Aging Successfully: 
Maximizing the Annual Wellness Visit

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Family Medicine / Geriatrics

Goals

- Putting the knowledge from today into practice
- Explain how the Medicare Annual Wellness Visit can be utilized to promote healthy aging.
- Name the members of the health care team involved in promoting healthy aging.
- Demographics --> Risk --> HCM --> AWV

Aging in the US

From Pyramid to Pillar: A Century of Change
Population of the United States

For the First Time in U.S. History Older Adults Are Projected to Outnumber Children by 2035

Projected percentage of population

Projected number (millions)
Aging Successfully

Positive developments

- Older adults are working longer by 2014, 23% of men and 15% of women were in the labor force.
- Education levels are increasing (by 2014, 25% of older adults had a bachelor's degree or more).
- Obesity rates among older adults have been increasing (40%).
- More older adults are divorced compared with previous generations. (Divorced women 65+: 3% in 1980 → 13% in 2015, divorced men 65+: 4% → 11%).

Challenges

- Women living alone: 65-74 yo: >27%, 75-84 yo: >42%, >85 yo: >56%.
- The aging of the baby boom generation could fuel a 75 percent increase in the number of Americans ages 65 and older requiring nursing home care.
- Demand for elder care will also be fueled by a steep rise in the number of Americans living with Alzheimer’s disease, which could nearly triple by 2050 to 14 million, from 5 million in 2013.

Social circumstances in old age

- Stressful life events
  - declining physical health
  - loss of independence
  - loss of a spouse or partner, family members, friends

  Typically become more common with advancing age

Brain changes in older adults

- The adult brain moves to an irreversible loss of function and a decline in global abilities with age
- Age-related loss in neurons, dendrites, enzymes, and neurotransmitters
Patient Centered Plan and Goals

Medicare Annual Wellness Visit

- Benefit for any patient with Medicare Part B
- Similar benefit in Medicare Advantage Plans
- Goes beyond health care maintenance recommendations
The IPFE is also known as the "Welcome to Medicare" preventive visit. The goals of the IPFE are health promotion, disease prevention, and detection.

Medicare pays for one beneficiary IPFE per lifetime not later than the first 12 months after the beneficiary’s eligibility date for Medicare Part B benefits.

**Billing**

Medicare covers an IPFE when performed by:

- Physician (a doctor of medicine or osteopathy)
- Qualified non-physician practitioner (a physician assistant, nurse practitioner, or certified clinical nurse specialist)

**The AWV or Annual Wellness Visit**

Medicare covers an annual AWV for patients:

- Who are no longer within 12 months of the effective date of their first Part B coverage period and
- Who have not gotten either an IPFE or AWV within the previous 12 months.

Medicare pays for only one first AWV. Medicare will pay for a subsequent AWV for each patient annually. **Note:** The elements in first and subsequent AWVs, and the codes to bill them, are different.
Done by Provider / Staff?

The Medicare guidelines for the Medicare Annual Wellness Visit (AWV) specifically state that any licensed healthcare provider can perform the Medicare Annual Wellness Visit. They even state that a registered dietitian can perform the visit. However, anyone below the level of an MD/PA must perform the visit under the “direct supervision” of the physician, which just means the supervisors must be available as a back-up for on-going consultation. Medicare also states there is no “incident to” requirement for the AWV. Regardless of who actually performs the visit, billing should always be done under the physician NPI in order to get full reimbursement; NPIs and the only get about 90% reimbursement if billed under their own NPI. The AWV is NOT a physical exam of any type. It is an educational visit for the patient to learn about their own health and set up a preventive screening schedule for the next 5-10 years. There is a long list of the specific requirements, but there is absolutely no reason for a physician to perform the visit themselves, especially since outside the AWV requirements may be subject to a patient copy and can get the practice into hot water unless they have a signed agreement from the patient stating they are aware of the potential cost and time. The AWV itself is free to the patient with no co-pay. Most practices do not have any idea what the AWV actually is. They assume it is a full physical exam. It pays to read the fine print.

