Annual Wellness Assessment

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Patient Full Name: _____ **DOB:** _____ (Date of Birth) **Gender:** □ **Male** □ **Female** □ **Other** (Check one)

Member ID#: _____ (Patient Identifier) **Health Plan:** _____ **Allergy:** _____ **Date:** _____ (Date of Service)

Vitals Signs	**BP:** ___ / ___	**HR:** _____ **Ht.:** _____ **ft.** _____ **in.** _____ **Wt. (lbs.)** _____ **BMI:** _____ CPT: □ **Z00.00** Normal exam | □ **Z00.01** Exam w/ abnormal findings

IHA/AHA CPT Codes: □ **G0402** Welcome to Medicare visit **|** □ **G0438** AWV, First visit **|** □ **G0439** AWV, Subsequent visit **|** □ **G0439** FQHC visit, IPPE, or AWV

Procedure Code □ **3008F** **|Check the Appropriate "BMI" Code below:**

□ BMI < 19 (Z68.10) | □ BMI 20.0-20.9 (Z68.20) | □ BMI 21.0-21.9 (Z68.21) | □ BMI 22.0-22.9 (Z68.22) | □ BMI 23.0-23.9 (Z68.23)

□ BMI 24.0-24.9 (Z68.24) | □ BMI 25.0-25.9 (Z68.25) | □ BMI 26.0-26.9 (Z68.26) | □ BMI 27.0-27.9 (Z68.27) | □ BMI 28.0-28.9 (Z68.28)

□ BMI 29.0-29.9 (Z68.29) | □ BMI 30.0-30.9 (Z68.30) | □ BMI 31.0-31.9 (Z68.31) | □ BMI 32.0-32.9 (Z68.32) | □ BMI 33.0-33.9 (Z68.33)

□ BMI 34.0-34.9 (Z68.34) | □ BMI 35.0-35.9 (Z68.35) | □ BMI 36.0-36.9 (Z68.36) | □ BMI 37.0-37.9 (Z68.37) | □ BMI 38.0-38.9 (Z68.38)

□ BMI 39.0-39.9 (Z68.39) | □ **BMI 40.0-44.9 (Z68.41)** | □ **BMI 45.0-45.9 (Z68.42)** | □ **BMI 50.0-50.9 (Z68.43)** | □ **BMI 60.0-69.0 (Z68.44)** | □ **BMI 70 or greater (Z68.45)**

Check the Appropriate "Blood Pressure" Procedures (SBP =Systolic BP; DBP =Diastolic BP):

□ **3074F**: SBP < 130 □ **3075F**: SBP 130-139 □ **3077F**: SBP 140 or over | □ **3078F**: DBP < 80 □ **3079F**: DBP 80-89 □ **3080F**: DBP 90 or over

(reason for visit)
History of Present Illness:

Review of systems

Past Medical, Family and Social History

Physical Exam (Please complete thoroughly each section unless the exam component was deferred)

IF DEFERRED CHECK HERE □		Normal	Abnormal	Describe Finding
□	GENERAL			
□	HEAD			
□	EYES			
□	ENT			
□	NECK			
□	RESP			
□	CV			
□	CHEST / BREAST			
□	GI			
□	LYMPH			
□	MS			
□	SKIN			
□	PSYCH			
□	NEURO	**Alert/Oriented to:** □ **Person** □ **Place** □ **Time** □ **Situation**		

OTHER LAB RESULTS (state specific findings & add diagnosis to assessment/plan)	
OTHER XRAY RESULTS (state specific findings & add diagnosis to assessment/plan)	

