may schedule another visit to address those issues *or* your doctor may charge the usual Medicare fees for such services that are beyond the scope of the Annual Wellness Visit.

If you would like to schedule an annual physical, including any lab work or other diagnostic testing, medication management, vaccinations, and other services, please understand that these services will be charged and covered according to Medicare's usual coverage guidelines. However, you may still develop a care plan based on the Annual Wellness Visit criteria.

We appreciate the trust you put in us to take care of your health care needs and hope that you will take advantage of this new benefit to work with your physician in creating your personalized prevention plan.

See the attached list to bring with you to your appointment.

## What you should bring to your Annual Wellness Visit:

The names of all your doctors:

|  |              |           | <u> </u>                               |  |
|--|--------------|-----------|--|--|
| Name   |              | Specialty |  |  |
|  |              |           |  |  |
|  |              |           |  |  |
|  |              |           |  |  |
|  |              |           |  |  |
|  |              |           |  |  |
|  |              |           |  |  |
|  |              |           |  |  |
|  |              |           |  |  |
| A list of all your medications   |              |           |  |  |
| Name of medicine   | Dose         |           | How medication is taken (1 daily, PRN) |  |
|  |              |           |  |  |
|  |              |           |  |  |
|  |              |           |  |  |
|  |              |           |  |  |
|  |              |           |  |  |
|  |              |           |  |  |
|  |              |           |  |  |
|  |              |           |  |  |
| Have you had any tests done in the   | past year?   |           | Yes No                                 |  |
| (such as blood tests, colonoscopy,   | mammograr    | ns        | , x-rays, CT scan, MRI, etc.)          |  |
| Test Na  | ma           |           | Date                                   |  |
| Test Na  | IIIIC        |           | Date                                   |  |
|  |              |           |  |  |
|  |              |           |  |  |
|  |              |           |  |  |
|  |              |           |  |  |
|  |              |           |  |  |
|  |              |           |  |  |
|  |              |           |  |  |
|  |              |           |  |  |
| Have you had any recent immuniza   | tions?       |           | Yes No                                 |  |
| Do you have a living will are advance  | n directive? |           | Yes No                                 |  |
| Do you have a living will or advance (If you have one, <i>please bring a cop</i> |              | /Οι       |  |  |

Health Risk Assessment Page 1

| Patie  | nt Name:   | DOB:  | Date:  |                  |
|--|--|---|--|------------------|
| Can you get places out of walking distance without help?                       |  | 9. How often do you have trouble taking medicines the way you have been told to take them?    |  |                  |
| *For example, can you travel alone by bus, taxi, or drive your own car?        |  | I do not have to take medicine  |  |                  |
|  |  | I always take them as prescribed  |  |                  |
| Yes  |  |   | Sometimes I take them as prescribed  |                  |
| No   |  |   | I seldom take them as prescribed   |                  |
| 2. Ca  | n you shop for groceries or clothes withc                          | out help?   | 10 During the post 4 weeks was some  |                  |
| Yes □  |  | 10. During the past 4 weeks, was someone available to help you if you needed and wanted help? |  |                  |
| No   |  |   | *For example, if you felt very nervous, lonely ogot sick and had to stay in bed, needed someon |                  |
| 3. Ca  | n you prepare your own meals?                                      |   | to, needed help with daily chores, or r  | needed help just |
| Yes  |  |   | taking care of yourself.   |                  |
| No   |  |   | Yes, as much as I wanted   |                  |
| 4. Ca  | n you do your own housework without h                              | elp?  | Yes, quite a bit   |                  |
| Yes  |  |   | Yes, some  |                  |
| No   |  |   | Yes, a little  |                  |
|  |  |   | No, not at all   |                  |
| <ul><li>5. Can you handle your own money without help?</li><li>Yes □</li></ul> |  | 11. How often in the past 4 weeks, have you had trouble eating well?                          |  |                  |
| No   |  |   | Never  |                  |
|  |  |   | Seldom   |                  |
| 6 Do   | you need help eating bathing drossing                              | or gotting  | Sometimes  |                  |
| 6. Do you need help eating, bathing, dressing, or getting around your home?    |  | Often   |  |                  |
| Yes  |  |   | Always   |                  |
| No   |  |   | 42 Herrichen in the most Armedia he  |                  |
| 7. Are you having difficulties driving your car?                               |  | 12. How often in the past 4 weeks, have you been bothered by your teeth or dentures?          |  |                  |
| No   |  |   | Never  |                  |
| Some   | etimes $\square$   |   | Seldom   |                  |
| Yes, o   | often 🗆  |   | Sometimes  |                  |
| Not a  | applicable, I do not use a car                                     |   | Often  |                  |
|  |  |   | Always   |                  |
| keep   | ve you been given any information to he track of your medications? | lp you  | 13. How often in the past 4 weeks, har problems using the telephone?                           | ve you had       |
| Yes  |  |   | Never  |                  |
| No   |  |   | Seldom   |                  |
|  |  |   | Sometimes  |                  |
|  |  |   | Often  |                  |

