Can you force patients to get an AWV? Not without risk.

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Question: *I'm a patient of a local primary care practice that recently sent me a letter saying they are "required by CMS to perform and submit annual wellness exam information on each Medicare/Medicare Advantage patient each year. Although CMS does not penalize the member when the AWV information is not submitted annually, your PCP/Provider is reported as being non-compliant with patient care, which does affect our standing and reimbursement with CMS." For that reason, the letter went on, "our office requires that all patients with Medicare/Medicare Advantage coverage undergo an AWV annually to continue to retain [the practice] as their Primary Care Physician (PCP)." Can they do that?*

Answer: First, Henry E. Norwood, an attorney with Kaufman Dolowich LLP in San Francisco, makes clear what you probably already know: "Medicare does not require Medicare beneficiaries to receive any health services as a condition to continued eligibility," he says.

Sometimes the law can require certain services be provided. Guillermo J. Beades, a partner in the health care litigation department at Frier Levitt in Florham Park, N.J., points to Supreme Court case law, including the 1905 case Jacobson v. Massachusetts, which affirmed a state's right to require inoculation (in this case, against smallpox) if there exists a sufficient public interest for it — a finding echoed in later COVID-era vaccine mandate rulings (PBN 10/17/22). But no court is likely to find a similar public interest requiring the AWV.

Why push to portray it as mandatory? Patricia A. Markus, partner with the Nelson Mullins firm in Raleigh, N.C., speculates that when the practice says a lack of patient AWV data means they'll be "reported as being non-compliant with patient care," they may be talking about how such data is used in the Merit-based Incentive Payment System (MIPS), "which permits physicians who regularly provide AWVs to increase their quality scores," she says.

Many MIPS quality measures and improvement activities can be tallied in the AWV encounter, including "Documentation of Current Medications in the Medical Record" (QM #130) and "Preventive Care and Screening: Screening for Depression and Follow-Up Plan" (QM #134 and IA_BMH_4). Those are not required, though.

Paul F. Schmeltzer, an attorney with Clark Hill LLP in Los Angeles, thinks it could be that "the practice wants to improve their Healthcare Effectiveness Data and Information Set (HEDIS) metrics" on which Medicare star ratings [STARS] are based. "AWVs can help improve HEDIS and STARS metrics by closing care gaps and collecting HEDIS data," he says. "This in turn could improve the practice's reimbursement rate."

But while that might supply a practice with motivation, it doesn't provide justification for a mandate. In fact, Markus says, "I expect many state medical licensing boards would describe such a scenario as a potential conflict of interest or even potential exploitation, as patients typically are free to choose both their providers and the medical items and services they will accept."

The remaining question is whether a practice billing Medicare can require AWVs, or anything else, as a condition of being seen by their providers on medical grounds.

Christopher J. Kutner, a partner in the health services practice group at Rivkin Radler LLP in Uniondale, N.Y., thinks the practice's motivation may be less self-dealing and more a genuine drive to improve patient health. The goal of the AWV, he says "is to [help the patient] avoid falls, avoid progression to a more acute set of symptoms," he says. "I've seen primary care practices send patients a notice saying if they don't comply with preventive screenings, they'll discharge them from the practice."

There are circumstances in which a practice may "fire" a patient for non-compliance, including nonadherence to prescribed treatment that, in the provider's opinion, renders their care ineffective (PBN 8/28/23). Lawyers advise both notice to the patient and documentation of the cause to protect the practice from patient abandonment charges from boards or civil action.

But while practices may fire patients for non-adherence, that usually applies to courses of treatment, such as statins for cholesterol, rather than something like an annual check-up. "Maybe the patient doesn't want the AWV for some legitimate reason — maybe they're working two jobs or whatever," Kutner says. "And if a practice discharges a patient and tells them that they have to find a new practice based on that, there may be some risk to the practice."

There are ways to entice patients to improve their AWV completion rates, Schmeltzer says. "They can inform patients about the benefits of an AWV and how it can contribute to the management of their health," Schmeltzer says. "The practice should also implement an annual process to proactively reach out to eligible patients to schedule AWVs."

And while the anti-kickback statute generally prohibits monetary compensation to patients, Schmeltzer says, practices can offer patients items or services — not cash — with a nominal value of no more than $15 per item and a maximum aggregate value of $75 per patient per year if they come in for an AWV. That may or may not be more likely to work, but it's less likely to alienate your patients, or trigger a board sanction, than trying to force them.

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