Risk Reduction

- Smoking
- Obesity
- Healthy Diet
- Exercise / Physical Activity

Subsequent AWVs include the following elements:

- Review of updated health risk assessment;
- Update medical and family history (As mentioned above, Medicare would like to include opioid use in the ‘Review of Medical and Family History’ element of the AWV. Providers are encouraged to pay close attention to opioid use during this element of the AWV. If a patient is using opioids, assess the benefit from other: non-opioid pain therapies instead, even if the patient does not have OUD but is possibly at risk.)
- Update of list of current providers and suppliers;
- Measurement of weight and blood pressure;
- Detection of cognitive impairment the patient may have;
- Update of the written screening schedule (such as a checklist);
- Update of the list of risk factors; and
- Provision of personalized health advice, and referral to appropriate health education or care.
Considerations

- Lifetime Risk
- Benefits to screen
- Harms of screen
- Patient Preference
- Functional Status
- Living Situation
- Social Support System
- Cost
- Quality of Life
- Life Expectancy

GUIDELINES

- ACP, USPSTF, CTF, NCI, NIH, AMA, ACC, AHA, AUA, ACOG, IOM
- USPSTF
  - evidence-based
  - frequent updates
  - factor in net benefit, quality of the evidence

https://www.uspreventiveservicestaskforce.org/
USPSTF Ratings

- **Recommendation: A** - routinely provide to eligible patients.
The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.

- **Recommendation: B** - routinely provide to eligible patients.
The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.

- **Recommendation: C** - no recommendation for or against routine provision of [the service].
At least fair evidence that [the service] can improve health outcomes but concludes that the balance of the benefits and harms is too close to justify a general recommendation.

- **Recommendation: D** - recommends against routinely providing [the service] to asymptomatic patients.
The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.

- **Recommendation: I** - evidence is insufficient to recommend for or against.
Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.
Estimated Cancer Deaths in the US in 2013

<table>
<thead>
<tr>
<th>Site</th>
<th>Men 308,920</th>
<th>Women 273,430</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung &amp; bronchus</td>
<td>28%</td>
<td>26%</td>
</tr>
<tr>
<td>Prostate</td>
<td>10%</td>
<td>14%</td>
</tr>
<tr>
<td>Colon &amp; rectum</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>Pancreas</td>
<td>6%</td>
<td>7%</td>
</tr>
<tr>
<td>Liver &amp; intrahepatic bile duct</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Leukemia</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>Esophagus</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>Urinary bladder</td>
<td>4%</td>
<td>3%</td>
</tr>
<tr>
<td>Non-Hodgkin lymphoma</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Kidney &amp; renal pelvis</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>All other sites</td>
<td>24%</td>
<td>25%</td>
</tr>
</tbody>
</table>

Total Number of Cancer Deaths Averted from 1991 to 2009 in Men and 1992 to 2009 in Women

The Lifetime Probability of Developing Cancer for Men, 2007-2009*

<table>
<thead>
<tr>
<th>Site</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>All sites</td>
<td>1 in 2</td>
</tr>
<tr>
<td>Prostate</td>
<td>1 in 6</td>
</tr>
<tr>
<td>Lung and bronchus</td>
<td>1 in 13</td>
</tr>
<tr>
<td>Colon and rectum</td>
<td>1 in 19</td>
</tr>
<tr>
<td>Urinary bladder</td>
<td>1 in 26</td>
</tr>
<tr>
<td>Melanoma</td>
<td>1 in 35</td>
</tr>
<tr>
<td>Non-Hodgkin lymphoma</td>
<td>1 in 43</td>
</tr>
<tr>
<td>Kidney</td>
<td>1 in 49</td>
</tr>
<tr>
<td>Leukemia</td>
<td>1 in 63</td>
</tr>
<tr>
<td>Oral Cavity</td>
<td>1 in 66</td>
</tr>
<tr>
<td>Stomach</td>
<td>1 in 92</td>
</tr>
</tbody>
</table>

* For those free of cancer at beginning of age interval.
† All sites exclude basal and squamous cell skin cancers and in situ cancers except urinary bladder.
‡ Includes invasive and in situ cancer cases.
§ Statistic for white men.
Source: SEER* (Statistical Research and Applications Branch, National Cancer Institute, 2012).

