Major Depression Disorders



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Depression Statistics

Statistics show that depression is associated with:

- A higher chronic disease burden
- Increased health care utilization
- Impaired functioning

Major depressive disorder (MDD) by the numbers

- Annual costs were $210.5 billion in 2010
  - Includes - workplace, direct and suicide-related expenditures
- 21% increased economic burden since 2005
- 6.2% increase in unemployment among persons with MDD
- Leading cause of disability in ages 15-44
- Most common psychiatric disorder in the general population

Bereavement does not exclude the dx of MDD (Lyness, 2016)

Nonpsychiatric providers only dx depression in 50% of depressed patients

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READ: Why is it important to diagnosis depression in the home?

Statistics show that depression is associated with increase in chronic diseases, increased healthcare utilization, and impaired functioning.
Specifically, Major Depressive Disorder, also known as MDD, costs $ 210.5 Billion dollars annually in 2010. The 210.5 billion is comprised of loss within the workplace, direct care and suicide related costs.
There has also been an increase in unemployment with MDD by 6.2%. MDD is also the leading cause of disability in ages 15-44 years and is the most common psychiatric disorder in the general population.
MDD is also a dx that is missed 50% of the time by non-psychiatric providers among depressed patients. Bereavement does not exclude the diagnosis of MDD.

Who gets depression?

Women more than men (Pratt & Brody, 2014)

Only 35.3% of individuals with depression see a mental health provider

According to the World Health Organization

- 11th leading cause of disability and mortality in World
- In the US- ranks second among all causes of disability
- Highly recurrent
  - >40% recurrence over 2 years
  - After 2 episodes, risk of recurrence within 5 years: 75%



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READ: Who gets depression?
Women more than men get depression.
Only 35.3% of diagnosed individuals actually see a mental health provider.

According to the World Health Organization, it's the 11th leading cause of disability and mortality. In the US, depression ranks second among all the causes for disability.
Depression has on average a > 40% recurrence rate over two years. After 2 episodes of depression the risk of recurrence within 5 years increases to 75%.

Major Depressive Disorder DSM V Criteria

Five (or more) of the following symptoms (on the next slide) have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The episode is not attributable to the direct physiological effects of a substance or to another medical condition. (DSM-V table)

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READ: Diagnosing MDD is based on DSM-V criteria. Members must have 5 of the following symptoms (I will review in more detail on the next slide) over a 2 week period and represent a change from previous functioning. Of these 5, at least one must be either: "depressed mood" or "loss of interest or pleasure". These symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
The effects of substances or other medical conditions can not attribute to this episode.

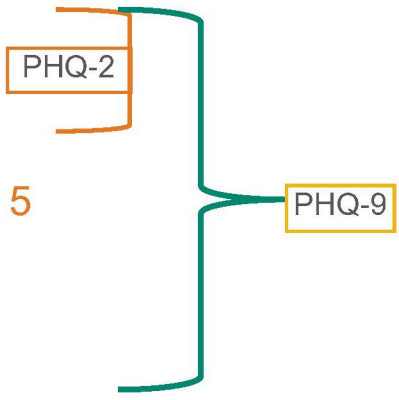
Major Depressive Disorder

5 or more of the following symptoms:

- Depressed mood
- Anhedonia (inability to experience pleasure)

Must have one of the 2 above within the 5

- Insomnia or hypersomnia
- Change in appetite or weight
- Psychomotor retardation or agitation
- Low energy
- Poor concentration
- Thoughts of worthlessness or guilt
- Recurrent thoughts of death or suicide



- 1-4 Minimal
- 5-9 Mild
- 10-14 Moderate
- 15-19 Moderately severe
- 20-27 Severe

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This slide shows the breakdown of the DSM V criteria and where they appear in the tablet.
PHQ-2 is within your ROS section
PHQ-9 is in the PSY tool and its completion may be required based on computer logic

Different types of MDD

Major Depressive Disorder should be specified by episode **and** either Severity **or** Remission status:

Step 1: Document Episode

Single

Recurrent

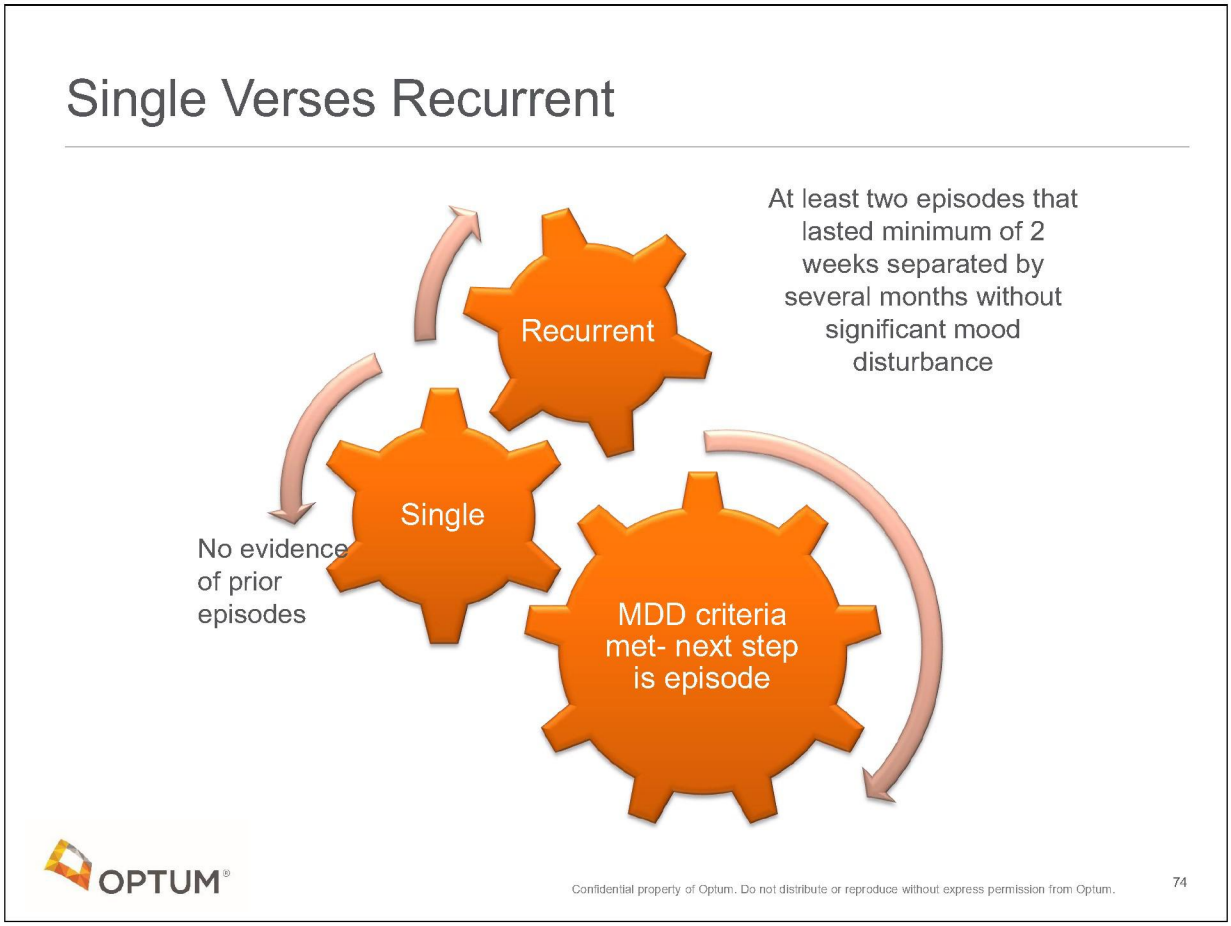
Step 2: Document **EITHER** severity **OR** remission

If MDD is active document severity:	**If in remission document status:**
• Mild	• Unspecified
• Moderate	• Partial
• Severe	• Full

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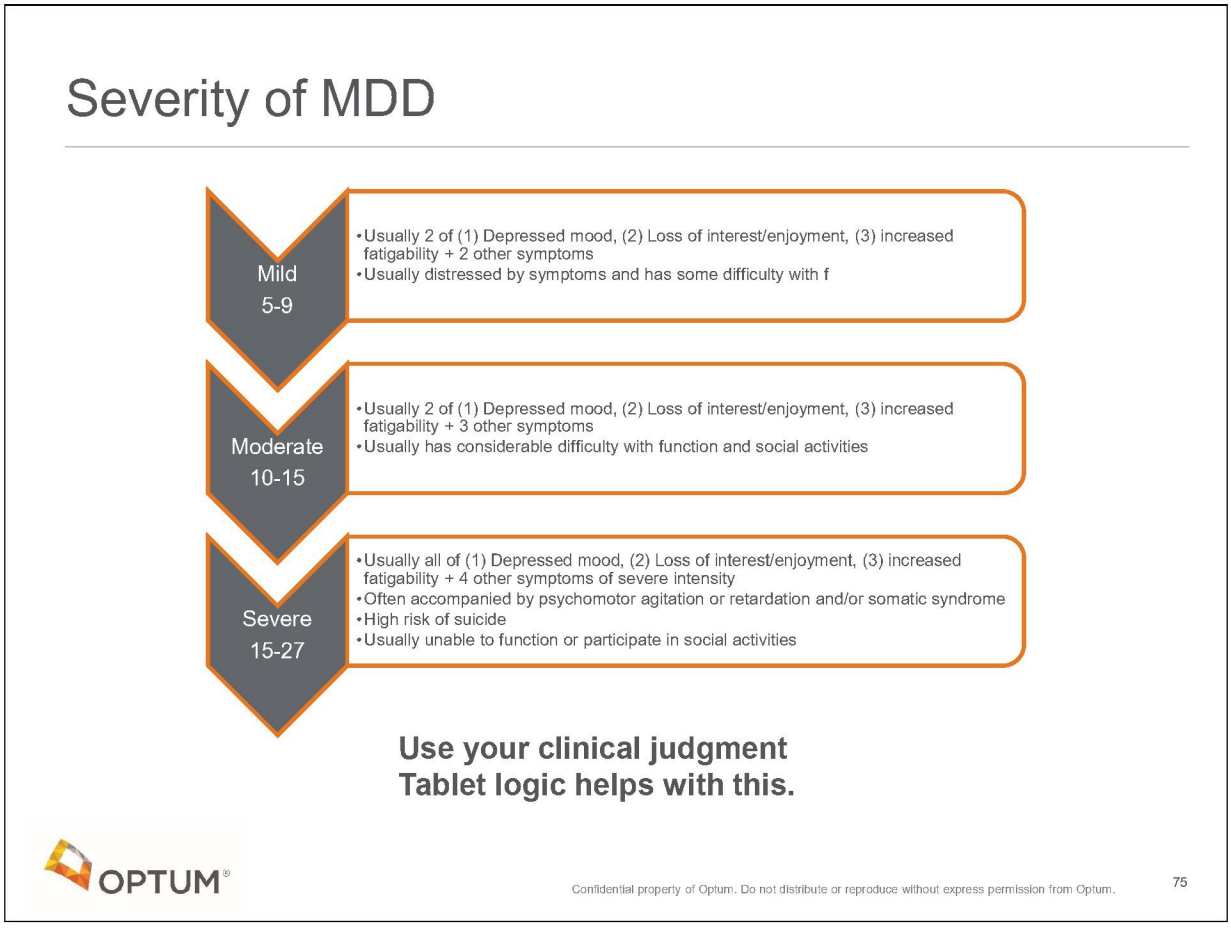
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When there is a diagnosis of MDD, the episode of either Single or Recurrent must be included, and then documented either Severity OR Remission status, you cannot have both Severity AND Remission selected.
MDD is either in remission or it is active - If it is Active, then specify Severity

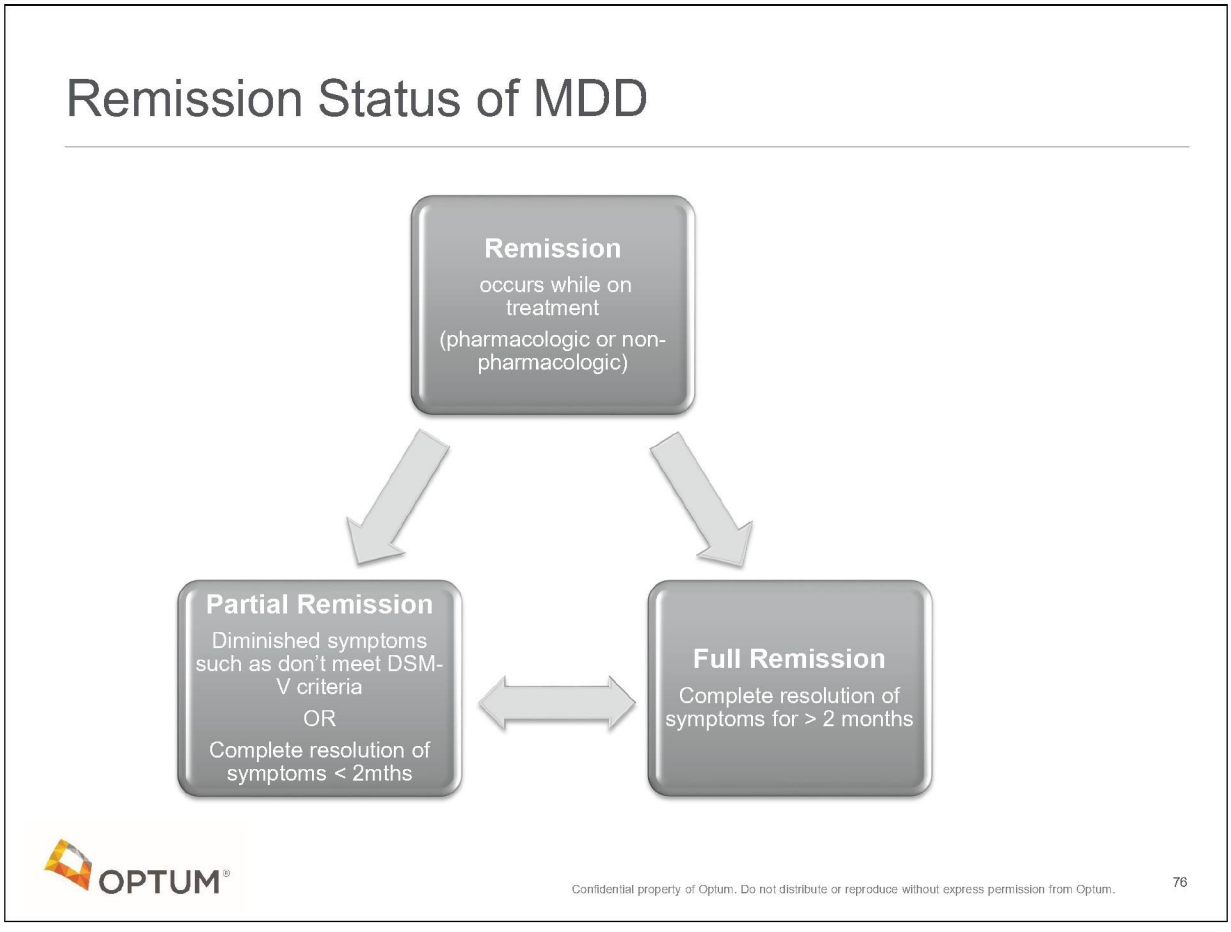


You can see in this example above that the MDD criteria has been met within the large gear on the slide. Now to help differentiate Single verses Recurrent, you need to ask a few probing questions about the member's depression: Have they had depression before? If so, when and how long did it last?

A member with no prior episodes with have MDD single episode.
A member with at least 2 prior episodes that lasted a minimum of 2 weeks separated by several months without significant mood disturbance would have MDD recurrent.



READ: You have identified the member to have MDD with either Single or Recurrent episodes, now the question becomes: Do they still have symptoms or are they in Remission?
If they have ongoing symptoms, then whether it is Mild, Moderate or Severe will be decided by you. You can see the three different levels and criteria on the slide. (no need to read these)
What is nice about this section and criteria is that it is built into the PSY tool and tablet logic. As you complete the PHQ 9 questions with the member the group of diagnosis applicable to the answers will be highlighted. You will use your clinical judgment to make the appropriate diagnosis.



If severity can't be decided because symptoms are resolved, you can identify MDD single or recurrent with remission status. These patients are those with MDD who are under treatment of some kind, thus their PHQ2/9 is not positive.
Full remission is defined as complete symptom resolution for > 2 months.
Partial remission is defined as diminished symptoms such as didn't meet the DSM V criteria (PHQ2/9 questions) OR complete resolution of symptoms < 2 months.
You can use some probing questions to help you decide that include:
"I see you are on Celexa, was that for depression?"
"How long have you been on this medication?"
"Has your depression/symptoms resolved since being on the medication? If so, how long have those symptoms been gone?"

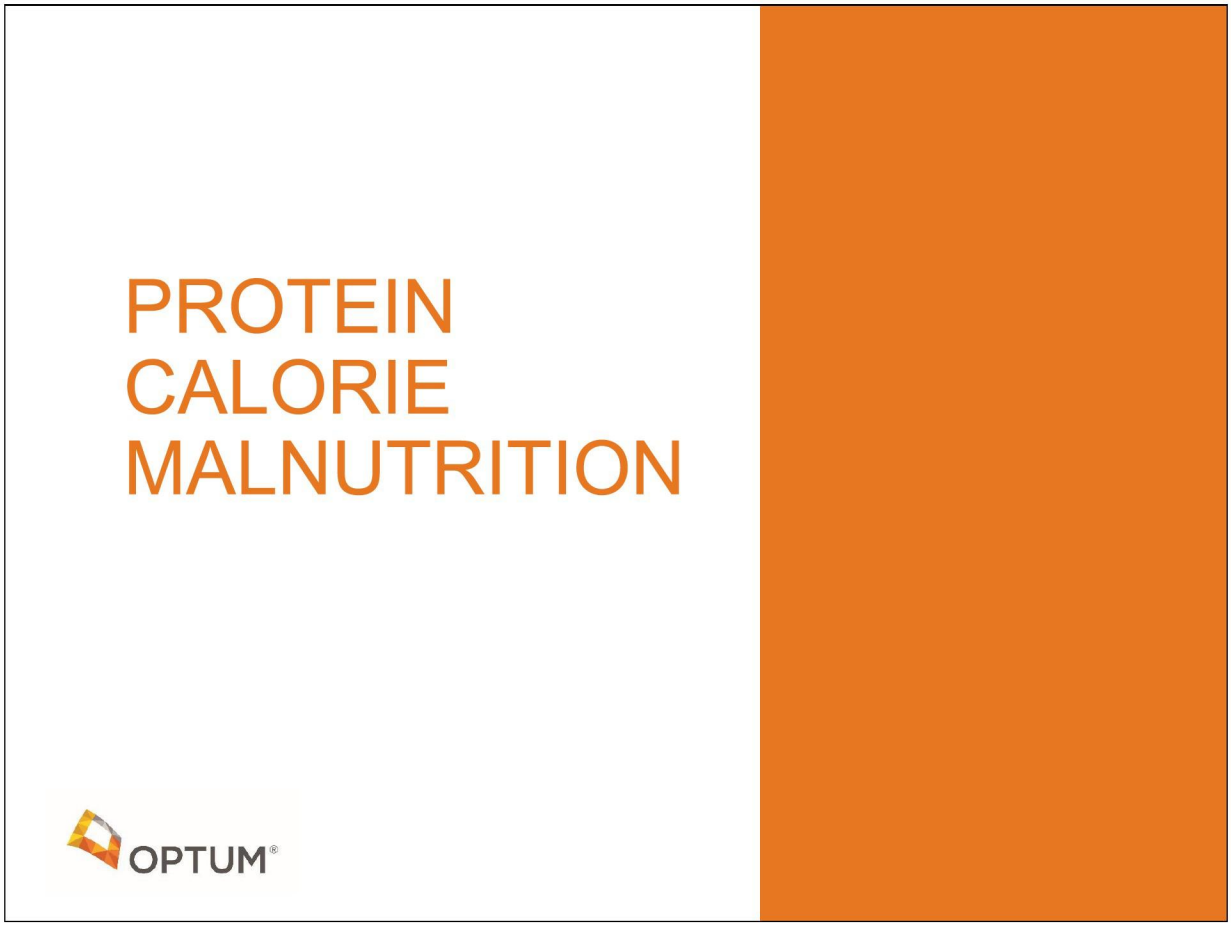
MDD Layers of Appropriate Diagnosis

Major depressive disorder, single episode	Major depressive disorder, recurrent
• Major depressive disorder, single episode, mild • Major depressive disorder, single episode, moderate • Major depressive disorder, single episode, severe without psychotic features • Major depressive disorder, single episode, severe with psychotic features • Major depressive disorder, single episode, in partial remission • Major depressive disorder, single episode, in full remission	• Major depressive disorder, recurrent, mild • Major depressive disorder, recurrent, moderate • Major depressive disorder, recurrent severe without psychotic features • Major depressive disorder, recurrent, severe with psychotic symptoms • Major depressive disorder, recurrent, in partial remission • Major depressive disorder, recurrent, in full remission

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READ: This slide lists all the diagnosis associated with Major Depressive Disorders. You can see the breakdown for either MDD - Single or MDD - Recurrent and then Severity or Remission status is listed below each of those.
All members with depression will have one of these diagnoses in our system.



Our first topic is Protein-Calorie Malnutrition, also known by the abbreviation PCM

Protein Calorie Malnutrition (PCM)

Definition:

Malnutrition is the condition that develops when the body does not get the right amount of the vitamins, minerals, proteins, and other nutrients it needs to maintain healthy tissues and organ function.

Causes of Malnutrition:

- lack of nutrients in the diet
- defective assimilation or utilization of nutrients

The most severe malnutrition problems are associated with Protein-Calorie Malnutrition (PCM) which occurs in both chronic and acute forms.

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Protein-Calorie Malnutrition is a condition that develops as the result of severe malnutrition. Malnutrition occurs when the intake of nutrients is inadequate to maintain a healthy body state. The most severe malnutrition problems are associated with Protein-Calorie Malnutrition, known as PCM, which can occur in both in chronic or acute forms.

Malnutrition in Obese Individuals

- Cachexia definition: General physical wasting and malnutrition usually associated with chronic disease.
- Research has shown that malnourished obese individuals have a higher risk of mortality that well-nourished persons with similar body mass Nutritional status is not body mass index
- Individuals who had lost weight due to bariatric surgery are at high risk for malnutrition
- Excess weight may not represent body fat
- An obese-appearing individual can also be malnourished



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Most clinicians are able to describe an individual as appearing cachectic, but do not always make the association with malnutrition or PCM though it is actually the same condition. Be aware that malnutrition can also be present in obese individuals too, especially in those that have had bariatric surgery.

(REF: Jan Critical Care Medicine in https://acphospitalist.org/archives/2015/02/nutrition.htm)

Associated Diseases related to PCM

- Cancer
- Alcohol abuse or dependence
- Liver, pulmonary, celiac, thyroid, pancreatic diseases
- Chronic Kidney disease/ESRD
- Pancreatitis
- Drug Abuse and/or dependence
- Anemia
- Dementia

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There are many conditions that can be associated with the diagnosis of protein-calorie malnutrition. Some are obvious such as cancer, liver disease, celiac disease and chronic respiratory illnesses, but it can also be associated in individuals with anemia, substance abuse, and dementia.

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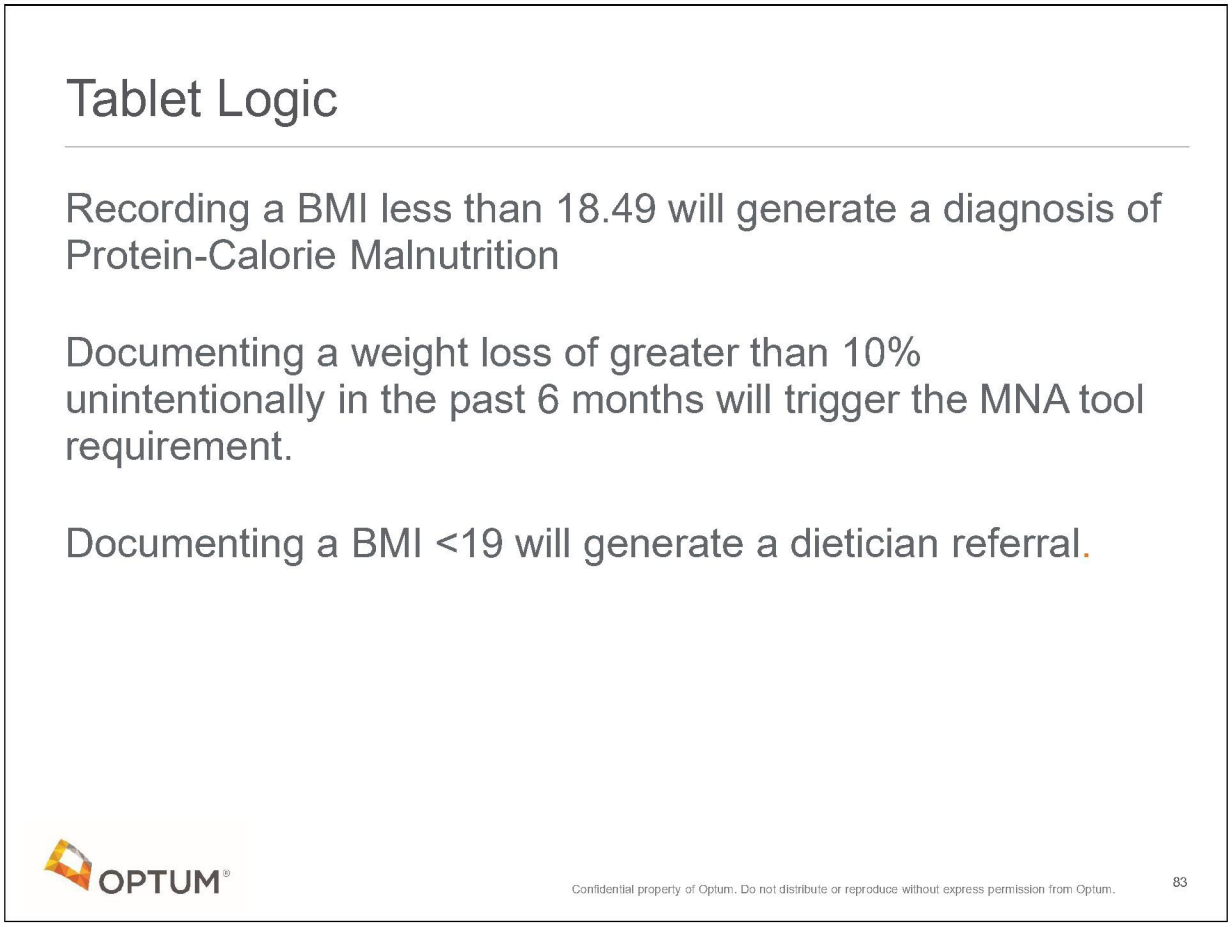
Diagnosing Tips

- Ask about their usual weight amount
- Inquire about any weight loss or weight gain – may need to simplify question of “greater than 10% in the past 6 months”
- Record BMI
- Explore an underlying medical conditions
- Document circumstances of weight loss
- Utilize the MNA tool when suspicion arises related to weight. It does not have to be RED to complete the tool.



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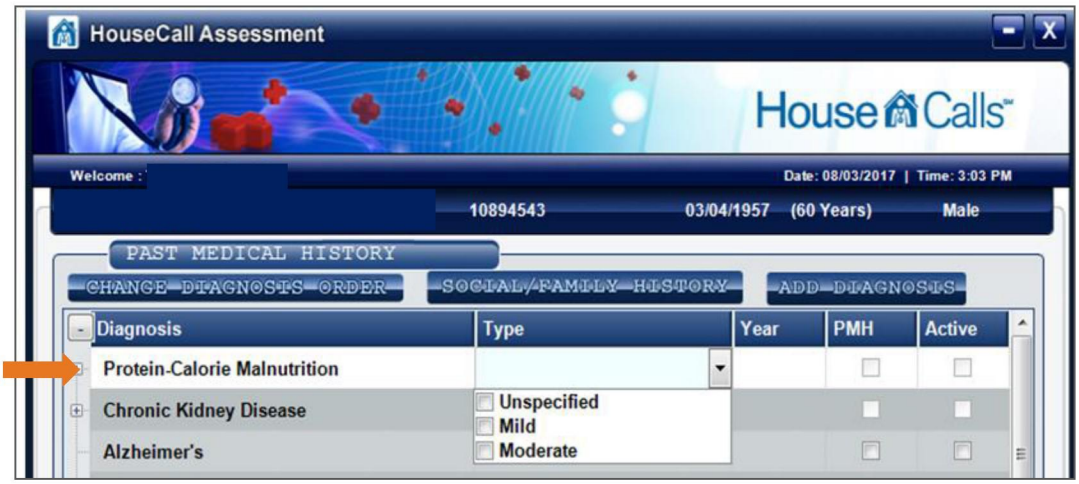
Here are some tips to diagnose Protein-Calorie Malnutrition: Ask the member what their usual weight is and about any recent weight loss or gain. Record their BMI by asking their stated height and using the scale, if at all possible, to record their weight. Explore any underlying medical conditions that could contribute to PCM and utilize the MNA tool to help identify problems with nutrition. The MNA tool does not have to turn RED for you to complete this tool. It is a great tool to assist in providing a complete nutritional picture of the member.



There is tablet logic built into the assessment to assist with diagnosing Protein-Calorie Malnutrition. When a BMI less than 18.49 is recorded, a diagnosis of Protein-Calorie malnutrition is added to the Diagnosis cart. Documenting a weight loss of greater than 10% within the past 6 months will trigger the MNA to turn RED and be mandatory to be completed prior to finalizing the assessment. When a BMI less than 19 is documented, a non-urgent referral is triggered for the dietician team.

Where To Document PCM in eHouseCalls

The Past Medical History section has PCM available with the three possible types: Unspecified, Mild, Moderate



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There are several places you can document PCM on the assessment. One place is on Page 3 , Past Medical History. It is a static choice on this page and if you mark it Active, it will also show up on page 15 the Diagnosis Confirmation page.

Diagnoses in eHC

- Protein Calorie Malnutrition-Mild
- Protein Calorie Malnutrition-Moderate
- Protein Calorie Malnutrition-Unspecified
- Unspecified Severe Protein Calorie Malnutrition

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These are the diagnoses that are available in the eHC applications for Protein Calorie malnutrition

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Severe/Morbid Obesity



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Severe/Morbid Obesity Definition

Overweight is defined as a BMI of 25 to 29.9 kg/m^2

Obesity is defined as a BMI of ≥30 kg/m^2.

Severe/morbid obesity is defined as a BMI ≥40 kg/m^2 **(or ≥35 kg/m^2 in the presence of comorbidities).** (Bray, 2015)

Therefore obesity with comorbid conditions can be diagnosed more specifically as:

- Morbid obesity due to excess calories

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READ: Obtaining an accurate BMI is important for gap closure. I will now review the definitions as it relates to ICD-10 classifications. As you know, the term "Overweight" is defined as having a BMI between 25-29.9, and "Obesity" is defined as a BMI equal to or greater than 30.
Morbid obesity can be captured for a BMI greater or equal to 40 OR equal to or greater than 35 when co-morbid conditions are present.
There is tablet logic in place to assist in capturing these diagnosis but let's discuss the details in the next slides.

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Diagnosing Severe/Morbid Obesity

Screening Measures:

- All adult patients are screened for overweight and obesity by measured height and weight from the scale (whenever possible), and calculating body mass index (BMI) as part of a HouseCalls visit.

Body Mass Index:

- The BMI quantifies the amount of tissue mass (muscle, fat, and bone) in an individual, and then categorize that person as underweight, normal weight, overweight, or obese based on that value
- Easy to measure and reliable
- BMI provides a better estimate of total body fat compared with body weight alone (Bray, 2016)
- BMI measurement is also a **Star/HEDIS** measure

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READ Slide: then say: weighing a member on the scale counts for STAR/HEDIS measures

Obesity Risk with Co-Morbid Conditions

Assessment of individuals risk status includes determination of their weight status as classified by their BMI:

- Co-Morbid conditions that support **Morbid Obesity due to excess calories** can include
  - Diabetes Type II
  - Hypertension
  - Hyperlipidemia
  - Cardiovascular disease
  - Coronary heart disease, cerebrovascular disease; peripheral artery disease, HF
  - Other arteriosclerotic diseases such as abdominal aortic aneurysm or carotid artery disease

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READ: Risk associated with obesity should be in relation to the degree of overweight as classified by their BMI and presence of comorbid conditions. Examples of comorbid conditions include Cardiovascular disease, DM Type II, and other arteriosclerotic diseases.
Therefore, when a BMI is between 35-39 with and the member has comorbid conditions, it can be classified as Morbid/Severe Obesity. Note: this is not part of tablet logic, so you may have to Add this diagnosis manually.

Diagnoses within eHC for Obesity

- Obesity (Body mass index >= 30
- BMI 45.0-49.9, adult
- BMI 50.0-59.9, adult
- Morbid Obesity Due to Excess Calories
- BMI 60.0-69.9, adult
- BMI 40.0-44.9, adult
- BMI 70 and over, adult



These are the diagnoses related obesity in eHC

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Osteoporosis



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Osteoporosis

Osteoporosis is defined as low bone mass and abnormal bone strength.

- Typically osteoporosis has no clinical manifestations until a fracture occurs.
- The most common fracture related to osteoporosis are vertebral and often times asymptomatic.
- The diagnosis and management of Osteoporosis in women ages 67 and older who had a fracture is one of the **HEDIS** measures.

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Osteoporosis

- Risk Factors:
  - Advanced age
  - Smoking
  - High alcohol intake
  - Rheumatoid arthritis
  - Previous fracture
  - Long term steroid use
  - Bone Mineral Density $\leq$ 2.5
  - Recommendations
- Bone density test
  - Women > 65 or younger if risk factors
  - Men – no recommendation for screening unless risk factors

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Additionally keep in mind the risk factors for osteoporosis as listed on the slide.

Be sure to recommend testing based on age, gender or risk factors.

Osteoporosis

Early diagnosis and quantification of bone loss is important to decrease risk factors and prevention of complications.

PMH:
- Compression fractures
- Colles' fx, hip fractures

Medications:
- Calcium, Vitamin D
- Bisphosphonates
- Estrogen
- PTH antagonists
- Evista, Prolia

ROS:
- Chronic steroid use
- "Weak thin bones"
- Fractures without known trauma
- Loss of height
- History of falls/balance disturbance

PE:
- Kyphosis
- Tenderness over spine
- Abnormal gait

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Early diagnosis and quantification of bone loss is important to decrease risk factors and prevention of complications. Here you can see where in the assessment critical clues may be present to alert you to a diagnosis of osteoporosis.

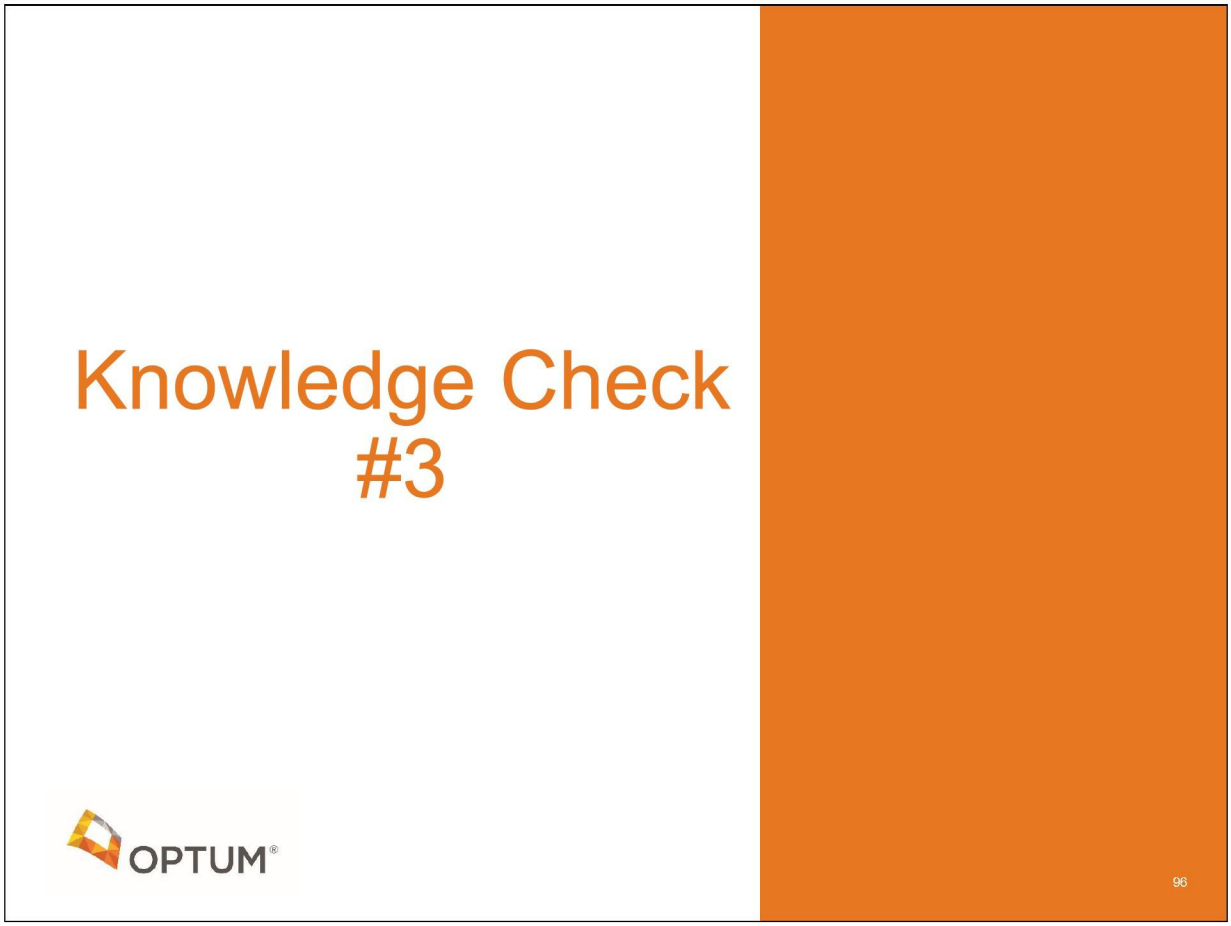
Diagnoses within eHC for Osteoporosis

- Osteoporosis
- Age-related osteoporosis with current pathological fracture, vertebra(e), sequela
- Personal history of (healed) osteoporosis fracture
- Age-related osteoporosis with current pathological fracture, unspecified femur, sequela

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These are the diagnoses related Osteoporosis in eHC

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Open knowledge check #3 polling questions



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Vascular Disease

Who is at Risk:

- Age ≥ 70 years
- Age 50 to 69 years with a history of smoking or diabetes
- Age 40 to 49 with diabetes and at least one other risk factor for atherosclerosis, hyperlipidemia, smoking, hypertension, diabetes
- Leg symptoms suggestive of claudication with exertion or ischemic pain at rest.
- Abnormal lower extremity pulse examination
- Known atherosclerosis at other sites (e.g., coronary, carotid, or renal artery disease).



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READ: The incidence of peripheral arterial disease progresses after the age of 40 and even younger in adults with co-morbid conditions such as smoking, diabetes, HTN and hyperlipidemia.

Vascular Disease

Clinical Presentation:

- As many as 50% of people with PAD are asymptomatic
- Most symptomatic patients with PAD present with lower extremity pain, either as classic intermittent claudication or atypical leg pain.
- Lower extremity pain can be located
  - Unilaterally, bilaterally, as buttock and hip, thigh, calf, or foot pain,
  - As a single pain or in combination
- Ischemic rest pain may be present
- Severe Diffuse pain can occur suddenly progressing to numbness and paralysis

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READ: Since as many as 50% of people with peripheral arterial disease are asymptomatic, clinicians can miss this disease if they are not careful. Typical symptoms include claudication, rest pain, and pain in multiple areas. Atypical pain may be present and difficult to distinguish from arthritis, spinal stenosis, fibromyalgia and neuropathy.

.

Diagnostic Hints for Vascular Disease

PMH:

- Arteriosclerosis
- Fem-pop bypass
- Erectile dysfunction
- Stents in extremities
- DVT
- HTN

Medications:

- Antiplatelets:
  - Clopidogrel (Plavix), Cilostazol (Pletal)
- Aspirin
- Anticoagulants:

  Warfarin, Xarelto, newer drugs

ROS:

- Sores on feet/legs that do not heal
- Claudication
- Cramping with or without pain in legs with activity
- LE edema
- Use of compression hose

PE:

- Color change in legs
- Decreased hair growth
- Slow nail growth
- Shiny skin
- Decreased pulses
- Temperature difference between lower extremities
- Stasis
- Hemosiderin stain

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Within the assessment look for diagnostic hints of vascular disease. REVIEW SLIDE

Diagnoses within eHC for Vascular Disease

There are over 500 diagnoses related to vascular diseases in the eHouseCall diagnosis cart



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There are 500 diagnoses in eHC table related to VD

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Rheumatoid Arthritis



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Rheumatoid Arthritis

- Affects 1.5 million Americans
- Onset usually between 30-50 years of age
- Autoimmune disorder

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Rheumatoid Arthritis

ROS:

- Joint stiffness that lasts 45 mins or more in the morning or after long rest and inactivity
- Joint pain and swelling

Medications:

- Methotrexate
- Low dose prednisone
- Plaquenil, Arava, etc.
- Biologics: Enbrel, Remicade, Humira, etc.

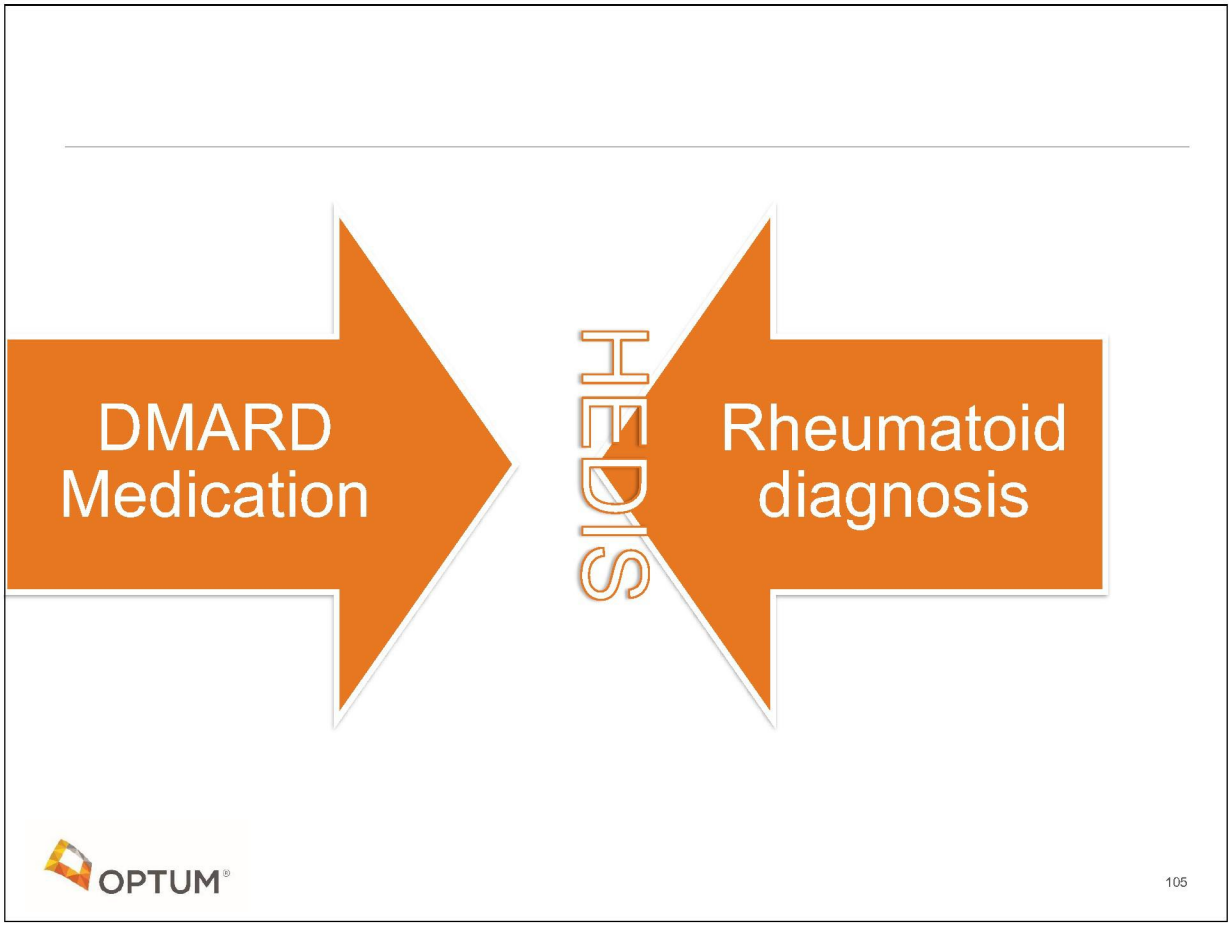
PE:

- Soft tissue swelling of MCP & PIP joints (not bony)
- Feels “boggy” on squeezing
- Marked deformities of hands – Swan Neck

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Clues for the HCP can be included in either the ROS, Medication section or PE within the assessment.



When a member is taking disease-modifying antirheumatic drugs (DMARD) medications it is important that the diagnosis of Rheumatoid arthritis is made.
The diagnosis of Rheumatoid Arthritis and it's link to DMARD's is one of the 17 HEDIS measures.
When a member has classic symptoms of Rheumatoid Arthritis a recommendation for a DMARD should be made to the PCP.

Diagnoses within eHC for Rheumatoid Arthritis

- Rheumatoid Nodule Left Ankle and Foot
- Rheumatoid Nodule Left Elbow
- Rheumatoid Nodule Left Hand
- Rheumatoid Nodule Left Hip
- Rheumatoid Nodule Left Knee
- Rheumatoid Nodule Left Shoulder
- Rheumatoid Nodule Left Wrist
- Rheumatoid Nodule Multiple Sites
- Rheumatoid Nodule Right Ankle and Foot
- Rheumatoid Nodule Right Elbow
- Rheumatoid Nodule Right Hand
- Rheumatoid Nodule Right Hip
- Rheumatoid Nodule Right Knee
- Rheumatoid Nodule Right Shoulder
- Rheumatoid Nodule Right Wrist



There are 229 diagnoses in eHC table related to RA this is a small sample of of the more common diagnoses

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Hyperparathyroidism



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Hyperparathyroidism

Approximately 100,000 people develop primary hyperparathyroidism (PHPT) in the US annually

- Ages of 50-60
- Women are three times more likely than men
- Risk increases with age
- 2 out of 1,000 women 60 years and over will develop hyperparathyroidism



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Approximately 100,000 people develop primary hyperparathyroidism (PHPT) in the US each year, usually between the ages of 50-60 and three times more often in women than men. Also, the risk increases with age; 2 out of 1,000 women 60 years and over will develop hyperparathyroidism

Hyperparathyroidism

Primary hyperparathyroidism

- The most common clinical presentation is asymptomatic hypercalcemia detected by routine screening

Normocalcemic primary hyperparathyroidism

- Primary hyperparathyroidism in which PTH levels are elevated but serum calcium is normal
  - Diagnosis is made when all secondary causes for hyperparathyroidism are ruled out, and ionized calcium levels are normal with Vitamin D deficiency

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UHG-SJC-037075

Hyperparathyroidism

Secondary hyperparathyroidism (SHPT)

- Occurs when the parathyroid gland appropriately responds to a reduced level of extracellular calcium. Causes:
  - Renal failure and impaired calcitriol (1,25 dihydroxyvitamin D) production
  - Inadequate calcium intake or absorption
  - *Vitamin D deficiency*
  - *Gastrointestinal diseases causing malabsorption*

Tertiary hyperparathyroidism

- May result from chronic SHPT
- CKD or kidney transplant, causing irreversible abnormal production of PTH
- PTH remains elevated even after serum calcium is normalized.

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Hyperparathyroidism

Signs/Symptoms

Asymptomatic or mild:

- Fatigue/need for sleep
- Muscle weakness
- Aches/pains in bones/joints
- Feeling depressed

Labs:

- Serum iPTH
- Serum calcium
- 25-Vit D
- Serum phosphorus
- GFR
- Serum creatinine
- 24hr Urine Calcium
- UMA/creatinine ratio*

Imaging

- Bone mineral density (DEXA Scan)
- Parathyroid ultrasound/CT/Scan
- Renal ultrasound/CT

Treatment

Treatment will vary based on type & severity:

- Monitor (PHPT)
- Surgery (PHPT)
- Calcimimetics
- Correct calcium, Vit D, phosphorus levels
- Treat any underlying or co-existing conditions
- Referral to endocrinologist/nephrologist

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Use the PMH ROS and Medication list to help assist with making your diagnosis

*urinary microalbumin/ creatinine ratio

Diagnoses in eHC

- Primary hyperparathyroidism
- Secondary hyperparathyroidism (of renal origin)
- Secondary hyperparathyroidism, non renal
- Other hyperparathyroidism
- Thyroid disease - Hyperparathyroidism

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These are the diagnoses that are available in the eHC applications for hyperparathyroidism

Chronic Kidney Disease



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Chronic Kidney Disease

- Chronic kidney disease (CKD) is a progressive loss of kidney function over a period of months or years.
- Higher levels of creatinine indicate a lower glomerular filtration rate and as a result a decreased capability of the kidneys to excrete waste products.
- According to the Foundation for IgA Nephropathy, the GFR is the rate at which the kidneys filter waste and relates to a member's "kidney function." (eGFR mL/min)



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Read slide

CKD Risk Factors/Causes

- Diabetes (# 1 cause)
- Hypertension
- Older Age
- Glomerular Disease
- Inherited and Congenital Kidney Diseases • Polycystic Kidney Disease
- Other
  - Medications (ibuprofen)
  - Poisons
  - Trauma

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The most common recognized cause of CKD is Diabetes. Hypertension is also a very common cause of chronic kidney disease. Other causes of CKD include:

Read slide

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Glomerular Filtration Rate (GFR)

- Best indicator for assessing kidney function
- 2009 Chronic Kidney Disease- Epidemiology Collaboration (CKD-EPI) Creatinine Calculator NKF, 2017
- Determines Staging of Kidney Disease
- GFR: Blood creatinine test, age, race and gender are part of the calculations
- **The Tablet now provides the GFR values for patients on an individual basis**.

KDIGO, 2012

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It is important to review the GFR and how this relates to kidney disease. The GFR is the best calculator according to the National Kidney Foundation is the 2009 CKD-EPI creatinine calculator. This value as you know determines the staging of the kidney disease. The tablet now provides us with the GFR values to assist us with diagnosing CKD. There is also a LearnSource on CKD that is great for review.

Diagnosing CKD

- Check the chart for GFR data. Is there GFR data for more than 3 months and 3 months apart from the initial one?
- Proteinuria can identify early kidney disease
- Do you have labs for BUN and Creatinine (SCr)?
- Is there CKD staging in the past medical history?
- CKD is based on evaluating both clinical and diagnostic information.
- If the member denies this history, remember we can diagnose CKD with evidential support.

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When considering a CKD diagnosis, remember there are some things to consider. Is there GFR data in the chart? Is there staging mentioned in the previous history. At the time of the visit, ask the member if they have any recent labs to check for CKD stage or if their PCP has told them the stage of their kidney disease. Remember creatinine is the value used to calculate the GFR. Is proteinuria documented in the chart?

FYI: BUN is not as stable according to the literature.

Diagnostic Hints for CKD

PMH:

- Long standing uncontrolled diabetes
- Long standing uncontrolled hypertension
- Iron deficiency anemia
- Inflammatory connective tissue disorders
  - Rheumatoid Arthritis
  - Systemic Lupus

Medications:

- ACE Inhibitors
- Angiotensin receptor blocker (ARB)
- Erythropoietin
- Calcium and Vitamin D supplements
- Phosphate binders

ROS:

- Nausea
- Vomiting
- Loss of appetite
- LE edema
- Fatigue and weakness
- Sleeping problems
- Decrease mental sharpness
- Muscle twitches and cramps
- Persistent itching

PE:

- Positive dipstick results
  - **Proteinuria**
  - Glycosuria
- LE edema
- Hypertension
- Diminished breath sound
- Dry skin

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Remember to consider these diagnostic Hints for CKD. Also there is a Learn Source on CKD, please review if you have any questions. Did the member have a positive protein in the urine during the visit?

KDIGO Recommendations: CKD

- >3 months of functional impairment:
  - GFR < 60 mL/min per 1.73 m^3

OR

- > 3 months of structural damage of the kidneys
  - Structural Damage (albuminuria >30mg/1g creatinine)
  - Abnormal renal imaging

KDIGO, 2012

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Be aware of the current definition of CKD. Although we may not have some of the information from the member. We should do our best to use probing questions to gain information when possible. Be familiar with the staging in relation to GFR. KDIGO (2012) CKD as > 3 months of either functional or structural impairment. Functional impairment is a GFR < 60; Structural damage is an albuminuria > 30 and/or abnormal renal imaging.

KDIGO Guidelines

- For staging purposes, patients should be staged to the criteria at the higher degree of staging.
- If a patient demonstrates with GFR < 30mL/min/1.73 $m2$, the APC should inquire about nephrologist referral.

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KDIGO, 2012

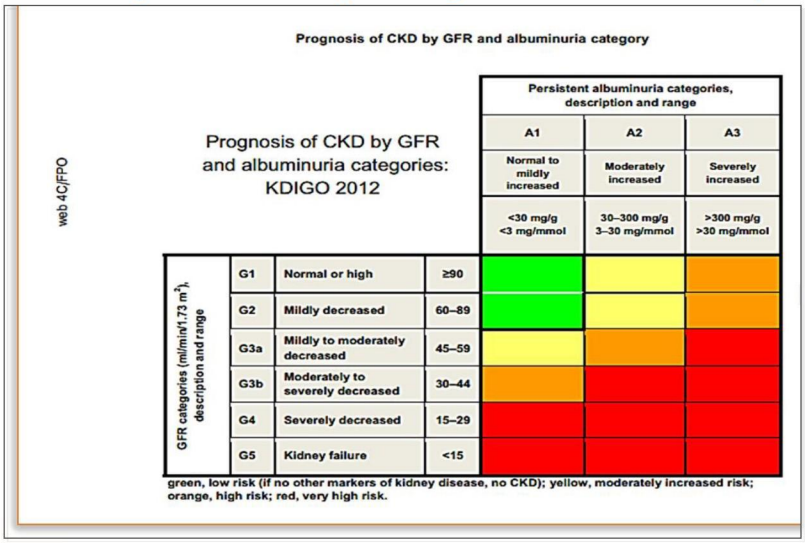
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Nomenclature for Diagnosing CKD

Prognosis of CKD by GFR & Albuminuria Categories: KDIGO 2012
Current CKD Nomenclature for kidney disease management.
Kidney Disease Improving Global Outcomes, 2012



Prognosis of CKD by GFR and albuminuria category

Prognosis of CKD by GFR and albuminuria categories: KDIGO 2012

web 4C/FPO

GFR categories (ml/min/1.73 m²), description and range				Persistent albuminuria categories, description and range		
				A1	A2	A3
				Normal to mildly increased	Moderately increased	Severely increased
				<30 mg/g <3 mg/mmol	30–300 mg/g 3–30 mg/mmol	>300 mg/g >30 mg/mmol
	G1	Normal or high	≥90			
	G2	Mildly decreased	60–89			
	G3a	Mildly to moderately decreased	45–59			
	G3b	Moderately to severely decreased	30–44			
	G4	Severely decreased	15–29			
	G5	Kidney failure	<15			

green, low risk (if no other markers of kidney disease, no CKD); yellow, moderately increased risk; orange, high risk; red, very high risk.

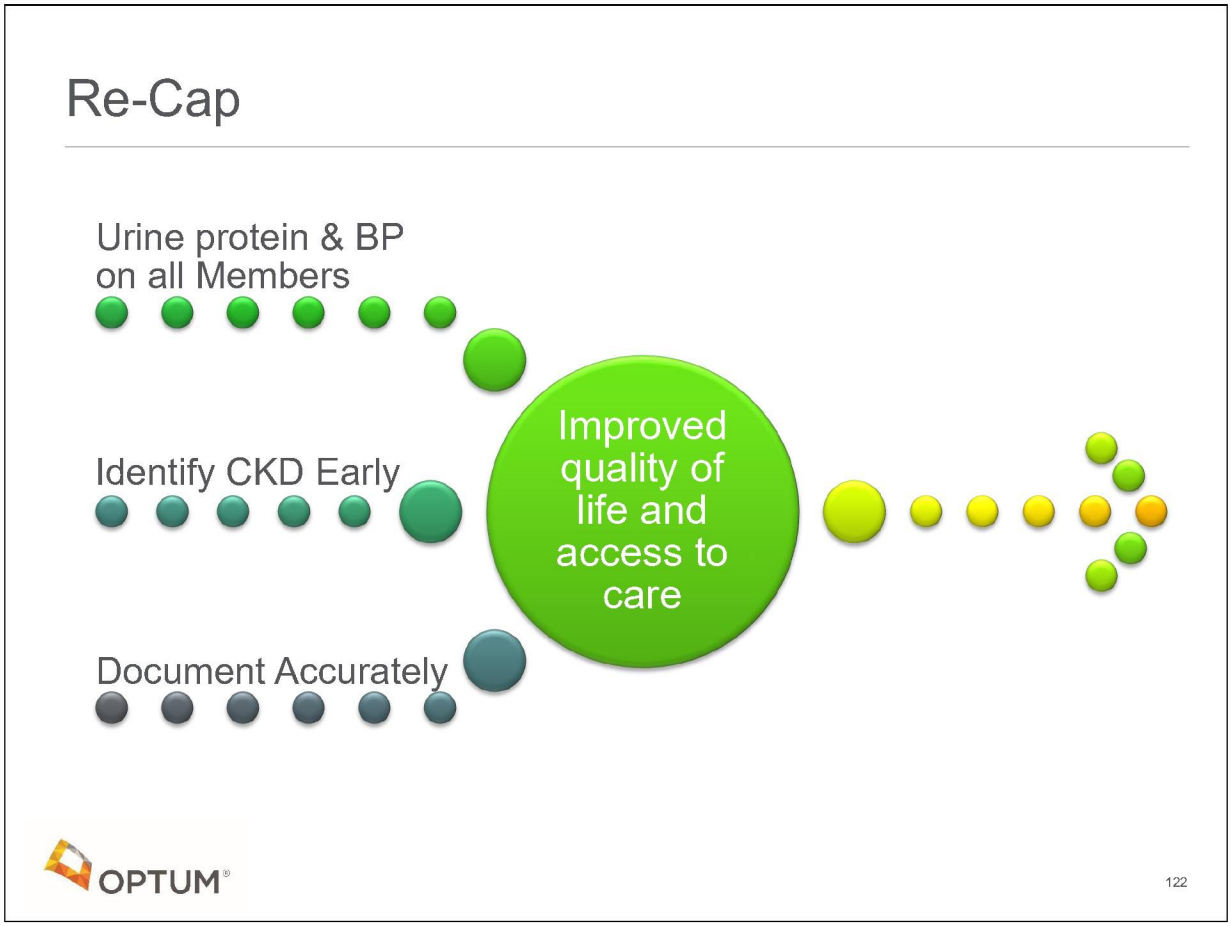
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Source: Kidney disease: Exploring Global Outcomes (KDIGO) Acute Kidney Injury Work Group. KDIGO Clinical Practice Guidelines for Acute Kidney Injury. *Kidney inter., Suppl,* 2012; 2: 1-138. Retrieved: https://www.kidney-international.org. Information from KDIGO used with permission.

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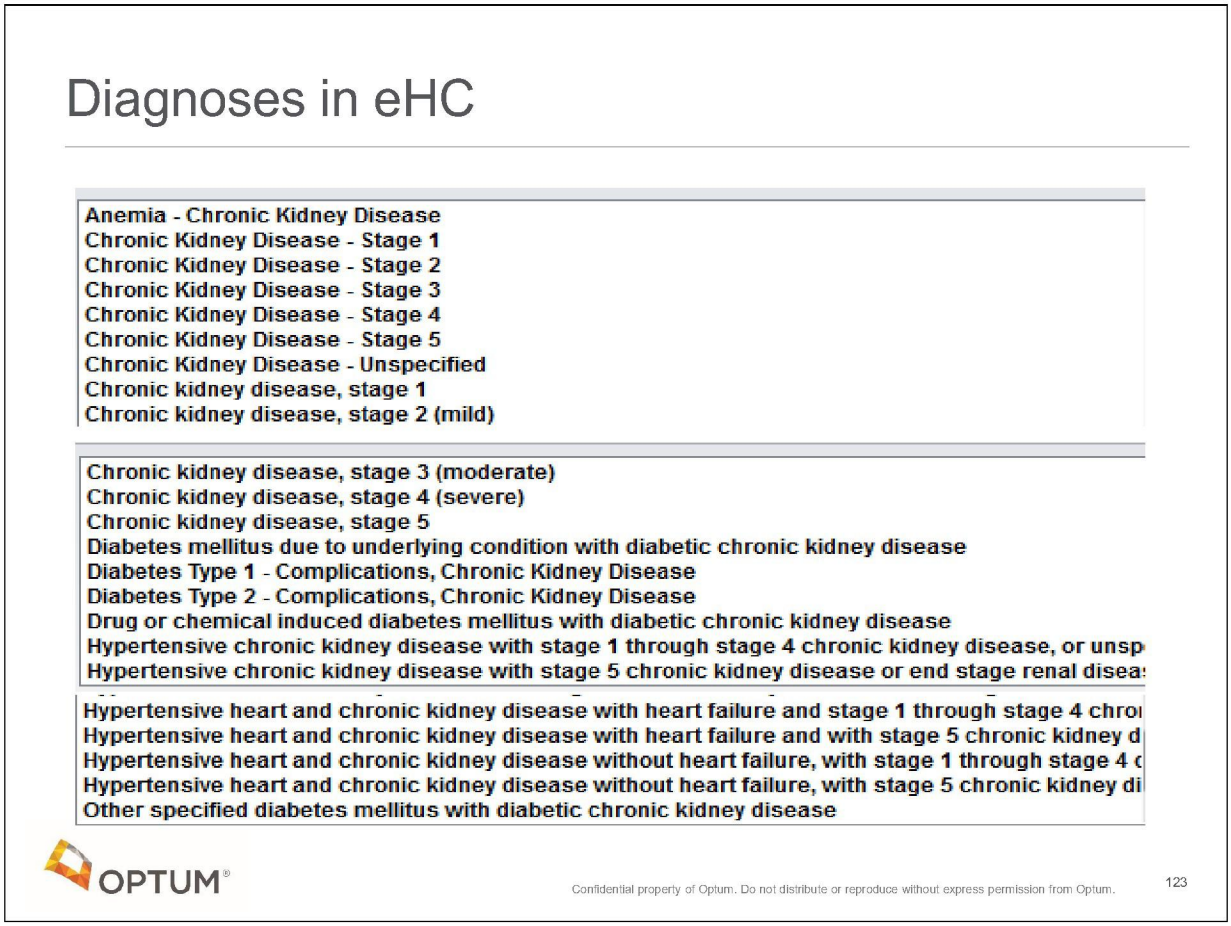
This is the current nomenclature for assisting the clinician with staging CKD. When utilizing this source, the APC should realize these conditions are based on both the GFR and albuminuria. The clinician may need to consult with the nephrologist if needed. IT is important as clinicians to understand the methodology of diagnosing CKD. Key: Green is low risk (if no other markers of kidney disease, no CKD); Yellow- moderate increased risk; Orange- high risk; and Red- Very high risk

CKD is based on a stable measurement over the preceding 3 months. The table above demonstrates the degree of risk for progression of CKD. The green indicates a person at low risk with no markers; the yellow demonstrates someone at a moderate risk (i.e someone with a GFR < 60); orange is high risk and red is someone at very high risk and needs close follow-up.

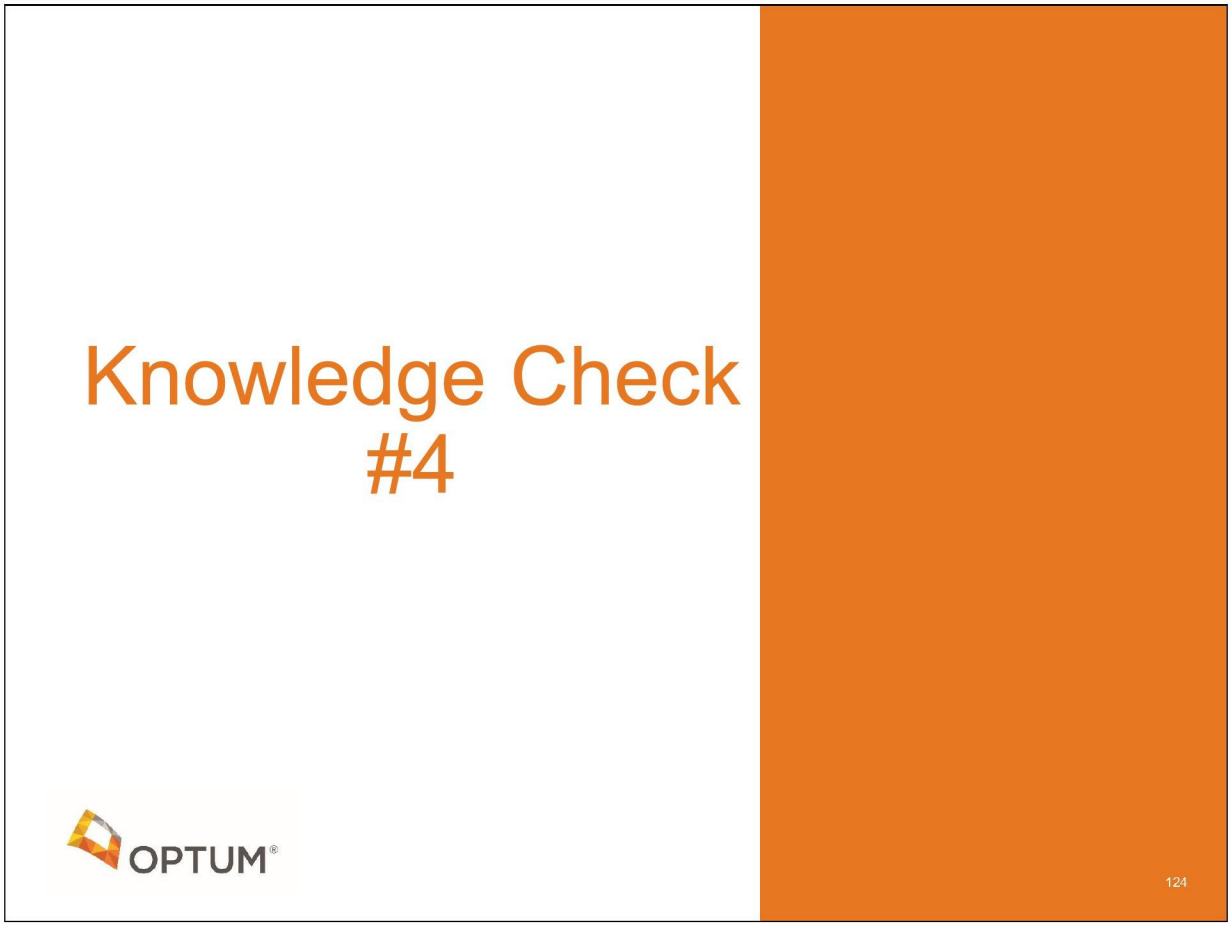


The HCP must obtain urine results for protein and BPs on all members and document accurately. This will ensure the member is identified early on with CKD. You may prevent progression of the disease. The end result for members is better care and full access to all of their available benefits.

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These are the diagnoses that are available in the eHC applications for CKD



Open knowledge check #4 polling questions



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QAClarification Guide

for Clinical QA Specialists

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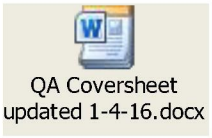
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QA Cover Sheet



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Minor Diagnosis List

Diagnosis	Clarification
Actinic Keratosis Allergic Rhinitis BPH Benign Essential Tremor Blind Legally BMI Candidiasis of skin and nails Cerumen Impaction Constipation Dry Eye Syndrome Diverticular Disease (except acute diverticulitis) Eczema Erectile Dysfunction Fatigue Fecal Incontinence Gait Abnormality Hearing Loss Hemorrhoids Irritable bowel syndrome Insomnia Osteopenia Overactive Bladder Proteinuria (trace to +2) Restless Leg Syndrome Seborrheic Keratosis Urinary Incontinence (all types) Varicose Veins Vasomotor Rhinitis Vitamin D Deficiency Vision Impairment	These diagnoses do NOT need substantiation in the assessment if they are active. The chart should NOT be returned to add these diagnoses if symptoms are present.
Anticoagulation Therapy, chronic, ongoing Antiplatelet Therapy, chronic, ongoing Chronic Aspirin Therapy Long Term Use of Oxygen Obesity, Morbid Obesity and Overweight Vitamin B12 Vitamin D deficiency	Do NOT return to add these diagnoses, but DO return if there is no support for these diagnoses in the assessment. For example, Chronic Aspirin Therapy is an active diagnosis but aspirin is not listed on the medication profile.

General QA Coding Guidelines

Duplicate diagnoses

Do **NOT** return the chart for duplicate diagnoses on the diagnosis confirmation page.

However, if multiple duplicate or similar diagnoses are active (for example >3 diagnoses) this can present a coding issue. The chart should be returned for the provider to select the most specific or appropriate diagnosis. For example:

Nonrheumatic mitral (valve) insufficiency	☑	☑ Stable ☐ Unstable ☐ Suboptimally Co
Nonrheumatic mitral (valve) prolapse	☑	☑ Stable ☐ Unstable ☐ Suboptimally Co
Nonrheumatic mitral (valve) stenosis	☑	☑ Stable ☐ Unstable ☐ Suboptimally Co
Nonrheumatic mitral valve disorder, unspecified	☑	☑ Stable ☐ Unstable ☐ Suboptimally Co
Other nonrheumatic mitral valve disorders	☑	☑ Stable ☐ Unstable ☐ Suboptimally Co

In general, if one of the duplicate diagnoses is 'unspecified' the diagnoses can be considered duplicates and the chart does not need to be returned. For example: *Atrial fibrillation, Unspecified* and *Paroxysmal atrial fibrillation* are duplicates and can remain active on the diagnosis confirmation page.

Conflicting diagnoses

The chart should be returned for any diagnoses that are conflicting.
Examples:

Seizure disorder, epilepsy AND *Seizures or Convulsions, non-epileptic*
Major Mild Depression AND *Major Severe Depression*

An example of a query for conflicting diagnoses: "The following active diagnoses are conflicting: Angina, stable and Angina, unstable. Please clarify."

Acute diagnoses (History-only diagnoses)

Some diagnoses are unlikely to be active during a HouseCalls visit. These diagnoses should be returned for substantiation.

Examples include:

- Cerebrovascular accident
- Transient Ischemic Attack
- Gastrointestinal bleed
- Syncope

Previous or 'History of' Diagnoses

The following diagnoses should remain active on the diagnosis confirmation page (with support in the assessment i.e. PMH). However, if these diagnoses are listed in the member's PMH or Surgery details, do NOT return the chart to add the diagnosis to the Diagnosis Confirmation page.

- History of Myocardial Infarction
- Previous Coronary artery bypass graft
- Cataracts-removed
- Previous angioplasty

Health Status Diagnoses (Z codes)

Status diagnoses should also remain active on the diagnosis confirmation page (with support in the assessment i.e. PMH). For a comprehensive list, Ctrl-click on the following link ICD 10 Categories Health Status (Z Codes)

Past Medical History

For the most part, any chronic diagnosis is considered substantiated if it is documented in the Past Medical History. For example, if Peripheral Vascular Disease is selected in the PMH it can be considered active and substantiated since it is a chronic condition (even if no findings are documented in the ROS or physical exam). An exception to this is if Chronic Aspirin Therapy is selected in the PMH and is also Active, but aspirin is not listed on the member's medication profile.

Cancers

Cancer is considered active when a member is undergoing, awaiting, foregoing, in remission (Leukemia, Lymphoma, Multiple Myeloma) or on treatment to prevent recurrence. Tamoxifen, as an example, is part of a 5 year treatment plan for cancers. The presence of the drug on the medication profile is support that the member is being treated for the cancer. Prostate cancer is considered active s/p seed implants for one year.

Free-texted diagnoses

If a diagnosis cannot be found in the tablet using the search feature within the Diagnosis Cart, it can be free texted under "Additional Diagnoses/Notes" on the Diagnosis Confirmation page (along with an assessment and plan).

Consider returning the chart for diagnoses that are unclear because an unfamiliar abbreviation was used. Coding uses www.medilexicon.com to look up abbreviations. Coding also looks at clinical findings to confirm a diagnosis in the case of abbreviations that stand for multiple diagnoses. However, if the abbreviation is not common or unclear, return the chart for clarification.

Free texted diagnoses must be added to the diagnosis confirmation page. Coding cannot capture diagnoses that are in an assessment note.(need to double check with coding on this)?

Writing QA Queries

In order to be in compliance, communication with providers cannot suggest a diagnosis or steer an HCP toward a particular diagnosis and cannot be presumptive, directing, prodding or probing. This document summarizes recent communication changes and provides examples of appropriate language to use:



The current QA list of **Commonly Used Coversheet Phrases** can be accessed here:



ICD 10 Overview

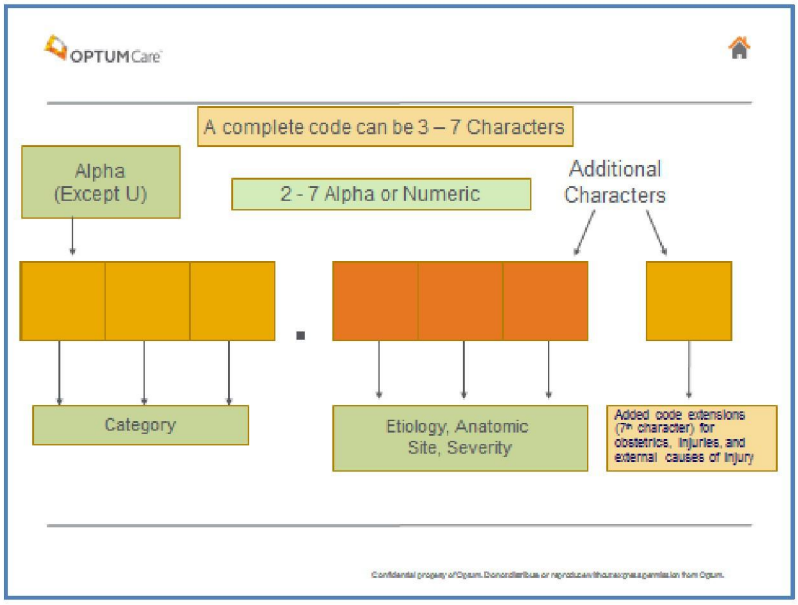
ICD-10-CM is divided into *an Alphabetic Index* (an alphabetical list of terms and their corresponding code) and *a Tabular List*, a structured list of codes divided into chapters based on body system or condition.

ICD-10-CM TABULAR LIST of DISEASES and INJURIES

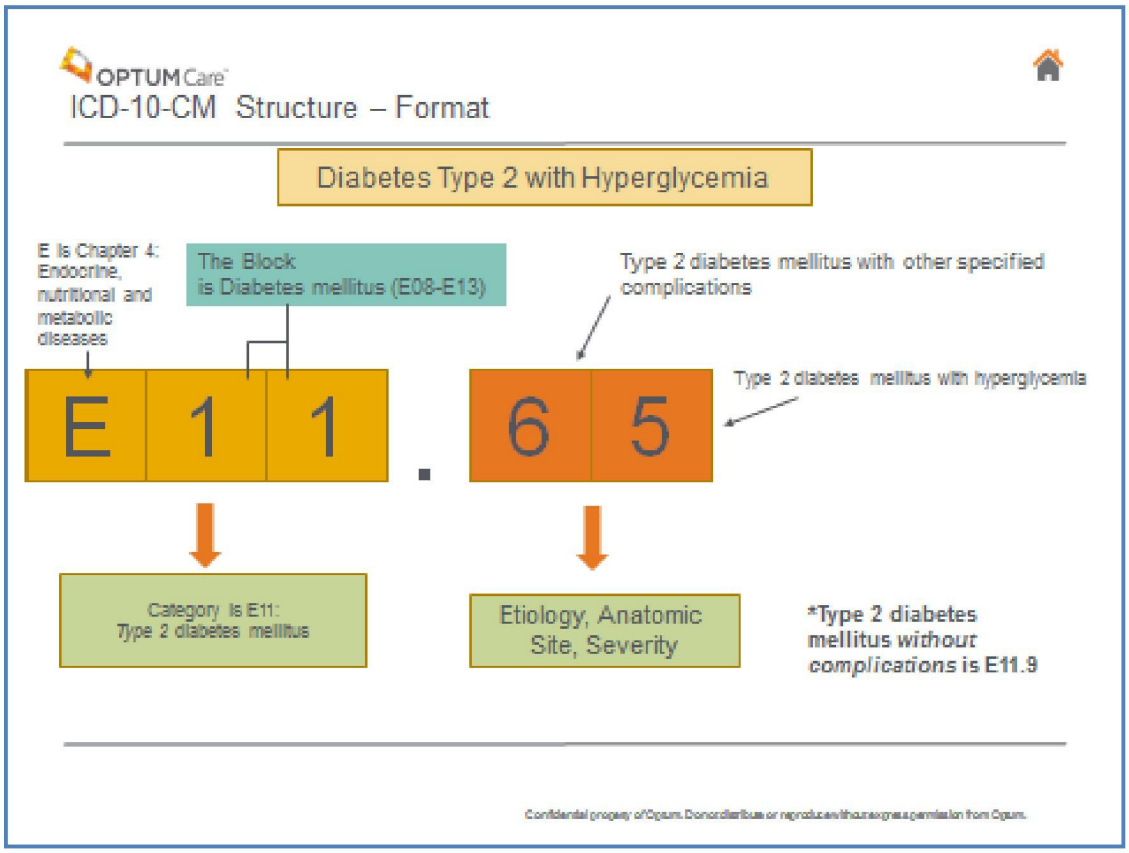
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2 Neoplasms (C00-D49)
3 Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)
4 Endocrine, nutritional and metabolic diseases (E00-E89)
5 Mental, Behavioral and Neurodevelopmental disorders (F01-F99)
6 Diseases of the nervous system (G00-G99)
7 Diseases of the eye and adnexa (H00-H59)
8 Diseases of the ear and mastoid process (H60-H95)
9 Diseases of the circulatory system (I00-I99)
10 Diseases of the respiratory system (J00-J99)
11 Diseases of the digestive system (K00-K95)
12 Diseases of the skin and subcutaneous tissue (L00-L99)
13 Diseases of the musculoskeletal system and connective tissue (M00-M99)
14 Diseases of the genitourinary system (N00-N99)
15 Pregnancy, childbirth and the puerperium (O00-O9A)
16 Certain conditions originating in the perinatal period (P00-P96)
17 Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)
18 Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)
19 Injury, poisoning and certain other consequences of external causes (S00-T88)
20 External causes of morbidity (V00-Y99)
21 Factors influencing health status and contact with health services (Z00-Z99)

The Tabular List is organized by 21 chapters, divided into blocks, categories, subcategories and codes. All categories are 3 characters. Subcategories are either 4 or 5 characters. A complete code may be 3, 4, 5, 6 or 7 characters. A code is considered invalid if all applicable characters are not included. Examples are provided on the following 2 pages.



Example 1: **Diabetes Type 2 with Hyperglycemia**



Diabetes Type 2 with Hyperglycemia **E11.65**

The Chapter is **E (E00-E89) Endocrine, nutritional and metabolic diseases**

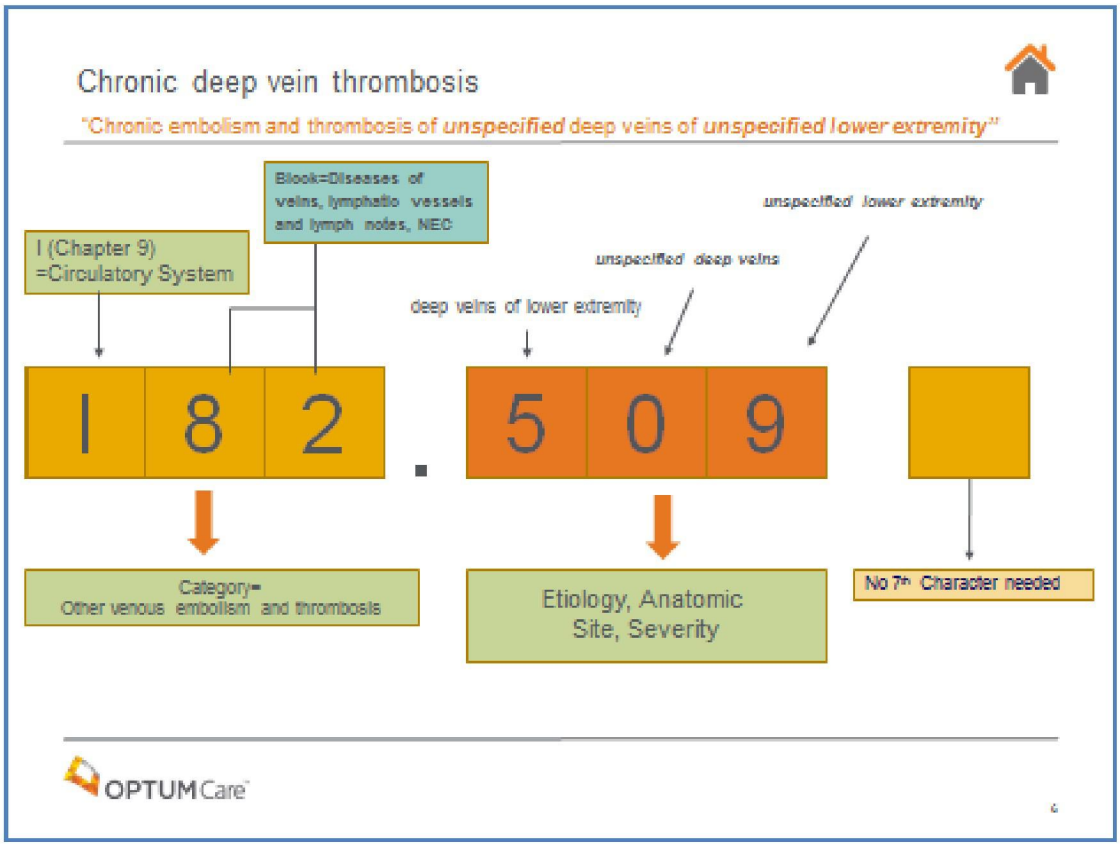
The Block is **Diabetes mellitus (E08-E13)**

The Category is **E11 Type 2 diabetes mellitus**

E11.6 Type 2 diabetes mellitus with other specified complications

E11.65 Type 2 diabetes mellitus with hyperglycemia

Example 2: **Chronic deep vein thrombosis**



Chronic deep vein thrombosis ICD10 Code is **I82.509**

The Chapter is I **(I00-I99)** or the **Circulatory system**

The Block is **(I80-I89) Diseases of veins, lymphatic vessels and lymph notes, NEC**

The Category is **I82 Other venous embolism and thrombosis**

I82.5 Chronic embolism and thrombosis of ***deep veins of lower extremity***

I82.50 Chronic embolism and thrombosis of ***unspecified deep veins*** of lower extremity

I82.509 Chronic embolism and thrombosis of unspecified deep veins of ***unspecified lower extremity***

Additional ICD 10 Resources

CMS Website https://www.cms.gov/medicare/Coding/ICD10/index.html

CDC http://www.cdc.gov/nchs/icd/icd10cm.htm

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ICD 10 Categories

Infectious and Parasitic Diseases

Diagnosis	ICD 10 Code	Clarification
Herpes Zoster	B02.9	Acute infection. Supported with active treatment
Tuberculosis	A15.0	Acute infection. Supported with active treatment

Neoplasms

Diagnosis	ICD 10 Code	Clarification
Cancer-Prostate	C61	If on prophylactic medicine, diagnosis should be active. Diagnosis is also considered active for one year s/p prostate seed implantation.
Cancer-Breast	C50.919	If on prophylactic medicine, such as tamoxifen, diagnosis should be active.
Cancer- Lymphoma Melanoma Multiple Myeloma	 C85.80 C43.9 C90.0	These diagnoses should remain active, even if the cancer is in remission.

Blood and Immune Disorders

Diagnosis	ICD 10 Code	Clarification
Anemia • Pernicious • Iron Deficiency • Sickle Cell • Neoplastic Disease • Chronic Kidney Disease • Unspecified	 D51.9 D50.9 D57.1 D63.0 D63.1 D64.9	
Coagulation Defect	D68.9	

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Endocrine/Nutritional/Metabolic

Diagnosis	ICD 10 Code	Clarification
Diabetes with Complications-Cataracts	E10.36 DMT1 E11.36 DMT2	Cataracts are considered an ophthalmic complication of diabetes Diagnosis should remain ACTIVE s/p cataract surgery/removal. The chart must have support that cataracts are a manifestation of diabetes (in PMH). If Diabetes with Complications-Cataracts is listed in the PMH and the member is s/p cataract removal, the chart should be returned to add the diagnosis of Diabetes with Complications-Cataracts to the diagnosis confirmation page.
Diabetes Type 2 with Hyperglycemia	E11.65	ICD-10 does not define glucose values for hyperglycemia, instead it is left to clinical judgment. Elevated blood glucose, glucose in the urine, and/or an elevated A1C is support for the diagnosis. Return the chart to capture the diagnosis (need to define parameters- such as A1C>9?)
Insulin Resistance	E88.81	Support includes: elevated FBG, member report?
Obesity, Morbid Obesity, Overweight	E66.9, E66.1, E66.3	Minor diagnoses Do not return the chart to add these diagnoses if support present. Can return if support is not present.

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Mental, Behavioral & Neurodevelopmental Disorders

Diagnosis	ICD 10 Code	Clarification
Major Mild Depression,Recurrent Major Mild Depression,Single Episode Major Moderate Depression,Recurrent Major Moderate Depression,Single Episode Major Severe Depression,Recurrent Major Severe Depression,Single Episode	F33.0 F32.0 F33.1 F32.1 F33.2 F32.2	Will wait to clarify- more codes to be added to tablet
Alcohol Abuse		
Alcohol Dependency		
Substance Abuse		

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Nervous system

Diagnosis	ICD 10 Code	Clarification
Chronic Pain	G89.29	If underlying diagnosis causing the pain is present, ie. DDD, Chronic Pain does not need to be active. If chronic pain diagnosis is present please include the underlying diagnosis for the chronic pain, when underlying diagnosis is clear.
Other Neuropathy	G58.9	If this diagnosis is active, chart should have clarification of what the "Other" neuropathy is referring to, such as carpal tunnel syndrome.
Peripheral Neuropathy	G62.9	Duplicate of Polyneuropathy, unspecified. Can have both diagnoses active.
Polyneuropathy, unspecified	G62.9	Duplicate of Peripheral neuropathy. Can have both diagnoses active. For specific polyneuropathy diagnoses, refer to the following Job Aid: **Neuropathy**
Seizure Disorder, epilepsy	G40.909	
Seizures or Convulsions, nonepileptic	R56.9	Symptom code only. Should use underlying diagnosis if known, such as Seizure disorder, epilepsy

Eye, Adnexa and Ear

Diagnosis	ICD 10 Code	Clarification
Blind Legally	H54.8	Minor diagnosis
Vision Impairment	H54.7	Minor diagnosis
Cataracts - Active	H25.9	Can be supported in the PMH *or* the PE
Cataracts-Removed	Z98.49	This is a Health status Z code and should remain active. Do not return chart to add diagnosis if it has been removed however.

