Mountain Community Health

What is a Medicare Wellness visit?

The Annual Medicare Wellness visit is intended to create or update a personalized wellness plan. It does contain elements that are similar to your yearly exam but is not a head-to-toe physical.

The exam will not include a hands-on exam, evaluation/ management of new or existing health problems, or medications that are part of your annual physical exam. These healthcare concerns can be reviewed at a follow-up visit with your primary care provider. The purpose of this exam is to review your current wellness and develop a personalized prevention plan to help prevent disease and disability based on your current health and risk factors. This is an additional covered benefit under your Medicare plan.

What does your first 'Welcome to Medicare' visit look like?

At your first Annual Wellness visit, your primary care provider will develop your personalized prevention plan and may review the following:

- Check your height, weight, blood pressure, and other routine measurements.
- Give you a health risk assessment.
    - This may include a questionnaire that you complete before or during the visit. The questionnaire asks about your health status, injury risks, behavioral risks, and urgent health needs.
- Review your functional ability and level of safety.
    - This includes screening for hearing impairments and your risk of falling.
- Your doctor must also assess your ability to perform activities of daily living (such as bathing and dressing), and your level of safety at home.
- Learn about your medical and family history.
- Make a list of your current providers, durable medical equipment (DME) suppliers, and medications.
    - Medications include prescription medications, as well as vitamins and supplements you may take.
- Create a written 5–10-year screening schedule or checklist.
- Your PCP should keep in mind your health status, screening history, and eligibility for age-appropriate, Medicare-covered preventive services.
- Screen for cognitive impairment, including diseases such as Alzheimer's and other forms of dementia.
- Screen for depression.
- Provide health advice and referrals to health education and/or preventive counseling services aimed at reducing identified risk factors and promoting wellness.
- Health education and preventive counseling may relate to weight loss, physical activity, and smoking.

Mountain Community Health

What do subsequent annual Medicare Wellness visits look like?

A member of your primary care team will review and update your personalized prevention plan and may revisit the following:

- Check your weight and blood pressure.
- Update your medications and vaccinations.
- Update the health risk assessment you completed.
- Update your medical and family history.
- Update your list of current medical providers and suppliers.
- Update your written screening schedule.
- Assess physical function and risk of falls.
- Screen for memory difficulties and depression.
- Provide health advice and referrals to health education and/or preventive counseling services.

Who is eligible for a Medicare Wellness visit?

Any Medicare beneficiary who:

- Has been receiving Medicare Part B benefits for at least 12 months, and
- Has not had an initial preventative physical examination (Welcome to Medicare) or a Annual Medicare Wellness visit within the past 12 months.

How often will Medicare pay for the annual Medicare Wellness visit?

Medicare will pay for the annual wellness visit once every 12 months. There is no co-payment or deductible for this visit.

Why did I get a bill?

The Medicare Wellness visit is a review of your general health but is not intended for the discussion of pre-existing conditions such as diabetes, high blood pressure, or medication adjustments. If during the course of your Medicare Wellness visit, your provider discovers and needs to investigate or treat new or existing symptoms or risk factors, this is considered diagnostic care. Medicare may bill you for any diagnostic care you receive during a preventive visit. We are happy to schedule a separate office visit appointment after the Medicare Wellness visit to address these other topics.

Why did I get a bill for laboratory services?

Medicare and Medicare Advantage insurances restrict the number of laboratory services that are allowed within a given period of time. For example, Medicare and Medicare Advantage plans typically cover once every 5 years lipid panels and cervical screenings. If these are done more than once during the allowed timeframe, you may get an out-of-pocket bill. Other lab out-of-pocket expenses may fall under diagnostic care as stated above. Please refer to your insurance policy.