HEDIS STAR Measures

SCREENING	RESULTS	ICD-10 CODE	DATE	CPT / HCPCS LEVEL II CODES
Breast Cancer Screening (every 2 yrs., ages 50-74)	**Mammogram Findings:**	**Z12.31**	DATE: _____	□ **3014F** Mammogram must be between **10/01/2022-12/31/2024** □ **2P** Modifier (Patient Refused) □ **77067** Screening mammography, bilateral (two-view study of each breast), including CAD when performed. □ **77066** Diagnostic mammography, including (CAD) when performed; bilateral
Colon Cancer Screening (ages 45-75yrs.)	**Results:** Positive □ Negative □	**Z12.11**	DATE: _____	□ **3017F** □ **2P** Modifier (Patient Refused) □ **82270** *FOBT* by peroxidase activity (e.g., guaiac), feces, 3 days consecutively collected specimens (yearly) □ **82274** *iFOBT/FIT* by immunoassay, qualitative, feces; 1-3 simultaneous determinations (yearly) □ **45330** Flexible Sigmoidoscopy (5yrs) □ **45378** Colonoscopy (10 yrs)
Rheumatoid Arthritis Drug Therapy (ART)	18 yrs. of age and older that are diagnosed with rheumatoid arthritis and are dispensed **at least one ambulatory prescription** for a disease-modifying anti-rheumatic drug (DMARD)	M05.00-M06.9 Dx: _____ Date: _____	Date DMARD Filled: _____	□ **4187F** DMARD therapy prescribed, dispensed, or administered □ **4196F** Patient not receiving first-time biologic disease-modifying anti-rheumatic drug therapy for rheumatoid arthritis □ **J0129** Injection, abatacept, 10 mg (directly supervised by a physician, not for use self-administered) □ **J0135** Adalimumab, 20 mg | □ **J7515** Cyclosporine, oral, 25 mg
Osteoporosis Management in Women who had a fracture (OMW)	67 - 85 yrs. of age after who suffered a fracture (**7/1/2023-6/30/2024**) and who had **either** a bone mineral density (BMD) test or a prescription for a drug to treat osteoporosis in the six months after the fracture	USE APPROPRIATE FRACTURE CODE Dx: _____	BMD Date: _____ *Or* Rx Fill Date: _____	□ **77081** DXA, 1 or more sites; (e.g., radius, wrist, heel) □ **77080** DXA, 1 or more sites; (e.g., hips, pelvis, spine) □ **4005F** Pharmacologic therapy (other than minerals/vitamins) for osteoporosis Prescribed □ **3095F** Central Dual-energy X-Ray Absorptiometry (DXA) results documented

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Date Of Birth — Date of Service

PATIENTS WITH DIABETES	RESULTS	ICD-10 CODE	DATE	CPT / HCPCS LEVEL II CODES
Diabetes Care: **Kidney Health Evaluation for Patients with Diabetes** *Must include **all three tests** and can only be closed through claims*	**Results:** □ **eGFR** ______________ estimated glomerular filtration rate. □ **uACR** ______________ **urine** albumin-creatinine ratio	USE APPROPRIATE DIABETIC CODE: ___________	DATE: ___________	**eGFR** Estimated glomerular filtration rate □ **80047, 80048, 80050, 80053, 80069, 82565** **uACR** Urine Albumin Creatinine Ratio □ **82043** Albumin; urine (e.g., microalbumin), quantitative □ **82570** Creatinine; urine
Diabetes Care: **Blood Sugar Controlled (annually)**	**HbA1c test results:** ______________	USE APPROPRIATE DIABETIC CODE ___________	DATE: ___________	□ **3044F** (<6.9%) □ **3051F** (7-7.9%) □ **3052F** (8-9%) □ **3046F** (>9%)
Diabetes Care: **Diabetic Eye Exam (annually)**	**Test Results:** ___________	USE APPROPRIATE DIABETIC CODE: ___________	DATE: ___________	**Diabetic Retinal Screening with Eye Care Professional WITH Evidence of Retinopathy (positive)** □ **2022F** (Dilated retinal eye exam) □ **2024F** (7 standard field stereoscopic photos) □ **2026F** (Eye imaging validated to match diagnosis from standard field stereoscopic retinal photos**)** **Diabetic Retinal Screening with an Eye Care Professional WITHOUT Evidence of Retinopathy (negative)** □ **2025F (**7 standard field stereoscopic photos) □ **2023F (**Dilated retinal eye exam with interpretation by optometrist/ophthalmologist; w/o evidence of retinopathy) □ **2033F (**Eye imaging validated to match diagnosis from standard field stereoscopic retinal photo results documented and reviewed; without evidence of retinopathy) □ **3072F (**Low risk for retinopathy; ***no evidence of retinopathy in the prior year*****)**

