Mercy Care Advantage would like your help in caring for our Older Adults

How can you help?

By having compliance with both of the following:

1. Care for Older Adult HEDIS Measure
2. Annual Wellness Visits for members

What is the Care for Older Adults HEDIS Measure?

Members age 66 and older who annually have each of the four measure requirements addressed:

1. **Medication Review:** *Required component of Annual Wellness Visit*
2. **Functional Status Assessment:** *Required component of Annual Wellness Visit*
3. **Pain Screening**: *Integral component of evaluation and management of patient visit*
4. **Advanced Care Planning**: *Required component for Initial Preventative Physical Examination (IPPE) AND optional reimbursable component of the Annual Wellness Visit*

**The F-codes listed below are Category II codes and are used for tracking for performance measures.*

What is required to meet each part of the Care for Older Adults HEDIS Measure?

1. Complete an annual review of the patient's medications.

This review should be documented in the patient's medical record by the prescribing provider or a clinical pharmacist and must include **ONE** of the **THREE OPTIONS**:

A. Medication list in chart- to include prescription and non-prescription medications, vitamins and supplements
Signature of a prescribing provider or clinical pharmacist that a medication review was completed
Date on which the medication review was performed

OR

B. Notation that the member is **not taking any medication**
Date when this was noted

OR

C. Transitional care management services either a 7 day or a 14 day

2. Complete an annual functional assessment of the patient's ability to perform:

Must include **ONE** of the **FOUR OPTIONS AND** the **date** it was performed:

A. Activities of Daily Living (ADL's) were assessed with at least **FIVE** of the following, including, but not limited to:

- Bathing, dressing, eating, transferring, using toilet, walking, continence

OR

B. Instrumental Activities of Daily Living (IADL's) were assessed or at least **FOUR** of the following were assessed, including, but not limited to:

- Shopping for groceries, driving or using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications, handling finances

OR

C. Notation that at least **THREE** of the **FOUR COMPONENTS** were assessed:

- Cognitive status.
- Ambulation status.
- Hearing, vision and speech (i.e., sensory ability; all three areas must be assessed).
- Other functional independence (e.g., exercise, ability to perform job)

OR

D. Standardized assessment tool *(not a complete list)* not limited to at least **ONE** of the following:

- SF-36®
- Assessment of Living Skills and Resources (ALSAR)
- Barthel ADL Index Physical Self-Maintenance (ADLS) Scale
- Bayer ADL (B-ADL) Scale
- Barthel Index
- Extended ADL (EADL) Scale
- Independent Living Scale (ILS)
- Katz Index of Independence in ADL
- Kenny Self-Care Evaluation
- Klein-Bell ADL Scale
- Kohlman Evaluation of Living Skills (KELS)
- Lawton & Brody's IADL scales
- Patient Reported Outcome Measurement Information System (PROMIS) Global or Physical Function Scales

**A functional status assessment limited to an acute or single condition, event or body system (e.g., lower back, leg) does not meet criteria for a comprehensive functional status assessment.*

**A functional status documentation of the assessment of cranial nerves corresponding specifically to hearing (cranial nerve VIII), vision (cranial nerve II) and speech (cranial nerve XII) with a result or finding meets criteria for this component*

**The components of the functional status assessment numerator may take place during separate visits within the measurement year.*

3. Complete an annual comprehensive pain assessment which includes at least three or more body systems or areas.

Must include **ONE** of the following **AND** the **date** it was performed:

A. Documentation that the patient was assessed for pain (which may include positive or negative findings for pain)

OR

B. Result of assessment using a standardized pain assessment tool, not limited to:

- Numeric rating scales (verbal or written)
- Face, Legs, Activity, Cry Consolability (FLACC) scale
- Verbal descriptor scales (5–7 Word Scales, Present Pain Inventory)
- Pain Thermometer
- Pictorial Pain Scales (Faces Pain Scale, Wong-Baker Pain Scale)
- Visual analogue scale
- Brief Pain Inventory
- Chronic Pain Grade
- PROMIS Pain Intensity Scale
- Pain Assessment in Advanced Dementia (PAINAD) Scale

**A notation of a pain management plan or pain treatment plan alone does not meet criteria*
**Chest pain alone does not meet criteria.*

4. Discuss the patients advanced care plan and retain a copy of the patient's advance care plan.

If the patient does not have an advanced care plan, we encourage you to discuss advanced care planning with the patient and document the conversation in the patient's medical record. Evidence of advanced care planning must include **ONE** of the **THREE OPTIONS**:

A. Presence of advanced care plan in record such as:
- *Advanced Directive: Living Will, Healthcare power of attorney, health care proxy*
- *Actionable medical orders: written instructions initiating, continuing withholding or withdrawing specific forms of life-sustaining treatment: Physicians Orders for Life sustaining Treatment (POLST), Five Wishes*
- *Living Will*
- *Name of surrogate decision maker* – written document designating someone other than the member to make future medical treatment choices

