# Annual Wellness Visit Guide

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

<table>
<thead>
<tr>
<th>Component</th>
<th>Objectives</th>
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| **Review of Health History** | 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.” |
| **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  
  - 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  
  - A review of medications for chronic conditions is sufficient documentation to report the code  
  - Clearly document a causal link between the disease and the complication such as diabetic neuropathy versus neuropathy and diabetes  
  - 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 200.01 (adult) or 200.121 (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 200.00 (adult) or 200.129 (child), “with normal findings” for chronic conditions that are stable or improving. Report the chronic condition in addition to the well exam. |