Statin Therapy for Patients with Cardiovascular Disease and Diabetes (SPC/SPD):		
Statin Therapy for Patients with Cardiovascular Disease (SPC)	Male: 21-75 or Female: 40-75 age with atherosclerotic cardiovascular disease (ASCD) and filled at least **one high or moderate-intensity statin medication** in measurement year (MY). **Exclude members in MY year or 1 year prio**r: with Pregnancy, IVF, Clomiphene use, ESRD, Cirrhosis, Myalgia, myositis, myopathy, or rhabdomyolysis.	□ **4013F -** Rx Dispensed: □ **Yes** □ **No** MED LIST: ____ Date Dispensed: ____________________________________
Statin Use in Persons with Diabetes (SUPD)	40-75 age: Diabetic patients on diabetes medication(s) and received **at least one statin medication** fill of any intensity during the measurement year. **Exclude Members**: with ESRD or in Hospice Care.	□ **4013F -** Rx Dispensed: □ **Yes** □ **No** MED LIST: ____ Date Dispensed: ____________________________________

Hierarchical Condition Category (HCC):		
DIAGNOSIS DESCRIPTION	**STATUS OF DIAGNOSIS**	
	□ **Stable** □ **Condition worsening** □ **Condition improving**	
	□ **Stable** □ **Condition worsening** □ **Condition improving**	
	□ **Stable** □ **Condition worsening** □ **Condition improving**	
	□ **Stable** □ **Condition worsening** □ **Condition improving**	
	□ **Stable** □ **Condition worsening** □ **Condition improving**	
	□ **Stable** □ **Condition worsening** □ **Condition improving**	
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	□ **Stable** □ **Condition worsening** □ **Condition improving**	
	□ **Stable** □ **Condition worsening** □ **Condition improving**	
	□ **Stable** □ **Condition worsening** □ **Condition improving**	
	□ **Stable** □ **Condition worsening** □ **Condition improving**	

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PATIENT EDUCATION:

Glaucoma ☐ Breast Self-Exam ☐ Testicular Self-Exam ☐ Cognitive Impairment ☐ Hearing Impairment ☐ Home Safety ☐ Abdominal Aortic Aneurysm ☐ STIs/STDs ☐
Nutrition ☐ Exercise ☐ Weight Loss ☐ Obesity ☐ Diabetes Self-Management ☐ Hep B Vaccinations ☐ Hep C Screening ☐ Substance Abuse ☐ Dementia/Alzheimer ☐
Lung Cancer Screening ☐ Prostate Cancer Screening ☐ Cervical & Vaginal Cancer Screening ☐ Other: _____

Care of Older Adults (COA)

Functional Status Assessment	Activities of Daily Living	**Z00.00** or **Z00.01**	☐ **1170F** Grooming ☐ Independent ☐ Min Assist ☐ Mod Assist ☐ Dependent Dressing: ☐ Independent ☐ Min Assist ☐ Mod Assist ☐ Dependent Walking: ☐ Independent ☐ Min Assist ☐ Mod Assist ☐ Dependent Bathing: ☐ Independent ☐ Min Assist ☐ Mod Assist ☐ Dependent Eating: ☐ Independent ☐ Min Assist ☐ Mod Assist ☐ Dependent Using Toilet: ☐ Independent ☐ Min Assist ☐ Mod Assist ☐ Dependent Transferring: ☐ Independent ☐ Min Assist ☐ Mod Assist ☐ Dependent
Pain Assessment/Screening	☐ No-pain present ☐ Pain present ☐ Pain Level 1-10: _____	**Z00.00** or **Z00.01**	☐ **1126F** if 0 pain level noted ☐ **1125F** if 1-10 level pain noted ☐ **0521F** Plan of care to address pain documented

Check both the "Medication List" and "Medication Review" Codes: ☐ **1159F Medication List** ☐ **1160F Medication Review**

List of Medications in Current Use for Medication Review (Name of Medication, Dosage Level and Quantity):