Ear and Mastoid process

Diagnosis	ICD 10 Code	Clarification
Hearing Loss	H91.90	Minor diagnosis

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Circulatory system

Hypertensive diseases (I10-I15)

Diagnosis	ICD 10 Code	Clarification
Secondary Hypertension	I15.9	Must have evidence of etiology: such as CKD, OSA, thyroid disorder, pheochromocytoma, Cushing syndrome, primary aldosteronism, chronic steroid use, etc…
Hypertension		Benign or Essential hypertension

Ischemic heart diseases (I20-I25)

Diagnosis	ICD 10 Code	Clarification
Angina • Stable • Unstable • Unspecified	 I25.10 I20.0 I20.9	
Cardiovascular Disease	I25.10	Maps to same code as CAD.
Atherosclerotic Heart Disease of native coronary artery without angina pctrs	I25.10	Maps to the same code (I25.10) as CVD and CAD
Atherosclerosis bypass of coronary artery of transplanted heart	I25.76	Heart transplant and Previous CABG must be documented in Surgery details
Coronary Artery Disease	I25.10	Maps to same code as CVD and Atherosclerotic Heart Disease
History of Myocardial infarction	I25.2	Can remain active diagnosis with supportive documentation. If member has a History of MI: CAD, CVD or Atherosclerotic Heart disease should also be active (I25.1). We can return chart to capture these diagnoses if needed.

Pulmonary heart diseases (I26-I28)

Diagnosis	ICD 10 Code	Clarification
Chronic pulmonary embolism	I27.82	
Pulmonary Embolism	I26.99	Acute PE- PMH only.

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Other forms of heart disease (I30-I52)

Diagnosis	ICD 10 Code	Clarification
Atrial Fibrillation • Unspecified • Chronic • Paroxysmal • Atrial Flutter	 I48.91 I48.2 I48.0	See Reference Document: Atrial Fibrillation If known, choose the most specific type.
Cardiac Arrhythmia	I49.9	If the specific arrhythmia is known, this diagnosis should not be used. For example, if a member has a history of AF or is on an anticoagulant/another medication that suggests AF, Atrial fibrillation should be used (from the Tips to Improve Documentation Specificity Job Aid)

Cerebrovascular diseases (I60-I69)

Diagnosis	ICD 10 Code	Clarification
Cerebral atherosclerosis, unspecified	I67.9	Cerebrovascular Disease, unspecified
Cerebrovascular Accident	I63.50	This is an acute diagnosis only. Return to substantiate diagnosis if active. Use the diagnosis of "Cerebrovascular Accident with Late Effects" for residual deficits s/p CVA
Cerebrovascular Accident with Late Effects	I69.90	Supported by PMH of CVA and one or more of the following sequelae:
Occlusion and stenosis of unspecified carotid artery (right, left or bilateral)	I65.29 (I65.21 through 3)	If member is s/p carotid endarterectomy, diagnosis is PMH only unless documented that member still has condition (ie in one artery)
Transient Ischemic Attack	I67.848	This is an acute diagnosis only. Return to substantiate diagnosis if active.

PVD-Diseases of arteries, arterioles and capillaries (I70-I79)

Diagnosis	ICD 10 Code	Clarification
Aneurysmal disease	I72.9	
Peripheral arterial disease- • Amputation for severe arterial vascular insufficiency • Claudication relieved by rest • Unknown	I73.9 (same code for all PAD/PVD diagnoses)	See Reference Document Hx PVD/PAD/ DM with PVD with medications OR Teachings/Recommendation/Plan TREATMENT / RX / PROCEDURES AND DVT • LE Ulcer

• Vascular reconstruction, bypass surgery, percutaneous revascularization in arteries of lower and upper extremities Peripheral Vascular Disease without DM		• Absent pulses (pedal and/or posterior tibial) • Hx Aortic atherosclerosis or aortic aneurysm or AAA • H/O IVC Filter • Aortic stent graft / femoral stent / iliac stent / any LE vascular surgery • 2 of the following: cool extremities, abnormal cap refill, hair loss, LE edema • Previous amputation and stents or grafts • Edema and Support Hose together are enough support • Claudication
Unspecified disorders of arteries and arterioles	I77.9	

Diseases of veins and lymphatic system (I80-I89)

Diagnosis	ICD 10 Code	Clarification
Chronic Deep venous thrombosis	I82.509	

Respiratory system

Diagnosis	ICD 10 Code	Clarification
Chronic obstructive pulmonary disease, unspecified	J44.9	See Reference Document COPD
Chronic respiratory failure		

Digestive System

Diagnosis	ICD 10 Code	Clarification
Inflammatory Bowel Disease	K42.9	Includes Crohns and Ulcerative Colitis
Diverticular Disease	K57.30	Diverticular disease of colon NOS Minor diagnosis- No substantiation needed. (with exception of acute diverticulitis)
Irritable Bowel Syndrome	K58.9	Minor diagnosis

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Skin and Subcutaneous tissue

Diagnosis	ICD 10 Code	Notes

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Musculoskeletal system and connective tissue

Diagnosis	ICD 10 Code	Clarification

GU System

Diagnosis	ICD 10 Code	Clarification
Chronic kidney disease, Stage I Chronic kidney disease, Stage II (mild) Chronic kidney disease, Stage III (moderate) Chronic kidney disease, Stage IV (severe) Chronic kidney disease, Stage V	N18.1 through 5	Use additional diagnosis to identify kidney transplant status if applicable (Z94.0). Diabetic CKD and Hypertensive CKD should also be active if applicable.
Kidney Disease- End stage renal disease on Dialysis	N18.6 & Z99.2	Both Kidney Disease- ESRD and Hemodialysis should be active diagnoses.
Kidney Disease- Chronic Kidney Disease	N18.9	Use if Stage of CKD is unknown.
Renal failure	N19	"Unspecified kidney failure" Chronic Kidney disease should be used instead (check with coding whether chart should be sent back if evidence for CKD in chart)
Erectile Dysfunction	N52.9	Minor diagnosis

Congenital Abnormalities

Diagnosis	ICD 10 Code	Clarification
Down Syndrome	Q90.9	
Polycystic kidney, unspecified	Q61.3	

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Symptoms/Signs/Abnormal Clinical and Laboratory

Diagnosis	ICD 10 Code	Clarification
Bradycardia, unspecified	R00.1	
Cachexia	R64	
Functional Quadriplegia	R53.2	
Fatigue/Chronic Fatigue Syndrome	R53.83/R53.82	
Hypoxemia	R09.2	
Urinary Incontinence	R32	
Bowel Incontinence	R15.9	
Vertigo	R42	
Proteinuria	R80.9	
Syncope	R55	Syncope and Collapse- Acute diagnosis only
Seizures or Convulsions, nonepileptic	R56.9	if member has a history of seizures and takes medication to prevent or control seizuresdo not use this diagnosis. Use Seizure Disorder Seizures/ Convulsions is a non-specific symptom and is not a diagnosis.

Injury/Poisoning and External Causes

Diagnosis	ICD 10 Code	Clarification
Spinal Cord Injury	S14.10	
Traumatic Wound	T14.8	
Surgical Wound	T81.89XA	

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Health Status (Z Codes)

Diagnosis	ICD 10 Code	Clarification
Amputations	Z89.xxx	Amputations should be PMH and active diagnoses
Anti-Coag Therapy - chronic, ongoing	Z79.01	MINOR DX. Do NOT return to add diagnosis, but if not supported DO return
Anti-Platelet Therapy - chronic, ongoing	Z79.02	MINOR DX. Do NOT return to add diagnosis, but if not supported DO return
Bilateral mastectomy /Unilateral mastectomy	Z90.13	Should remain active diagnosis. Do not send back to add Dx if listed in Surgery Details.
BMI	Z68.41 through 45	MINOR DX. Do not return chart to add BMI diagnosis- coding can capture BMI from the physical exam. If pre-populated to the diagnosis confirmation page, these diagnoses should not be removed.
Cataracts-Removed	Z98.49	Can be active Dx but do NOT return to add if diagnosis has been removed
Chronic Aspirin Therapy	Z79.82	Do NOT return to add diagnosis, but if not supported DO return
Chronic Insulin Therapy	Z79.4	Do not return the chart to add this diagnosis if insulin is on the medication profile (Coding will capture).If a member has Type 1 diabetes, insulin use is implied and there is no need to add the diagnosis of Chronic Insulin Therapy. However, if this diagnosis is active on a member with Type 1 DM, we do not need to return the chart to have it removed.
Colostomy	Z93.3	Must be supported in physical exam
Gastrostomy status	Z93.1	Must be supported in physical exam
Ileostomy	Z93.2	Must be supported in physical exam
Hemodialysis	Z99.2	
Long Term Use of Oxygen	Z99.81	MINOR DX. Do NOT return to add diagnosis, but DO return if not supported
Previous angioplasty	Z98.61	PMH and active diagnosis
Previous Coronary artery bypass graft	Z95.1	PMH and active diagnosis
Tracheostomy	Z93.0	Need support in physical exam
Transplants	Z94.xx	Transplants should be PMH and active diagnoses

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Reference Documents

Assessment Tools

ADL/Barthel Index



Barthel_ADL.pdf

Patient Health Questionnaire (PHQ-9)

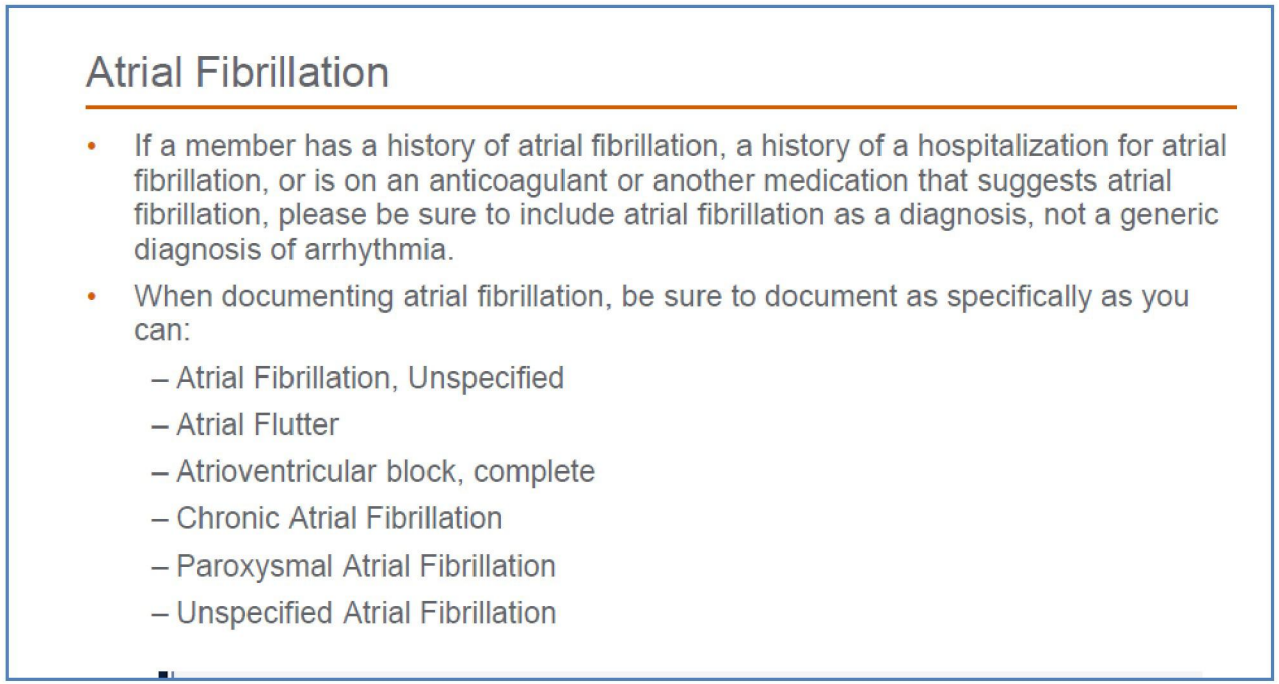


PHQ_9.pdf

Mini Nutritional Assessment

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Atrial Fibrillation



Portal References available: *"Atrial fibrillation algorithm"* and *"Diagnosing in the Home Series for HouseCalls Practitioners: Atrial Fibrillation"*





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COPD

Portal reference available: Diagnosing in the Home Series: COPD

Diagnosing_COPD_in_the_Home_514v1.p

Diabetes



Diabetes documentation Job Aid 10-9-15

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Heart Failure

Diagnosing CHF in the Home

BOSTON CRITERIA

History – Maximum 4 points	Sign/Symptom	Points
	Resting dyspnea	4
	Orthopnea	4
	Paroxysmal nocturnal dyspnea	3
	Dyspnea walking level	2
	Dyspnea climbing	1
Physical Exam – Max 4 points	Sign/Symptom	Points
	Heart rate ≥ 110	2
	Heart rate 91-109	1
	Rales at higher than basilar areas	2
	Rales at basilar areas only	1
	Wheezing	3
	S3	3

Scoring: 8 points or more: definite heart failure 5 – 7 points: possible heart failure
4 or less points: heart failure unlikely

FRAMINGHAM CRITERIA

Major Criteria	Signs
	Paroxysmal nocturnal dyspnea
	Rales
	S3
	Weight loss > 4.5 Kg in 5 days in response to RX
Minor Criteria – not related to other diagnoses	**Signs**
	Bilateral ankle edema
	Nocturnal cough
	Dyspnea on ordinary exertion
	Hepatomegaly
	Tachycardia HR > 120 bpm

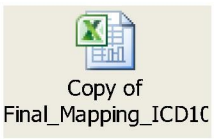
Scoring: 2 Major Criteria or 1 Major plus 2 Minor Criteria makes the diagnosis of CHF

ICD 10 HouseCalls Reference Guides

ICD10 "Quick Reference Guide" Job Aid v 10 6 with navigation (document for HouseCalls practitioners)



Final Mapping ICD10 9-17-15

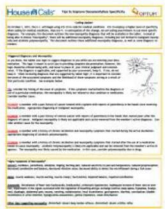


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Neuropathy

Job Aids available:

Tips to Improve Documentation Specificity 8.3.15



Neuropathy and Coding Tips Job Aid 8.3.15



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Peripheral Vascular Disease/Peripheral Arterial Disease

Preventive Screening Guidelines

Member Handout and Portal references:





Vaccination	
Influenza	Recommended yearly
Pneumovax	Members who smoke or have chronic medical conditions 1 dose before age 65. May revaccinate 1 time after 5 years before age 65. Everyone - Once after age 65.
Herpes Zoster	Everyone - Once after age 60.
Tdap/TD	Recommended every 10 years
Prevnar 13	Once after age 65 who have already received the initial Pneumovax Providers do not need to include this, but do not deduct a point if the recommendation is included.?
Preventative Screening Criteria	
Colon Cancer	**Colonoscopy every 10 years (age 50-75) OR FOBT yearly (age 50-75)** If the colonoscopy has not been done at all or has not been done in 10+ years, look for Recommendations, Member Education, and the Ask you PCP letter to reflect that screening was recommended. If a provider is flagged to leave a FOBT with the member, do NOT deduct points. Providers are not able to do (PIN) labs for FOBT. Not recommended after the age of 75, unless the medical rational is specifically documented for the member (polyps in previous exam, for example)
Mammogram	**Recommended every two years from age 50-74** Not recommended after age of 74 Deduct points if a mammogram was recommended in a male

Dexa Scan	**Recommended in females after age 65** Recommended if member has risk factors present Once a Dexa Scan is completed, there are not specific guidelines as to when another should be done. Due to this, do not deduct points if provider recommends a Dexa Scan in a member who has already had one. Do not deduct points if a Dexa Scan is: Recommended on a male who is over the age of 70 or has risk factors Has been done in the past, and the provider did NOT recommend another one be done in the recommendations.
Dilated Retinal & Glaucoma Exam	If member is **diabetic** this is recommended **yearly** regardless of age. Do not deduct points if this was or was not recommended in non-diabetic members. Providers are to use their discretion.
Cholesterol Screening	Adults ≥21 with heart disease or LDL ≥190 mg/dL Adults 40-75 with type 2 Diabetes or have a high risk of heart disease.
Low Dose Chest CT	Every year for smokers **with 30 pack-year smoking** history that currently smoke or quit within last 15 years (ages 55-80)

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Protein Calorie Malnutrition

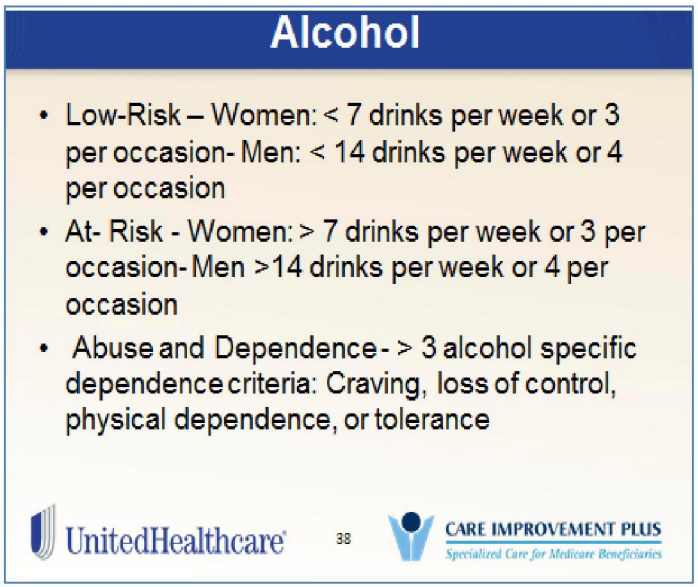
Must have one of the following combinations (Either A, B, C, D, **OR** E):

A	B	C	D	E
MNA less than 17 with malnourished **OR** Risk of malnutrition documented **AND** Medication/nutritional supplement **OR** Dietary consult **OR** Education on well balanced plate **OR** Meds or treatment or teaching	2 of the following: • Weight < 100 • Unintentional weight loss • Cachectic • History of Cancer • BMI <19 and treatment (meds) or teaching	Albumin less than 3 and treatment	Unintentional weight loss >10% in 6 months and treatment	Cachectic, Malnourished, muscle wasting, emaciated, or muscle atrophy

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Psychiatric Disorders

Substance Abuse



Portal Reference available: *"Diagnosing Substance Abuse in the Home"*

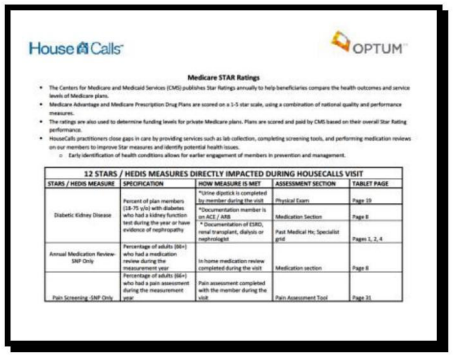


Major Depression

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STARS/HEDIS Measures

This document summarizes the 12 STARS / HEDIS measures directly impacted during a HouseCalls visit.



House Calls

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Medicare STAR Ratings

- The Centers for Medicare and Medicaid Services (CMS) publishes Star Ratings annually to help beneficiaries compare the health outcomes and service levels of Medicare plans.
- Medicare Advantage and Medicare Prescription Drug Plans are scored on a 1-5 star scale, using a combination of national quality and performance measures.
- The ratings are also used to determine funding levels for private Medicare plans. Plans are scored and paid by CMS based on their overall Star Rating performance.
- HouseCalls practitioners close gaps in care by providing services such as lab collection, completing screening tools, and performing medication reviews on our members to improve Star measures and identify potential health issues.
  - Early identification of health conditions allows for earlier engagement of members in prevention and management.

12 STARS / HEDIS MEASURES DIRECTLY IMPACTED DURING HOUSECALLS VISIT

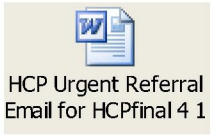
STARS / HEDIS MEASURE	SPECIFICATION	HOW MEASURE IS MET	ASSESSMENT SECTION	TABLET PAGE
Diabetic Kidney Disease	Percent of plan members (18-75 y/o) with diabetes who had a kidney function test during the year or have evidence of nephropathy	*Urine dipstick is completed by member during the visit *Documentation member is on ACE / ARB * Documentation of ESRD, renal transplant, dialysis or nephrologist	Physical Exam Medication Section Past Medical Hx; Specialist grid	Page 19 Page 8 Pages 1, 2, 4
Annual Medication Review-SNP Only	Percentage of adults (66+) who had a medication review during the measurement year	In home medication review completed during the visit	Medication section	Page 8
Pain Screening -SNP Only	Percentage of adults (66+) who had a pain assessment during the measurement year	Pain assessment completed with the member during the visit	Pain Assessment Tool	Page 31

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Urgent Referrals

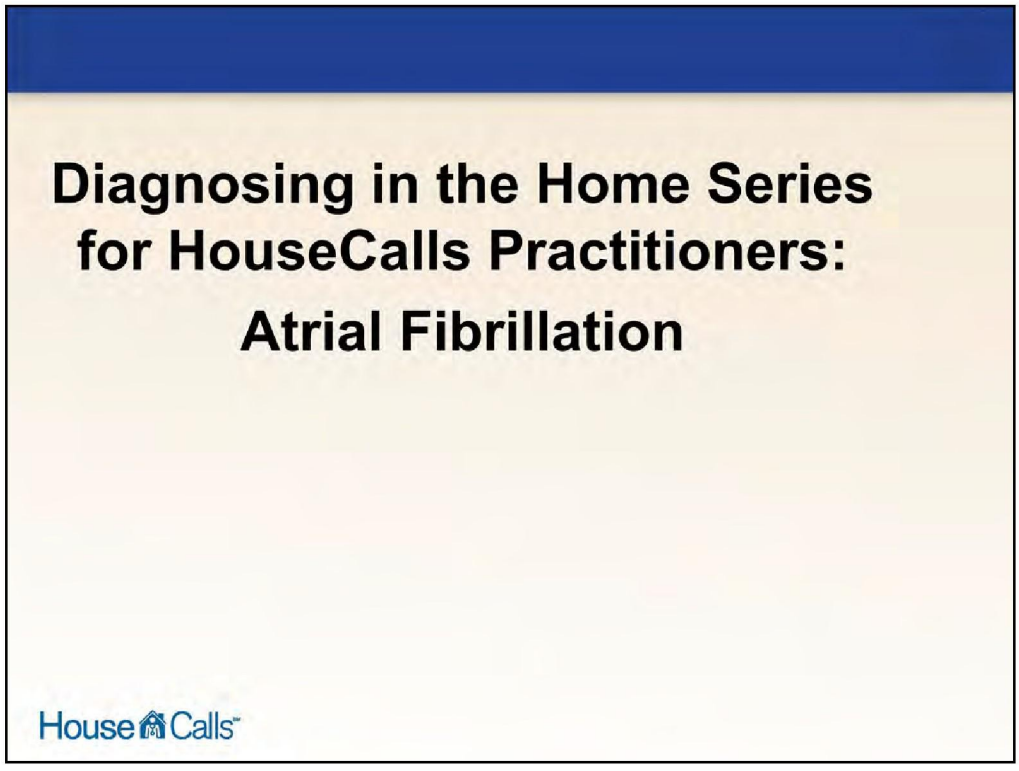
Severe Dyspnea, RR >35	Examination - Respiratory Rate >35
Severe Hypertension	Examination - Blood Pressure: Systolic >=200 Or Diastolic >=120
Severe hypotension	Examination - Blood Pressure: Systolic <=80
Tachycardia	Examination -Heart Rate: >110
Bradycardia	Examination -Heart Rate: <50
Acute vision Change of 48 hours or less	ROS-EENT-EYES: Changes in Vision: When=48 hours or less
Abdominal Pain	ROS - Gastrointestinal: Abdominal Pain = Y and Examination-Gastrointestinal - pain to Palpitation=Y
Protein of 3+ or 4+ on urine dipstick	Examination: Urine Dipstick-Protein = 3+ or 4+ and the Dx of renal disease not present in Past medical history or is not active in Dx cart.
Glucose of 3+ or 4+ on urine dipstick	Examination: Urine Dipstick - Glucose = 3+ or 4+
PHQ9 of 20 or greater	PHQ9 of 20 or greater
Thoughts of self harm	PHQ9 -The answer to Question #9 is greater than zero

HCP Urgent Referral E-mail Process



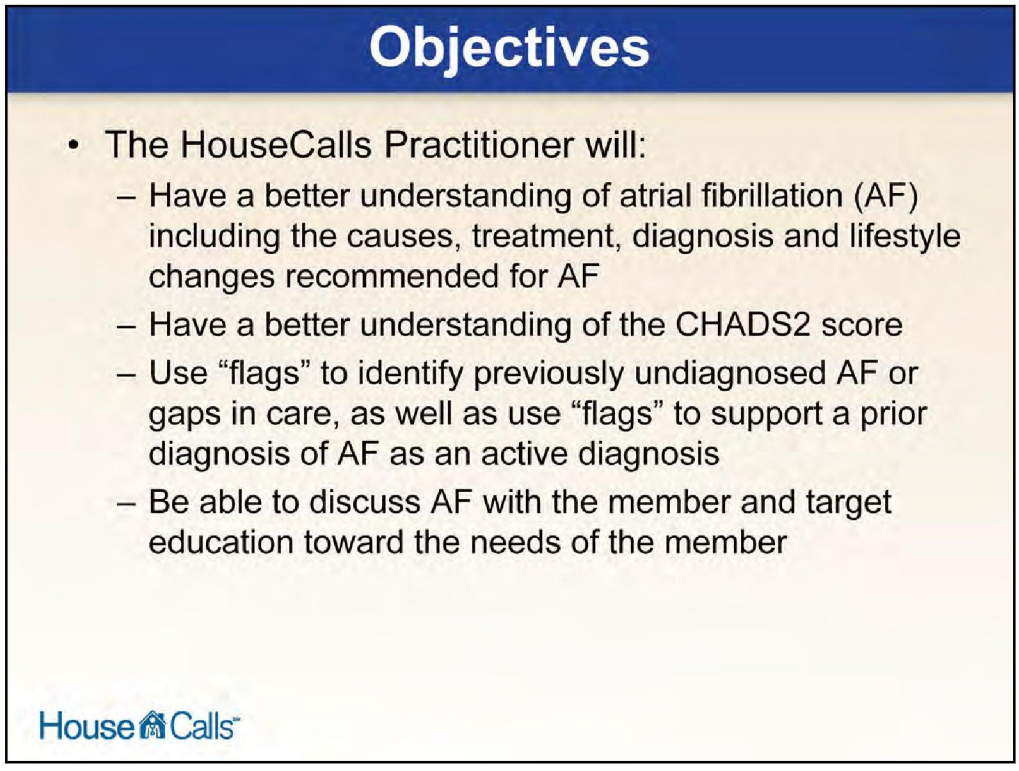
Behavioral Health Urgent Referral Process





Welcome to our “Diagnosing in the Home Series for HouseCalls Practitioners”. This module will focus on Atrial Fibrillation.

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Upon completing this presentation the HouseCalls practitioners will:

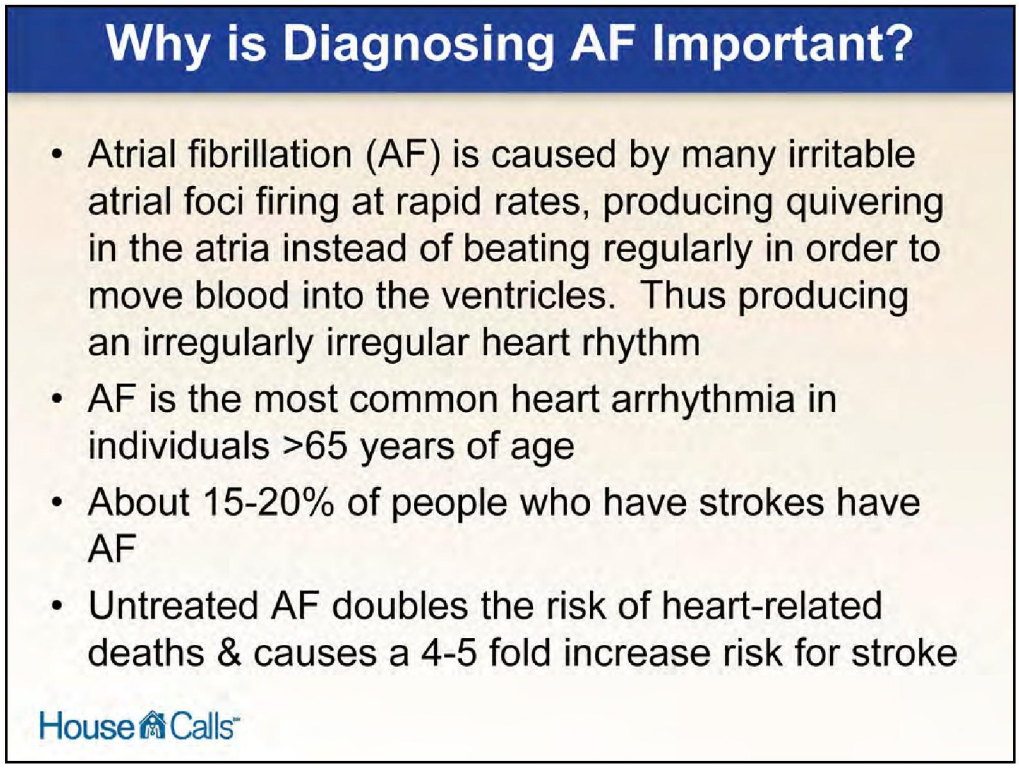
-Have a better understanding of atrial fibrillation including causes, treatment, diagnosis and lifestyle changes

-Have a better understanding of the CHADS2 score

-Be able to use "flags" to identify previously undiagnosed AF or gaps in care, as well as use "flags" to support a prior diagnosis of AF of AF as an active diagnosis

-Be able to discuss atrial fibrillation with the member and target education toward the needs of the member

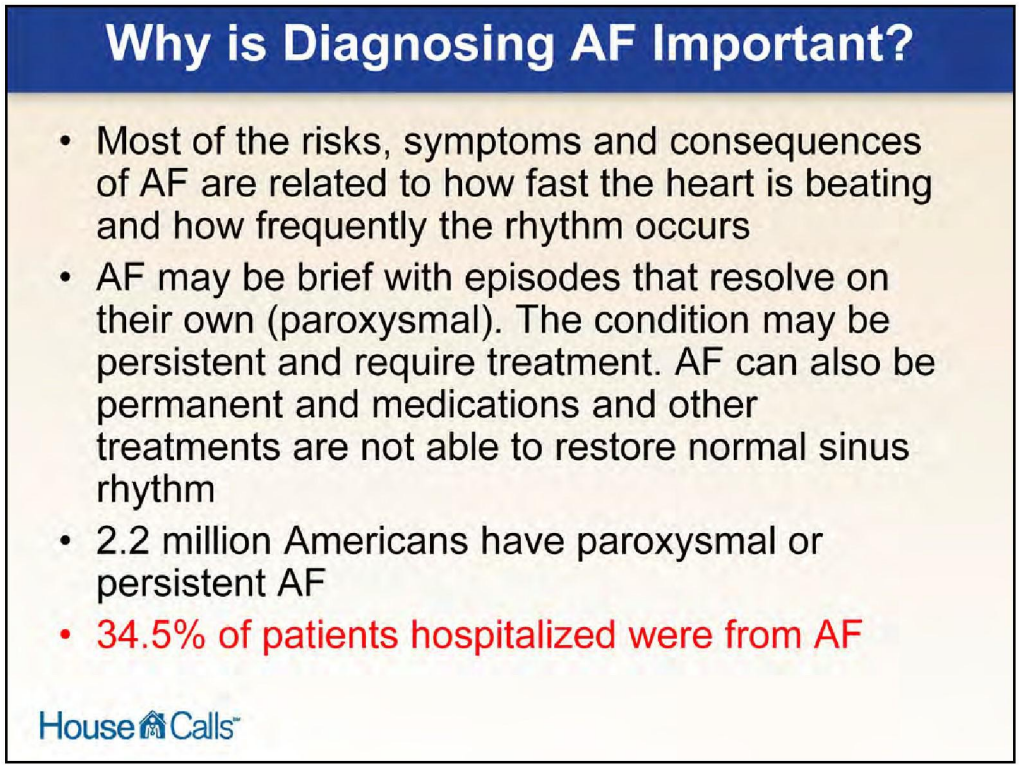
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Why is diagnosing AF important?

Normal sinus rhythm occurs when the SA (or sinus node), the heart's pacemaker is the dominant center of initiates the electrical cycle of the heart. Atrial fibrillation, or AF, occurs when many atrial foci start firing at rapid rates producing quivering in the atria instead of beating regularly in order to move blood into the ventricles. Due to the quivering, there may be pooling of blood in the atria which can lead to stroke (which we will talk about later in the presentation). This rapid firing of impulses produces the characteristic irregularly irregular heart rhythm of AF. AF is the most common heart arrhythmia in individuals over the age of 65. For those patients who have a history of a stroke, 15-20% of them also have atrial fib. Untreated AF doubles the risk of heart-related deaths. This includes a 4-5 fold increase in the risk for a stroke.

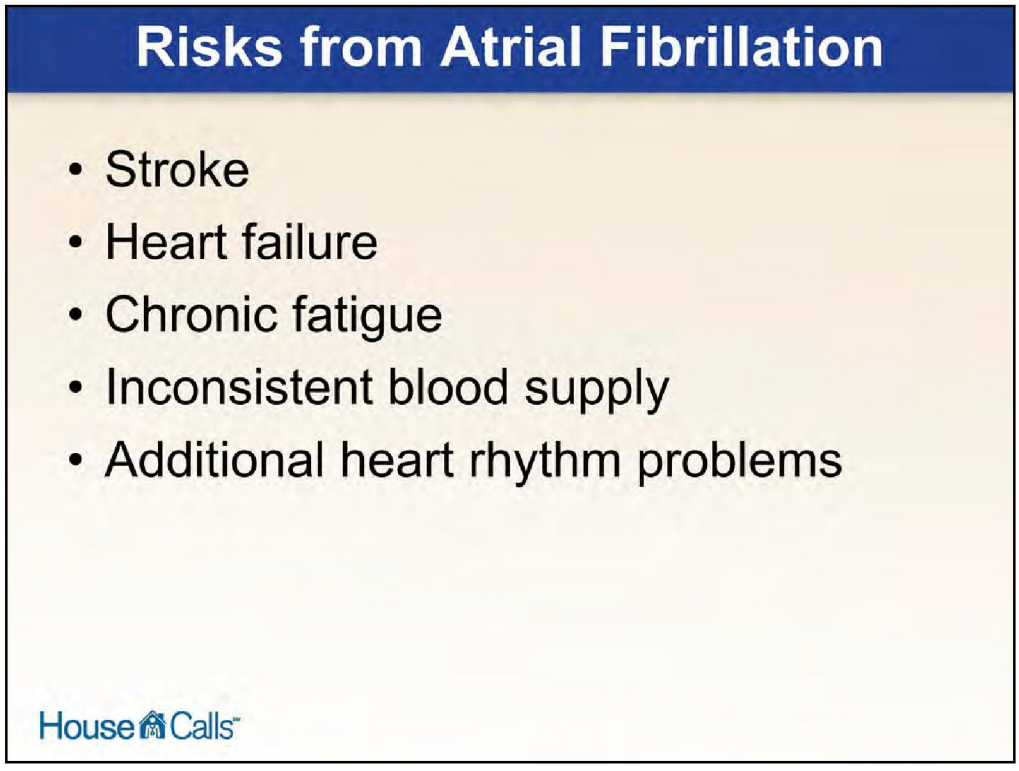
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Continuing with why diagnosing AF important-

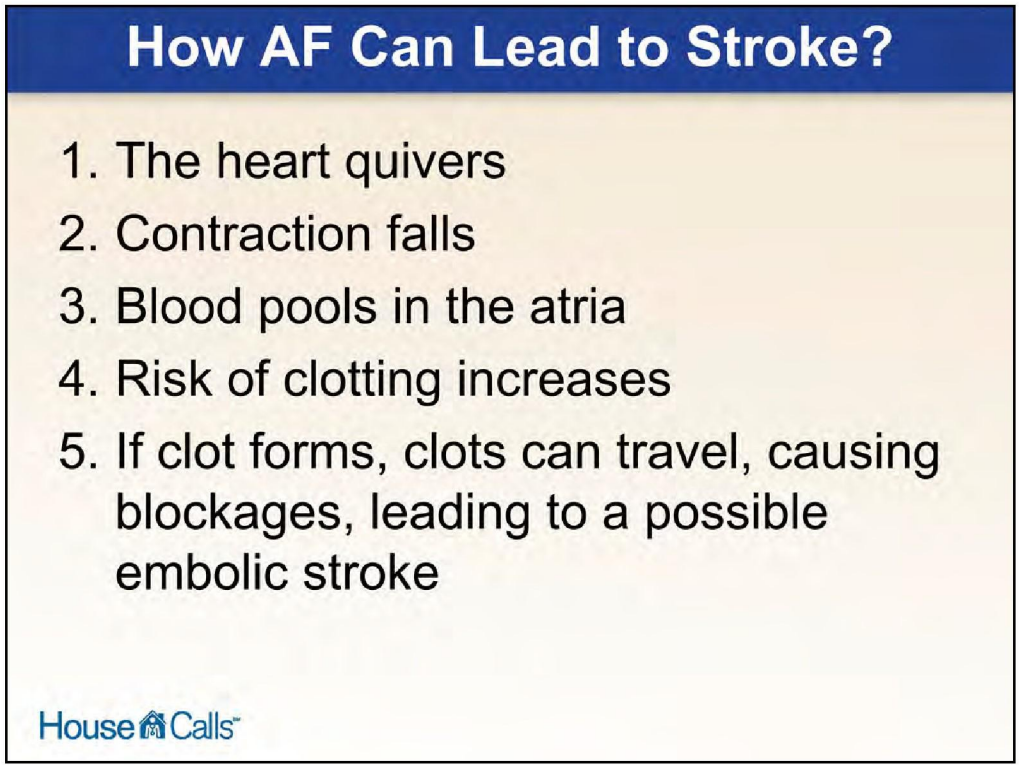
-AF, its risks, symptoms and consequences are related to how fast the heart is beating and how often a patient experiences atrial fib. Episodes can be brief and resolve on their own. AF may also be persistent and require treatments or it can be permanent where medications and treatments are not able to restore sinus rhythm. As many as 2.2 million Americans have paroxysmal or persistent atrial fib and of the patients hospitalized, 34.5% were from AF.

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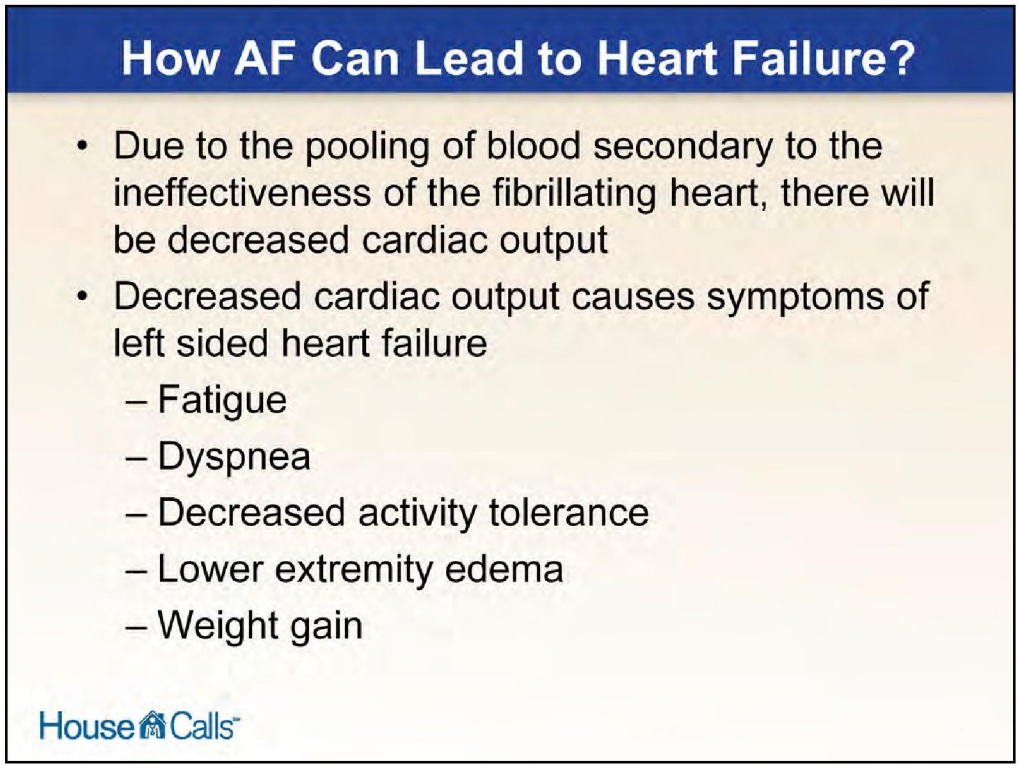
Please note the risks from atrial fibrillation. These include stroke, heart failure, chronic fatigue, inconsistent blood supply and additional heart rhythm problems.

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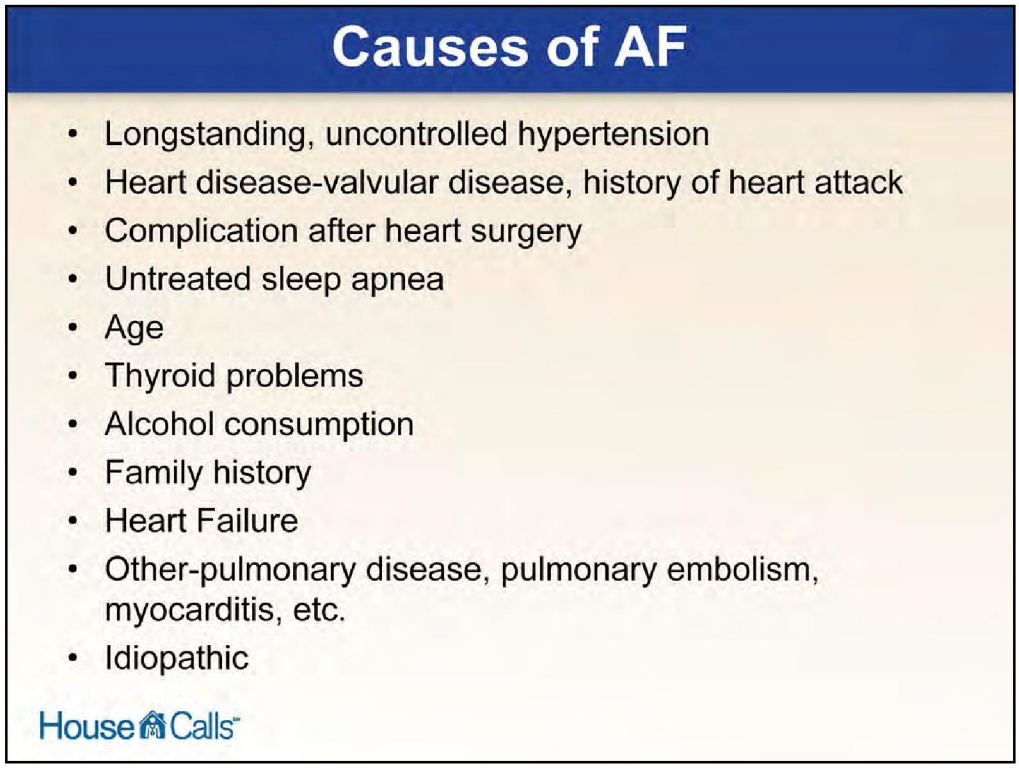
So how can a fib lead to a stroke? First, as explained before, the heart begins to quiver, leading to the strength of the heart contraction decreasing, blood pools in the atria, which increases the risk of clotting. If a clot forms and then travels, causing a blockage, this can lead to a possible embolic stroke.

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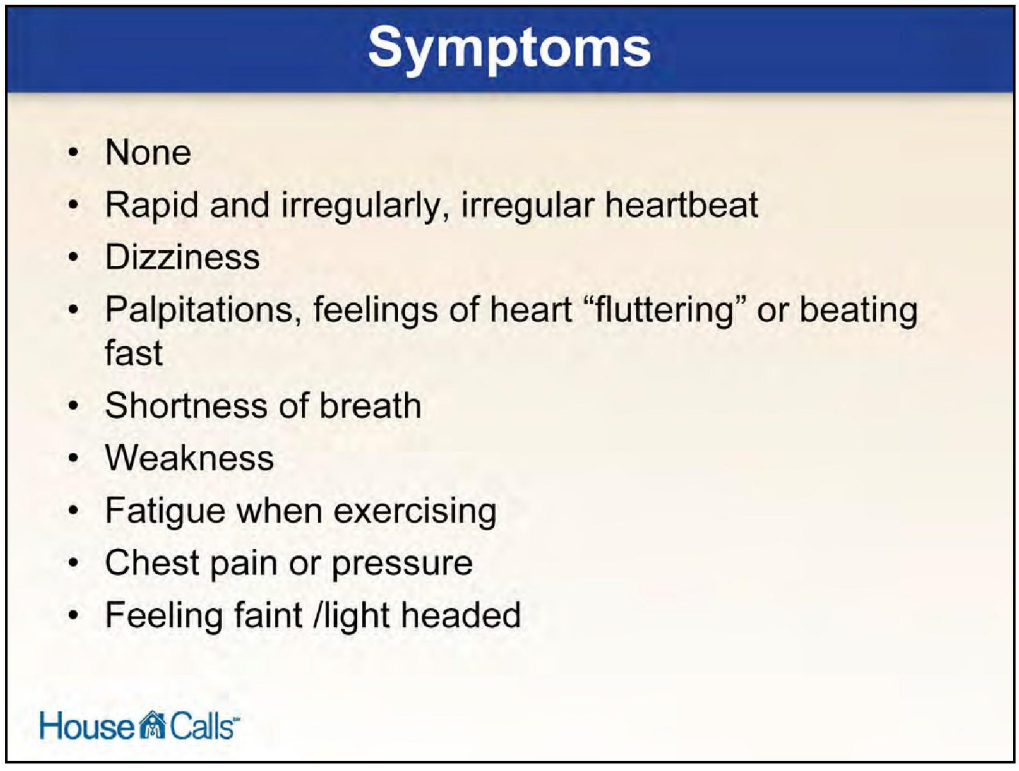
AF leads to heart failure due to decreased cardiac output from blood backing up into the pulmonary veins and ultimately the lungs. The fluid in the lungs can then cause symptoms of left sided heart failure including fatigue and shortness of breath, leading to increased physical and mental fatigue and decreased activity tolerance. As a practitioner, you may see these symptoms and/or edema in the lower extremities and resultant weight gain.

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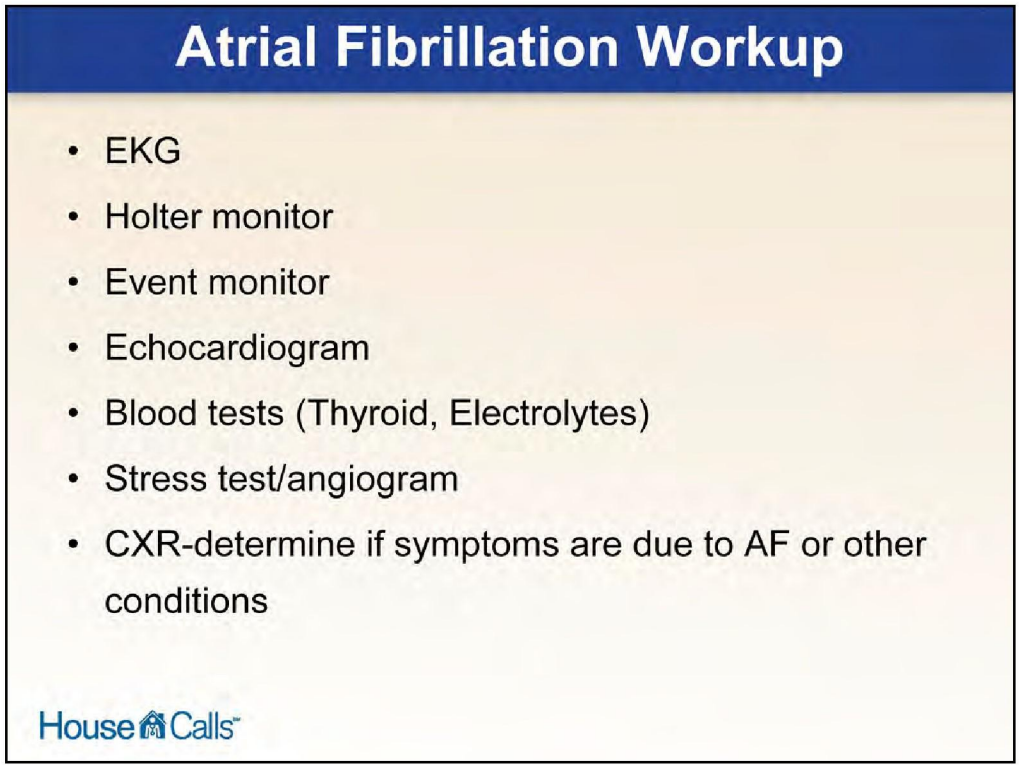
There are many causes of AF including longstanding, uncontrolled high blood pressure, heart disease-including heart valve problems and history of a myocardial infarction. Complications after heart surgery, untreated sleep apnea, age, thyroid problems, increased alcohol consumption and heart failure are also causes. Other causes include pulmonary disease, pulmonary embolism, myocarditis and finally the cause of atrial fib may be unknown

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Symptoms can vary widely-individuals may have no symptoms, feel like the heart is beating rapid and irregular, feelings of being dizzy, experiencing palpitations or the heart "fluttering," shortness of breath, weakness, fatigue when exercising, chest pain or pressure and feeling faint or light headed.

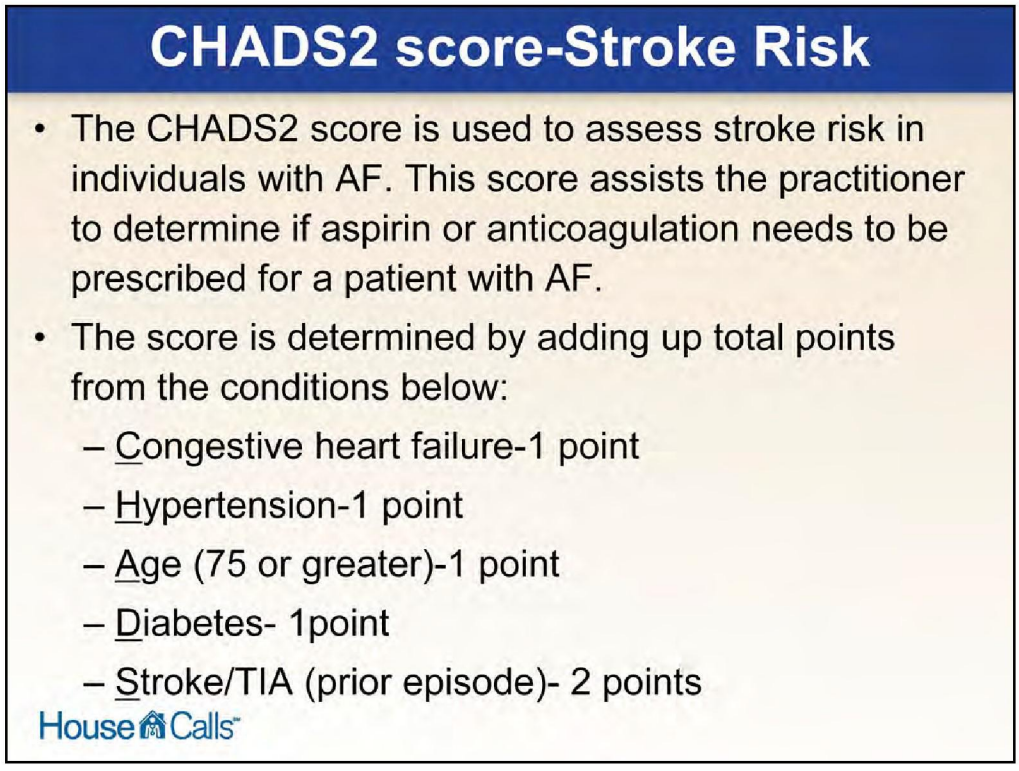
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Individuals can expect some or all of these tests for an atrial fibrillation work up-

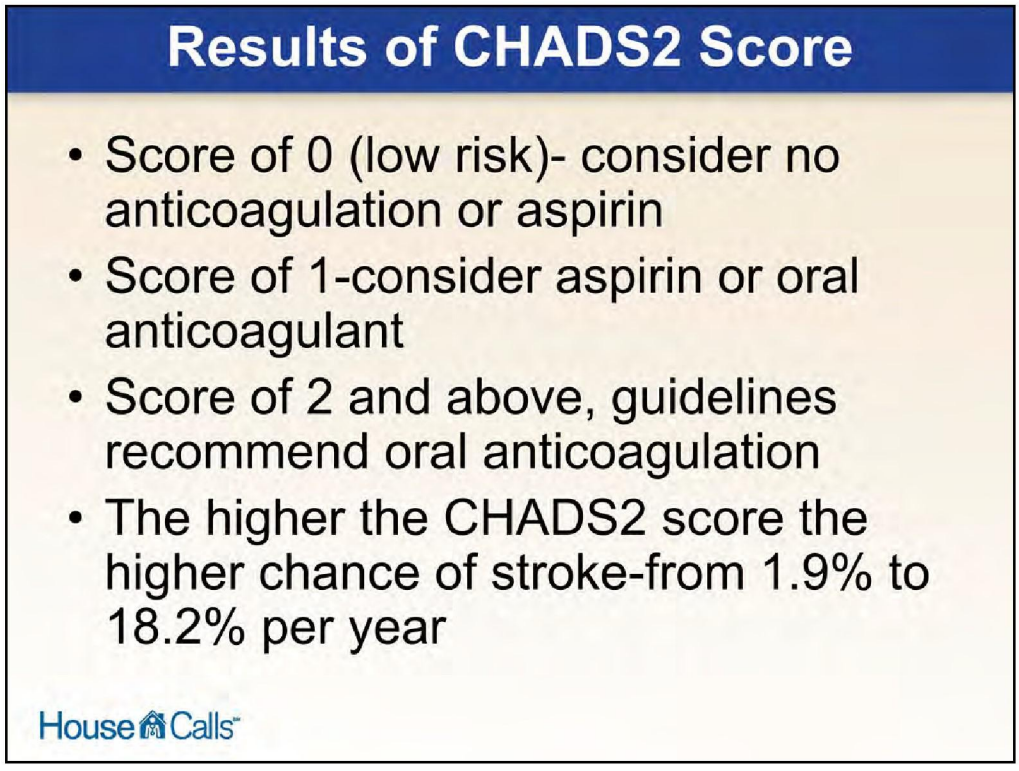
- an EKG- which will reveal absent p waves, an irregular ventricular rhythm, and a rapid rate (in new onset AF that is not rate controlled).
- a holter monitor- which checks the heart rhythm and rate over a 24-48 period.
- an event monitor- or long term heart monitor.
- an echocardiogram- used to assess for emboli, valve issues, and measure ejection fraction.
- blood tests- for example thyroid function tests to determine if the AF was caused by hyperthyroidism. It would also be important to check a metabolic panel to see if there are any electrolyte imbalances. It also may be important to check N-terminal pro-B-type natriuretic peptide or NT proBNP. B-type natriuretic peptide or BNP and NT proBNP are produced by the left ventricle in response to stress (the heart having to work harder). It is well known that these increase in heart failure. However, elevated NT proBNP has been noted to be highly predictive of new onset AF. In patients with new-onset AF but no clinical or radiographic evidence of heart failure, plasma NT-proBNP levels rise progressively to a peak during the first 24 h and then rapidly fall. The NT proBNP will also decline after cardioversion.
- a stress test or angiogram-to assess if cardiac blockage may be causing atrial fib
- and finally a CXR to determine if symptoms are due to AF or other conditions.

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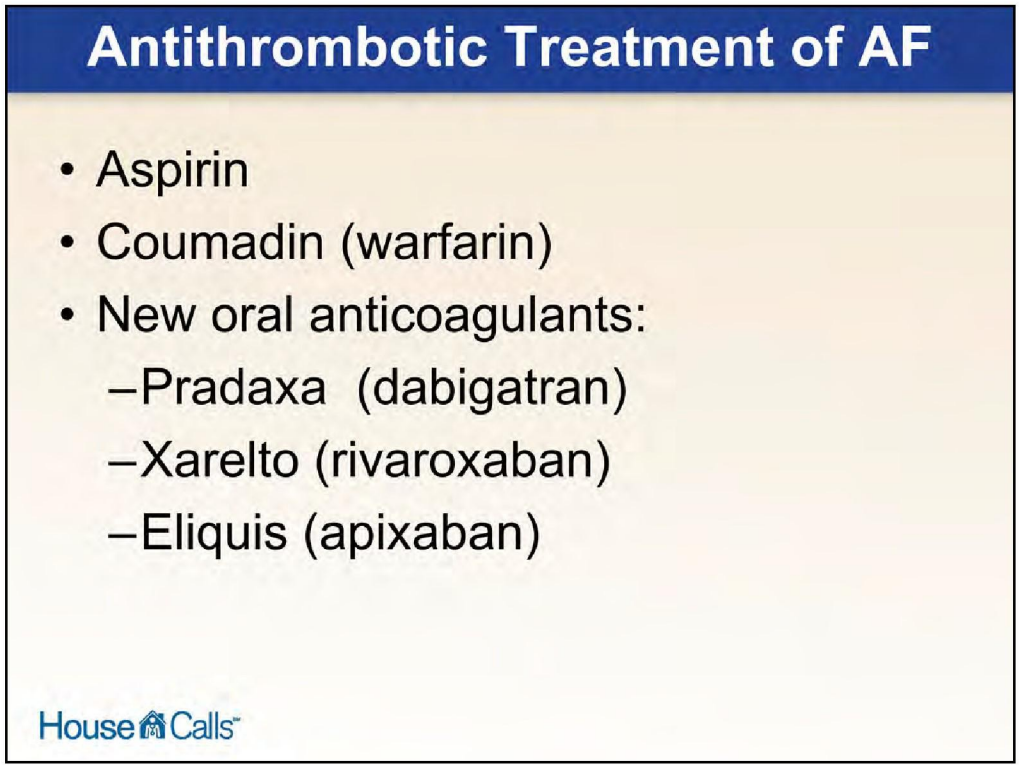
The CHADS2 score is used to assess stroke risk in individuals with atrial fib. This score assists the practitioner to determine if aspirin, which is an antiplatelet, or anticoagulation needs to be prescribed for a patient with atrial fibrillation. The score is determined by adding up the total points from the conditions listed. A patient is given one point for each of these conditions-congestive heart failure, hypertension, age and diabetes. For a prior stroke or TIA, 2 points are given. The CHA2DS@-VASc is a more refined and inclusive score, including vascular disease, age 65-74 and gender. The thought is that this score may be more accurate in determining stroke risk in those with atrial fibrillation.

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Here is a breakdown of how the CHADS2 score is then used to determine the need for antithrombotic medication. For a score of 0 the individual is consider low risk and the practitioner will consider either the option of no anticoagulation or just an aspirin. For a score of 1, the practitioner will consider either aspirin or oral anticoagulant. A score of 2 and above, the guidelines recommend oral anticoagulation. The higher the CHADS2 score, the higher the chance of stroke. The risk of stroke can be from 1.9%-18.2% based on the CHADS2 score.

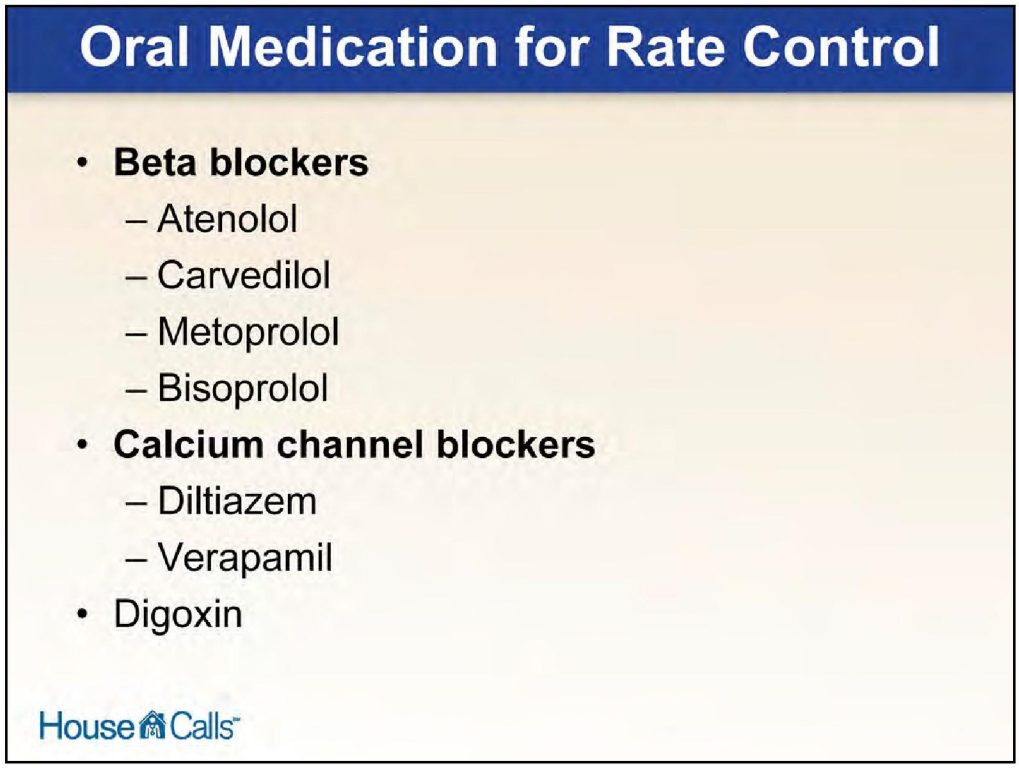
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Antithrombotic treatments for AF include aspirin and warfarin. Other common oral antithrombotic medications, which are also anticoagulants include Pradaxa, Xarelto and Eliquis.

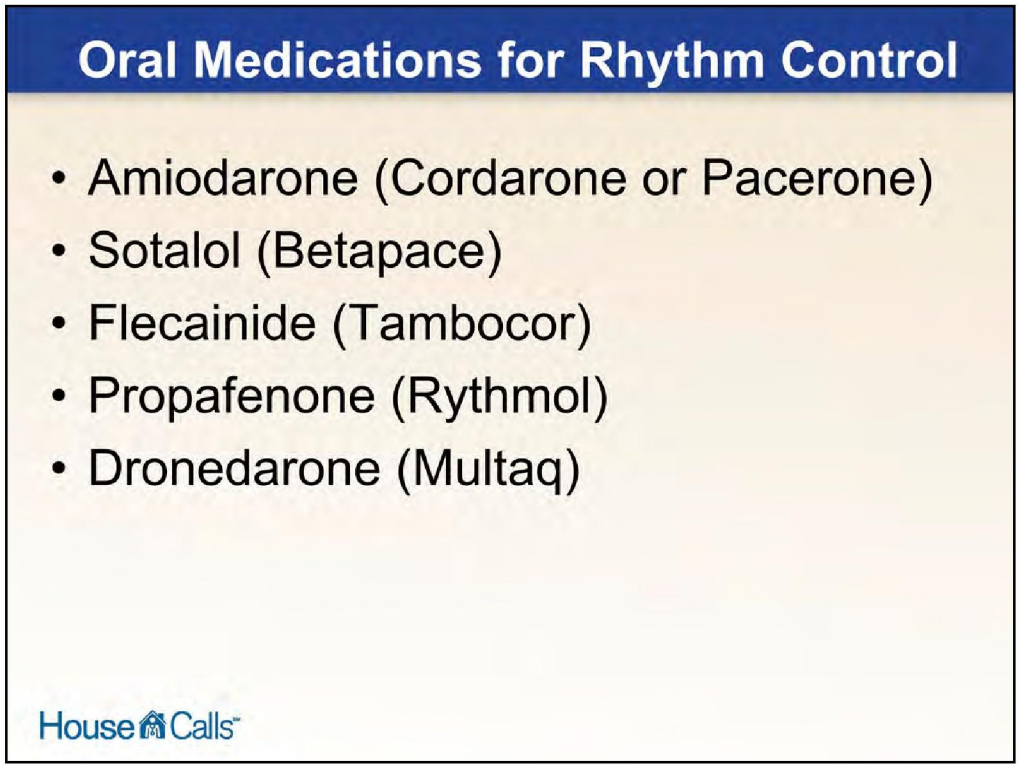
The new oral agents demonstrate several advantages over warfarin, including a rapid onset of action, a broad therapeutic window, low inter-patient variability and (to date) minimal drug or dietary interactions. These properties allow these new agents to be administered in fixed doses without monitoring, making them potentially more convenient to use than warfarin in the outpatient setting. It is important to note that while these medications have the benefit of no lab monitoring and fixed dosing, these medications still carry the bleeding risks associated with other anticoagulants. Additionally, while there are many risks and drug interactions with warfarin, elevated levels of warfarin can be counteracted with vitamin K, these new medications do not have this as an option.

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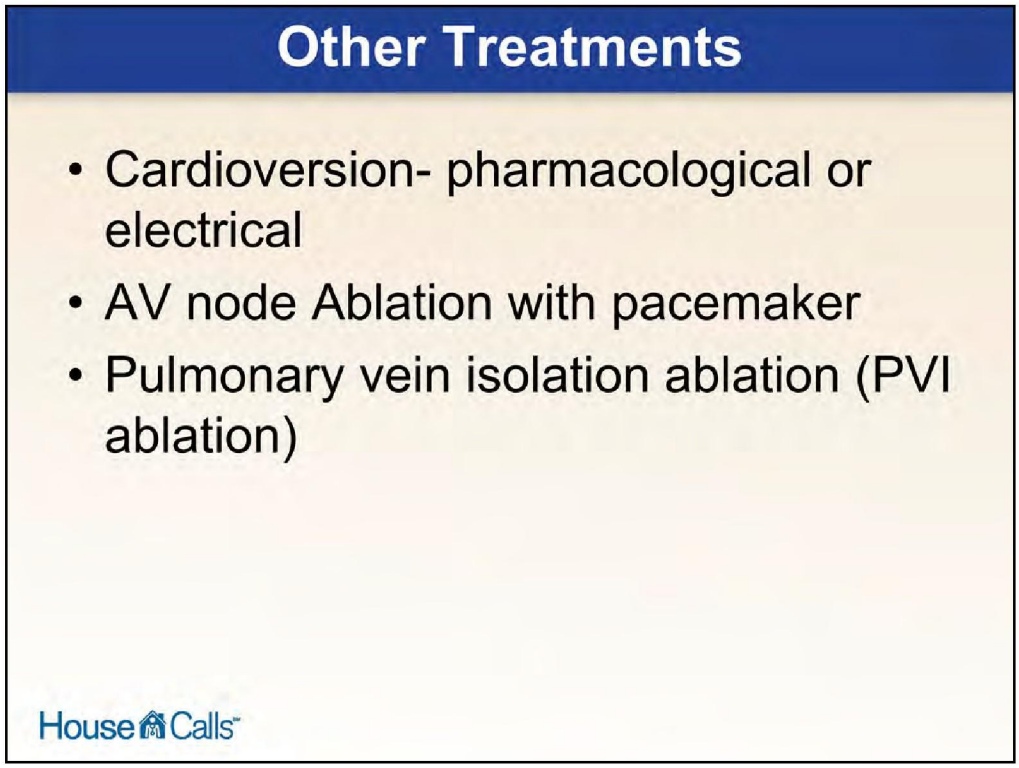
There are both medications for rate control and rhythm control. Here are the oral medications for rate control. Beta blockers which include-atenolol, carvedilol, metoprolol and bisoprolol. Calcium channel blockers include diltiazem and verapamil. And finally digoxin is another option for rate control.

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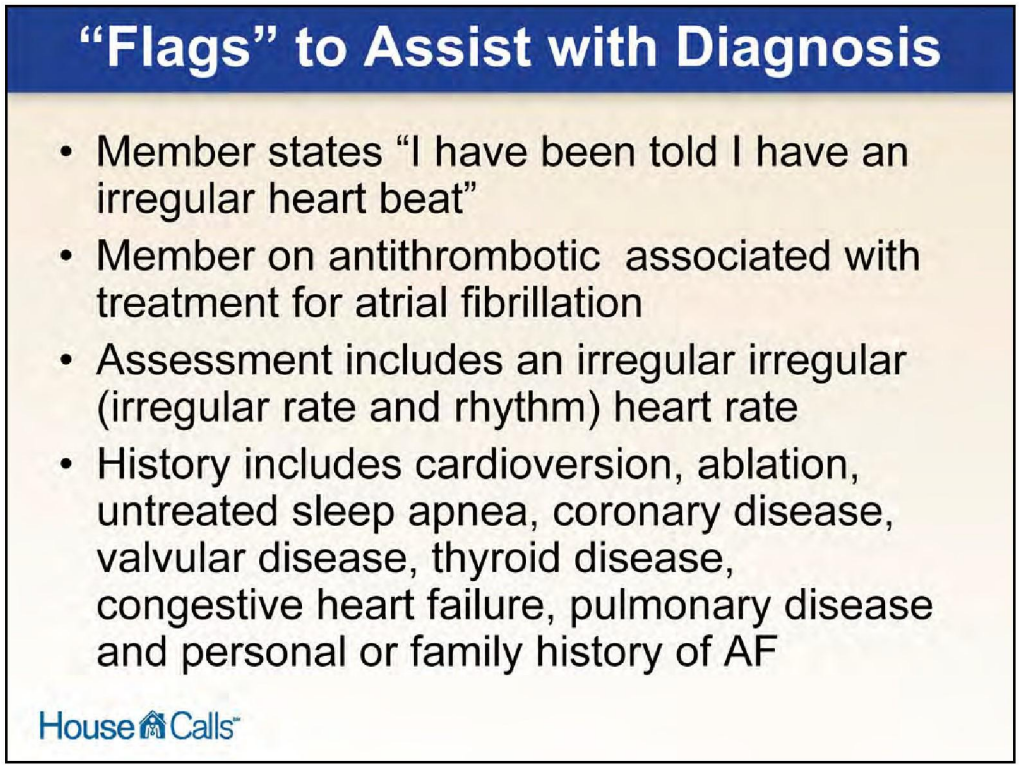
The oral medications for rhythm control include amiodarone, sotalol, flecainide, propafenone and dronedarone.

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Other treatments may include cardioversion, which may be pharmacological or electrical, AV node ablation with insertion of a pacemaker and pulmonary vein isolation ablation.

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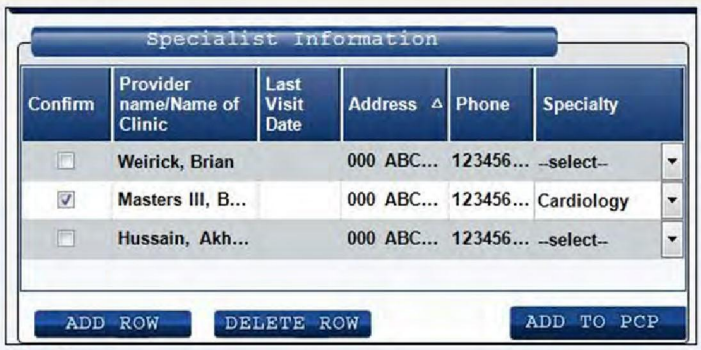
Some "flags" to assist with diagnosing atrial fib would be if a member states "I have been told I have an irregular heart beat," a member is on antithrombotic medication associated with treatment for atrial fibrillation, your assessment includes an irregularly irregular heart rate-meaning you hear an irregular rate and rhythm- and lastly the member's history includes one or more of the following- cardioversion, ablation, untreated sleep apnea, coronary disease, valvular disease, thyroid disease, congestive heart failure, pulmonary disease or family history of atrial fibrillation.

The following slides will review the places on the assessment where the clues to the diagnosis of Atrial Fibrillation are documented.

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A fib in the Assessment

In the Specialist section (page 2), there may be a heart specialist prefilled or the member may tell you they see a Cardiology specialist:



House Calls™

HIGHLY CONFIDENTIAL

A fib in the Assessment

In the Surgery section (page 2), you may see the following:



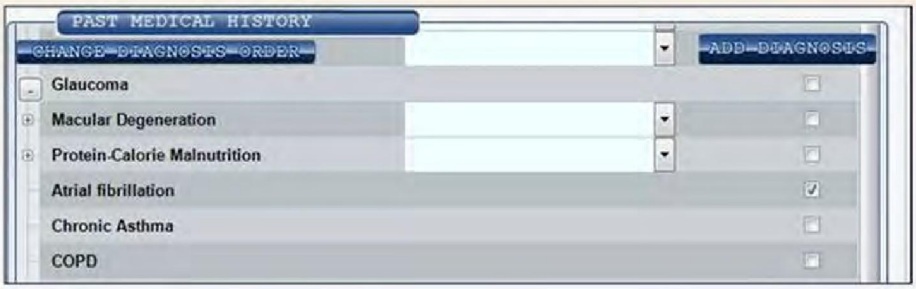
House Calls

In the Surgery section, you may see pre-loaded surgeries or the member may tell you they have had AV Node ablation surgery or pulmonary vein isolation ablation

HIGHLY CONFIDENTIAL

A fib in the Assessment

In the PMH section (page 3), the member may tell you they have a history of Atrial fibrillation:



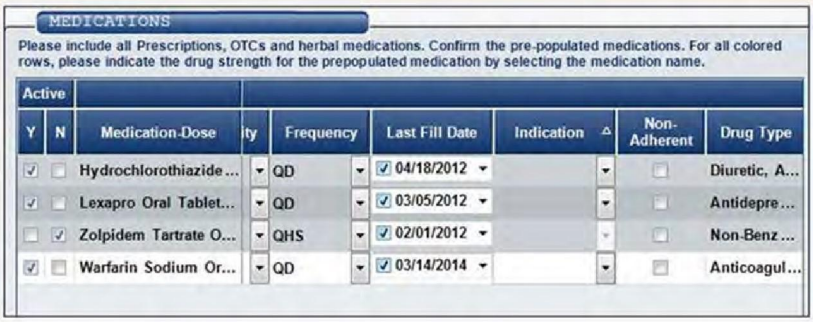
House Calls

In the Past Medical History section, the member may indicate a history of Atrial Fibrillation, or heart quivering or irregular heart beat, or it may be pre-populated from previous assessments or data.

HIGHLY CONFIDENTIAL

A fib in the Assessment

In the Medication section (page 4), the member may be taking antithrombotic medications :



MEDICATIONS

Please include all Prescriptions, OTCs and herbal medications. Confirm the pre-populated medications. For all colored rows, please indicate the drug strength for the prepopulated medication by selecting the medication name.

Active							
Y	N	Medication-Dose	Frequency	Last Fill Date	Indication	Non-Adherent	Drug Type
☑	☐	Hydrochlorothiazide...	QD	☑ 04/18/2012		☐	Diuretic, A...
☑	☐	Lexapro Oral Tablet...	QD	☑ 03/05/2012		☐	Antidepre...
☐	☑	Zolpidem Tartrate O...	QHS	☑ 02/01/2012		☐	Non-Benz...
☑	☐	Warfarin Sodium Or...	QD	☑ 03/14/2014		☐	Anticoagul...

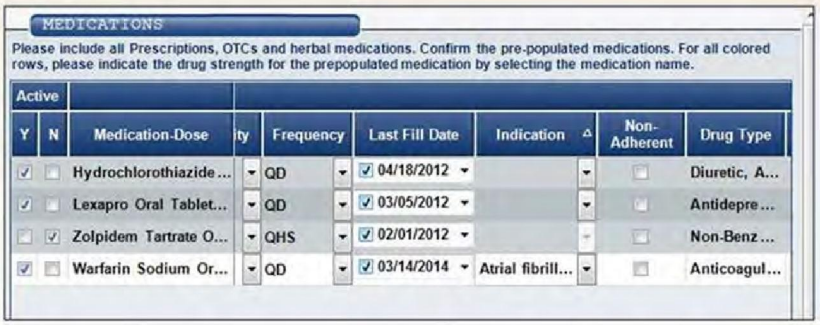
House Calls™

In the Medication section, the member may indicate or have pre-loaded medications such as anti-coagulants or anti-thrombotics as we listed previously. On the tablet, only the term “anticoagulant” is listed from the pull-down menu.

HIGHLY CONFIDENTIAL

A fib in the Assessment

In the Medication section (page 4), the member may be taking antithrombotic medications :



MEDICATIONS

Please include all Prescriptions, OTCs and herbal medications. Confirm the pre-populated medications. For all colored rows, please indicate the drug strength for the prepopulated medication by selecting the medication name.

Active								
Y	N	Medication-Dose	ity	Frequency	Last Fill Date	Indication	Non-Adherent	Drug Type
☑	☐	Hydrochlorothiazide...		QD	☑ 04/18/2012		☐	Diuretic, A...
☑	☐	Lexapro Oral Tablet...		QD	☑ 03/05/2012		☐	Antidepre...
☐	☑	Zolpidem Tartrate O...		QHS	☑ 02/01/2012		☐	Non-Benz...
☑	☐	Warfarin Sodium Or...		QD	☑ 03/14/2014	Atrial fibrill...	☐	Anticoagul...

House Calls

The indication for the medication should also be listed. The choices will be either common indications for the medication (above the Green line) or diagnoses from your Medication cart.

HIGHLY CONFIDENTIAL

A fib in the Assessment

On the Diagnosis confirmation page (page 15), document the use of ongoing anticoagulant or anti-platelet therapy:



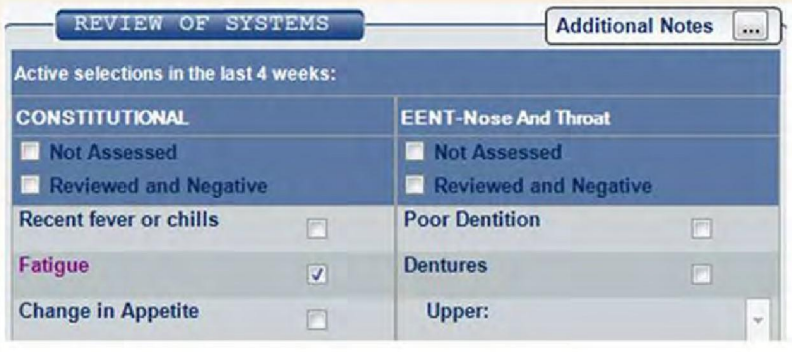
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By selecting Medication Use diagnosis from the Diagnosis confirmation page, these choices will also be available on your Medication Indication drop-down on page 4.

HIGHLY CONFIDENTIAL

A fib in the Assessment

In the ROS section (pages 8-9), the member may indicate fatigue:



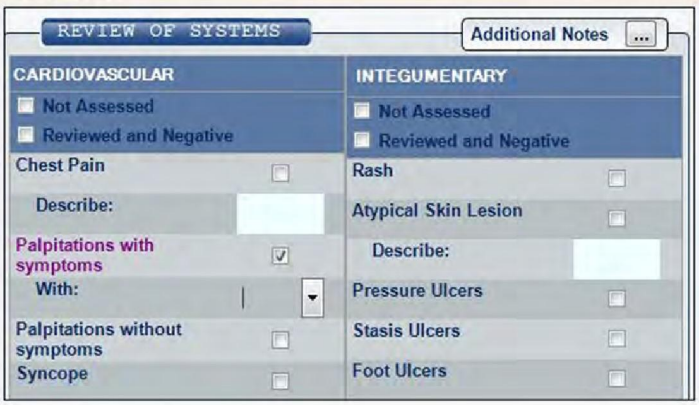
House Calls

The next few slides show some of the positive areas in the ROS on the assessment that would suggest the diagnosis of Afib.

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A fib in the Assessment

In the ROS section (pages 8-9), the member may indicate palpitations with or without symptoms:

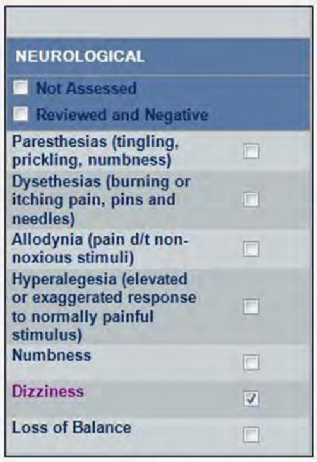


House Calls™

HIGHLY CONFIDENTIAL

A fib in the Assessment

In the ROS section (pages 8-10), the member may indicate dizziness:



NEUROLOGICAL	
Not Assessed	
Reviewed and Negative	
Paresthesias (tingling, prickling, numbness)	☐
Dysethesias (burning or itching pain, pins and needles)	☐
Allodynia (pain d/t non-noxious stimuli)	☐
Hyperalegesia (elevated or exaggerated response to normally painful stimulus)	☐
Numbness	☐
Dizziness	☑
Loss of Balance	☐

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A fib in the Assessment

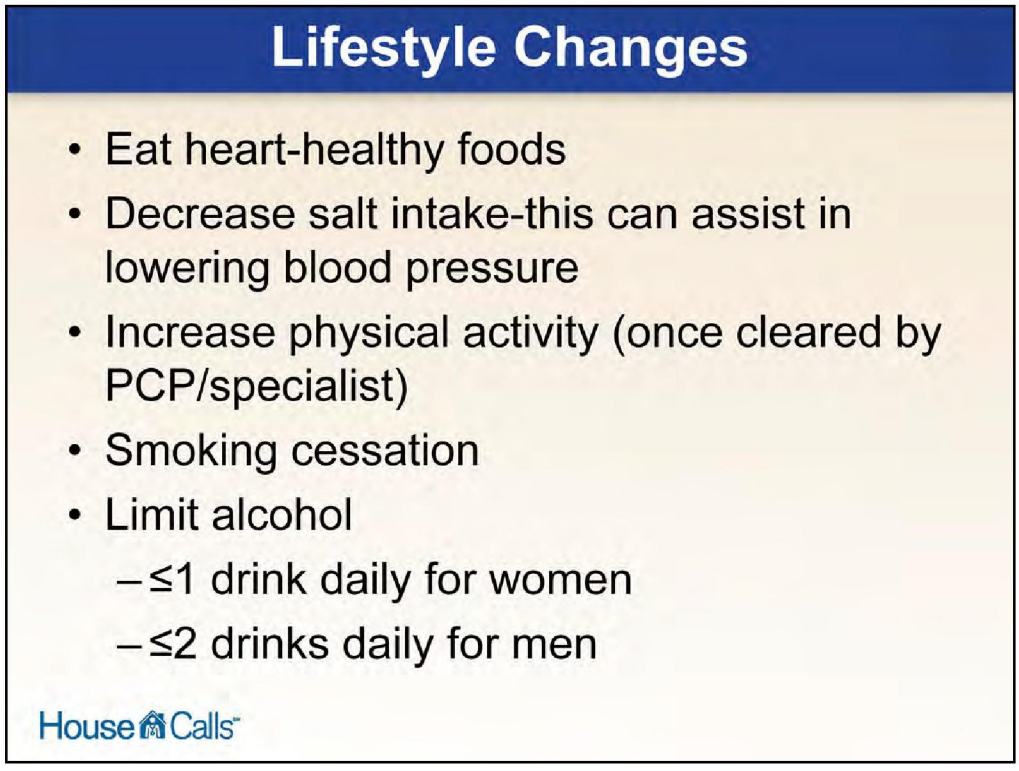
In the cardiovascular exam section (page 12), you may discover an irregular-irregular heart rate:



House Calls

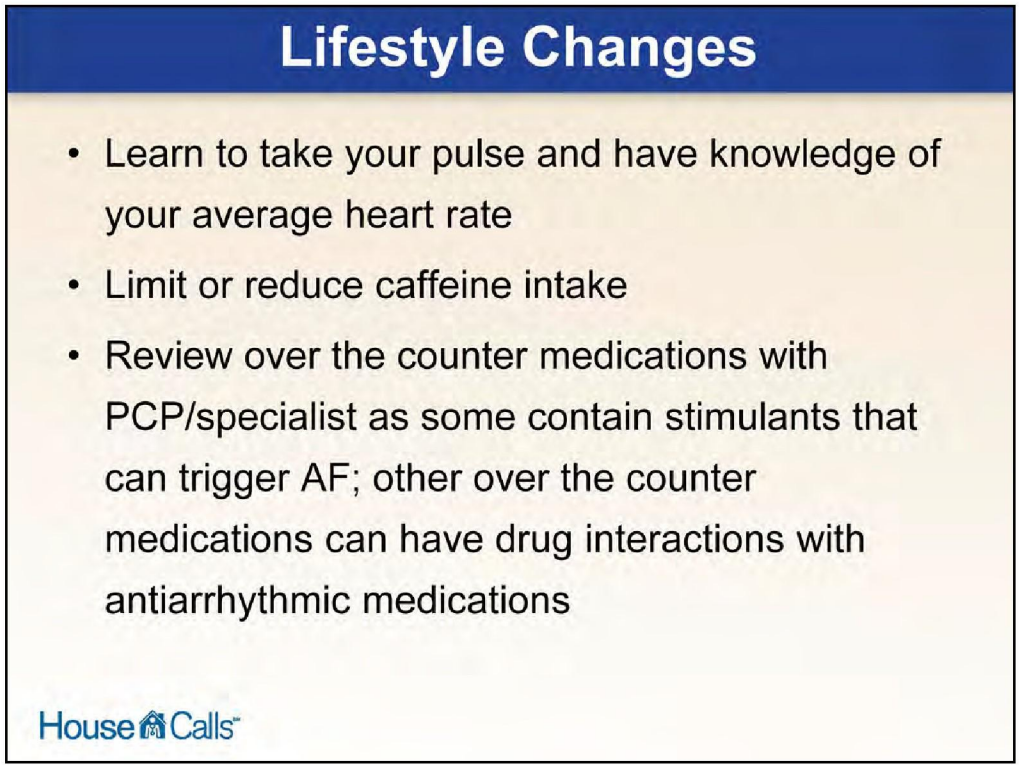
It is up to each practitioner to familiarize themselves with the information presented here about diagnosing Afib.

