Welcome to Medicare Visit Quick Check List for Providers

Provider Quick Check List

- **Review and Reconcile:**
  - Histories component:
    - Problems.
    - Procedure History.
    - Family History.
      - Review medical events in the beneficiary's family, including diseases that may be hereditary or place the beneficiary at risk.
    - Social History
      - Include any history of alcohol, tobacco, and illicit drug use.
  - Allergies component.
  - Home Medications.
    - All home medications, calcium, vitamins, and supplements must be included.
- **Complete PHQ-2 and PHQ-9 Depression Screening** located in the Scales and Assessments component on AMB Workflow (if not completed by clinical staff.)
  - If the patient is positive for depression, follow the steps in the Depression Screening Recommendation Workflow document on the Quality measures section of the Clinical EHR website.
- Add the appropriate **This Visit Problems** to the Problem List.
  - Add the appropriate Welcome to Medicare preventative visit ICD-10-CM code: Z00.00.
- **Tag the following items to add to the Objective/Physical Exam** free text component within the note:
  - The Healthcare Decision Maker. Document the patient's end-of-life planning and the providers agreement with the patient regarding:
    - The patient's ability to prepare an advance directive in case an injury or illness causes the patient to be unable to make health care decisions.
    - Whether or not you are willing to follow the patient's wishes as expressed in an advance directive.
  - Opioid Risk Tool.
    - If concerns are identified in the risk factors completed by the clinical staff, further assessments or referrals should be completed as indicated.
  - Infections Disease Risk Screening (include if completed, not required.)
  - Health Risk Assessment (include if completed, not required.)
  - Functional Assessment.
  - Hearing and Vision Screening.
  - Home Safety Screening.
  - Mini-Cog (include if completed, not required.)
  - Conley Fall Risk Scale.
  - Instrumental ADL Adult.
- The following are not included in the Medicare Wellness Visit created by the clinical staff and needs to be included in the **Objective/Physical Exam component**: Nutrition, Physical Activity, Heart and Lung.
- Address all **Recommendations** due today.
  - Educate, counsel, and refer for other preventive services and include a brief written plan, such as a checklist, for the patient to obtain the services, including:
    - A once-in-a-lifetime screening electrocardiogram (EKG/ECG).
      - Order an in-office ECG Order.
      - IDC10 code: Z00.00.

  - Order the appropriate screenings based on the Recommendations and other preventive services that Medicare covers.
- Provide Patient with a **written plan regarding individual recommendations**.
  - Create and insert the Health Maintenance Auto Text into the Patient Instructions component. This will automatically carry over to the Ambulatory Clinical Summary, which is printed for the patient at the end of their visit.
- Provide education, counseling, and referral, if needed.
  - Complete as appropriate based on the previous components. For example, if the patient has a new heart issue, refer to cardiology.
- Review any current **opioid prescriptions**. For a patient with a current opioid prescription, review the patient's potential Opioid Use Disorder (OUD) risk factors. This can also be tagged from the clinical staff note if it was completed. Evaluate the patient's pain severity and current treatment plan. Provide information on non-opioid treatment options and refer to a specialist, as appropriate.
- Add appropriate orders via the **QOC MPage**.
  - Add G0403 (EKG) manually searched through New Order Entry.
  - Add G0402 (Welcome Visit) using found in Other Visit Charges section.
  - Add other orders as indicated, if not added by clinical staff (ex. immunization order).
- Document the patient's visit using the **Medicare Wellness Exam Note**.