The Lifetime Probability of Developing Cancer for Women, 2007-2009*

<table>
<thead>
<tr>
<th>Site</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>All sites</td>
<td>1 in 3</td>
</tr>
<tr>
<td>Breast</td>
<td>1 in 8</td>
</tr>
<tr>
<td>Lung and bronchus</td>
<td>1 in 16</td>
</tr>
<tr>
<td>Colon &amp; rectum</td>
<td>1 in 21</td>
</tr>
<tr>
<td>Uterine corpus</td>
<td>1 in 38</td>
</tr>
<tr>
<td>Non-Hodgkin lymphoma</td>
<td>1 in 52</td>
</tr>
<tr>
<td>Urinary bladder</td>
<td>1 in 87</td>
</tr>
<tr>
<td>Melanoma</td>
<td>1 in 54</td>
</tr>
<tr>
<td>Ovary</td>
<td>1 in 72</td>
</tr>
<tr>
<td>Pancreas</td>
<td>1 in 69</td>
</tr>
<tr>
<td>Uterine cervix</td>
<td>1 in 147</td>
</tr>
</tbody>
</table>

* For those free of cancer at beginning of age interval.
† All sites exclude basal and squamous cell skin cancers and in situ cancers except urinary bladder.
‡ Includes invasive and in situ cancer cases.
§ Statistic for white women.
Source: SEER* (Statistical Research and Applications Branch, National Cancer Institute, 2012).
### Women 50-64 visits every 1-2 years

#### Key screening recommendations
- Breast cancer mammogram with or without CBE: q 1-2 years age 50-74 (USPSTF B)
- Lung screening: ≥ 5 years (USPSTF A)
- Colorectal cancer screening: 50-75 years, sensitivity: colonoscopy q10- sigmoidoscopy q5 + fecal immunochemical q2 > hemoccult
- Discussion of aspirin use for stroke prevention: age 55-79 (USPSTF A)

#### Risk stratified recommendations
- DEXA: 50-64 use FRAX tool, consider if 9.3% 10 year risk (USPSTF B)
- Breast cancer chemoprevention: once in women at high risk (USPSTF B)
- BRCA mutation testing: consider if 9.3% 10 year risk (USPSTF A)
- HIV & syphilis: no interval, adults and adolescents at increased risk (USPSTF A)

#### Vaccinations
- Shingles vaccine: once age ≥ 50 (not for immunosuppressed)
- Tetanus: every 10 years (not for immunosuppressed)

#### Counseling
- Obesity / healthy diet
- Tobacco and alcohol misuse

### Women 65 and older visits every year

#### Key screening recommendations
- Breast cancer mammogram with or without CBE: q 1-2 years through age 74 (USPSTF B)
- Lung screening: ≤ 5 years through 74, consider ≥ 75. (USPSTF A)
- Colorectal cancer screening: through age 75 years, consider ≥ 75 sensitivity: colonoscopy q10- sigmoidoscopy q5 + fecal immunochemical q2 > hemoccult
- Discussion of aspirin use for stroke prevention: age 55-79 (USPSTF A)

#### Risk stratified recommendations
- Breast cancer chemoprevention: once in women at high risk (USPSTF B)
- BRCA mutation testing: for high risk (USPSTF B)
- Diabetes type II: q 3 years if sustained BP > 135/80
- HIV & syphilis: no interval, adults and adolescents at increased risk (USPSTF B)

#### Vaccinations
- Pneumococcal vaccine: once age ≥ 65
- Shingles vaccine: once age ≥ 60 (not for immunosuppressed)

#### Counseling
- Obesity / healthy diet
- Tobacco and alcohol misuse

### Men 50-64 visits every 1-2 years

#### Key screening recommendations
- Blood pressure check: q 2 years (USPSTF A)
- Lipids: age 20-34, ≥ 5 years if increased risk for CHD
- Diabetes: q 3 years if sustained BP > 135/80 (USPSTF B)
- HIV & syphilis: no interval, adults and adolescents at increased risk (USPSTF A)