HIGHLY CONFIDENTIAL



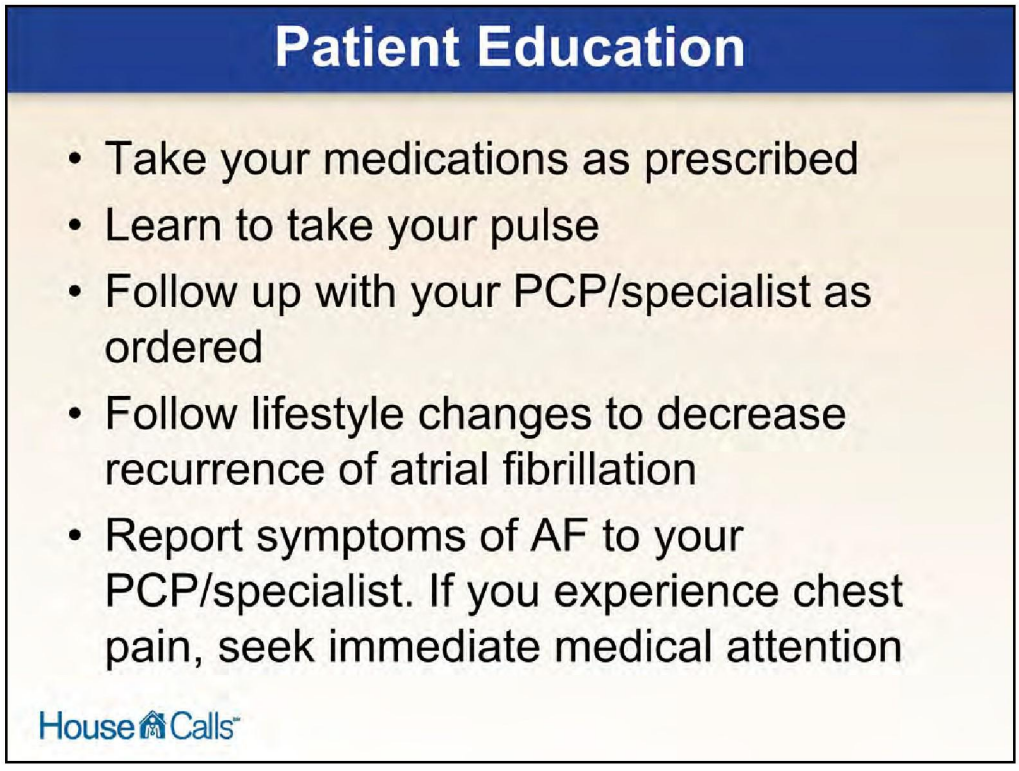
There are some lifestyle changes we can recommend to the member who is diagnosed with atrial fibrillation. These include-eating heart-healthy foods, decrease salt intake-which may assist in lowering blood pressure, increase physical activity (once cleared by their primary/specialist) and limit alcoholic beverages to no more than 1 drink daily for women and no more than 2 drinks daily for men. A drink is defined as one 12-ounce beer, 4 ounces of wine, 1.5 ounces of 80-proof spirits or 1 ounce of 100-proof spirits.

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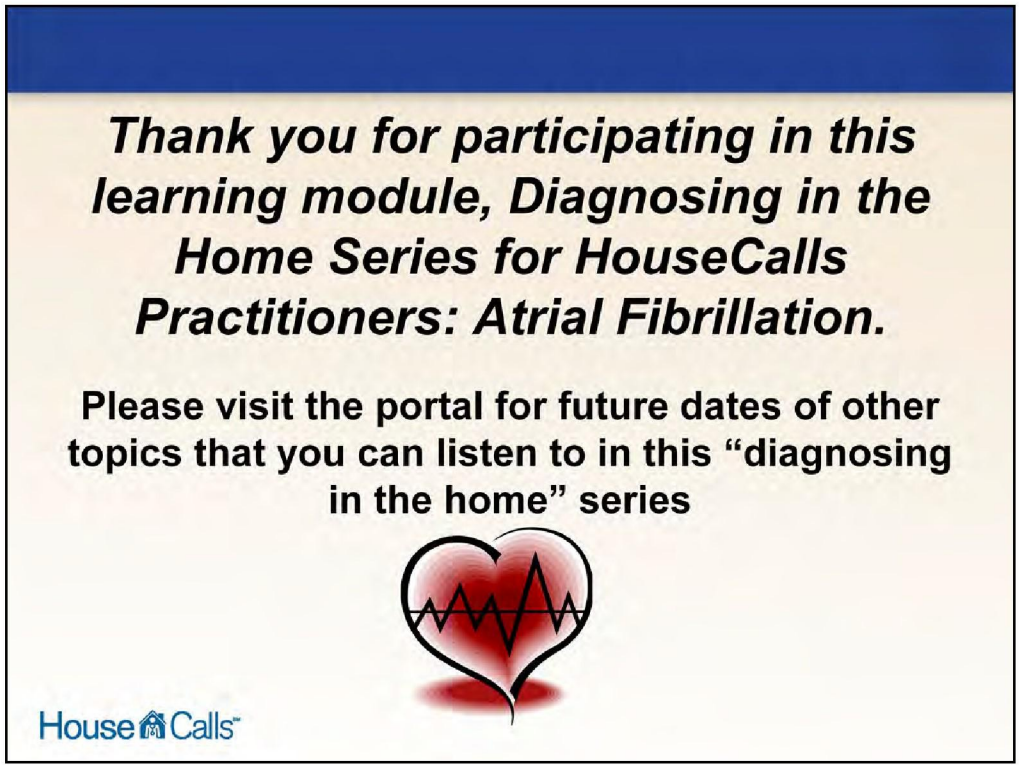
Also, we can educate members on taking their pulse. This may help them to better understand their average heart rate, as well as if they are going in and out of atrial fibrillation. We can advise them to limit or reduce their caffeine intake and finally we may suggest that they review any over the counter medications with their primary and/or specialist, as some of these medications contain stimulants that can trigger atrial fib, while others can have drug interactions with antiarrhythmic medications.

HIGHLY CONFIDENTIAL UHG-SJC-037207



Lastly, but just as important, is educating the member to take their medications as prescribed, learn to take their pulse, follow up with their primary or specialist as ordered, follow lifestyle changes to decrease recurrence of atrial fibrillation and always report symptoms of atrial fib to their primary or specialist. If an individual experiences chest pain, they should be educated to seek immediate medical attention.

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Thank you for participating in this atrial fibrillation learning module, which is part of the "Diagnosing in the Home Series for HouseCalls Practitioners." Please visit the portal for future dates of other topics that you can listen to in this series.

HIGHLY CONFIDENTIAL

Patient Education

2011 ACCF/AHA/HRS Focused Update on the Management of Patients With Atrial Fibrillation (Updating the 2006 Guideline). Circulation, 2011: 123: 104-123.
http://circ.ahajournals.org

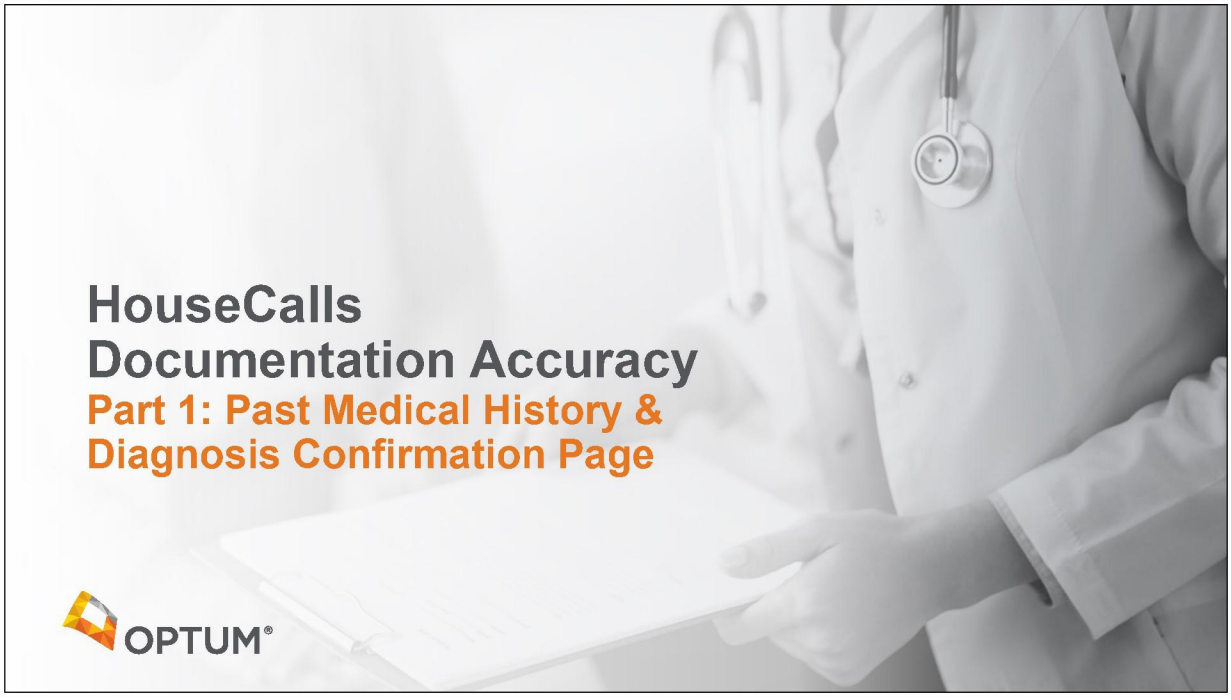
ACC/AHA/ESC 2006 Guidelines for the Management of Patients With Atrial Fibrillation-Executive Summary. Circulation, 2006: 114:700-752.
http://circ.ahajournals.org

ACC/AHA/ESC Guidelines for the Management of Patients With Atrial Fibrillation With the north American Society of Pacing and Electrophysiology. Circulation, 2001; 104: 2118-2150.
http://circ.ahahournals.org

Atrial Fibrillation. http://www.mayoclinic.com/health/atrial-fibrillation/DS00291

Atrial Fibrillation (AF or Afib).
http://www.heart.org/HEARTORG/Conditions/Arrythmia

HIGHLY CONFIDENTIAL



Welcome to the HouseCalls Documentation Accuracy Learnsource Part 1: Past Medical History and the Diagnosis Confirmation Page

Documentation Accuracy: Objective



Review the clinical decision-making process with a focus on the **diagnosis confirmation page** and **past medical history** (PMH).

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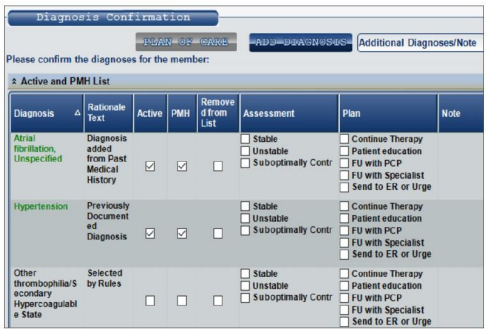
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The objective of this LearnSource is to review the clinical decision-making process when approaching the Diagnosis Confirmation page and Past Medical History or PMH in eHouseCalls.

Approaching the Diagnosis Confirmation Page

- Use your clinical judgement to determine the appropriate status of each diagnosis.
- Review every diagnosis for clinical accuracy.
- Is the condition new, current, resolved, or unconfirmed?
- Consider the member's reported history, medications, lab/data, physical exam, POC testing and screening results in your decision making.

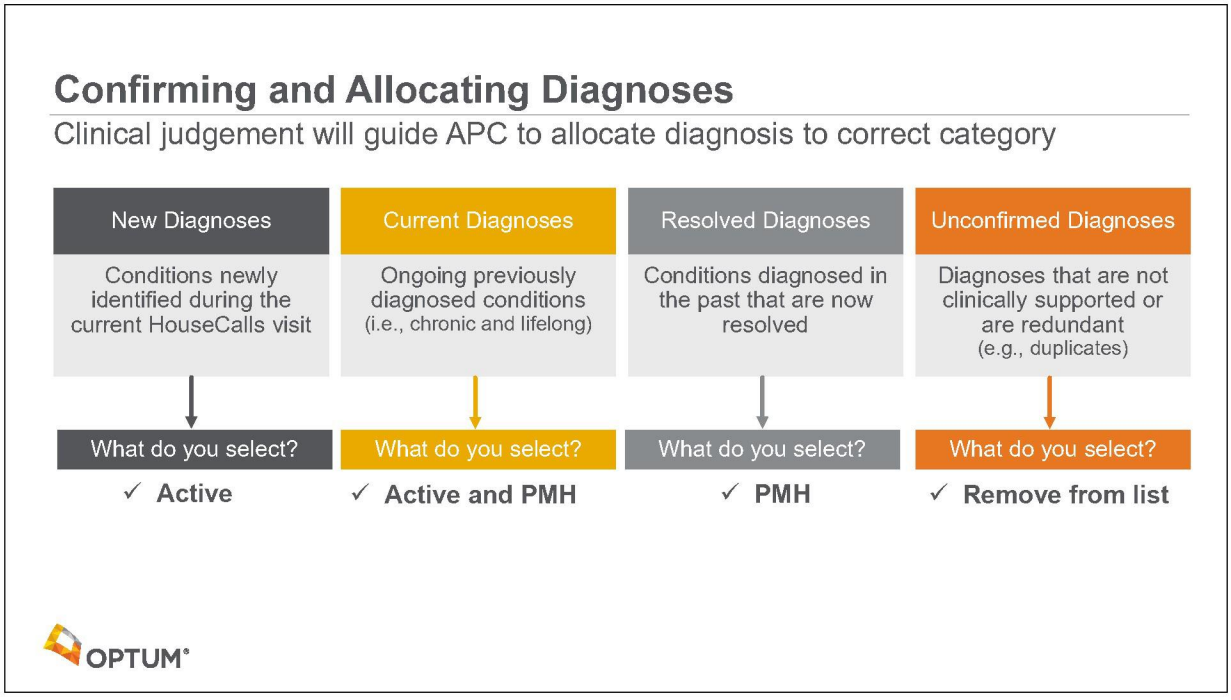
Page 15 in eHC



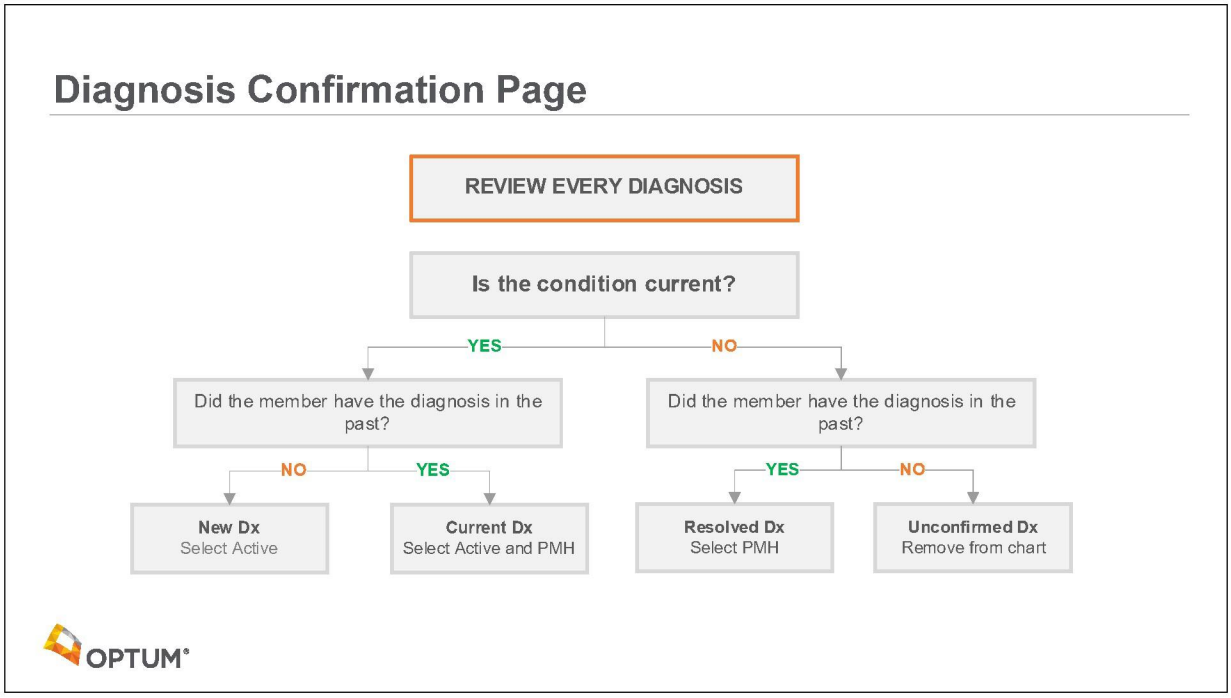
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3

When approaching the diagnosis confirmation page, or page 15 in eHouseCalls, always use your clinical judgement to determine the correct status of each diagnosis.
Review each diagnosis for clinical accuracy. Is the diagnosis new or a current and ongoing condition for the member? Has the condition resolved? Or are you unable to confirm whether the member has the diagnosis?
Consider all the evidence – including the member's reported history, medications, lab data if available, physical exam findings, Point of Care testing and screening results performed during your visit.
Also consider how the diagnosis was populated to the diagnosis confirmation page by reviewing the Rationale linked to each diagnosis.
For example, was the condition added from the Past Medical History section or page 3?
Was the condition previously documented from a prior HouseCalls visit, medical chart or claim?
Diagnoses may also be added by SMART logic or rules.



Let's review the 4 options for confirming and allocating diagnoses to the correct category: new, current, resolved or unconfirmed.
First, a "new diagnosis" is one that is first identified by you during the current HouseCalls visit. Select the Active checkbox on the Diagnosis Confirmation page.
"Current diagnoses" include all chronic and lifelong conditions that were previously diagnosed. Select Active and PMH for the member's current, ongoing conditions.
"Resolved diagnoses" are any conditions diagnosed in the past and are now fully resolved; they should be documented as PMH only.
And finally, any diagnosis that is not clinically supported is an "unconfirmed diagnosis" and should be removed from the assessment. Select the 'Remove from list' option.
Also note that any duplicate or redundant diagnoses should also be removed.



This algorithm demonstrates the clinical decision-making process for diagnosis allocation.

First, review each diagnosis and consider whether the condition is current for the member.
If your answer is YES, determine if the member had the condition in the past or prior to your HouseCalls visit. If not, the diagnosis is a newly identified condition. A common example of a new diagnosis is Peripheral Vascular Disease based on QuantaFlo results.
If the member had the diagnosis prior to your HouseCalls visit, consider the diagnosis Current. Common examples of CURRENT conditions include diabetes or hypertension.
If you determine a condition is not current and no longer impacting the member, the diagnosis is considered to be Resolved or PMH only. Common 'resolved conditions' include infections or some cancers that has been fully treated and cured.
Finally, if you cannot confirm the presence of the condition either currently or in the past, remove the diagnosis from the chart.

Removing Diagnoses – Reasons for Removal



No clinical evidence
- Unable to confirm as Active or PMH

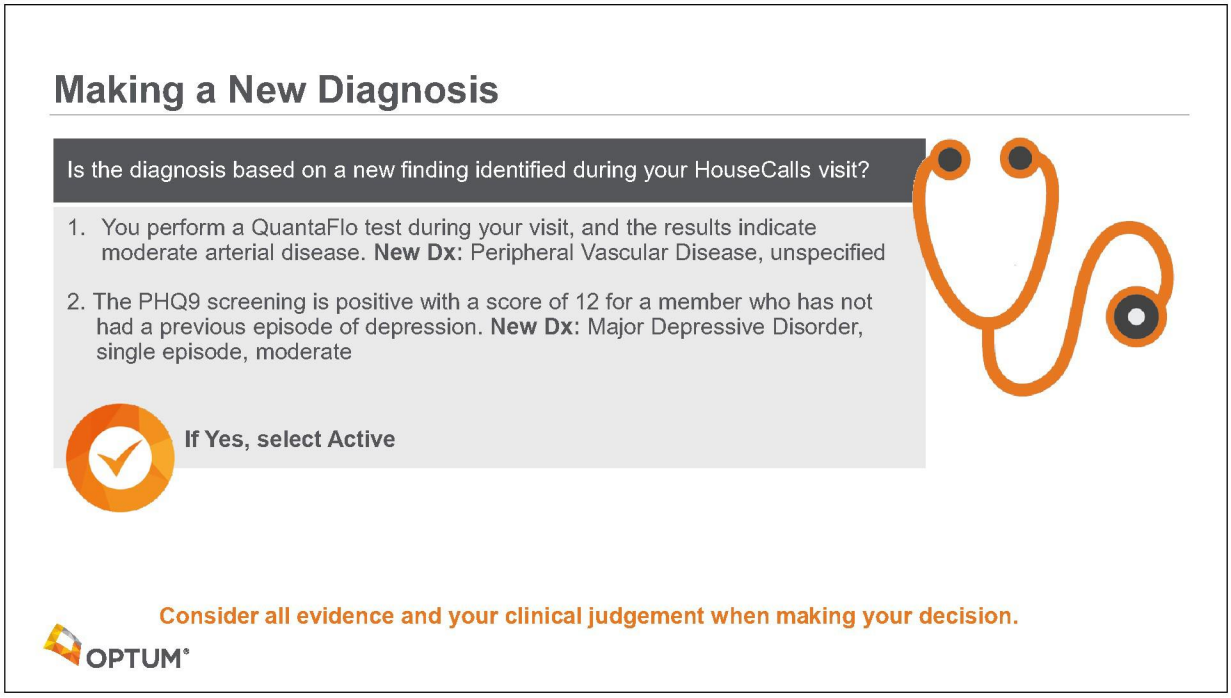
Resolved Condition
- PMH only

Duplicate Diagnosis
- Multiple or redundant diagnosis

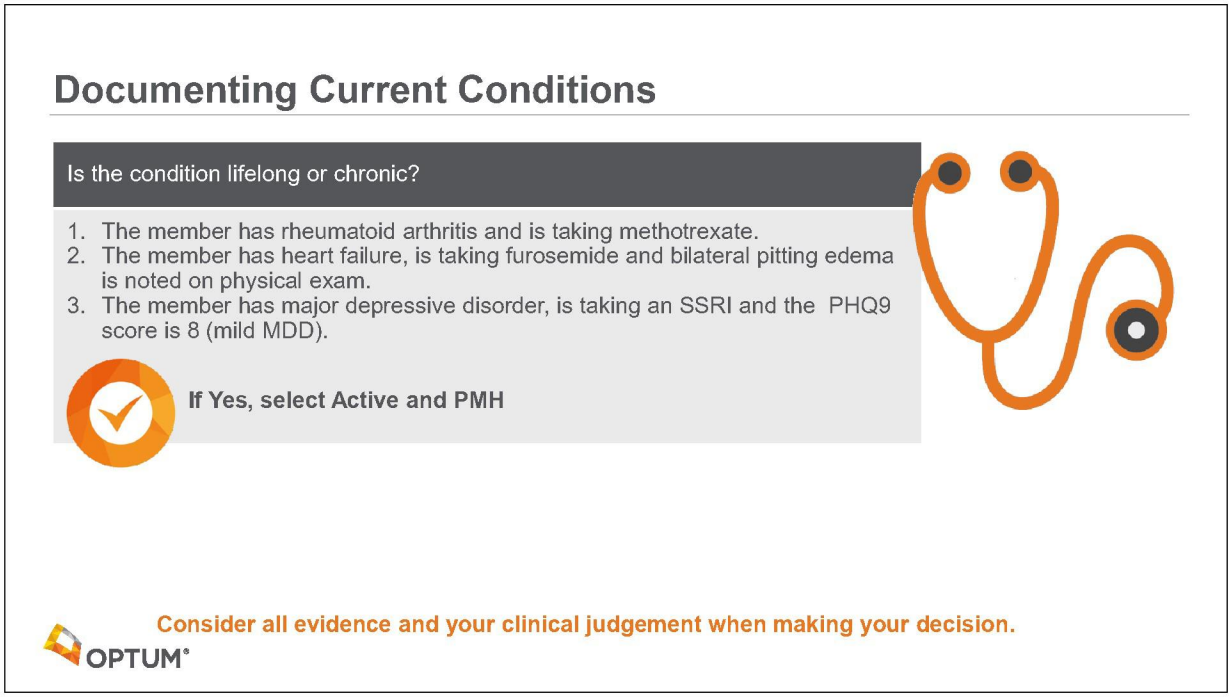
Other
- Enter other reason for removal

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In eHouseCalls, when a diagnosis is selected for removal, a pop-up window will display to enter a reason for removal.
Select "No clinical evidence" if the diagnosis cannot be confirmed as Active or PMH.
Select "Resolved condition" if the member had the condition in the past but the condition is no longer present.
Select "Duplicate diagnosis" if the diagnosis is redundant because a more accurate diagnosis was selected for the condition.
If "Other" is selected, enter a reason in the available free text box.

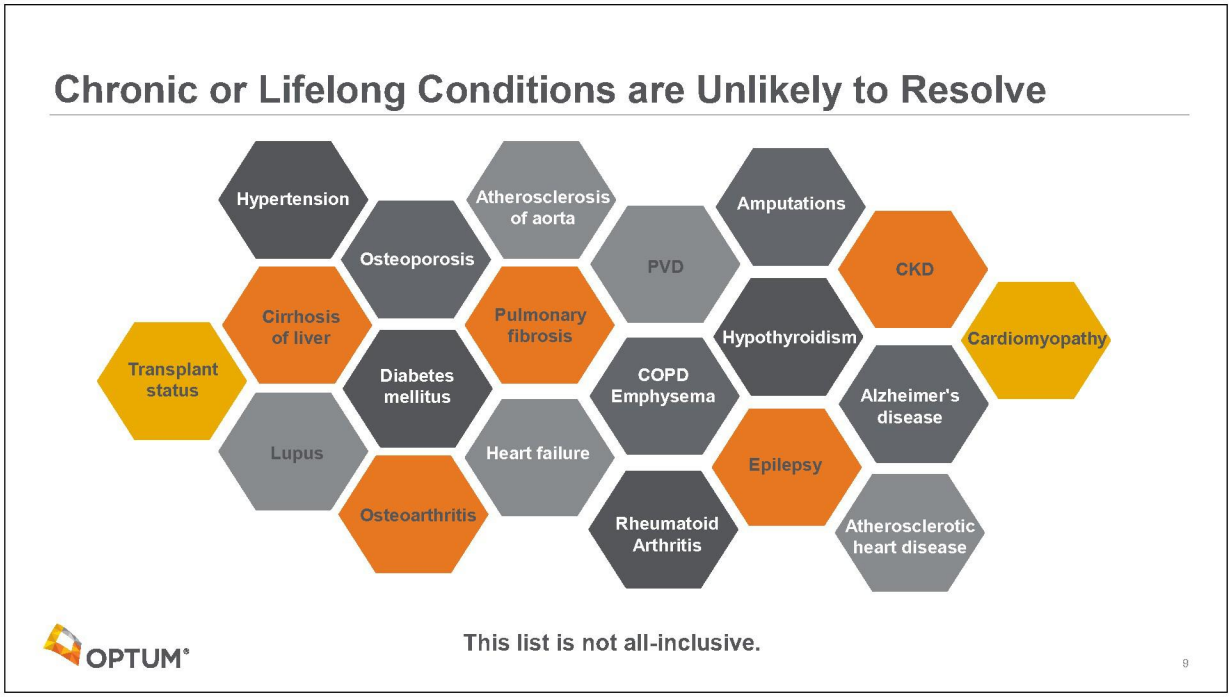


Let's review each of the 4 categories for diagnosis allocation using common examples encountered in a HouseCalls visit.
Example 1 is a new diagnosis of PVD based on QuantaFlo results. You perform a QuantaFlo test during your visit, and the results indicate moderate arterial disease.
Example 2 is a new diagnosis of Major Depressive Disorder, single episode, moderate severity level based on a PHQ9 score of 12 for a member who has not had a previous episode of depression.
Select the Active checkbox for all NEW diagnoses.

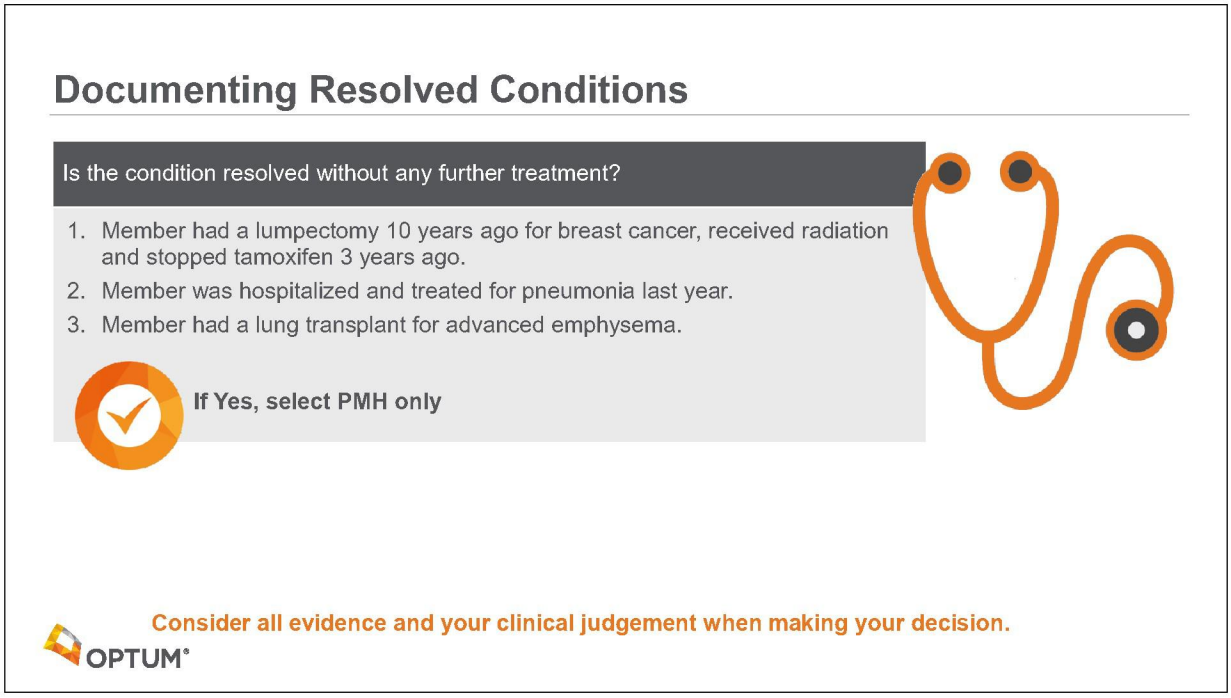


When determining whether a diagnosis is current, consider if the condition is typically lifelong or chronic. Is the member receiving active treatment, medication or ongoing evaluation and monitoring? Are lab results or other screenings available to support the condition?
Several examples of current diagnoses encountered during the HouseCalls visit include:
The member has rheumatoid arthritis and is taking methotrexate.
The member has heart failure, is taking furosemide and bilateral pitting edema is noted on physical exam.
The member has depression, is prescribed an SSRI and the PHQ9 score is 8 at the time of the visit indicating a current severity level of mild.

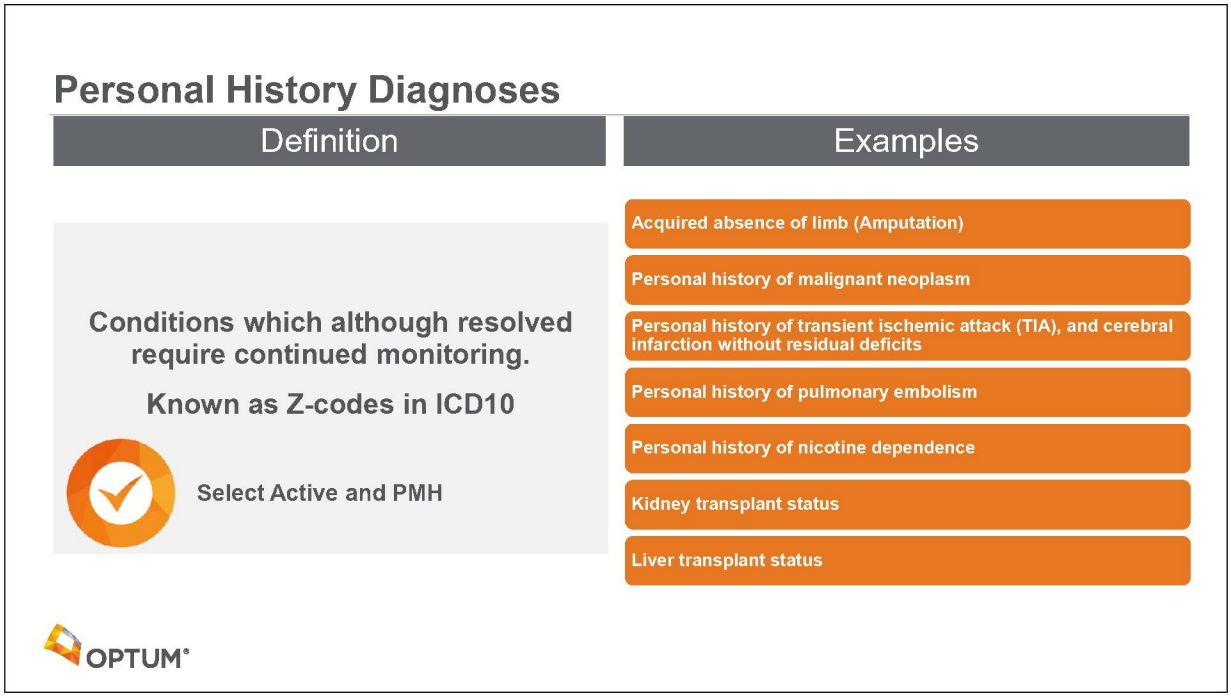
Select both the Active and PMH checkboxes in eHouseCalls for all current conditions.



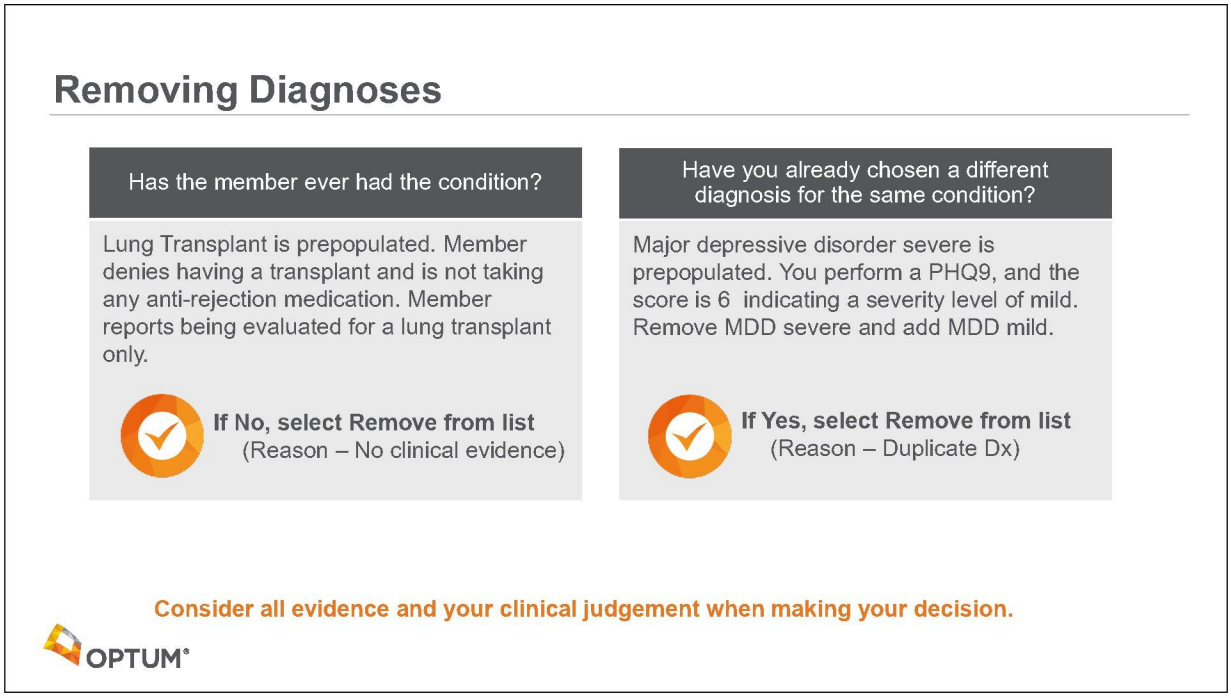
It is important to review all chronic conditions with the member for accuracy.
Remember that chronic conditions are unlikely to resolve. These conditions are typically not cured once acquired; they are considered lifelong and permanent. Keep in mind that chronic conditions may or may not require treatment. Examples include Atherosclerotic heart disease, COPD and heart failure.



Several examples of Resolved conditions include:
Member had a lumpectomy 10 years ago for breast cancer, received radiation and stopped tamoxifen 3 years ago.
Member was hospitalized and treated for pneumonia last year.
Member had a lung transplant for advanced emphysema.
Remember that any condition documented in PMH is confirmation the member was once diagnosed with the condition. Therefore, review each diagnosis and confirm that the member had the condition previously. If you are unable to confirm, remove the diagnosis from the chart.
Remember to use your clinical judgement when considering all the evidence for or against a diagnosis.



Certain diagnoses have 'personal history' or 'status' codes, known as Z codes in ICD10.
These diagnoses represent conditions that may have been treated in the past or are resolved but require ongoing monitoring and follow up.
Therefore, these personal history diagnoses should be included on the diagnosis confirmation page and documented as both Active and PMH.
Some examples are shown here and include personal history of malignant neoplasm, transplant status, and amputations.



Finally, when reviewing the diagnosis confirmation page ensure all diagnoses are confirmed.
In the first example, a lung transplant diagnosis is prepopulated. When reviewing your member's medical history, the member denies having a transplant and is not taking any anti-rejection medication. The member does however report being evaluated for a lung transplant. In this case, the diagnosis should be removed due to "no clinical evidence".
A diagnosis should also be removed if you have already chosen a more accurate or specific diagnosis for the condition. In the 2nd example on the right, MDD severe is prepopulated. You perform a PHQ9, and the score is 6 indicating a current severity level of mild. In this case, you would remove MDD severe and add MDD mild.
It is important to refine the diagnosis list and remove any duplicates which may potentially be conflicting.
Remember that all prepopulated diagnoses in PMH must be reviewed and confirmed. Any diagnosis in PMH becomes part of the medical record.

Documentation Tips

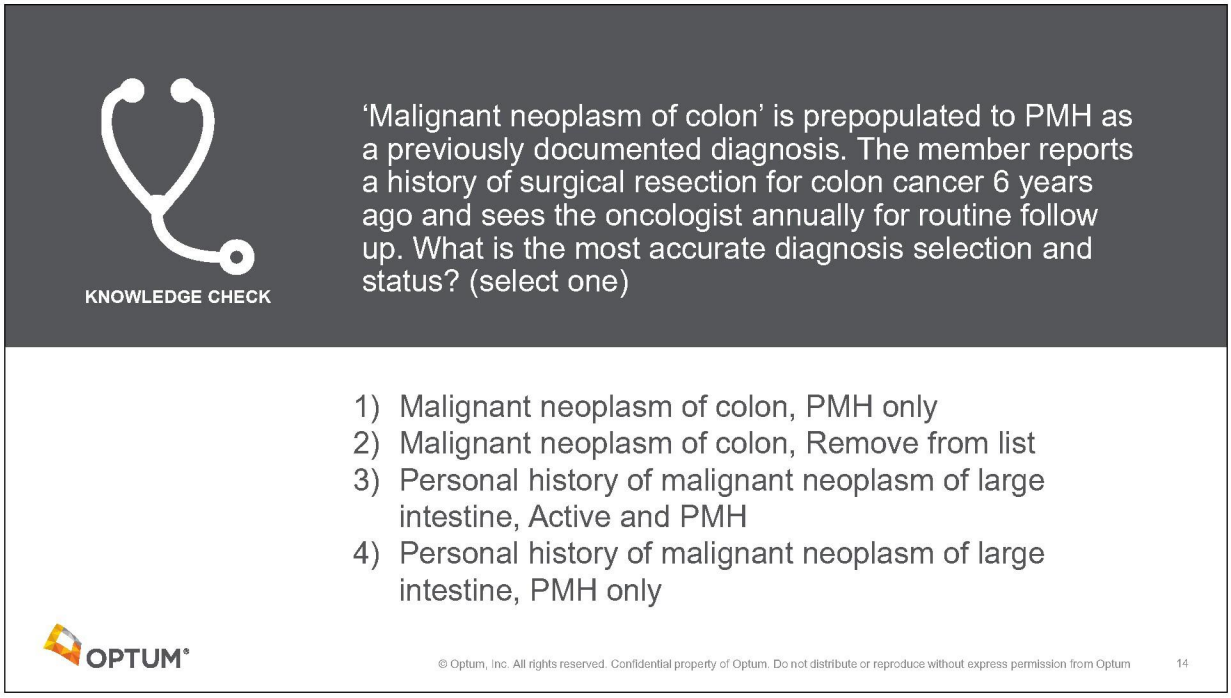
- Ensure all chronic conditions are active if clinically supported or removed if unconfirmed.
- Only keep the diagnoses you can support.
- Remember ALL diagnoses including those in PMH become a part of the medical record.
- If there are multiple diagnoses for the same condition, keep the one you can support.
- Ensure there are no conflicting diagnoses.
- Verify that all diagnoses are clinically supported when finalizing your diagnoses.



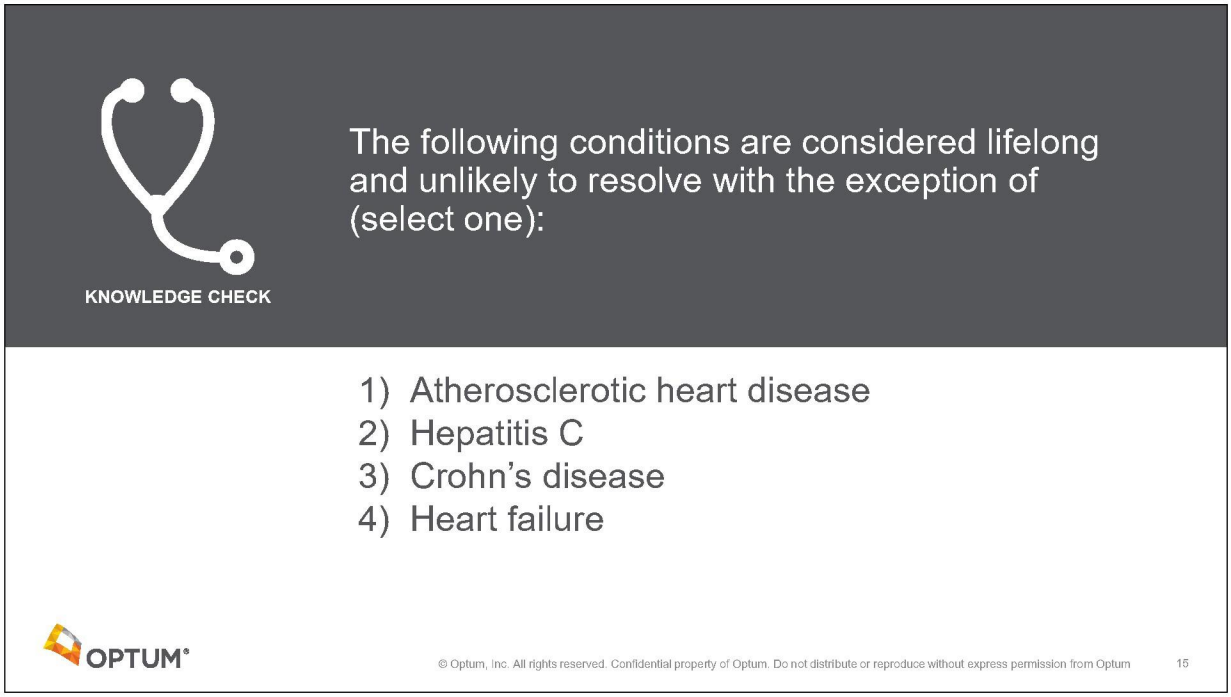
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Let's review several documentation tips.

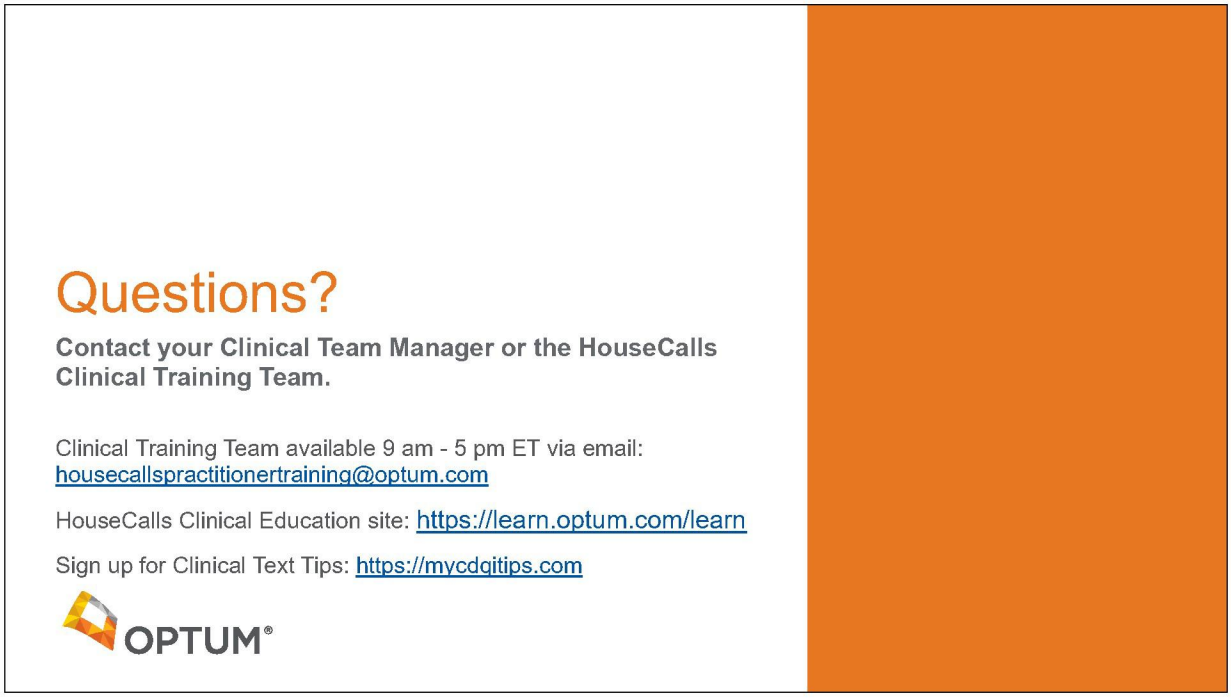
Ensure all chronic conditions are active if clinically supported or removed if unconfirmed.
Only keep the diagnoses you can support.
Remember all diagnoses including those in PMH become a part of the medical record.
If there are multiple diagnoses for the same condition, keep the one you can support and remove any duplicate or redundant diagnoses.
Ensure there are no conflicting diagnoses.
When finalizing your diagnoses, pause and verify that all diagnoses are clinically supported within the assessment.



Knowledge check. Advance slide to highlight answer.
The correct answer is #3 Personal history of malignant neoplasm of large intestine, Active and PMH. Personal history diagnoses should be captured on the diagnosis confirmation page. Select Active and PMH.



Knowledge check. Advance slide to highlight answer.
The correct answer is #2 Hepatitis C. The cure rate for Hepatitis C has increased to more than 95% with the use of antiviral medications.



This concludes the HouseCalls Documentation Accuracy Learnsource Part 1 Diagnosis confirmation page and the Past Medical History.
For any questions, please contact your CTM or the HouseCalls Clinical Training Team.

Optum CLINICAL SUSPECT TOOL for Coders

(Approved for use 1/04/2021)

Introduction: This Suspect Tool is intended for use to: 1) Confirm codes based on the documentation found in the chart; 2) May be used for suspecting; however, the patient should have additional clinical indicators relevant to a disease process or established diagnosis if suspecting for complications or specificity, i.e., "Patient is diagnosed with Polyneuropathy and Hypothyroidism, suspect for G63, "Polyneuropathy in other diseases."

Disclaimer: Any potential condition(s) identified must be clinically significant (medically necessary), impact health, and require or affect patient care, treatment, or management. It is always the Clinician's responsibility to make this decision. Diagnoses listed are not an all-inclusive list. Refer to the current year ICD-10-CM code book for any diagnosis not listed.

***Notes**: ICD-10 codes ending in a dash (-) indicate additional characters are required to make it a complete valid code. Diagnoses codes in grayed-out italics are necessary for buddy coding.*

DRUG LEVELS / MEDICATIONS	POTENTIAL CODES
Medications alone are generally not sufficient to suspect conditions, unless there is a 1:1 correlation. Medications can be used as support for a documented diagnosis. or in conjunction with clinical indicators, such as physical exam findings, etc.	
Advair / albuterol / Atrovent / Combivent / Flovent / Proair / Pulmicort / Serevent / Spiriva / theophylline	COPD (J44.-) / Simple chronic bronchitis (J41.0) / Obstructive chronic bronchitis (J44.-) / Chronic obstructive asthma (J44.-)
Coumadin (warfarin) / Eliquis / Jantoven (warfarin) / Lovenox / Pradaxa / Xarelto	A fib (I48.91) / Secondary hypercoagulable state (D68.69) / Acute DVT (I82.40-) / Chronic DVT (I82.50-)/ Acute PE (I26.99) / Chronic PE (I27.82)
Amiodarone / Digoxin / flecainide / Sotalol	Atrial fibrillation (I48.91) / CHF (I50.9) / PSVT (I47.1)
Depakote / Dilantin /Keppra / Klonopin / Lamictal / Neurontin / phenobarbital* / phenytoin / Tegretol	Epilepsy or Seizure D.O. (G40.909) / Seizures or Convulsions (Not Specified) (R56.9)
Byetta / Farxiga (dapagliflozin) / glipizide / Glucophage / glyburide/ Insulin / Invokana (canagliflozn) / Jardiance (empagiflozin) / Ozempic (semaglutide) / Victoza (liraglutide)	DM 2 w/o complications (E11.9) / DM 2 w/ hyperglycemia (E11.65) (immunodeficiency d/t conditions classified elsewhere (D84.81)) / DM 2 w/complication(s) (E11.2-, E11.3-, E11.4-, E11.5-, E11.6-)
Aldactone (spironolactone) / Coreg (carvedilol) / Bumex (bumetanide) / Demedex (torsemide) / Lasix (furosemide)	CHF (I50.9) / Cirrhosis (K70.3-, K74.60) (immunodeficiency d/t conditions classified elsewhere (D84.81)) / Secondary Hyperaldosteronism (E26.1)
Megace	Protein-Calorie Malnutrition (E46) (If severe, immunodeficiency d/t conditions classified elsewhere (D84.81))
Cymbalta / Lyrica / Neurontin (gabapentin)	Polyneuropathy (G62.9) (If DM with hyperglycemia is cause, immunodeficiency d/t conditions classified elsewhere (D84.81))
Imdur / isosorbide / nitrates / Nitroglycerin	Angina pectoris (I20.9)
Enbrel / Humira / methotrexate / Plaquenil / Remicade	RA (M06.9) / SLE (M32.9) / Psoriatic arthritis (M40.50) / Immunodeficiency due to drugs (D84.821)
Azilect / Cogentin / Comtan / Mirapex / Selegiline / Sinemet	Parkinson's disease (G20)
Arimidex / Aromasin / Femara / Herceptin / Perjeta / Tamoxifen	Breast cancer (C50.91-) (with malignancy, immunodeficiency d/t conditions classified elsewhere (D84.81))
Casodex / Eulixin / Lupron / Zoladex	Prostate cancer (C61) (with malignancy, immunodeficiency d/t conditions classified elsewhere (D84.81))
Avastin – Injections	Off-label treatment for Wet macular degeneration (H35.32) when injected into the eye

PHYSICAL EXAM FINDINGS (Can be used as support for documented diagnoses or clinical indicators for suspecting)		
SECTION	**FINDINGS**	**POTENTIAL DIAGNOSES CODES**
VITALS	BMI ≤ 18.9	Malnutrition (E46) (immunodeficiency d/t conditions classified elsewhere if severe (D84.81))
	BMI ≥ 40 (or ≥ 35 with co-morbidities)	Morbid obesity (E66.01 + BMI code: Z68.4- or Z68.35-Z68.39)
ACCESSORIES / EXTRAS	Dialysis graft	CKD 5 (N18.5) / ESRD (N18.6) /Renal dialysis status (Shunt) (Z99.2) (with dialysis, immunodefeciency d/t external causes (D84.822)) / Noncompliance (Z91.15)
	Ostomy / Colostomy	Artificial opening status (Z93.3)

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SECTION	FINDINGS	POTENTIAL DIAGNOSES CODES
ACCESSORIES / EXTRAS	PEG tube / Gastrostomy	Artificial opening status (Z93.1)
	Prosthetics	Amputation status - BKA (Z89.51-) / AKA (Z89.61-)
	Tracheostomy	Tracheostomy status (Z93.0)
CARDIOVASCULAR	AICD	CHF (I50.9)
	Irregularly irregular rhythm	A fib (I48.91) / Secondary hypercoagulable state (D68.69)
EXTREMITIES	Prosthetic	Amputation status - BKA (Z89.51-) / AKA (Z89.61-)
	Diminished pulses or pulses 0 or 1+	PVD (I73.9) / Diabetic PVD (E11.51)
SKIN	Ulcer / Decubitus / Breakdown	Pressure ulcer: Sacrum (L89.15-) / Heel (L89.6-) Ulcer lower limbs (L97.-) / Chronic ulcer other site (L98.4-)
NEUROLOGICAL	Shuffling gait or Dyskinesia or Akinesia or Cogwheeling	Parkinson's disease (G20)
	Hemiplegia / Hemiparesis	Hemiplegia (G81.9-) / Late effect CVA with hemiplegia (I69.-) / (see various late effect CVA codes)
	Monoplegia / Monoparesis	Monoplegia (G83.-) / Late effect CVA with monoplegia (I69.-) / (see various late effect CVA codes)
	Paraplegia / Paraparesis	Paraplegia (G82.-)
CONSTITUTIONAL	Dependent for all ADLs	Functional quadriplegia (R53.2)

LABS/TESTING			
LAB/TEST	**DESCRIPTION**	**POTENTIAL DIAGNOSES CODES**	
GFR Calculation (Diagnosis requires two abnormal GRF and/or ACR >90 days apart)	GFR ≥ 90 + 2 abnl ACR, >90 days apart	CKD 1 (N18.1)	*For CKD, consider combo codes*: HTN & CKD 5, ESRD (I12.- & N18.-) HTN & HF & CKD 1-4 (I13.0 & I50.- & N18.-) HTN & HF & CKD 5, ESRD (I13.11 & I50.- & N18.-)
	GFR 60-89 + 2 abnl ACR, >90 days apart	CKD 2 (N18.2)	
	GFR 45-59 x 2	CKD 3A (N18.31)	
	GFR 30-44 x 2	CKD 3B (N18.32)	
	GFR 15-29 x 1	CKD 4 (N18.4)	
	GFR < 15	CKD 5 (N18.5) or ESRD (N18.6) and if on dialysis, immunodeficiency d/t external causes (D84.822)	
↓ Albumin	< 3.5	Protein-Calorie Malnutrition (E46) (If severe, immunodeficiency d/t conditions classified elsewhere (D84.81))	
CBC:			
Platelets	Platelets < 150 x 2, >30 days apart	Thrombocytopenia (D69.6)	
WBC	ANC < 1500	Neutropenia (D70.9) (Depending on cause, immunodeficiency d/t conditions classified elsewhere (D84.81))	
A1c	≥ 6.5 x 2	DM 2 w/o complications (E11.9) DM 2 w/hyperglycemia (E11.65) (immunodeficiency d/t conditions classified elsewhere (D84.81))/ / DM 2 w/hypoglycemia (E11.649) DM 2 w/complications (combo E11.2-, E11.3-, E11.4-, E11.5-, E11.6-) Look at: 1. GFR; 2. VPT/DPN/Sudoscan; 3. ABI/QuantaFlo/Flochec; 4. Lipids	
Glucose	FBS > 126 x 2 RBS > 200 x 2		
UA	+ Protein + Blood	CKD stage 1-5, ESRD (N18.1-N18.6, see stages above) (If dialysis, immunodeficiency d/t external causes (D84.822))// DM w/CKD (E11.22 & N18.1-N18.6, *N18.9*) / DM nephropathy (E11.21)	
PTH	iPTH > 65	Hyperparathyroidism (E21.3) / Secondary hyperparathyroidism, renal origin (N25.81) if hx of kidney problems (If dialysis, immunodeficiency d/t external causes (D84.822))//abnormal GFR/abnormal serum creatinine then suspect	
Hepatitis panel	+ HBsAg / + Anti-HCV or HCV Ab Hep C viral load not 0	Chronic hepatitis B (B18.1) Chronic hepatitis C (B18.2)	
Rheumatoid factor	+ RF or + Anti-CCP	Rheumatoid arthritis (M06.9)	

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STUDY / SCREENING	DESCRIPTION	POTENTIAL DIAGNOSES CODES
Chest x-ray / CT chest / MRI spine / CT/US of abd/pelvis / US of RUQ / Peripheral x-ray (knee/shoulder/ankle)	Atherosclerosis Vascular calcification	Atherosclerosis/calcifications of aorta (I70.0) Atherosclerosis of native arteries of extremities (I70.2-) Atherosclerosis/calcifications of renal artery (I70.0) Atherosclerosis/calcifications of femoral artery/extremities (I70.2-)
Chest x-ray / CT chest / MRI spine	Congestive heart failure	CHF (I50.9)
	Pulmonary fibrosis	Pulmonary fibrosis/ILD (J84.10)
	Emphysema / Emphysematous	Emphysema (J43.9)
CT/US of abd/pelvis / US of RUQ	Cirrhosis	Cirrhosis of liver (K74.60) (immunodeficiency d/t conditions classified elsewhere (D84.81))
	Portal hypertension	Portal hypertension (K76.6)
	Aneurysm	Abdominal aortic aneurysm (I71.4)
ECHO	PA pressure > 40 mmHg & TRV > 2.8 m/s (280 cm/s)	Pulmonary hypertension (I27.20)
	EF < 45%	Heart failure (I50.9)
	Atrial fibrillation	Atrial fibrillation (I48.91)
VPT / DPN *(Done on either R or L)* **Sudoscan / NCV**	VPT: Abnormal ≥ 25 DPN: Abnormal Amplitude < 4 or >32 AND Velocity < 40 or >70. See DPN graph. Monofilament/Tuning Fork: abnormal or decreased sensation	*Peripheral neuropathy (G60.9)* DM polyneuropathy (E11.42) (If DM with hyperglycemia is cause of DM polyneuropathy, immunodeficiency d/t conditions classified elsewhere (D84.81)) Polyneuropathy in other disease (G63) Alcoholic polyneuropathy (G62.1) Polyneuropathy (G62.9)
ABI / QuantaFlo/ Flochec	ABI: Abnormal < 0.91 or >1.30 QuantaFlo: Abnormal < 0.91 or >1.40 Flochec: Abnormal < 0.50	Peripheral vascular disease (I73.9)) Diabetic PVD (E11.51), if diabetes present (If DM with hyperglycemia is cause, Immunodeficiency d/t conditions classified elsewhere (D84.81))
O2 Sat	≤ 88	Chronic respiratory failure (J96.11
PFT's	FEV1/FVC < 0.70	COPD (J44.-) / Chronic obstructive asthma (J44.-)
Mini-Mental States Exam	Score <24	Unspecified dementia without behavioral disturbance (F03.90)
Mini-Cog Exam	Score <3	
SLUMS	Score <19-20	

CONSULT NOTES WITH ASSOCIATED POTENTIAL DIAGNOSES CODES

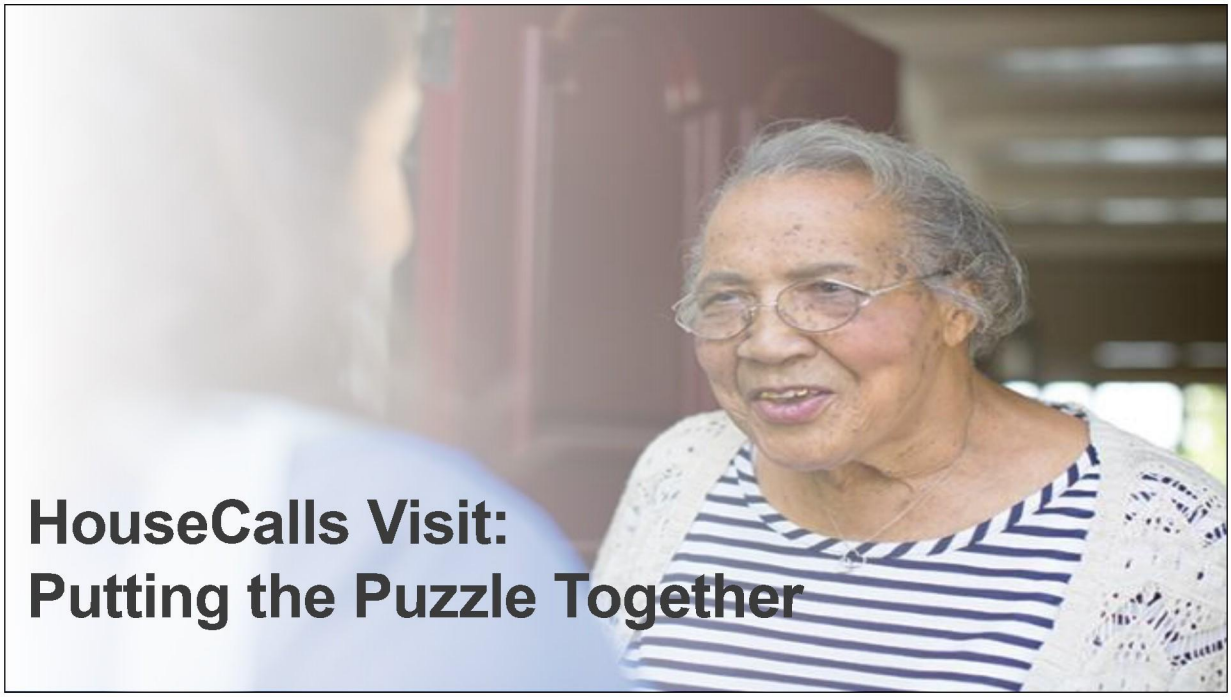
(In reviewing the Consult notes found within the chart, the coder may, based on the documentation provided, confirm, suspect, or pend a code. Any code confirmable through a specialist note should have the appropriate provider name.)

SPECIALTY	POTENTIAL DIAGNOSES CODES
Cardiology	**ECHO**: EF < 45% = CHF (I50.-) / PA pressure > 40 mmHg & TRV > 2.8 m/s (280 cm/s) = Secondary pulmonary hypertension (I27.2-) **Notes**: A fib (I48.91) / Secondary hypercoagulable state due to A fib (D68.69) / AV block, complete (I44.2) / Paroxysmal supraventricular tachycardia/PSVT (I47.1) / Sinoatrial node dysfunction/SSS (I49.5)
Gastroenterology	Cirrhosis of liver (K74.60) (immunodeficiency d/t conditions classified elsewhere (D84.81)) / Chronic hepatitis (K73.9K) / Chronic pancreatitis (K86.1) / Crohn's disease (K50.90) (immunodeficiency d/t conditions classified elsewhere (D84.81) / Esophageal varices w/ or w/o bleed (I85.0-, I85.1-) / Malnutrition (E46) (If severe, immunodeficiency d/t conditions classified elsewhere (D84.81)) / Portal hypertension (K76.6)
Nephrology / Renal	CKD I-V, ESRD (N18.1-N18.6, *see stages and combo codes under LABS*) / DM nephropathy (E11.21) (If DM with hyperglycemia is cause, immunodeficiency d/t conditions classified elsewhere (D84.81)) / Secondary hyperparathyroidism, renal (N25.81) / Secondary hyperparathyroidism, non-renal (E21.1) / Renal dialysis status (Z99.2) (If dialysis, immunodeficiency d/t external causes (D84.822))
Neurology	Hemiplegia (G81.9-) / Monoplegia (G83.1-, G81.2-) / Late effect CVA with hemiplegia (I69.-) / Monoplegia (I69.-); (see various late effect CVA codes) / Seizures or Convulsions (Not Specified) (R56.9) / Epilepsy or Seizure D.O. (G40.909) / Parkinson's disease (G20) / *Peripheral neuropathy (G60.9)* / DM peripheral autonomic neuropathy (E11.43) (If DM with hyperglycemia is cause, immunodeficiency d/t conditions classified elsewhere (D84.81)) / DM polyneuropathy (E11.42) (If DM with hyperglycemia is cause, immunodeficiency d/t conditions classified elsewhere (D84.81))/ Polyneuropathy in other disease (G63) / Alcoholic polyneuropathy (G62.1) / Dementia (F03.90) / Normal pressure Hydrocephalus (G91.2)

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SPECIALTY	POTENTIAL DIAGNOSES CODES
Oncology / Hematology	Any active cancer/malignant neoplasm (specify site) _____ (with malignancy, immunodeficiency d/t conditions classified elsewhere (D84.81)) / Hodgkin's disease (C81.90) *even in remission*/ Leukemia/multiple myeloma (C90.- to C95.-) *even in remission* / Lymphoma (C81.- to C88.-) *even in remission* / Depending on cause for aplastic anemia (D61.9) / Neutropenia (D70.9) / Thrombocytopenia (D69.6) / Pancytopenia (D61.818) consider Immunodeficiency d/t conditions classified elsewhere (D84.81))/ Polycythemia vera (D45) / Protein Calorie Malnutrition (E46) (If severe, immunodeficiency d/t conditions classified elsewhere (D84.81))
Ophthalmology	***Requires laterality R/L/bilateral;*** DM retinopathy (E11.319) / DM with mild nonproliferative DM retinopathy w/macular edema (E11.321) or w/o macular edema (E11.329) / Proliferative diabetic retinopathy w/o macular edema (E11.351) or w/macular edema (E11.359) / Wet macular degeneration (H35.32) (If DM with hyperglycemia is cause, immunodeficiency d/t conditions classified elsewhere (D84.81))
Podiatry	*Neuropathy (G60.9)* / Diabetic neuropathy (E11.40) / PVD (I73.9) / PVD due to diabetes (E11.51) (If DM with hyperglycemia is cause, immunodeficiency d/t conditions classified elsewhere (D84.81)) Skin ulcers of lower limb (L97.-) / Chronic ulcer other specified site (L98.4-) / Diabetic ulcer (E11.621 or E11.622 & L97.- or L98.4-) (If DM with hyperglycemia is cause, immunodeficiency d/t conditions classified elsewhere (D84.81)
Pulmonology	COPD (J44.-) / Simple chronic bronchitis (J41.0) / Obstructive chronic bronchitis (J44.-) / Chronic obstructive asthma (J44.-) / Emphysema (J43.0) / Chronic Cor pulmonale (I27.81) / Pulmonary hypertension I27.2-) / Pulmonary fibrosis or ILD (J84.10) / Diffuse (idiopathic) (interstitial) pulmonary fibrosis (J84.112) / Chronic respiratory failure (J96.11)/ Sarcoidosis (D86.0) / Bronchiectasis w/o exacerbation (J47.9)
Rheumatology	Rheumatoid arthritis (M06.9) / Sicca syndrome (M35.00) / Sytemic lupus erythematosus/SLE (M32.9) / Psoriatic arthopathy (M40.50)
Vascular	PAD/PVD/Peripheral vascular disease (I73.9) / Diabetic PVD (E11.51) (If DM with hyperglycemia is cause, immunodeficiency d/t conditions classified elsewhere (D84.81)) / Atherosclerosis of native arteries of extremities (I70.2-) / Gangrene (I96) /Amputation status: BKA (Z89.51-) /AKA (Z89.61-) / Toe (Z89.41-, Z89.42-) / Non-Pressure ulcers (L98.---) / Pressure ulcers (L89.---) *NOTE:* (PU includes site and stage.)

Disclaimer: Any potential condition(s) identified must be clinically significant, impact health, and require or affect patient care, treatment, or management. It is always the Clinician's responsibility to make this decision. Diagnoses listed are not an all-inclusive list. Refer to the current year ICD-10-CM code book for any diagnosis not listed.


HouseCalls Visit:
Putting the Puzzle Together

Objectives

- Describe CMS Risk Adjustment methodology in relation to HouseCalls
- Demonstrate the impact of accurate clinical documentation and Risk adjustment factor
- Explain eHouseCalls Smart Logic and clinical concepts related to capturing diagnoses and documenting to the highest specificity
- Explain how to utilize evidence from the PMH, ROS, medications and physical exam to diagnose during HouseCalls visits
- Identify diagnoses frequently encountered during HouseCalls visits
- Describe diagnostic criteria for selected diagnoses in ICD-10

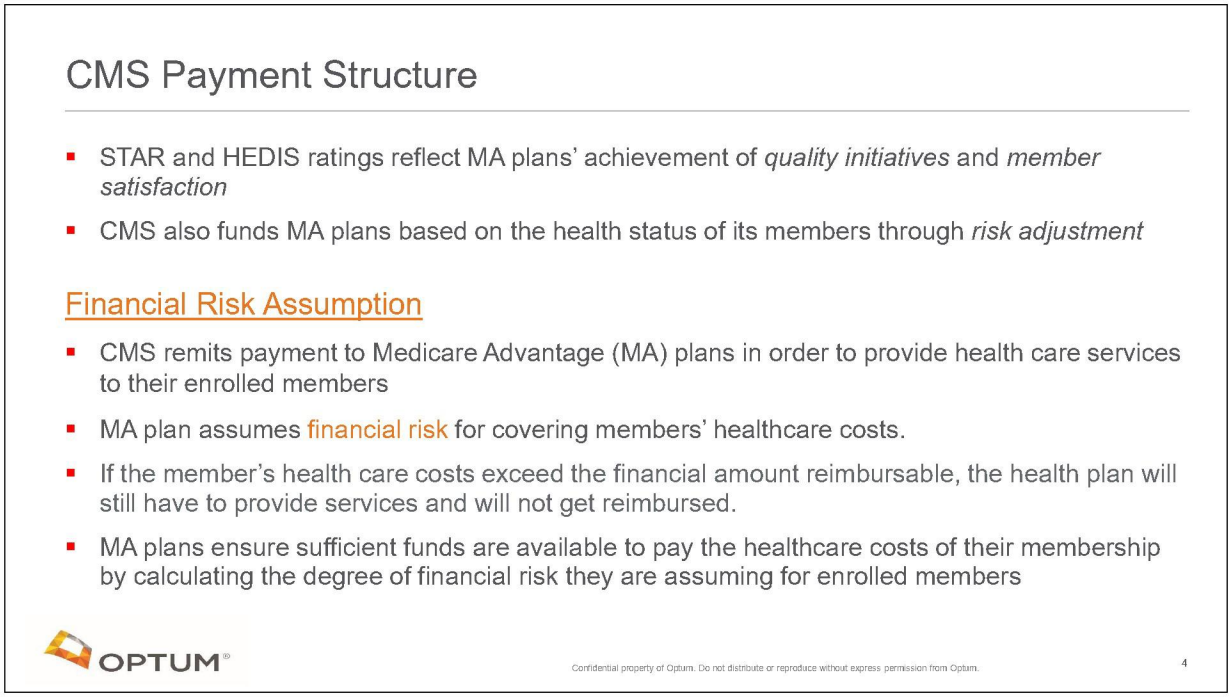
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Diagnosing during the HouseCalls visit is an expectation for all practitioners, however it does involve thinking critically about the entire clinical presentation of the member. The goal is to avoid over diagnosing and/or under diagnosing.
Since documentation plays a vital role in this, we will begin by discussing the CMS risk adjustment methodology and how it impacts the HouseCalls visit. Then we will present ways to identify and capture common chronic illness encountered during HouseCalls visits and assist you in putting the puzzle together to integrate all clinical evidence into a clear understanding of your members health status.

Risk Adjustment Factor
and
Hierarchical Category Code





In a previous presentation, we discussed how Star and HEDIS quality measures impact the funding of health plans by CMS. Also included in the CMS payment structure, is the risk adjustment process. This concept begins with understanding that when health plans enroll members, they are assuming financial risk for covering that members health care costs. In order for health plans to determine the amount of financial risk they are assuming for a member, they must utilize the risk adjustment process.

Risk Adjustment Factor Methodology

Risk adjustment offsets the cost of providing health insurance to high-risk individuals

- Benefits health plans that enroll a greater-than-average number of high-risk individuals such as those with complex chronic conditions
- The health plan receives additional compensation to make up for extra health care costs for a Medicare Advantage (MA) patient through calculation of their **risk adjustment factor**



The CMS **risk adjustment** payment methodology impacts health plans by allowing for:

- Fair and accurate payments to MA health plans
- Payments that support an enrollee's medical care needs
- Adjusted capitated payments for MA health plan enrollees

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Risk adjustment is a method to offset the cost of providing health insurance for individuals who represent a relatively high risk to insurers, such as those with chronic health conditions.
Under risk adjustment, a health plan who enrolls a greater-than-average number of high-risk individuals can ensure that theyreceive fair and accurate payments from CMS which will support the health care costs of enrolled members.

This is determined by calculation of their Risk adjustment factor. The RAF ensures that health plans receive reimbursement for the health care services they deliver

Risk Adjustment Factor

- Calculation of the **risk adjustment factor (RAF)** is based on the **predicted health status** of the member and used to estimate health care costs for a member by determining the additional **payment** a health plan receives from the Center for Medicare & Medicaid Services (CMS).
- Determined by calculating the sum of fixed factors and reported factors which impact a members' health

Fixed Factors



Age & Gender

Geographical location

\+

Reported Factors



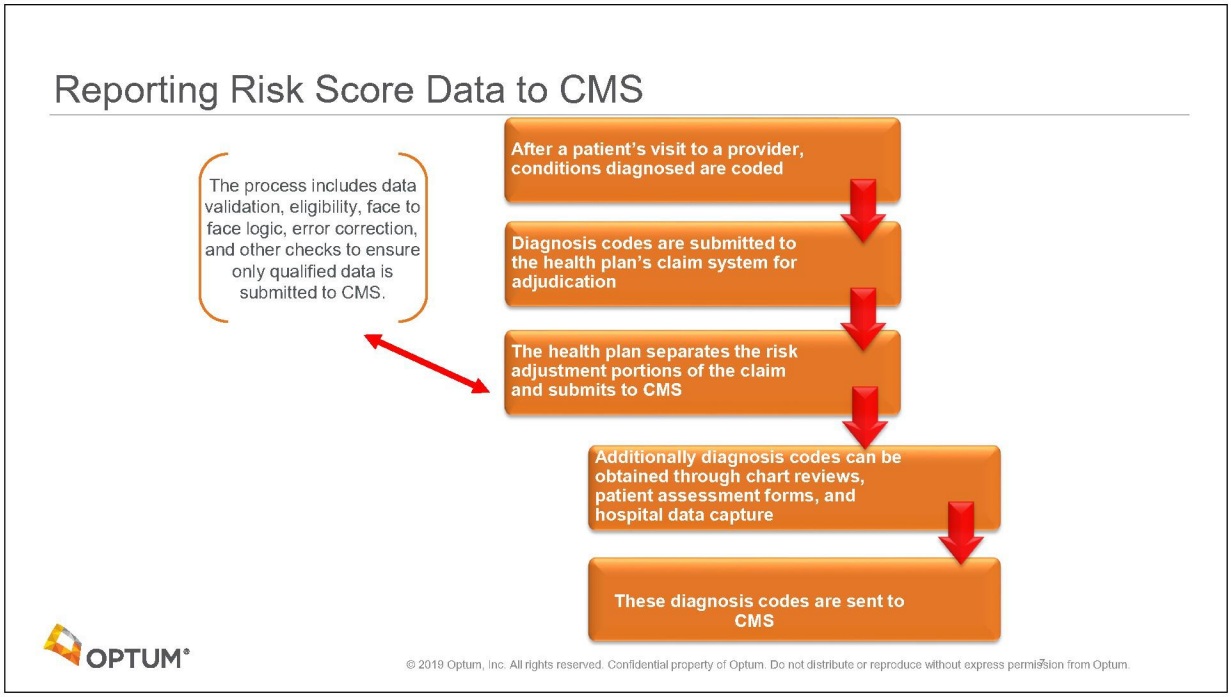
Chronic medical conditions as ICD-10 diagnoses codes

= **Risk Adjustment Factor**

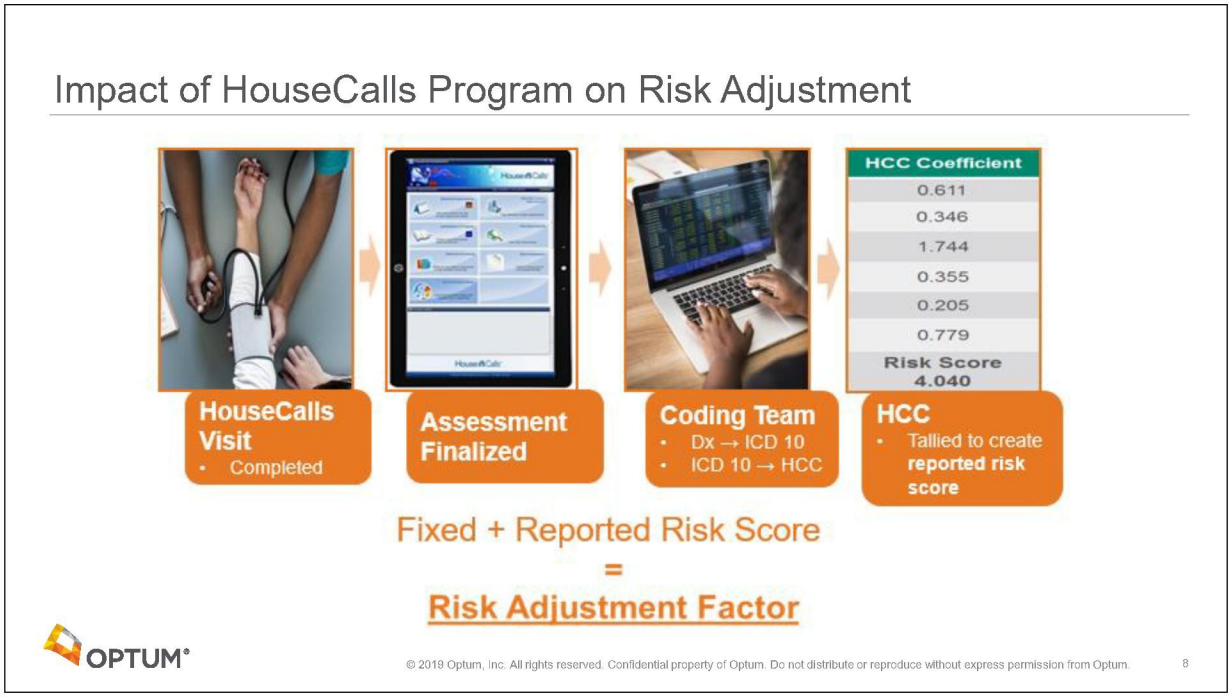
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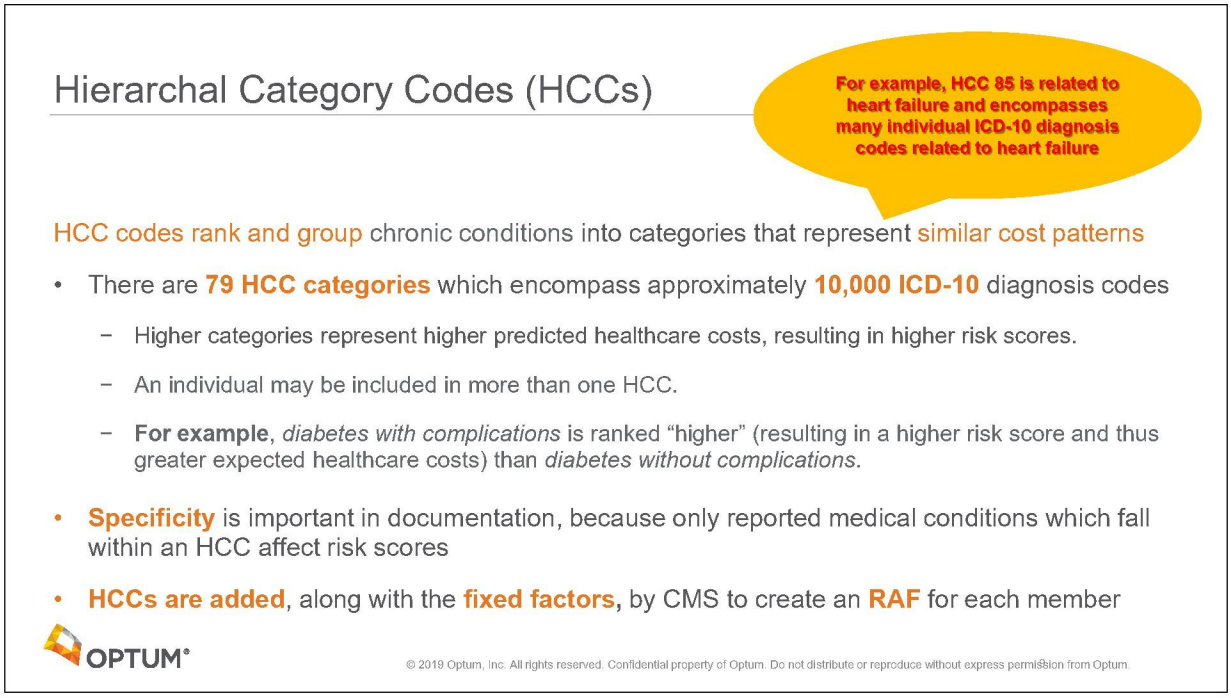
Because health plans cannot guarantee a person's health status, the RAF is based off of the predicted health status of a member. It combines fixed criteria, such as age, gender and geographic location, and reported criteria that we must report to CMS regarding the members chronic health conditions.



Reported risk data can also be gathered from provider visits, chart reviews, hospital data and patients assessment forms. As health plan receive this information, it must be validated and cross-checked to ensure only qualified data gets sent to CMS



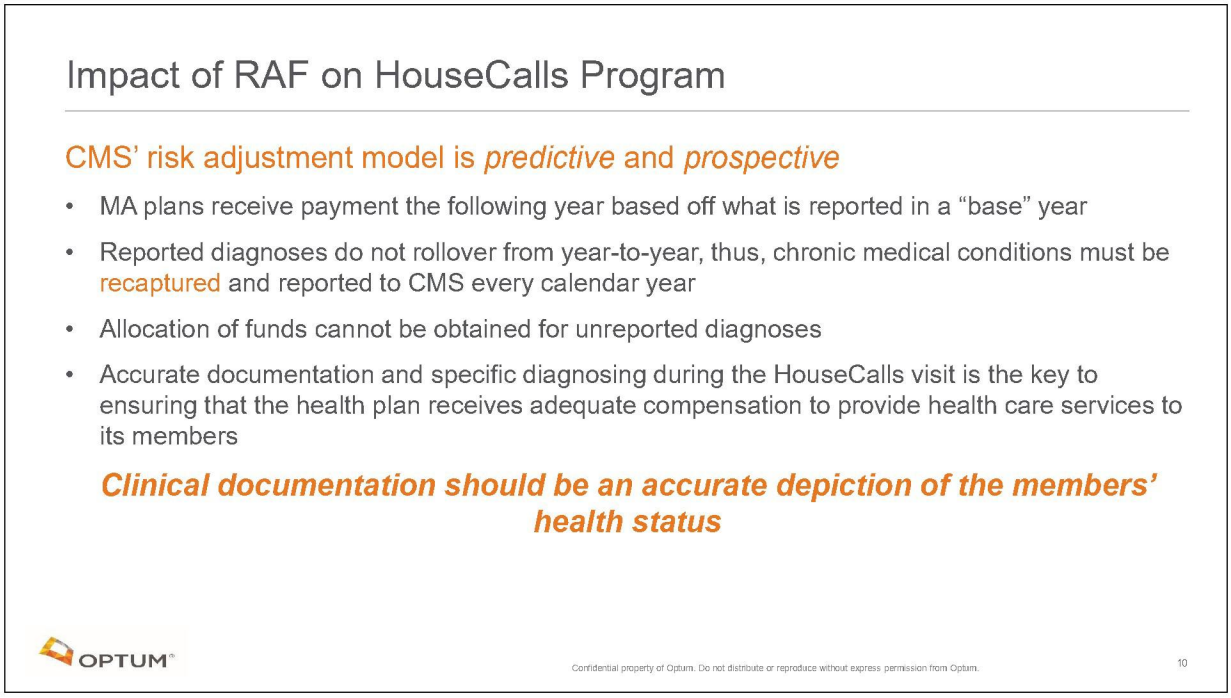
As a HouseCalls practitioner, you have an integral role in gathering this reported criteria as you document diagnoses and chronic conditions in the home. Once we complete the HouseCalls visit and finalize the assessment, the coding team translates our documented diagnoses into corresponding ICD 10 codes. ICD 10 codes are then ranked within hierarchal category codes (HCCs) to group diagnoses that have similar cost patterns. These HCCs are tallied to provide the reported risk score which is then added to the fixed criteria to get the Risk Adjustment Factor.



After Here is some more background on those HCC codes. Diagnoses that have similar health care costs are ranked into an HCC. The higher the category, the higher the health care costs associated with that HCC.

READ EXAMPLE

Since a person may have several diagnoses, they may also have several HCCs used to predict their health status from year to year. Over 10,000 chronic conditions and their corresponding ICD-10 codes are encompassed within 79 HCC codes. It is important to document diagnose as specifically as possible to ensure the most accurate RAF score can be determined.



CMS-HCC risk adjustment model is prospective: It uses health status in a "base year" to predict costs in the following year. Also, reported diagnoses do not rollover from year to year, so every calendar year chronic medical conditions must be re-reported to CMS. Your clinical documentation is the key to ensuring an accurate RAF can be calculated because funds cannot be obtained for unreported diagnoses. Remember, you are the only one seeing the member, and your documentation should be an accurate depiction of that members health status. This means that anyone looking at your documentation should be able to "see" the same clinical picture that you saw during the HCV.

Clinical Documentation



Lets talk more about clinical documentation

Documentation and Coding Impact and the Risk Score

Each **January,** the portion of the risk score related to chronic conditions **resets** for the following payment year (due to lagged risk score model).

Adjustments are made to the risk score based on data reported in face-to-face encounters with the member.

Our providers use various tools to **prompt** their **review** of chronic medical conditions.

These prompts are based on data from office and hospital visits, screening values from **prior and current years**.



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January 1st of every year the reported medical conditions for members resets. To assist you in recapturing diagnoses, eHouseCalls will suggest previously documented conditions for you to review and consider

Recapture

Recapture is **documenting** the same **chronic conditions** from **one year to the next**. This ensures consistency and accuracy for the members and the PCP. Documentation at the highest level of specificity year to year is a clinical best practice.



Recapturing occurs by confirming diagnoses are still active from:

- Previous HouseCalls visits
- Pre-populated claims data
- Based on data obtained at the visit

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When we use the term recapture in HouseCalls, we are referring to re-documenting the same chronic conditions from one year to the next based on evidence that you gather in the assessment. Many chronic conditions can be recaptured because once a person has been diagnosed, the condition is unlikely to resolve. For example, if a member had COPD last year, it is highly likely that they continue to have COPD in the current year because COPD is not a condition which resolves. If there continues to be evidence for a condition, such as COPD, it should be recaptured and redocumented each year.

Why is accurate and specific documentation important?