Name of RX & OTC Medications	Dosage/Frequency	Quantity	Refill Dates with Changes in Dosage/Frequency

Advance Care Planning (ACP)

66-80 years of age with advanced illness, an indication of frailty, or who are receiving palliative care, and adults **81 years** of age and older who had advance care planning during 2024.	Evidence of **claims/encounter** for an Advanced directive, living will, power of attorney, health care proxy, etc.	**Z00.00** or **Z00.01**	☐ **1123F** ACP or surrogate decision-maker in Medical Chart ☐ **1124F** ACP discussed and documented in the medical record (did not wish to or was unable to provide an ACP or name a surrogate decision-maker) ☐ **2P** Patient Refused ***Exclude: Hospice Care***

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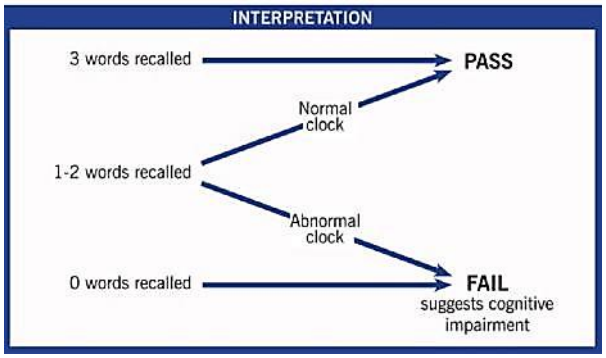
PATIENT EDUCATION:

Dementia

Step1: Three Word Registration
Look directly at the person and say, "Please listen carefully. I will say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now." If the person is unable to repeat the words after move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies. For repeated administrations, the use of an alternative word list is recommended.

Version 1	Version 2	Version 3	Version 4	Version 5	Version 6
Banana Sunrise Chair	Leader Season Table	Village Kitchen Baby	River Nation Finger	Captain Garden Picture	Daughter Heaven Mountain



Step2: Clock Drawing
(Clock Drawing page can be found at the end of the form) Say: "Next, I want you to draw a clock for me. First, put in all the numbers where they go." When that is completed, say: "Now, set the hands to 10 past 11." Use a preprinted circle for this exercise. Repeat instructions as needed as this is not a memory test. Move to Step 3 if the clock is not complete within three minutes.

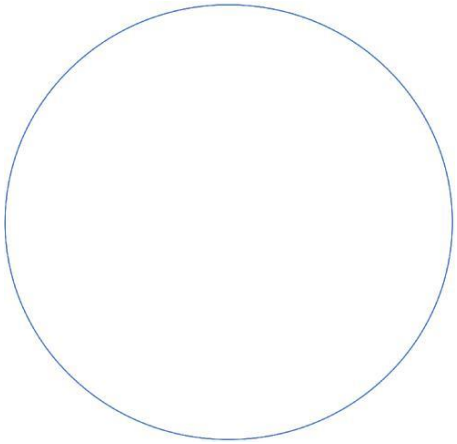
Step3: Three Word Recall
Ask the person to recall the three words you stated in Step 1. Say: "What were the three words I asked you to remember?" Record the word list version number and the person's answers below.

Word List version: _____ **Person's Answers:** _____

Dementia Scoring

Word Recall (**0-3 points**) _____	1 point for each word spontaneously recalled without cueing.
Clock Draw (**0 or 2 points**) _____	Normal clock = 2 points. A normal clock has all numbers placed in the correct sequence and approximate correct position (e.g., 12, 3, 6, and 9 are in anchor positions) with no missing or duplicate numbers. Hands are pointing to the 11 and 2 (11:10). Hand length is not scored. Inability or refusal to draw a clock (abnormal) = 0 points.
Total Score: (**0-5 points**) _____	Total score = Word Recall score + Clock Draw score. A cut point of <3 on the Mini-Cog™ has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of <4 is recommended as it may indicate a need for further evaluation of cognitive status.

