Annual Wellness Visit Guide

home state health

Use this guide to assist with documentation of the Annual Wellness Visit in the patient chart.

Component	Objectives
☐ Review of Health History Summary	The Home State Health History Summary identifies suspected chronic/complex conditions the patient may have based on claims data. Please review this document prior to or during the Annual Wellness Visit and: • Review and address all present conditions • Verify all conditions, medications, DME, injections/infusions • Rule out any suspected conditions or address them *Example:"Patient is suspected to have GI condition due to previous gastrostomy procedure as an infant. Reviewed history and confirmed with parent this is no longer an active problem."*
	Chief Complaint
☐ Statement validating medical necessity reason for visit	Example: *"Patient is here today for their Annual Wellness Exam."*
	History (Subjective)
☐ History of present illness	• Status and severity of all conditions • Features of each condition (location, quality, timing, severity) Example: *[Patient Name] is a 10-year-old male previously diagnosed with spastic quadriplegic cerebral palsy. Combination treatment includes physical therapy and Diazepam 1mg/kg, daily, for seizures."*
☐ Past medical and social history	• Document smoking, ETOH, and drug use/dependence • Verify current medication list is up-to-date • Review and update past medical history and active problems lists • Avoid using "history of" for a condition that is chronic but currently stable, such as COPD, DM, or Quadriplegia Example: *"Reviewed medication list with patient and confirmed dose and use are accurate."*
☐ Pertinent and focused review of systems	• As a thorough complexity review of systems • Typically an extended ROS (2-9 systems)
	Exam (Objective)
☐ Vitals	• Height, weight, body mass index, blood pressure—indicate method and other measurements as deemed appropriate based on medical and family history
☐ Physical examination	• Detailed physical exam based on the conditions present or requested by patient
Medical Decision Making	**Provider's Statement and Treatment Plan for Condition(s)**
	Assessment

☐ Medical diagnoses for visit	• Document and code to the highest specificity
	• Document and code for all chronic conditions at least once annually
	  o Even if a condition is managed by a specialist, the condition should be listed with documentation of who is managing it and how it is being managed
	  o A review of mediations for chronic conditions is sufficient documentation to report the code
	  o Clearly document a causal link between the disease and the complication such as diabetic neuropathy versus neuropathy and diabetes
	  o Confirm acute or chronic condition status
	Example: *"Patient has mild depressed bipolar I disorder, without psychotic features."*

	Plan
☐ Treatment/management for conditions	• Document the treatment and follow-up for conditions—labs, referrals, procedures, follow-up, medication prescribed, etc. Examples (could be a smart phone phrase or quick text): *"Diabetes is well-controlled, continue medications and RTC in two weeks for follow-up."* *"Patient has stage IV breast cancer, is seeing Dr. Smith, oncologist at ABC Hospital, currently being treated with chemotherapy."*
	Closing the Chart Note
☐ Signature	Examples of an acceptable signature: • Legible full signature or first initial and last name followed by credentials and date signed • Illegible signature over a typed or printed name followed by credentials and date signed • "'Electronically signed by' followed by provider's name, credentials, and date signed
☐ Diagnosis Code (Z00.- is always listed first)	• Use Z00.01 (adult) or Z00.121 (child), "with abnormal findings" which describes *any* abnormality that is present at time of the routine examination. Supplemental diagnoses, such as chronic conditions that had to be addressed, should also be coded. • Use Z00.00 (adult) or Z00.129 (child), "with normal findings" for chronic conditions that are stable or improving. Report the chronic condition in addition to the well exam.