- Meets quality guidelines
- Standards of care
  - National/state regulatory agencies
  - Departmentally
- Improves communication – PCP, referral agencies
- Increases recognition of co-morbid conditions and response to treatment
- Validates care

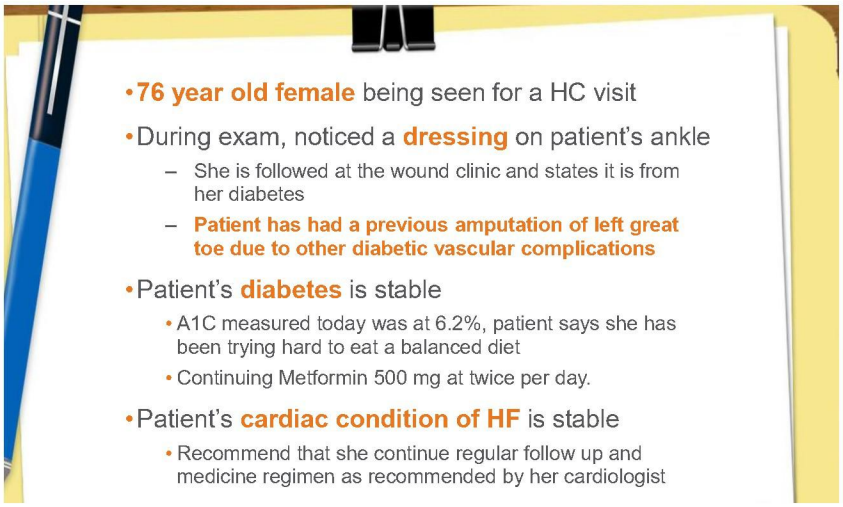


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Accurate and specific documentation proves that the health plan is meeting quality guidelines, maintaining standards of care, enhancing communication and validating the care that members receive from their PCPs.

Case Study: Clinical Scenario

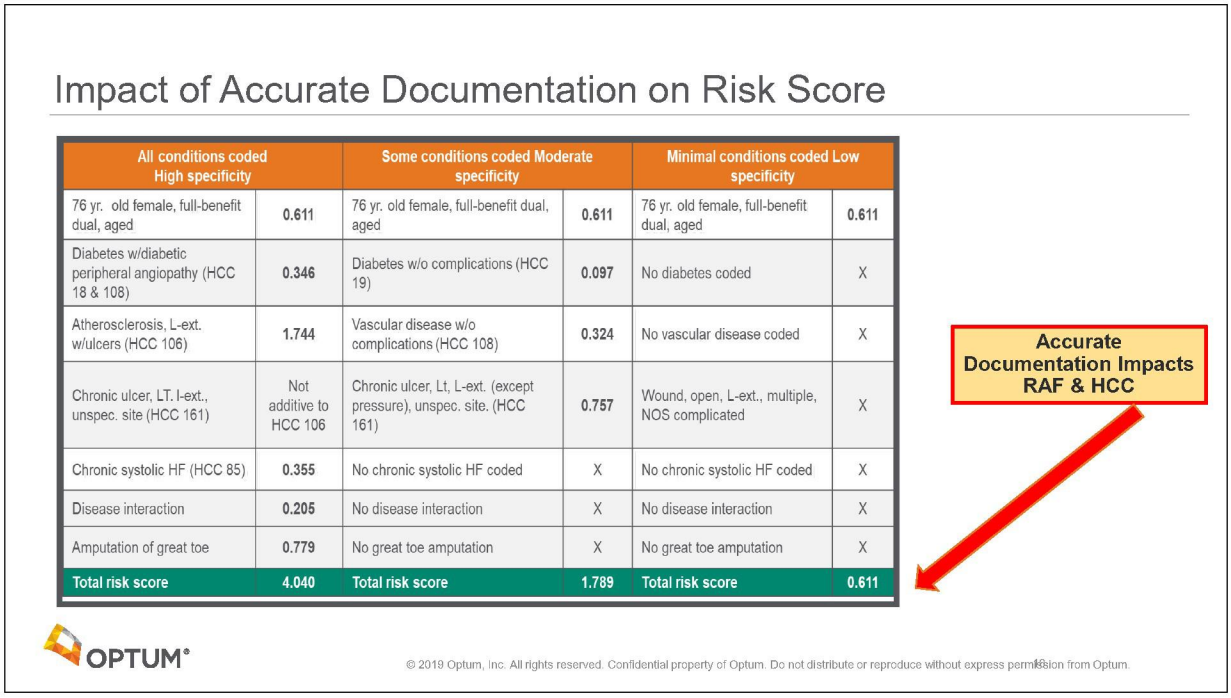


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Lets review a case study to demonstrate the impact of documentation. Here is the scenario, there is a 76 year old female being seen for a HouseCalls visit…

READ SLIDE



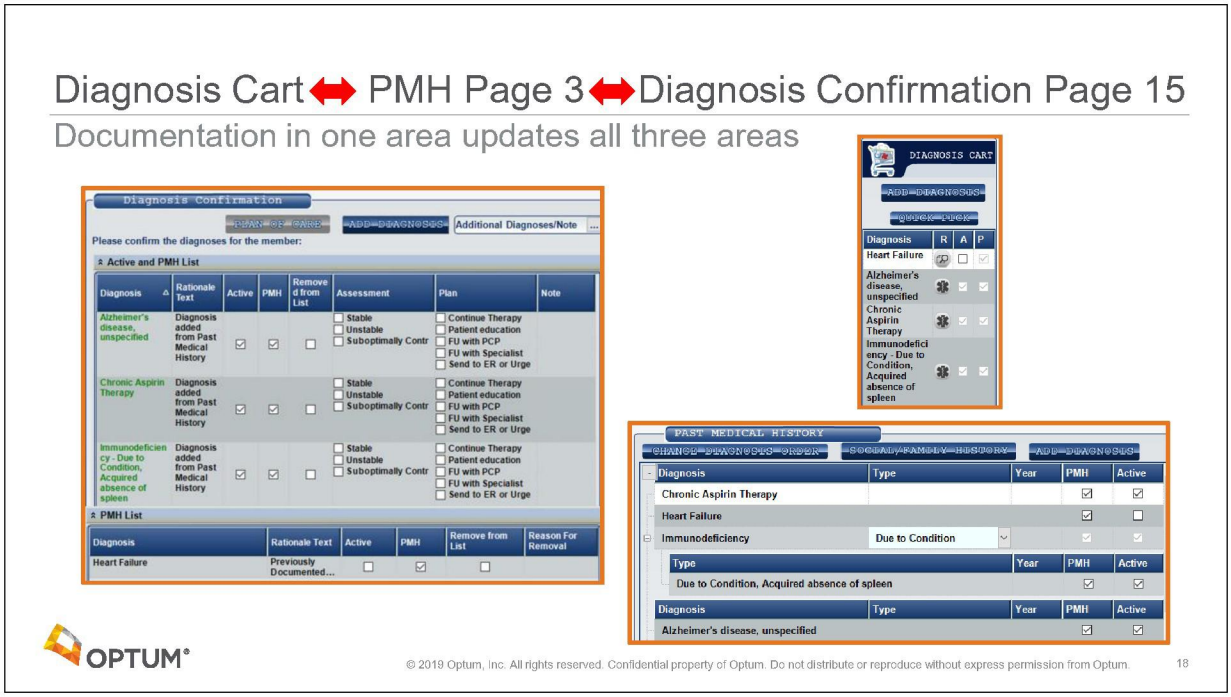
This slide provides a visual of the impact that accurate diagnosing and documenting can have on the risk score.

To lead to better member outcomes and more accurate payments, providers should:
Recapture previously reported medical conditions
Document preventative and diagnostic screenings to close quality gaps
Document all chronic medical conditions yearly with an assessment and plan

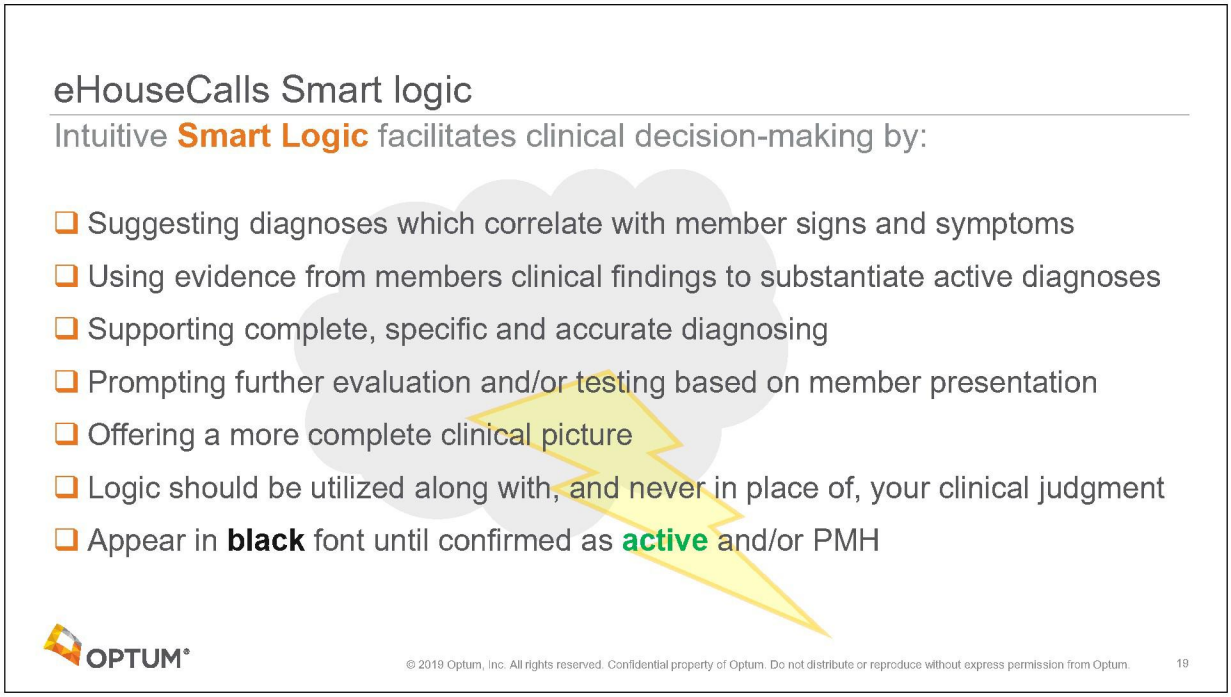
Diagnosing in eHouseCalls



We will now move into diagnosing within eHouseCalls



The diagnosis cart, PMH page 3 and diagnosis confirmation page all talk to one another. What you document in one area will update in all 3 areas. The location of the diagnoses may vary depending on the area, but the documentation will always be the same



Within eHouseCalls, Smart logic is a helpful feature which will assist you in capturing the most relevant conditions of your members.

READ SLIDE

Putting the Puzzle Together

Putting the puzzle together by selecting a diagnosis after you have captured evidentiary support in the following sections:

- ✓ Surgical History
- ✓ ROS
- ✓ Medications
- ✓ Physical Exam
- ✓ Screenings



Integrate all the evidence in addition to your own clinical knowledge, judgment, expertise and understanding of pathophysiology– Consider what can you confirm? What can be substantiated?

- ✓ Captured directly or Indirectly Via Smart Logic
- ✓ What can be captured to the highest Specificity ?
- ✓ How do I get to the most specific diagnosis?
- ✓ How do I determine is it my choice or did it get there via smart logic?

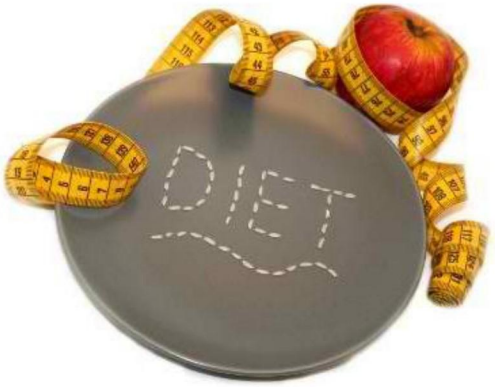
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Capturing diagnoses to the highest specificity during the HCV is like putting a puzzle together. The pieces of your puzzle incorporate evidentiary support that you will gather from the Surgical History, PMH, ROS, Medications, Physical exam and screenings. You also want to incorporate your clinical judgment and expertise because you are the clinician in the home conducting the HCV. While reviewing your documentation, consider what evidence you have and the members clinical presentation. Ask yourself questions like "What evidence can be gleaned by assessment of the members medications"; "how can I link information from the ROS and PE" "How do I understand the underlying condition – remember patho and critically think. Can the disease and the manifestation be linked"; " What underlying clues can be evaluated base on observation and assessment". Look at each section in ehc – each section serves to capture and substantiate the Diagnosis Confirmation Page. And do not forget that ehc has intuitive smart logic – so just because you did not directly select a condition does not mean it not applicable. Best practice to review all diagnosis no matter how it got there.
This deck helps us look at conditions that are frequently seen during the HCV. Each presentation visualizes the sections where you can find documentation and evidence to support those diagnoses. Lets get started…

Constitutional System

- Overweight
- Obesity
- Morbid Obesity
- Protein Calorie Malnutrition



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In this section, we will look at the Consitutional conditions that can be seen with regards to weight. Do not forgte the importance of weighing and measuring your member.

Weight-Related Smart Logic Rules

Review of Systems and/or Physical Exam findings	Diagnosis
ROS: Unintentional Weight loss	Protein Calorie Malnutrition
BMI ≥ 25 to 29.99	**Overweight**
BMI ≥ 30 to < 35	**Obesity**
BMI ≥ 35 – 39.99 (in absence of comorbidities)	**Obesity**
BMI ≥ 35 with comorbidities*	**Morbid Obesity**
BMI ≥ 40	**Morbid Obesity**



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Co-morbid conditions that support Morbid Obesity with a BMI 35-39.99

- Diabetes Type 2
- Hypertension
- Hyperlipidemia
- Cardiovascular disease
- Sleep Apnea
- Coronary heart disease
- Cerebrovascular disease
- PAD
- Heart Failure
- Other arteriosclerotic diseases such as abdominal aortic aneurysm or carotid artery disease

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Smart logic in the tablet will assist you in the diagnosing weight related conditions for members with elevated BMI.

REVIEW SLIDE

Put the Puzzle Together: Protein Calorie Malnutrition (PCM)

Is there a history of…?

- Cancer
- Drug / substance abuse or dependence
- Liver, pulmonary, celiac, thyroid, pancreatic disorders
- CKD/ ESRD
- Anemia
- Declining health or acute illness
- Dementia
- Bariatric surgery



Physical Exam

- MNA score < 17*
- Cachexia

Is the member prescribed…?

- Megestrol (Megace)
- Marinol
- Medical cannabis
- Mirtazipine (Remeron)
- Meal replacements (Ensure, Boost)

Does the member report?

- Greater than 10% weight loss in past 6 months
- Poor appetite or intake
- Nausea / vomiting

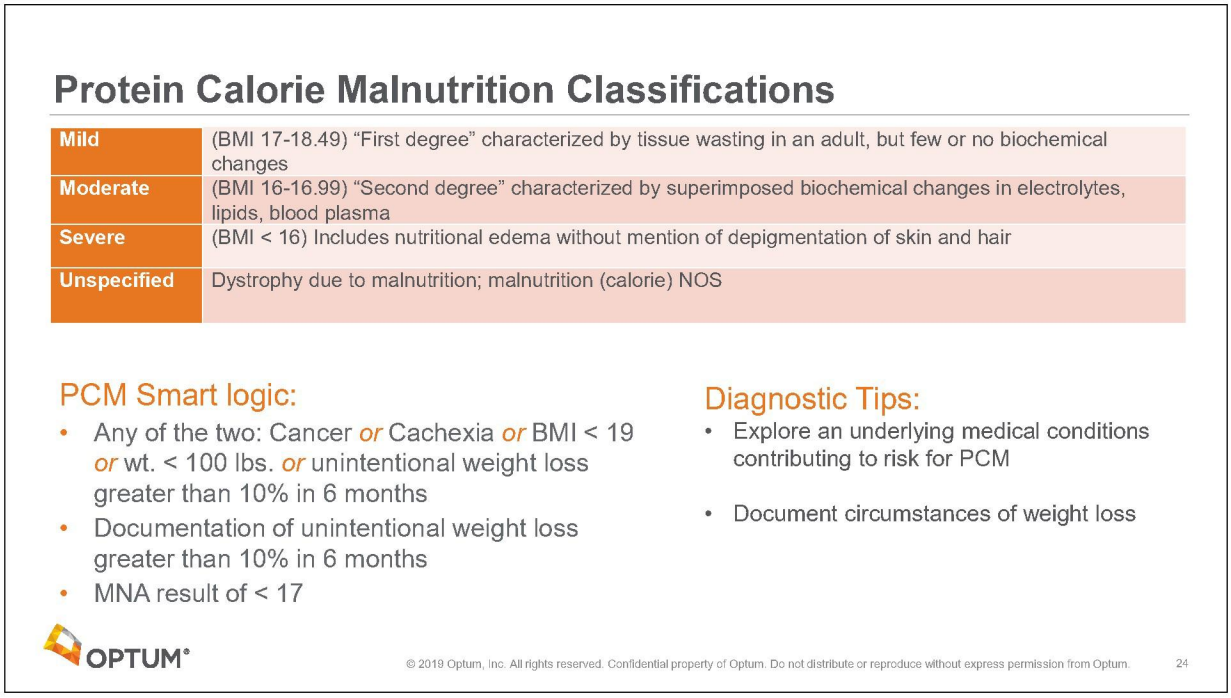
*BMI measurement is considered in the diagnosis of PCM but, alone, is insufficient to diagnose PCM.

Use the MNA tool to diagnose PCM when suspicion arises. MNA tool does not have to be RED to be completed

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On the opposite of the spectrum, Protein-Calorie Malnutrition is a condition that develops as the result of severe malnutrition. Most clinicians are able to describe an individual as appearing cachectic, but do not always make the association with malnutrition or although it is actually the same condition. Be aware that malnutrition can also be present in obese individuals too, especially in those that have had bariatric surgery.
Consider that... Underweight persons can have a normal nutritional status and Obese persons can be malnourished.
Be certain to review the entire clinical picture because BMI alone is not sufficient to diagnose PCM. There are many conditions that can be associated with the diagnosis of protein-calorie malnutrition. Some are obvious such as cancer, liver disease, celiac disease and chronic respiratory illnesses, but it can also be associated in individuals with anemia, substance abuse, and dementia.
REVIEW PMH, ROS, PE and Meds



Once a diagnosis of PCM has been established through the MNA tool, the BMI indicated the severity of malnutrition. There is tablet logic built into the assessment to assist with diagnosing Protein-Calorie Malnutrition. When a BMI less than 18.49 is recorded, a diagnosis of Protein-Calorie malnutrition is added to the Diagnosis cart. Documenting a weight loss of greater than 10% within the past 6 months will trigger the MNA to turn RED and be mandatory to be completed prior to finalizing the assessment.

Cardiovascular System

- Atrial Fibrillation
- Other Thrombophilia/ Secondary Hypercoagulability
- Heart Failure
- Secondary hyperaldosteronism
- Peripheral Vascular Disease



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Put the Puzzle Together: Atrial Fibrillation

Is there a history of…?
- Cardioversion
- Irregular heart rate
- Pharmacological ablation



Is the member prescribed…?
- Warfarin
- Aspirin
- Antiarrhythmics
- Dabigatran (Pradaxa)
- Apixaban (Eliquis)
- Rivaroxaban (Xarelto)

Does the member report?
- Rapid, irregular, fast heart rate
- Fluttering heart rate
- Dizziness, syncope, fainting episodes

Physical Exam
- Irregularly Irregular heart rhythm

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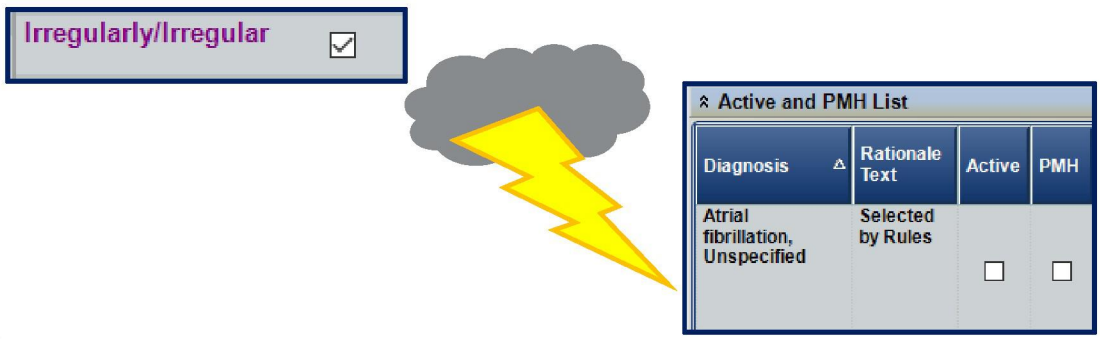
Atrial fibrillation is the most common irregularly irregular heart rhythm. There will be clues to this diagnosis within the PMH/ROS/ PE & Meds. REVIEW SLIDE

Anticoagulant use with the presence of an arrhythmia without a history or diagnosis of PE/DVT or very recent joint replacement should raise your concern about atrial fibrillation.

Smart Logic Rule: Atrial Fibrillation (A-fib)

→ Irregularly/Irregular heart rhythm is selected in the physical exam then,

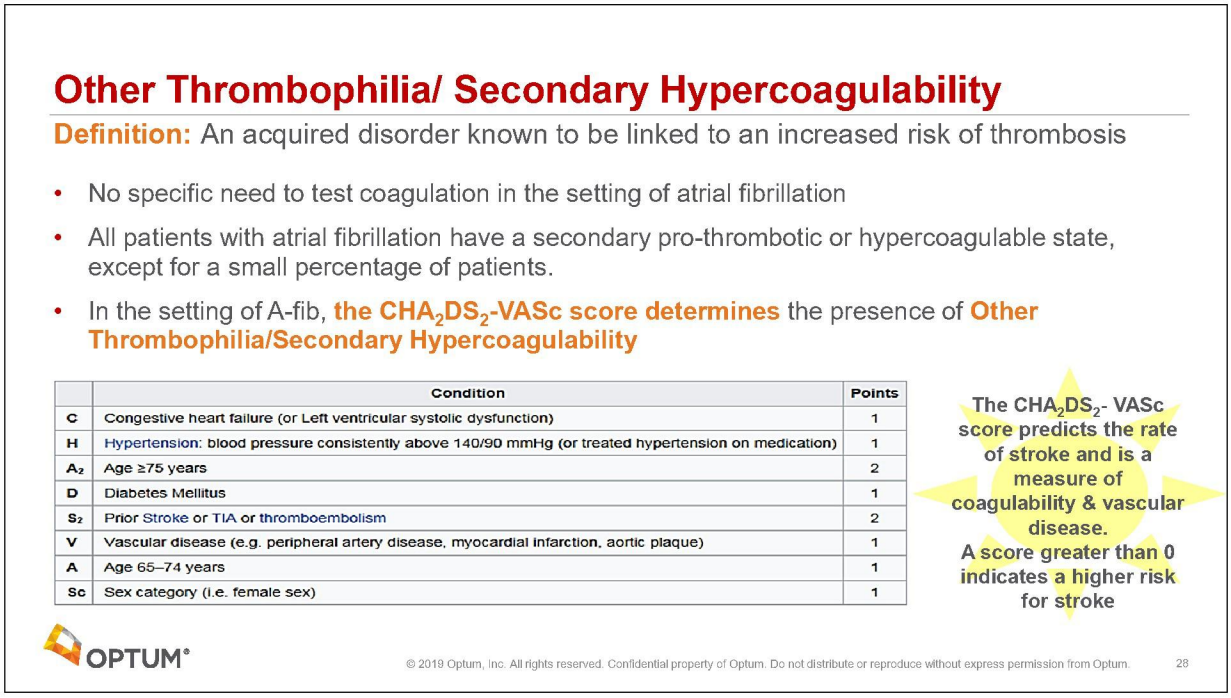
→ Atrial Fibrillation, unspecified will populate in the Diagnosis Cart/ DCP/ Page 3



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When irregularly irregular heart rhythm is documented in the physical exam, smart logic will populate the diagnosis of Atrial fibrillation to the diagnosis cart, DCP and page 3. You should review this diagnosis and confirm it as active if appropriate.



A diagnosis commonly associated with atrial fibrillation is other thrombophilia which refers to secondary hypercoagulability. This is an acquired disorder that is known to be linked to an increased risk of thrombosis. Atrial fibrillation is a condition which often causes an increased risk of thrombosis.

AF can cause stasis of blood resulting in thrombus formation which may dislodge, cut off supply to the brain, and cause a stroke. This is why persons with atrial fibrillation frequently are prescribed anticoagulants. But there is a validated method to determine if anticoagulation to prevent stroke is needed in persons with atrial fibrillation called the CHADS2-VASc score.

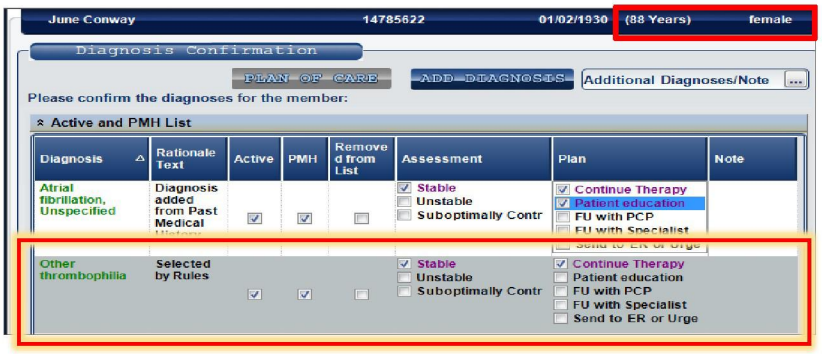
According to the CHADS2- VASc, antioagulation is indicated in most patients age 65-74 or in most patients with comorbidities including hypertension, congestive heart failure, diabetes, prior history stroke/TIA, or vascular disease. Always use clinical judgment when selecting diagnoses.

A score greater than 0 corresponds to a higher risk for stroke due to thrombus formation. Scores greater than 0 confirm a diagnosis of Other thrombophilia in members who have afib

Smart Logic Rule: Other Thrombophilia

- ✓Atrial Fibrillation (active or PMH) is documented **AND**
- ✓Member meets any of the CHADVASC criteria **OR** Is taking an anticoagulant medication, then

Other Thrombophilia will populate within the Diagnosis Cart/ DCP/ Page 3



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The diagnosis of Other Thrombophilia will be suggested by smart logic when atrial fibrillation is documented and if the member meets any of the CHADVASC criteria or is taking an active anticoagulant medication

Heart Failure: Using the Framingham Criteria

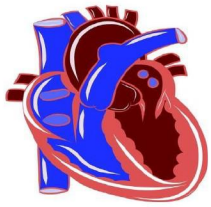
The Framingham Criteria is a validated tool used to diagnose heart failure

Identify the concurrent presence of either:

2 Major criteria

or

1 Major and 2 Minor criteria



Major criteria are:

- Paroxysmal nocturnal dyspnea
- Weight loss of 4.5 kg in 5 days in response to treatment
- Neck vein distention
- S_3 gallop
- Rales
- Acute pulmonary edema

Minor criteria are:

- Nocturnal cough
- Dyspnea on ordinary exertion
- Tachycardia (rate of 120 bpm)
- Bilateral ankle edema

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Heart Failure is a complex clinical syndrome and has increasing prevalence with aging.
To establish the diagnosis of HF, a validated tool was developed as a result of the Framingham study. If you can identify the concurrent presence of either 2 Major criteria or 1 Major and 2 Minor criteria from this tool, then you can diagnose Heart Failure in the home.

Major criteria include:
Paroxysmal nocturnal dyspnea
Weight loss of 4.5 kg in 5 days in response to treatment
Neck vein distention
Rales
Acute pulmonary edema
S 3 gallop

Minor Criteria are:
Nocturnal cough
Dyspnea on ordinary exertion
Tachycardia (rate of 120 bpm)
Bilateral ankle edema

While there are some items that are not able to be measured in the home such as determining pulmonary edema and paroxysmal nocturnal dyspnea, many of the criteria can be identified during a HouseCalls visit.

Put the Puzzle Together: Heart Failure

Is there a history of…?
- Longstanding HTN
- Myocardial Infarction
- Valvular Disease or Cardiomyopathy

Does the member report?
- Non-productive cough
- Dyspnea at rest
- Weight gain or edema
- Extra pillows at night to sleep?
- Lightheadedness or dizziness
- Fatigue and weakness
- Feelings of a racing heartbeat



Is the member prescribed…?
- ACE/ARB
- Beta Blockers
- Diuretics
- Digoxin

Physical Exam
- Peripheral edema
- Adventitious breath sounds
- Ascites
- S_3 or S_4
- Resting tachycardia
- Diaphoresis

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Diagnosing heart failure in the home can be done by reviewing the PMH, ROS Medications and Physical exam. Evidence of HF related to excess fluid accumulation includes lower extremity edema, which is more pronounced when the member is upright; abdominal distention from ascites, and rales on auscultation. Use common language, rather than medical terms, when asking the members about their symptoms

Additional findings include resting sinus tachycardia, narrow pulse pressure, diaphoresis, and signs of peripheral vasoconstriction as noted by cool, pale, and sometimes cyanotic extremities. An irregularly irregular pulse is suggestive of atrial fibrillation, which frequently accompanies HF
Peripheral edema may also cause ascites, scrotal edema, hepatomegaly, and splenomegaly.

The finding of an S3 gallop is highly specific (approx. 90 percent) in the presence of elevated left atrial pressures.

Secondary Hyperaldosteronism

Definition: The excessive production of aldosterone caused by extra-adrenal disorders

Decreased renal perfusion resulting from…

- Impaired cardiac function in Heart Failure
- Portal hypertension in Cirrhosis



... Triggers the renin-angiotensin-aldosterone system, which results in increased aldosterone production

** Fluid retention is a manifestation of excessive aldosterone. When edema or ascites are present in persons with HF or cirrhosis, this is evidence of Secondary Hyperaldosteronism

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Secondary Hyperaldosteronism is the excessive production of aldosterone. This is usually caused by an extra-adrenal disorders such as heart failure, and/or cirrhosis and has been confirmed in the literature because they cause decreased renal perfusion which triggers the RAAS system to produce increased aldosterone.

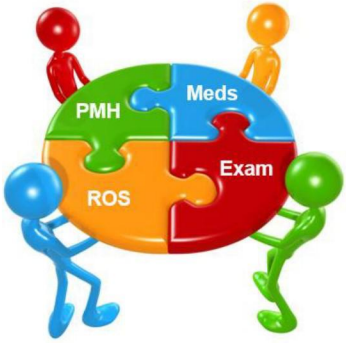
This is the reason behind prescribing aldosterone blocker, such as spironolactone, in heart failure patients when edema is present.

From a clinical standpoint, it is assumed that individuals with cirrhosis or heart failure, when significant edema or ascites is present, also have secondary hyperaldosteronism.

Put the Puzzle Together: Secondary Hyperaldosteronism

Is there a history of…?
- Cirrhosis or liver disease
- Heart Failure
- Kidney disease

Does the member report?
- Swelling in the extremities
- Fatigue
- Headache
- Paralysis that comes and goes
- Muscle weakness
- Numbness



Is the member prescribed…?
- Loop diuretics
  - Furosemide
  - Torsemide
  - Bumetanide
- Aldosterone receptor blockers
  - Spironolactone (Aldactone)
  - Eplerenone

Physical Exam
- Edema
- Ascites

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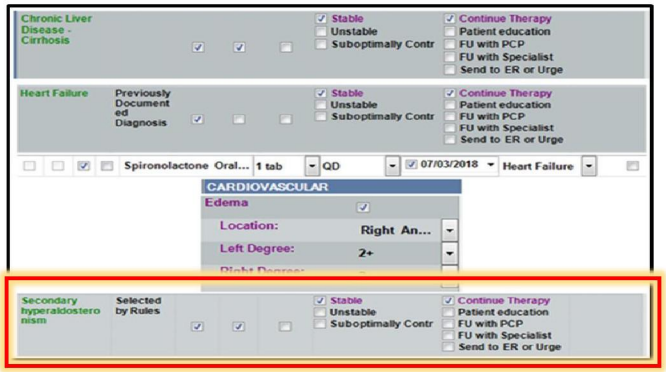
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Evidence of increased aldosterone is fluid retention. When signs of fluid retention or medications to treat fluid retention are present in members with HF or cirrhosis, secondary hyperaldosteronism can be confirmed

Smart Logic Rule: Secondary Hyperaldosteronism

- ✓ Heart Failure or Cirrhosis is documented **AND**
- ✓ Documentation of edema **OR** an aldosterone antagonist or loop diuretic as an active medication, then

Secondary Hyperaldosteronism will populate within the Diagnosis Cart/ DCP/ Page 3



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Smart logic will suggest this diagnosis in members who have documented HF and cirrhosis with documentation of edema or a loop diuretic or aldosterone antagonist

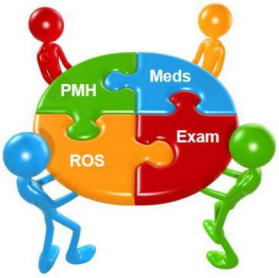
Put the Puzzle Together: Peripheral Vascular Disease

Is there a history of…?

- Atherosclerosis (cardiac, renal, carotid)
- Fem-pop bypass/ stent
- Erectile dysfunction
- HTN
- Smoking

Does the member report?

- Non-healing LE wounds
- Claudication
- Cramping pain in legs w/ or w/o activity



Is the member prescribed…?

- Anticoagulants
- Aspirin
- Antiplatelets
  - Clopidogrel (Plavix)
  - Cilostazol (Pletal)

Physical Exam

- Color change in legs
- Decreased/slow hair & nail growth
- Shiny skin
- Decreased pulses
- Cool extremities
- Hemosiderin stain on skin
- Abnormal QuantaFlo results

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Next we will discuss PVD. PAD is the most common form of PVD and many risk factors such as increasing age, co morbid conditions and smoking can place a person at risk for PAD. Since as many as 75% of people with peripheral arterial disease are asymptomatic, clinicians can miss this disease if they are not careful. So pay attention to the full clinical picture and look for diagnostic hints of vascular disease. REVIEW SLIDE

Understanding PVD Diagnosis

Diagnoses examples for Arterial Disease:

- Peripheral Vascular Disease, Unspecified
- Atherosclerosis of native arteries of extremities with intermittent claudication,
- Other atherosclerosis of native arteries of extremities, bilateral legs
- Unspecified atherosclerosis of native arteries of extremities, bilateral legs

➢ **When documenting arterial disease, use *PVD* or *Atherosclerosis* diagnoses**

Diagnoses examples for Venous Disease:

- Venous insufficiency (chronic) (peripheral)
- Asymptomatic varicose veins of bilateral lower extremities

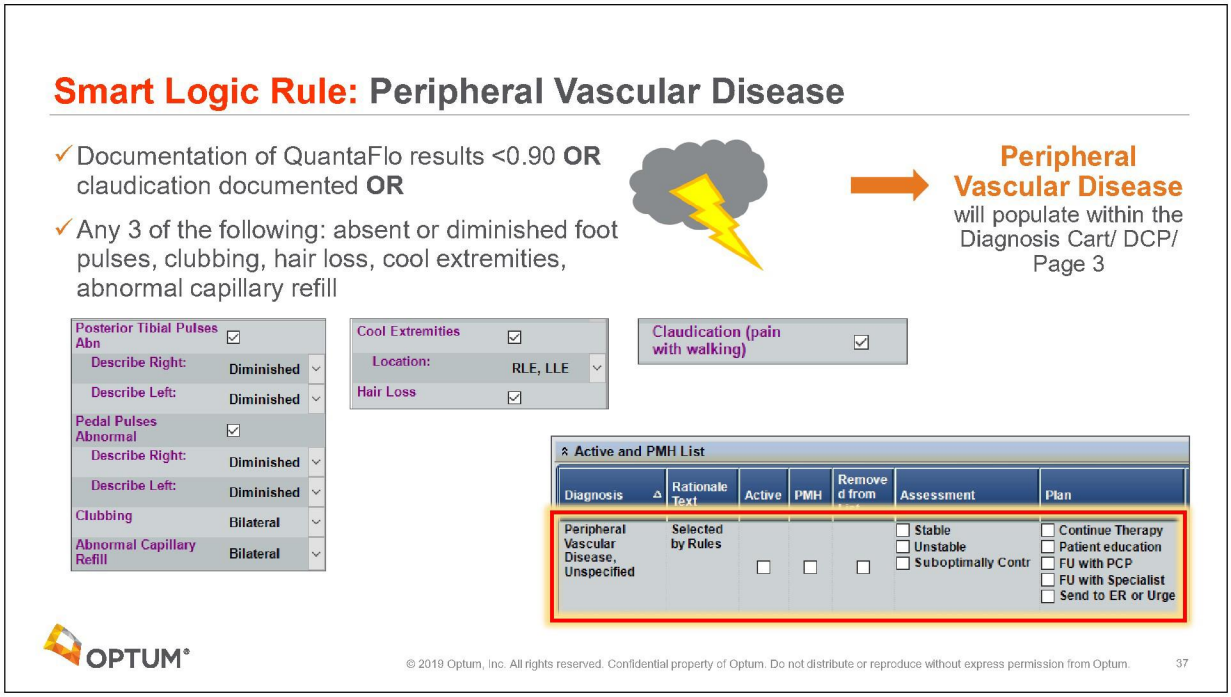
➢ **When documenting venous disease, diagnose the specific venous condition**



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In HouseCalls visits, the diagnosis of PVD translates to PAD. This can be documented generally as PVD unspecified, or as one of the atherosclerosis of the lower extremities diagnoses. If a member has venous disease, document the specific venous condition and do not use the PVD diagnosis to reference venous disorders



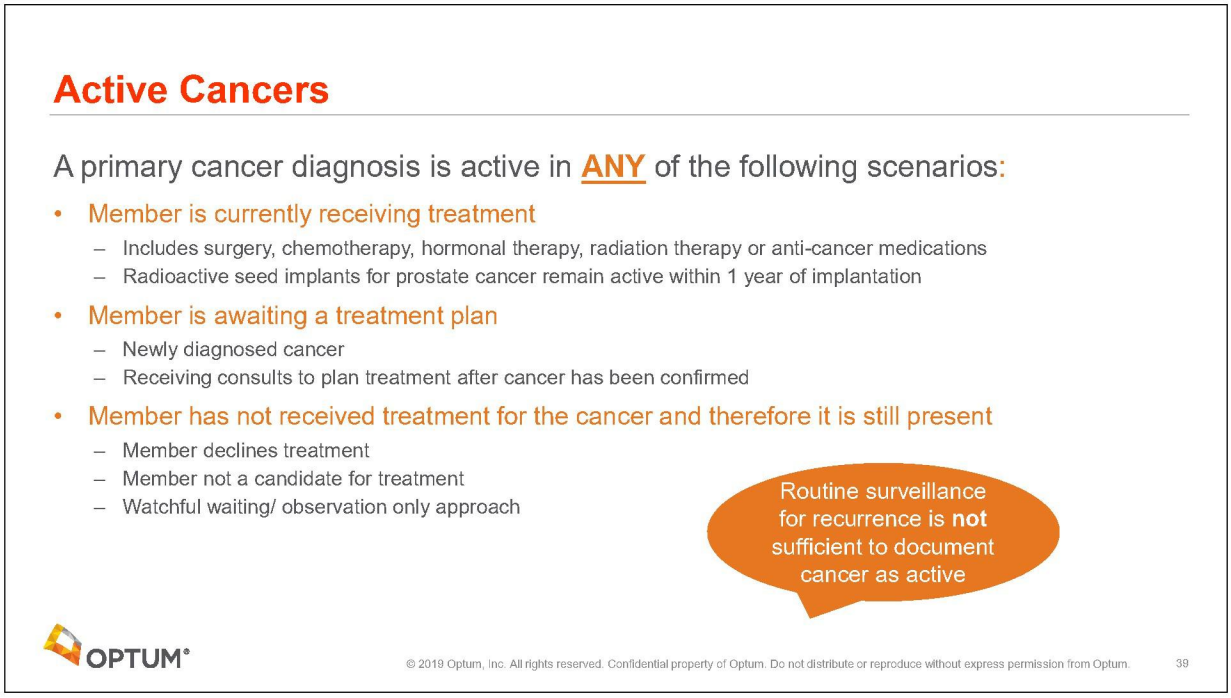
If abnormal QF results or claudication is documented, this will populate the diagnosis of PVD by smart logic. Or if the member has 3 clinical symptoms indicative of PVD, the diagnosis will also populate.

Cancers

- Active Cancer
- History of Cancer
- Blood Cancers



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When documenting cancer in the HCV, it is necessary to distinguish members with active cancers from those with a history of cancer. The next 2 slides details this criteria.

REVIEW SLIDE

History of Cancer

Personal history of cancer diagnoses are equivalent to 'history of'

Indicates that treatment of the cancer is complete, and the cancer is resolved. This diagnosis is used for primary malignancies only

Personal history of cancer diagnosis is appropriate when ALL of the following criteria have been met:

- Member has completed treatment for primary cancer at its site **AND**
- There is no further treatment planned to the primary site **AND**
- There is no evidence of any existing primary malignancy at the site

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REVIEW SLIDE

Put the Puzzle Together: *Active Cancer* or *History of* Cancer?

Does the member report?

- Oncology specialists
- Current cancer treatment?
- Awaiting a treatment plan?
- Treatment being deferred
- Further treatment planned
- Evidence of existing malignancy

Is the member prescribed…?

- Chemotherapy
- Radiation
- Hormonal therapy
- Pending Surgery



Is there a history of…?

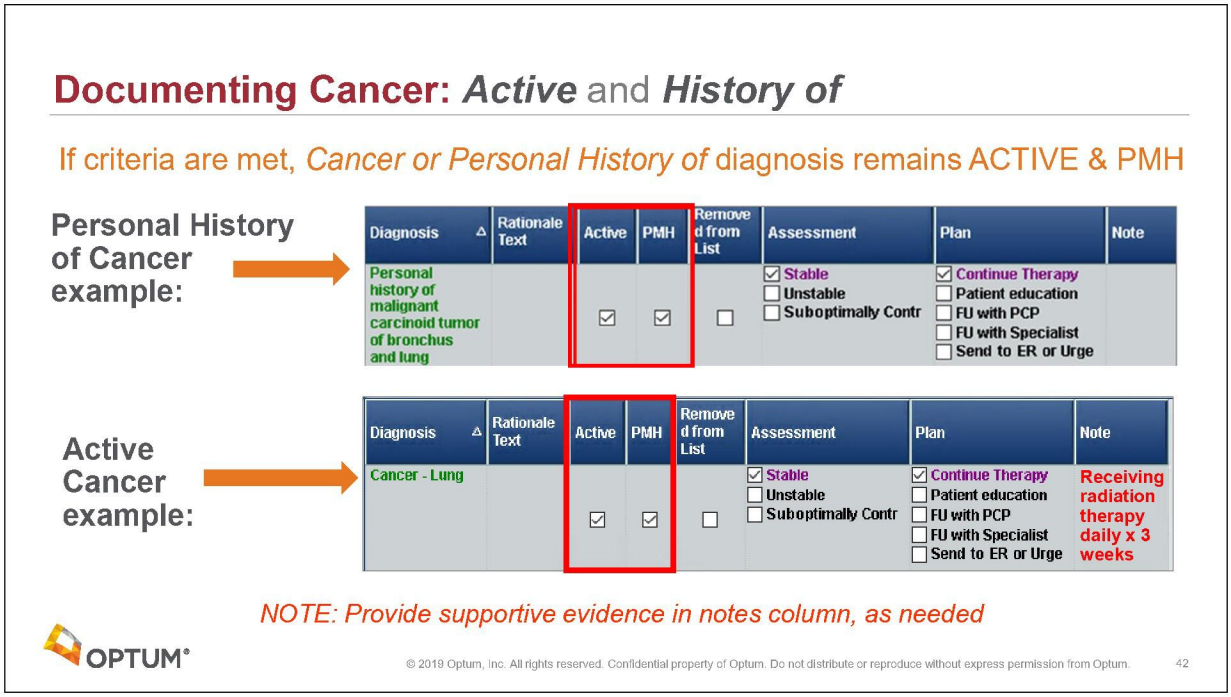
- Surgical resection
- Completed radiation therapy
- Completed chemotherapy

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In order to determine active cancer from history of cancer, the member is your best source of information when asked the right questions. Here are some tips to assist your decision-making…

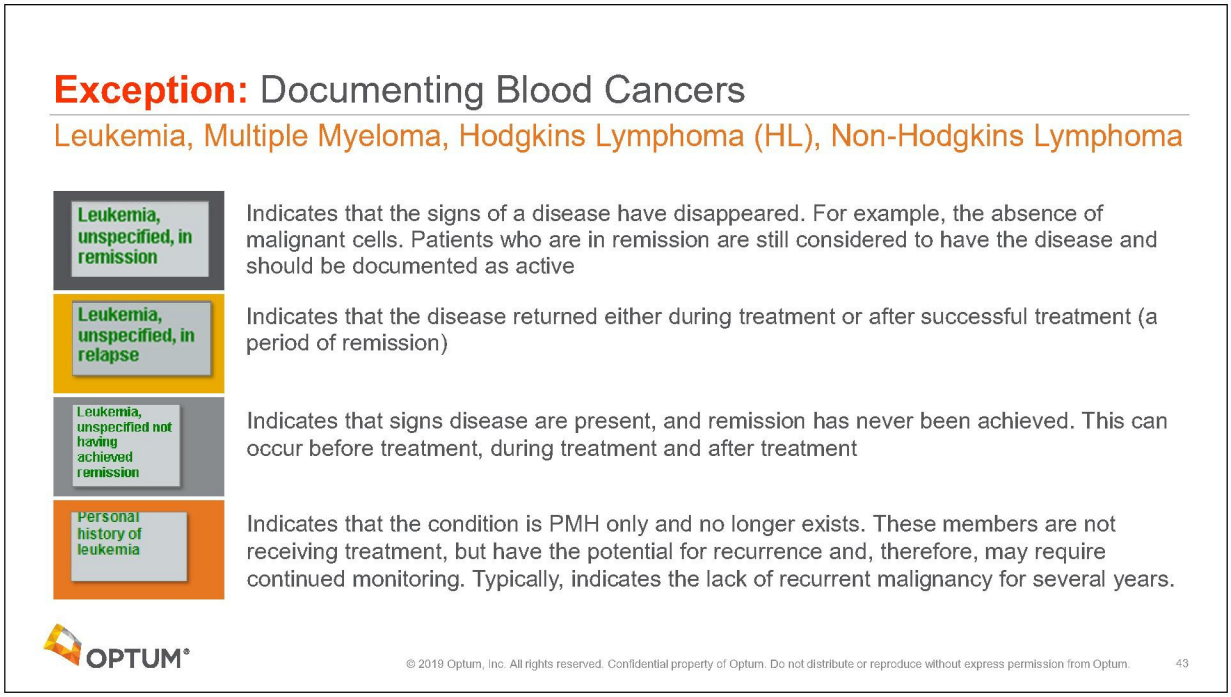
REVIEW SLIDE



Within eHC, this slide shows the difference between these 2 cancer diagnosis. The history of cancer diagnoses will always leads with Personal History of, followed by the type of cancer.

Regardless of cancer type, both active and history of cancers will always be both active and PMH. A person never gets rid of their history and therefore the history is always active.

Utilize the notes column to add supportive evidence for your designation if not documented elsewhere in the assessment. This is helpful especially in the instance of documenting cancer diagnoses



When it comes to blood cancers, however, there are exceptions this documentation. This is because a common treatment goal for blood cancers is to achieve remission, not necessarily cure because they have a somewhat higher rate of recurrence. The remission identifiers should be used, when appropriate, if documenting blood cancers such leukemia, multiple myeloma, hodgkins lymphoma and non-hodgkins lymphoma.

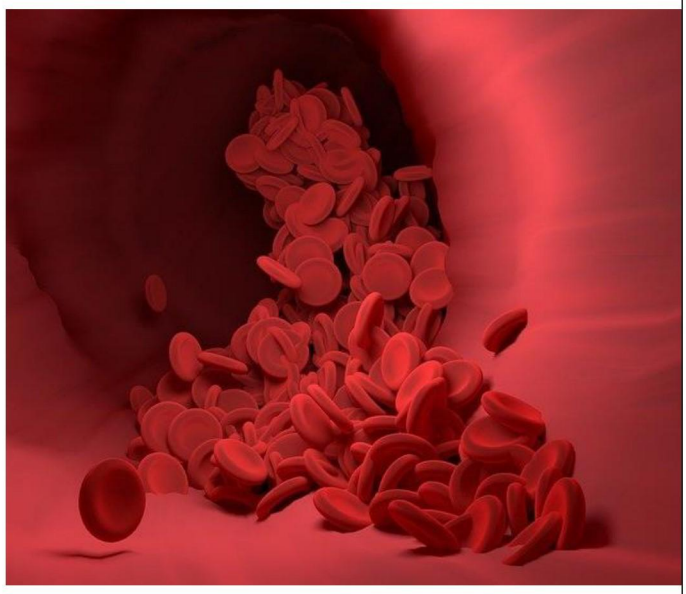
REVIEW SLIDE

It can be difficult to determine if a blood cancer is in remission or if the member has a personal history of the blood cancer. In the literature, there is not a clearly defined time frame which indicates when a cancer goes from being in remission to personal history. The practitioner must use their clinical judgement.
Members who have a remote history of a cancer are more likely to have competed treatment several years ago whereas members in remission may have completed treatment more recently.

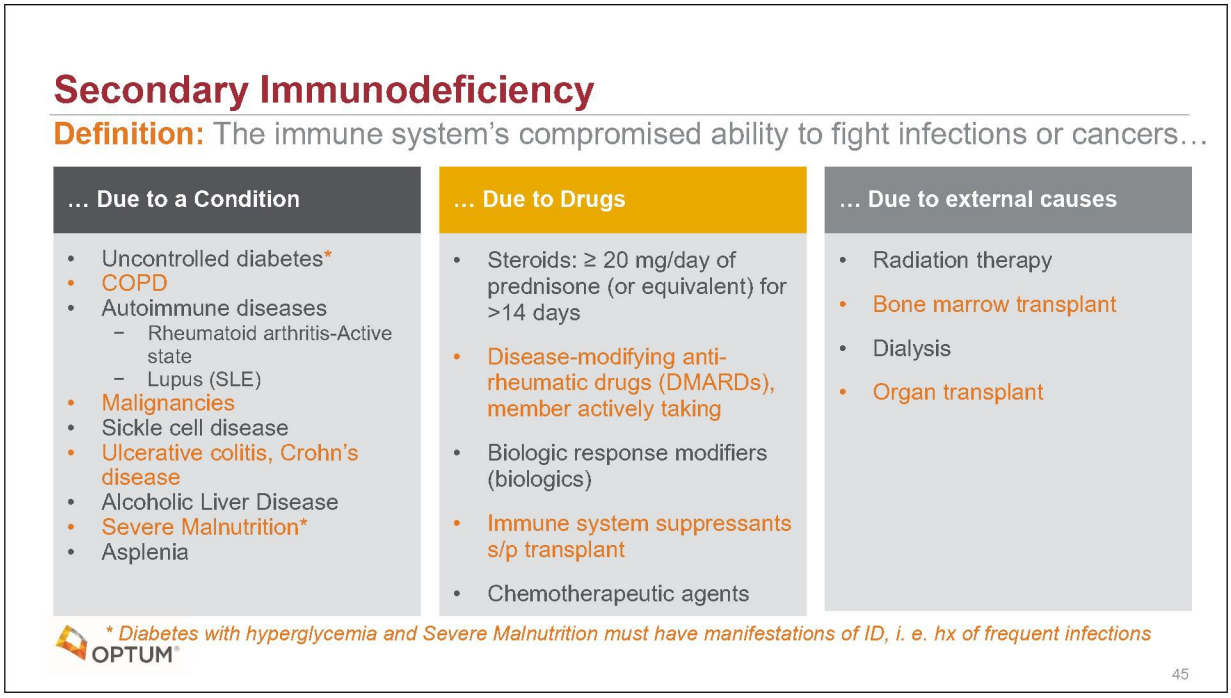
Diseases of the Blood

- Secondary Immunodeficiency

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In eHC, secondary immunodeficiency is classified as a disease of the blood



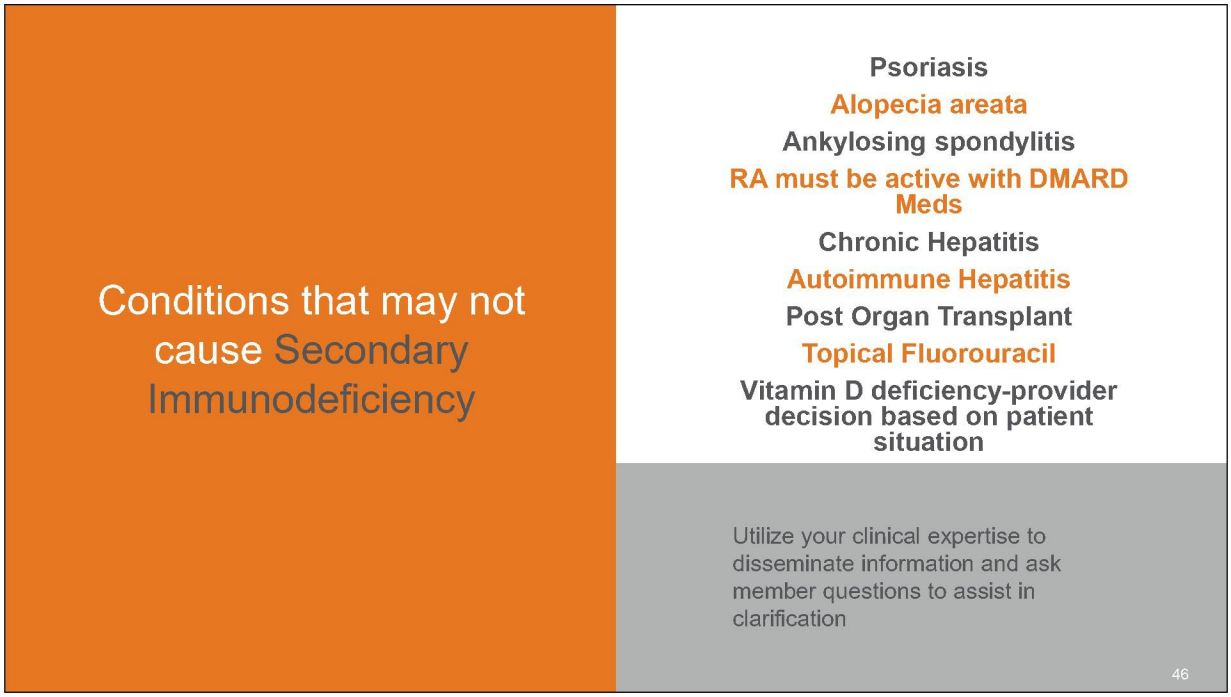
This refers to the immune systems ability to fight infections or cancers due to a the presence of a condition, medication or external cause

All these diagnosis are already available in the eHouseCalls tablet:

Immunodeficiency due to conditions classified elsewhere
Was created for an immunocompromised state due to a specific medical condition
Immunodeficiency due to drugs
Was created for immunodeficiency due to medications that interfere with the immune system. These medication include but are not limited to immunosuppressants , corticosteroids and chemotherapy
This list is not exhaustive, only a subset of potential medications are listed
Immunodeficiency due to external causes
Was created for an immunodeficiency caused by external factors such as exposure to radiation therapy or due to bone marrow transplant.
When discussing organ transplant address the medications involved for rejection prevention and that the organ itself could cause immunodeficiency.

Note: HIV/AIDS clinically is a secondary immunodeficiency, but CMS coding guidelines exclude it from these codes in ICD-10

While the condition of rheumatoid arthritis may confer an immunodeficiency state, the immunodeficiency state is only considered present when the rheumatoid arthritis is in an active state and would generally require medication management with DMARDS or other rheumatologic medica



Does the condition, Vitamin D deficiency, cause secondary immunodeficiency (SID)?
• While vitamin D levels of less than 30 may infer immunodeficiency in some situations, clinical management is unlikely to change and therefore it is recommended for each provider to make a decision based on each patient's situation. Furthermore, routinely checking Vitamin D levels is not recommended. The USPSTF reports, "the evidence is insufficient to assess the benefits and harms of screening for Vitamin D deficiency in asymptomatic adults." We do not recommend educating clinicians to document an immunodeficiency state due to Vitamin D deficiency alone, but to assess each patient and situation using clinical judgement to determine if a SID state exis

Put the Puzzle Together: Secondary Immunodeficiency (ID)

Is there a history of…?

- Conditions linked to ID
- External causes linked to ID
- Organ transplant

Is the member prescribed…?

- Medications linked ID, examples:
  - Prednisone 20mg x 14+ days
  - Humira
  - Methotrexate
  - Prograf
  - CellCept
  - Carboplatin



Does the member report…?

- Manifestations of ID
  - Recurrent infections of the mouth, eyes, respiratory and/or digestive tract
  - Frequent ear & skin infections
  - Recurrent fever
  - Severe bacterial infections
  - Systemic fungal infections
  - Infections w/ opportunistic pathogens
  - ≥ 3 bacterial infections per year each lasting > 4 weeks

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The rule of thumb in adults is that ≥ 3 bacterial infections per year each lasting over 4 weeks should prompt further investigation for ID because people with an immunodeficiency disorder tend to have one infection after another. Infections of the mouth, eyes, and digestive tract are common. Thrush, a fungal infection of the mouth, may be an early sign of an immunodeficiency disorder. Sores may form in the mouth. People may have chronic gum disease (gingivitis) and frequent ear and skin infections.

Assess the members medications, external causes and diagnoses to pick up on this diagnosis

Genitourinary System

- Chronic Kidney Disease



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Chronic Kidney Disease Staging

Need two GFRs ≥ 90 days apart

Stages of CKD	Description	eGFR (mL/min) (Lab test)
Stage 1	• 2 results of proteinuria 90+ days apart • Signs of mild kidney disease but with normal or better GFR	≥ 90
Stage 2	• 2 results of proteinuria 90+ days apart • Signs of mild kidney disease with reduced GFR	89 - 60
Stage 3a Moderate		2 results 90+ days apart: **45 - 59**
Stage 3b Moderate		2 results 90+ days apart: **30 - 44**
Stage 4 Severe		2 results 90+ days apart: **15 - 29**
Stage 5 End Stage		2 results 90+ days apart: **< 15**



Smart Logic Rule:

✓ Presence of two or more prepopulated GFRs ≥ 90 days apart will add the diagnosis of CKD with the corresponding stage

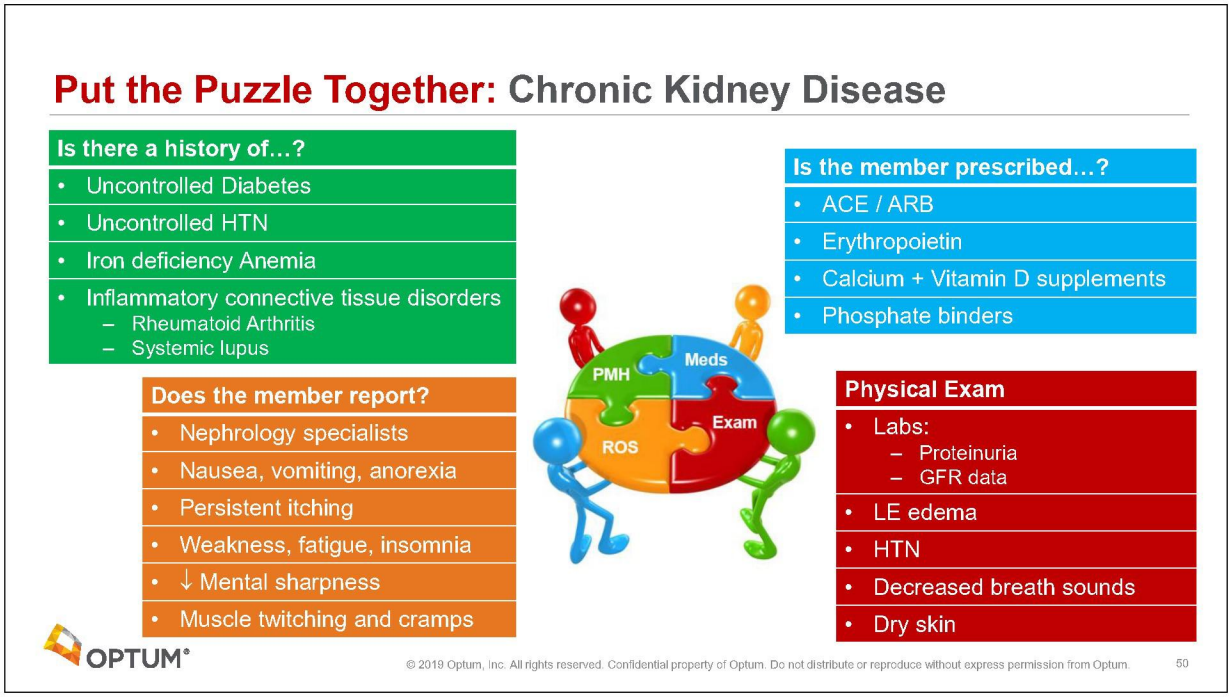
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CKD is a progressive loss of kidney function over a period of months or years. It is important to review the GFR and how this relates to kidney disease.
2009 Chronic Kidney Disease- Epidemiology Collaboration (CKD-EPI) Creatinine Calculator the best calculator according to the National Kidney Foundation. BUN is not as stable according to the literature.

The GFR determines the staging of the kidney disease. The tablet now provides us with the GFR values to assist us with diagnosing CKD. There is also a LearnSource on CKD that is great for review.

REVIEW GFR and staging and smart logic rules



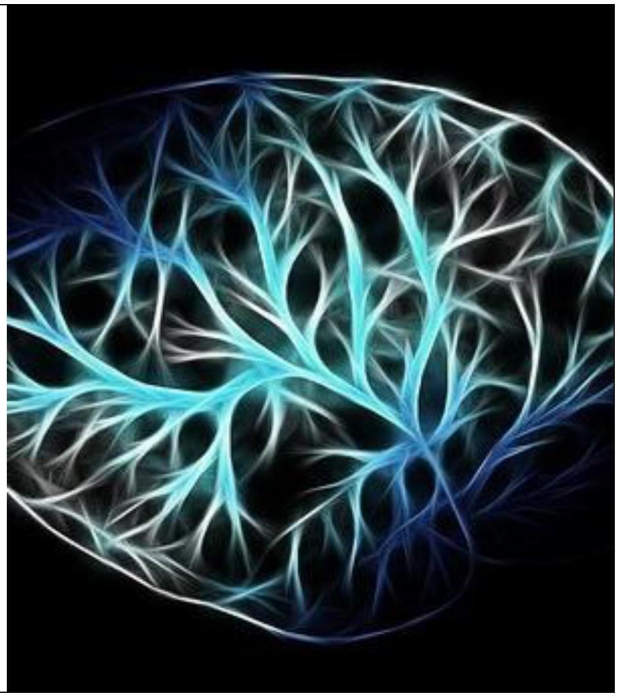
The most common recognized cause of CKD is Diabetes. Hypertension is also a very common cause of chronic kidney disease. Other causes of CKD include:

Read slide

Neurological System

- Dementia
- Polyneuropathy

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Put the Puzzle Together: Dementia

Is there a history of…?

- Advanced Age
- Atherosclerotic vascular disease
- CVA
- Diabetes
- Huntington's disease
- HIV
- Head trauma
- Down's Syndrome

Physical Exam

- Abnormal Mini-Cog exam
- Agitation
- Disorientation



Is the member prescribed…?

- Donepezil (Aricept)
- Rivastigmine (Exelon)
- Galantamine (Razadyne)
- Namenda (Memantine)

Does the member/ family report?

- Family history
- Memory loss/ misplacing things
- Depression / hallucinations
- Speech difficulties
- Difficulty performing familiar tasks
- Poor judgment
- Problems with abstract thinking
- Night agitation/ wandering/ pacing

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The greatest risk factor for the development of Alzheimer's disease or other dementias is increasing age. However there are other risk factors which play a critical role in the development of dementia such as genetics/family history. American Diabetes Association states that 3 in 4 older adults with diabetes will experience some form of dementia.

The signs and symptoms a member may exhibit during your visit, include cognitive issues such as memory loss, difficulty performing familiar tasks, language problems, disorientation, poor judgment, and/ or misplacing thing. Some members may display behavioral symptoms such as psychosis, aggression, agitation, wandering, pacing and delusions. It is important to know that members may exhibit cognitive symptoms, behavioral symptoms or both.

Donepezil (Aricept) is approved to treat all stages of Alzheimer's. Rivastigmine (Exelon) is approved to treat mild to moderate Alzheimer's. Galantamine (Razadyne) is approved to treat mild to moderate Alzheimer's.

Mini-Cog Dementia Screening

- Mini-Cog tool can identify cognitive impairment, but cannot diagnose Dementia
- An abnormal Mini-Cog exam warrants a recommendation for further screening for Dementia screening



Negative Dementia Screening



- Correctly recalls all 3 words

OR

- Recalls 1-2 words & CDT is normal

Positive Dementia Screening

- Recall score 0

OR

- Recalls 1-2 words & CDT is abnormal



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The mini-cog is insufficient to diagnose dementia, however cognitive impairment can be identified and recommendation for additional screening should be made when the mini-cog is abnormal.

A negative screening for dementia means that the minicog result was normal. A positive dementia screening means the minicog result was abnormal.

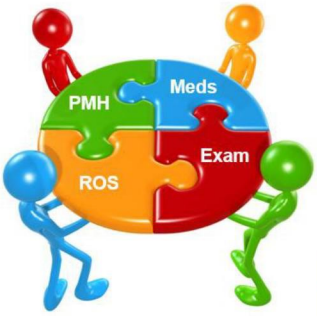
Put the Puzzle Together: Systemic Causes of Polyneuropathy

Is there a history of…?

- Diabetes
- Cancer w/ or w/o treatment
- Thyroid disorders
- Autoimmune disorders
- Vitamin deficiencies
- HIV

Does the member report?

- Neuropathic symptoms
- Dysphagia or gastroparesis
- Impaired balance/ coordination
- Urine or fecal incontinence



Is the member prescribed…?

- Meds to treat neuropathy:
  - Pregabalin
  - Duloxetine
  - Gabapentin
- Meds that cause neuropathy:
  - Amiodarone
  - Metronidazole
  - Fluoroquinolones
  - Chemotherapy agents
- B Vitamin supplements

Physical Exam

- Abnormal MNF, Achilles reflex and/or vibratory sensation
- Muscle weakness and/or wasting

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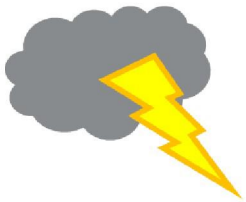
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Polyneuropathy - has a wide variety of causes, ranging from the common, such as diabetes mellitus, alcohol abuse, and HIV infection, to the rare, such as some unusual forms of Charcot-Marie-Tooth (CMT) disease. It also often occurs as a side effect of medication or as a manifestation of systemic disease.

REVIEW SLIDE

Smart Logic Rule: **Polyneuropathy**

✓Tablet will search for potential systemic etiologies for polyneuropathy.



Polyneuropathy due to etiology…
will populate within the Diagnosis Cart/ DCP/ Page 3

✓Consider the onset of neuropathic symptoms and the likelihood of those symptoms arising as a result of a particular condition

✓**Consider** the timing of the onset of symptoms. If the symptoms started before the diagnosis or use of a particular medication, the neuropathy is likely not related to that condition or medication. Consider another cause

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READ SLIDE

Metabolic Disorders

- Diabetes Mellitus



Put the Puzzle Together: Diabetes Mellitus Complications

Is there a history of…?

- Hyperlipidemia
- CKD/ ESRD/ Dialysis
- Uncontrolled blood glucose
- PVD
- Cataracts, retinopathy, glaucoma

Does the member report?

- Specialists
  - Nephrology
  - Ophthalmology
  - Cardiovascular
  - Podiatry
- Neuropathic symptoms



Is the member prescribed…?

- Meds to treat neuropathy
- Glaucoma medications
- Insulin therapy
- Medication non-adherence

Physical Exam

- Abnormal MNF, Achilles reflex and/or vibratory sensation
- Non-pressure ulcers
- Cataracts
- Urine protein
- Hyperglycemia: Hba1c > 7.0%, urine glucose, glucose >180 mg/dL
- Hypoglycemia: glucose <70 mg/dL

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As you are aware DM is the 7th leading cause of death in the US and a major contributor to heart disease and stroke. It is important to document to the highest level of specificity with appropriate complications.
Any of the following complications whose development or progress is impacted by the diabetes has the potential to impact the member's overall health.

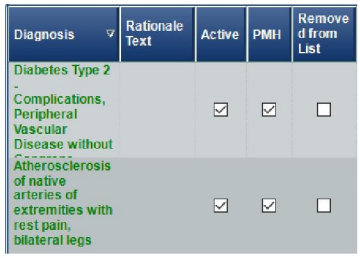
Diabetes Type 2 and Complications

- Ensure linkage of all complications to Diabetes.
- It is not appropriate to document the complication separately as this creates duplication.
- *Unless the condition can be documented with higher specificity (i. e. CKD with stage). See example below with Diabetes type 2 with complications – Peripheral Vascular Disease:

Remove *PVD, unspecified* from the list
Reason > Duplicate Diagnosis



Keep *Atherosclerosis…* diagnosis because it brings higher specificity to the type of PVD



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In ICD-10, the diagnoses of Diabetes and the complication are linked together. When selecting the complication, it is not appropriate to also code the complication separately. Unless it can be documented with higher specificity such as in the case of CKD where it is also coded separately

Here is another example where we would code the separate diagnoses.

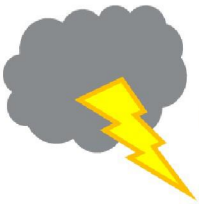
REVIEW DM with PVD example

Smart Logic Rule: **Diabetes Type 2 and Complications**

✓Documentation of any Diabetes type 1 or 2 diagnosis

AND

✓A potential complication of Diabetes



Diabetes type 1 or 2 with complications…
will populate within the Diagnosis Cart/ DCP/ Page 3

*If Diabetes 1 or 2 without complications was active, this will go to the PMH list in preference of the more accurate with complication diagnosis

Active and PMH List

Diagnosis	Rationale Text	Active	PMH	Removed from List
Chronic Kidney Disease - Stage 3, Stage 3 Unspecified		☑	☑	☐
Diabetes Type 2 - Complications, Cataracts	Selected by Rules	☐	☐	☐
Diabetes Type 2 - Complications, Chronic Kidney Disease	Selected by Rules	☐	☐	☐
Diabetes Type 2 - With hyperglycemia		☑	☑	☐

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REVIEW SLIDE

Pulmonary System

- Chronic Obstructive Pulmonary Disease (COPD)
- Respiratory Failure

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Put the Puzzle Together: COPD

Is there a history of…?

- Chronic bronchitis
- (Chronic obstructive) Asthma
- Emphysema
- Non-specific lung disease
- History of childhood resp illness

Is the member prescribed…?

- Inhalers
- Nebulizers
- Surfactants
- Oxygen



Does the member report?

- >15 pack year smoking history
- Exposure to 2nd hand smoke
- Chronic cough
- Sputum production
- Dyspnea
- Wheezing
- Spirometry/ Pulmonary function tests

Physical Exam

- Barrel Chest
- Diminished lung sounds
- Pursed lip breathing

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Cigarette smoking is the most important risk factor for COPD. But typically if a member has a less than 10-15 pack history, in the absence of other environmental exposures, they are unlikely to have a diagnosis of COPD.
However, the single best variable for predicting those individuals who will develop COPD have a history of 40 pack years of smoking.

When diagnosing COPD use the PMH, SH, ROS Meds and PE- Read slide

Smart Logic Rule: COPD

- ✓Documentation of active medication indicated for the treatment of COPD, i.e.
  - ✓Spiriva
  - ✓Symbicort
  - ✓Combivent

Active				
Y	N	Medication-Dose	Quantity	Frequency
☑	☐	Spiriva Respimat Inhalation Aerosol Solution 1.25 MCG/ACT	1 puff	QD



Chronic Obstructive Pulmonary Disease will populate within the Diagnosis Cart/ DCP/ Page 3

Active and PMH List

Diagnosis	Rationale Text	Active	PMH	Removed from List
Chronic obstructive pulmonary disease, unspecified	Selected by Rules	☐	☐	☐

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READ SLIDE

Put the Puzzle Together: Respiratory Failure

Hypoxemia caused by conditions that affect the interstitial and alveolar walls of the lungs

Is there a history of interstitial or alveolar lung disease?

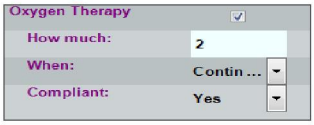
- COPD
- Pulmonary emboli
- Asthma
- Sleep apnea
- Pulmonary HTN
- Cor pulmonale



Smart Logic Rule - Documentation of…

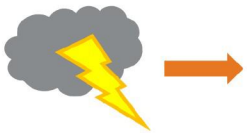
✓ The diagnosis *Long-term use of oxygen* **OR**

✓ Oxygen therapy in the ROS



Is the member prescribed…?

- Oxygen



Respiratory Failure will populate within the Diagnosis Cart/ DCP/ Page 3

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Respiratory Failure (RF) results from a decrease in oxygen being available or processed in the body and organs and/or from a condition that limits the removal of carbon dioxide from the blood. The use of home O2 is an indication of RF, however the Hypoxemia must be caused by conditions that affect the interstitial and alveolar walls of the lungs such as READ SLIDE

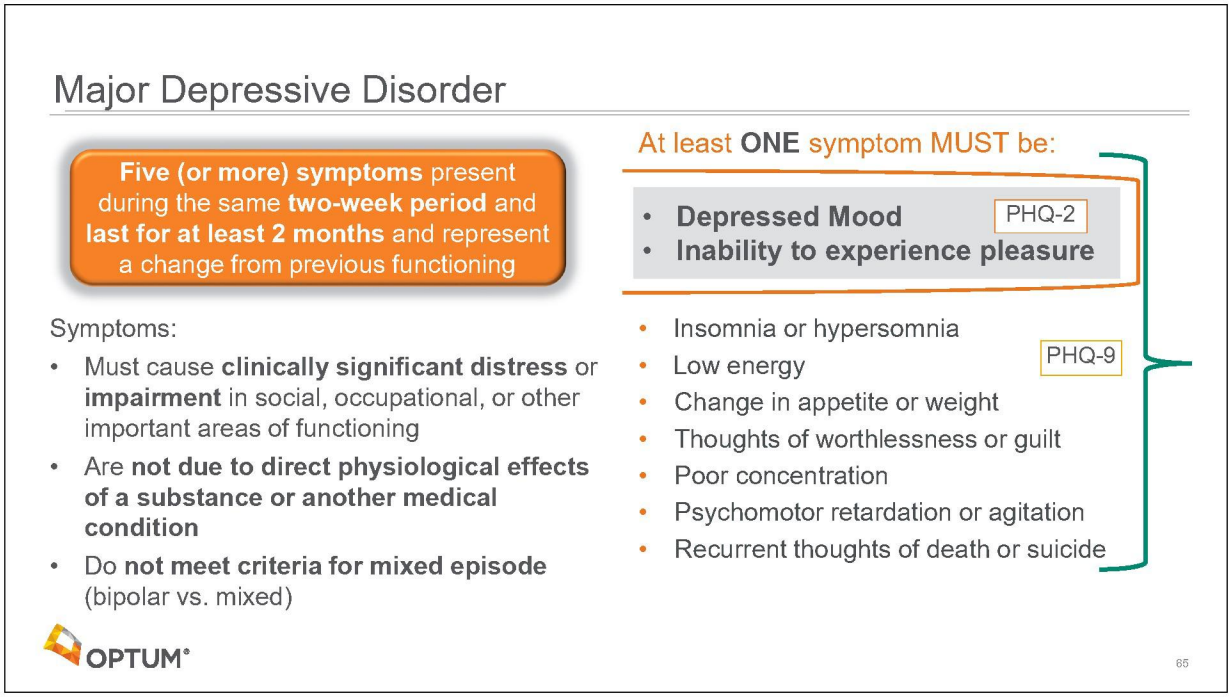
REVIEW SMART LOGIC RULE

Psychological System

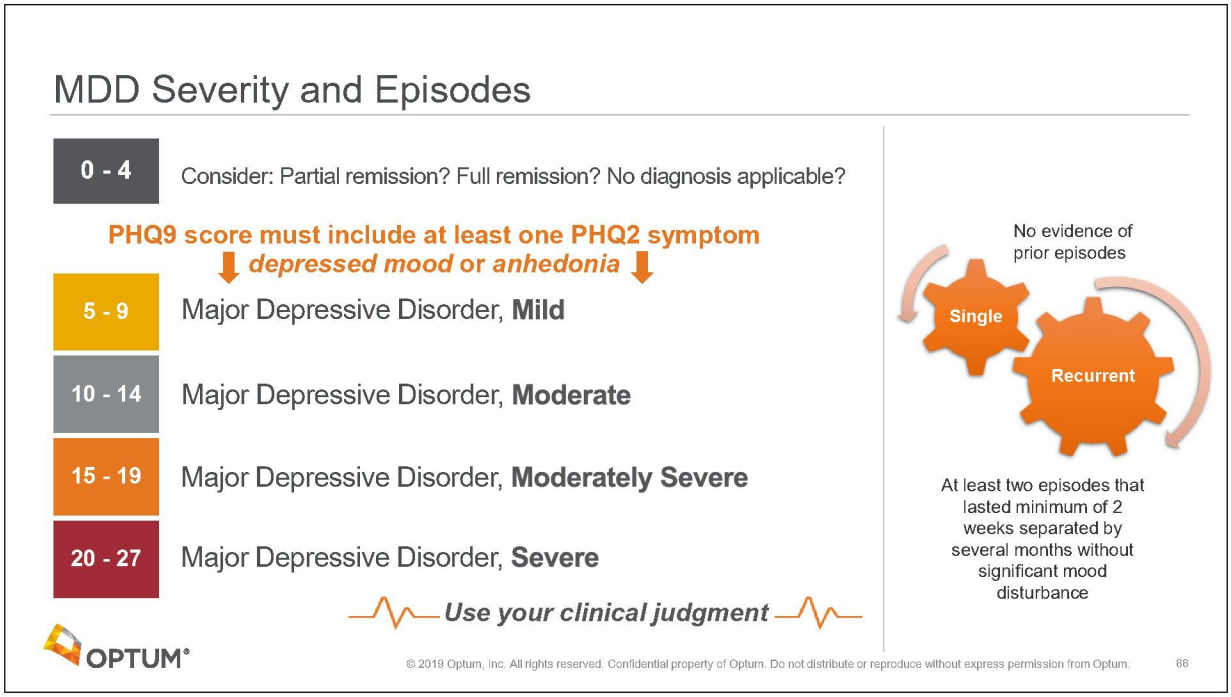
- Major Depressive Disorder
- Substance Abuse

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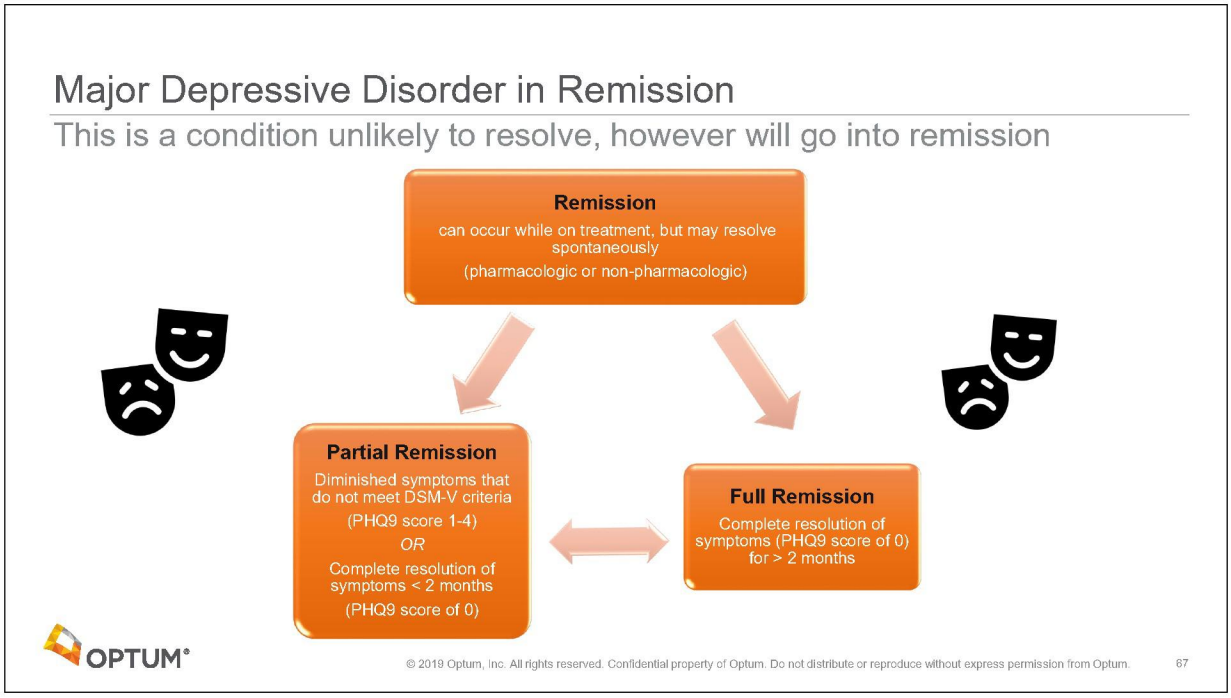
MDD is the most common psychiatric disorder in the general population. MDD is also a dx that is missed 50% of the time by non-psychiatric providers so we must be attuned to capturing this diagnosis. Listed here are the DSM V symptom criteria for the diagnosis of MDD. Once all of the PSY tool questions are answered, the tablet will calculate a PHQ9 score. However, there is more to consider when diagnosing MDD than just the PHQ9 score. The first 2 symptoms are the PHQ-2 questions on page 10 in the ROS in eHousecalls. They are also the top 2 questions within the PHQ9 depression screening PSY tool. In order for a person to be diagnosed with non-remission types of MDD, they must report the presence of at least one PHQ2 symptom, depressed mood or anhedonia. This can become rather complex because at times our members may report the presence of other symptoms and the tablet will still calculate a PHQ9 score of 5 or greater. But remember that if they do not indicate the PHQ2 symptoms, the diagnosis of non-remission types of MDD is not applicable to them. In a case like this, there may be other conditions contributing to their symptomology and using our clinical judgement will help distinguish other etiologies. We cannot diagnose depression if the member is not depressed. So, this tool can only be used correctly in conjunction with your clinical decision-making ability. Also note that there will be instances where completion of the PSY tool may be required based on tablet logic.



Once a diagnosis is derived, the episode of either Single or Recurrent must be included, and then documented either Severity as mild moderate severe or in remission. The PHQ9 score will determine the severity of MDD. Now to help differentiate Single verses Recurrent, you need to ask a few probing questions about the member's depression:
Have they had depression before? If so, when and how long did it last?

A member with no prior episodes with have MDD single episode.
A member with at least 2 prior episodes that lasted a minimum of 2 weeks separated by several months without significant mood disturbance would have MDD recurrent.

PHQ9 scores between 0-4 (less than 5) can indicate remission or that no diagnosis of depression is applicable. Use your clinical judgement



If symptoms are partially or completely resolved, you can identify MDD single or recurrent with remission status. These patients are still considered to have MDD but are improved with treatment and in remission due to treatment. Treatment can be with or with out medication and can include lifestyle changes (i.e. exercise, ECT, music therapy, art therapy).

Full remission is defined as complete symptom resolution for > 2 months.
Partial remission is defined as diminished symptoms such as didn't meet the DSM V criteria (PHQ2/9 questions) OR complete resolution of symptoms < 2 months.

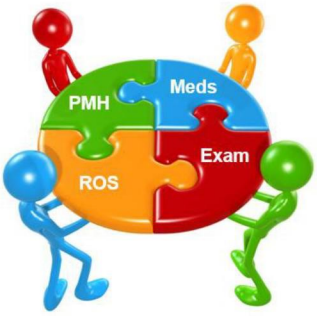
You can use some probing questions to help you decide that include:
"I see you are on Celexa, was that for depression?"
"How long have you been on this medication?"
"Has your depression/symptoms resolved since being on the medication? If so, how long have those symptoms been gone?"

Put the Puzzle Together: Major Depressive Disorder

Does the member report?
- PHQ-9 symptoms
- Single or recurrent episodes

Physical Exam
- Depressed, crying, tearful
- Flat affect

Is there a history of…?
- Previous depression episodes
- Manic or hypomanic episodes*



Is the member prescribed…?
- Selective serotonin reuptake inhibitors
  - Sertraline (Zoloft)
  - Vortioxetine (Trintellix)
- Serotonin-norepinephrine reuptake inhibitors
  - Duloxetine (Cymbalta)
  - Desvenlafaxine (Pristiq)
- Bupropion (Wellbutrin)
- Tricyclic antidepressants
- Mirtazapine (Remeron)
- Trazodone (Desyrel)

***Individuals with Major depressive disorder only do not have manic episodes**

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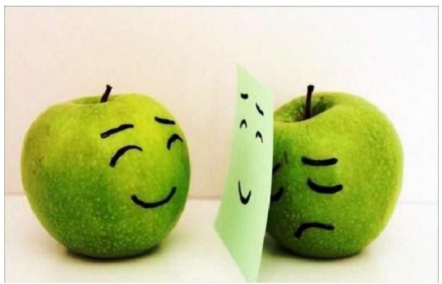
REVIEW SLIDE

PMH and Resolved? Or In Remission?

Psychiatric & Alcohol and Drug Abuse diagnoses

- Many chronic conditions remain with a person for the rest of their life.
- These conditions never truly resolve, however may compensate with treatment or go into remission
- **Many psychiatric** and **all alcohol and drug abuse** diagnoses have a high rate of recurrence or relapse which is clinically significant and impacts future health care
- Utilize the remission status and support the diagnosis with evidence





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Smart Logic Rule: **Substance Abuse**

✓ Documentation of drug abuse in Social History

Drug Use	☑ Current ☐ Former ☐ Never



Active and PMH List

Diagnosis	Rationale Text	Active	PMH	Removed from
Substance abuse	Selected by Rules	☐	☐	☐

Select the most specific diagnosis in the tablet based on your assessment findings and remove the diagnosis of 'Substance abuse' if prepopulated by tablet logic and select the associated substance if known.

Search diagnoses by name:

SUBST

- Alcohol dependence with intoxication, uncomplicated
- Alcohol dependence with intoxication, unspecified
- Alcohol dependence, in remission
- Cannabis abuse with cannabis-induced anxiety disorder
- Cannabis abuse with intoxication delirium
- Cannabis abuse with intoxication with perceptual disturbance
- Cannabis abuse with intoxication, uncomplicated
- Cannabis abuse with intoxication, unspecified
- Cannabis abuse with other cannabis-induced disorder

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Piece it Together

Case Study: John Doe

*Place responses in the Chat



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Now that we have review these diagnoses, lets test your knowledge with a case study. We will follow the scenario of John Doe through 5 questions regarding his diagnoses. Please place your responses in the chat and we will review the answers after each question

John Doe, 70-year-old male



What are the PMH (resolved) diagnoses?