OR

B. Documentation of an advanced care planning **discussion** with the provider **AND** the **date** it was discussed. (*documentation of discussion must be noted in the measurement year)*
- *Notation of a discussion or initiation of a discussion by a provider*
- *Oral statements such as conversations with relatives or friends about life-sustaining treatment and end-of-life care, or patient designation of an individual who can make decisions on behalf of the patient.*
  **Evidence of oral statements must be noted in the medical record*

OR

C. Notation that the member previously executed an advanced care plan.

**Advanced Care Planning documentation that a provider asked the member if an advance care plan was in place and the member indicated a plan was not in place is not considered a discussion or initiation of a discussion*

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CODES FOR TRACKING PERFORMANCE MEASURES

****Claim submission with coding can be used to make a member compliant without a medical record review****

MEETS SCREENING CRITERIA		
Advanced Care Planning		
Code System	**Code**	**Definition**
CPT	99497	Advanced care planning including the explanation and discussion of advanced directives such as standard forms (with completion of such forms) when performed by the physician or other qualified health care professional: first 30 minutes, face to face with the patient, family member(s), and/or surrogate. The service carries an eligible charge, and also a co-payment for the patient unless preformed as part of an Annual Wellness Visit
CPT	**99798**	Each additional 30 minutes (Listed separately in addition to code for primary procedure)
CPT II	1123F	Advanced care planning discussed and documented: advanced care plan or surrogate decision marker documented in the medical record
CPT II	1124F	Advanced care planning discussed and documented: patient did not wish or was not able to name a surrogate decision maker or provide and advance care plan
CPT II	1157F	Advanced care plan or similar legal document present in the medical record
CPT II	1158F	Advanced care planning discussion documented in the medical record
HCPCS	S0257	Counseling and discussion regarding advanced directives or end of life care planning and decisions, with patient and/or surrogate (list separately in addition to code for appropriate evaluation and management service)
Medication List		
Code System	**Code**	**Definition**
CPT II	1159F	Medication list documented in medical record
HCPCS	G8427	Eligible professional attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications
MEDICATION LIST MUST ALSO INCLUDE ONE OF THE MEDICATION REVIEW CODES TO MEET CRITERIA		
Medication Review		
Code System	**Code**	**Definition**
CPT II	90863	Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
CPT II	99605	Medication therapy management service(s) provided by a PCP or clinical pharmacist face to face with a patient, with assessment and intervention if provided; initial 15 minutes, new patient
CPT II	99606	Initial 15 minutes, established patient
CPT II	1160F	Review of all medications by a prescribing practitioner or clinical pharmacist (such as, prescriptions, OTCs, herbal therapies and supplements) documented in the medical record
Transitional Care Management alone meets Medication Review compliance		
Code System	**Code**	**Definition**
CPT	99495	Transitional Care Management 14 Day
CPT	99496	Transitional Care Management 7 Day
Functional Status Assessment		
Code System	**Code**	**Definition**
CPT II	1170F	Functional status assessed
Pain Assessment		
Code System	**Code**	**Definition**
CPT II	1125F	Pain severity quantified: pain present

CPT II	1126F	No pain present

What are the Initial Preventive Physical Exam (IPPE) and Annual Wellness Visits (AWV)?

The **Initial Preventive Physical Exam**, also known as the "Welcome to Medicare Preventative Visit" has the goals of health promotion, disease prevention and detection. It is available during the first 12 months of coverage only.

The **Annual Wellness Visit** is a preventive wellness visit and **not** a "routine physical checkup" that includes a **Health Risk Assessment** (HRA) identifies chronic diseases, injury risks, modifiable risk factors, and urgent health needs. The Annual Wellness Visit provides an excellent opportunity for members and their providers to collaborate on a Personalized Prevention Plan.

**All elements must be provided before submitting a claim for the AWV.*

The Annual Wellness Visit is a covered benefit for all Mercy Care Advantage members:

A one-time **Initial Preventive Physical Examination** *(IPPE)* **(G0402)** during the first 12 months of coverage;

OR

If a member did not receive an IPPE during that time, they are eligible for the **Initial Annual Wellness Visit** and **a personalized prevention plan of service** *(AWV and PPS)* **(G0438);**

AND

After receiving either the IPPE or the Initial AWV and PPPS, members are eligible for the **Subsequent AWV and personalized prevention plan of service** *(Subsequent AWV and PPS)* **(G0439)** each year they are covered.