#### Risk stratified recommendations
- Abdominal aortic aneurysm screening: one-time for men aged 65-75 who have ever smoked cigarettes, (USPSTF B)
- Diabetes: q 3 years if sustained BP > 135/80 (USPSTF B)
- HIV & syphilis: no interval, adults and adolescents at increased risk (USPSTF A)

#### Vaccinations
- Shingles vaccine: once age ≥ 50 (not for immunosuppressed)

#### Counseling
- Obesity / healthy diet
- Tobacco and alcohol misuse

### Men 65 and older visits every year

#### Key screening recommendations
- Blood pressure check: annually (USPSTF A)
- Lipids: age 20-34, ≤ 5 years through age 74; consider ≥ 75. (USPSTF A)
- Diabetes: ≥ 5 years if sustained BP > 135/80 (USPSTF B)
- HIV & syphilis: no interval, adults and adolescents at increased risk (USPSTF A)

#### Risk stratified recommendations
- Abdominal aortic aneurysm screening: one-time for men aged 65-75 who have ever smoked cigarettes, (USPSTF B)
- Diabetes: q 3 years if increased risk for CHD
- Diabetes II: q 3 years if sustained BP > 135/80 (USPSTF B)

#### Vaccinations
- Pneumococcal vaccine: once age ≥ 65

#### Counseling
- Obesity / healthy diet
- Tobacco and alcohol misuse
1. Review the beneficiary's medical and social history
   - At a minimum, collect information about:
     - Past medical and surgical history, experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments
     - Current medications and supplements (including calcium and vitamins)
     - Family medical history (review of medical events in the beneficiary's family, including conditions that may be hereditary or place the beneficiary at risk)
     - History of alcohol, tobacco, and illicit drug use
     - Diet
     - Physical activities
   - We encourage providers to pay close attention to opioid use during this part of the FTEC, which includes opioid use disorders (OUD). If a patient is using opioids, assess the benefits for other non-opioid pain therapies instead, even if the patient does not have OUD but is possibly at risk. Refer to the CMS Roadmap to Address the Opioid Epidemic for more information on controlling opioid misuse.

2. Review the beneficiary's potential risk factors for depression and other mood disorders
   - Use any appropriate screening instrument. You may select from various available standardized screening tools designed for this purpose. For more information, refer to the Depression section on the Substance Abuse and Mental Health Services Administration's Screening Tools website.

3. Review the beneficiary's functional ability and level of safety
   - Use appropriate screening questions or standardized questionnaires recognized by national professional medical organizations to review, at a minimum, the following areas:
     - Activities of daily living
     - Fall risk
     - Hearing impairment
     - Home safety

4. End-of-life planning, on beneficiary agreement
   - End-of-life planning is verbal or written information provided to the beneficiary about:
     - The beneficiary's ability to prepare an advance directive in case an injury or illness causes them to be unable to make healthcare decisions
     - If you are willing to follow the beneficiary's wishes expressed in an advance directive
4. Exam

Obtain the following:
- Height, weight, body mass index, and blood pressure
- Visual acuity screen
- Other factors deemed appropriate based on the beneficiary's medical and social history and current clinical standards

6. Educate, counsel, and refer based on the previous five components

7. Educate, counsel, and refer for other preventive services

Based on the results of the review and evaluation services in the previous components, provide appropriate education, counseling, and referral.

Includes a brief written plan, such as a checklist, for the beneficiary to obtain:
- A once-in-a-lifetime screening electrocardiogram (EKG/ECG), as appropriate
- The appropriate screenings and other preventive services Medicare covers including the Annual Wellness Visit
FREQUENTLY ASKED QUESTIONS (FAQs)

What are the other Medicare Part B preventive services? ........................................... 6
Is the IPPE the same as a beneficiary’s yearly physical? ....................................................... 7
Are clinical laboratory tests part of the IPPE? ................................................................. 7
Do deductible or coinsurance/copayment apply for the IPPE? ........................................... 7
If a beneficiary enrolls in Medicare in 2017, can he or she have the IPPE in 2018 if it was not performed in 2017? ................................................................. 7

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