PMH: Shingles in 2016, bilateral cataract extraction, atrial fib, heart failure, HTN, PVD, hyperlipidemia, CABG w/stents, Type 2 Diabetes, thyroidectomy in 1998 r/t cancer, left lung transplant, depression since 2 years ago and at age 40, hospitalized for pneumonia 3 months ago, sober from alcohol x 31 years, Lupus, sciatica

Medications: Claritin, ASA, Plavix, Lasix, 2L Oxygen, metoprolol, Prilosec, simvastatin, Lantus, Empagliflozin, vitamin B12, levothyroxine, CellCept, amiodarone, amitriptyline

ROS: Cough, SOB with moderate activity, 2L of O_2 continuous, leg pain with walking relieved with rest, PHQ9 score of 3 (PHQ2 score 0), CPap

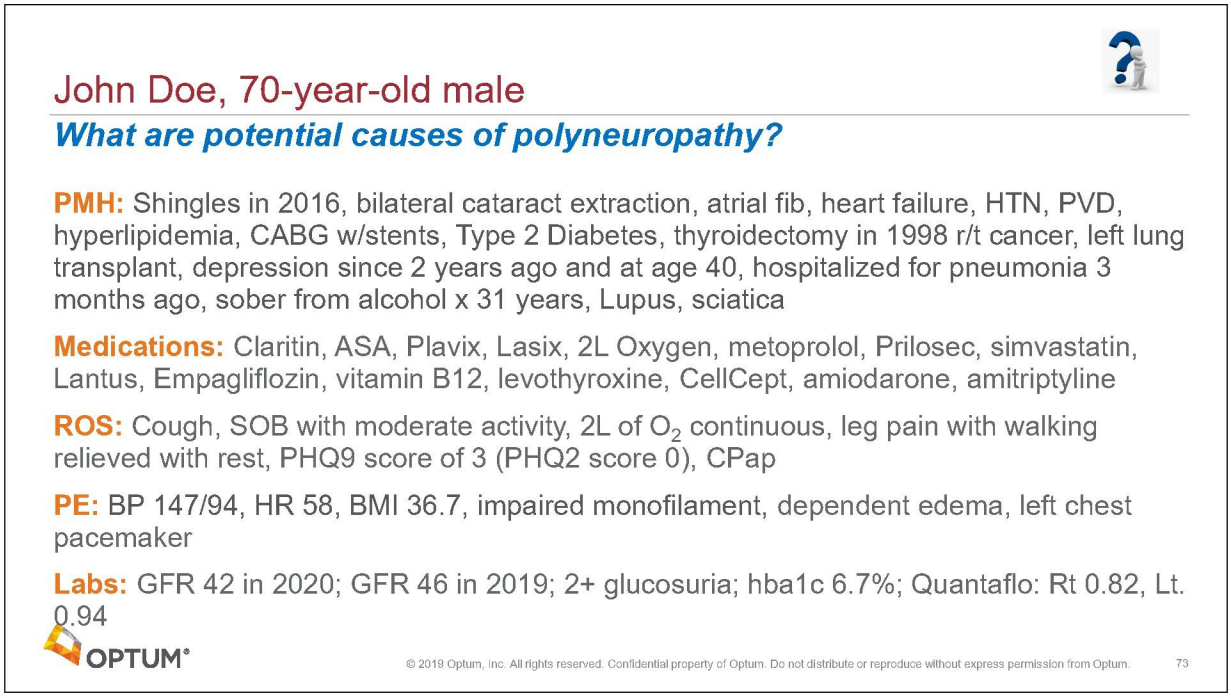
PE: BP 147/94, HR 58, BMI 36.7, impaired monofilament, dependent edema, left chest pacemaker

Labs: GFR 42 in 2020; GFR 46 in 2019; 2+ glucosuria; hba1c 6.7%; Quantaflo: Rt 0.82, Lt. 0.94

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What are the PMH diagnoses?:
Shingles
Pneumonia
DM with cataracts (since they were removed)



What are potential causes of polyneuropathy?
Polyneuropathy must be caused by a systemic etiology
-due to vitamin b12 deficiency
-due to diabetes
-due to hypothyroidism
-due to drugs (amiodarone)
-due to Lupus
-due to cancer of the thyroid

NOT SCIATICA. This is a mononeuropathy due to nerve entrapment and not a systemic cause

John Doe, 70-year-old male



What are the potential causes of Immunodeficiency?

PMH: Shingles in 2016, bilateral cataract extraction, atrial fib, heart failure, HTN, PVD, hyperlipidemia, CABG w/stents, Type 2 Diabetes, thyroidectomy in 1998 r/t cancer, left lung transplant, depression since 2 years ago and at age 40, hospitalized for pneumonia 3 months ago, sober from alcohol x 31 years, Lupus, sciatica

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ID due to condition – Lupus
ID due to external cause- transplant (lung)
ID due to drugs – Cellcept (anti-rejection drug)

John Doe, 70-year-old male



What are the Diabetic complications?

PMH: Shingles in 2016, bilateral cataract extraction, atrial fib, heart failure, HTN, PVD, hyperlipidemia, CABG w/stents, Type 2 Diabetes, thyroidectomy in 1998 r/t cancer, left lung transplant, depression since 2 years ago and at age 40, hospitalized for pneumonia 3 months ago, sober from alcohol x 31 years, Lupus, sciatica

Medications: Claritin, ASA, Plavix, Lasix, 2L Oxygen, metoprolol, Prilosec, simvastatin, Lantus, Empagliflozin, vitamin B12, levothyroxine, CellCept, amiodarone, amitriptyline

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Polyneuropathy
CKD
PVD
Hyperlipidemia
Chronic insulin therapy

Not DM2 with hyperglycemia. Hba1c is normal. 2+ glucose is due to empagliflozin (Jardiance). This is an SGLT2 inhibitor and the mechanism of action is excreting glucose through the kidney. This is an expected finding on this medication

John Doe, 70-year-old male



What are the active diagnoses for the Cardiovascular system?

PMH: Shingles in 2016, bilateral cataract extraction, atrial fib, heart failure, HTN, PVD, hyperlipidemia, CABG w/stents, Type 2 Diabetes, thyroidectomy in 1998 r/t cancer, left lung transplant, depression since 2 years ago and at age 40, hospitalized for pneumonia 3 months ago, sober from alcohol x 31 years, Lupus, sciatica

Medications: Claritin, ASA, Plavix, Lasix, 2L Oxygen, metoprolol, Prilosec, simvastatin, Lantus, Empagliflozin, vitamin B12, levothyroxine, CellCept, amiodarone, amitriptyline

ROS: Cough, SOB with moderate activity, 2L of O_2 continuous, leg pain with walking relieved with rest, PHQ9 score of 3 (PHQ2 score 0), CPap

PE: BP 147/94, HR 58, BMI 36.7, impaired monofilament, dependent edema, left chest pacemaker

Labs: GFR 42 in 2020; GFR 46 in 2019; 2+ glucosuria; hba1c 6.7%; Quantaflo: Rt 0.82, Lt. 0.94

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-Atrial fibrillation
-Other thrombophilia (chadvasc points for HTN, HF, age. Does not need to be on an anticoagulant)
-Heart failure
-Secondary hyperaldosteronism
-HTN
-Presence of a cardia pacemaker
-atherosclerosis of native coronary arteries
-personal history of thyroid cancer
-PVD/ Atherosclerosis of bilateral LE with intermittent claudication

MEDS:
-chronic aspirin therapy
-antiplatelet therapy

John Doe, 70-year-old male



What are the active diagnoses related to Psych/ Mental Health?

PMH: Shingles in 2016, bilateral cataract extraction, atrial fib, heart failure, HTN, PVD, hyperlipidemia, CABG w/stents, Type 2 Diabetes, thyroidectomy in 1998 r/t cancer, left lung transplant, depression since 2 years ago and at age 40, hospitalized for pneumonia 3 months ago, sober from alcohol x 31 years, Lupus, sciatica

Medications: Claritin, ASA, Plavix, Lasix, 2L Oxygen, metoprolol, Prilosec, simvastatin, Lantus, Empagliflozin, vitamin B12, levothyroxine, CellCept, amiodarone, amitriptyline

ROS: Cough, SOB with moderate activity, 2L of O_2 continuous, leg pain with walking relieved with rest, PHQ9 score of 3 (PHQ2 score 0), CPap

PE: BP 147/94, HR 58, BMI 36.7, impaired monofilament, dependent edema, left chest pacemaker

Labs: GFR 42 in 2020; GFR 46 in 2019; 2+ glucosuria; hba1c 6.7%; Quantaflo: Rt 0.82, Lt. 0.94

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-MDD in partial remission, recurrent
-alcohol dependence in remission

John Doe, 70-year-old male



What are the remaining active diagnoses?

PMH: Shingles in 2016, bilateral cataract extraction, atrial fib, heart failure, HTN, PVD, hyperlipidemia, CABG w/stents, Type 2 Diabetes, thyroidectomy in 1998 r/t cancer, left lung transplant, depression since 2 years ago and at age 40, hospitalized for pneumonia 3 months ago, sober from alcohol x 31 years, Lupus, sciatica

Medications: Claritin, ASA, Plavix, Lasix, 2L Oxygen, metoprolol, Prilosec, simvastatin, Lantus, Empagliflozin, vitamin B12, levothyroxine, CellCept, amiodarone, amitriptyline

ROS: Cough, SOB with moderate activity, 2L of O_2 continuous, leg pain with walking relieved with rest, PHQ9 score of 3 (PHQ2 score 0), CPap

PE: BP 147/94, HR 58, BMI 36.7, impaired monofilament, dependent edema, left chest pacemaker

Labs: GFR 42 in 2020; GFR 46 in 2019; 2+ glucosuria; hba1c 6.7%; Quantaflo: Rt 0.82, Lt. 0.94

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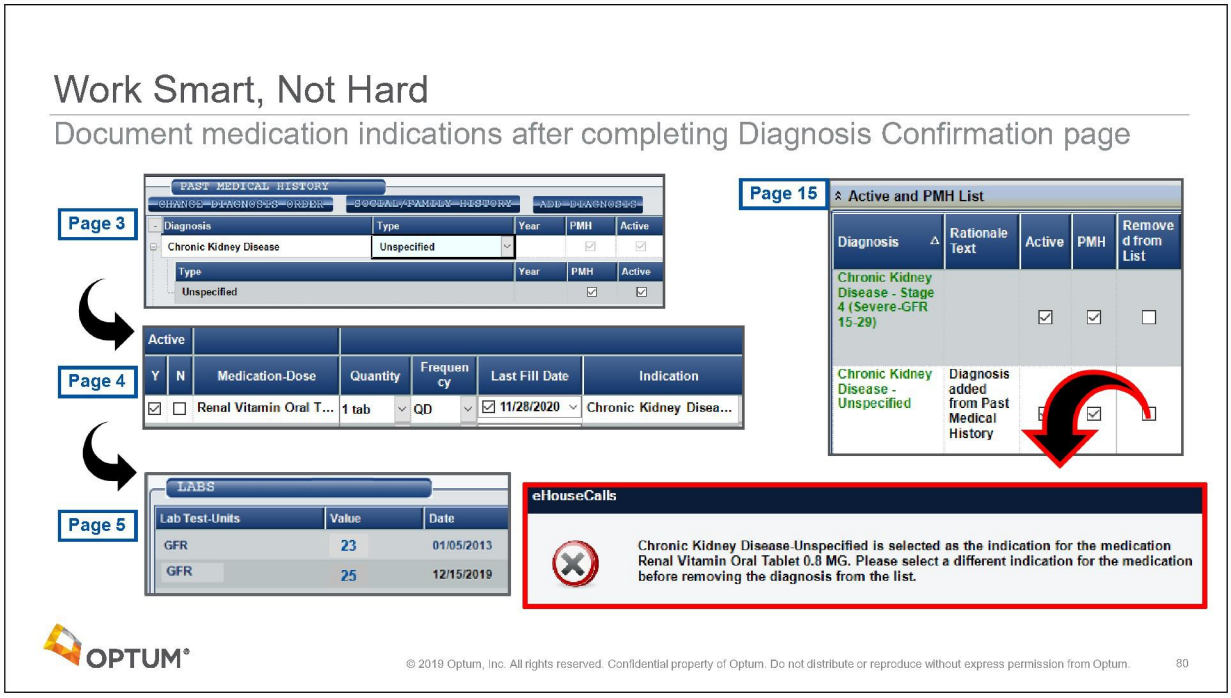
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-Cataracts removed
-respiratory failure
-allergic rhinitis
-vitamin b12 deficiency
-GERD
-long term use of oxygen
-Sleep apnea
-personal history of thyroid cancer
-Post-surgical/ postprocedural hypothyroidism
-CKD, stage 3 unspecified (GFR 42 is stage 3b; GFR 46 is stage 3a)

Best Practices for Documentation

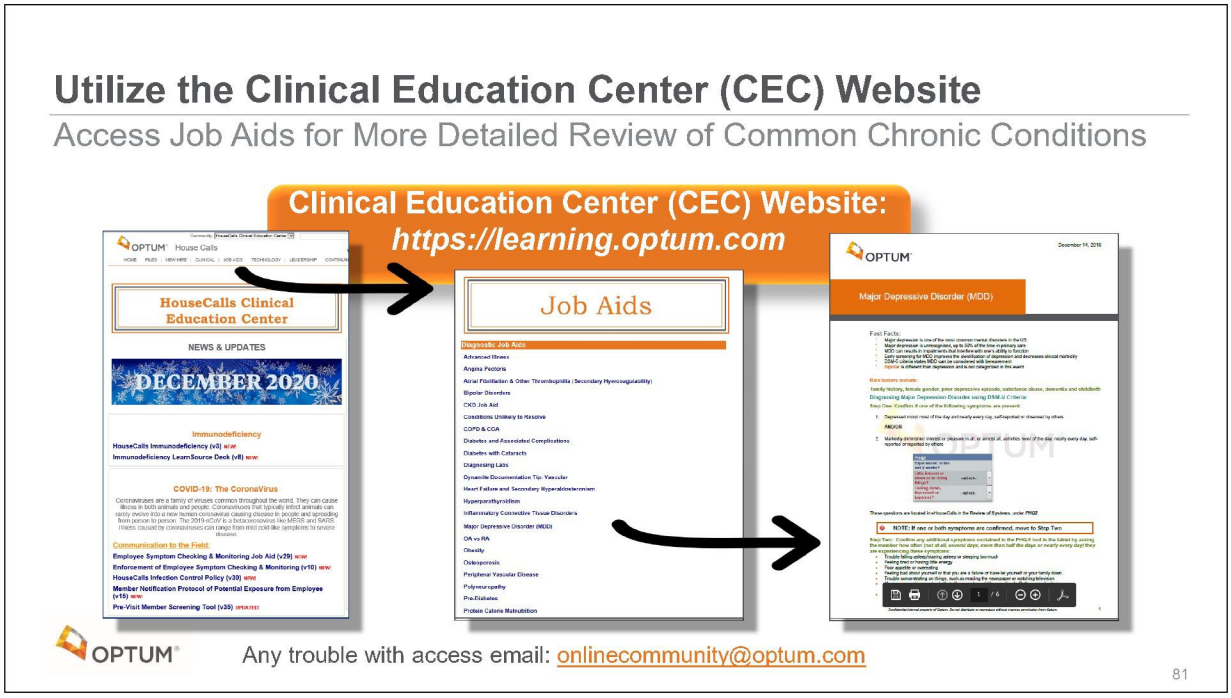


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You will find this suggestion to be extremely helpful as you move thru the assessment. We recommend to document medications on page 4, but do not link indications to them until you have finished the diagnosis confirmation page. At page 4 you have only just begun to meet the member and have not completed a large portion of the assessment which might impact your decision-making. Consider this example...

On page 3, you are documenting the members PMH and they report an unspecified stage of CKD which you document.
When documenting the medications on page 4, you link their renal vitamin to the diagnosis CKD unspecified.
Then on page 5 you notice the member has 2 GFRs indicative of stage 4 CKD. So you add this to the diagnosis cart.
When you arrive on the diagnosis confirmation page, you want to remove the CKD unspecified diagnosis in preference of the more specific CKD stage 4 diagnosis, but when you select remove from list, an alert message arrives that you cannot remove CKD unspecified because you selected it an indication for the renal vitamin. Now you must go back to page 4 unlink the unspecified diagnosis, then select the med indication as CKD stage 4. then go back to page 15 and remove the unspecified CKD from the list.
In order to work smart and no hard, clean up your diagnosis list on page 15 first, and then go back to page 4 to link the med indications



A more thorough and detailed review of all the conditions we reviewed today is available o the CEC website in individual job aids.

REVIEW SLIDE



Thank you for making our members healthier and the healthcare system work better for everyone!

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Raise your hand for any questions


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Disease Specific Training

Heart Failure and Atherosclerotic Heart Disease

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Objectives

- Review Heart Failure (HF) and Coronary Arterial Disease (CAD)
- Diagnosing HF and CAD during a HouseCalls Visit
- Describe Medicare Advantage Review
- Provide overview of HEDIS & Stars and how these are related to HF and CAD
- Discuss standards of care in the treatment of HF and CAD
- Review Member Education for HF and CAD

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Purpose of Disease Specific Training

Identify HF and CAD as a diagnoses:

- Documenting the diagnoses affects the overall care of the member
- Successful closure of gaps in care
- Overall better management of chronic conditions like HF and CAD



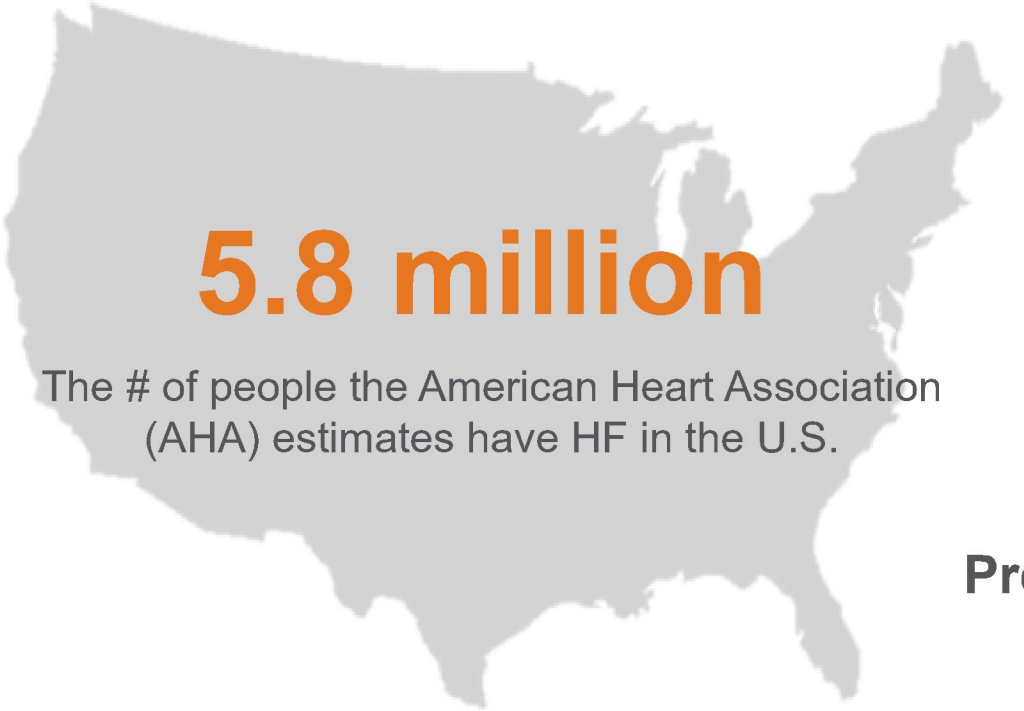
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Prevalence of Heart Failure

According to Framingham Heart Study the prevalence of HF is:



5.8 million

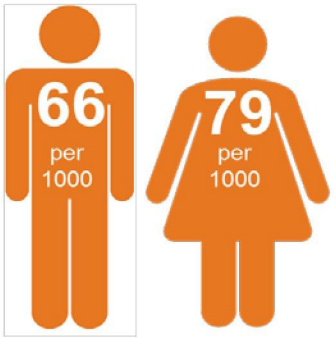
The # of people the American Heart Association (AHA) estimates have HF in the U.S.

8

per 1000

At age 50 to 59 years

Prevalence at Ages 80-89 Years



The prevalence in African-Americans is reported to be **25 percent higher** than in white people.

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Heart Failure



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Fast Facts: Heart Failure (HF)

- An estimated 23 million people with heart failure worldwide
- An update from the American Heart Association (AHA) estimated that HF has increased from 5.7 to 6.5 million and the prevalence will increase by 46% from 2012 to 2030 resulting in more than 8 million people with HF in the United States
- 1 million hospital admissions annually
- The prevalence of HF and left ventricular (LV) dysfunction increases steeply with age
- The Framingham Heart Study found HF in 8 per 1000 men age 50 to 59 years, increasing to 66 per 1000 at ages 80 to 89 years; similar values (8 and 79 per 1000) were noted in women
- The prevalence in African-Americans is reported to be 25 percent higher than in Caucasians

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Heart Failure Definition

Complex clinical syndrome:

- Structural or functional cardiac disorder that impairs the ability of the heart to provide sufficient output to meet the perfusion and oxygenation requirements of the tissues while maintaining normal filling pressures
- It is characterized by specific symptoms, such as dyspnea and fatigue, and signs, such as those related to fluid retention
- There is no specific diagnostic test for HF (Measures of LV function (ie: echo) are helpful if available
- Clinical diagnosis that is based upon a careful history and physical examination

American Heart Association (n.d), Borlaug, B. (2016)

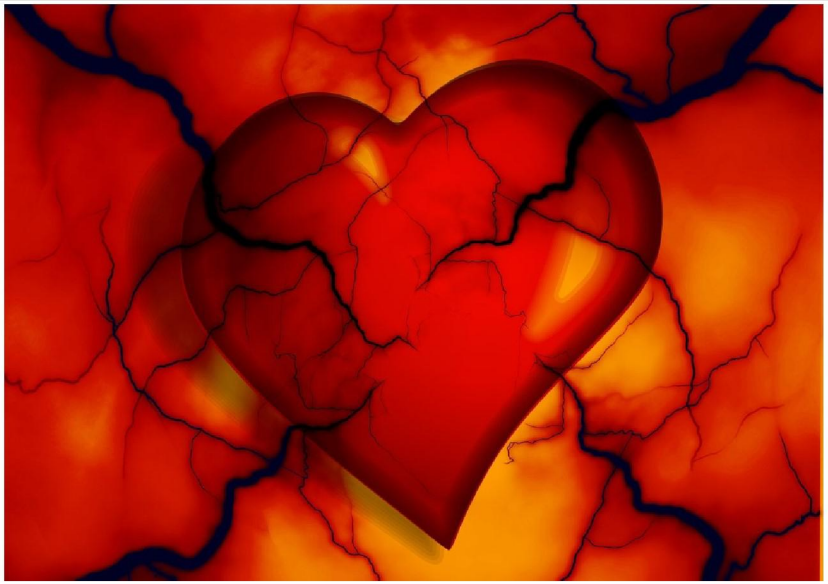
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Definition

Two Major Mechanisms How Heart Failure Can Occur



Systolic dysfunction –

- impaired cardiac contractile function

Heart Failure with Reduced LV Ejection Fraction (HF-REF)

Diastolic dysfunction –

- abnormal cardiac relaxation, stiffness or filling

Heart Failure with Preserved LV Ejection Fraction (HF-PEF)

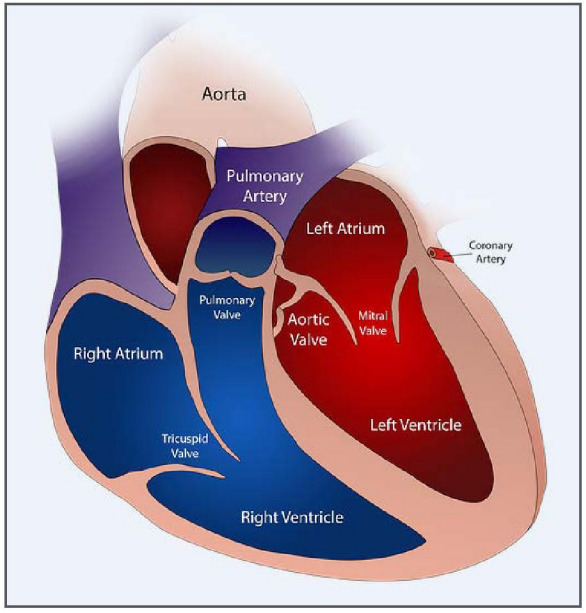
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Heart Failure Risk Factors

- Hypertension with and without left ventricular hypertrophy (LVH)
- Coronary disease, particularly myocardial infarction (MI)
- Diabetes mellitus
- Valvular Heart Disease
- Kidney disease
- Obesity
- Cigarette Smoking



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The Framingham Heart Study

- The prevalence of coronary disease as a cause of heart failure
- Increased 41 percent per calendar decade in men and 25 percent in women
- Diabetes increased by more than 20 percent per decade



Framingham Heart Study

The Framingham Heart Study is a project of the National Heart, Lung, & Blood Institute & Boston University.

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Stages of Heart Failure

The American College of Cardiology (ACC) and American Heart Association (AHA) have developed a classification of heart failure based on stages of the syndrome.

Stage	Description
A: High risk for developing heart failure	Hypertension, diabetes mellitus, CAD, family history of cardiomyopathy
B: Asymptomatic heart failure	Previous MI, LV dysfunction, valvular heart disease
C: Symptomatic heart failure	Structural heart disease, dyspnea and fatigue, impaired exercise tolerance
D: Refractory end-stage heart failure	Marked symptoms at rest despite maximal medical therapy

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Heart Failure Stages by Symptoms

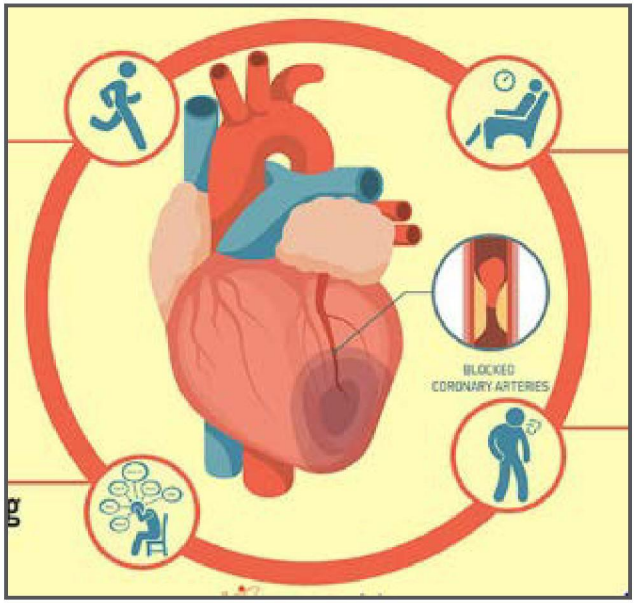
Stage A

Breathlessness or tiredness (with brisk walk, a jog or taking flights of stairs)

Stage B

Comfortable when resting

Heart races or breathlessness when walking a block or taking the stairs



Stage C

Palpitation or tiredness with simple tasks like getting up from the sofa and walking over to the kitchen

Stage D

Heart and breath go faster even at rest.

Tiredness even while sitting.

Anxiety and palpitations almost all the time

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Heart Failure Diagnosis: The Framingham Criteria

The Framingham Criteria is a validated tool used for the diagnosing of heart failure.

It consists of identifying the concurrent presence of either

2 Major criteria *or* 1 Major and 2 Minor criteria

While not all of the criteria are identifiable during a HouseCalls visit, a large number can be documented.

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Heart Failure: Using the Framingham Criteria

Major criteria include the following:

- Paroxysmal nocturnal dyspnea
- Weight loss of 4.5 kg in 5 days in response to treatment
- Neck vein distention
- Rales
- Acute pulmonary edema
- S_3 gallop

Minor criteria are as follows:

- Nocturnal cough
- Dyspnea on ordinary exertion
- Tachycardia (rate of 120 bpm)
- Bilateral ankle edema

If you can identify either 2 Major *or* 1 Major and 2 Minor elements of the criteria that are present concurrently, then you can diagnosis HF in the home

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Diagnosing Heart Failure during a HCV

Past Medical History

- Systolic hypertension with and without left ventricular hypertrophy (LVH)
- Coronary Heart Disease (Myocardial Infarction)
- Valvular Heart Disease
- Diabetes
- Kidney disease
- Obesity
- Cigarette Smoking

Medications

- Angiotensin-Converting Enzyme Inhibitors
- Angiotensin Receptor Blockers
- Beta Blockers
- Digoxin
- Diuretics
- Aldosterone Antagonists
- Hydralazine and Nitrates

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Diagnosing Heart Failure during a HCV

Review of Systems

- Fatigue and weakness
- Dyspnea on ordinary exertion
- LE edema
- Nocturnal cough
- Sleep disorders
- Decreased mental sharpness

Physical Exam

- LE edema
- Abdominal distention
- Rales
- Neck vein distention
- Resting sinus tachycardia
- Narrow pulse pressure
- Irregularly irregular pulse
- Presence of a S3 or S4 gallop

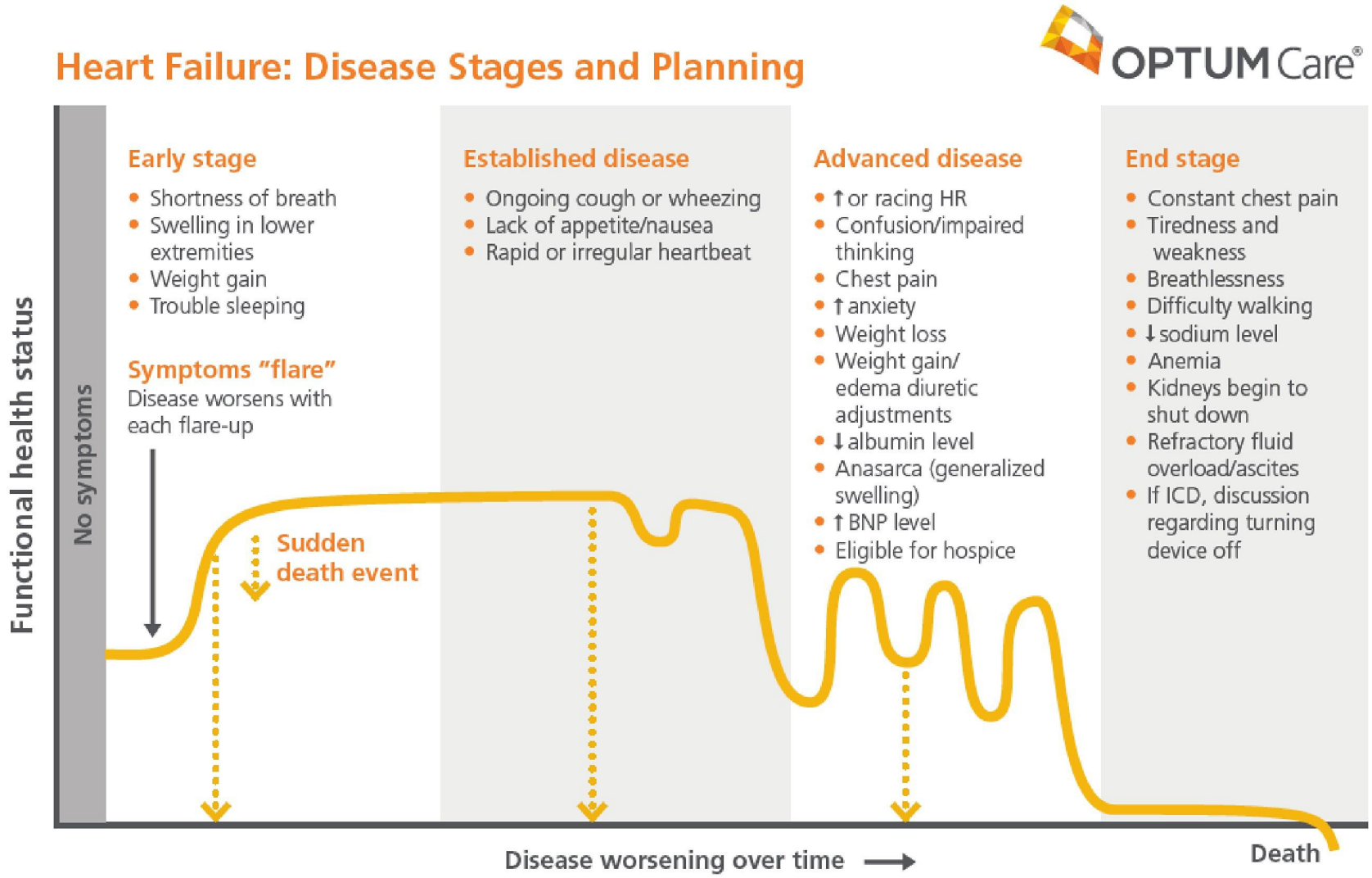
American Heart Association (n.d.) Diagnosing Heart Failure Retrieved 3/19/2018 from: http://www.heart.org/HEARTORG/Conditions/HeartFailure/DiagnosingHeartFailure/Diagnosing-Heart-Failure_UCM_002047_Article.jsp#.Wst6cJXD_cs

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Heart Failure Trajectory



Adapted from HF Disease Trajectory by UnitedHealthcare & Goodlin. JAM Coll Cardiol. 2009; 54(5)

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Secondary Hyperaldosteronism

Secondary Hyperaldosteronism

The excessive production of aldosterone caused by an extra-adrenal disorder, such as heart failure, cirrhosis.

Practical Diagnosis

While secondary hyperaldosteronism is very common in many disorders, one can assume the diagnosis in persons with cirrhosis, or CHF in whom there is significant edema, or ascites.

In fact, this is why spironolactone is indicated for treatment of stage D, class III-IV HF patients. In this edematous state patients are considered to have secondary hyperaldosteronism.

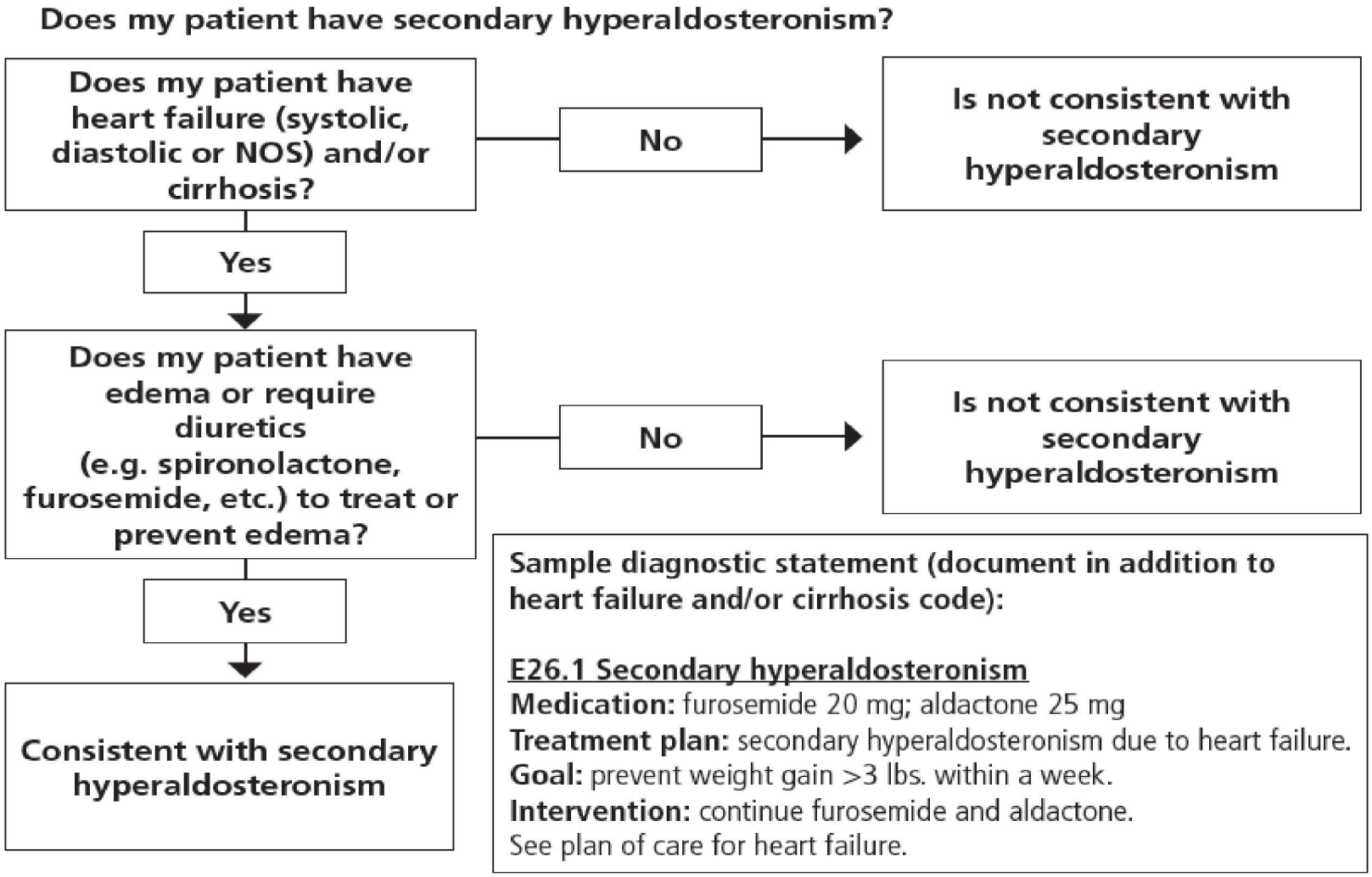


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Secondary Hyperaldosteronism



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Atherosclerotic Artery Disease



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Fast Facts: Coronary Artery Disease (CAD)

- Heart disease is the **leading cause** of death for both men and women in the U.S
- **630,000 Americans** die from heart disease each year—that's **1 in every 4 deaths**
- Coronary heart disease is the most common type of heart disease, killing about **366,000 people** in 2015
- In the United States, someone has a heart attack **every 40 seconds**
- **Each minute**, more than one person in the U.S. dies from a heart disease-related event
- Heart disease is the **leading cause** of death for people in most racial/ethnic groups in the United States
- Heart disease costs the United States about **$200 billion** each year. This total includes the cost of health care services, medications, and lost productivity

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Risk Factors- Coronary Artery Disease

- Men greater than Women
- Increasing age
- Family History
- Uncontrolled hypertension
- High blood cholesterol
- Metabolic syndrome, such as diabetes type II
- Obesity
- Lack of exercise and poor diet, including consumption of processed meat, trans fats, and fast foods

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Diagnosing Coronary Artery Disease during a HCV

Past Medical History

- Long standing hypertension
- HX of Myocardial Infarction
- Angina
- Coronary Artery Bypass
- Cardiac Stent
- Hyperlipidemia
- Metabolic Syndrome
- Diabetes
- Obesity
- Cigarette Smoking

Medications

- Statins
- Nitroglycerin patches, sprays, or tablets
- Low-dose aspirin
- Calcium channel blockers
- Angiotensin-Converting Enzyme Inhibitors
- Beta Blockers

Review of Systems

- Chest Pain
- SOB

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Stars and HEDIS



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What is HEDIS and Stars Measures?

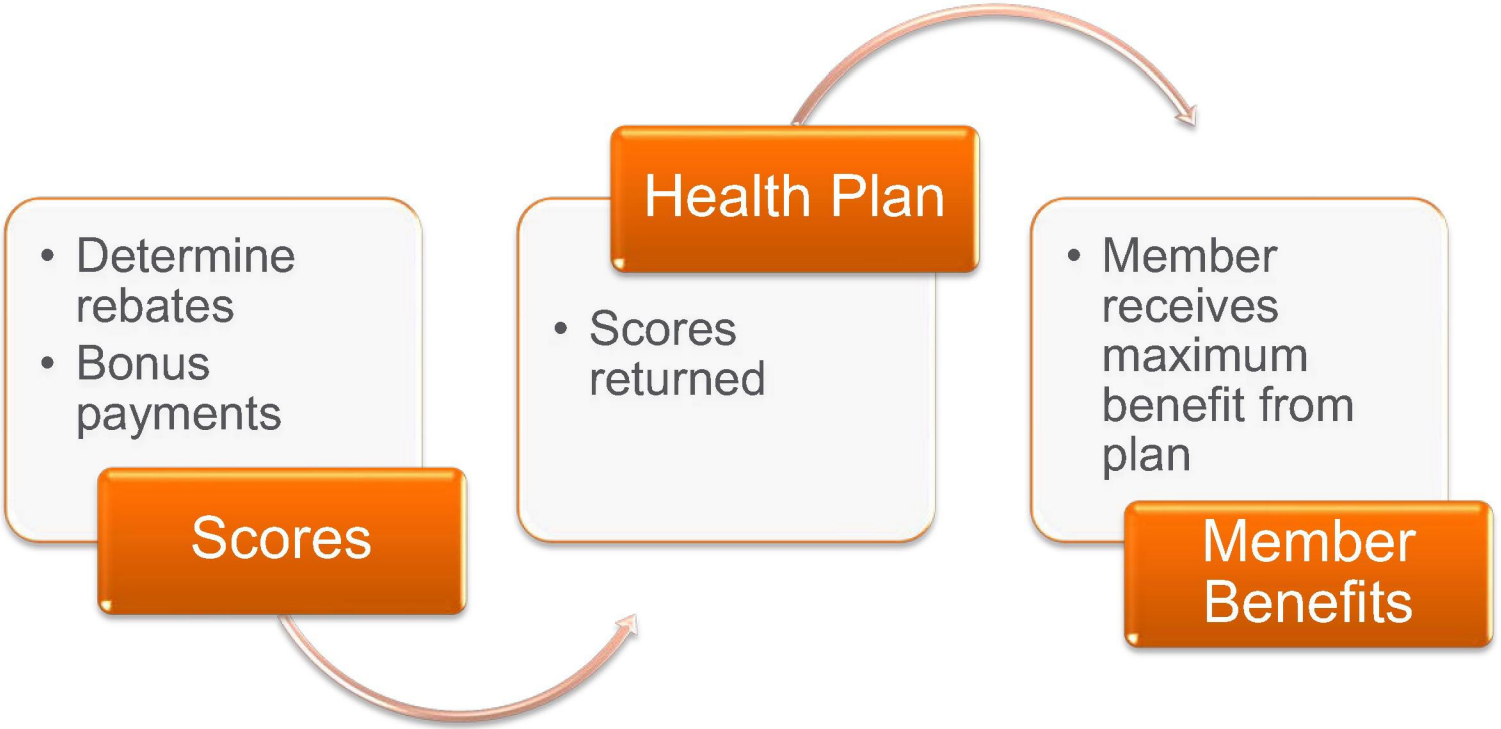
- HEDIS: Healthcare Effectiveness Data & Information Set
  - Tool to measure performance of health plans & is used by 90% of healthcare plans across the US.
  - HEDIS contains 81 measures across 5 domains of care
  - HEDIS assists beneficiaries with making the best decisions for their healthcare annually.

- Stars Measures
  - Benchmarks for the delivery of care
  - Some HEDIS measures have Star Weights
  - Star Measures
    - **Medication Adherence to HTN and Statin medications**

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Results for HEDIS and Stars Measures



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Medicare Star Rating System



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Stars and HEDIS Measures for Heart Failure

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Gaps at Risk



- APC identifies a member at risk for HF/CAD by evaluating Blood pressure and medication therapy
- Outcomes: Member has better prognosis for their disease process
- Outcomes: The plan may have more benefits available for the member identified
- **Better documentation means better care for our members!**

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Stars and HEDIS Specific for HF/CAD

STARS/HEDIS MEASURE	Specification	How Measure Is Met	Assessment	Tablet Page
Blood Pressure Control	Members aged 18-75 with diabetes blood pressure reading <140/90	BP reading	Physical Exam	Page 11
Persistence of Beta Blocker Treatment after Heart Attack	Members ≥18 years who were hospitalized and discharged with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.		Medications	Page 4

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Stars and HEDIS Specific for HF/CAD

STARS/HEDIS MEASURE	Specification	How Measure Is Met	Assessment	Tablet Page
Statin Therapy for Patients with Cardiovascular Disease	Males 21–75 years & and females 40–75 years who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported: ***Received Statin Therapy***. *D*ispensed at least one high-intensity or moderate-intensity statin ***Statin Adherence 80%***. Remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.	Document On Statin therapy	Medication	Page 4

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Stars and HEDIS: HF/CAD

- Obtaining accurate **blood pressure** and documentation
- Assessing for members who have HF/CAD for **beta blocker and statin therapy**





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Standards of Care in the Treatment of Heart Failure/Coronary Artery Disease

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Standards of Care for Heart Failure



Lifestyle Modifications

Blood Pressure Management

Medications

Kidney International Supplements (2012) 2, 341-342, doi:10.1038/kisup.2012.50

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Standards of Care: Lifestyle Modification

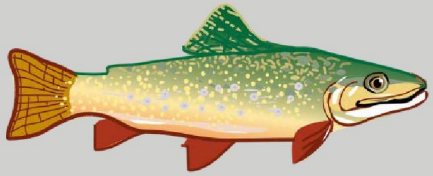
Changes in diet and lifestyle is recommended to treat heart failure.

- Dietary sodium and fluid restrictions
  - **<2 g/day of dietary sodium and 2 L/day of fluid**
- Monitoring daily weights
- Smoking Cessation
- Limit alcohol
- Cardiac rehab and exercise

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Quick Tips for Nutrition

	**Choose foods with less salt (sodium). Teach removing salt shaker at the table.**
	**Select the right kinds and the leaner types of proteins**
	**Choose foods healthier for your heart: lean cuts of meat, skinless chicken, fish, fruits, veggies & beans.**
	**Read the Nutrition Fact Labels: Look at sodium, potassium and phosphorus amounts.**

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Standards of Care: Blood Pressure Management

Adequate control is defined as meeting any of the following criteria:

- Members 18–59 years of age whose BP was <140/90 mm Hg
- Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg
- Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg

Cohen, 2016; JAMA, 2014

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Standards of Care: Blood Pressure Management

Individualize BP targets and agents according to:

- Age
- Co-existent CV disease and other co-morbidities
- Risk of progression of HF/CAD
- Inquire about postural dizziness
  - Assess patients for postural hypotension due to BP lowering agents

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Standards of Care: Medications

Medications frequently prescribed for HF/CAD members include:

- Angiotensin-Converting Enzyme Inhibitors
- Angiotensin Receptor Blockers
- **Beta Blockers**
- Digoxin
- Diuretics
- Aldosterone Antagonists
- Hydralazine and Nitrates
- **Statins**

The greatest benefit of these medications is the prevention of cardiovascular events.

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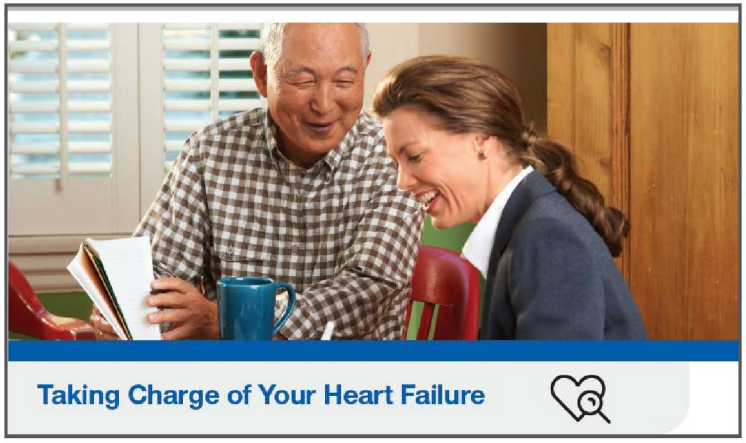
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Member Education

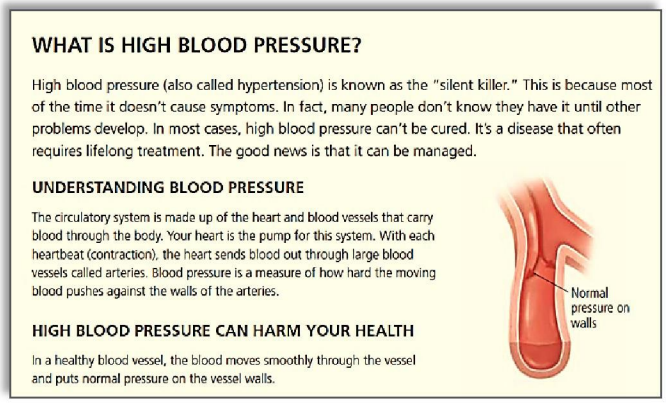


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Education Materials Available in Portal



What is High Blood Pressure?



WHAT IS HIGH BLOOD PRESSURE?

High blood pressure (also called hypertension) is known as the "silent killer." This is because most of the time it doesn't cause symptoms. In fact, many people don't know they have it until other problems develop. In most cases, high blood pressure can't be cured. It's a disease that often requires lifelong treatment. The good news is that it can be managed.

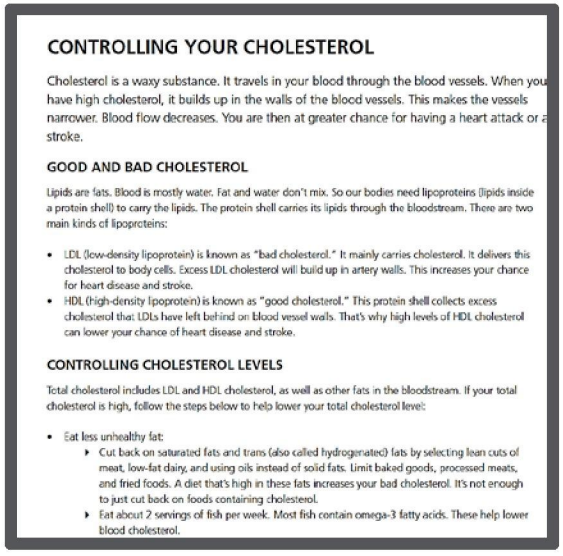
UNDERSTANDING BLOOD PRESSURE

The circulatory system is made up of the heart and blood vessels that carry blood through the body. Your heart is the pump for this system. With each heartbeat (contraction), the heart sends blood out through large blood vessels called arteries. Blood pressure is a measure of how hard the moving blood pushes against the walls of the arteries.

HIGH BLOOD PRESSURE CAN HARM YOUR HEALTH

In a healthy blood vessel, the blood moves smoothly through the vessel and puts normal pressure on the vessel walls.

Controlling Your Cholesterol



CONTROLLING YOUR CHOLESTEROL

Cholesterol is a waxy substance. It travels in your blood through the blood vessels. When you have high cholesterol, it builds up in the walls of the blood vessels. This makes the vessels narrower. Blood flow decreases. You are then at greater chance for having a heart attack or a stroke.

GOOD AND BAD CHOLESTEROL

Lipids are fats. Blood is mostly water. Fat and water don't mix. So our bodies need lipoproteins (lipids inside a protein shell) to carry the lipids. The protein shell carries its lipids through the bloodstream. There are two main kinds of lipoproteins:

- LDL (low-density lipoprotein) is known as "bad cholesterol." It mainly carries cholesterol. It delivers this cholesterol to body cells. Excess LDL cholesterol will build up in artery walls. This increases your chance for heart disease and stroke.
- HDL (high-density lipoprotein) is known as "good cholesterol." This protein shell collects excess cholesterol that LDLs have left behind on blood vessel walls. That's why high levels of HDL cholesterol can lower your chance of heart disease and stroke.

CONTROLLING CHOLESTEROL LEVELS

Total cholesterol includes LDL and HDL cholesterol, as well as other fats in the bloodstream. If your total cholesterol is high, follow the steps below to help lower your total cholesterol level:

- Eat less unhealthy fat:
  - Cut back on saturated fats and trans (also called hydrogenated) fats by selecting lean cuts of meat, low-fat dairy, and using oils instead of solid fats. Limit baked goods, processed meats, and fried foods. A diet that's high in these fats increases your bad cholesterol. It's not enough to just cut back on foods containing cholesterol.
  - Eat about 2 servings of fish per week. Most fish contain omega-3 fatty acids. These help lower blood cholesterol.



✓ **DASH Diet**

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Referrals for Heart Failure

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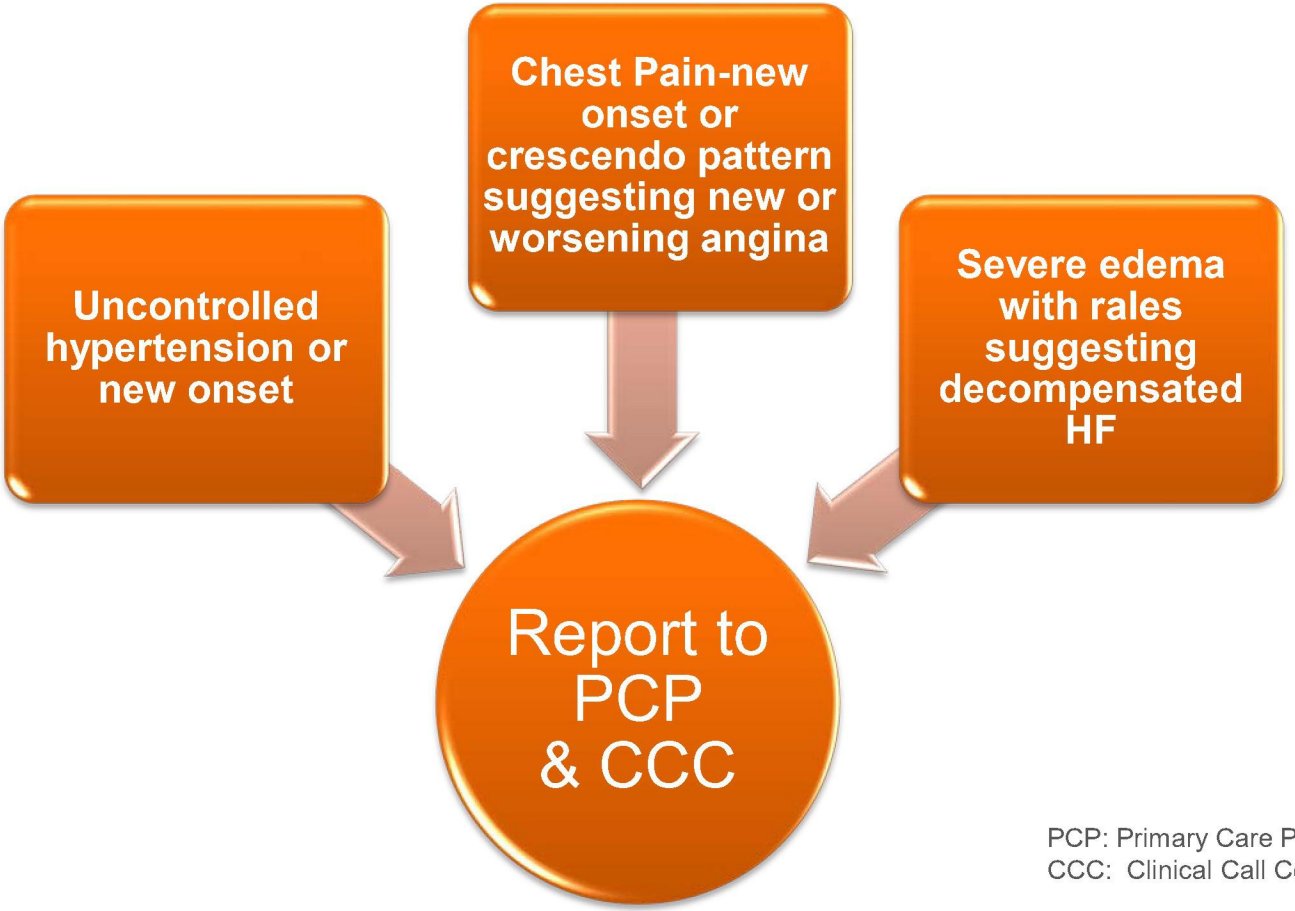
Referral Program Overview

Program	Description
Heart Failure Program	Member interacts 1:1 RN. Member is provided with a scale and tablet to transmit weight and symptoms information. Aim is to prevent heart failure exacerbations, enable member to recognize changes in symptoms and reduce unnecessary hospitalizations

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Management of Urgent Referrals: Heart Failure



PCP: Primary Care Provider
CCC: Clinical Call Center

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Case Study #1

HPI:78 year old female seen for Post Discharge Visit after hospitalization for dyspnea. Pt was diagnosed with new onset heart failure and discharged home with new meds; carvedilol, lisinopril, and furosemide but has not filled them yet.

PE: VS: Stable; NAD
Heart: RRR
Lungs: Decreased breath sounds ; trace edema
Echo: no results available
DC instructions reviewed.

What should the A/P reflect?

A. Heart failure, unspecified (CHF NOS)

B. Acute systolic (congestive) heart failure

C. Combined systolic/diastolic (congestive) heart failure

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Case Study #1 - Revealed

B. Heart failure, unspecified (CHF NOS)

A/P: Pt education on HF, encourage compliance with all meds, daily a.m. weight check, and low sodium diet. Monitor symptoms and follow-up as directed.

Why? Since no echo results are present it is difficult to determine the more specific type of heart failure. Also, the member is currently in a compensated state due to recent hospitalization.

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Case Study #2

HPI:78 year old female being seen for a HC PDV after recent hospitalization for dyspnea. Pt was diagnosed with new onset heart failure and discharged with new meds carvedilol, Lisinopril, and spironolactone.

PE: VS: Stable; NAD

Heart: RRR w/S3 gallop and laterally displaced PMI

Lungs: Decreased breath sounds throughout, slight rales noted

Ext: 2+ lower extremity edema

Hospital paperwork Echo results show an EF 35%, LV size is moderately enlarged, normal pulmonary arterial pressure.

What should the Assessment reflect?

A. Heart failure, unspecified (CHF NOS)
B. Systolic (congestive) heart failure, unspecified
C. Combined systolic/diastolic (congestive) heart failure
D. Secondary hyperaldosteronism
E. Both B and D

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Case Study #2 - Revealed

E. Systolic (congestive) heart failure, unspecified and Secondary Aldosteronism

Why? Referring back to slide 4, we see that Systolic HF involves:

- Systolic HF or HF W/ Reduced Ejection Fraction (HFrEF)
- Pumping problem
- Dilated, weak heart and/or thin ventricular wall
- Impaired ventricular pumping function
- EF less than 40% ("reduced" EF) [hers was 35%]
- And she still has symptoms (rales & edema)

Plan: Pt education on HF, encourage compliance with all meds, daily a.m. weight check, and low sodium diet. Monitor symptoms and follow-up with health coach in one week.

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In Summary . . .

Importance of Diagnosing and Documenting HF and CAD:

- More accurate documentation & early detection of HF and CAD during HouseCalls visits
- Education to our members
- Members receive their full benefit allocation
- Decrease re-hospitalizations
- Meet **STARs & HEDIS** measures (assessing blood pressures, statins and beta blockers) on all HF/CAD members

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Heart Failure Resources

Clinical Education Center (CEC) Website:

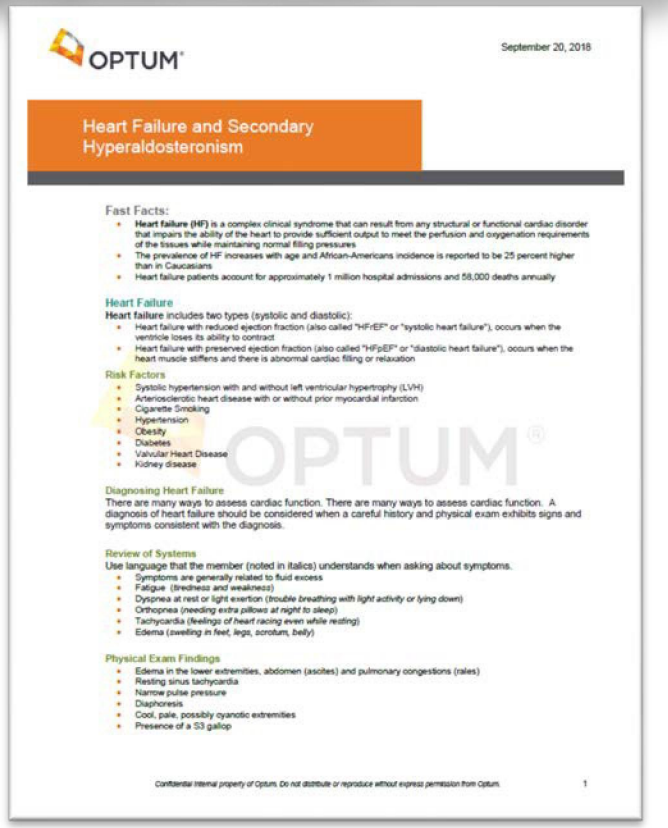
https://learning.optum.com



Job Aids

Diagnostic Job Aids

- Advanced Illness
- Angina Pectoris
- Atrial Fibrillation & Other Thrombophilia (Secondary Hyercoagulability)
- Bipolar Disorders
- CKD Job Aid
- Conditions Unlikely to Resolve
- COPD & COA
- Diabetes and Associated Complications
- Diabetes with Cataracts
- Diagnosing Labs
- Dynamite Documentation Tip: Vascular
- Heart Failure and Secondary Hyperaldosteronism
- Hyperparathyroidism
- Inflammatory Connective Tissue Disorders
- Major Depressive Disorder (MDD)
- OA vs RA
- Obesity
- Osteoporosis
- Peripheral Vascular Disease
- Polyneuropathy
- Pre-Diabetes
- Protein Calorie Malnutrition
- RA/Osteoarthritis
- Chronic Respiratory Failure
- Substance Use Disorder



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September 20, 2018

Heart Failure and Secondary Hyperaldosteronism

Fast Facts:

- **Heart failure (HF)** is a complex clinical syndrome that can result from any structural or functional cardiac disorder that impairs the ability of the heart to provide sufficient output to meet the perfusion and oxygenation requirements of the tissues while maintaining normal filling pressures
- The prevalence of HF increases with age and African-Americans incidence is reported to be 25 percent higher than in Caucasians
- Heart failure patients account for approximately 1 million hospital admissions and 58,000 deaths annually

Heart Failure

Heart failure includes two types (systolic and diastolic):

- Heart failure with reduced ejection fraction (also called "HFrEF" or "systolic heart failure"), occurs when the ventricle loses its ability to contract
- Heart failure with preserved ejection fraction (also called "HFpEF" or "diastolic heart failure"), occurs when the heart muscle stiffens and there is abnormal cardiac filling or relaxation

Risk Factors

- Systolic hypertension with and without left ventricular hypertrophy (LVH)
- Arteriosclerotic heart disease with or without prior myocardial infarction
- Cigarette Smoking
- Hypertension
- Obesity
- Diabetes
- Valvular Heart Disease
- Kidney disease

Diagnosing Heart Failure

There are many ways to assess cardiac function. There are many ways to assess cardiac function. A diagnosis of heart failure should be considered when a careful history and physical exam exhibits signs and symptoms consistent with the diagnosis.

Review of Systems

Use language that the member (noted in italics) understands when asking about symptoms.

- Symptoms are generally related to fluid excess
- Fatigue (*tiredness and weakness*)
- Dyspnea at rest or light exertion (*trouble breathing with light activity or lying down*)
- Orthopnea (*needing extra pillows at night to sleep*)
- Tachycardia (*feelings of heart racing even while resting*)
- Edema (*swelling in feet, legs, scrotum, belly*)

Physical Exam Findings

- Edema in the lower extremities, abdomen (ascites) and pulmonary congestions (rales)
- Resting sinus tachycardia
- Narrow pulse pressure
- Diaphoresis
- Cool, pale, possibly cyanotic extremities
- Presence of a S3 gallop

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Thank You!

If you have any additional questions, please reach out to your CTM.

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References

American Heart Association (n.d.) Diagnosing Heart Failure Retrieved 3/19/2018 from: http://www.heart.org/HEARTORG/Conditions/HeartFailure/DiagnosingHeartFailure/Diagnosing-Heart-Failure_UCM_002047_Article.jsp#.Wst6cJXD_cs

Borlaug, B. (2017) Pathophysiology of heart failure with preserved ejection fraction. Up to date. Retrieved from. https://www.uptodate.com/contents/pathophysiology-of-heart-failure-with-preserved-ejection-fraction?source=search_result&search=pathophysiology+of+diastolic+heart+failure&selectedTitle=1%7E150

Borlaug, B. (2016) Clinical manifestations and diagnosis of heart failure with preserved ejection fraction. Up to date. Retrieved from: https://www.uptodate.com/contents/clinical-manifestations-and-diagnosis-of-heart-failure-with-preserved-ejection-fraction?source=search_result&search=Clinical+manifestations+and+diagnosis+of+heart+failure+with+preserved+ejection+fraction&selectedTitle=1%7E110

Colucci, W. (2016) Evaluation of the patient with suspected heart failure. Up to date. Retrieved from: https://www.uptodate.com/contents/evaluation-of-the-patient-with-suspected-heart-failure?source=search_result&search=evaluation+heart+failure&selectedTitle=1%7E150

Colucci, W (2017) Investigational and emerging therapies for heart failure. Up to date. Retrieved from: https://www.uptodate.com/contents/investigational-and-emerging-therapies-for-heart-failure?source=search_result&search=Investigational+and+emerging+therapies+for+heart+failure&selectedTitle=1%7E150

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References

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Welcome to HouseCalls Training for the Hepatitis C Initiative & Quick Lab Review

July, 2021

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Lab Overview

HouseCalls

1. Review New Urine Dipstick Changes
2. Review Point of Care Labs & Universal A1C
3. Discuss FOBT
4. Review common errors with Labs

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Urine Dipstick- New with Release 2.28.0.0 (tentative: July 16, 2021)

Mandatory for Diabetic members

NPH Gap Criteria

- Member will be flagged for this test prior to visit

Criteria:

- Ages 18-75 with diabetes & attention for nephropathy

Criteria for closing Gap

- Urine dipstick for protein completed
- ACE or ARB listed on medication list as active or inactive (inactive is with last fill date in current year)
- Nephrologist documented in eHC

Exclusions

- Documentation of ESRD, or dialysis
- Documentation of acute renal failure or renal transplant

Members who are Non-diabetic will not be required to have urine dipstick

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Lab Review

A1C Criteria

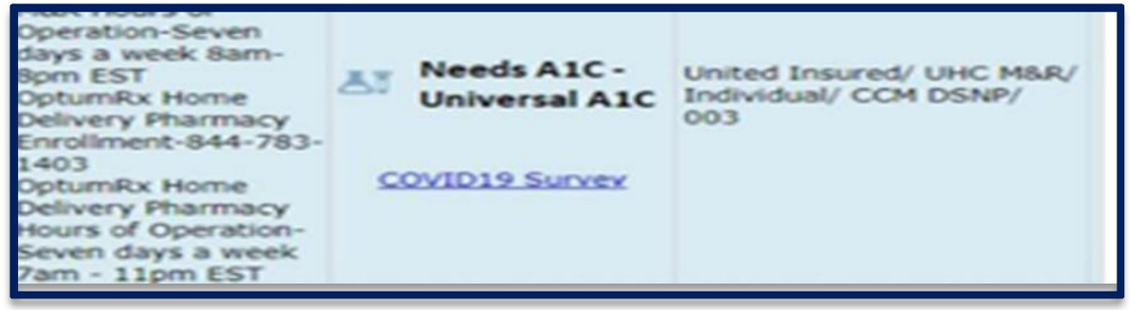
Universal (Non-Diabetic)

FOBT

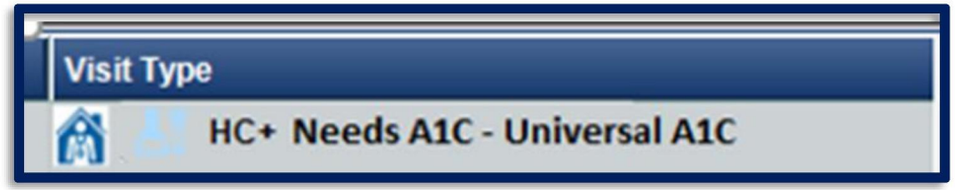
Identification of Flagged Labs

How do you know if a lab should be done?

- Practitioner Portal, Appointment Section -lab icon present if the member is flagged



- eHouseCalls Appointment grid- Visit type column locate the lab flag



- Diagnostic Tool Bar has “lab” tool and if it is red, the member has been flagged



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Diabetic Member: PIN (Practitioner Identified Need) Criteria

Consider performing a PIN A1C on Diabetic members between the ages of 18-75 if they have NOT been flagged for a lab and meet any of the following criteria

- **No A1C reported in current calendar year**
- **Member has no recall of having A1C**
- **A1C elevated and over 3 months ago**



Use discretion and clinical judgment for A1C elevation, in the past we have performed if member has A1C > 9% as a suggestion

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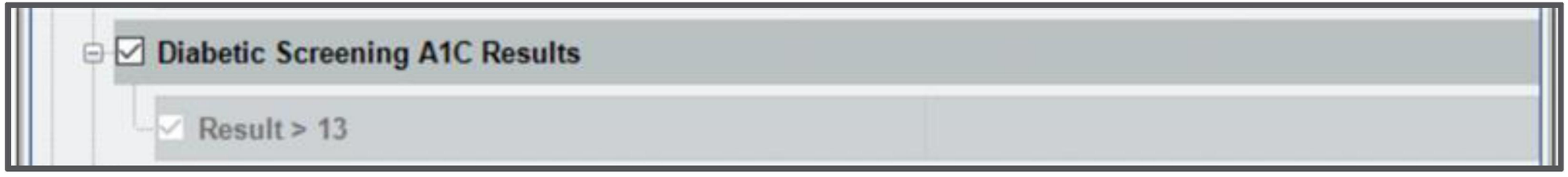
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Elevated A1C Results for Diabetics & Workflow

☑ Diabetic Screening A1C Results

Elevated Results For Diabetic Members

1. Notify the Member's PCP if results are **greater** than 13
2. Generate an Urgent Care Manager referral
3. Educate the Member on HC Referral and ask if they accept
4. Document per policy in CRD tool



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Non-diabetic Member Universal A1C Screening

System Flagged and PIN criteria

Plans	Criteria for Non-Diabetic Member (Universal)
M & R individual & DSNP	Flagged as Universal A1C or can be PIN lab
C & S DSNP	Member is non-diabetic
URS Group Retirees	Must be in plans as mentioned
ALL States	Ages 45-80
	BMI 25 or greater
	Reassess BMI during visit and if 25 or greater, perform testing

Don't forget to document "A1C completed per screening protocol" in non-urgent communication

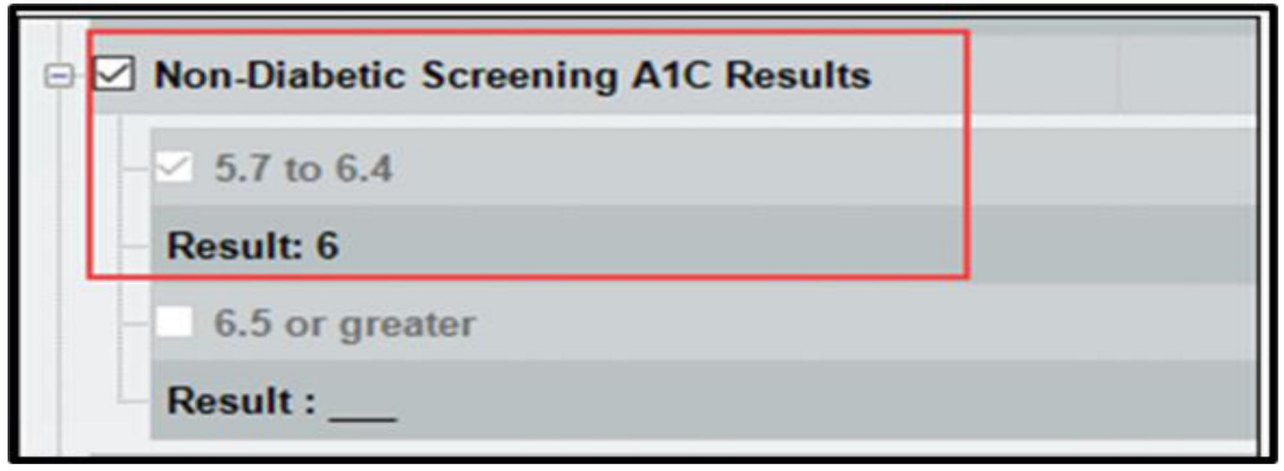
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Pre-Diabetic A1C Result for Non-Diabetic Members

- If A1C levels fall between 5.7-6.4%, it is **NOT** required to document a call to PCP or EMS. **DO NOT** Call PCP or **Clinical Help Desk**
- **DO NOT** diagnose pre-diabetes based on a single A1C result. Encourage the member to follow up with provider for further direction
- In the CRD tool, contact details will not be mandatory (**RED** in color) and a referral can be generated without documenting the contact details
- When a universal A1C level of 5.7 - 6.4 is documented, the CRD tool will display as follows:



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Non-Diabetic A1C Levels & Workflow

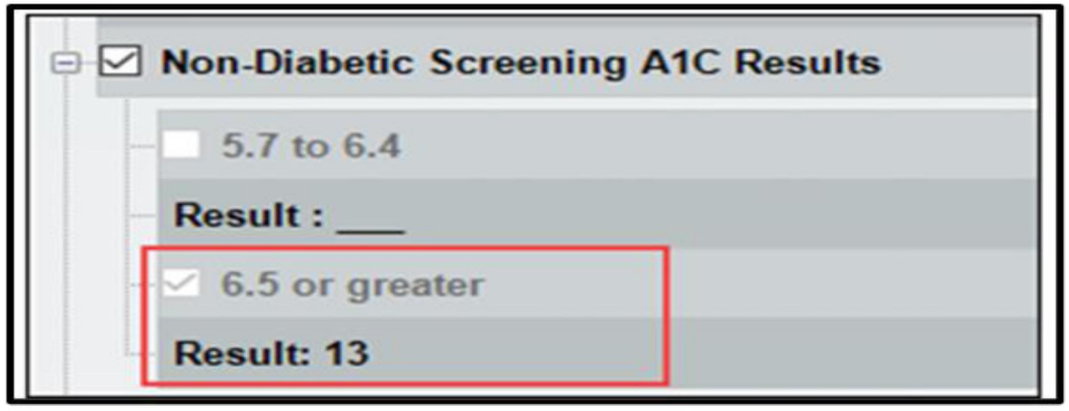
☐ Non-Diabetic Screening A1C Results

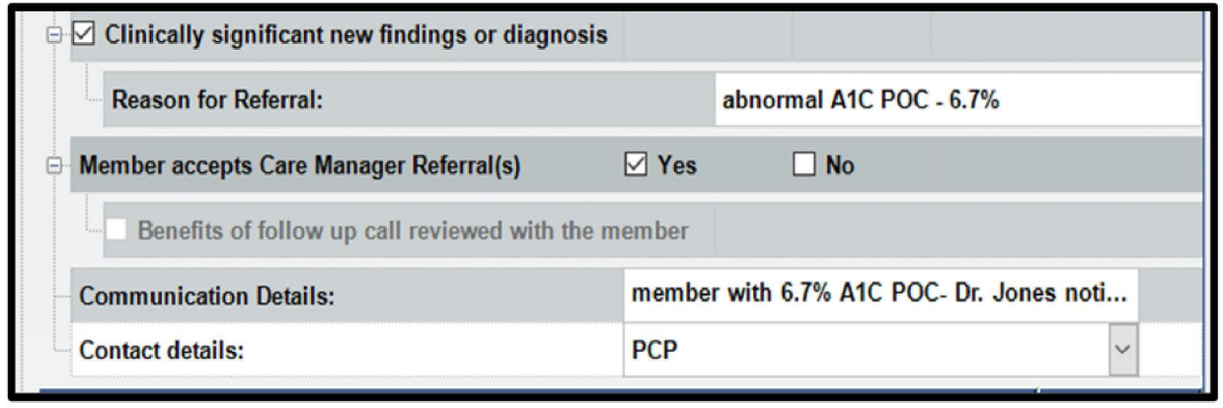
Non-Diabetic Members with Diabetic A1C Results

- Within the CRD tool, the Non- Diabetic Screening A1C results referral gets auto selected for 6.5 or greater levels
- **Be careful** diagnosing diabetes based on a single A1C result

APC steps consist of:

1. Notifying the members PCP
2. Generating an Urgent Care Manager referral
3. Documenting per policy in CRD tool



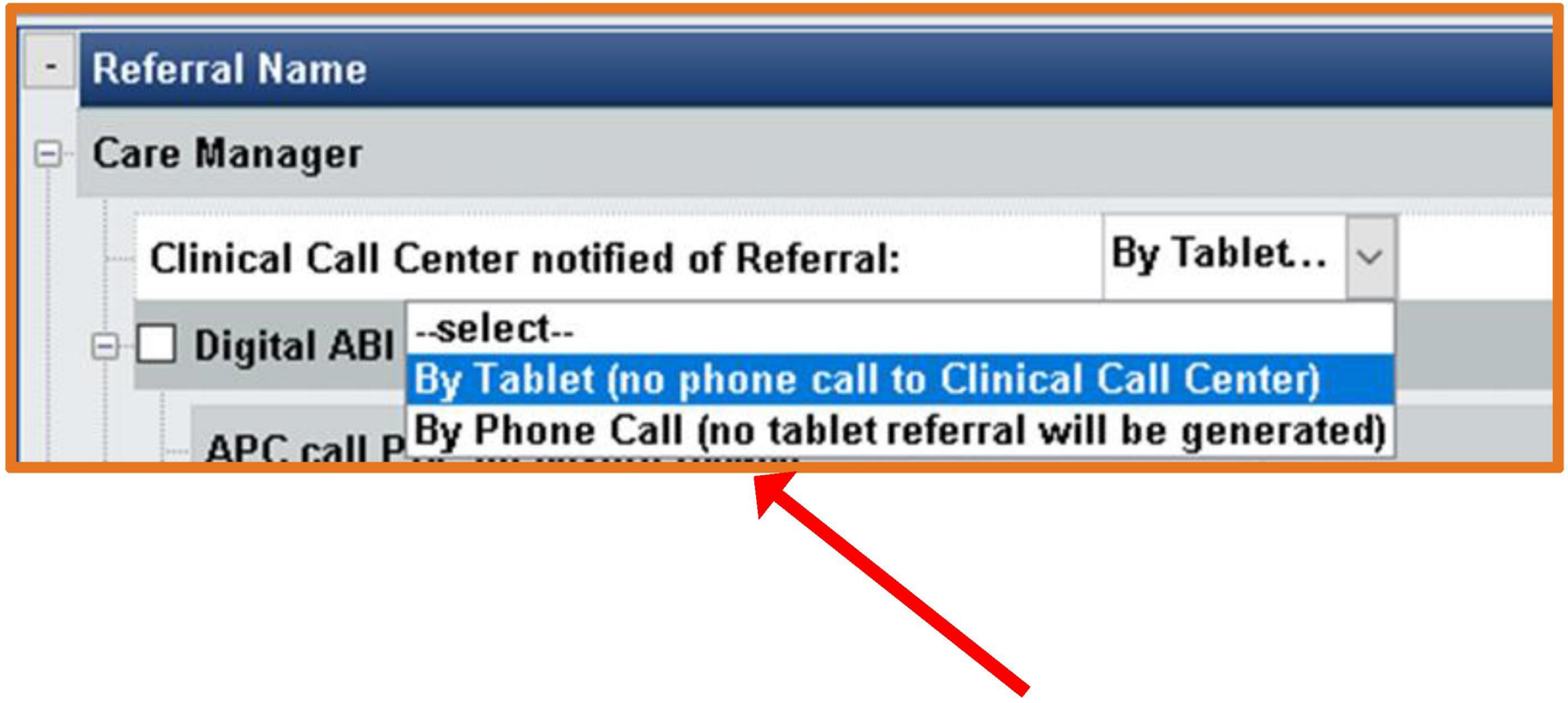


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CRD Documentation



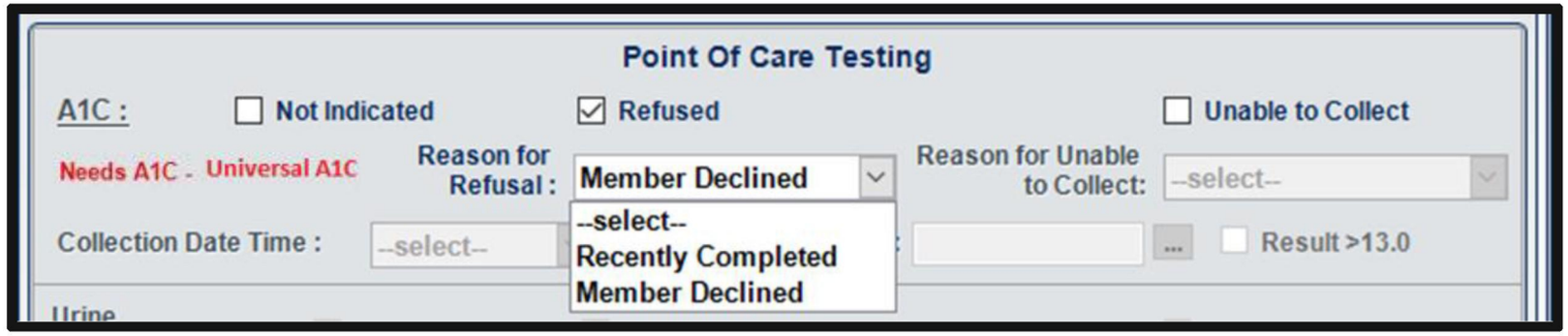
Refer to Care Management by Tablet

Please do not call Clinical Help Desk for any Universal Labs

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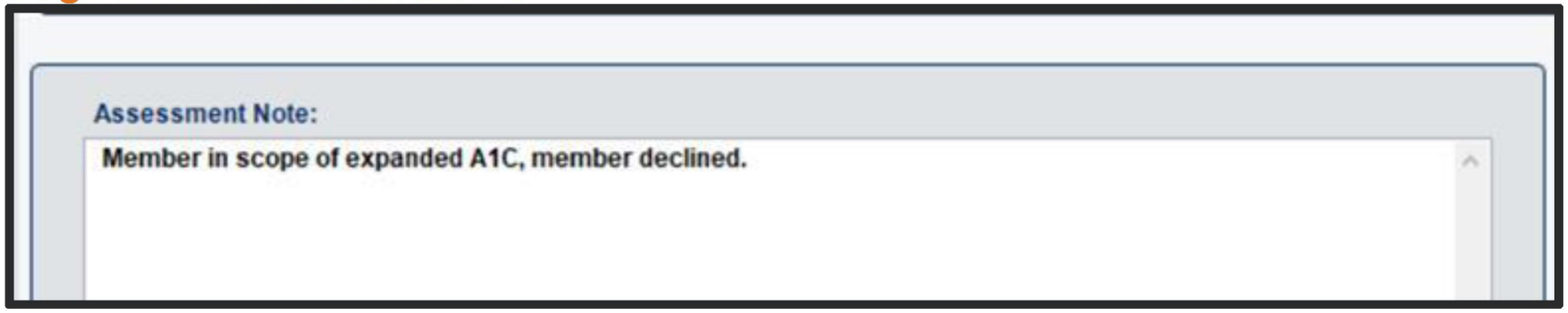
Documenting A1C Screening Refusal

If the member refuses the screening, document Member Declined in the A1C lab drop down:



If member has BMI < 25 and/or is out of age range, select *"Not Indicated"*

Page 18-Assessment Notes



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FOBT PIN Criteria

The following are the criteria for initiating a PIN iFOBT lab

iFOBT

Ages: Eligible if aged 50-75 and the member has not had:

- A colonoscopy within the past 10 years *or*
- A Flex Sig within the past 5 years *or*
- A Cologuard within the past 3 years (FIT-DNA) *or*
- A fecal occult blood test within the current calendar year
- Or if they cannot recall their last colorectal screening test or deny any colorectal screening

Please do not leave kit unless member meets criteria, or you are documenting on a paper assessment

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Documentation for FOBT

eHouseCalls page 6, Preventative Screenings

- If member reports previous FOBT, select "Yes"
- Enter "Year"
- Enter "Month"
- Was the sample collected at Provider's office as result of digital rectal exam? Select **Office**
- Did the member collect the stool sample and return per instructions? Select **Lab**



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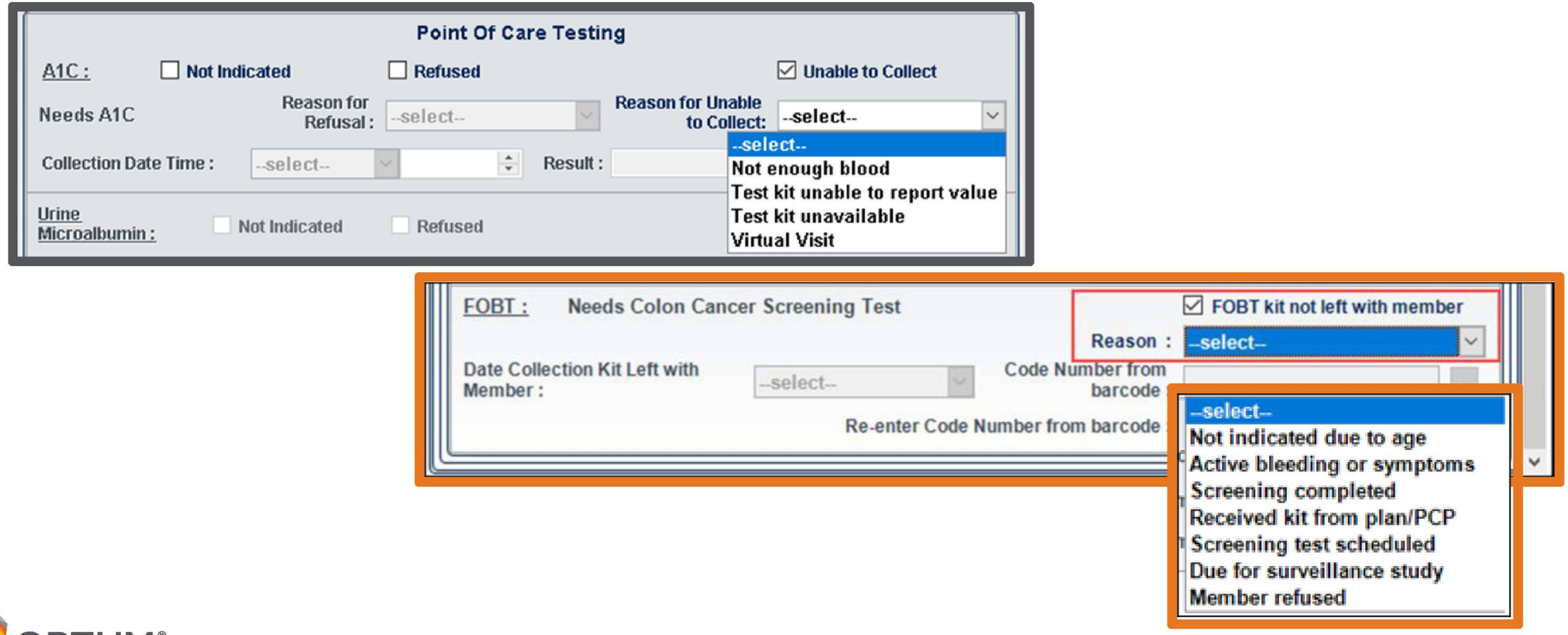
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Lab Refusals & Incomplete Documentation



Unable to Collect/Perform Labs

If the member refuses or you are unable to collect, **select** the appropriate reason from the drop-down box.