AND an Optional Element

Advanced Care Planning *(CPT-99497)* to include the explanation and discussion of advanced directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional: *first 30 minutes*, face to face with patient, family members(s) and/or surrogate. *(A diagnosis code is required and should be consistent with a beneficiary's exam)*

Advanced Care Planning *(CPT-99498)* - same requirements as above for each additional 30 minutes *(List separately in addition to code for primary procedure)*

**The AWV does not include any clinical laboratory tests, but you may make referrals for such tests as part of the AWV, if appropriate.*

** Generally, you may provide other medically necessary services on the same date of service as an AWV. The deductible and coinsurance/copayment apply for these other medically necessary services.*

**When you provide a significant, separately identifiable, medically necessary Evaluation and Management (E/M) service in addition to the AWV, Medicare may pay for the additional service. Report the Current Procedural Terminology (CPT) code with modifier -25. That portion of the visit must be medically necessary to treat the beneficiary's illness or injury or to improve the functioning of a malformed body member.*

Where can I find out more about the ABC's of the Initial Preventive Physical Examination

(IPPE)?

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243320.html

Where can I find out more about the ABC's of the Annual Wellness Visit (AWV) and the Subsequent Annual Wellness Visit *(Page 7)*?

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_chart_ICN905706.pdf

Where can I find out more about the Health Risk Assessment (HRA)?

https://www.cdc.gov/policy/hst/HRA/FrameworkForHRA.pdf

Where can I find out more about the Medicare Preventive Services?

https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html

What are the required elements needed to meet an Annual Wellness Visit and Subsequent Annual Wellness Visit?

1. **Acquire/ Update Member information:**
   A. Administer HRA
   B. Establish/Update a list of current providers and suppliers
   C. Establish/Update members Medical/Social History and Family History
   D. Review members potential risk factors for depression including past experiences with depression or other mood disorders
   E. Review /Update members functional ability and level of safety

2. **Assessment and Discussion (Physical Exam)**
   A. Exam
   B. Establish /Update /Detect any cognitive impairment member may have

3. **Counsel Member**
   A. Establish/ Update a written screening schedule for member, checklist for next 5-10 years as appropriate
   B. Establish /Update a list of risk factors and conditions for which the primary , secondary, or tertiary interventions are recommended or underway for the member
   C. Furnish personalized health advice to ember and a referral as appropriate to health education or preventative counseling services or programs. Educate, Counsel and Refer based on previous components and other preventative services when appropriate
   D. Furnish advanced care planning services /Advanced Directives

How can I ensure I am reaching all my members?

At the beginning of each year you will receive a letter with a list of members who are eligible for one of the following services:

1) Initial Preventive Physical Exam IPPE
2) AWV with PPS
3) Subsequent AWV with a PPS

If it is known that a member had one of the above services that date will be on your report. In August a second report of eligible members as of claims from 7/31 is available on request.

What is the Annual Wellness Visit provider form and why should I fill it out?

The Annual Wellness provider form was designed to help providers address the required items of an Annual Wellness Visit and ensure that members are receiving these valuable and critical services. Mercy Care Advantage HMO SNP collects this information as part of NCQA HEDIS reporting requirements.

1) **Provider form:** We request that you complete and send back to us along with the actual office note from the visit. If you follow this form you will address all the questions you should be addressing at each Annual Wellness Visit.
2) **Member form:** Annual Wellness Visit Checklist that members can complete when at your office which can start a conversation about several of the required items in an Annual Wellness Visit. This is not required to be sent back to the health plan, but if it is used by office we would like it returned with the office note and provider form.

The Annual Wellness Visit Provider and Members forms are available on the health plan website. https://www.mercycareplan.com/providers/mca/forms they are found under "Forms".

I have a copy of a patient's Advance Care Plan in their chart. Is that sufficient evidence?

Yes. Please send the documentation with your completed Annual Wellness Visit provider form and office visit note. If the patient states he/she has an Advance Care Plan but you do not have a copy, notate that you discussed it with your patient in your office note. You may also wish to obtain a copy to include in the medical record.

**You must report a diagnosis code when submitting a claim for Advanced Care Planning as an optional element of AWV. Since you are not required to document a specific diagnosis code for ACP as an optional element AWV, you may choose any diagnosis code consistent with a beneficiary's exam.*

What if I have members on my list but I've never seen some of these patients before?

At Mercy Care Advantage HMO SNP members are assigned a primary care provider upon enrollment. Reach out to these members to establish care and complete the Annual Wellness Visit. If you determine that this member is seeing another provider, please let you Provider Representative know, so they may be assigned to the correct provider and are removed from your roster.

If you do not who your Provider Representative is, they can be located at on the health plan website at: https://www.mercycareplan.com/providers/mca/

Where do I send the completed Annual Wellness Visit Provider Form and office visit note?

There are 2 ways you can submit information:

1) **Fax** the completed provider form and Annual Wellness visit office note to **1-860-907-3724**
2) **Upload** the completed provider form and Annual Wellness visit office note to the Mercy

Provider portal using the HEDIS Record Submission category.