Health Risk Assessment Page 2

| Patient Name:  | DOB:                        | Date:   |                    |  |
|--|-----------------------------|---|--------------------|--|
| Always   |                             | 20. During the past 4 weeks, how would you rate your general health?                    |                    |  |
| 14. Have you been given any information to help you identify hazards in your house that might hurt you?  |                             | Excellent   |                    |  |
|  |                             | Very good   |                    |  |
| Yes $\square$  |                             | Good  |                    |  |
| No 🗆   |                             | Fair  |                    |  |
| 15. Do you always fasten yo a car?   | ur seatbelt when you are in | Poor  |                    |  |
| Yes, Usually   |                             | 21. How have things been going for y weeks?   | ou in the past 4   |  |
| Yes, Sometimes   |                             | Very well – could hardly be better  |                    |  |
| No   |                             | Pretty good   |                    |  |
| 16. Have you had soy in the  | nact 12 months (vaginal     | Good and bad are about equal  |                    |  |
| 16. Have you had sex in the oral or anal)?   | past 12 months (vaginal,    | Pretty bad  |                    |  |
| Yes □  |                             | Very bad – could hardly be worse  |                    |  |
| No   17. Have you ever had a sexually transmitted disease?   |                             | 22. How confident are you that you can control and manage most of your health problems? |                    |  |
|  |                             | Very confident  |                    |  |
| Yes  |                             | Somewhat confident  |                    |  |
| No 🗆   |                             | Not very confident  |                    |  |
| 18. During the past 4 weeks, how much bodily pain have you generally had?                                |                             | I do not have any health problems   |                    |  |
| No pain  |                             | 23. Over the past 2 weeks, have you   |                    |  |
| Very mild pain   |                             | little interest or pleasure in doing thi  | ngs?               |  |
| Mild pain  |                             | Yes 🗆   |                    |  |
| Moderate pain  |                             | No 🗆  |                    |  |
| Sever pain   |                             | 24. Over the past 2 weeks, have you depressed or hopeless?                              | been feeling down, |  |
| 19. During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes? |                             | Yes $\square$   |                    |  |
| Very heavy   |                             | No 🗆  |                    |  |
| Heavy  |                             | 25. Are you a smoker?   |                    |  |
| Moderate   |                             | No  |                    |  |
| Light  |                             | Yes, and I might quit   |                    |  |
| Very light   |                             | Ves but I am not ready to quit  | П                  |  |

| Patie          | nt Name:                            | DOB:               | Date: |
|----------------|-------------------------------------|--------------------|-------|
| 26. D<br>year? | id you have a drink containing a    | lcohol in the past |       |
| Yes            |                                     |                    |       |
| No             |                                     |                    |       |
| 27. H<br>year? | ave you fallen two (2) or more t    | imes in the past   |       |
| Yes            |                                     |                    |       |
| No             |                                     |                    |       |
| 28. W          | Vere you injured in any falls in th | ne past year?      |       |
| Yes            |                                     |                    |       |
| No             |                                     |                    |       |