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Hepatitis C Educational Presentation

LetsGetChecked (LGC) Screening

HEP C

https://www.letsgetchecked.com/us/en/home-hepatitis-b-c-test/

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Learning Targets for HouseCalls: Hepatitis C Lab

Learning targets consist of the following:



- Purpose for Hep C Training
- Review Hepatitis C documentation of completion and refusals
- Discuss Hepatitis C screening talking points
- Member teaching and talking points

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Purpose

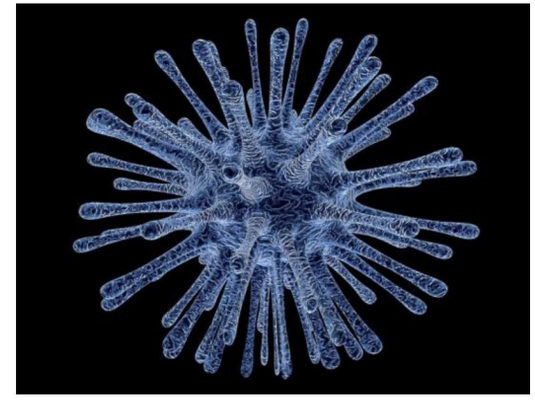
The purpose of this program is to screen for Hepatitis C in the home in accordance with national recommendations and guidelines

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Fast Facts: Hepatitis C

- Hep C is a viral infection that causes liver inflammation and damage spread through contact with blood from an infected person
- The most commonly reported bloodborne infection in the U.S
- Viruses invade normal cells in the body
- There is currently no vaccine for hepatitis C
- Early diagnosis and treatment of chronic hepatitis C can prevent liver damage, cirrhosis and liver cancer
- 2.7 – 3.9 Million persons in U.S. have Chronic Hep C



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Hepatitis C (HCV) Risk Factors and Testing Recommendations

Risk Factors

Persons with a history of:

- IV drug use
- Kidney dialysis
- Blood transfusions prior to July 1992
- Organ transplants prior to July 1992

Testing Recommendations

CDC recommends HCV screening:

- once in lifetime for all adults aged 18 and older*
- All pregnant women during every pregnancy*
- One time testing among person with conditions, such as HIV and history of risk factors
- Routine periodic testing for persons with ongoing risk factors

USPSTF recommends HCV screening in (asymptomatic) adults aged 18-79 years (Grade B)

*except in areas where there is a <1% prevalence

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Hepatitis C Overview for HouseCalls Members

Background:

- 85-90% of hepatitis C deaths in UHC are in our Medicare population
- UHC is requesting APCs with HouseCalls to offer hepatitis C screening through the vendor "LetsGetChecked"
- Members must be eligible for the test
- Members will be up to 75 years of age

Eligibility Includes:

- M & R Individual/DSNP
- Group Retiree
- C & S DSNP
- Up to 75 years old

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High Level Steps for Hep C Screening Completion Consists of:

- ✓ Member Identified by claims and data analysis
- ✓ Member Flagged and Scheduled for HouseCalls Visit
- ✓ Once flagged and scheduled – Kit and educational Leave behind will be mailed to member
- ✓ APC confirms that member received Hep C Kit during introductory call
- ✓ During HCV – APC conducts Hep C Screen & arranges for pickup
- ✓ **IF** kit not available in Member's home – APC conducts education of screening completion for Member to complete
- ✓ APC documents status of Hep C screening in Lab Tool

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Hep C Test Delivery Process

Once Order Received, LGC will dispatch a Hep C Test to member

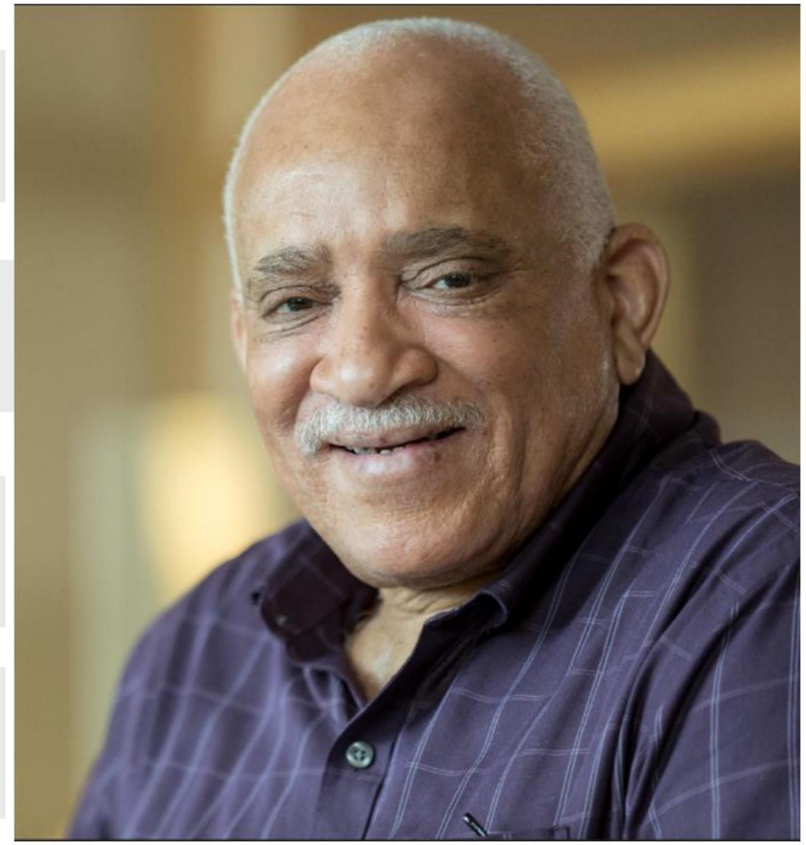
During the appointment confirmation call, HouseCalls will confirm that the member received the kit and has set it aside for their scheduled in-home visit

If there is an issue with the delivery, LGC can issue a replacement kit

The HouseCalls team can contact LetsGetChecked at (855-440-1975) from 8am—8pm ET/5am-5pm PT to request a replacement kit

Welcome Letter is included in the package with instructions for the member to store the kit in a safe place until the HC Practitioner arrives to collect the sample

Reminder: Discuss the test during the Pre-Visit Communication to make sure member knows to put the kit in a cool dry place until arrival of APC



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Member Identification

- Plan Scope



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Hepatitis C Screening Participation

Eligibility Criteria: Screening is for the following members

- **In Scope:** M&R Individual/DSNP, Group Retiree, C&S DSNP
- **Out of scope for Hep C**: M&R: People's Health, C&S: MASCO, URS - US Virgin Islands, CDO, OAH, E&I, External Clients
- **Out of scope modalities:** Signify, Virtual Visits, Post Acute Visits
- **All States**

Screening Tool - Lets Get Checked Test Kit





Verify Plan Information

In eHC , the type of insurance plan for the Member can be identified in the CDO/Client/Sub-Client columns.



Line of Business	Client	Sub Client	CDO
C&S	DSNP		

In Practitioner Portal, the type of insurance plan for the Member can be identified in the Master/Client/LOB/Sub client/Employer Group/CDOHPBP column

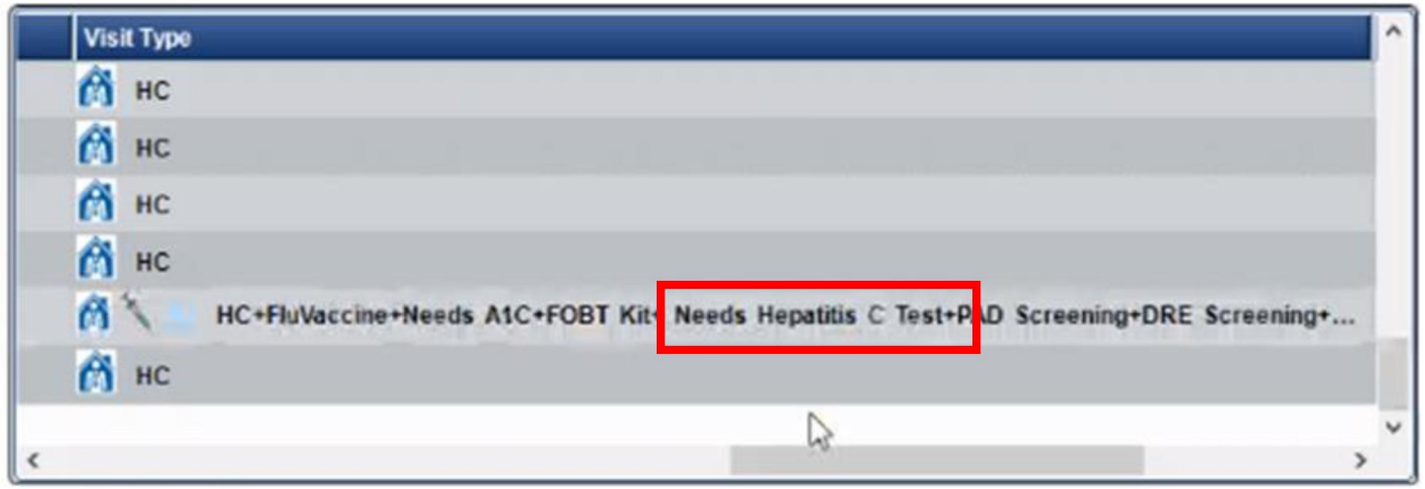


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Member Identification Overview

Flagged member can be noted in eHC Visit Type & Diagnostic Tool Bar

Visit Type



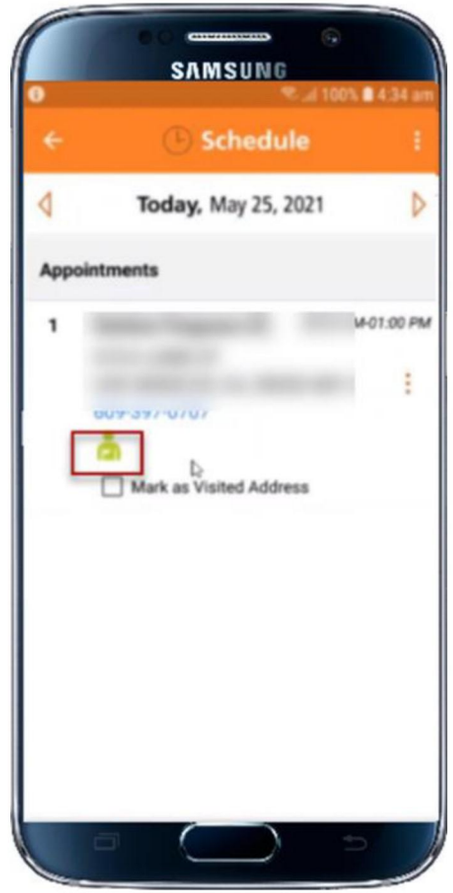
Diagnostic Tool Bar

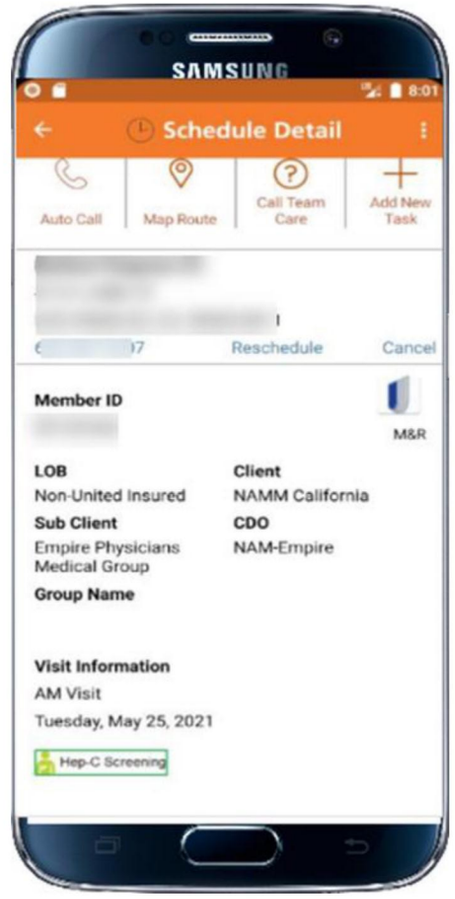


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HEP- C Flag in PMA

- In an upcoming update to the **Provider Mobile App (PMA)**, scheduled Hep-C screening appointment details will be indicated with an icon and flag
- The new icon is displayed below the appointment address and phone details of the ***Schedule*** screen
- The ***Schedule Detail*** screen will also display the icon in the *Visit Information* section





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How To Complete

- Test Procedure
- eHC Lab Tool Documentation



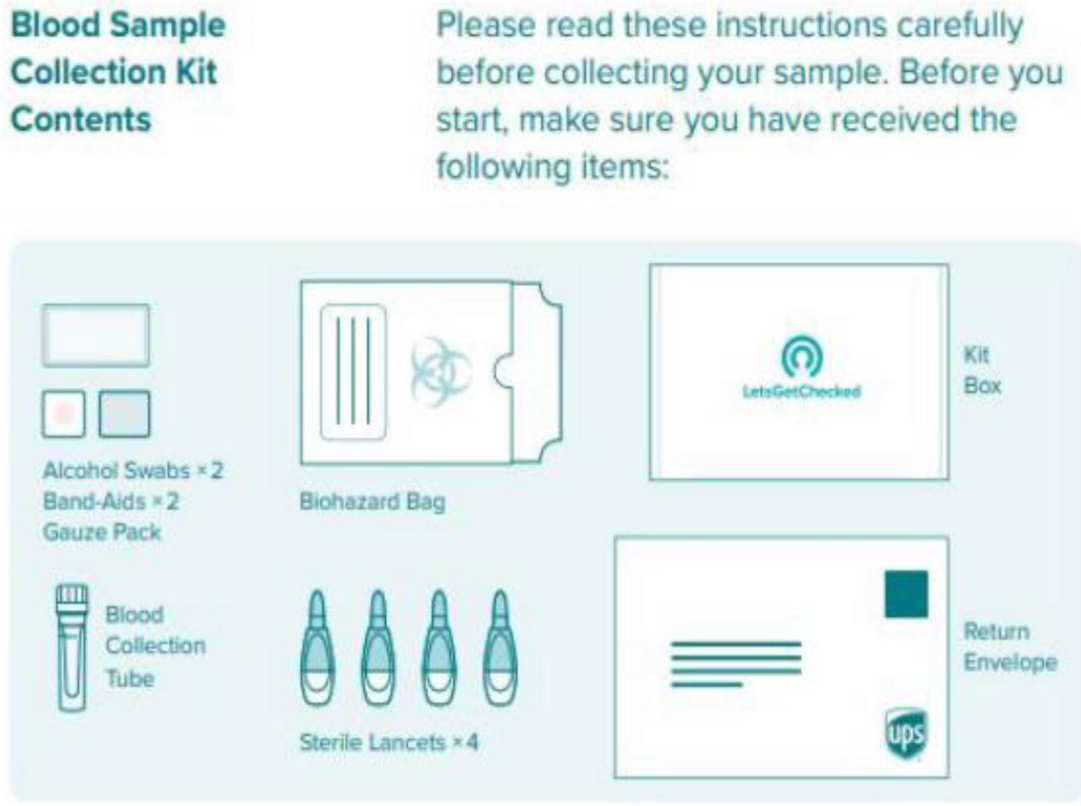
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LetsGetChecked Sample Collection

Kits contain all necessary components to complete the sample collection process and return via UPS back to LetsGetChecked

Note:

- *Members in New York state will receive a 600µL BD blood collection tube in the kit and the sample will be processed by a partner lab.*
- *All other members will receive a 300ul LH Sarstedt blood collection tube in the kit and the sample will be processed by the LGC lab*
- *The sample collection process and return process is the same*

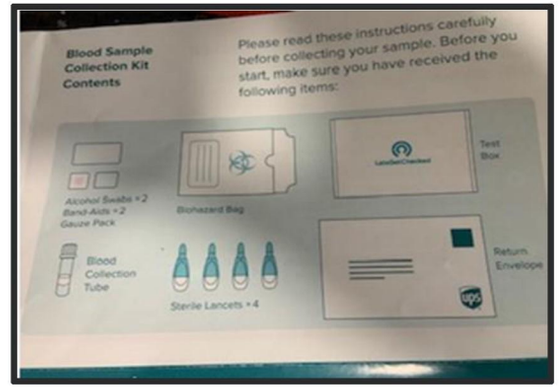


Blood Sample Collection Kit Contents

- Test Box
- Alcohol Swabs x2
- Band-Aids X2
- Gauze Pack
- Biohazard Bag
- Blood Collection Tube
- Sterile Lancets x4
- Return Envelope







If received damaged, replacement kit is to be arranged by APC contacting the LGC program number at 855-440-1975, M-F, 8 am – 8 pm ET



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Sample Collection and Mail Instructions

Each test kit contains detailed instructions on how to complete the screening

Helpful Tips:

- Fill in the label on the outside of the biohazard bag with the **sample collection date**, **member DOB**, and **member gender**. Note this kit has been registered to the member it was addressed to
  - Only use the kit if you confirm the name on the label on the test box matches the member you are visiting
- Follow the detailed instructions in the kit to complete the test
- Collect the sample and schedule pickup
- Each test kit contains a prepaid **UPS** envelope that must be picked up from member's home
  - Call the following number for pick-up from member's home: 1-800-742-5877 ***OR***
  - Visit the following website to schedule pick-up: https://wwwapps.ups.com/pickup/schedule

*If the HouseCalls practitioner or member is having **any** issues completing the test, please encourage them to contact LetsGetChecked at (855) 440-1975 from 8am-8pm EST / 5am-5pm PST*

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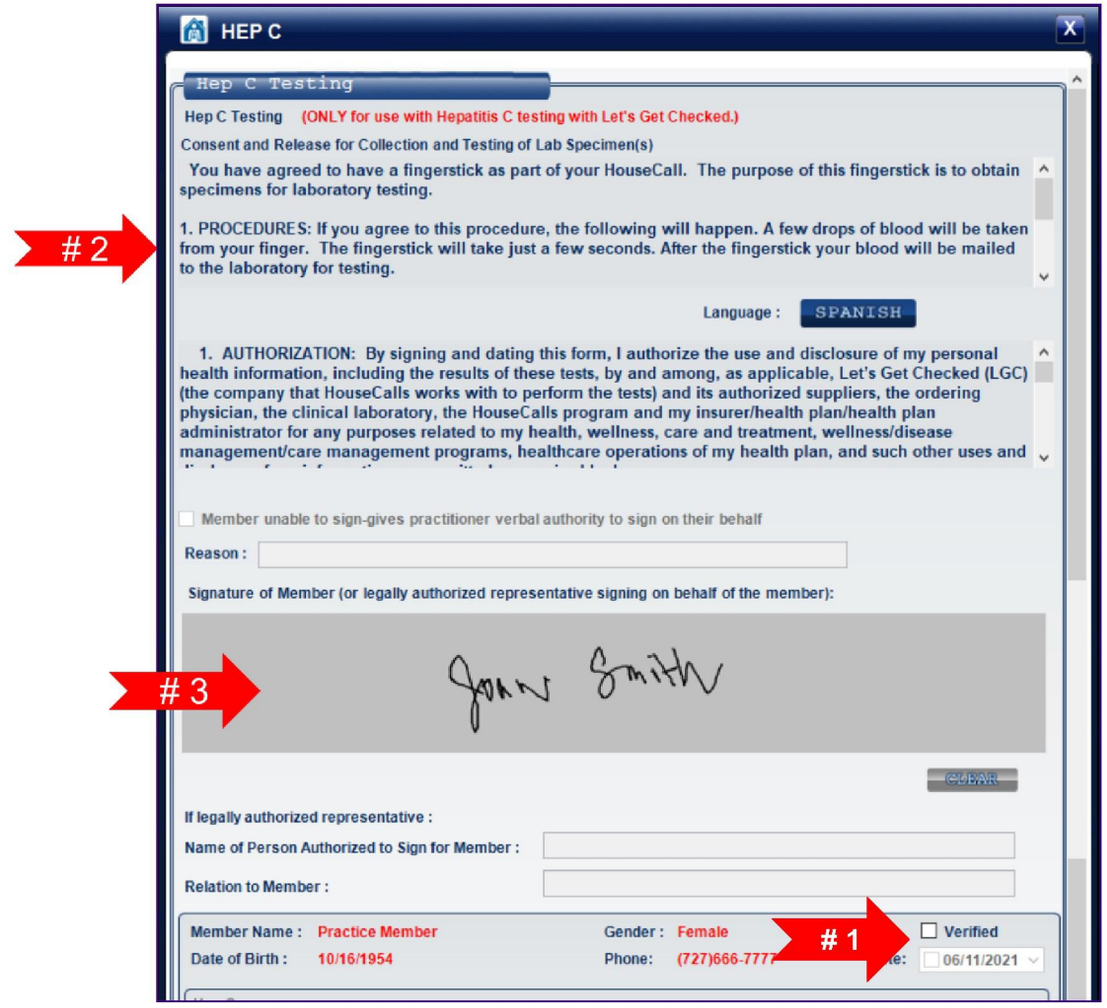
APC Procedures for Hepatitis C Screening

Review consent with Member and obtain signature

1. Verify Member Plan Information

Plan Name:	AARP MedicareComplete Plus (HMO-POS)

2. **Open the Hep C Tool** HEP C
3. Verify Member Name, Gender & DOB and **click Verified checkbox**
4. **Review consent statement** with member
5. Capture **Member Signature** to obtain consent

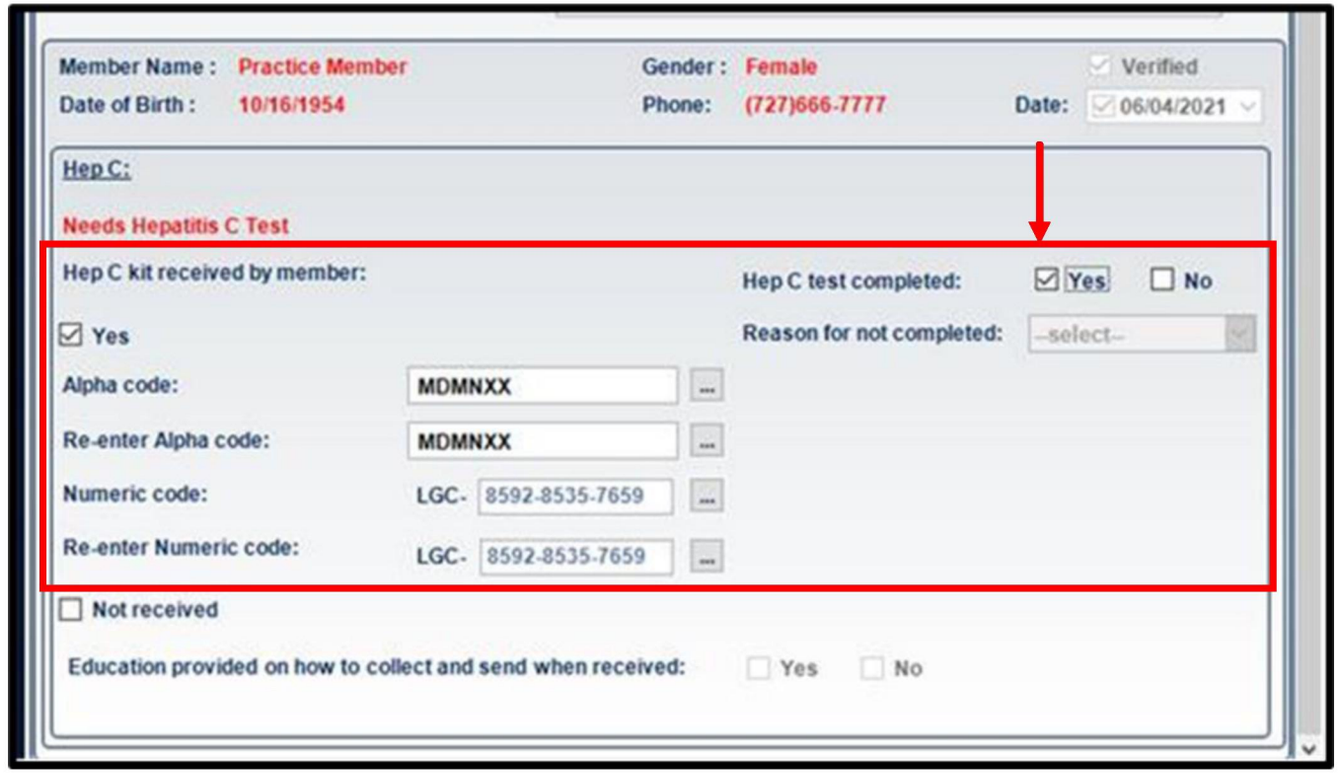


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Hep C Test

Kit *Received* and Test *Completed*

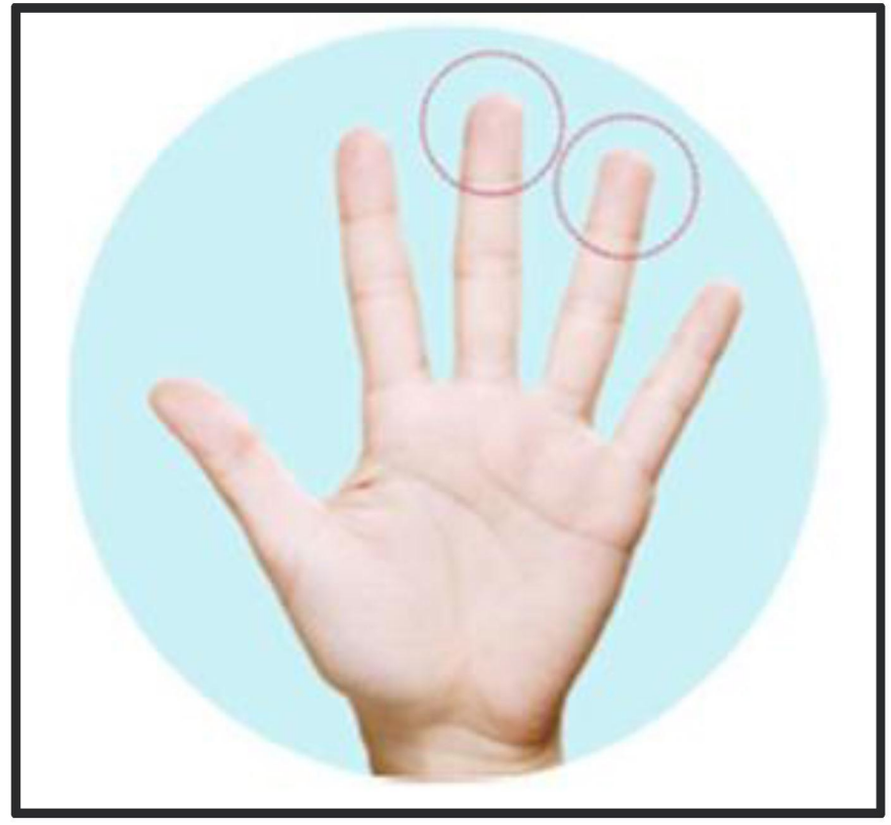
1. Document **"Yes"** under Hep C kit received by member
2. Document Alpha code - 6 letters and Numeric code (example) LCG-6137-0553-7708
3. Document **"Yes"** to Hep C test completed



Hep C Test - LetsGetChecked (LGC) - Lab Completion

Have the Member do the following:

- Prepare the member for the screening. Have member wash their hands using warm water to promote blood flow and dry thoroughly.
- Prepare to take the sample. Take the lancet and twist to remove the thin tab to pierce the member's finger once you have used the alcohol pad to cleanse area. Nails that are too long may make sample collection difficult.
- Position lancet on the rounded end of the right or left finger of the member. Press down firmly until you hear a click.
- Wipe away first drop of blood – do this with a gauze pad – firmly massage to retrieve new droplet of blood. Massage and do not touch or squeeze the fingertip.
- Hold tube in an angle manner to collect the sample in the blood collection tube.

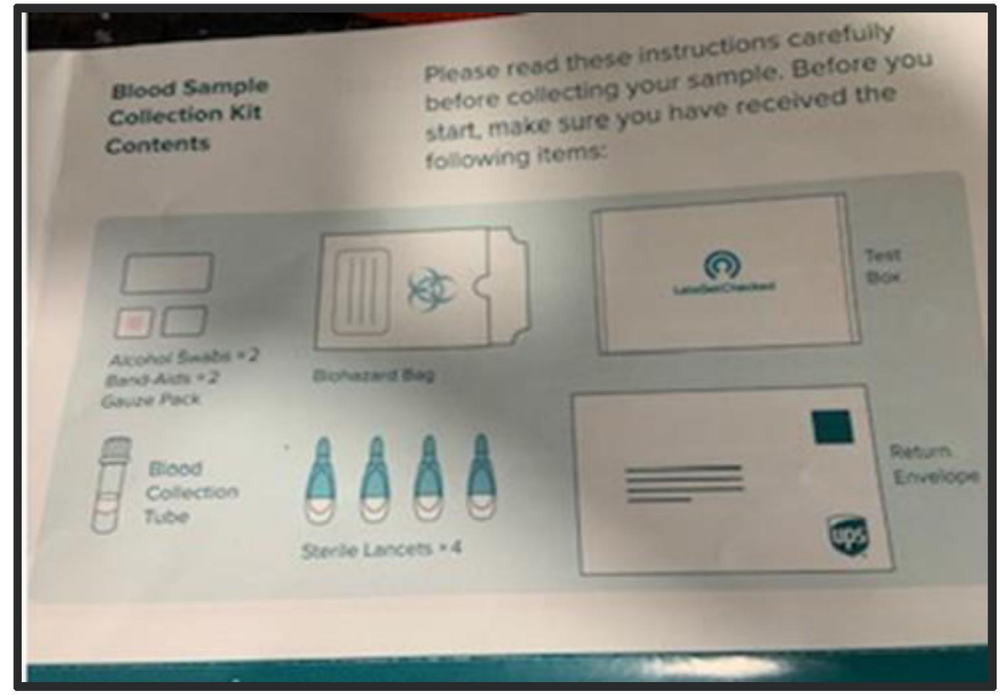


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Screening Steps

Hep C Test: *Sample collection tube*

- Hold at angle to ensure diminished spillage and lightly tap the droplets of blood against the inside of the blood collection tube
- Fill to the top line marked on the inside of the tube
- Replace the lid on the blood collection tube and press down firmly until you hear a click
- Mix the sample by turning the tube upside down ten (10) times ***(Ensure tube is properly closed – vital to preserve sample for the laboratory)***
- Ensure label is in biohazard bag and firmly seal the sample in the biohazard bag
- Place the biohazard bag into the test box. **DO NOT** remove the white pad in the biohazard bag
- Sample is ready to be returned. UPS shipment should have been arranged for pickup





Hep C Test

Blood Sample Collection Kit Step – by – Step Instructions

1. Check test kit instructions and review with member
2. Arrange for UPS pickup – Please contact UPS to arrange pickup
   - ✓ Visit: https://wwwapps.ups.com/pickup/schedule
   - ✓ or call 1-800-742-5877 to schedule kit pickup
3. Review details on specimen label – It is important to review the prefilled label located on the biohazard bag
4. If this information is missing, the lab will not be able to process the sample



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Process for UPS Pick up

APC will arrange for pick-up

1. Visit site: https://wwwapps.ups.com/pickup/schedule or call **1-800-742-5877**
2. Call the number and request “schedule pick-up
3. The prompt will ask how many packages, say “one”
4. The prompt will ask about tracking number, the APC will read the TN on the envelope.
5. The tracking number will be repeated back to the APC by prompt and the APC will review and confirm
6. The prompt will read off and confirm address: confirm and follow remaining prompts to complete

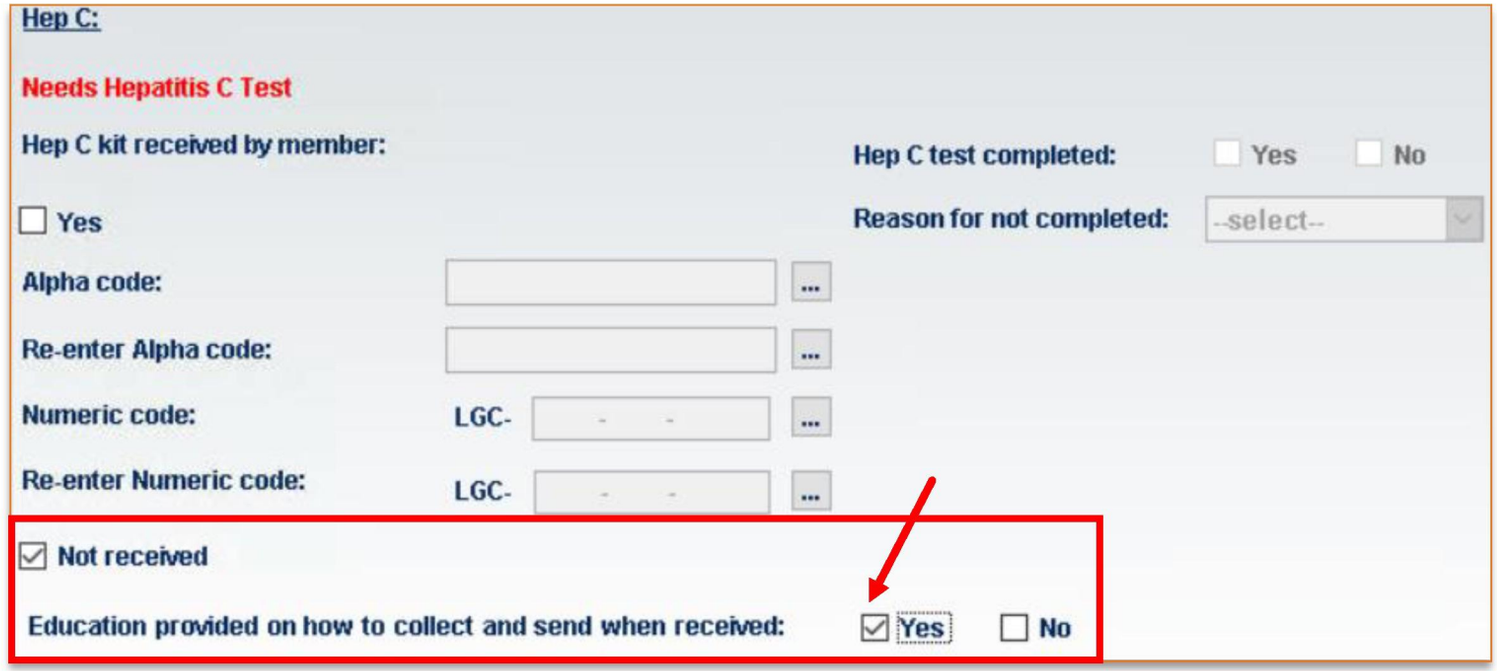
APC will not transport kit to UPS facility due to temperature constraints

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Screening Steps

Hep C Test: *Screening Kit Not Available During HCV*

- ✓ Document in the lab tool that the screening was **NOT RECEIVED**
- ✓ Select that Education was provided on how to collect



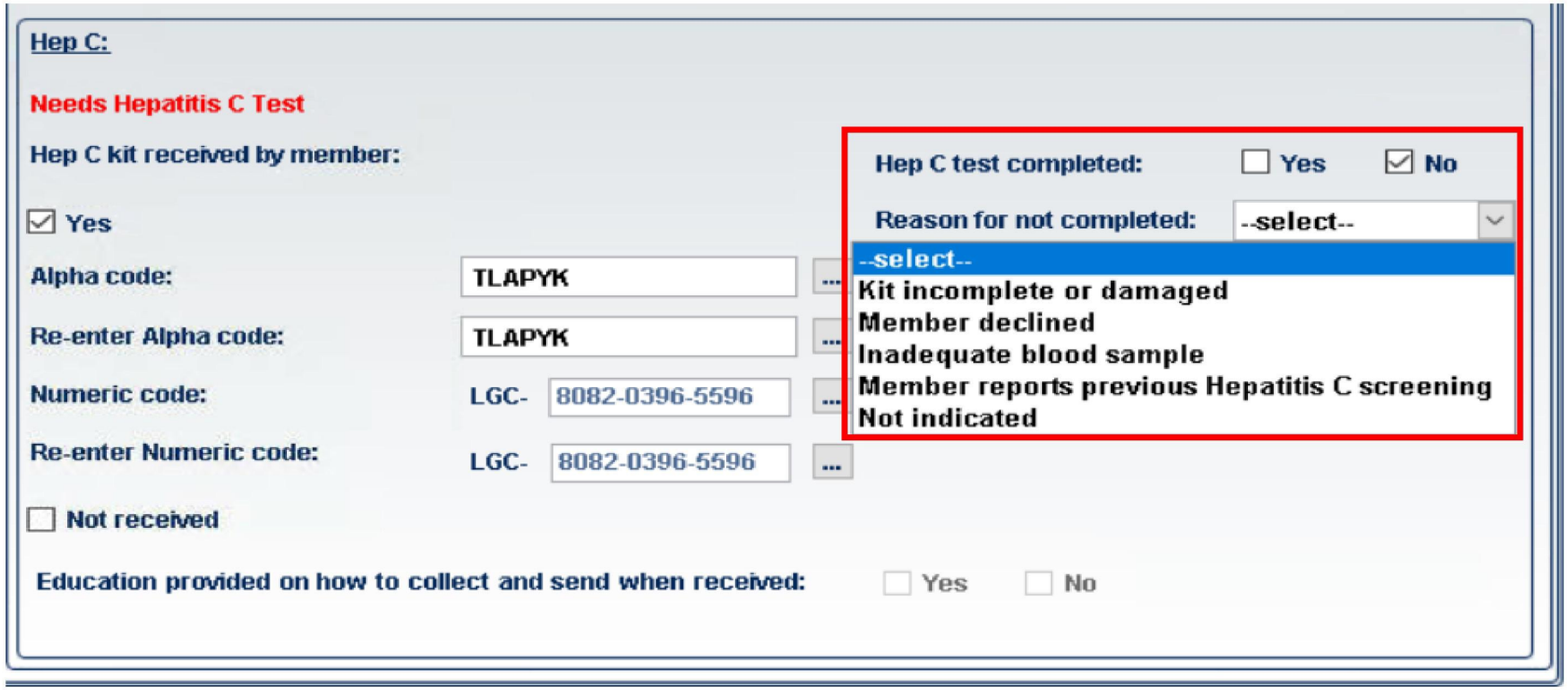


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Screening Steps

Hep C Test: *Kit Available but Test Not Completed During HCV*

If the Hep C Screening kit is **NOT** completed during the HCV, document in the lab tool that the screening was not completed with the following options:



Supplies

- Kit Storage
- Addressing Supply Shipment



Hepatitis-C Test Kit Storage



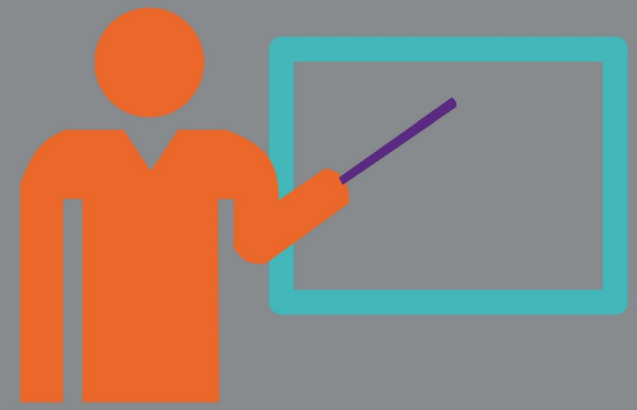
- Keep dry and away from sunlight
- An expiration date will be noted on the kit box
- One Kit utilization per member – kit contents cannot be reused
- Do not use if the kit or any items included within it are damaged, faulty or if any items are absent from the kit
- Discard the kit in the member's trash if the member declines the test or it is not used for some reason



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Teaching Tips

- Addressing Member Questions & Concerns



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Addressing Member Questions



How will you perform the screening?

- LGC Kit will be completed via a finger stick and blood sample collection



Why are you doing this screening today?

- Hep C antibodies will always show up, so if you've previously gotten positive results; even after you had treatment, results will still come back positive
- Educate members this test is Hep C, not Hep B as they may have had Hep B in the past
- Remind member that they will receive Educational Sheet in the mail with the kit – review with member if needed



Will I get the results?

- Members with abnormal results will be contacted by LGC nurse
- Result letters will be mailed to member and PCP

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Important Reminders



- Contact UPS to arrange pick up of lab kit once completed
- Lab envelope will be pre-filled with member demographic information – if not auto populated - you will be able to fill it in
- Ensure that the sample (blood collection tube) is placed in biohazard bag and tightly sealed
- Educate member on screening completion and select not received in the Hep C tool that the kit was not available during HCV
- Please note that this Screening will not transfer into AYPCP or Education Section of page 16
- Leave Behind handout will be mailed with the kit – APC will not need to leave one



Next Steps

- ✓ There will be a test group with an enabled Hep C Tool to test member
- ✓ Feedback call will discuss process and any technical difficulties, date TBD
- ✓ Any questions and/or concerns do not hesitate to reach out to your **CTM**
- ✓ If member doesn't have a kit on the weekends or there are issues on the weekends, the member will need to call LGC on Monday
- ✓ **DO NOT** forget to review your Member Information the night before
- ✓ Refer to Hepatitis- C Screening Job Aid on the CEC
- ✓ **IF** member did not receive kit or needs replacement kit call **855-440-1975 ET/5am-5pm PT, Monday-Friday**
- ✓ Any trouble logging into the CEC – contact clientlearning@optum.com

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Thank You

Thank you for all you do in helping our members live healthier lives & making the healthcare system work better for everyone!

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Returning Revisions:

If the 2nd amendment does not pass QA and the chart needs to be returned to the HCP a 3rd time:

1) Send an email to both the HCP and CTM and cc: Stacy Park (refer to the template below).
2) Mark the email as High Importance.
3) Return the Revision to the HCP at the same time. The information included under "Reason for return" below should be included in the "Reviewer Comments" section of the QA Coversheet.
4) Attach the QA Reference handout "How to Complete a QA Documentation Discrepancy" to the email *(handout is in development- attach when available).*

Our goal is to avoid returning the chart for a 3rd time (or after the HCP has written 2 amendments). Therefore, consider whether the amendment has at least addressed the major issues and can be accepted 'As- Is'. If unsure, please reach out to Stacy for direction.

Email Template (erase information in red before sending):

Good morning/afternoon:

The amendment for the following Documentation Discrepancy has not passed QA Review 2 or more times:

Member ID#
Date of HouseCalls visit:

Reason for return *(choose one or more as applicable):*

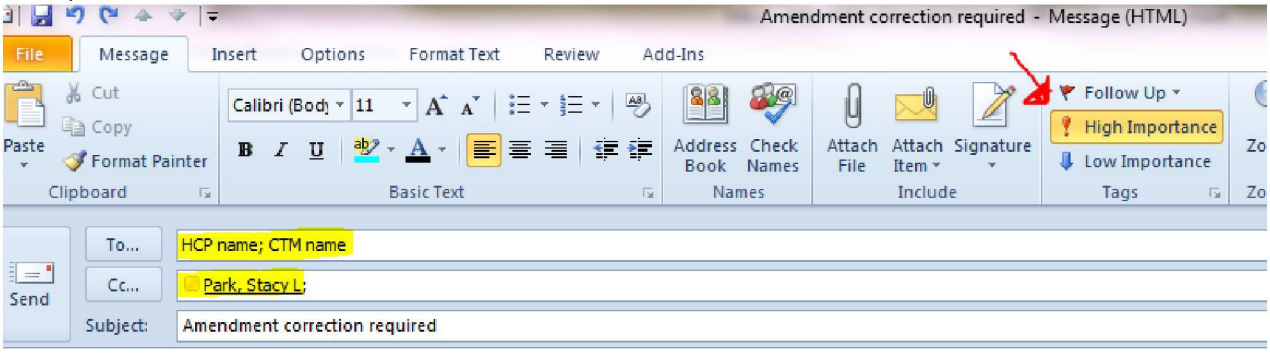
- Comments to the QA team are included in the amendment.
- The amendment is not specific regarding the changes requested.
- The amendment did not address the following issue: _____

(Add additional instruction for the HCP if needed, but keep comments brief)

The chart has been returned to your Portal under "Documentation Discrepancy". Please complete and return at your earliest convenience.
If you need further assistance, please contact your CTM. The QA team is also available Monday through Friday 9am-5pm EST. Voicemail is available 24 hours. 1.855.247.8474, Option 3
Email: HouseCallsClinicalQA_DL@ds.uhc.com

Thank you for your commitment to quality documentation.

Example:



Good morning/afternoon:

The amendment for the following Documentation Discrepancy has not passed QA Review 2 or more times:

Member ID# 5555555
Date of HouseCalls visit: 6/1/2017

Reason for return:

- The amendment did not address the following issue: The SMART goal for the diagnosis of Proteinuria was not revised.

The chart has been returned to your Portal under "Documentation Discrepancy". Please complete and return at your earliest convenie
If you need further assistance, please contact your CTM. The QA team is also available Monday through Friday 9am-5pm EST. Voicem
Email: HouseCallsClinicalQA_DL@ds.uhc.com

Thank you for your commitment to quality documentation.

Thank you,
(your signature)

HouseCalls

HIPAA Privacy Notice
Acknowledgement

I acknowledge that HouseCalls presented me with the Notice of Privacy Practices. I had the opportunity to review the Notice of Privacy Practices prior to initialing this form. I understand that a hard copy of the Notice of Privacy Practices is available upon request.

Is this a virtual visit: ☐ Yes ☐ No

For Virtual Visits:

I am required to notify you of our HouseCalls Privacy Practices. They can be found at Housecallsvisit.com if you wish to view. Also, a paper copy of the Privacy Practices can be mailed upon request.

Practitioner directed member to Housecallsvisit.com for opportunity to view the Notice of Privacy Practice. Member was also notified a paper copy can be mailed upon request.

☐ Yes

Member Initials: _____ Date:

☐ Member/Patient unable to initial

Reason: Member/Patient Refused to Initial, Illiterate, Cannot Write, Cannot Sign, Unable or Difficult to Write Due to Tremors, Altered Mental State, Dementia, Weakness, POA or Other Person Present Signed for Member, Member Blind or Limited Vision, Refuses to Sign/Initial, Mentally Challenged or Disabled, Bedbound, Assessment Completed Later, thus No Member Signature, Performed on Paper Assessment, Video Virtual Visit

Member Name: ID: Date of Birth: Gender:

Address: _____ Phone: _____

Plan Name: _____ Alt Phone: _____

Practitioner Name: _____ ID: _____ Scheduled Date: _____

Best time to call member: _____ Care Manager: _____ Care Mgr Phone: _____

LIS Level: _____ Language Indicator: _____

Race: White , Black or African American , American Indian and Alaska Native , Asian , Native Hawaiian and Other Pacific Islander , Some Other Race , Two or More Races , Asked but No Answer , Unknown

Ethnicity: Hispanic/Latino , Not Hispanic/Latino , Asked but No Answer , Unknown

Subscriber ID: _____ Reason for Visit: 360 , HouseCalls

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HouseCalls

Member Name: ID: Date of Birth:

NEW DEMOGRAPHIC INFORMATION

First Name: _____

Last Name: _____

DOB: _____ Alt Phone: _____

Physical Address

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____

Zip Code: _____

Mailing Address ☐ Same As Physical Address

Address Line 1: _____

Address Line 2: _____

City: _____ State: _____

Zip Code: _____

Assessment took place in: Member Home , Video virtual visit - FaceTime , Video virtual visit - SightCall , Video virtual visit - Google Duo , Video virtual visit - HC Tablet CS CDO OAH , Video virtual visit - Vivify PHS - UHC 90 Day Program , HouseCalls and Post Acute , Video Virtual Visit - HouseCalls and Post Acute - FaceTime , Video Virtual Visit - HouseCalls and Post Acute - Google Duo , Video Virtual Visit - HouseCalls and Post Acute - Sight Call , In-Office , Alternate Location , Other

Other: _____

Non-Member contact

First Name	Middle Name	Last Name	Type	Phone	Relationship	Consent Given To Be Present?
						☐
						☐

Can you count on your family / Caregiver for help and support ☐ Yes ☐ No

What would you like me to focus on in your visit today? Lifestyle changes to improve my health,Preventive screenings/vaccinations,Resources to help in my daily life,Medications,Managing chronic conditions,Public health concerns,No issues/Not applicable,Other

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HouseCalls

Member Name: ID: Date of Birth:

Other:

Your Primary Care Provider will receive a summary of this visit not the entire assessment.

PCP Information Confirmed: ☐ Yes ☐ No ☐ Member Does Not Have PCP ☐ Member needs assistance finding a PCP

PCP: _____

Address: _____ Phone: _____

Complete this section below only if PCP Information above is incorrect

First Name: _____ Middle Name: _____ Last Name: _____ Credential: BDS,DMD,DO,MBBS,MD,NP,OD,PA,PhD _____

Address Line1: _____ Address Line2: _____

State: _____ City: _____ Zip5: _____

Phone : _____ Specialty : ☐Allergy and Immunology ☐Cardiology ☐Dermatology ☐Emergency Medicine ☐Endocrinology ☐Family/General/Internal Medicine ☐Gastroenterology ☐General surgery ☐Geriatric Medicine ☐Hematology/Oncology ☐Hepatology ☐Hospice and Palliative Medicine ☐Infectious Disease ☐Nephrology ☐Neurological Surgery ☐Neurology ☐Obstetrics/Gynecology ☐Ophthalmology ☐Optometry ☐Orthopedic Surgery ☐Otolaryngology ☐Pain Medicine ☐Podiatry ☐Psychiatry/Psychology ☐Pulmonary Disease ☐Radiation Oncology ☐Rheumatology ☐Unknown Physician Specialty ☐Urology ☐Vascular Surgery ☐Other

SPECIALIST INFORMATION

(Enter Specialist (s) in the past 12 months)

Confirm	Provider name / Name of Clinic	Last Visit Date	Address	Phone	Specialty
☐					☐Allergy and Immunology ☐Cardiology ☐Dermatology ☐Emergency Medicine ☐Endocrinology ☐Family/General/Internal Medicine ☐Gastroenterology ☐General surgery ☐Geriatric Medicine ☐Hematology/Oncology ☐Hepatology ☐Hospice and Palliative Medicine ☐Infectious Disease ☐Nephrology ☐Neurological Surgery ☐Neurology ☐Obstetrics/Gynecology ☐Ophthalmology ☐Optometry ☐Orthopedic Surgery ☐Otolaryngology ☐Pain Medicine ☐Podiatry ☐Psychiatry/Psychology ☐Pulmonary Disease ☐Radiation Oncology ☐Rheumatology ☐Unknown Physician Specialty ☐Urology ☐Vascular Surgery ☐Other
☐					☐Allergy and Immunology ☐Cardiology ☐Dermatology ☐Emergency Medicine ☐Endocrinology ☐Family/General/Internal Medicine ☐Gastroenterology ☐General surgery ☐Geriatric Medicine ☐Hematology/Oncology ☐Hepatology ☐Hospice and Palliative Medicine ☐Infectious Disease ☐Nephrology ☐Neurological Surgery ☐Neurology ☐Obstetrics/Gynecology ☐Ophthalmology ☐Optometry ☐Orthopedic Surgery ☐Otolaryngology ☐Pain Medicine ☐Podiatry ☐Psychiatry/Psychology ☐Pulmonary Disease ☐Radiation Oncology ☐Rheumatology ☐Unknown Physician Specialty ☐Urology ☐Vascular Surgery ☐Other

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HouseCalls

Member Name: ID: Date of Birth:

Confirm	Provider name / Name of Clinic	Last Visit Date	Address	Phone	Specialty
☐					☐Allergy and Immunology ☐Cardiology ☐Dermatology ☐Emergency Medicine ☐Endocrinology ☐Family/General/Internal Medicine ☐Gastroenterology ☐General surgery ☐Geriatric Medicine ☐Hematology/Oncology ☐Hepatology ☐Hospice and Palliative Medicine ☐Infectious Disease ☐Nephrology ☐Neurological Surgery ☐Neurology ☐Obstetrics/Gynecology ☐Ophthalmology ☐Optometry ☐Orthopedic Surgery ☐Otolaryngology ☐Pain Medicine ☐Podiatry ☐Psychiatry/Psychology ☐Pulmonary Disease ☐Radiation Oncology ☐Rheumatology ☐Unknown Physician Specialty ☐Urology ☐Vascular Surgery ☐Other
☐					☐Allergy and Immunology ☐Cardiology ☐Dermatology ☐Emergency Medicine ☐Endocrinology ☐Family/General/Internal Medicine ☐Gastroenterology ☐General surgery ☐Geriatric Medicine ☐Hematology/Oncology ☐Hepatology ☐Hospice and Palliative Medicine ☐Infectious Disease ☐Nephrology ☐Neurological Surgery ☐Neurology ☐Obstetrics/Gynecology ☐Ophthalmology ☐Optometry ☐Orthopedic Surgery ☐Otolaryngology ☐Pain Medicine ☐Podiatry ☐Psychiatry/Psychology ☐Pulmonary Disease ☐Radiation Oncology ☐Rheumatology ☐Unknown Physician Specialty ☐Urology ☐Vascular Surgery ☐Other

SURGERY DETAILS

Surgery	Year	Month

ADMISSIONS (list all admissions within the past 12 months)

Year	Month	Number of Days	Hospital	Diagnosis

Had three (3) or more Emergency Room visits in the last three (3) months? ☐Yes ☐No

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Clinical Review

Diagnosis	Type	Year	Active	Resolved
Diabetes Type 1	Type	Year	Active	Resolved
	☐ Without complications		☐	☐
	☐ With hyperglycemia		☐	☐
	☐ With hyperglycemia, Immunodeficiency due to condition		☐	☐
	☐ With hypoglycemia without coma		☐	☐
	☐ Complications, Acanthosis nigricans		☐	☐
	☐ Complications, Cataracts		☐	☐
	☐ Complications, Chronic Kidney Disease, Stage 1 (GFR >=90)		☐	☐
	☐ Complications, Chronic Kidney Disease, Stage 2 (Mild-GFR 60-89)		☐	☐
	☐ Complications, Chronic Kidney Disease, Stage 3, Stage 3a (Moderate-GFR 45-59)		☐	☐
	☐ Complications, Chronic Kidney Disease, Stage 3, Stage 3b (Moderate-GFR 30-44)		☐	☐
	☐ Complications, Chronic Kidney Disease, Stage 3, Stage 3 Unspecified		☐	☐
	☐ Complications, Chronic Kidney Disease, Stage 4 (Severe-GFR 15-29)		☐	☐
	☐ Complications, Chronic Kidney Disease, Stage 5 (Failure-GFR < 15)		☐	☐
	☐ Complications, Chronic Kidney Disease, Stage 5 (Failure-GFR < 15), Member has not yet started dialysis		☐	☐
	☐ Complications, Chronic Kidney Disease, Stage 5 (Failure-GFR < 15), Member declined dialysis		☐	☐
	☐ Complications, Chronic Kidney Disease, End Stage Renal Disease (GFR < 15 or Chronic Dialysis), ESRD on Dialysis (GFR < 15 or Chronic Dialysis)		☐	☐
	☐ Complications, Chronic Kidney Disease, End Stage Renal Disease (GFR < 15 or Chronic Dialysis), ESRD on Dialysis (GFR < 15 or Chronic Dialysis), Immunodeficiency due to external cause		☐	☐
	☐ Complications, Chronic Kidney Disease, End Stage Renal Disease (GFR < 15 or Chronic Dialysis), Member noncompliance with renal dialysis		☐	☐
	☐ Complications, Chronic Kidney Disease, Unspecified		☐	☐
	☐ Complications, End Stage Renal Disease		☐	☐
	☐ Complications, Erectile Dysfunction		☐	☐
	☐ Complications, Gangrene		☐	☐
	☐ Complications, Gastroparesis		☐	☐
	☐ Complications, Glaucoma		☐	☐
	☐ Complications, Hyperlipidemia unspecified		☐	☐
	☐ Complications, Nephropathy		☐	☐
	☐ Complications, Palmar fascial fibromatosis [Dupuytren]		☐	☐

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HouseCalls

Member Name: ID: Date of Birth:

Diagnosis	Type	Year	Active	Resolved
Diabetes Type 1	Type	Year	Active	Resolved
	☐ Complications, Peripheral Vascular Disease with Gangrene		☐	☐
	☐ Complications, Peripheral Vascular Disease without Gangrene		☐	☐
	☐ Complications, Polyneuropathy		☐	☐
	☐ Complications, Retinopathy Unspecified		☐	☐
	☐ Complications, Trigger finger unspecified finger		☐	☐
	☐ Complications, Ulcers		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Ankle, Left, Bone necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Ankle, Left, Breakdown of skin		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Ankle, Left, Fat layer exposed		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Ankle, Left, Muscle necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Ankle, Left, Unspecified		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Ankle, Right, Bone necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Ankle, Right, Breakdown of skin		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Ankle, Right, Fat layer exposed		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Ankle, Right, Muscle necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Ankle, Right, Unspecified		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Foot, Left, Bone necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Foot, Left, Breakdown of skin		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Foot, Left, Fat layer exposed		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Foot, Left, Muscle necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Foot, Left, Unspecified		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Foot, Right, Bone necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Foot, Right, Breakdown of skin		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Foot, Right, Fat layer exposed		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Foot, Right, Muscle necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Foot, Right, Unspecified		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Lower leg, Left, Bone necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Lower leg, Left, Breakdown of skin		☐	☐

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HouseCalls

Member Name: ID: Date of Birth:

Diagnosis	Type	Year	Active	Resolved
Diabetes Type 1	Type	Year	Active	Resolved
	☐ Complications, Ulcers, Non-pressure ulcer, Lower leg, Left, Fat layer exposed		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Lower leg, Left, Muscle necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Lower leg, Left, Unspecified		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Lower leg, Right, Bone necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Lower leg, Right, Breakdown of skin		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Lower leg, Right, Fat layer exposed		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Lower leg, Right, Muscle necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Lower leg, Right, Unspecified		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Left, Bone necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Left, Breakdown of skin		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Left, Fat layer exposed		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Left, Muscle necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Left, Unspecified		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Right, Bone necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Right, Breakdown of skin		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Right, Fat layer exposed		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Right, Muscle necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Right, Unspecified		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Other, Bone necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Other, Breakdown of skin		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Other, Fat layer exposed		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Other, Muscle necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Other, Unspecified		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Thigh, Left, Bone necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Thigh, Left, Breakdown of skin		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Thigh, Left, Fat layer exposed		☐	☐

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HouseCalls

Member Name: ID: Date of Birth:

Diagnosis	Type	Year	Active	Resolved
Diabetes Type 1	Type	Year	Active	Resolved
	☐ Complications, Ulcers, Non-pressure ulcer, Thigh, Left, Muscle necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Thigh, Left, Unspecified		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Thigh, Right, Bone necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Thigh, Right, Breakdown of skin		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Thigh, Right, Fat layer exposed		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Thigh, Right, Muscle necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Thigh, Right, Unspecified		☐	☐
	☐ Complications, Unspecified		☐	☐

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HouseCalls

Member Name: ID: Date of Birth:

Diagnosis	Type	Year	Active	Resolved
Diabetes Type 2	Type	Year	Active	Resolved
	☐ Without complications		☐	☐
	☐ With hyperglycemia		☐	☐
	☐ With hyperglycemia, Immunodeficiency due to condition		☐	☐
	☐ With hypoglycemia without coma		☐	☐
	☐ Complications, Acanthosis nigricans		☐	☐
	☐ Complications, Cataracts		☐	☐
	☐ Complications, Chronic Kidney Disease, Stage 1 (GFR >=90)		☐	☐
	☐ Complications, Chronic Kidney Disease, Stage 2 (Mild-GFR 60-89)		☐	☐
	☐ Complications, Chronic Kidney Disease, Stage 3, Stage 3a (Moderate-GFR 45-59)		☐	☐
	☐ Complications, Chronic Kidney Disease, Stage 3, Stage 3b (Moderate-GFR 30-44)		☐	☐
	☐ Complications, Chronic Kidney Disease, Stage 3, Stage 3 Unspecified		☐	☐
	☐ Complications, Chronic Kidney Disease, Stage 4 (Severe-GFR 15-29)		☐	☐
	☐ Complications, Chronic Kidney Disease, Stage 5 (Failure-GFR < 15)		☐	☐
	☐ Complications, Chronic Kidney Disease, Stage 5 (Failure-GFR < 15), Member has not yet started dialysis		☐	☐
	☐ Complications, Chronic Kidney Disease, Stage 5 (Failure-GFR < 15), Member declined dialysis		☐	☐
	☐ Complications, Chronic Kidney Disease, End Stage Renal Disease (GFR < 15 or Chronic Dialysis), ESRD on Dialysis (GFR < 15 or Chronic Dialysis)		☐	☐
	☐ Complications, Chronic Kidney Disease, End Stage Renal Disease (GFR < 15 or Chronic Dialysis), ESRD on Dialysis (GFR < 15 or Chronic Dialysis), Immunodeficiency due to external cause		☐	☐
	☐ Complications, Chronic Kidney Disease, End Stage Renal Disease (GFR < 15 or Chronic Dialysis), Member noncompliance with renal dialysis		☐	☐
	☐ Complications, Chronic Kidney Disease, Unspecified		☐	☐
	☐ Complications, Diabetic dermatitis		☐	☐
	☐ Complications, End Stage Renal Disease		☐	☐
	☐ Complications, Erectile Dysfunction		☐	☐
	☐ Complications, Gangrene		☐	☐
	☐ Complications, Gastroparesis		☐	☐
	☐ Complications, Glaucoma		☐	☐
	☐ Complications, Hyperlipidemia unspecified		☐	☐
	☐ Complications, Nephropathy		☐	☐
	☐ Complications, Palmar fascial fibromatosis [Dupuytren]		☐	☐
	☐ Complications, Peripheral Vascular Disease with Gangrene		☐	☐

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Diagnosis	Type	Year	Active	Resolved
Diabetes Type 2	Type	Year	Active	Resolved
	☐ Complications, Peripheral Vascular Disease without Gangrene		☐	☐
	☐ Complications, Polyneuropathy		☐	☐
	☐ Complications, Retinopathy Unspecified		☐	☐
	☐ Complications, Trigger finger unspecified finger		☐	☐
	☐ Complications, Ulcers		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Ankle, Left, Bone necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Ankle, Left, Breakdown of skin		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Ankle, Left, Fat layer exposed		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Ankle, Left, Muscle necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Ankle, Left, Unspecified		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Ankle, Right, Bone necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Ankle, Right, Breakdown of skin		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Ankle, Right, Fat layer exposed		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Ankle, Right, Muscle necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Ankle, Right, Unspecified		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Foot, Left, Bone necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Foot, Left, Breakdown of skin		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Foot, Left, Fat layer exposed		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Foot, Left, Muscle necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Foot, Left, Unspecified		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Foot, Right, Bone necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Foot, Right, Breakdown of skin		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Foot, Right, Fat layer exposed		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Foot, Right, Muscle necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Foot, Right, Unspecified		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Lower leg, Left, Bone necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Lower leg, Left, Breakdown of skin		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Lower leg, Left, Fat layer exposed		☐	☐

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HouseCalls

Member Name: ID: Date of Birth:

Diagnosis	Type	Year	Active	Resolved
Diabetes Type 2	Type	Year	Active	Resolved
	☐ Complications, Ulcers, Non-pressure ulcer, Lower leg, Left, Muscle necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Lower leg, Left, Unspecified		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Lower leg, Right, Bone necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Lower leg, Right, Breakdown of skin		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Lower leg, Right, Fat layer exposed		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Lower leg, Right, Muscle necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Lower leg, Right, Unspecified		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Left, Bone necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Left, Breakdown of skin		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Left, Fat layer exposed		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Left, Muscle necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Left, Unspecified		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Right, Bone necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Right, Breakdown of skin		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Right, Fat layer exposed		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Right, Muscle necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Right, Unspecified		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Other, Bone necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Other, Breakdown of skin		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Other, Fat layer exposed		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Other, Muscle necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Other, Unspecified		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Thigh, Left, Bone necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Thigh, Left, Breakdown of skin		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Thigh, Left, Fat layer exposed		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Thigh, Left, Muscle necrosis		☐	☐

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HouseCalls

Member Name: ID: Date of Birth:

Diagnosis	Type	Year	Active	Resolved
Diabetes Type 2	Type	Year	Active	Resolved
	☐ Complications, Ulcers, Non-pressure ulcer, Thigh, Left, Unspecified		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Thigh, Right, Bone necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Thigh, Right, Breakdown of skin		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Thigh, Right, Fat layer exposed		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Thigh, Right, Muscle necrosis		☐	☐
	☐ Complications, Ulcers, Non-pressure ulcer, Thigh, Right, Unspecified		☐	☐
	☐ Complications, Unspecified		☐	☐
	☐ Chronic insulin therapy		☐	☐
Cataract Age-Related	Type	Year	Active	Resolved
	☐ Active		☐	☐
	☐ Removed		☐	☐
Unspecified glaucoma			☐	☐
Macular Degeneration	Type	Year	Active	Resolved
	☐ Unspecified		☐	☐
Protein-Calorie Malnutrition	Type	Year	Active	Resolved
	☐ Unspecified		☐	☐
	☐ Mild		☐	☐
	☐ Moderate		☐	☐
	☐ Severe		☐	☐
Transplant	Type	Year	Active	Resolved
	☐ Bone		☐	☐
	☐ Bone marrow		☐	☐
	☐ Cornea		☐	☐
	☐ Heart		☐	☐
	☐ Heart and Lung		☐	☐
	☐ Intestine		☐	☐
	☐ Kidney		☐	☐
	☐ Liver		☐	☐
	☐ Lung		☐	☐
	☐ Pancreas		☐	☐
	☐ Skin		☐	☐
	☐ Stem Cell		☐	☐
	☐ Other transplanted organ and tissue		☐	☐
	☐ Transplanted organ and tissue, Unspecified		☐	☐

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Diagnosis	Type	Year	Active	Resolved
Immunodeficiency	Type	Year	Active	Resolved
	☐ Due to External Cause,Radiation therapy		☐	☐
	☐ Due to External Cause,Bone marrow transplant		☐	☐
	☐ Due to External Cause,Dialysis		☐	☐
	☐ Due to External Cause,Organ transplant		☐	☐
	☐ Due to Condition,Lupus		☐	☐
	☐ Due to Condition,Rheumatoid - Arthritis		☐	☐
	☐ Due to Condition,Cirrrhosis		☐	☐
	☐ Due to Condition,Diabetes Type 1 - Hyperglycemia		☐	☐
	☐ Due to Condition,Diabetes Type 2 - Hyperglycemia		☐	☐
	☐ Due to Condition,Ulcerative colitis - unspecified with other complication		☐	☐
	☐ Due to Condition,Crohn's disease - unspecified - with other complication		☐	☐
	☐ Due to Condition,Sickle cell disease		☐	☐
	☐ Due to Condition,Acute leukemia - not having achieved remission		☐	☐
	☐ Due to Condition,Chronic leukemia - not having achieved remission		☐	☐
	☐ Due to Condition,Lymphoma		☐	☐
	☐ Due to Condition,Multiple Myeloma		☐	☐
	☐ Due to Condition,Acquired absence of spleen		☐	☐
Asthma			☐	☐
Chronic obstructive pulmonary disease, unspecified			☐	☐
Emphysema			☐	☐
Pneumonia			☐	☐
Obstructive sleep apnea			☐	☐
Tuberculosis	Type	Year	Active	Resolved
	☐ Current		☐	☐
	☐ Past		☐	☐
	☐ Prophylaxis		☐	☐
Sick sinus syndrome			☐	☐
Atrial fibrillation, Unspecified			☐	☐
Anti-Coag Therapy - chronic, ongoing			☐	☐
Cardiac murmur, unspecified			☐	☐
History of Myocardial infarction			☐	☐
Heart Failure			☐	☐
Hypertension			☐	☐
Hyperlipidemia, unspecified			☐	☐
Previous Coronary artery bypass graft			☐	☐
Previous angioplasty			☐	☐

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Diagnosis	Type	Year	Active	Resolved
Chronic Kidney Disease	Type	Year	Active	Resolved
	☐ Stage 1 (GFR >=90)		☐	☐
	☐ Stage 2 (Mild-GFR 60-89)		☐	☐
	☐ Stage 3, Stage 3a (Moderate-GFR 45-59)		☐	☐
	☐ Stage 3, Stage 3b (Moderate-GFR 30-44)		☐	☐
	☐ Stage 3, Stage 3 Unspecified		☐	☐
	☐ Stage 4 (Severe-GFR 15-29)		☐	☐
	☐ Stage 5 (Failure-GFR < 15)		☐	☐
	☐ Stage 5 (Failure-GFR < 15), Member has not yet started dialysis		☐	☐
	☐ Stage 5 (Failure-GFR < 15), Member declined dialysis		☐	☐
	☐ End Stage Renal Disease (GFR < 15 or Chronic Dialysis), ESRD on Dialysis (GFR < 15 or Chronic Dialysis)		☐	☐
	☐ End Stage Renal Disease (GFR < 15 or Chronic Dialysis), ESRD on Dialysis (GFR < 15 or Chronic Dialysis), Immunodeficiency due to external cause		☐	☐
	☐ End Stage Renal Disease (GFR < 15 or Chronic Dialysis), Member noncompliance with renal dialysis		☐	☐
	☐ Unspecified		☐	☐
Presence of coronary angioplasty implant and graft			☐	☐
Angina	Type	Year	Active	Resolved
	☐Stable ☐Member prescribed an anti-angina medication, or another medication with the indication of Angina on the member medication list ☐Member states has known Angina, but opted not to take medication or medication is contraindicated		☐	☐
	☐ Unstable		☐	☐
	☐Unspecified ☐Member prescribed an anti-angina medication, or another medication with the indication of Angina on the member medication list ☐Member states has known Angina, but opted not to take medication or medication is contraindicated		☐	☐
Renal lithiasis			☐	☐
Chronic Aspirin Therapy			☐	☐
Gastro-esophageal reflux disease without esophagitis			☐	☐

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HouseCalls

Member Name: ID: Date of Birth:

Diagnosis	Type	Year	Active	Resolved
Chronic Liver Disease	Type	Year	Active	Resolved
	☐ Chronic Hepatitis B		☐	☐
	☐ Chronic Hepatitis C		☐	☐
	☐ Cirrhosis		☐	☐
	☐ Cirrhosis, Immunodeficiency due to condition		☐	☐
	☐ Unspecified		☐	☐
	☐ Nonalcoholic Fatty Liver Disease		☐	☐
Thyroid Disease	Type	Year	Active	Resolved
	☐ Hypothyroidism		☐	☐
	☐ Hyperthyroidism		☐	☐
	☐ Thyroid Nodule		☐	☐
	☐ Hyperparathyroidism, Unspecified		☐	☐
Degenerative disc disease	Type	Year	Active	Resolved
	☐ Cervical		☐	☐
	☐ Thoracic		☐	☐
	☐ Lumbar		☐	☐
Osteoporosis			☐	☐
Osteopenia			☐	☐
Arthritis	Type	Year	Active	Resolved
	☐ Osteo		☐	☐
	☐ Rheumatoid		☐	☐
	☐ Rheumatoid, Immunodeficiency due to condition		☐	☐
Gout, Unspecified			☐	☐
Osteomyelitis			☐	☐
Peripheral Vascular Disease, Unspecified			☐	☐
Deep Vein Thrombosis, Chronic	Type	Year	Active	Resolved
	☐ Right lower extremity		☐	☐
	☐ Left lower extremity		☐	☐
	☐ Right upper extremity		☐	☐
	☐ Left upper extremity		☐	☐
	☐ Lower extremity, bilateral		☐	☐
	☐ Upper extremity, bilateral		☐	☐
	☐ Unspecified lower extremity		☐	☐
	☐ Unspecified upper extremity		☐	☐

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Member Name: ID: Date of Birth:

Diagnosis	Type	Year	Active	Resolved
Monoplegia	Type	Year	Active	Resolved
	☐ Due to Head Injury		☐	☐
	☐ Unspecified Cause, Unspecified, Left lower extremity, Dominant side		☐	☐
	☐ Unspecified Cause, Unspecified, Left lower extremity, Non dominant side		☐	☐
	☐ Unspecified Cause, Unspecified, Left upper extremity, Dominant side		☐	☐
	☐ Unspecified Cause, Unspecified, Left upper extremity, Non dominant side		☐	☐
	☐ Unspecified Cause, Unspecified, Right lower extremity, Dominant side		☐	☐
	☐ Unspecified Cause, Unspecified, Right lower extremity, Non dominant side		☐	☐
	☐ Unspecified Cause, Unspecified, Right upper extremity, Dominant side		☐	☐
	☐ Unspecified Cause, Unspecified, Right upper extremity, Non dominant side		☐	☐
	☐ Late effect of CVA, Left lower extremity, Dominant side		☐	☐
	☐ Late effect of CVA, Left lower extremity, Non dominant side		☐	☐
	☐ Late effect of CVA, Left upper extremity, Dominant side		☐	☐
	☐ Late effect of CVA, Left upper extremity, Non dominant side		☐	☐
	☐ Late effect of CVA, Right lower extremity, Dominant side		☐	☐
	☐ Late effect of CVA, Right lower extremity, Non dominant side		☐	☐
	☐ Late effect of CVA, Right upper extremity, Dominant side		☐	☐
	☐ Late effect of CVA, Right upper extremity, Non dominant side		☐	☐

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Diagnosis	Type	Year	Active	Resolved
Hemiplegia/Hemiparesis	Type	Year	Active	Resolved
	☐ Due to Head Injury		☐	☐
	☐ Unspecified Cause, Flaccid, Left, Dominant side		☐	☐
	☐ Unspecified Cause, Flaccid, Left, Non dominant side		☐	☐
	☐ Unspecified Cause, Flaccid, Right, Dominant side		☐	☐
	☐ Unspecified Cause, Flaccid, Right, Non dominant side		☐	☐
	☐ Unspecified Cause, Spastic, Left, Dominant side		☐	☐
	☐ Unspecified Cause, Spastic, Left, Non dominant side		☐	☐
	☐ Unspecified Cause, Spastic, Right, Dominant side		☐	☐
	☐ Unspecified Cause, Spastic, Right, Non dominant side		☐	☐
	☐ Unspecified Cause, Unspecified, Left, Dominant side		☐	☐
	☐ Unspecified Cause, Unspecified, Left, Non dominant side		☐	☐
	☐ Unspecified Cause, Unspecified, Right, Dominant side		☐	☐
	☐ Unspecified Cause, Unspecified, Right, Non dominant side		☐	☐
	☐ Late effect of CVA, Left, Dominant side		☐	☐
	☐ Late effect of CVA, Left, Non dominant side		☐	☐
	☐ Late effect of CVA, Right, Dominant side		☐	☐
	☐ Late effect of CVA, Right, Non dominant side		☐	☐
Paraplegia, Unspecified			☐	☐
Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits			☐	☐
Amyotrophic lateral sclerosis			☐	☐
Amyloidosis			☐	☐
Multiple Sclerosis			☐	☐
Cerebral Palsy			☐	☐
Myasthenia Gravis			☐	☐
Guillain-Barre			☐	☐
Huntington disease			☐	☐
Parkinson's disease			☐	☐
Seizure disorder, epilepsy			☐	☐
Alzheimer's disease, unspecified			☐	☐
Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety			☐	☐
Major depressive disorder, mild	Type	Year	Active	Resolved
	☐ Single Episode		☐	☐
	☐ Recurrent		☐	☐

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HouseCalls

Member Name: ID: Date of Birth:

Diagnosis	Type	Year	Active	Resolved
Major depressive disorder, moderate	Type	Year	Active	Resolved
	☐ Single Episode		☐	☐
	☐ Recurrent		☐	☐
Major depressive disorder, severe without psychotic features	Type	Year	Active	Resolved
	☐ Single Episode		☐	☐
	☐ Recurrent		☐	☐
Major depressive disorder in partial remission	Type	Year	Active	Resolved
	☐ Single Episode		☐	☐
	☐ Recurrent		☐	☐
Major depressive disorder in full remission	Type	Year	Active	Resolved
	☐ Single Episode		☐	☐
	☐ Recurrent		☐	☐
Schizophrenia, unspecified			☐	☐
Paranoid Schizophrenia			☐	☐
Anemia	Type	Year	Active	Resolved
	☐ Neoplastic Disease		☐	☐
	☐ Chronic Kidney Disease		☐	☐
	☐ Iron Deficiency		☐	☐
	☐ Pernicious		☐	☐
	☐ Sickle Cell		☐	☐
	☐ Sickle Cell Trait		☐	☐
	☐ Unspecified		☐	☐

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Member Name: ID: Date of Birth:

Diagnosis	Type	Year	Active	Resolved
Cancer	Type	Year	Active	Resolved
	☐ Acute leukemia - not having achieved remission		☐	☐
	☐ Basal cell carcinoma of skin - unspecified		☐	☐
	☐ Bladder		☐	☐
	☐ Bone		☐	☐
	☐ Brain		☐	☐
	☐ Breast		☐	☐
	☐ Cervical		☐	☐
	☐ Chronic leukemia - not having achieved remission		☐	☐
	☐ Chronic leukemia - not having achieved remission, Immunodeficiency due to condition		☐	☐
	☐ Colon		☐	☐
	☐ Colorectal		☐	☐
	☐ Gastric		☐	☐
	☐ Larynx		☐	☐
	☐ Liver		☐	☐
	☐ Lung		☐	☐
	☐ Lymphoma		☐	☐
	☐ Melanoma		☐	☐
	☐ Ovarian		☐	☐
	☐ Multiple Myeloma		☐	☐
	☐ Multiple Myeloma, Immunodeficiency due to condition		☐	☐
	☐ Pancreatic		☐	☐
	☐ Prostate		☐	☐
	☐ Renal		☐	☐
	☐ Thyroid		☐	☐
	☐ Uterine		☐	☐
	☐ Unspecified		☐	☐
	☐ Acute leukemia - not having achieved remission, Immunodeficiency due to condition		☐	☐
	☐ Lymphoma, Immunodeficiency due to condition		☐	☐

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HouseCalls

Member Name: ID: Date of Birth:

MEDICATIONS/SUPPLEMENTS: Please include all Prescriptions,OTCs and herbal medications. Confirm the pre-populated medications.

Please indicate if the medication is a Sample (S), VA Supply (V), received via Pharmacy Program (P) or is Member Initiated (M).

Has member been discharged from the hospital in the past 30 days ☐ Yes ☐ No

Member provided discharge summary sheet of medications for review and reconciliation ☐ Yes ☐ No

D/C Med		Active		Medication - Dose	Quantity	Frequency	Last Fill Date	Indication	Non-Adherent	Drug Type	Prescriber	S/V/P/M	Note
Y	N	Y	N										
☐	☐	☐	☐						☐				
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HouseCalls

Member Name: ID: Date of Birth:

D/C Med		Active		Medication - Dose	Quantity	Frequency	Last Fill Date	Indication	Non-Adherent	Drug Type	Prescriber	S/V/P/M	Note
Y	N	Y	N										
☐	☐	☐	☐						☐				

Enter the total amount prescribed (days supply) for statin medication documented above : 30-days supply , 60-days supply , 90-days supply , Other

Other :

Immunodeficiency due to drugs: ☐ Yes ☐ No

Medications:

Comprehensive medication review done with member? ☐ Yes ☐ Refused ☐ Unable to Assess ☐ Reviewed, no active medications or supplements

Alzheimer's/Dementia, Meds Not Present, Caregiver Not Present, No Original Containers

Prescription Refill Documentation

Medication-Dose	Pharmacy and Phone No.	Quantity	Frequency	Amount Prescribed	Refills	PCP notified of refill
						☐
						☐
						☐
						☐
						☐
						☐

MEDICAL DEVICES: Please list any medical devices, such as glucometers or nebulizer, below.