Clock Drawing



PLEASE FAX COMPLETED FORMS TO (818) 332-1165

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Medicare Health Outcomes Survey (HOS):			
Management of Urinary Incontinence in Older Adults (MUI)	□ Continence □ Incontinence	**Z71.89**	□ **1090F** Presence or absence of urinary incontinence assessed. □ **0509F** Urinary incontinence plan of care documented.
Fall Risk Management (FRM)	Fall prevention Number of falls this year: #_____	**Z71.89**	□ **1101F** *No falls* in the past year or *only one fall without injury* in the past year For two or more falls both codes **[3288F & 1100F]** are required on the claim form □ **3288F** Fall risk assessment documented. □ **1100F** *Two or more falls* in the past year or any fall with injury in the past year
Physical Activity for Adults (POA)	□ Exercise counseling □ Increase physical activity □ Maintain physical activity	**Z71.89**	□ **4245F** Counseled during the initial visit to maintain or resume normal activities
Consumer Assessment of Healthcare Providers & Systems (CAHPS):			
Flu Vaccinations for Adults (FVA)	Influenza Virus Vaccine	**Z23**	□ **1030F** Influenza immunization status assessed □ **4274F** Influenza immunization administered or previously received □ **4274F** Influenza immunization administered or previously received
Medical Assistance with Smoking and Tobacco Use Cessation (MSC)	□ Non-smoker	**Z13.89**	□ **1036F** Current non-smoker tobacco
	□ Smoker □ Smoking cessation counseling	**F17.200**	□ **1034F** Current smoker tobacco □ **1035F** Current smokeless tobacco user □ **4004F** Cessation intervention, counseling
Pneumococcal Vaccination	Immunization in adults	**Z23**	□ **1022F** Pneumococcus immunization status assessed □ **4040F** Pneumococcal vaccine administered or previously received

Depression Screening (PHQ9): **HCPCS □ G0444 | □ G8431 POSITIVE | □ G8510 NEGATIVE | □ G8511 POSITIVE, PATIENT REFUSED CARE PLAN**

Over the last 14 days, how often have you been bothered by any of the following problems?	□ 0	□ 1 to 6	□7 to 11	□ 12+
Little interest or pleasure in doing things	□ 0	□ 1	□2	□ 3
Feeling down, Depressed, or hopeless	□ 0	□ 1	□2	□ 3
Trouble falling asleep, staying asleep, or sleeping too much	□ 0	□ 1	□2	□ 3
Feeling tired or having little energy	□ 0	□ 1	□2	□ 3
Poor appetite or overeating	□ 0	□ 1	□2	□ 3
Trouble concentrating on such things as reading the newspaper or watching TV	□ 0	□ 1	□2	□ 3
Feeling bad about yourself, feeling that you are a failure, feeling that you have let yourself or your family down	□ 0	□ 1	□2	□ 3
Moving or speaking so slowly that other people could have noticed or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	□ 0	□ 1	□2	□ 3
Thinking that you would be better off dead or that you want to hurt yourself in some way	□ 0	□ 1	□2	□ 3

Diagnosis Guide	**Total score: Depression Severity**	**Single Episode**	**Recurrent**
	1-4 Minimal Depression **5-9 Mild Depression** **10-14 Moderate depression** **15-19 Moderately severe depression - Refer to Case Management** **20-27 Severe depression - Refer to Case Management** (Scores that are in the bolded ranges: consider an ICD 10 DX (HCC))	**F32.0** Mild	**F33.0** Mild
		F32.1 Moderate	**F33.1** Moderate
		F32.2 Severe w/out psychotic features	**F33.2** Severe w/out psychotic features
		F32.3 Severe with psychotic features	**F33.3** Severe with psychotic features
		F33.8 Other recurrent depressive disorders	
		F33.9 MDD, recurrent, unspecified	

Total score: _____

Unable to complete the depression assessment due to: □ **Unresponsive** □ **Uncooperative** □ **Severe Dementia** □ **Patient Refused** □ **Other** (explain below)

On Treatment for Depression: Yes □ No □

Additional Notes / Comments:

I have reviewed this visit with the member, and I hereby verify all the above is correct.

Provider's Name (Print): _____ **Provider's Signature:** _____

Date: _____ **Provider Credential (e.g., MD, DO, NP, PA):** _____

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