Annual Wellness Visit Frequent Asked Questions (FAQs) – For Staff

What is an Annual Wellness Visit (AWV)? Why is this important?	The Annual Wellness Visit (AWV) is a way for patients and Primary Care Providers to keep patients as healthy as possible in a proactive approach. This visit allows for greater emphasis and focuses on personal preventive needs and risk factors. It is also a time to review patients' existing health problems, and determine what health issues may become a concern in the future and how to prevent them. Patients and their PCP will develop or update their personalized prevention plan to maintain health and to stay current with preventive care.
Is the Annual Wellness Visit the same as a yearly physical exam?	No, this visit is a preventive wellness visit and not a "routine physical checkup" or a head-to-toe physical exam. However, some Medicare Advantage plans allow combining or 'bundling' the AWV (not IPPE)
What if my patient already completed their physical exam this year, why do they still need an Annual Wellness Visit?	Through Wellness Visits, we can help patients stay healthy, prevent problems, and make sure each patient is up to date on screenings so we can catch any health problems they might have, early.
Who pays for the Annual Wellness Visit?	Medicare pays 100%. There are no out of pocket expenses for the patient. If additional tests or screenings are completed or ordered during the same visits that aren't covered under these preventive benefits, there may be a copay or cost share for the patient.
Can the Annual Wellness Visit be combined with other types of problem-focused visits? (e.g. BP follow-up, Diabetes care follow-up, medication review, etc.)	Before scheduling the Wellness Visit, ask your care team if you can combine your Wellness Visit with a problem-focused visit, such as a blood pressure (BP) or diabetes (DM) follow-up, or medication review follow-up. However, anything additional addressed during the visit may be subject to copay.
Do patients have to wait exactly 1 year (365 days + 1 day) in between Annual Wellness Visits?	No, patients can have the AWV any time once per calendar year, and can schedule <365 days from last year's AWV, IF they have the following Medicare Advantage coverage: Regence, Premera, United HealthCare Yes, patients wait at least 365 days + 1 day from last year's AWV to schedule their next AWV, IF they have the following Medicare Advantage coverage: Amerigroup, Humana (Northwest only), Molina
What is Medicare Advantage?	Medicare Advantage (MA) Plans, also known as Medicare Part C, are offered by private (commercial) insurers approved by Medicare. Medicare Advantage includes Medicare Part A (hospital insurance) and Medicare Part B (medical insurance). Most MA Plans offer extra coverage, such as vision, hearing, and dental (check with individual plan to verify). Most MA plans include prescription drug coverage (Medicare Part D) depending on the insurer.
What are HEDIS measures?	Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used to measure performance on important dimensions of health care and service across more than 90% of the U.S.'s health care providers. HEDIS progress and performance results are used to identify where our health system needs to focus its improvement areas. Our UW Medicine health system's yearly performance on HEDIS measures determines the reimbursements and incentivizes we receive the following CY, which largely contribute to our funding ability to gain the resources to provide the highest question of care. **Refer to: Common HEDIS Measures*
What is a Care Gap?	HEDIS prevention and screening metrics (quality measures) must be met with each eligible MA patient according to each of the measure's measurement criteria (patient age/sex/diagnoses and measurement CY). When these HEDIS metrics are not based on these criteria, this results in a Care Gap. Care Gaps are tracked by individual patient, provider, clinic, organization and health system.
What is a Risk Gap?	Providers must diagnosis and document their patients' diagnoses (acute, chronic, co-existing), which means updating and refreshing these diagnoses *each year*. The diagnoses that require an update or refresh are called HCCs (Hierarchical Conditions Category). Year-to-year, HCCs help to identify which individuals with serious or chronic illness and assigns a risk factor score based upon a combination of health conditions and demographic details. Determines the Risk Adjustment Factor.