Medical Device	Description

Barriers to Adherence

☐Member forgets to take the medication ☐Member cannot afford the medication ☐Member doesn't feel well when they take the medication
☐Concerned with side effects ☐No perceived benefit

ALLERGIES

Allergies: ☐ Yes ☐ NKA (If Yes please complete below table)

Known Allergies:

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HouseCalls

Member Name: ID: Date of Birth:

Drug / Allergen	Allergy / Reaction

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HouseCalls

Member Name: ID: Date of Birth:

VACCINATION HISTORY

Vaccination	Status	Months	Year	Reason for not receiving vaccine
Influenza				☐ Don't Remember ☐ Refused/Declined ☐ Allergic ☐ Unaware of Vaccine ☐ Cost Prohibitive ☐ Not Indicated ☐ Not Yet Scheduled
Pneumovax	☐ Received after age 65 ☐ Received before age 65 – One dose ☐ Received before age 65 – Two doses ☐ Received - date unknown			☐ Don't Remember ☐ Refused/Declined ☐ Allergic ☐ Unaware of Vaccine ☐ Cost Prohibitive ☐ Not Indicated ☐ Not Yet Scheduled
Herpes Zoster	☐ Received - date unknown			☐ Don't Remember ☐ Refused/Declined ☐ Allergic ☐ Unaware of Vaccine ☐ Cost Prohibitive ☐ Not Indicated ☐ Not Yet Scheduled
Tdap/Td	☐ Received within last 10 years ☐ Received greater than 10 years ago ☐ Within last 5 years ☐ Received - date unknown			☐ Don't Remember ☐ Refused/Declined ☐ Allergic ☐ Unaware of Vaccine ☐ Cost Prohibitive ☐ Not Indicated ☐ Not Yet Scheduled
Prevnar 13	☐ Received after age 65 ☐ Received - date unknown			☐ Don't Remember ☐ Refused/Declined ☐ Allergic ☐ Unaware of Vaccine ☐ Cost Prohibitive ☐ Not Indicated ☐ Not Yet Scheduled
Prevnar 15	☐ Received after age 65 ☐ Received - date unknown			☐ Don't Remember ☐ Refused/Declined ☐ Allergic ☐ Unaware of Vaccine ☐ Cost Prohibitive ☐ Not Indicated ☐ Not Yet Scheduled
Prevnar 20	☐ Received after age 65 ☐ Received - date unknown			☐ Don't Remember ☐ Refused/Declined ☐ Allergic ☐ Unaware of Vaccine ☐ Cost Prohibitive ☐ Not Indicated ☐ Not Yet Scheduled

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HouseCalls

Member Name: ID: Date of Birth:

Vaccination	Status	Months	Year	Reason for not receiving vaccine
COVID-19 Dose 1	☐ Received ☐ Not received			☐ Don't Remember ☐ Refused/Declined ☐ Allergic ☐ Unaware of Vaccine ☐ Cost Prohibitive ☐ Not Indicated ☐ Not Yet Scheduled
COVID-19 Dose 2	☐ Received ☐ Not received			☐ Don't Remember ☐ Refused/Declined ☐ Allergic ☐ Unaware of Vaccine ☐ Cost Prohibitive ☐ Not Indicated ☐ Not Yet Scheduled

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HouseCalls

Member Name: ID: Date of Birth:

PREVENTATIVE SCREENINGS

Screening Test	Test done?	Year	Month	Results	Additional Info	Performing Provider
Colonoscopy	☐Yes ☐No ☐Refused ☐Don't Remember ☐Not Indicated ☐Total Colectomy			☐Normal ☐Polyps ☐Cancer ☐Other ☐Unknown		
Flexible Sigmoidoscopy	☐Yes ☐No ☐Refused ☐Don't Remember ☐Not Indicated ☐Total Colectomy			☐Normal ☐Polyps ☐Cancer ☐Other ☐Unknown		
FIT-DNA	☐Yes ☐No ☐Refused ☐Don't Remember ☐Not Indicated ☐Total Colectomy			☐Normal ☐Abnormal ☐Unknown	☐Lab	
FOBT(guaiac or immunochemical)	☐Yes ☐No ☐Refused ☐Don't Remember ☐Not Indicated ☐Total Colectomy			☐Normal ☐Abnormal ☐Unknown	☐Office ☐Lab	
Mammogram	☐Yes ☐No ☐Refused ☐Don't Remember ☐Not Indicated ☐Bilateral Mastectomy			☐Normal ☐Abnormal, not cancer ☐Cancer ☐Unknown		
Bone Density Screening	☐Yes ☐No ☐Refused ☐Don't Remember ☐Not Indicated			☐Normal ☐Osteopenia ☐Osteoporosis ☐Unknown	T-Score:	☐Completed or offered at HouseCalls visit Test performed date: ☐Recently Completed ☐Member Refused at HCV ☐Not Indicated ☐Unable to perform Reasons: Involuntary movements, Amputee, Inconsistent results, Increased wrist adipose tissue, Video Virtual Visit

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HouseCalls

Member Name: ID: Date of Birth:

Screening Test	Test done?	Year	Month	Results	Additional Info	Performing Provider
Diabetic Retinal Screening	☐Yes ☐No ☐Refused ☐Don't Remember ☐Not Indicated			☐No retinopathy ☐Retinopathy ☐No Interpretation ☐Unknown ☐Other	☐Test performed or offered during HouseCalls visit and images sent to optometrist/ophthalmologist for interpretation Test performed date: ☐Results Reviewed ☐Recently Completed ☐Member Refused at HCV ☐Not Indicated ☐Unable to perform Reasons: Poor image quality, Involuntary movements, Eyelid drooping, Pupil constriction, Video Virtual Visit	☐Optometrist/Ophthalmologist Provider:

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HouseCalls

Member Name: ID: Date of Birth:

SOCIAL HISTORY/RISK FACTORS

Risk Factor	Use	Counseling	
Cigarettes	☐ Current ☐ Former ☐ Never	☐ Interested in quitting ☐ Counseled to quit ☐ "Commit to Quit" left with member	Years since last smoked: 15 years or less,Greater than 15 years Packs per day: <5 cigs/Day,¼ pack,½ pack,¾ pack,1 pack,1 ½ packs,2 packs,2 ½ packs,3 packs,>3 packs Years Smoking: _____ Pack Years: _____
Other Tobacco	☐ Current ☐ Former ☐ Never	☐ Interested in quitting ☐ Counseled to quit	
Drug Use	☐ Current ☐ Former ☐ Never	☐ Interested in quitting ☐ Counseled to quit	
Alcohol	☐ Current ☐ Former ☐ Never	☐ Interested in quitting ☐ Counseled to quit	Drinks per week: _____ Drinks per Occasion: _____
	CAGE Screening :		☐ Refused
	Have you felt you should cut down on your drinking?		☐ Yes ☐ No
	Have others annoyed you by criticizing your drinking?		☐ Yes ☐ No
	Have you ever felt guilty about your drinking?		☐ Yes ☐ No
	Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?		☐ Yes ☐ No
Life Planning	Does the member have an Advance Directive?		☐ Yes ☐ No
	Are you interested in the Advance Care Planning pamphlet?		☐ Yes ☐ No
	Advance Care Planning pamphlet left with member?		☐ Yes ☐ No
DME/Assistive Device	Does the member use an assistive device? ☐ Cane ☐ Walker ☐ Wheelchair ☐ Motorized Wheelchair		☐ Yes ☐ No
Outside Services	Does the member recieve any outside services ? ☐Home Health ☐Home Delivered Meals ☐Home and Community Services ☐Hospice ☐Adult Day Care ☐Physical Therapy ☐Occupational Therapy ☐Speech Therapy		☐ Yes ☐ No

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HouseCalls

Member Name: ID: Date of Birth:

Family History

☐ Reviewed and Negative ☐ Do not remember / Unknown ☐ Unable to assess Cognitive Impairment,Language Barrier

Disease	Relationship	Disease	Relationship
☐ Alcohol/Drug Abuse	☐Mother ☐Father ☐Son ☐Daughter ☐Sister(s) ☐Brother(s) ☐Don't Remember/Unknown	☐ Hyperlipidemia	☐Mother ☐Father ☐Son ☐Daughter ☐Sister(s) ☐Brother(s) ☐Don't Remember/Unknown
☐ Alzheimer's Disease/Dementia	☐Mother ☐Father ☐Son ☐Daughter ☐Sister(s) ☐Brother(s) ☐Don't Remember/Unknown	☐ Hypertension	☐Mother ☐Father ☐Son ☐Daughter ☐Sister(s) ☐Brother(s) ☐Don't Remember/Unknown
☐ Breast Cancer	☐Mother ☐Father ☐Son ☐Daughter ☐Sister(s) ☐Brother(s) ☐Don't Remember/Unknown	☐ Melanoma	☐Mother ☐Father ☐Son ☐Daughter ☐Sister(s) ☐Brother(s) ☐Don't Remember/Unknown
☐ CAD/MI	☐Mother ☐Father ☐Son ☐Daughter ☐Sister(s) ☐Brother(s) ☐Don't Remember/Unknown	☐ Ovarian Cancer	☐Mother ☐Father ☐Son ☐Daughter ☐Sister(s) ☐Brother(s) ☐Don't Remember/Unknown
☐ Cancer-Other	☐Mother ☐Father ☐Son ☐Daughter ☐Sister(s) ☐Brother(s) ☐Don't Remember/Unknown	☐ Prostate Cancer	☐Mother ☐Father ☐Son ☐Daughter ☐Sister(s) ☐Brother(s) ☐Don't Remember/Unknown
☐ Colon Cancer	☐Mother ☐Father ☐Son ☐Daughter ☐Sister(s) ☐Brother(s) ☐Don't Remember/Unknown	☐ Rheumatoid Arthritis	☐Mother ☐Father ☐Son ☐Daughter ☐Sister(s) ☐Brother(s) ☐Don't Remember/Unknown

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HouseCalls

Member Name: ID: Date of Birth:

Disease	Relationship	Disease	Relationship
☐ Depression	☐Mother ☐Father ☐Son ☐Daughter ☐Sister(s) ☐Brother(s) ☐Don't Remember/Unknown	☐ Stroke	☐Mother ☐Father ☐Son ☐Daughter ☐Sister(s) ☐Brother(s) ☐Don't Remember/Unknown
☐ Diabetes	☐Mother ☐Father ☐Son ☐Daughter ☐Sister(s) ☐Brother(s) ☐Don't Remember/Unknown		

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REVIEW OF SYSTEMS

Active selections in the last 4 weeks:

CONSTITUTIONAL ☐ Not Assessed ☐ Reviewed and Negative	
Recent fever or chills	☐
Fatigue	☐
Change in Appetite	☐
Unintentional weight loss greater than 10% in 6 months	☐
Reason:	Recent Hospitalization, Grieving loss of a loved one, Receiving Chemotherapy, Regaining Weight, No reason identified for weight loss
Weight gain in the last 4 weeks	☐

HEAD ☐ Not Assessed ☐ Reviewed and Negative	
Headaches	☐
Type:	☐ Recurrent/Severe ☐ New Onset ☐ Migraines ☐ Sinus ☐ Tension

EENT - EYES ☐ Not Assessed ☐ Reviewed and Negative	
Blurred Vision	Left, Right, Bilateral
Drainage	Left, Right, Bilateral
Itching	Left, Right, Bilateral
Pain	Left, Right, Bilateral
Changes in Vision	Left, Right, Bilateral
When:	48 hours or less, Past week, Past Month, >1 Month
Describe:	
Legally Blind	Left, Right, Bilateral
Glasses/Contacts	☐

EENT - EARS ☐ Not Assessed ☐ Reviewed and Negative	
Tinnitus	Left, Right, Bilateral
Ear Pain	Left, Right, Bilateral
Change in Hearing	Left, Right, Bilateral
Hearing Aid	Left, Right, Bilateral

EENT - NOSE AND THROAT ☐ Not Assessed ☐ Reviewed and Negative	
Nasal Congestion	☐
Poor Dentition	☐
Dentures	☐
Upper:	☐ Intact & Fit Well ☐ Poorly Fitting ☐ Broken ☐ NA
Lower:	☐ Intact & Fit Well ☐ Poorly Fitting ☐ Broken ☐ NA
Trouble Chewing	☐
Oral Lesions	☐
Oral/Facial Pain	☐
Hoarse	☐
Sore Throat	☐
Difficulty Swallowing	☐

RESPIRATORY ☐ Not Assessed ☐ Reviewed and Negative	
Cough	☐
Sputum	☐
Type:	☐ Clear ☐ Colored ☐ Bloody
SOB	☐
Type:	☐ At Rest ☐ Orthopnea ☐ PND ☐ With NL Daily Activity ☐ With Moderate Exertion
Wheezing	☐
Snoring	☐
CPAP/BiPAP	☐
Compliant:	Yes, No
Oxygen Therapy Prescribed?	Yes, No
How much:	
When:	Continuous, Intermittent, With Sleep
Compliant:	Yes, No

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HouseCalls

Member Name: ID: Date of Birth:

REVIEW OF SYSTEMS

CARDIOVASCULAR ☐ Not Assessed ☐ Reviewed and Negative	
Chest Pain	☐
Describe:	
Palpitations with symptoms	☐
With:	☐ Lightheadedness ☐ Dizziness
Palpitations without symptoms	☐
Syncope	☐
Weighing at least 3x/week	☐
Dependent Edema	☐
Claudication	☐
Use Compression Hose	☐

GASTROINTESTINAL ☐ Not Assessed ☐ Reviewed and Negative	
Heartburn	☐
Nausea	☐
Vomiting	☐
Vomiting Blood	☐
Diarrhea	☐
Constipation	☐
Black Stools	☐
Bloody Stools	☐
Hemorrhoids	☐
Fecal Incontinence	☐
Abdominal Pain	☐
Change in Bowel Habits	☐
Describe:	

GENITOURINARY ☐ Not Assessed ☐ Reviewed and Negative	
Urgency	☐
Frequency	☐
Dysuria	☐
Difficulty Urinating	☐
Incontinence	☐
Type:	☐ Urge ☐ Stress ☐ Mixed ☐ Total
Blood in Urine	☐
Nocturia	☐
Per night:	1, 2, 3, 4+

INTEGUMENTARY ☐ Not Assessed ☐ Reviewed and Negative	
Rash	☐
Atypical Skin Lesion	☐
Describe:	
Diabetic Ulcers	☐
Pressure Ulcers	☐
Stasis Ulcers	☐
Foot Ulcers	☐
Skin Tears, Abrasions, Lacerations	☐
Surgical Wound	☐
Easy Bruising	☐
Poor Healing of Wounds	☐

NEUROLOGICAL ☐ Not Assessed ☐ Reviewed and Negative	
Paresthesias (tingling, prickling, numbness)	☐
Dysethesias (burning or itching pain, pins and needles)	☐
Allodynia (pain d/t non-noxious stimuli)	☐
Hyperalegesia (elevated or exaggerated response to normally painful stimulus)	☐
Numbness	☐
Dizziness	☐
Loss of Balance	☐
Seizures	☐
Date of Last Seizure:	
Memory Problems	☐
Difficulty Speaking	☐
Major Motor Weakness	☐
Tremors	☐
Describe:	

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REVIEW OF SYSTEMS

MUSCULOSKELETAL ☐ Not Assessed ☐ Reviewed and Negative	
Gait Disturbances	☐
Neck Pain	☐
Neck Stiffness	☐
Back Pain	☐
Back Stiffness	☐
Unexplained Leg Pain	☐
Leg Muscle Cramping	☐
Leg Pain at Rest	☐
Muscle Pain	☐
Location:	
Joint Pain	☐
Left:	Shoulder, Elbow, Wrist, Finger(s), Hip, Knee, Ankle, Toe(s)
Right:	Shoulder, Elbow, Wrist, Finger(s), Hip, Knee, Ankle, Toe(s)
Joint Swelling	☐
Left:	Shoulder, Elbow, Wrist, Finger(s), Hip, Knee, Ankle, Toe(s)
Right:	Shoulder, Elbow, Wrist, Finger(s), Hip, Knee, Ankle, Toe(s)
Joint Stiffness	☐
Left:	Shoulder, Elbow, Wrist, Finger(s), Hip, Knee, Ankle, Toe(s)
Right:	Shoulder, Elbow, Wrist, Finger(s), Hip, Knee, Ankle, Toe(s)
Morning Stiffness	☐
How long:	>1 hr, <1 hr
Fractures	☐
Location:	Shoulder, Clavicle, Arm, Wrist, Hand, Finger, Ribs, Spine, Hip, Leg, Ankle, Multiple Sites, Toe
Date of Last Fracture:	

ENDOCRINE ☐ Not Assessed ☐ Reviewed and Negative	
Polydipsia (increased thirst)	☐
Polyphagia (increased hunger)	☐
Polyuria (increased urination)	☐
Heat Intolerance	☐
Cold Intolerance	☐
Hypoglycemic Events	☐

DIABETIC TESTING ☐ Not Applicable	Yes	No
Diabetic Testing	☐	☐
When?	☐ Fasting ☐ Before Meals ☐ After Meals ☐ Random ☐ Occasional ☐ Daily ☐ Twice Daily ☐ Other	
Range:		
Period of time of range:	Within last week, Within last month, Within last 3 months	
Member Reported A1C:		
A1C Date:		

PSYCHOLOGICAL ☐ Not Assessed ☐ Reviewed and Negative	
Depression	☐
Anxiety	☐
Hallucinations	☐
Night Agitation	☐
Insomnia	☐
Periods of High Energy	☐
Racing Thoughts	☐

PHQ2	
Experienced in the last 2 weeks?	
Little interest or pleasure in doing things?	0-Not at all, 1-Several Days, 2-More than half the days, 3-Nearly every day
Feeling down, depressed or hopeless?	0-Not at all, 1-Several Days, 2-More than half the days, 3-Nearly every day
Unable to Assess	☐
Reason:	Alzheimer's/Dementia, Language barrier

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HouseCalls

Member Name: ID: Date of Birth:

Additional Notes:

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HouseCalls

Member Name: ID: Date of Birth:

EXAMINATION

CONSTITUTIONAL	
Height	
Could not be documented:	Cognitive impairment, Bilateral lower extremity amputation
Weight	
Weight source	From Scale, Member Stated, Practitioner Estimate
BMI:	
Blood Pressure:	
Arm:	Left, Right
Repeat Blood Pressure:	
Arm:	Left, Right
Taken:	<30 minutes, >30 minutes, >30 mins after HTN Meds
Unable to Perform:	Member Refused, Video Virtual Visit
Respiratory Rate:	
Unable to Perform:	Member Refused, Video Virtual Visit
Heart Rate:	
Unable to Perform:	Member Refused, Video Virtual Visit
Wearing Oxygen:	☐
Temp:	

URINE DIPSTICK	
Member Refused	☐
Unable to void	☐
Unable to collect	☐
Reason:	Incontinent, On dialysis, Video Virtual Visit
Protein	Trace, +1, +2, +3, +4, Negative
Glucose	Trace, +1, +2, +3, +4, Negative

GENERAL APPEARANCE

☐ **Abnormal**

☐ **WNL:** Well groomed, well nourished, appropriately dressed

Unkempt	☐
Cachectic	☐
Obese	☐

HEENT - EYES

☐ **NA or Unable to Assess** ☐ **Abnormal**

☐ **WNL:** PERRLA, EOMI, bilateral sclera non icteric, no erythema, drainage, discharge

Abnormal EOM	Left, Right, Bilateral
Abnormal Pupils	☐
Describe Right:	☐ Unequal ☐ Dilated ☐ Pinpoint
Describe Left:	☐ Unequal ☐ Dilated ☐ Pinpoint
Cataracts Present	Left, Right, Bilateral
Icteric Sclera	Left, Right, Bilateral
Erythema	Left, Right, Bilateral
Drainage/Discharge	Left, Right, Bilateral

HEENT - EARS

☐ **NA or Unable to Assess** ☐ **Abnormal**

☐ **WNL:** auditory canals clear bilaterally, TMs intact, no discharge, no lesions, hearing grossly normal

Cerumen	Left, Right, Bilateral
Lesions	Left, Right, Bilateral
Hearing Aid	Left, Right, Bilateral
TM Abnormal	Left, Right, Bilateral
Discharge	Left, Right, Bilateral
Hearing Abnormal	Left, Right, Bilateral

HEENT - NOSE/MOUTH/THROAT

☐ **NA or Unable to Assess** ☐ **Abnormal**

☐ **WNL:** Oropharyngeal mucosa moist, without lesions, no erythema or exudate, dentition in good repair, without lesions

Poor Dentition	☐
Lesions	☐
Location:	
Dentures	☐
Location:	Upper, Lower, Both
Erythema	☐
Location:	
Mucosa Dry	☐

HEENT - NECK

☐ **NA or Unable to Assess** ☐ **Abnormal**

☐ **WNL:** Without visible venous distention, no lymphadenopathy, no thyromegaly

Lymphadenopathy	Left, Right, Bilateral
Enlarged Thyroid	Left, Right, Bilateral
Visible Venous Distention	Left, Right, Bilateral

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EXAMINATION

RESPIRATORY

☐ NA or Unable to Asses ☐ Abnormal

☐ WNL: Clear to auscultation

Pursed Lip Breathing	☐
Barrel Chest	☐
Cyanosis	☐
Location:	
Rhonchi	☐
Location:	☐ RUL ☐ RML ☐ RLL ☐ LUL ☐ LLL
Rales	☐
Location:	☐ RUL ☐ RML ☐ RLL ☐ LUL ☐ LLL
Wheezes	☐
Location:	☐ RUL ☐ RML ☐ RLL ☐ LUL ☐ LLL
Diminished Breath Sounds	☐
Location:	☐ RUL ☐ RML ☐ RLL ☐ LUL ☐ LLL
Tracheostomy	☐

CARDIOVASCULAR

☐ NA or Unable to Asses ☐ Abnormal

☐ WNL: S1S2 Normal, HRR, no adventitious sounds, no carotid bruits, no peripheral edema

Carotid Bruit	Left, Right, Bilateral
Regularly/Irregular	☐
Irregularly/Irregular	☐
S3	☐
S4	☐
Other abnormalities of heart beat	☐
Murmur	☐
If yes:	Systolic, Diastolic, Undetermined
Type	Known, Unknown
Pacemaker	☐
Location:	Right Chest, Left Chest
ICD	☐
Location:	Right Chest, Left Chest

CARDIOVASCULAR

☐ NA or Unable to Asses ☐ Abnormal

☐ WNL: S1S2 Normal, HRR, no adventitious sounds, no carotid bruits, no peripheral edema

Edema	☐
Location:	☐ Right Thigh ☐ Left Thigh ☐ Right Pretibial ☐ Left Pretibial ☐ Right Ankle ☐ Left Ankle ☐ Right Pedal ☐ Left Pedal
Left Degree:	None, Non-pitting, Trace, 1+, 2+, 3+, 4+, Undetermined
Right Degree:	None, Non-pitting, Trace, 1+, 2+, 3+, 4+, Undetermined

GASTROINTESTINAL

☐ NA or Unable to Asses ☐ Abnormal

☐ WNL: Abdomen soft, non-tender, +BS

Ascites	☐
Distended Abdomen	☐
Hernia	☐
Location:	☐ Umbilical ☐ Ventral
Bowel Sounds Absent	☐
Location:	☐ Right Upper Quadrant ☐ Left Upper Quadrant ☐ Right Lower Quadrant ☐ Left Lower Quadrant
Pain to Palpation	☐
Location:	☐ Right Upper Quadrant ☐ Left Upper Quadrant ☐ Right Lower Quadrant ☐ Left Lower Quadrant
Masses	☐
Colostomy Status	☐
Ileostomy Status	☐
PEG Tube	☐
Other artificial openings of gastrointestinal tract status	☐

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EXAMINATION

GENITOURINARY ☐ NA or Unable to Assess ☐ Abnormal ☐ WNL: No CVAT, no catheter or ostomy device	
CVA Tenderness	☐
Urostomy	☐
Catheter	☐
Type:	Foley, Suprapubic
Cutaneous-Vesicostomy status	☐
Appendico-Vesicostomy status	☐
Other Cystostomy status	☐
Other Artificial openings of urinary tract status	☐
Other Artificial opening status	☐

MUSCULOSKELETAL AND LE ☐ NA or Unable to Assess ☐ Abnormal ☐ WNL: No Deformities, pulses intact, normal capillary refill	
Amputations	☐
Type:	Right BKA, Left BKA, Right AKA, Left AKA, Right Foot, Left Foot, Right Toe(s), Left Toe(s), Right Great Toe, Left Great Toe, Right Thumb, Left Thumb, Right Finger(s), Left Finger(s), Right Hand, Left Hand, Right Wrist, Left Wrist, Right Shoulder, Left Shoulder
Abnormal Gait	☐
Shuffle Gait	☐
Stiffness in Neck and Extremities	☐
Muscle Rigidity	☐
Cog Wheeling	☐
Pill Rolling	☐
ROM Abnormal	☐
Location:	Neck, Back, Shoulders, Elbows, Wrists, Fingers, Hips, Knees, Ankles, Toes
Joint Swelling	☐
Location:	Shoulder, Elbow, Wrist, Finger(s), Hip, Knee, Ankle, Toe(s)
Crepitus	☐
Swan neck deformity	Left, Right, Bilateral
Erythema	☐
Location:	RUE, LUE, RLE, LLE
Cool Extremities	☐
Location:	RUE, LUE, RLE, LLE
Hair Loss	☐
Venous Stasis	Left, Right, Bilateral
Varicosities/Varicose Veins	Left, Right, Bilateral

Posterior Tibial Pulses Abn	☐
Describe Right:	Normal, Diminished, Absent
Describe Left:	Normal, Diminished, Absent
Pedal Pulses Abnormal	☐
Describe Right:	Normal, Diminished, Absent
Describe Left:	Normal, Diminished, Absent
Clubbing	Left, Right, Bilateral
Abnormal Capillary Refill	Left, Right, Bilateral

PAD SCREENING	
Member Refused	☐
Recently Completed	☐
Unable to Perform	☐
Reason:	☐ Ambient light ☐ Physical malformation ☐ Involuntary movement ☐ Inconclusive results ☐ Video Virtual Visit
Left Foot	
NA	☐
Right Foot	
NA	☐

MONOFILAMENT EXAM	☐ Refused
Right Foot	NA/Unable to Assess, Normal, Impaired
Left Foot	NA/Unable to Assess, Normal, Impaired

VIBRATORY TESTING	☐ Refused
Right Foot	NA/Unable to Assess, Normal, Impaired
Left Foot	NA/Unable to Assess, Normal, Impaired

ACHILLES REFLEX TESTING	☐ Refused
Right:	NA/Unable to Assess, Absent, 1+, 2+, 3+, 4+
Left:	NA/Unable to Assess, Absent, 1+, 2+, 3+, 4+

FOOT EXAM ☐ NA or Unable to Assess ☐ Abnormal ☐ WNL: Normal symmetry, normal range of motion, without tenderness, swelling, discoloration, nodules, or deformity	
Infection	☐
Deformity	☐
Ulceration	☐
Gangrene	☐
Describe:	
Callous or Corn	☐

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EXAMINATION

FOOT EXAM

☐ **NA or Unable to Assess** ☐ **Abnormal**

☐ **WNL:** Normal symmetry, normal range of motion, without tenderness, swelling, discoloration, nodules, or deformity

Bunions	☐
Nails Thick/Fungus	☐
Cracked or Scaly thickened skin	☐

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EXAMINATION

NEUROLOGICAL ☐ **NA or Unable to Assess** ☐ **Abnormal** ☐ **WNL:** A&O x'4, no focal or motor deficits, sensation intact, no tremors or aphasia			
Somnolent	☐		
Tremors	☐		
If Yes	At Rest, Intention		
Impaired Balance/Coordination	☐		
Dominant Side:	Left, Right		
Strength Assessment			
Right Upper Extremity:	Normal, Weak, Paralyzed, Amputee		
Left Upper Extremity:	Normal, Weak, Paralyzed, Amputee		
Right Lower Extremity:	Normal, Weak, Paralyzed, Amputee		
Left Lower Extremity:	Normal, Weak, Paralyzed, Amputee		
Paralysis Type:	Spastic, Flaccid, Unspecified		
PSYCHOLOGICAL ☐ **NA or Unable to Assess** ☐ **Abnormal** ☐ **WNL:** Appropriate,Coherent and cooperative			
Flat Affect	☐		
Depressed	☐		
Manic	☐		
Disoriented	☐		
Uncooperative	☐		
Agitated	☐		
Confused	☐		
Hostile	☐		

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HouseCalls

Member Name: ID: Date of Birth:

SKIN

☐ WNL: ☐ Abnormal ☐ Unable to assess/perform

Abnormality Type	Location	Size(mm) LxWxD/H	Description	Severity/ stage	Left/Right /Bilateral	Under Treatment	New Wound /Ulcer	Unable to Assess
Atypical Lesions			Asymmetry, Border Irregularity, Color Variegation > 1/3 inch, Dressing present, dry and intact		Left, Right, Bilateral	☐	☐	☐
Non-Pressure Ulcer	Thigh, Lower leg, Ankle, Midfoot/Heel, Foot, Other		Erythematous, Clear Drainage, Purulent Drainage, Granulated, Necrotic, Eschar, Indurated, Dressing present, dry and intact	Breakdown of skin, Fat layer exposed, Muscle necrosis, Bone necrosis, Unspecified	Left, Right, Bilateral	☐	☐	☐
Pressure Ulcer	Head, Elbow, Upper back, Lower back, Sacral, Hip, Buttock, Ankle, Heel, Contiguous back, buttock and hip, Other		Erythematous, Clear Drainage, Purulent Drainage, Granulated, Necrotic, Eschar, Indurated, Dressing present, dry and intact	Stage I, Stage II , Stage III, Stage IV, Unstageable	Left, Right, Bilateral	☐	☐	☐
Rash			Bulla, Coalescing, Discrete, Erythematous, Generalized, Linear, Localized, Plaque, Pustule, Wheal, Vesicular, Dressing present, dry and intact		Left, Right, Bilateral	☐	☐	☐
Skin Tear, Laceration, Abrasion			Erythematous, Clear Drainage, Purulent Drainage, Bleeding, Dressing present, dry and intact		Left, Right, Bilateral	☐	☐	☐
Surgical Wound			Erythematous, Clear Drainage, Purulent Drainage, Bleeding, Dressing present, dry and intact		Left, Right, Bilateral	☐	☐	☐
						☐	☐	☐
						☐	☐	☐
						☐	☐	☐

Additional Notes:

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HouseCalls

Member Name: ID: Date of Birth:

ACTIVE: The specified condition applies to the member at the time of the assessment

RESOLVED: The member previously had the condition, but it is no longer applicable at the time of the assessment

ASSESSMENT

- Stable
- Unstable
- Suboptimally Controlled

PLAN

- Continue Therapy
- Patient education
- FU with PCP
- FU with Specialist
- Send to ER or Urgent Care

DIAGNOSIS CONFIRMATION

(Please refer to the practitioner portal for the full list of diagnoses)

Please review the diagnoses for the member:

Diagnosis	Active	Resolved	Assessment	Plan	Note
Alcohol abuse, uncomplicated	☐	☐			
Angina - Stable Angina Documentation: ☐ Member prescribed an anti-angina medication, or another medication with the indication of Angina on the member medication list ☐ Member states has known Angina, but opted not to take medication or medication is contraindicated	☐	☐			
Angina - Unstable	☐	☐			
Angina - Unspecified Angina Documentation: ☐ Member prescribed an anti-angina medication, or another medication with the indication of Angina on the member medication list ☐ Member states has known Angina, but opted not to take medication or medication is contraindicated	☐	☐			
Arthritis - Gouty	☐	☐			
Arthritis - Osteo	☐	☐			
Arthritis - Rheumatoid Rheumatoid Arthritis Documentation: ☐ Member prescribed a DMARD, or another medication with the indication of Rheumatoid arthritis on the member medication list ☐ Member states has known RA, but opted not to take medication or is contraindicated ☐ Member has 1 or more musculoskeletal findings on ROS or Physical Exam	☐	☐			
Arthritis - Rheumatoid, Immunodeficiency due to condition	☐	☐			
Asthma	☐	☐			

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HouseCalls

Member Name: ID: Date of Birth:

DIAGNOSIS CONFIRMATION

(Please refer to the practitioner portal for the full list of diagnoses)

Please review the diagnoses for the member:

Diagnosis	Active	Resolved	Assessment	Plan	Note
Atrial fibrillation, Unspecified A Fib, A Flutter, Any arrhythmia Documentation: ☐ Member prescribed Anticoag, antiarrhythmic drug, or another medication with the indication of Atrial fibrillation on the member medication list ☐ Member has an irregularly irregular rhythm as documented on Physical Exam ☐ Member states known Atrial fibrillation and not on medication	☐	☐			
Benign prostatic hyperplasia without lower urinary tract symptoms	☐	☐			
Cataract Age-Related - Active	☐	☐			
Cataract Age-Related - Removed	☐	☐			
Chronic obstructive pulmonary disease, unspecified	☐	☐			
Diabetes Type 1 - Complications, Acanthosis nigricans	☐	☐			
Diabetes Type 1 - Complications, Cataracts	☐	☐			
Diabetes Type 1 - Complications, Chronic Kidney Disease, Stage 1 (GFR >=90)	☐	☐			
Diabetes Type 1 - Complications, Chronic Kidney Disease, Stage 2 (Mild-GFR 60-89)	☐	☐			
Diabetes Type 1 - Complications, Chronic Kidney Disease, Stage 3, Stage 3a (Moderate-GFR 45-59)	☐	☐			
Diabetes Type 1 - Complications, Chronic Kidney Disease, Stage 3, Stage 3b (Moderate-GFR 30-44)	☐	☐			
Diabetes Type 1 - Complications, Chronic Kidney Disease, Stage 3, Stage 3 Unspecified	☐	☐			
Diabetes Type 1 - Complications, Chronic Kidney Disease, Stage 4 (Severe-GFR 15-29)	☐	☐			
Diabetes Type 1 - Complications, Chronic Kidney Disease, Stage 5 (Failure-GFR < 15)	☐	☐			
Diabetes Type 1 - Complications, Chronic Kidney Disease, Stage 5 (Failure-GFR < 15), Member has not yet started dialysis	☐	☐			
Diabetes Type 1 - Complications, Chronic Kidney Disease, Stage 5 (Failure-GFR < 15), Member declined dialysis	☐	☐			
Diabetes Type 1 - Complications, Chronic Kidney Disease, End Stage Renal Disease (GFR < 15 or Chronic Dialysis), ESRD on Dialysis (GFR < 15 or Chronic Dialysis)	☐	☐			
Diabetes Type 1 - Complications, Chronic Kidney Disease, End Stage Renal Disease (GFR < 15 or Chronic Dialysis), ESRD on Dialysis (GFR < 15 or Chronic Dialysis), Immunodeficiency due to external cause	☐	☐			
Diabetes Type 1 - Complications, Chronic Kidney Disease, End Stage Renal Disease (GFR < 15 or Chronic Dialysis), Member noncompliance with renal dialysis	☐	☐			
Diabetes Type 1 - Complications, Chronic Kidney Disease, Unspecified	☐	☐			
Diabetes Type 1 - Complications, End Stage Renal Disease	☐	☐			

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HouseCalls

Member Name: ID: Date of Birth:

DIAGNOSIS CONFIRMATION

(Please refer to the practitioner portal for the full list of diagnoses)

Please review the diagnoses for the member:

Diagnosis	Active	Resolved	Assessment	Plan	Note
Diabetes Type 1 - Complications, Erectile Dysfunction	☐	☐			
Diabetes Type 1 - Complications, Gangrene Peripheral Vascular Disease Documentation: ☐ Member has QF of less than 0.90 ☐ Member reported previous diagnosis of PVD ☐ Other Clinical Support	☐	☐			
Diabetes Type 1 - Complications, Gastroparesis	☐	☐			
Diabetes Type 1 - Complications, Glaucoma	☐	☐			
Diabetes Type 1 - Complications, Hyperlipidemia unspecified	☐	☐			
Diabetes Type 1 - Complications, Nephropathy	☐	☐			
Diabetes Type 1 - Complications, Palmar fascial fibromatosis [Dupuytren]	☐	☐			
Diabetes Type 1 - Complications, Peripheral Vascular Disease with Gangrene Peripheral Vascular Disease Documentation: ☐ Member has QF of less than 0.90 ☐ Member reported previous diagnosis of PVD ☐ Other Clinical Support	☐	☐			
Diabetes Type 1 - Complications, Peripheral Vascular Disease without Gangrene Peripheral Vascular Disease Documentation: ☐ Member has QF of less than 0.90 ☐ Member reported previous diagnosis of PVD ☐ Other Clinical Support	☐	☐			
Diabetes Type 1 - Complications, Polyneuropathy	☐	☐			
Diabetes Type 1 - Complications, Retinopathy Unspecified	☐	☐			
Diabetes Type 1 - Complications, Trigger finger unspecified finger	☐	☐			
Diabetes Type 1 - Complications, Ulcers	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Ankle, Left, Bone necrosis	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Ankle, Left, Breakdown of skin	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Ankle, Left, Fat layer exposed	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Ankle, Left, Muscle necrosis	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Ankle, Left, Unspecified	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Ankle, Right, Bone necrosis	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Ankle, Right, Breakdown of skin	☐	☐			

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HouseCalls

Member Name: ID: Date of Birth:

DIAGNOSIS CONFIRMATION

(Please refer to the practitioner portal for the full list of diagnoses)

Please review the diagnoses for the member:

Diagnosis	Active	Resolved	Assessment	Plan	Note
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Ankle, Right, Fat layer exposed	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Ankle, Right, Muscle necrosis	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Ankle, Right, Unspecified	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Foot, Left, Bone necrosis	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Foot, Left, Breakdown of skin	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Foot, Left, Fat layer exposed	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Foot, Left, Muscle necrosis	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Foot, Left, Unspecified	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Foot, Right, Bone necrosis	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Foot, Right, Breakdown of skin	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Foot, Right, Fat layer exposed	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Foot, Right, Muscle necrosis	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Foot, Right, Unspecified	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Lower leg, Left, Bone necrosis	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Lower leg, Left, Breakdown of skin	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Lower leg, Left, Fat layer exposed	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Lower leg, Left, Muscle necrosis	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Lower leg, Left, Unspecified	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Lower leg, Right, Bone necrosis	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Lower leg, Right, Breakdown of skin	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Lower leg, Right, Fat layer exposed	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Lower leg, Right, Muscle necrosis	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Lower leg, Right, Unspecified	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Left, Bone necrosis	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Left, Breakdown of skin	☐	☐			

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HouseCalls

Member Name: ID: Date of Birth:

DIAGNOSIS CONFIRMATION

(Please refer to the practitioner portal for the full list of diagnoses)

Please review the diagnoses for the member:

Diagnosis	Active	Resolved	Assessment	Plan	Note
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Left, Fat layer exposed	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Left, Muscle necrosis	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Left, Unspecified	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Right, Bone necrosis	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Right, Breakdown of skin	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Right, Fat layer exposed	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Right, Muscle necrosis	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Right, Unspecified	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Other, Bone necrosis	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Other, Breakdown of skin	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Other, Fat layer exposed	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Other, Muscle necrosis	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Other, Unspecified	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Thigh, Left, Bone necrosis	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Thigh, Left, Breakdown of skin	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Thigh, Left, Fat layer exposed	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Thigh, Left, Muscle necrosis	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Thigh, Left, Unspecified	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Thigh, Right, Bone necrosis	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Thigh, Right, Breakdown of skin	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Thigh, Right, Fat layer exposed	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Thigh, Right, Muscle necrosis	☐	☐			
Diabetes Type 1 - Complications, Ulcers, Non-pressure ulcer, Thigh, Right, Unspecified	☐	☐			
Diabetes Type 1 - Complications, Unspecified	☐	☐			
Diabetes Type 1 - Without complications	☐	☐			

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HouseCalls

Member Name: ID: Date of Birth:

DIAGNOSIS CONFIRMATION

(Please refer to the practitioner portal for the full list of diagnoses)

Please review the diagnoses for the member:

Diagnosis	Active	Resolved	Assessment	Plan	Note
Diabetes Type 1 - With hyperglycemia	☐	☐			
Diabetes Type 1 - With hyperglycemia, Immunodeficiency due to condition	☐	☐			
Diabetes Type 1 - With hypoglycemia without coma	☐	☐			
Diabetes Type 2 - Chronic insulin therapy	☐	☐			
Diabetes Type 2 - Complications, Acanthosis nigricans	☐	☐			
Diabetes Type 2 - Complications, Cataracts	☐	☐			
Diabetes Type 2 - Complications, Chronic Kidney Disease, Stage 1 (GFR >=90)	☐	☐			
Diabetes Type 2 - Complications, Chronic Kidney Disease, Stage 2 (Mild-GFR 60-89)	☐	☐			
Diabetes Type 2 - Complications, Chronic Kidney Disease, Stage 3, Stage 3a (Moderate-GFR 45-59)	☐	☐			
Diabetes Type 2 - Complications, Chronic Kidney Disease, Stage 3, Stage 3b (Moderate-GFR 30-44)	☐	☐			
Diabetes Type 2 - Complications, Chronic Kidney Disease, Stage 3, Stage 3 Unspecified	☐	☐			
Diabetes Type 2 - Complications, Chronic Kidney Disease, Stage 4 (Severe-GFR 15-29)	☐	☐			
Diabetes Type 2 - Complications, Chronic Kidney Disease, Stage 5 (Failure-GFR < 15)	☐	☐			
Diabetes Type 2 - Complications, Chronic Kidney Disease, Stage 5 (Failure-GFR < 15), Member has not yet started dialysis	☐	☐			
Diabetes Type 2 - Complications, Chronic Kidney Disease, Stage 5 (Failure-GFR < 15), Member declined dialysis	☐	☐			
Diabetes Type 2 - Complications, Chronic Kidney Disease, End Stage Renal Disease (GFR < 15 or Chronic Dialysis), ESRD on Dialysis (GFR < 15 or Chronic Dialysis)	☐	☐			
Diabetes Type 2 - Complications, Chronic Kidney Disease, End Stage Renal Disease (GFR < 15 or Chronic Dialysis), ESRD on Dialysis (GFR < 15 or Chronic Dialysis), Immunodeficiency due to external cause	☐	☐			
Diabetes Type 2 - Complications, Chronic Kidney Disease, End Stage Renal Disease (GFR < 15 or Chronic Dialysis), Member noncompliance with renal dialysis	☐	☐			
Diabetes Type 2 - Complications, Chronic Kidney Disease, Unspecified	☐	☐			
Diabetes Type 2 - Complications, Diabetic dermatitis	☐	☐			
Diabetes Type 2 - Complications, End Stage Renal Disease	☐	☐			
Diabetes Type 2 - Complications, Erectile Dysfunction	☐	☐			
Diabetes Type 2 - Complications, Gangrene Peripheral Vascular Disease Documentation: ☐ Member has QF of less than 0.90 ☐ Member reported previous diagnosis of PVD ☐ Other Clinical Support	☐	☐			

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HouseCalls

Member Name: ID: Date of Birth:

DIAGNOSIS CONFIRMATION

(Please refer to the practitioner portal for the full list of diagnoses)

Please review the diagnoses for the member:

Diagnosis	Active	Resolved	Assessment	Plan	Note
Diabetes Type 2 - Complications, Gastroparesis	☐	☐			
Diabetes Type 2 - Complications, Glaucoma	☐	☐			
Diabetes Type 2 - Complications, Hyperlipidemia unspecified	☐	☐			
Diabetes Type 2 - Complications, Nephropathy	☐	☐			
Diabetes Type 2 - Complications, Palmar fascial fibromatosis [Dupuytren]	☐	☐			
Diabetes Type 2 - Complications, Peripheral Vascular Disease with Gangrene Peripheral Vascular Disease Documentation: ☐ Member has QF of less than 0.90 ☐ Member reported previous diagnosis of PVD ☐ Other Clinical Support	☐	☐			
Diabetes Type 2 - Complications, Peripheral Vascular Disease without Gangrene Peripheral Vascular Disease Documentation: ☐ Member has QF of less than 0.90 ☐ Member reported previous diagnosis of PVD ☐ Other Clinical Support	☐	☐			
Diabetes Type 2 - Complications, Polyneuropathy	☐	☐			
Diabetes Type 2 - Complications, Retinopathy Unspecified	☐	☐			
Diabetes Type 2 - Complications, Trigger finger unspecified finger	☐	☐			
Diabetes Type 2 - Complications, Ulcers	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Ankle, Left, Bone necrosis	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Ankle, Left, Breakdown of skin	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Ankle, Left, Fat layer exposed	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Ankle, Left, Muscle necrosis	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Ankle, Left, Unspecified	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Ankle, Right, Bone necrosis	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Ankle, Right, Breakdown of skin	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Ankle, Right, Fat layer exposed	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Ankle, Right, Muscle necrosis	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Ankle, Right, Unspecified	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Foot, Left, Bone necrosis	☐	☐			

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HouseCalls

Member Name: ID: Date of Birth:

DIAGNOSIS CONFIRMATION

(Please refer to the practitioner portal for the full list of diagnoses)

Please review the diagnoses for the member:

Diagnosis	Active	Resolved	Assessment	Plan	Note
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Foot, Left, Breakdown of skin	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Foot, Left, Fat layer exposed	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Foot, Left, Muscle necrosis	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Foot, Left, Unspecified	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Foot, Right, Bone necrosis	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Foot, Right, Breakdown of skin	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Foot, Right, Fat layer exposed	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Foot, Right, Muscle necrosis	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Foot, Right, Unspecified	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Lower leg, Left, Bone necrosis	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Lower leg, Left, Breakdown of skin	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Lower leg, Left, Fat layer exposed	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Lower leg, Left, Muscle necrosis	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Lower leg, Left, Unspecified	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Lower leg, Right, Bone necrosis	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Lower leg, Right, Breakdown of skin	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Lower leg, Right, Fat layer exposed	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Lower leg, Right, Muscle necrosis	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Lower leg, Right, Unspecified	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Left, Bone necrosis	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Left, Breakdown of skin	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Left, Fat layer exposed	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Left, Muscle necrosis	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Left, Unspecified	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Right, Bone necrosis	☐	☐			

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HouseCalls

Member Name: ID: Date of Birth:

DIAGNOSIS CONFIRMATION

(Please refer to the practitioner portal for the full list of diagnoses)

Please review the diagnoses for the member:

Diagnosis	Active	Resolved	Assessment	Plan	Note
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Right, Breakdown of skin	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Right, Fat layer exposed	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Right, Muscle necrosis	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Midfoot/Heel, Right, Unspecified	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Other, Bone necrosis	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Other, Breakdown of skin	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Other, Fat layer exposed	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Other, Muscle necrosis	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Other, Unspecified	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Thigh, Left, Bone necrosis	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Thigh, Left, Breakdown of skin	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Thigh, Left, Fat layer exposed	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Thigh, Left, Muscle necrosis	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Thigh, Left, Unspecified	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Thigh, Right, Bone necrosis	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Thigh, Right, Breakdown of skin	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Thigh, Right, Fat layer exposed	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Thigh, Right, Muscle necrosis	☐	☐			
Diabetes Type 2 - Complications, Ulcers, Non-pressure ulcer, Thigh, Right, Unspecified	☐	☐			
Diabetes Type 2 - Complications, Unspecified	☐	☐			
Diabetes Type 2 - Without complications	☐	☐			
Diabetes Type 2 - With hyperglycemia	☐	☐			
Diabetes Type 2 - With hyperglycemia, Immunodeficiency due to condition	☐	☐			
Diabetes Type 2 - With hypoglycemia without coma	☐	☐			
Functional Quadriplegia	☐	☐			
Gastro-esophageal reflux disease without esophagitis	☐	☐			

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HouseCalls

Member Name: ID: Date of Birth:

DIAGNOSIS CONFIRMATION

(Please refer to the practitioner portal for the full list of diagnoses)

Please review the diagnoses for the member:

Diagnosis	Active	Resolved	Assessment	Plan	Note
Heart Failure Heart Failure Documentation: ☐ Member heart failure drug, diuretic, or another medication with the indication of Heart Failure on the member medication list ☐ Member states has known HF, but opted not to take medication or medication is contraindicated ☐ Other Clinical Support	☐	☐			
Hemiplegia/Hemiparesis - Due to Head Injury	☐	☐			
Hemiplegia/Hemiparesis - Late effect of CVA, Left, Dominant side	☐	☐			
Hemiplegia/Hemiparesis - Late effect of CVA, Left, Non dominant side	☐	☐			
Hemiplegia/Hemiparesis - Late effect of CVA, Right, Dominant side	☐	☐			
Hemiplegia/Hemiparesis - Late effect of CVA, Right, Non dominant side	☐	☐			
Hemiplegia/Hemiparesis - Unspecified Cause, Flaccid, Left, Dominant side	☐	☐			
Hemiplegia/Hemiparesis - Unspecified Cause, Flaccid, Left, Non dominant side	☐	☐			
Hemiplegia/Hemiparesis - Unspecified Cause, Flaccid, Right, Dominant side	☐	☐			
Hemiplegia/Hemiparesis - Unspecified Cause, Flaccid, Right, Non dominant side	☐	☐			
Hemiplegia/Hemiparesis - Unspecified Cause, Spastic, Left, Dominant side	☐	☐			
Hemiplegia/Hemiparesis - Unspecified Cause, Spastic, Left, Non dominant side	☐	☐			
Hemiplegia/Hemiparesis - Unspecified Cause, Spastic, Right, Dominant side	☐	☐			
Hemiplegia/Hemiparesis - Unspecified Cause, Spastic, Right, Non dominant side	☐	☐			
Hemiplegia/Hemiparesis - Unspecified Cause, Unspecified, Left, Dominant side	☐	☐			
Hemiplegia/Hemiparesis - Unspecified Cause, Unspecified, Left, Non dominant side	☐	☐			
Hemiplegia/Hemiparesis - Unspecified Cause, Unspecified, Right, Dominant side	☐	☐			
Hemiplegia/Hemiparesis - Unspecified Cause, Unspecified, Right, Non dominant side	☐	☐			
Hyperlipidemia, unspecified	☐	☐			
Hypertension	☐	☐			
Major depressive disorder in full remission - Recurrent	☐	☐			
Major depressive disorder in full remission - Single Episode	☐	☐			
Major depressive disorder in partial remission - Recurrent	☐	☐			
Major depressive disorder in partial remission - Single Episode	☐	☐			

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HouseCalls

Member Name: ID: Date of Birth:

DIAGNOSIS CONFIRMATION

(Please refer to the practitioner portal for the full list of diagnoses)

Please review the diagnoses for the member:

Diagnosis	Active	Resolved	Assessment	Plan	Note
Major depressive disorder, mild - Recurrent	☐	☐			
Major depressive disorder, mild - Single Episode	☐	☐			
Major depressive disorder, moderate - Recurrent	☐	☐			
Major depressive disorder, moderate - Single Episode	☐	☐			
Major depressive disorder, severe without psychotic features - Recurrent	☐	☐			
Major depressive disorder, severe without psychotic features - Single Episode	☐	☐			
Morbid Obesity Due to Excess Calories	☐	☐			
Osteoporosis	☐	☐			
Parkinson's disease	☐	☐			
Peripheral Vascular Disease, Unspecified Peripheral Vascular Disease Documentation: ☐ Member has QF of less than 0.90 ☐ Member reported previous diagnosis of PVD ☐ Other Clinical Support	☐	☐			
Schizophrenia, unspecified	☐	☐			
Seizure disorder, epilepsy	☐	☐			
Substance abuse	☐	☐			
Thyroid Disease - Hyperparathyroidism, Unspecified	☐	☐			
Thyroid Disease - Hyperthyroidism	☐	☐			
Thyroid Disease - Hypothyroidism	☐	☐			
Thyroid Disease - Thyroid Nodule	☐	☐			
Unspecified atherosclerosis of native arteries of extremities, unspecified extremity	☐	☐			

Please add Assessment and Plan as appropriate :

Additional Diagnoses/Notes :

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HouseCalls

Member Name: ID: Date of Birth:

Member Education

Required Education	
☐ Falls and Fractures	Yes, No
☐ Recommended Screenings and Vaccinations	Yes, No
☐ Medication Disposal (paper delivery required)	I attest that verbal education and written information were provided to the member/responsible party regarding safe disposal of medications and drug takeback programs per CMS criteria., Member declines written information, however verbal education regarding safe disposal of medications and the DEA website were provided.
☐ UHC Your Annual Health Guide (UHC Only)	Yes, No

General Education	
☐ Advanced Care Planning	
☐ Cancer	
☐ Caregiving	
☐ Chronic Pain Management	
☐ COVID vaccine facts	
☐ Getting Physically Active	
☐ HouseCalls COVID Patient Guide	
☐ HouseCalls Notice of Privacy Policy	
☐ Monkeypox	
☐ Shingles	
☐ Tobacco Cessation	
☐ Vital Signs	
☐ Weight Loss	

Client and Referral Materials	
☐ M&R COVID Patient Guide	Yes, No
☐ Missouri Medicaid	Yes, No
☐ OptumRx	Yes, No
☐ Dispatch Health Flyer provided to member	
☐ Landmark Brochure for HouseCalls	Yes, No
☐ OAH DSNP flyer	
☐ Prospero Plus Leave-Behind for HouseCalls	

Cardiovascular	
☐ Atrial Flutter and Atrial Fibrillation	
☐ High blood pressure	
☐ Statins	
☐ Managing your Cholesterol	
☐ Symptoms of a Heart Attack	
☐ Taking charge of your Heart Failure	

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HouseCalls

Member Name: ID: Date of Birth:

Endocrine	
☐ Diabetes Diet Tips	
☐ Diabetes Eye Problems	
☐ Diabetes Foot Health	
☐ Diabetic Peripheral Neuropathy	
☐ Preventing Type 2 Diabetes	
☐ Taking charge of your Diabetes	
☐ Thyroid Disorders	
Gastrointestinal	
☐ Constipation	
☐ Hepatitis C	
Genitourinary	
☐ Kidney Disease	
☐ Overactive Bladder	
Musculoskeletal and Lower Extremities	
☐ Osteoporosis	
☐ Peripheral Arterial Disease	
Neurological	
☐ Memory Health	
☐ Stroke	
Nutrition	
☐ Build a Healthy Meal	
☐ Plate Planner	
Psychological	
☐ Anxiety	
☐ Depression	
☐ Grief and Loss	
☐ Mental Health Quick Tips	
☐ SUD Hotline	
☐ Tips to Manage Insomnia	
Respiratory	
☐ Metered-Dose Inhaler	
☐ Obstructive Sleep Apnea	
☐ Taking Charge of your COPD	
☐ Treating COPD	
Medications	
☐ Managing Medications	
☐ OTC Pain Management	
Labs	
☐ HgA1C Blood Sugar	Yes, No
☐ iFOBT Education	Yes, No

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Member Name: ID: Date of Birth:

Other Education	
☐ Foot Care	
☐ Diet	☐ Low Fat ☐ Low Salt ☐ High Fiber
☐ Fall Risk Education	☐ Balance ☐ Vision ☐ DME ☐ Medication Review
☐ Medications	☐ Self-Management ☐ Adherence ☐ Communication barrier ☐ Time Management ☐ Polypharmacy
☐ Screening Studies	☐ Bone Density Screening ☐ Low-dose chest CT ☐ Colorectal Cancer screening ☐ Diabetic Retinal Screening ☐ HbA1C ☐ Mammogram ☐ Pap ☐ Spirometry
☐ Vaccinations	☐ Influenza ☐ Pneumovax ☐ Herpes Zoster ☐ Tetanus shot ☐ Prevnar 15 ☐ Prevnar 20 ☐ COVID-19 Dose 1 ☐ COVID-19 Dose 2

Other:

☐ Was I able to help you with your questions today?	Yes, No, No issues/Not applicable

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HouseCalls

Member Name: ID: Date of Birth:

RECOMMENDATIONS	
☐ Medications	☐ ACEI/ARB ☐ Antidepressant ☐ Aspirin ☐ Beta Blocker ☐ Diuretic ☐ Statin
☐ Lab Tests	☐ HbA1C ☐ LDL ☐ Microalbumin, urine ☐ Creatinine/GFR ☐ TSH
☐ Screening Studies	☐ Bone Density Screening ☐ Low-dose chest CT ☐ Colorectal Cancer screening ☐ Diabetic Retinal Screening ☐ Mammogram ☐ Pap ☐ Spirometry
☐ Vaccinations	☐ Influenza ☐ Pneumovax ☐ Herpes Zoster ☐ Tetanus shot ☐ Prevnar 15 ☐ Prevnar 20 ☐ COVID-19 Dose 1 ☐ COVID-19 Dose 2
☐ DME	☐ Cane ☐ Walker ☐ Wheelchair ☐ Hospital Bed ☐ Diabetic Shoes
☐ Medication Adherence	☐ PCP Follow Up ☐ Education
☐ Tobacco Cessation	☐ PCP Follow Up ☐ Education

Additionally, include any non-urgent communication to the PCP. Estimated turnaround time to the PCP is approximately 2-4 weeks.

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HouseCalls

Member Name: ID: Date of Birth:

ACTIVITIES OF DAILY LIVING

☐ WNL ☐ Unable to Assess ☐ Member Refused

Barthel Index of Activities of Daily Living

	Score
1. BOWELS ☐ 2 Continent ☐ 1 Occasional accident (once/week) ☐ 0 Incontinent (or needs to be given enemas)	
2. BLADDER ☐ 2 Continent (for over 7 days) ☐ 1 Occasional accident (max. once per 24 hours) ☐ 0 Incontinent, or catheterized and unable to manage	
3. GROOMING ☐ 1 Independent face/hair/teeth/shaving (implements) ☐ 0 Needs help with personal care	
4. TOILET USE ☐ 2 Independent (on and off, dressing, wiping) ☐ 1 Needs some help, but can do something alone ☐ 0 Dependent	
5. FEEDING ☐ 2 Independent (food provided within reach) ☐ 1 Needs help cutting, spreading butter, etc. ☐ 0 Unable	
6. TRANSFER ☐ 3 Independent ☐ 2 Minor help (verbal or physical) ☐ 1 Major help (one or two people, physical), can sit ☐ 0 Unable - no sitting balance	
7. MOBILITY ☐ 3 Independent (but may use any aid, e.g., stick) ☐ 2 Walks with help of one person (verbal or physical) ☐ 1 Wheelchair independent including corners etc. ☐ 0 Immobile	
8. DRESSING ☐ 2 Independent (including buttons, zips, laces, etc.) ☐ 1 Needs help, but can do about half unaided ☐ 0 Dependent	
9. STAIRS ☐ 2 Independent up and down ☐ 1 Needs help (verbal, physical, carrying aid) ☐ 0 Unable	
10. BATHING ☐ 1 Independent (or in shower) ☐ 0 Dependent	

TOTAL SCORE : _____

Sources:
• Collin C, Wade DT, Davies S, Horne V. The Barthel ADL Index: a reliability study. Int Disabil Stud. 1988;10(2):61-63.
• Mahoney FI, Barthel DW. Functional evaluation: the Barthel Index. Md State Med J. 1965;14:61-65.
• Wade DT, Collin C. The Barthel ADL Index: a standard measure of physical disability? Int Disabil Stud. 1988;10(2):64-67.

HouseCalls

Member Name: ID: Date of Birth:

COMPREHENSIVE PAIN ASSESSMENT: Numeric Rating Scale

Unable to Assess ☐ Reason: Cognitive Impairment,Language Barrier

Pain: ☐ Yes ☐ No

Type of Pain:

Acute Pain: ☐ Yes (Pain that comes on quickly, can be severe and lasts a relatively shorter period of time)

Chronic Pain: ☐ Yes (Pain that extends beyond the expected period of healing, usually greater than 6 month)

Location(s) of pain:

Description of pain: Sharp/stabbing,Burning,Dull/achy,Throbbing,Tender,Nagging,Pressure,Radiating/Shooting

On a scale of 0-10:

0- No Pain 1-3 Mild Pain 4-7 Discomforting - Moderate Pain 8-10 Distressing, Intense, Unbearable - Severe Pain

Pain Score:

Now: 0,1,2,3,4,5,6,7,8,9,10 At Best: 0,1,2,3,4,5,6,7,8,9,10 At Worst: 0,1,2,3,4,5,6,7,8,9,10 Pain Goal: Pain Free,Mild Pain,Controlled

Pain Evaluation:

1. What makes your pain better? Pain medications as needed,Pain medications on a regular basis,Pain Clinic,Rest,Massage,Relaxation,Ice,Heat
2. What makes your pain worse? Physical activity,Movement,Cold,Heat
3. How would you describe how much your pain has been relieved in the past week? All of the time,Most of the time,Some of the time,Very little of the time,Not at all
4. Is the amount of relief that you are receiving high enough to make a real difference in your life? ☐ Yes ☐ No
5. Are you meeting your pain goal? ☐ Yes ☐ No

Based on the above, practitioner assessment of member pain:

☐ Controlled the best it can be

☐ Controlled with medications

☐ Controlled without medications

☐ Uncontrolled and needing further pain management evaluation

HIGHLY CONFIDENTIAL UHG-SJC-038271

HouseCalls

Member Name: ID: Date of Birth:

THE MINI-COG ASSESSMENT

☐ Member Refused ☐ Unable to Assess

This instrument combines an un-cued 3-item recall test with a clock drawing test (CDT).

1. Instruct the member to listen carefully to and remember 3 unrelated words and then to repeat the words.
2. Instruct the member to draw the face of a clock. After they put the numbers on the clock face, ask them to draw the hands of the clock to read a specific time. The instructions can be repeated but no additional instructions should be given. Give the member as much time as needed to complete the task. The clock exercise serves to distract from recall.
3. Ask the member to repeat the 3 previously presented words.

Scoring: Give 1 point for each recalled word. Score 1-3.

A score of 0 indicates positive screen for dementia.
A score of 1 or 2 with an abnormal clock draw test (CDT) indicates positive screen for dementia
A score of 1 or 2 with a normal CDT indicates negative screen for dementia.
A score of 3 indicates negative screen for dementia.

Clock Drawing: ☐ Normal ☐ Abnormal ☐ Unable to Perform

Member's Score: _____ ☐ **Dementia**

☐ **Recommend further screening for Dementia**

HIGHLY CONFIDENTIAL UHG-SJC-038272

HouseCalls

Member Name: ID: Date of Birth:

SOCIAL DETERMINANTS OF HEALTH

Personal Characteristics:

Have you been discharged from the Armed Forces of the United States?

Yes,No,Choose Not to Answer

Do you receive care from a VA clinic?

Yes,No,Choose Not to Answer

What is the name and address of the VA clinic you attend?

Name : _____ Address : _____

State : _____ City : _____ Zip5 : _____ Phone : _____ Ext : _____

Do you need more assistance at home than you currently receive?

Yes,No,Choose Not to Answer

Family and Home:

Are you worried about losing your housing?

Yes,No,Choose Not to Answer

Money and Resources:

What is your current work situation?

Employed,Unemployed and seeking work,Unemployed but not seeking work (ex: Retired, Disabled, Unpaid primary care giver),Choose Not to Answer

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed?

☐This is not a problem for me ☐Food ☐Clothing ☐Utilities ☐Child Care ☐Prescriptions ☐Medical Care ☐Dental Care ☐Mental Health Care ☐Vision Care ☐Phone ☐Choose Not to Answer

Has lack of transportation kept you from any of the following?

☐This is not a problem for me ☐Medical appointments ☐Work ☐Obtaining items needed for daily living? Such as food, clothing, supplies ☐Choose Not to Answer

Social and Emotional Health:

How often do you see or talk to people that that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings).

None,Once a week,Twice a week,Three or more times a week,Choose Not to Answer

Additional Questions:

Do you feel physically and emotionally safe where you currently live?

Yes,No,Choose Not to Answer

Social Needs:

In order to see if you qualify for any financial assistance programs that could help you with your medical or prescription drugs, I am going to ask you a couple of financial questions - are you ok with that?	☐ Yes ☐ No
Is your monthly income - which would include Social Security:	☐ Less than $1500 per month ($2000 per married couple) ☐ Greater than $1500 per month ($2000 per married couple) ☐ Refused
☐ Support Groups - Alzheimer's	
☐ Support Groups - Cancer	
☐ Respite Care	

HouseCalls

Member Name: ID: Date of Birth:

Falls Risk Assessment

Clinician to ask the member the following questions and check "Yes" or "No" accordingly

☐ Yes (2)	☐ No (0)	Have you fallen in the past year?
☐ Yes (2)	☐ No (0)	Do you use or have you been advised to use a cane or walker to get around safely?
☐ Yes (1)	☐ No (0)	Have you lost some feeling in your feet?
☐ Yes (1)	☐ No (0)	Do you feel unsteady when walking?
	Total	_____

1. If score is less than 3: Low risk
   - Document on AYPCP and advise member to communicate with provider if fall risk worsens
   - Provide Falls and Fractures member education brochure
   - No other assessment needed at this time
2. If score is 3 or 4: Moderate to High risk
   - Document on AYPCP and in the non-urgent collaboration section
   - Provide member education
   - Provide Falls and Fractures brochure
   - Call PCP if clinically indicated
3. If score is 5 or more: High risk
   - Document on AYPCP and in the urgent referral section
   - Provide member education
   - Provide Falls and Fractures brochure
   - Call PCP *

☐ PCP not called

Reason: PCP already aware: member uses DME device properly (cane and/or walker) and is steady/safe, PCP already aware: member/family uses fall precautions

* If member is successfully using an assistive device call to PCP not required and based on clinical judgment.

Education Topics: bone density screening, vision screening, medication review, physical therapy, exercise, home safety measures such as grab bars and tripping hazards, feet and footwear check.

HIGHLY CONFIDENTIAL UHG-SJC-038274

HouseCalls

Member Name: ID: Date of Birth:

ASSESSMENT NOTES:

Support Services :

Practitioner should attempt to call Support Services while in home with the member. Member should only be instructed to call the number on the back of the insurance card in the event Support Services could not be reached while in the home.

- ☐ Called Support Services and Connected with Live Agent
- ☐ Member asked to call the number on the back of insurance card

Reason(s) for call:: ☐Needs PCP,☐Needs PCP annual visit,☐Needs PCP follow-up,☐Needs veteran assistance,☐Needs Bone Density Screening,☐Needs Diabetic Retinal Screening,☐Needs Mammogram,☐Benefit Questions,☐Social Determinants of Health,☐Physical activity services,☐Needs Behavioral Health provider,☐Prescription home delivery

Personal Protective Equipment Documentation:

Member: Wore mask,Declined to wear mask

Household member(s) present during visit: No household member present,Wore mask,Declined to wear mask

Practitioner protective gear: Mask,First Aid Kit,Ziplock Sandwich bags,Face shield,Goggles,Gloves,N95 mask,Gown,Shoe covers,None worn

PPE removed per policy and discarded: ☐ Yes ☐ No

HIGHLY CONFIDENTIAL UHG-SJC-038275

HouseCalls

Member Name: ID: Date of Birth:

Signature of the member:

Consent Language:

In accordance with your health plan Notice of Privacy Practices, HouseCalls provides the results of today's visit with your other treating providers as part of our commitment to ensure continuity of care. In the event you have any health information relating to sensitive conditions HouseCalls must obtain your consent in order to share the information with your treating providers.

Sensitive Diagnosis Consent:

I consent to the HouseCalls program and my health plan disclosing my health information including diagnosis or treatment information, if any, on mental health, substance abuse, HIV/AIDS, and other sensitive conditions to my primary care physician and other providers for referrals, care coordination, case management, and treatment. This consent is voluntary and I will not be denied benefits or treatment if I do not sign this form. The consent will expire in one year. I may cancel this authorization at any time. I can request a list of the entities my information has been given to as part of this consent.

Consent to share sensitive diagnoses: ☐ Yes ☐ No

Note: If member unable to consent and no POA available select No

Member / POA Signature: _____

Minnesota Consent:

By signing below, I authorize HouseCalls and/or related/affiliated entities to release my health information that is required to carry out treatment, payment, and health care operations purposes. Releases may be made to insurance companies, health plans, government programs, and other health care providers involvement in my care and treatment.

Member / POA Signature: _____

Reason member unable to sign: _____

Printed Name of Practitioner: _____ Actual Date of assessment: _____

Signature of the Practitioner: _____

HIGHLY CONFIDENTIAL UHG-SJC-038276

HouseCalls

Member Name: ID: Date of Birth:

Practitioner Accompaniment

☐ Member gives consent for the following person(s) to attend the HouseCalls visit:

Practitioner Accompanied By:

Role	Name
☐ Staff Member	
☐ Student	
☐ Other	

HIGHLY CONFIDENTIAL UHG-SJC-038277

HouseCalls

Member Name: ID: Date of Birth:

ASK YOUR PRIMARY CARE PROVIDER (PCP)

Member name: _____

☐ I need to bring this letter to my PCP. My next appointment is on _____	☐ I need to call the number on the back of my member ID card for help finding a PCP. Then, I need to make an appointment with my PCP and bring this letter.

HouseCalls practitioner name: _____ Today's date: _____

Blood Pressure (BP): _____ / _____ Heart Rate: _____ Weight: _____ Height: _____ BMI: _____

☐ High ☐ Normal

Why do I need to see my PCP? See my PCP about items with a " √" in box below.

- √ **Annual Wellness Visit with PCP**
- ☐ Follow up for blood pressure
- ☐ Follow up for diabetes
- ☐ Other _____
- ☐ Follow up for testing or findings from today's visit
- ☐ Follow up for breathing
- ☐ Follow up for heart health

Tests I had today:	Why do I need this test?	Results
☐ **Urine test to check my kidneys**	Checks how well my kidneys are working and if I have sugar in my urine	Protein: _____ (Macroalbumin) Sugar: _____ UAC ratio: _____ (Microalbumin)
☐ **Blood sugar test for diabetes**	Helps tell if I'm at risk for diabetes or if my diabetes is under control	Hemoglobin A1c: _____ ☐ Good job! ☐ Continue to monitor ☐ Talk to your doctor
☐ **Colon cancer screening test (iFOBT)**	Checks to see if I'm at risk for colon cancer and may need follow up testing	Mail your kit for you and your PCP to receive your results in 4-6 weeks.
☐ **Circulation screening (QuantaFlo™)**	Checks how well my blood flows in my legs and if I'm at higher risk of heart problems	Right leg: ☐ Normal/Borderline 1.4-0.90 ☐ Mild/Moderate 0.89-0.30 ☐ Severe 0.29-0.00 ☐ Symptoms Left leg: ☐ Normal/Borderline 1.4-0.90 ☐ Mild/Moderate 0.89-0.30 ☐ Severe 0.29-0.00 ☐ Symptoms
☐ **Bone density screening**	Checks if I'm at higher risk of hip and other fractures	☐ Normal -0.9 and above ☐ Osteopenia -1.0 to -2.4 ☐ Osteoporosis -2.5 and below
☐ **Eye test to check for risk of vision loss**	Checks for any problems in the back of my eye	Test results will be mailed to you and your PCP within 2-4 weeks.

Do I need other tests? Talk to my PCP about items with a "√" in box below.**

General Tests

- ☐ Vision test
- ☐ Hearing test
- ☐ Cognitive screening
- ☐ Bone density
- ☐ Sleep study
- ☐ Dental exam
- ☐ Diabetic eye exam
- ☐ Abdominal aortic ultrasound
- ☐ Spirometry

HouseCalls

Member Name: ID: Date of Birth:

Blood Tests

☐ Serum creatinine ☐ Cholesterol levels ☐ Hepatitis C screening

Cancer Screening

☐ Low dose chest CT ☐ Pap smear ☐ Breast cancer screening ☐ Colon cancer screening

Do I need any vaccines? Talk to my PCP about items with a "√" in box below.**

☐ Flu ☐ Pneumovax®23 ☐ Pneumonia vaccine (Your PCP can tell you which one is right for you.)

☐ Shingles ☐ Hepatitis B ☐ Tetanus/Diphtheria/Pertussis ☐ COVID-19 Vaccine

** Some of the screenings or vaccines may not be covered 100% by your insurance. Please call the toll-free Customer Service number on the back of your member ID card.

Do I need any medications? Talk to my PCP about items with a "√" in box below.

Heart & Circulatory

☐ ACEI

☐ ARB

☐ Aspirin

☐ Beta blocker

☐ Diuretic

☐ Statin

Diabetes

☐ Blood sugar medication

Lungs

☐ Inhaler to help me breathe when I'm short of breath

Other Systems

☐ Bladder control medication

☐ Other _____

Wellness recommendations to talk about with my PCP: Talk about items with a "√" in box below.

☐ Help to quit using tobacco ☐ How to prevent falling ☐ Plan for physical activities

☐ Bladder control ☐ Ways to improve hearing ☐ Exercise therapy

☐ Healthy eating ☐ Advance directive ☐ Check my blood sugar at home

☐ Options to support walking or balance ☐ Other _____

I may receive separate letters in the mail √ Summary of my visit ☐ Plan of Care **or phone call from a HouseCalls**

☐ Pharmacist ☐ Care navigator ☐ Social worker ☐ Nurse care manager

Other services that may help me:

☐ Palliative care ☐ Home health ☐ Physical therapy ☐ Mental health program

☐ Respite care ☐ Support groups ☐ Community services

☐ Condition management program _____

☐ Reasons _____

Important Phone Numbers

Customer Service: Call the number on the back of your member ID card.

HouseCalls program:1-866-686-2504, TTY **771,** Monday - Friday, 8 a.m. - 8:30 p.m. ET, 5 a.m. - 5:30 p.m.PT

References

American Diabetes Association. Standards of Medical Care in Diabetes 2018, Diabetes Care, 41 (Supplement 1). Yancy et al. 2013 ACCF/AHA guideline for the management of heart failure: a report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. Circulation. 2013,128:e240-e327; Global Initiative for Chronic Obstructive Lung Disease (GOLD) 2018. Available from: http://goldcopd.org; United States Preventive Services Task Force. Available from: www.uspreventiveservicestaskforce.org.

Health and wellness information from your health plan.

HouseCalls

Member Name: ID: Date of Birth:

☐ **Refused** ☐ **Unable to Assess**

DEPRESSION SCREENING TOOL

PHQ-9: Circle the member's response to the questions below and total the score.

Over the *last 2 weeks,* how often have you been bothered by any of the following problems?

	Not at all (0)	Several Days (1)	More Than Half the days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling/staying asleep, sleeping too much.	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

Total Score _____ = **(add the columns)** _____ + _____ + _____

Of the problems checked off on the questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (assess functional status)

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Depression Remission Diagnoses:

- ☐ Major depressive disorder in partial remission - Single episode
- ☐ Major depressive disorder in partial remission - Recurrent
- ☐ Major depressive disorder in full remission - Single episode
- ☐ Major depressive disorder in full remission - Recurrent

If the member scores **5-9 OR Mild Depression:**

- ☐ Major depressive disorder, mild - Single episode
- ☐ Major depressive disorder, mild - Recurrent

If member scores **10-14 OR Moderate Depression**

- ☐ Major depressive disorder, moderate - Single episode
- ☐ Major depressive disorder, moderate - Recurrent

If the member scores **15-19 OR Moderately Severe Depression OR 20-27 Severe Depression**

- ☐ Major depressive disorder, severe without psychotic features - Single episode
- ☐ Major depressive disorder, severe without psychotic features - Recurrent

☐ No diagnosis of major depression applicable at this time.

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HouseCalls

Member Name: ID: Date of Birth:

Other mental health diagnoses: ☐ Schizophrenia, unspecified ☐ Bipolar disorder ☐ Paranoid schizophrenia

☐ Other: _____

Therapy

On Meds/Not On Meds On Meds,Not On Meds Controlled/Not Controlled Controlled,Not Controlled

☐ On Therapy Type of Therapy ☐Individual Counseling ☐Group Counseling ☐Medication Therapy ☐Community Support Groups

From the Primary Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD PHQ). The PHQ was developed by Drs. Robert L. Spitzer,Janet B.W. Williams, Kurt Kroenke and colleagues. For research information, contact Dr. Spitzer at rls@columbia.edu. PIRME-MD is a trademark of Pfizer Inc. Copyright 1999 Pfizer Inc. All right reserved. Reproduced with permission.

HouseCalls

Member Name: ID: Date of Birth:

LAB Testing (ONLY for use with point of care A1C and urine microalbumin dipstick testing.)

Consent and Release for Collection and Testing of Lab Specimen(s)

You have agreed to have a fingerstick as part of your HouseCall. The purpose of this fingerstick is to obtain specimens for laboratory testing.

1. PROCEDURES: If you agree to this procedure, the following will happen. A few drops of blood will be taken from your finger. The fingerstick will take just a few seconds. After the fingerstick your blood will be mailed to the laboratory for testing.

2. RISKS/DISCOMFORTS: The risks of having a fingerstick include temporary pain from the fingerstick, bruising, and rarely, infection. Some patients may experience dizziness, possibly lightheaded or rarely fainting.

3. CONSENT: All of the questions I have asked have been answered to my satisfaction. I agree to this procedure.

☐ **Blood Test Consent**

1. AUTHORIZATION: By signing and dating this form, I authorize the use and disclosure of my personal health information, including the results of these tests, by and among, as applicable, BioIQ (the company that HouseCalls works with to perform the tests) and its authorized suppliers, the ordering physician, the clinical laboratory, the HouseCalls program and my insurer/health plan/health plan administrator for any purposes related to my health, wellness, care and treatment, wellness/disease management/care management programs, healthcare operations of my health plan, and such other uses and discloses of my information as permitted or required by law.

Any recipient of my personal information will be required to keep the information confidential and to only use it in accordance with this authorization or as permitted by law.

This authorization shall expire one year from the date I sign it. I may revoke my authorization to BioIQ to use and disclose my personal information sooner than one year, in writing, in accordance with the procedures set forth in BioIQ's privacy policies.

I understand that revoking this authorization will not have any effect on actions already taken in reliance on this authorization.

I may obtain a copy of this authorization, as well as the applicable privacy policies, by contacting BioIQ, Attn: Security Officer, 1222 State St, Ste. 200, Santa Barbara, CA 93101.

I understand that my participation in this program is voluntary and if I do not agree to have my results and participation shared, I may not participate in this lab work program.

☐ **BIOIQ Authorization**

☐ Member unable to sign-gives practitioner verbal authority to sign on their behalf:

Reason: _____

_____

Signature of Member (or legally authorized representative signing on behalf of the member): **Date** _____

If legally authorized representative:

Name of Person Authorized to Sign for Member: _____

Relation to Member: _____

HIGHLY CONFIDENTIAL UHG-SJC-038282

HouseCalls

Member Name: ID: Date of Birth:

Member Name: _____ Gender: _____ Date of Birth: _____ ☐ Verified

Practitioner Identified Need (PIN)

☐**A1C** **A1C Indication:** A1C not done this year, Last A1C > 9, Member does not recall last test, Universal Eligible

☐**FOBT** **FOBT Indication:** No colorectal screening reported, Colonoscopy >10 years ago, Fecal occult blood test >1 year ago, Member does not recall last test, Last flexible sigmoidoscopy >5 years ago

☐**MAU** **MAU Indication:** Urine dipstick negative for protein, Urine dipstick trace for protein

POINT OF CARE TESTING

A1C: ☐ Not Indicated Reason for Not Indicated: Diabetic - A1C completed this year and result < 9, Non diabetic Universal - A1c done in the past year, Non diabetic Universal - BMI < 25

☐ Refused Reason for Refusal: Member Declined

☐ Unable to Collect Reason for Unable to Collect: Not enough blood, Test kit unable to report value, Test kit unavailable, Video Virtual Visit

Collection Date Time: _____ Result: _____ ☐ Result >13.0

Urine Microalbumin: ☐ Not Indicated ☐ Refused Reason for Refusal: Recently Completed, Member Declined

☐ Unable to Collect Reason for Unable to Collect: Incontinent, On dialysis, Unable to void

Collection Date Time: _____

Albumin: 10 mg/L, 30 mg/L, 80 mg/L, 150 mg/L

Creatinine: 0.1 g/L, 0.5 g/L, 1 g/L, 2 g/L, 3 g/L

UAC ratio: <30 mg/g (normal), 30-300 mg/g (abnormal), >300 mg/g (high abnormal), Cannot be determined

CRE (g/L)	ALB (mg/L)			
	10	**30**	**80**	**150**
0.1	Cannot be determined	30-300mg/g (abnormal)	>300mg/g (high abnormal)	>300mg/g (high abnormal)
0.5	<30mg/g (normal)	30-300mg/g (abnormal)	30-300mg/g (abnormal)	30-300mg/g (abnormal)
1	<30mg/g (normal)	30-300mg/g (abnormal)	30-300mg/g (abnormal)	30-300mg/g (abnormal)
2	<30mg/g (normal)	<30mg/g (normal)	30-300mg/g (abnormal)	30-300mg/g (abnormal)
3	<30mg/g (normal)	<30mg/g (normal)	<30mg/g (normal)	30-300mg/g (abnormal)

BIOIQ TESTING

Blood Testing: ☐ Refused ☐ Unable to Collect Reason for Refusal: Recently Completed, Member Declined

Collection Date Time: _____ Code Number from barcode: _____

Test(s) Requested: ☐A1C ☐LDL

FOBT: ☐ FOBT kit not left with member Reason: Not indicated due to age, Active bleeding or symptoms, Screening completed, Received kit from plan/PCP, Screening test scheduled, Due for surveillance study, Member refused, Video Virtual Visit

Date Collection Kit Left with Member: _____ Code Number from barcode: _____

HIGHLY CONFIDENTIAL UHG-SJC-038283

HouseCalls

Member Name: ID: Date of Birth:

Hep C Testing (ONLY for use with Hepatitis C testing with Let's Get Checked.)

Consent and Release for Collection and Testing of Lab Specimen(s)

You have agreed to have a fingerstick as part of your HouseCall. The purpose of this fingerstick is to obtain specimens for laboratory testing.

1. PROCEDURES: If you agree to this procedure, the following will happen. A few drops of blood will be taken from your finger. The fingerstick will take just a few seconds. After the fingerstick your blood will be mailed to the laboratory for testing.

2. RISKS/DISCOMFORTS: The risks of having a fingerstick include temporary pain from the fingerstick, bruising, and rarely, infection. Some patients may experience dizziness, possibly lightheaded or rarely fainting.

3. CONSENT: All of the questions I have asked have been answered to my satisfaction. I agree to this procedure.

1. AUTHORIZATION: By signing and dating this form, I authorize the use and disclosure of my personal health information, including the results of these tests, by and among, as applicable, Let's Get Checked (LGC) (the company that HouseCalls works with to perform the tests) and its authorized suppliers, the ordering physician, the clinical laboratory, the HouseCalls program and my insurer/health plan/health plan administrator for any purposes related to my health, wellness, care and treatment, wellness/disease management/care management programs, healthcare operations of my health plan, and such other uses and discloses of my information as permitted or required by law.

Any recipient of my personal information will be required to keep the information confidential and to only use it in accordance with this authorization or as permitted by law.

This authorization shall expire one year from the date I sign it. I may revoke my authorization to LGC to use and disclose my personal information sooner than one year, in writing, in accordance with the procedures set forth in LGC's privacy policies.

I understand that revoking this authorization will not have any effect on actions already taken in reliance on this authorization.

I may obtain a copy of this authorization, as well as the applicable privacy policies, by contacting LetsGetChecked.

To request additional information, or make any of the requests described above, you may contact LetsGetChecked at dpo@letsgetchecked.com or via toll free phone number at +1 (888) 396-7375 or through our website: https://www.letsgetchecked.com/us/en/

I understand that my participation in this program is voluntary and if I do not agree to have my results and participation shared, I may not participate in this lab work program.

☐ Member unable to sign-gives practitioner verbal authority to sign on their behalf

Reason: _____

Signature of Member (or legally authorized representative signing on behalf of the member):

_____

If legally authorized representative:

Name of Person Authorized to Sign for Member: _____

Relation to Member: _____

HIGHLY CONFIDENTIAL UHG-SJC-038284

HouseCalls

Member Name: ID: Date of Birth:

Member Name: _____ Gender: _____ ☐ Verified

Date of Birth: _____ Phone: _____ Date: _____

Hep C:

Hep C test completed: ☐ Yes ☐ No

Reason for not completed: Member declined, Inadequate blood sample, Member reports previous Hepatitis C screening, Not indicated, Kit incomplete or damaged, Member completed prior to HC visit, Member discarded kit

Alpha code: _____

Numeric code: _____

HIGHLY CONFIDENTIAL UHG-SJC-038285

HouseCalls

Member Name: ID: Date of Birth:

Assessment Date: _____

HEALTH RISK ASSESSMENT

Who is providing answers to/assisting with the completion of this assessment? ☐ Member ☐ Caregiver

Have you served in the US Armed Forces?

- ☐ I have not served in the US Armed Forces
- ☐ I served in the US Armed Forces and use VA (Veterans Healthcare Administration Benefit
- ☐ I served in the US Armed Forces and do not use VA (Veterans Healthcare Administration Benefits)
- ☐ Choose not to answer

Current health conditions:

Compared to others your age, how would you describe your health?

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

Are you being treated for or have you been told you have any of the following?

- ☐ COPD/Emphysema
- ☐ Mental Health Need (Anxiety, Depression, Schizophrenia, Bi-Polar Disorder)
- ☐ Diabetes (sugar diabetes) or too much sugar in your blood
- ☐ Heart problems (irregular heartbeat, heart attack, or heart surgery)
- ☐ Heart Failure or Enlarged Heart
- ☐ High Blood Pressure
- ☐ Kidney dialysis
- ☐ None
- ☐ Doesn't know
- ☐ Declines to answer

Prescription drugs:

How many different medications do you take each day (including prescriptions and over the counter medications)?

- ☐ 0-7
- ☐ 8 or more

Hospital stays:

In the last year, how many times have you stayed overnight as a patient in the hospital?

- ☐ 0
- ☐ 1 time
- ☐ 2-3 times
- ☐ 4 or more times

Help at Home:

On a scale of 0-10 how much physical pain have you experienced over the past 72 hours? Zero equals no pain and ten equals the worst pain possible.

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10
- ☐ Choose not to answer

Do you need help with any of the following activities? Check all that apply

- ☐ Bathing
- ☐ Grooming
- ☐ Using the restroom
- ☐ Eating
- ☐ Dressing
- ☐ Mobility (Moving around)
- ☐ Transfers (example: move from bed to chair)
- ☐ I do not need any help

If for any reason you need help with day-to-day activities such as bathing, etc., do you have the help you need?

- ☐ I get all the help I need
- ☐ I could use a little more help
- ☐ I need a lot more help

Memory and mood:

Is it hard for you to concentrate, remember things, or make decisions?

- ☐ Yes
- ☐ No

HouseCalls

Member Name: ID: Date of Birth:

Over the last two weeks, how often have you been bothered by little interest or pleasure in doing things?

- ☐ Not at all (0)
- ☐ Several Days (1)
- ☐ More than half the days (2)
- ☐ Nearly every day (3)

Over the last two weeks, how often have you been feeling down, depressed or hopeless?

- ☐ Not at all (0)
- ☐ Several Days (1)
- ☐ More than half the days (2)
- ☐ Nearly every day (3)

PHQ-2 Score:

Other:

In the past year, have you been unable to get any of the following when you really needed it? (Check all that apply)

- ☐ Food
- ☐ Clothing
- ☐ Utilities
- ☐ Phone
- ☐ Medicine or Health Care
- ☐ Transportation
- ☐ Housing
- ☐ None Needed

Do you have personal, spiritual, or cultural preferences that may affect your health care choices? For example, no blood products to be used.

- ☐ Yes
- ☐ No
- ☐ Choose not to answer

How many times in the past year have you used a recreational drug or a prescription medication for non-medical reasons? (For example, because of the way it made you feel)

- ☐ Never
- ☐ Less than monthly
- ☐ Monthly
- ☐ Weekly
- ☐ Daily
- ☐ Declined to answer

Do you provide care for or look after someone who needs assistance with their care?

- ☐ Yes
- ☐ No

Medication Disposal:

- ☐ I attest verbal education and written information were provided to the member/responsible party regarding safe disposal of medications and drug takeback programs per CMS criteria.
- ☐ Member Declined written information, however, verbal education regarding safe disposal of medications and DEA website provided.

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2003). The Patient Health Questionnaire-2: validity of a two-item depression screener. Medical care, 41(11), 1284-1292. Developed by Drs. Robert L. pitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce , translate, display or distribute. Copyright © 2020 UnitedHealth Group All Rights Reserved. Any use, copying or distribution without written permission from UnitedHealth Group is prohibited.

HouseCalls

Member Name: ID: Date of Birth:

COMPREHENSIVE REFERRAL DISPLAY		
☐ Optum at home member needs care level assessment		
Referral Name		
Care Manager	Follow up provided by	
	Clinical Call Center notified of Referral:	By Phone Call
	☐ QuantaFlo™ Test for Peripheral Artery Disease	APC call PCP for severe results
		☐ PCP contacted with results
		Date PCP contacted
		☐ Contacting PCP not indicated
		Reason: ☐PCP contacted previously ☐Scheduled to see PCP
		☐ Mild 0.89 to 0.60
		Result: Left Foot __ Right Foot __
		☐ Moderate 0.59 to 0.30
		Result: Left Foot __ Right Foot __

		☐ Severe 0.29 to 0.00
		Result: Left Foot __ Right Foot __
	☐ Ultrasound Wrist Scan For Bone Density	Result: __
	☐ Retinal Eye Exam Abnormal	
	☐ Urine Microalbumin	Highly Abnormal (> 300 mg/g)
	☐ Mini Cog Test Abnormal	
	☐ High Fall Risk	
	☐ Non-Diabetic Screening A1C Results	☐ 5.7 to 6.4
		Result : ___
		☐ 6.5 or greater
		Result : ___
	☐ Diabetic Screening A1C Results	☐ Result > 13
	☐ Three or more ER visits in the last three months	
	☐ Discharged from hospital in past 30 days	

	☐ Malnourished	
	Communication Details:	
	☐ Clinically significant new findings or diagnosis	Reason for Referral:
	Member accepts Care Manager Referral(s) and consents to post visit follow up call(s) ☐ Yes ☐ No	☐ Benefits of follow up call reviewed with the member
	Contact details:	☐PCP ☐EMS ☐Behavioral Health ☐Dispatch Health ☐Family/Legally Authorized Representative ☐Health Plan Representative/Member Services
Social Work	Follow up provided by	
	Clinical Call Center notified of Referral:	By Phone Call
	Emergent and Urgent - Behavioral Health	☐ PHQ9 Score 20 to 27
		Result: __
		☐ Suicidal With or Without a Plan
		☐ Danger to Self or Others

		☐ Severely unstable mental health
		☐ Severe agitation
	Urgent - Social Work	☐ Child in Care of Incapacitated Adult
		☐ Suspected Abuse or Neglect
		☐ No Food or Electricity or Running Water
		☐ PHQ9 Score 15 to 19
		Result: __
	Member accepts Social Work Referral(s) and consents to post visit follow up call(s) ☐ Yes ☐ No	☐ Benefits of follow up call reviewed with the member
	Communication Details:	
	Contact details:	☐PCP ☐Mental Health Provider ☐EMS ☐Behavioral Health ☐Family/Legally Authorized Representative ☐Health Plan Representative/Member Services ☐Child Protective Services ☐Adult Protective Services

Mini Nutritional Assessment
MNA®

Nestlé Nutrition Institute

☐ Unable to Assess ☐ Member Refused

Last name: First name:

Sex: Age: Weight, kg: Height, cm: Date:

Complete the screen by filling in the boxes with the appropriate numbers.
Add the numbers for the screen. If score is 11 or less, continue with the assessment to gain a Malnutrition Indicator Score.

Screening

A Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?
0 = severe decrease in food intake
1 = moderate decrease in food intake
2 = no decrease in food intake ☐

B Weight loss during the last 3 months
0 = weight loss greater than 3kg (6.6lbs)
1 = does not know
2 = weight loss between 1 and 3kg (2.2 and 6.6 lbs)
3 = no weight loss ☐

C Mobility
0 = bed or chair bound
1 = able to get out of bed / chair but does not go out
2 = goes out ☐

D Has suffered psychological stress or acute disease in the past 3 months?
0 = yes 2 = no ☐

E Neuropsychological problems
0 = severe dementia or depression
1 = mild dementia
2 = no psychological problems ☐

F Body Mass Index (BMI) = weight in kg / (height in m)^2 ☐
0 = BMI less than 19
1 = BMI 19 to less than 21
2 = BMI 21 to less than 23
3 = BMI 23 or greater ☐

Screening score (subtotal max. 14 points) ☐☐

12-14 points: ☐ Normal nutritional status
8-11 points: ☐ At risk of malnutrition
0-7 points: ☐ Malnourished

For a more in-depth assessment, continue with questions G-R

Assessment

G Lives independently (not in nursing home or hospital)
1 = yes 0 = no ☐

H Takes more than 3 prescription drugs per day
0 = yes 1 = no ☐

I Pressure sores or skin ulcers
0 = yes 1 = no ☐

J How many full meals does the patient eat daily?
0 = 1 meal
1 = 2 meals
2 = 3 meals ☐

K Selected consumption markers for protein intake
- At least one serving of dairy products (milk, cheese, yoghurt) per day — yes ☐ no ☐
- Two or more servings of legumes or eggs per week — yes ☐ no ☐
- Meat, fish or poultry every day — yes ☐ no ☐

0.0 = if 0 or 1 yes
0.5 = if 2 yes
1.0 = if 3 yes ☐.☐

L Consumes two or more servings of fruit or vegetables per day?
0 = no 1 = yes ☐

M How much fluid (water, juice, coffee, tea, milk...) is consumed per day?
0.0 = less than 3 cups
0.5 = 3 to 5 cups
1.0 = more than 5 cups ☐.☐

N Mode of feeding
0 = unable to eat without assistance
1 = self-fed with some difficulty
2 = self-fed without any problem ☐

O Self view of nutritional status
0 = views self as being malnourished
1 = is uncertain of nutritional state
2 = views self as having no nutritional problem ☐

P In comparison with other people of the same age, how does the patient consider his / her health status?
0.0 = not as good
0.5 = does not know
1.0 = as good
2.0 = better ☐.☐

Q Mid-arm circumference (MAC) in cm
0.0 = MAC less than 21
0.5 = MAC 21 to 22
1.0 = MAC greater than 22 ☐.☐

R Calf circumference (CC) in cm
0 = CC less than 31
1 = CC 31 or greater ☐

Assessment (max. 16 points) ☐☐.☐
Screening score ☐☐.☐
Total Assessment (max. 30 points) ☐☐.☐

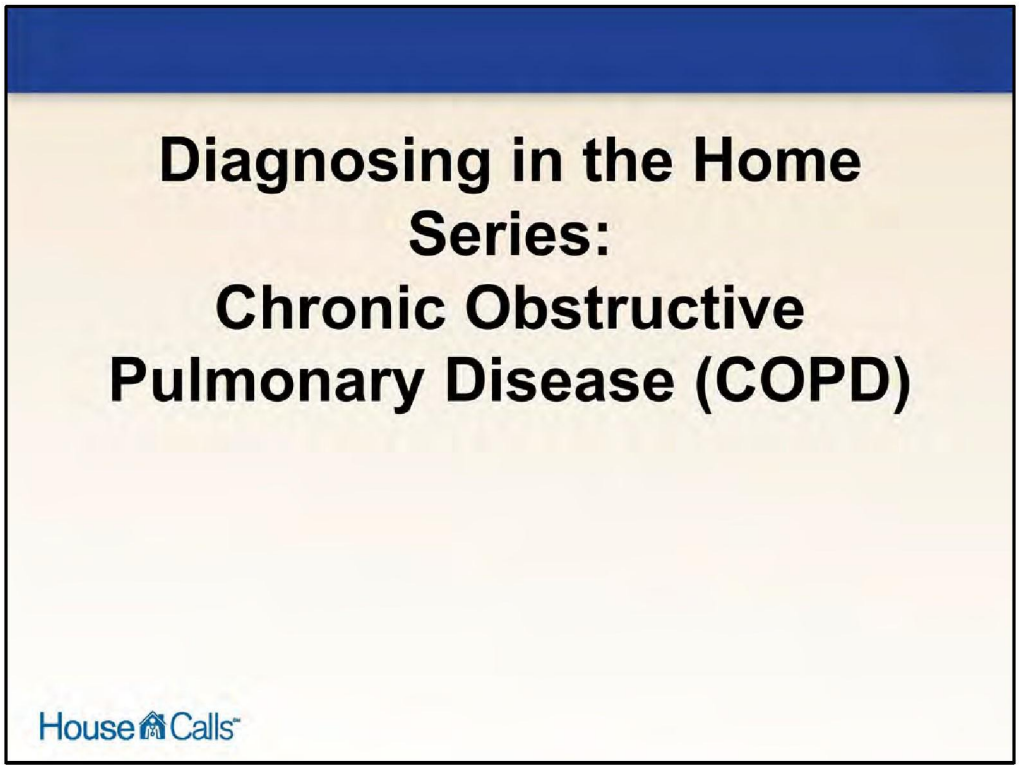
Malnutrition Indicator Score

24 to 30 points	☐	Normal nutritional status
17 to 23.5 points	☐	At risk of malnutrition
Less than 17 points	☐	Malnourished

References
1. Vellas B, Villars H, Abellan G, *et al.* Overview of the MNA® - Its History and Challenges. *J Nutr Health Aging.* 2006; **10:456**-465.
2. Rubenstein LZ, Harker JO, Salva A, Guigoz Y, Vellas B. Screening for Undernutrition in Geriatric Practice: Developing the Short-Form Mini Nutritional Assessment (MNA-SF). *J. Geront.* 2001; **56A**: M366-377
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Welcome to our "Diagnosing in the Home Series for HouseCalls Practitioners". This module covers identifying COPD during a HouseCalls visit.

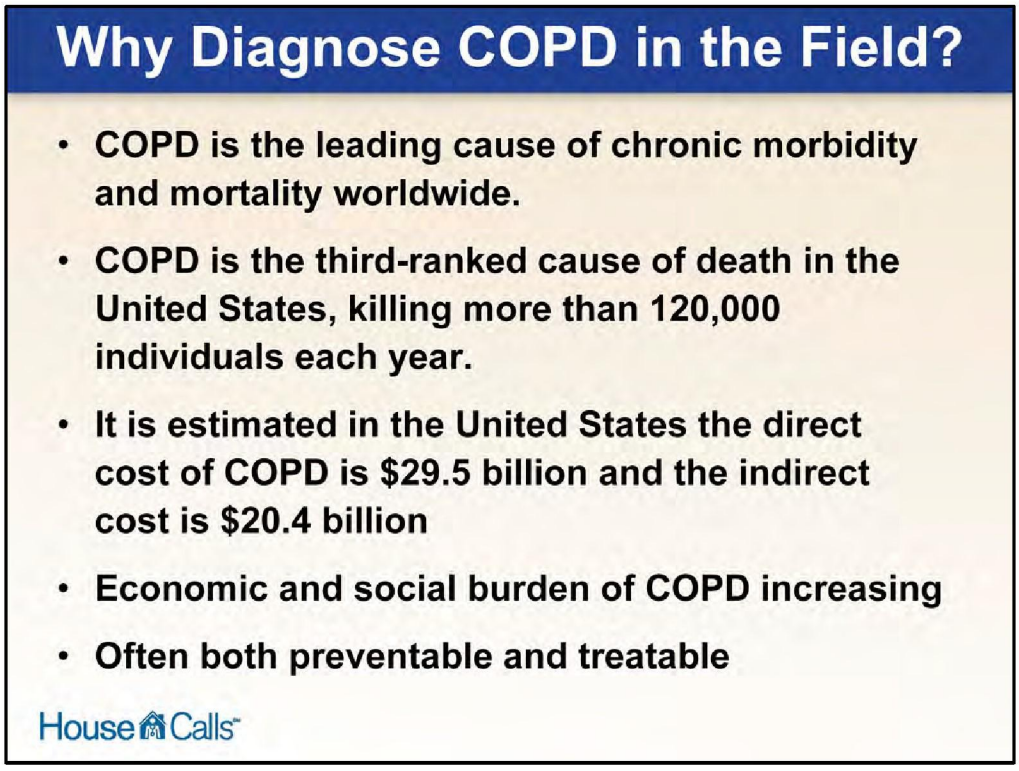
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Objectives

- The HouseCalls Practitioner will:
  - Use "flags" to identify previously undiagnosed or diagnosed COPD or gaps in care
  - Feel more comfortable diagnosing COPD in the field
  - Adequately discuss COPD with the Member & target education towards individual needs
  - Accurately document COPD related findings & avoid common QA pitfalls

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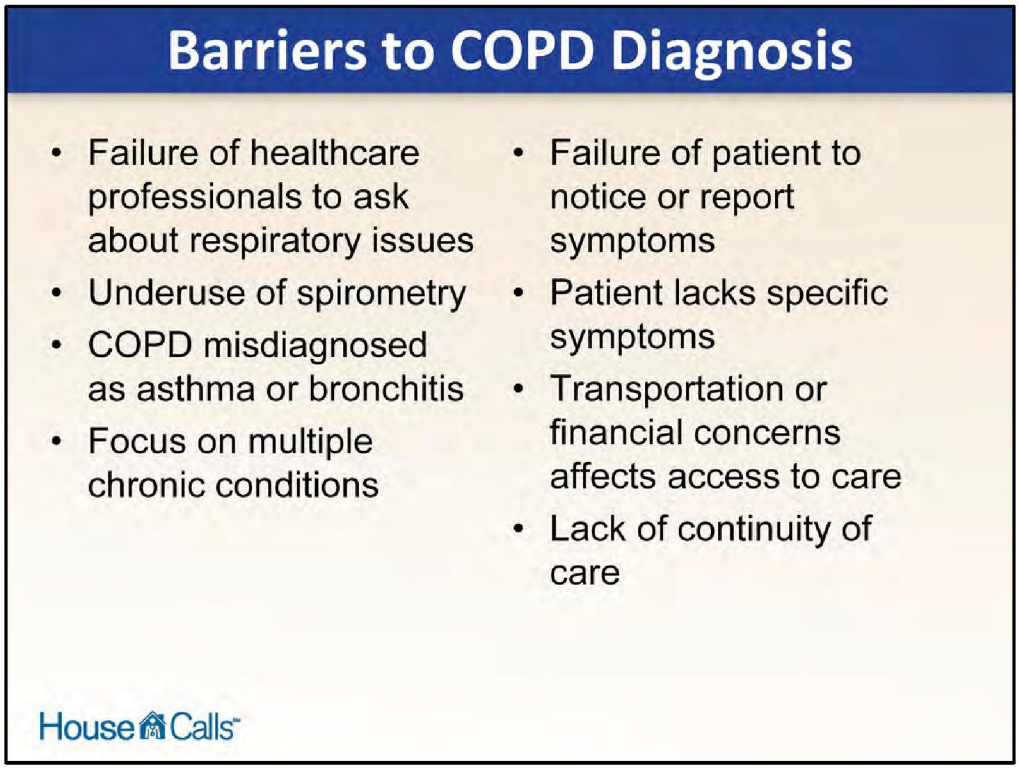
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Why Diagnose COPD in the Field?

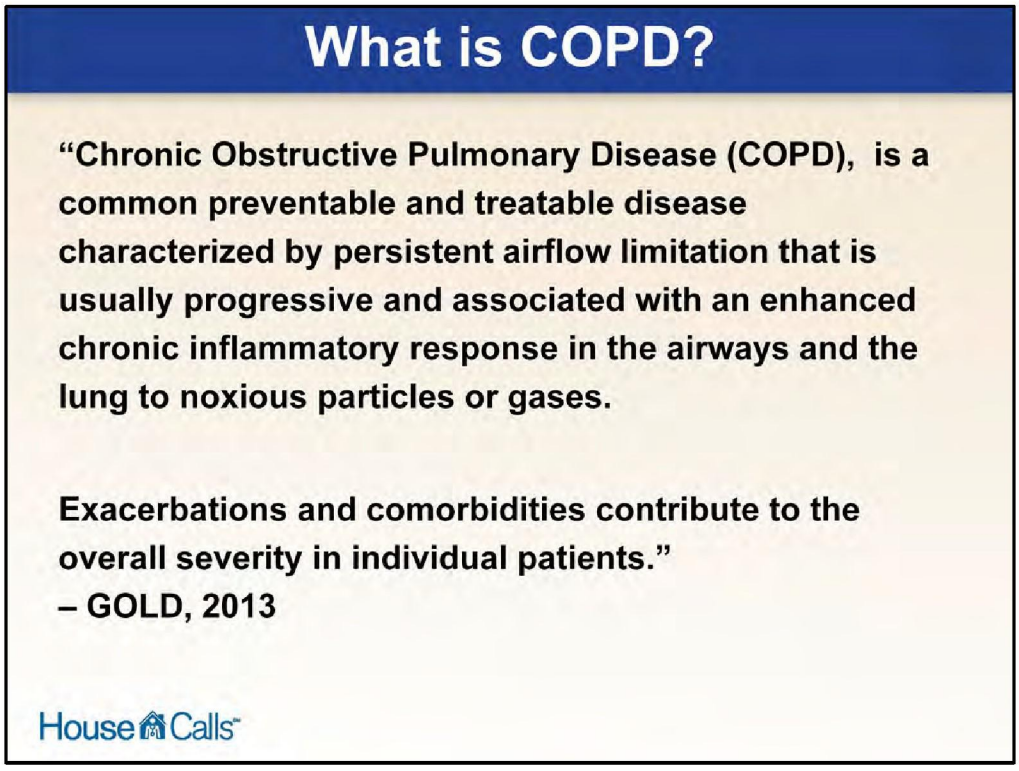
- COPD is the leading cause of chronic morbidity and mortality worldwide. (GOLD, 2014)
- COPD is the third-ranked cause of death in the United States, killing more than 120,000 individuals each year.(Rennard 2014)
- It is estimated in the United States the direct cost of COPD is $29.5 billion and the indirect cost is $20.4 billion
- The economic and social burden of COPD is projected to increase in coming decades due to continued exposure to COPD risk factors and the aging of the world's population(GOLD, 2014)
- As a consequence of its high prevalence and chronicity, COPD causes high resource utilization with frequent office visits, frequent hospitalizations due to acute exacerbations, and the need for chronic therapy (eg, supplemental oxygen therapy, medication). Often both preventable and treatable.

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What are some of the barriers to diagnosing COPD? Often, it is the failure of healthcare professionals to simply ask about respiratory issues, especially since patients often fail to notice or report symptoms. COPD may be misdiagnosed as asthma, bronchitis, or "winter colds". Spirometry is underutilized, especially when the patient lacks specific symptoms. With limited amount of face-to-face time with the PCP, often the focus is on multiple chronic conditions. There may also be lack of continuity of care. This is often seen when transportation or financial concerns affects access to care.

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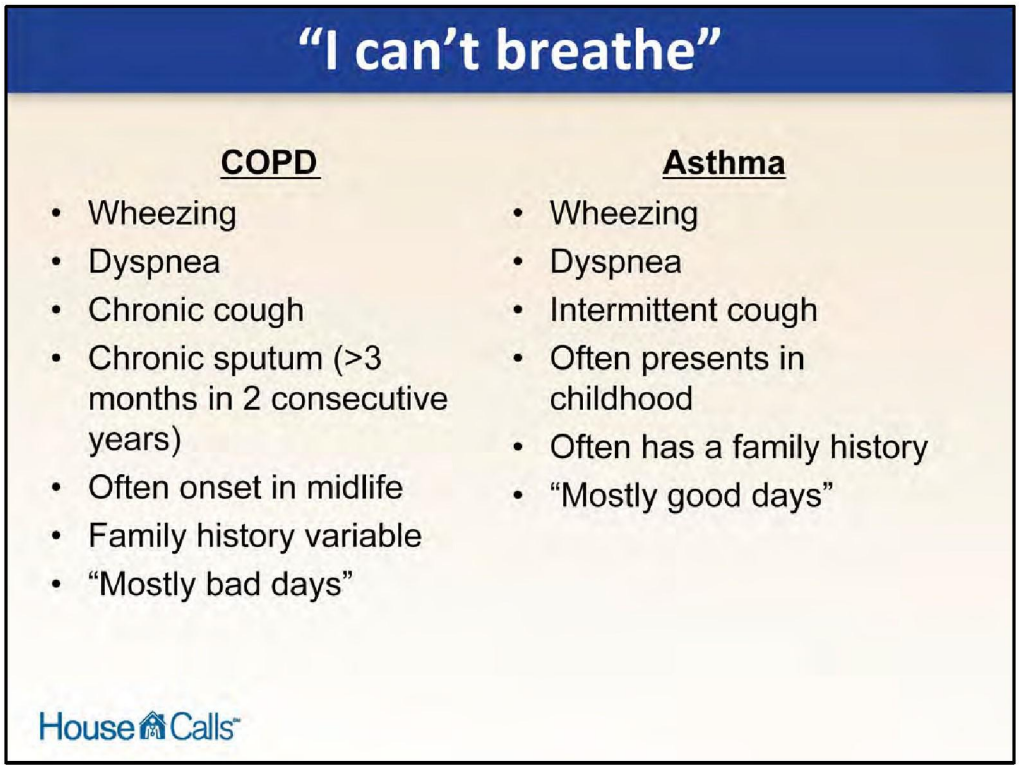


The Global Initiative for Chronic Obstructive Lung Disease (Gold)– a project initiated by the National Heart, Lung, and Blood Institute (NHLBI) and the World Health Organization (WHO) defines COPD as: "COPD is a common preventable and treatable disease characterized by persistent airflow limitation that is usually progressive and associated with an enhanced chronic inflammatory response in the airways and the lung to noxious particles or gases. Exacerbations and comorbidities contribute to the overall severity in individual patients." Many previous definitions of COPD have emphasized the terms emphysema and chronic bronchitis which are not in the definition used in this or other GOLD definitions.

COPD is present only if chronic airflow obstruction occurs; chronic bronchitis without airflow obstruction is not included within COPD

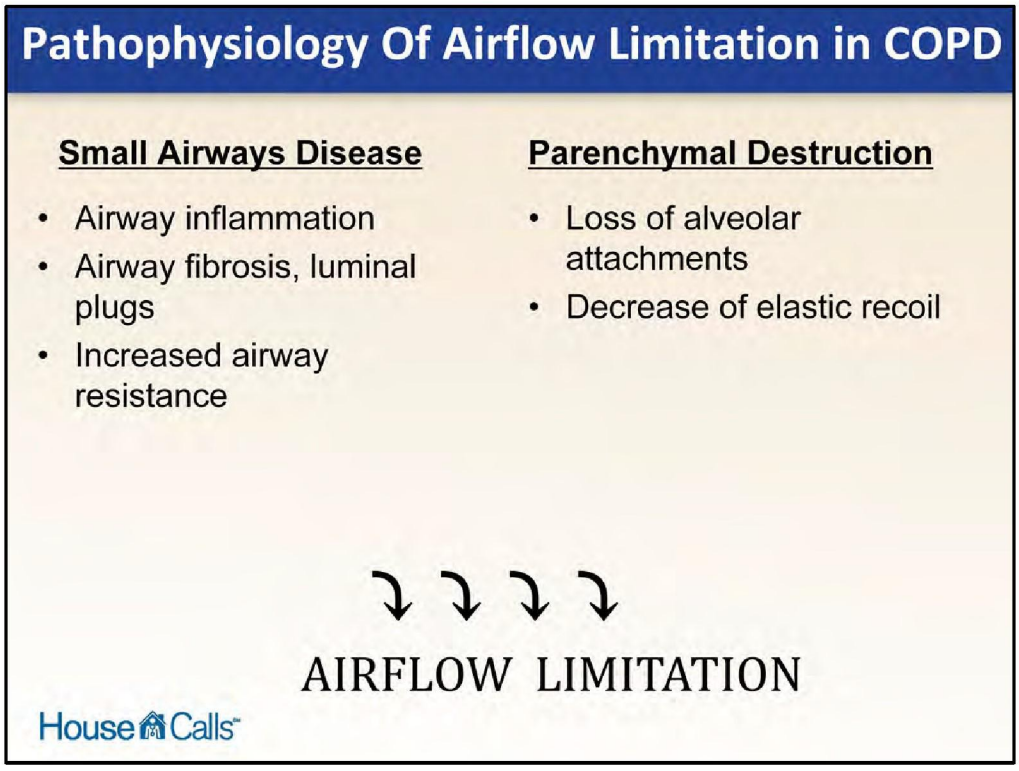
Patients with asthma whose airflow obstruction is completely reversible are not considered to have COPD

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Although both COPD and Asthma are associated with chronic inflammation of the respiratory tract, there are differences in the inflammatory cells between the two diseases. They will have differences in physiological effects, symptoms, and therapy response. Some COPD patients have features consistent with asthma.

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Simply, the inflammation in the respiratory tract of a COPD patient is a modified response to chronic irritants such as tobacco smoke. The chronic inflammation causes structural changes resulting from repeated injury and repair, which then lead to decreased FEV1 (forced expiratory volume). A chronic, productive cough can trigger more mucus hypersecretion. The predominant pathologic changes of COPD are found in the airways, but changes are also seen in the lung parenchyma. Airways abnormalities in COPD include chronic inflammation, increased numbers of goblet cells, mucus gland hyperplasia, fibrosis, narrowing and reduction in the number of small airways, and airway collapse due to the loss of tethering caused by alveolar wall destruction in emphysema.

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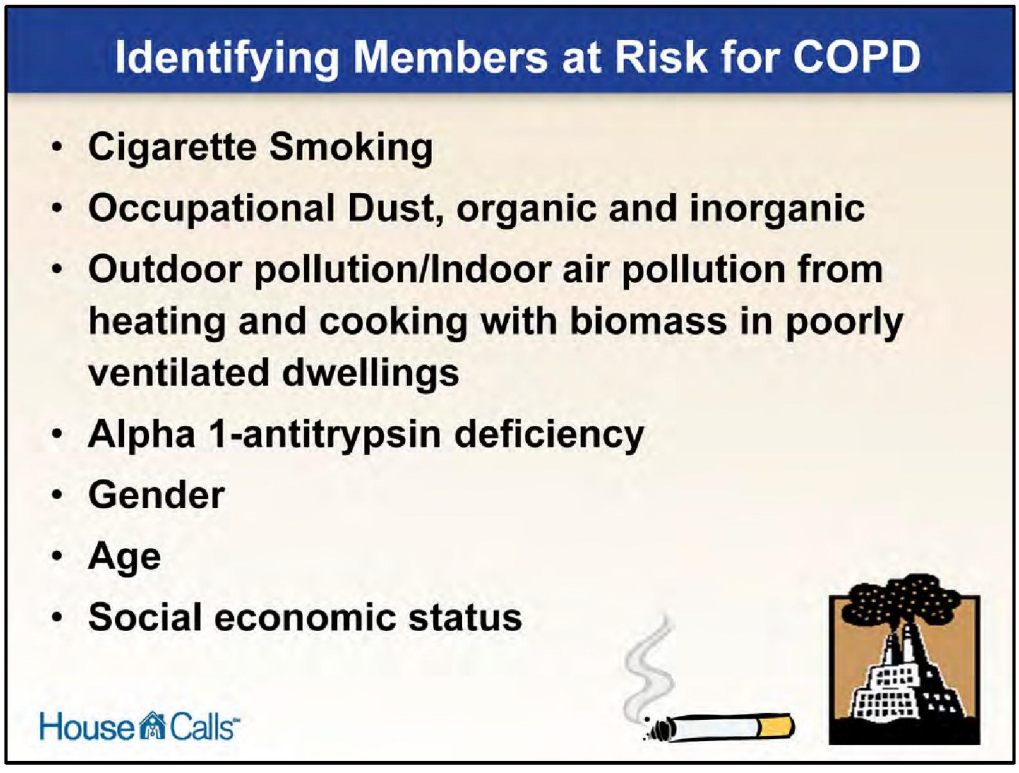
Clinical Diagnosis of COPD

Based upon the following findings:

- **The presence of symptoms suggestive of COPD (dyspnea at rest or on exertion, cough with or without sputum production, progressive limitation of activity) are suggestive of the diagnosis.**
- **Spirometry showing airflow limitation (FEV1/FVC ratio less than 70% or less than the lower limit of normal PLUS an FEV1 less than 80% of predicted) that is not completely reversible with an inhaled bronchodilator is the hallmark of the diagnosis of COPD.**
- **Absence of an alternative explanation for the symptoms and airflow limitation.**

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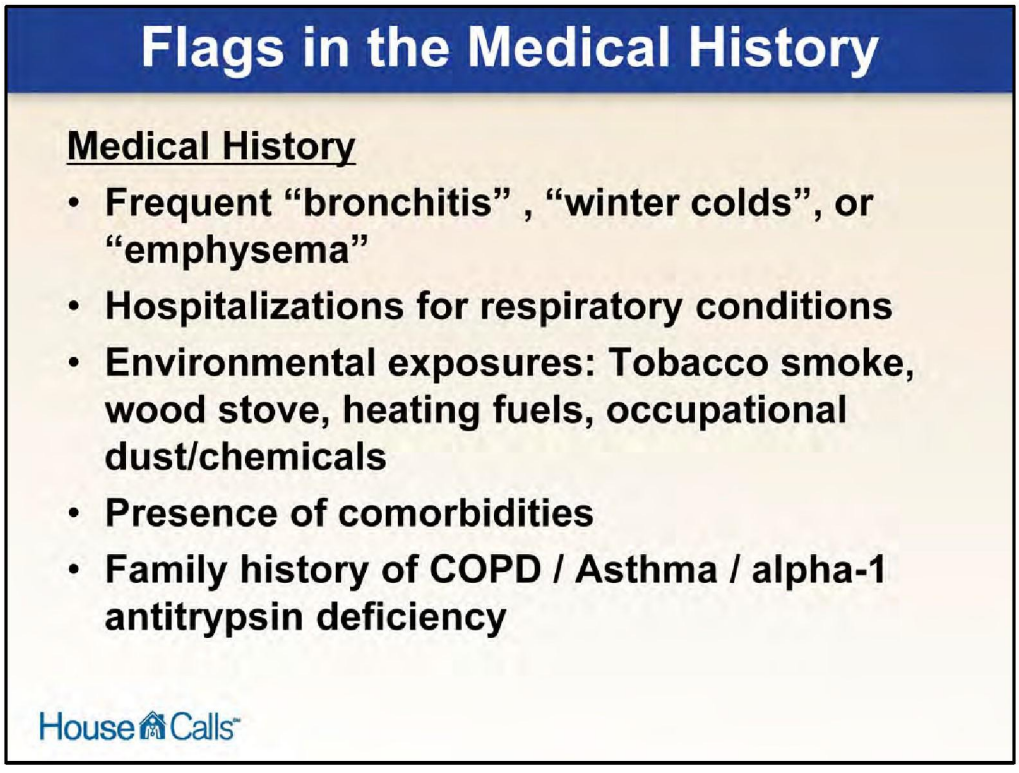
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An estimated 50% of the 24 million adults in the USA who have COPD are thought to be misdiagnosed or undiagnosed. This makes it vital that we are able to identify members at risk for COPD. The most important risk factor for COPD is cigarette smoking and the amount and duration of smoking contribute to disease severity. A key step in the evaluation of patients with suspected COPD is to ascertain the number of pack years smoked (packs of cigarettes per day multiplied by the number of years), as 80% of patients with COPD have a history of cigarette smoking. Asking their age when they started using tobacco products as well as the age of quitting is useful, as patients may underestimate the number of years they smoked.

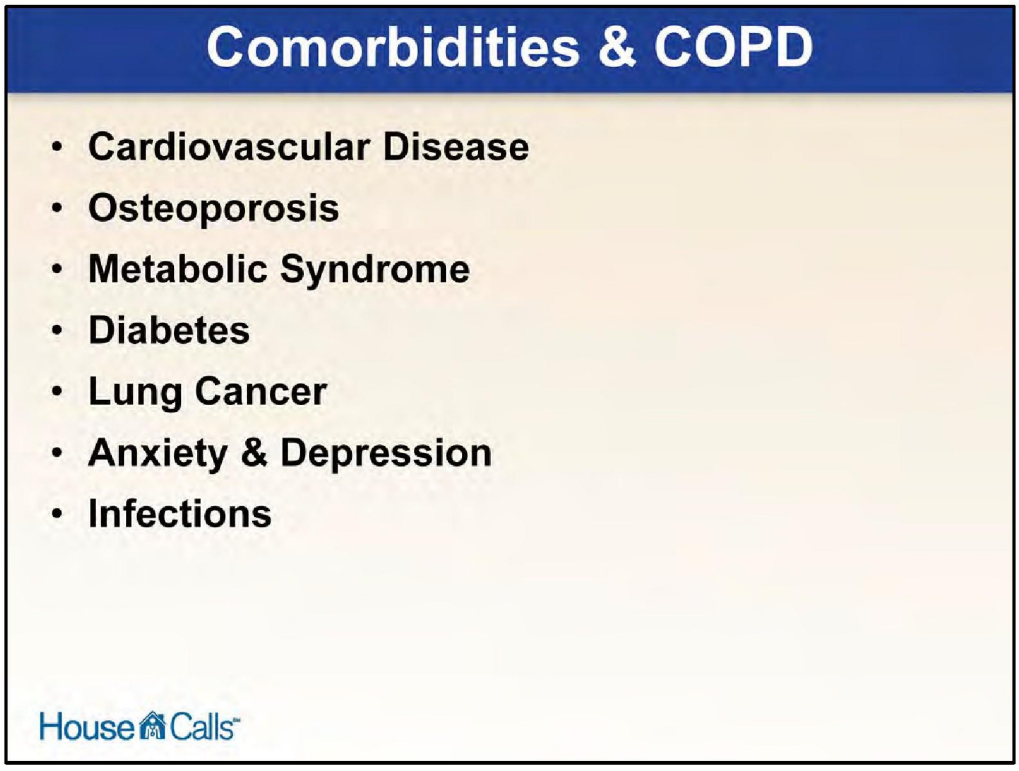
- Exposure to occupational fumes, organic or inorganic dusts, woodburning stoves, can help to explain the 20% of patients with COPD (defined by lung function alone) who die from COPD who never smoked.
- Growing awareness of Alpha 1-antitrypsin deficiency. This is an inherited condition that causes the enzyme elastase to break down elastin in the lungs which leads to the destruction of alveolar walls. Levels should be checked in individuals that develop COPD before the age of 45.
- Gender, men generally develop COPD more than women, however, mortality in females has more than doubled over the last 20 yrs .
- Age -The prevalence of COPD in patient age 65 or greater is 4 times higher than patients age 45-64.
- Social economic status- it is not totally clear whether tis pattern reflects exposure to indoor and outdoor air pollutants, crowding, poor nutrition, infections, or other factors that are related to low socioeconomic status

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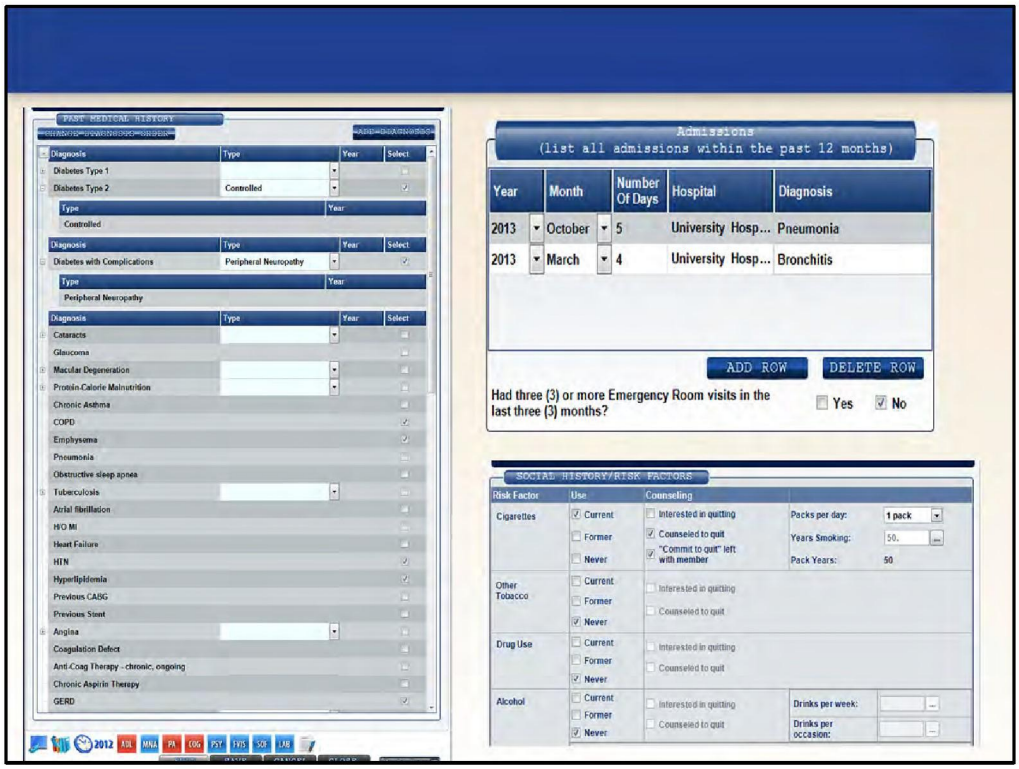
Flags within the PMH that can assist the practitioner with diagnosing COPD in the home are patterns of symptom development. For example, frequent "bronchitis" , "winter colds", or "emphysema". Asthma may also be a risk factor for COPD. After adjusting for smoking, adults with asthma were found to have a twelve fold higher risk of acquiring COPD. Hospitalizations for respiratory conditions, environmental exposures: tobacco smoke, exposure to wood burning stoves, heating fuels, occupational dust/chemicals, Presence of comorbidities and Family history of COPD / Asthma / alpha-1 antitrypsin deficiency.

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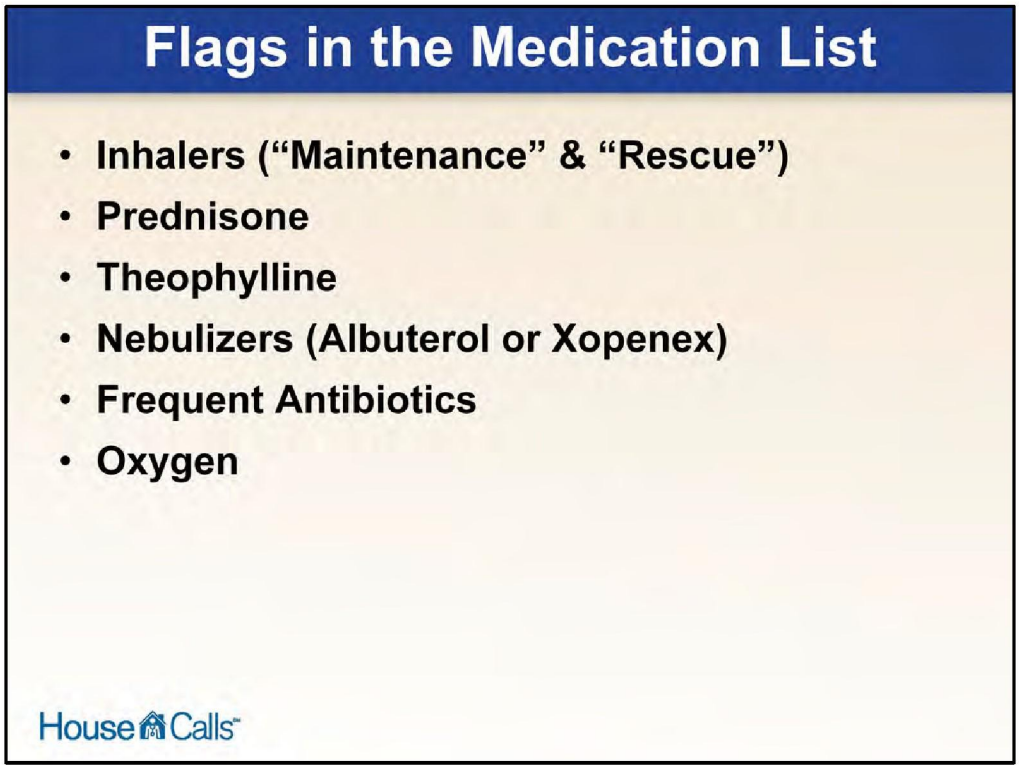
Look for these comorbidities that are often linked to the presence COPD. Inflammatory mediators in the circulation may initiate or worsen comorbidities such as heart disease, CHF, osteoporosis, normocytic anemia, metabolic syndrome, diabetes, chronic infection, anxiety and depression. Pulmonary hypertension may develop late in the disease.

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Take a moment to review screen images from the Tablet to look for clues in the PMH and social history that may suggest COPD.

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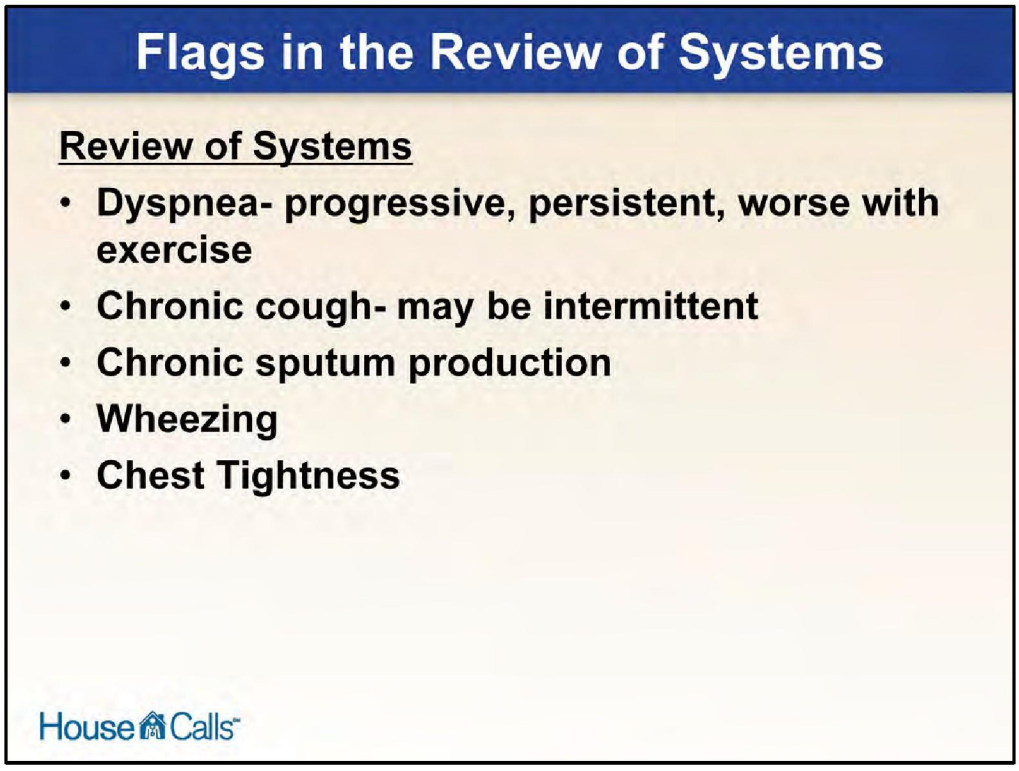


Flags within the Medication list that can assist the practitioner with diagnosing COPD in the home include various "maintenance" and "rescue" inhalers. Bronchodilators include Beta 2 agonists and anticholinergics (such as Ipratropium). Also look for prednisone, theophylline, albuterol or Xopenex nebulizer, frequent antibiotic usage, and the notation of oxygen.

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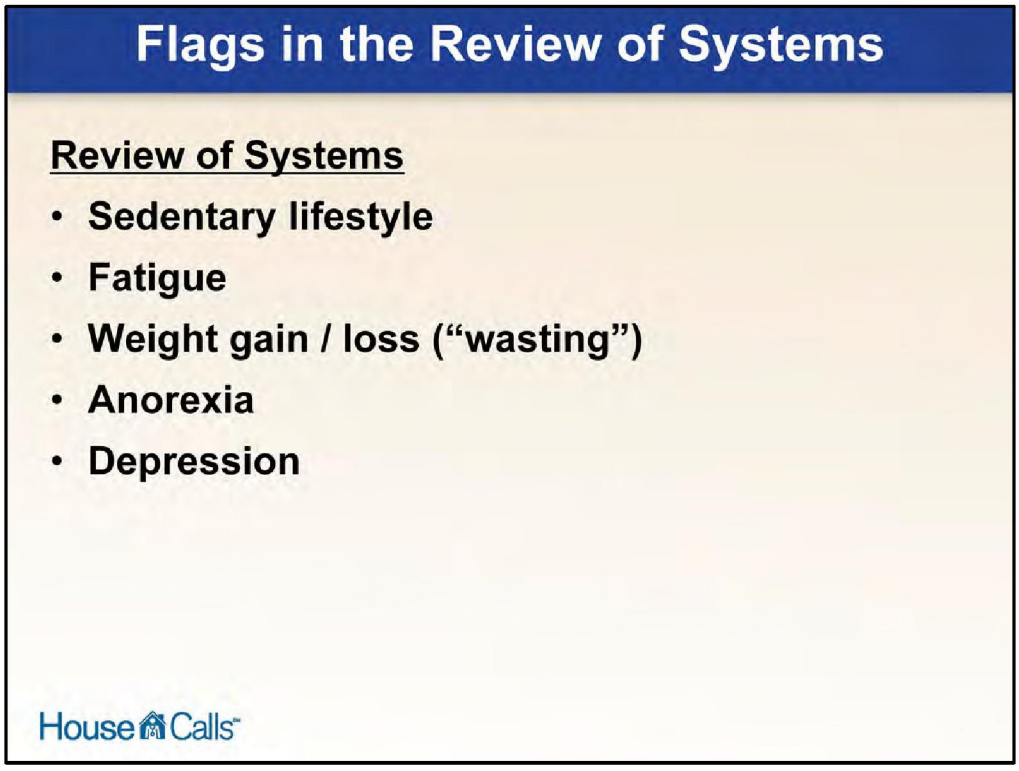
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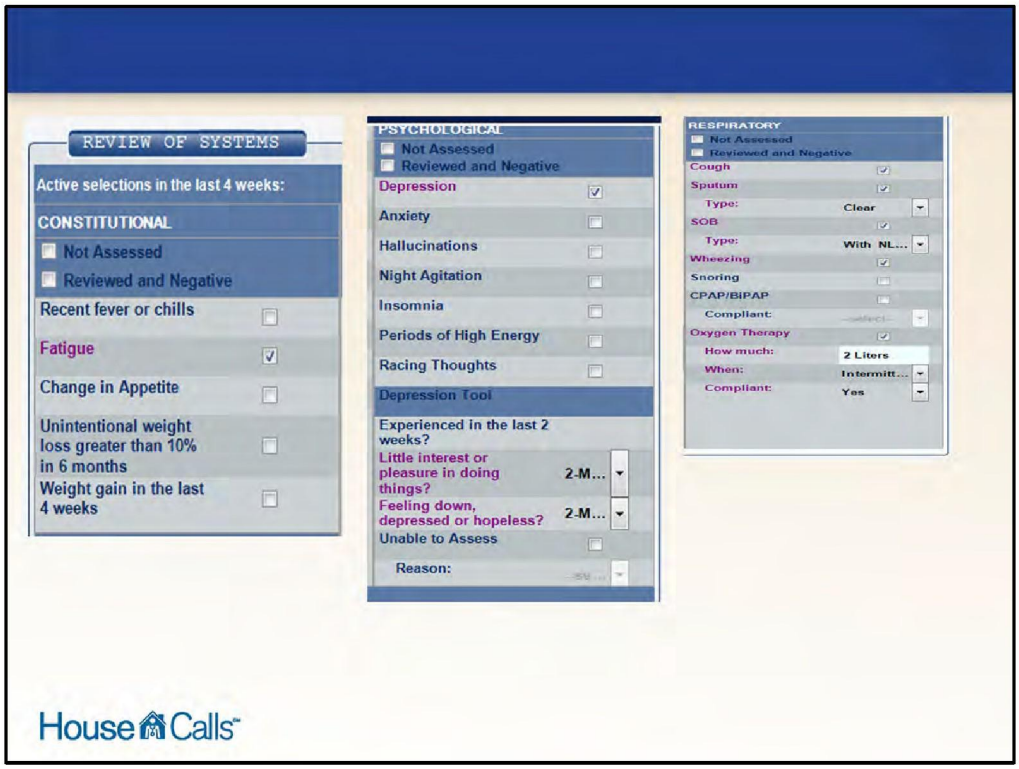
The three cardinal symptoms of COPD that a member may complain of during the ROS are dyspnea, chronic cough, and sputum production and the most common early symptom is exertional dyspnea. Less common symptoms include wheezing and chest tightness.

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Patients who have an extremely sedentary lifestyle but few complaints require careful questioning to elicit a history that is suggestive of COPD. Some patients unknowingly avoid exertional dyspnea by shifting their expectations and limiting their activity. They may be unaware of the extent of their limitations or that their limitations are due to respiratory symptoms, although they may complain of fatigue. Patients with COPD may experience weight gain (due to activity limitations), weight loss (possibly due to dyspnea while eating), or feelings of depression or anxiety. Weight loss ("wasting") generally reflects more advanced disease and is associated with a worse prognosis. However, the majority of COPD patients are overweight or obese.

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Take a moment to review screen images from the Tablet to look for clues in the review of systems that may suggest COPD

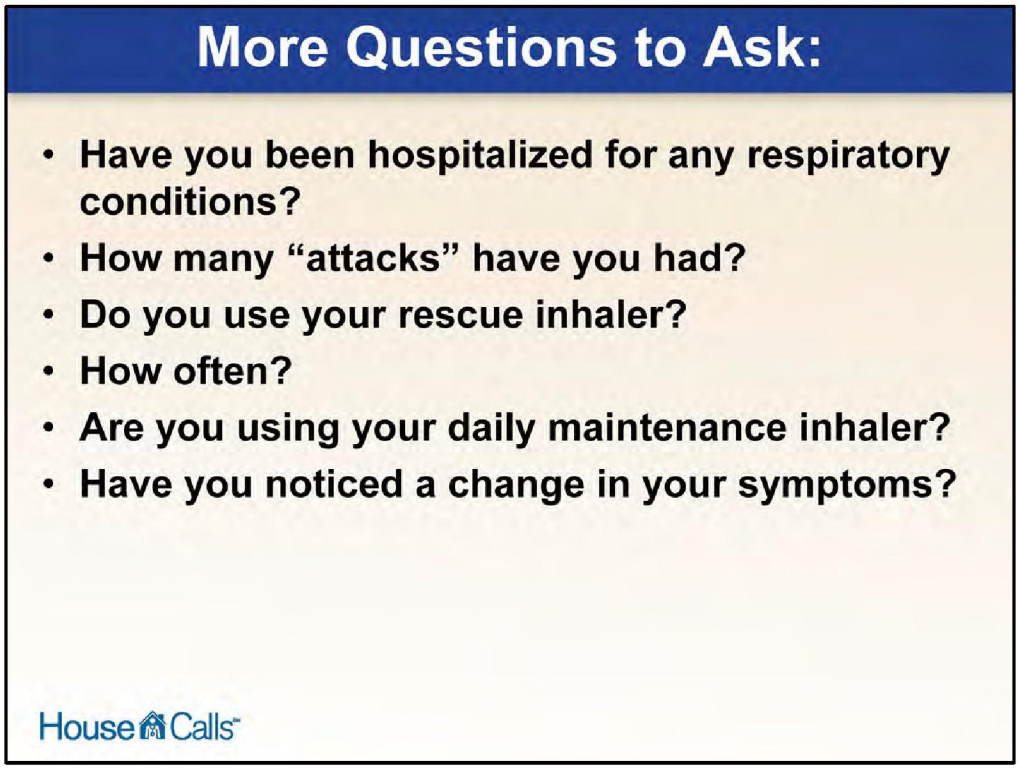
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Diagnosing COPD Exacerbation

- According to GOLD 2013, the "diagnosis of an exacerbation relies exclusively on the clinical presentation of the patient complaining of an acute change of symptoms (baseline dyspnea, cough, and/or sputum production) that is beyond normal day-to-day variation… leading to a change of medication. "
- Prevention, early detection, and prompt treatment of exacerbations are vital to improving outcomes.
- The HouseCalls Practitioner is actively involved in these three areas.

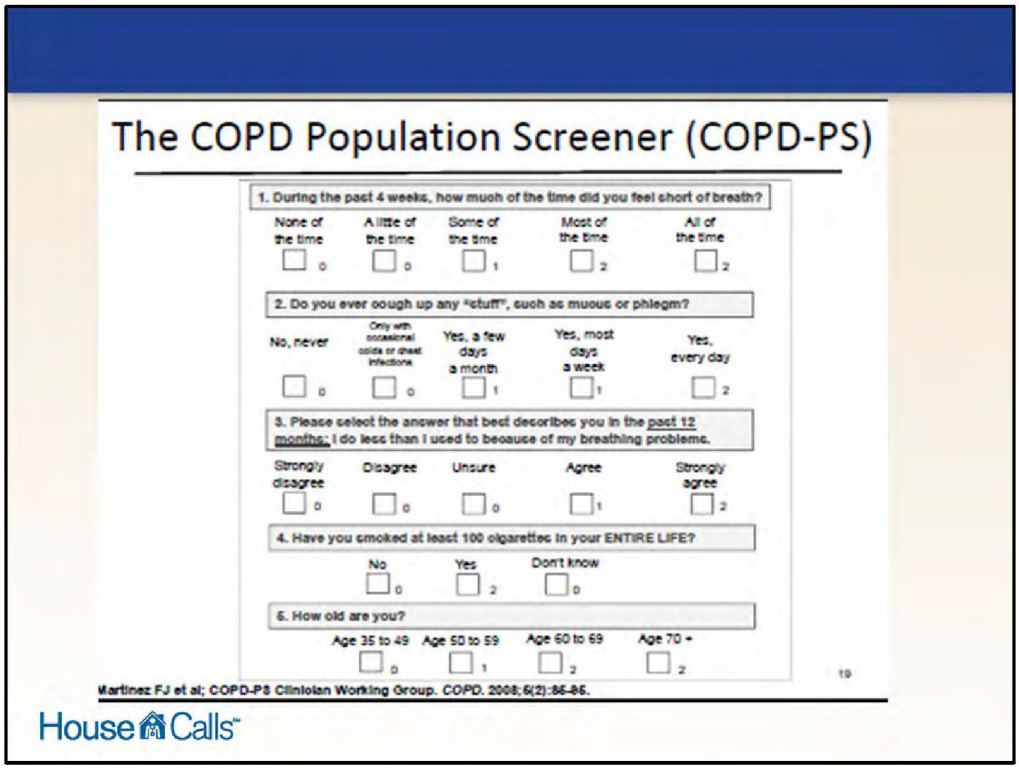
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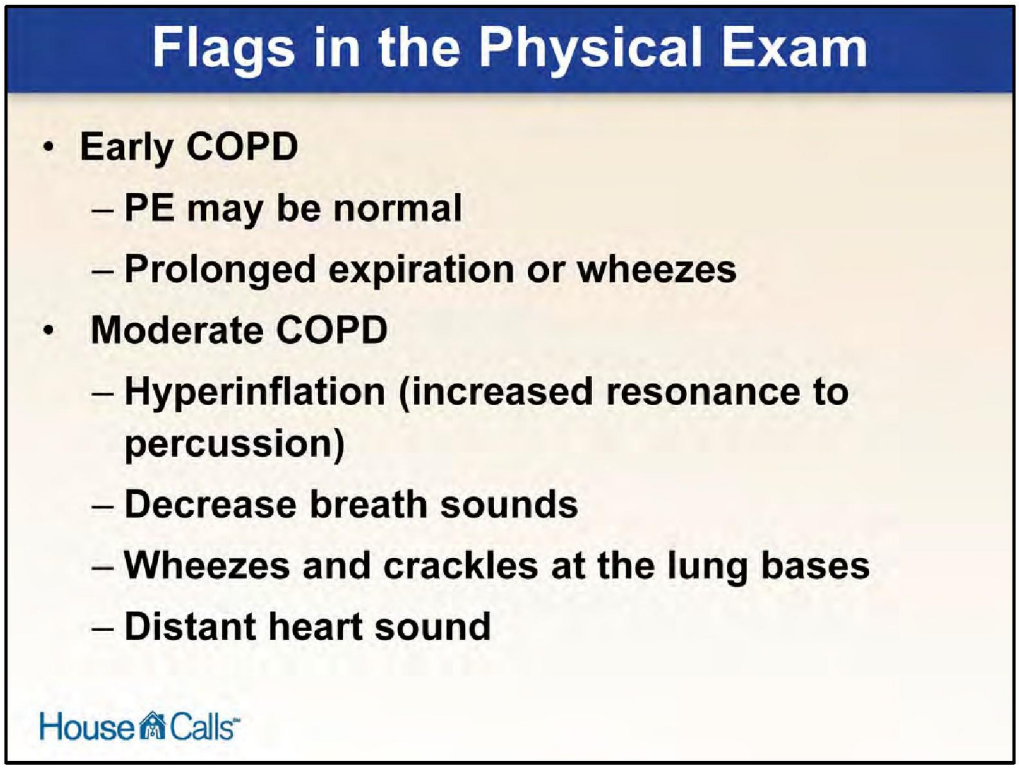
The Member's risk increases if they have had 2 or more exacerbations annually, previous hospitalization, or worsening of airflow per spirometry. These are some of the questions we should be asking the member at the visit.

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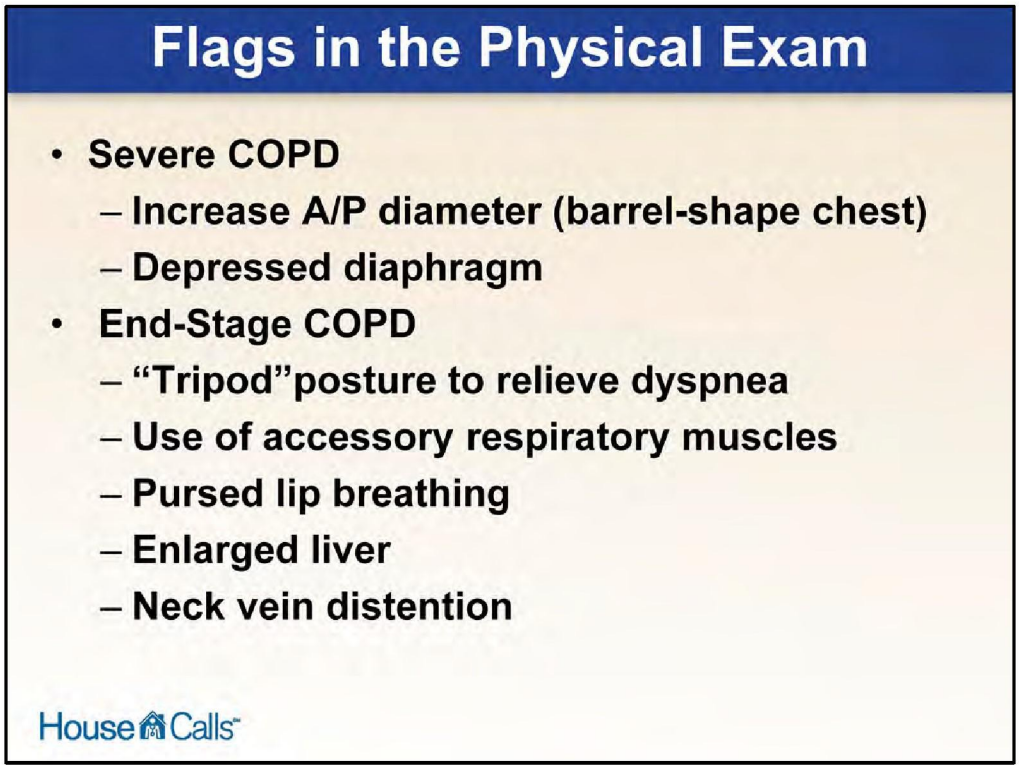
Tools such as the COPD-PS are useful to help classify the severity of the condition.

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Early in the disease, the physical examination may be normal, or may show only prolonged expiration or wheezes on forced exhalation. However, as the severity of the airway obstruction increases, physical examination may reveal hyperinflation (eg, increased resonance to percussion), decreased breath sounds, wheezes, crackles at the lung bases, and/or distant heart sounds.

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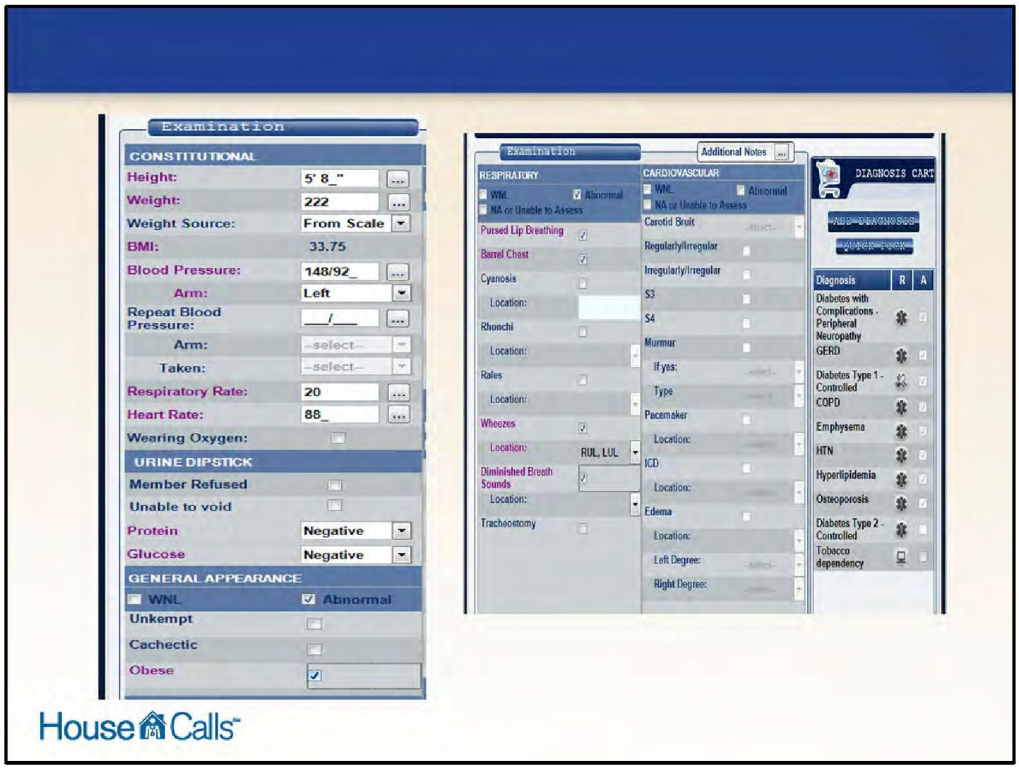


Features of severe disease include an increased anteroposterior diameter of the chest ("barrel-shaped" chest) and a depressed diaphragm with limited movement based on chest percussion.

Patients with end-stage COPD may adopt positions that relieve dyspnea, such as leaning forward with arms outstretched and weight supported on the palms or elbows ("tripodding"). This posture may be evident during the examination or may be suggested by the presence of callouses or swollen bursae on the extensor surfaces of forearms.

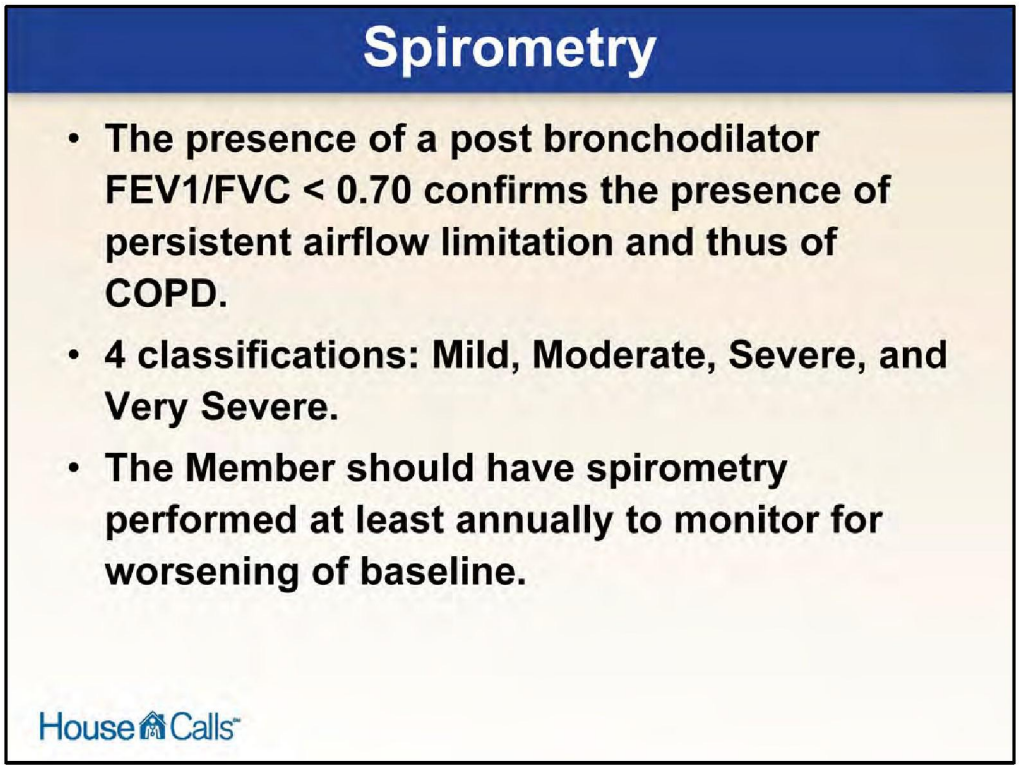
Other physical examination findings include use of the accessory respiratory muscles of the neck and shoulder girdle, expiration through pursed lips, and an enlarged, tender liver due to right heart failure. Neck vein distention may also be observed because of increased intrathoracic pressure, especially during expiration.

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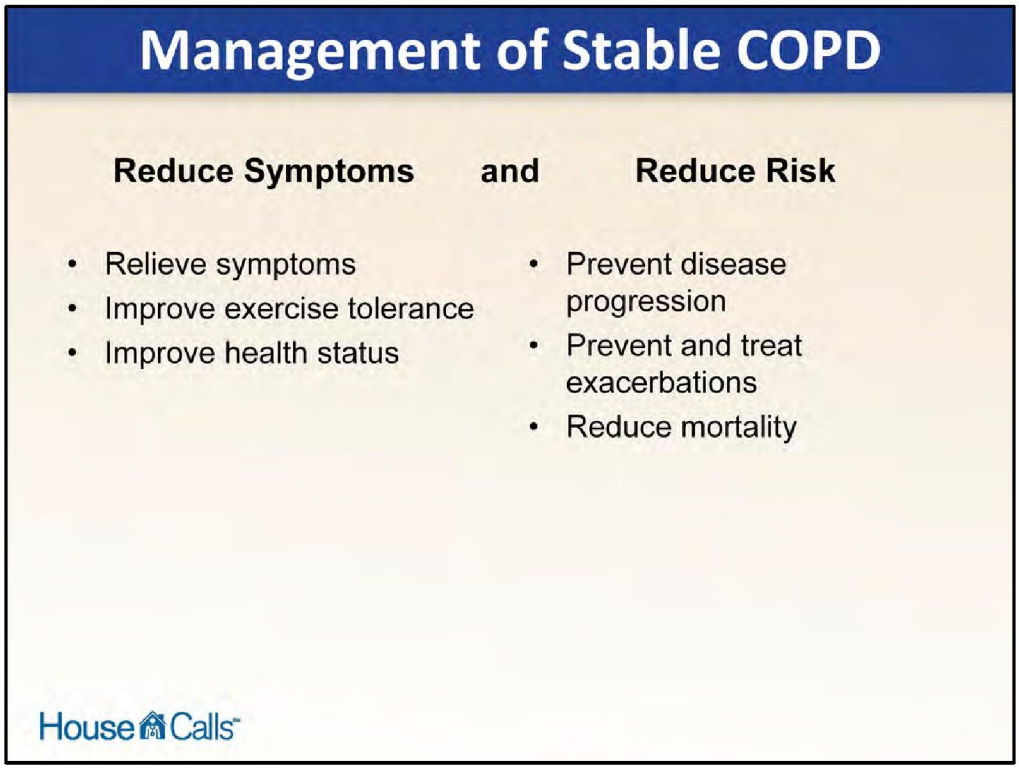
Take a moment to review screen images from the Tablet to look for clues in the physical exam that may suggest COPD.

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Although not available in the field at this time, spirometry is an important tool in the diagnosis of COPD and as a way to monitor progression of disease.

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In management of COPD, our goals are focused on reducing symptoms and reducing risks.

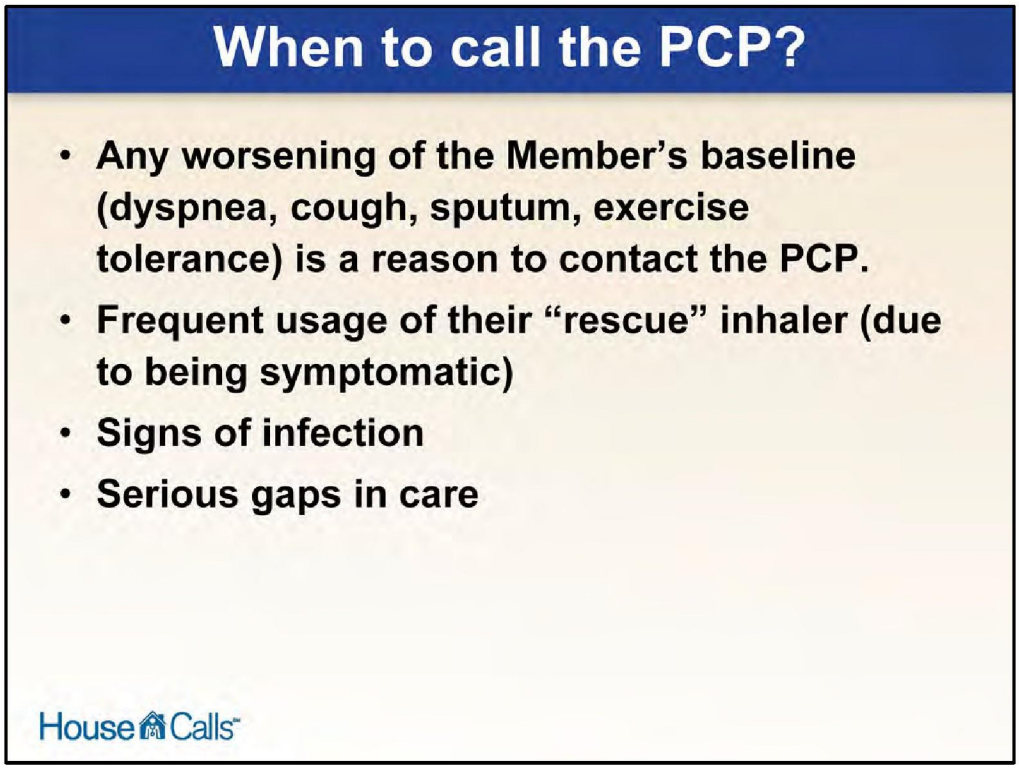
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Patient Education

- Smoking Cessation!
- Basic information about COPD
- Compliance with inhalers / meds as prescribed
- Immunizations
- Self management skills
- When to call PCP
- Nutritional counseling & adequate hydration
- Manage Comorbidities
- Pulmonary Rehabilitation
- Advance Directives & end-of-life issues

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We should notify the PCP for any worsening of the Member's baseline, signs of infection, or for serious gaps in care.

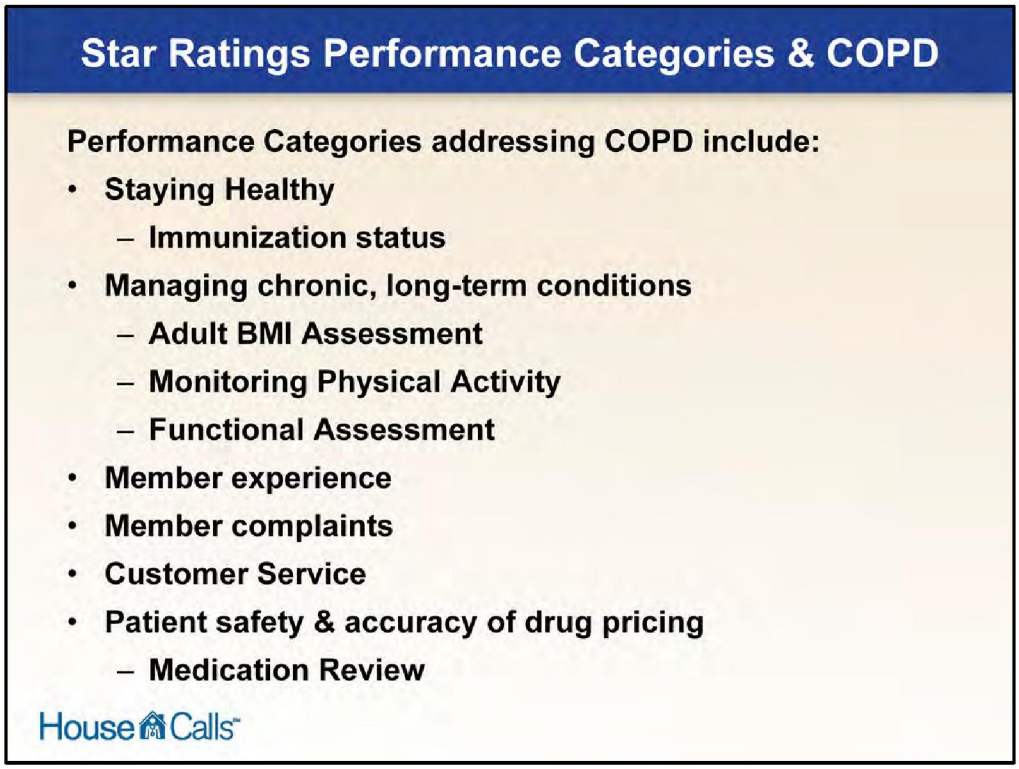
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"Ask Your Doctor" letter

- If the Member hasn't had a spirometry performed within the past year ("Is it time for my annual spirometry?")
- If the Member isn't controlled on current therapy ("Do I need to adjust my medications?")
- Highlight need for immunizations (especially Pneumovax and seasonal flu vaccine)

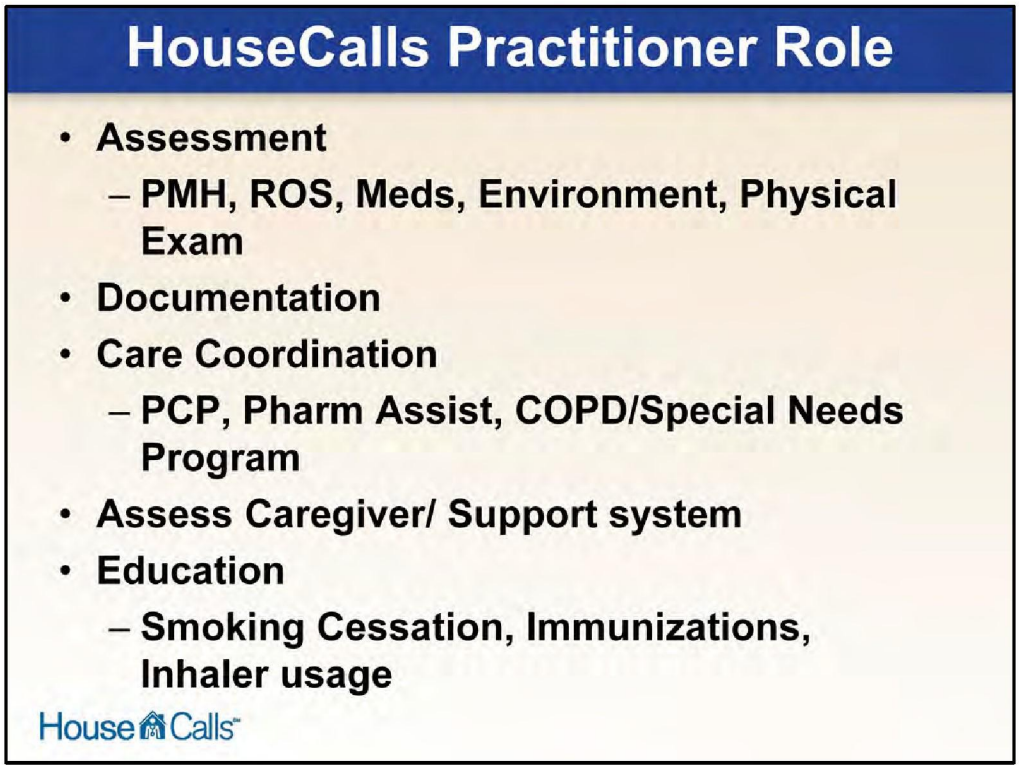
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Star Ratings Performance Categories addressing COPD are listed above. Immunization Status to especially include pneumovax and seasonal influenza vaccines.

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In summary, the HouseCalls Practitioner has a vital role in the diagnosis of COPD and/or exacerbations, medication review, care coordination, assessing support systems, education, and accurate documentation. Remember, COPD is often a preventable and treatable disease, and HouseCalls Practitioners can make a difference!

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References / Resources

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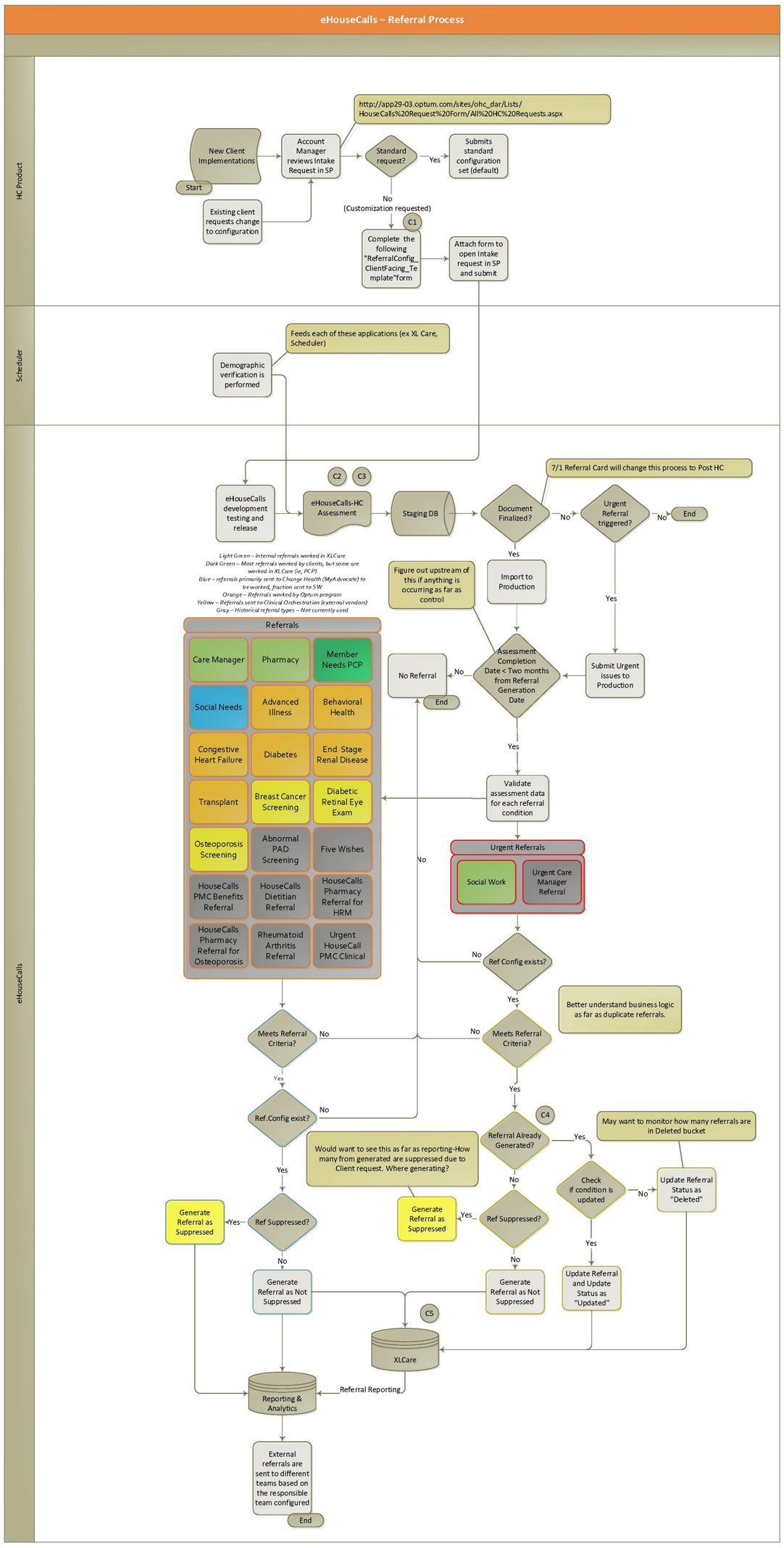
Thank you for participating in this learning module, "Diagnosing in the Home Series for HouseCalls Practitioners: Diagnosing COPD in the Home".

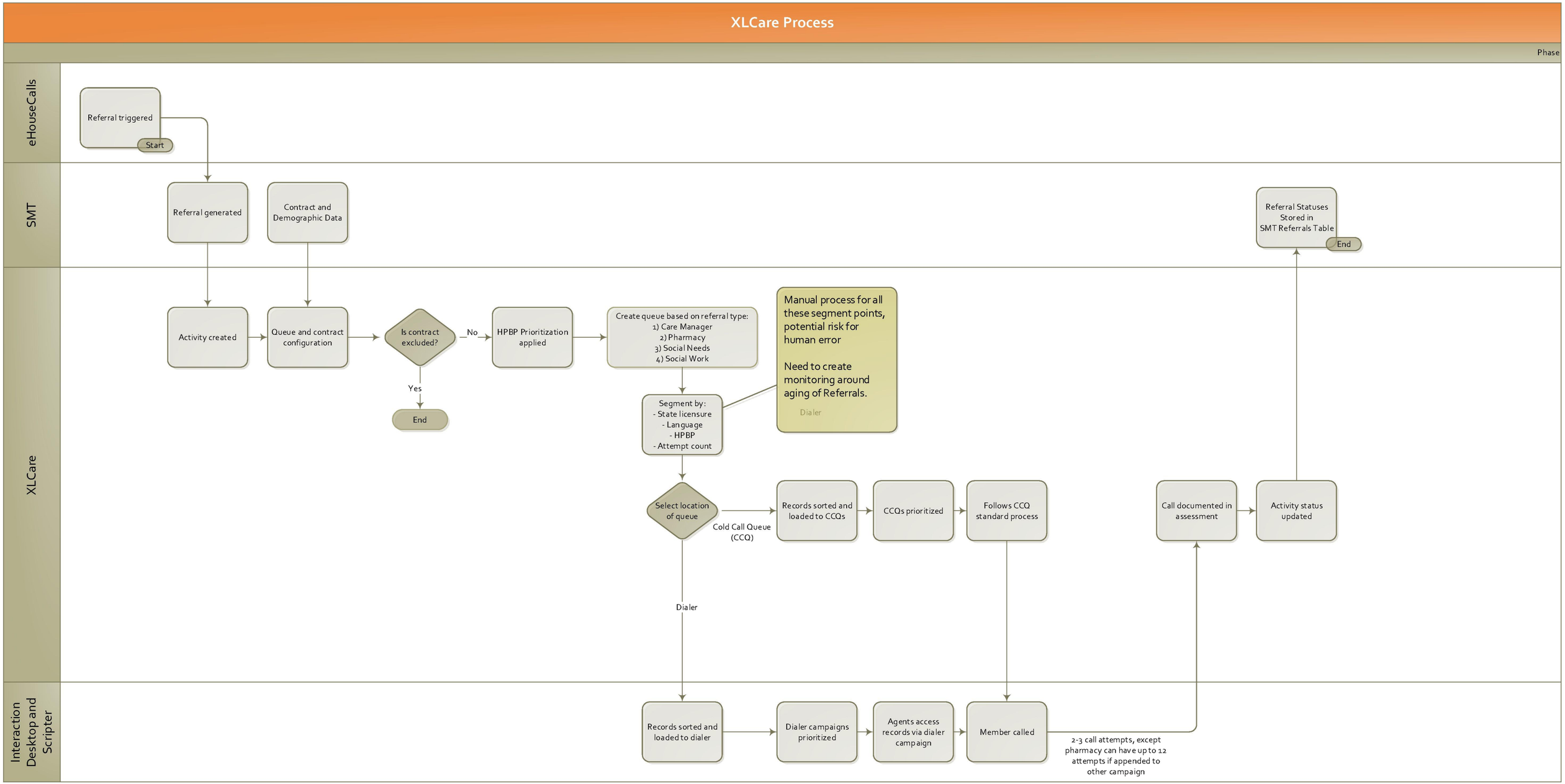
We welcome you to review others in the series. Watch the Portal for the release dates!



House Calls

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eHouseCalls – Referral Process
HC Product
Scheduler
eHouseCalls
http://app29-03.optum.com/sites/ohc_dar/Lists/HouseCalls%20Request%20Form/All%20HC%20Requests.aspx
New Client Implementations
Start
Account Manager reviews Intake Request in SP
Standard request?
Yes
Submits standard configuration set (default)
No
(Customization requested)
C1
Existing client requests change to configuration
Complete the following "ReferralConfig_ClientFacing_Template"form
Attach form to open Intake request in SP and submit
Feeds each of these applications (ex XL Care, Scheduler)
Demographic verification is performed
eHouseCalls development testing and release
C2
C3
eHouseCalls-HC Assessment
Staging DB
Document Finalized?
7/1 Referral Card will change this process to Post HC
No
Urgent Referral triggered?
No
End
Yes
Light Green – Internal referrals worked in XLCare
Dark Green – Most referrals worked by clients, but some are worked in XLCare (ie, PCP)
Blue – referrals primarily sent to Change Health (MyAdvocate) to be worked, fraction sent to SW
Orange – Referrals worked by Optum program
Yellow – Referrals sent to Clinical Orchestration (external vendors)
Gray – Historical referral types – Not currently used
Figure out upstream of this if anything is occurring as far as control
Import to Production
Yes
Referrals
Care Manager
Pharmacy
Member Needs PCP
Social Needs
Advanced Illness
Behavioral Health
Congestive Heart Failure
Diabetes
End Stage Renal Disease
Transplant
Breast Cancer Screening
Diabetic Retinal Eye Exam
Osteoporosis Screening
Abnormal PAD Screening
Five Wishes
HouseCalls PMC Benefits Referral
HouseCalls Dietitian Referral
HouseCalls Pharmacy Referral for HRM
HouseCalls Pharmacy Referral for Osteoporosis
Rheumatoid Arthritis Referral
Urgent HouseCall PMC Clinical
No Referral
No
End
Assessment Completion Date < Two months from Referral Generation Date
Submit Urgent issues to Production
Yes
Validate assessment data for each referral condition
Urgent Referrals
Social Work
Urgent Care Manager Referral
No
Ref Config exists?
Yes
Better understand business logic as far as duplicate referrals.
Meets Referral Criteria?
No
Meets Referral Criteria?
Yes
Yes
Ref.Config exist?
No
C4
Referral Already Generated?
Yes
May want to monitor how many referrals are in Deleted bucket
Would want to see this as far as reporting-How many from generated are suppressed due to Client request. Where generating?
Check if condition is updated
No
Update Referral Status as "Deleted"
Yes
Generate Referral as Suppressed
Yes
Ref Suppressed?
Generate Referral as Suppressed
Yes
Ref Suppressed?
No
Yes
No
Generate Referral as Not Suppressed
Generate Referral as Not Suppressed
Update Referral and Update Status as "Updated"
C5
XLCare
Reporting & Analytics
Referral Reporting
External referrals are sent to different teams based on the responsible team configured
End


XLCare Process
Phase
eHouseCalls
SMT
XLCare
Interaction Desktop and Scripter
Referral triggered
Start
Referral generated
Contract and Demographic Data
Activity created
Queue and contract configuration
Is contract excluded?
No
Yes
End
HPBP Prioritization applied
Create queue based on referral type:
1) Care Manager
2) Pharmacy
3) Social Needs
4) Social Work
Manual process for all these segment points, potential risk for human error
Need to create monitoring around aging of Referrals.
Dialer
Segment by:
- State licensure
- Language
- HPBP
- Attempt count
Select location of queue
Cold Call Queue (CCQ)
Records sorted and loaded to CCQs
CCQs prioritized
Follows CCQ standard process
Dialer
Records sorted and loaded to dialer
Dialer campaigns prioritized
Agents access records via dialer campaign
Member called
2-3 call attempts, except pharmacy can have up to 12 attempts if appended to other campaign
Call documented in assessment
Activity status updated
Referral Statuses Stored in SMT Referrals Table
End

Immunodeficiency & Immunosuppression Query & Amendment Education Learn Source



OPTUM

1

Welcome to HouseCalls Immunodeficiency & Immunosuppression Query & Amendment Education Learn Source

Objective

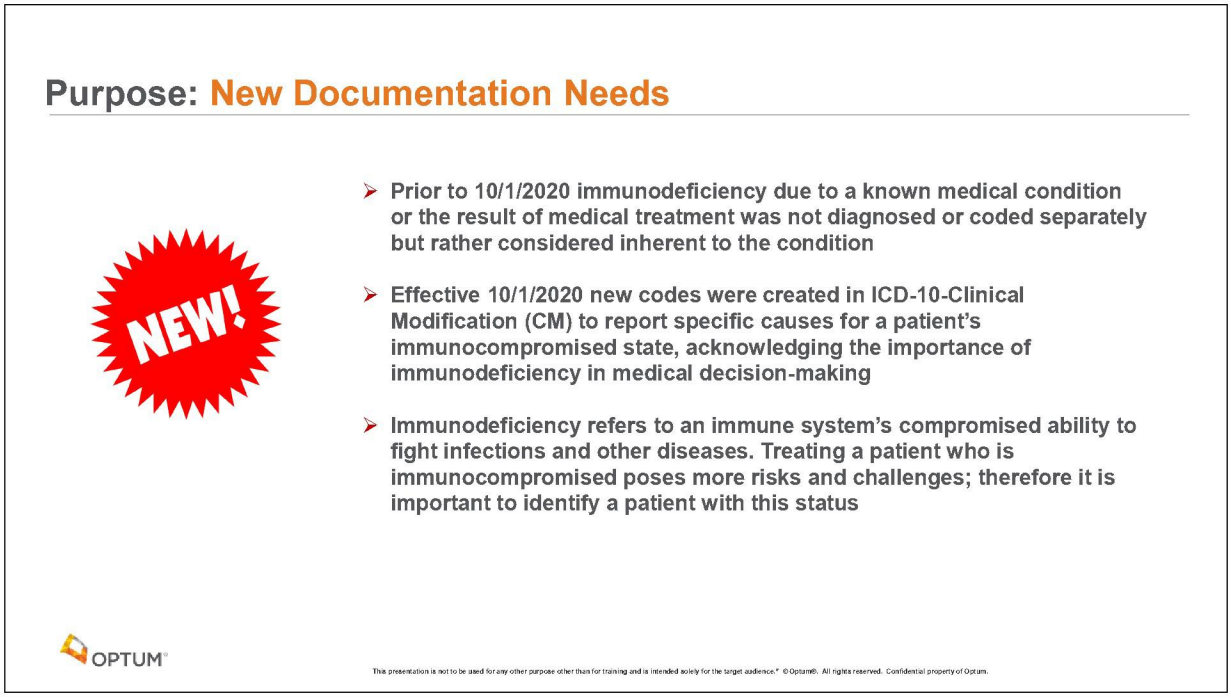


- Identify new diagnosis descriptors for immunodeficiency effective October 1, 2020.
- Apply appropriate documentation of immunodeficiency status in eHC application
- Review Query Amendments & Documentation
- Present Case Study examples to depict documentation of immunodeficiency

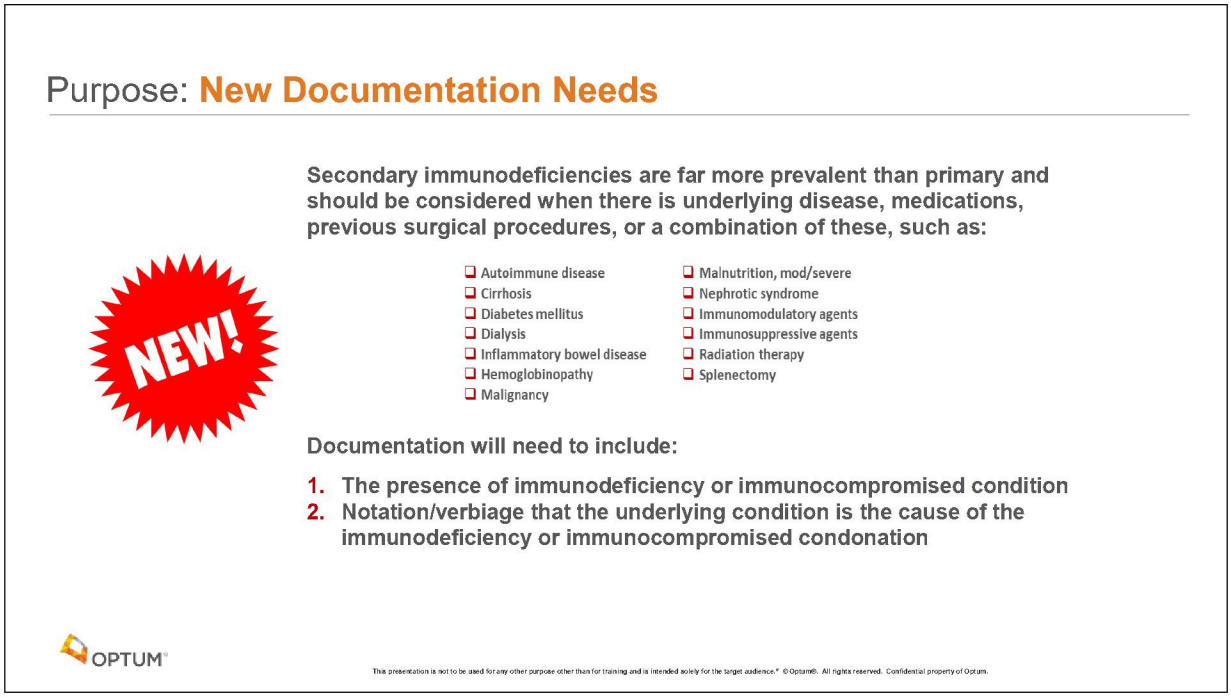
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Read Bullets



Documenting to the highest specificity is our goal at HouseCalls. Additionally, adhering to CMS guidelines and being in line to correct ICD-10 diagnosis correlation is also important. Aligning to our goals and mission, updates to clinical documentation with regards to immunodeficiency will be presented in this learn source. There have been recent changes and updates. Due to these recent updates, our documentation in eHC will have to be reflective of the changes. This learnsource is to give you an overview of the new diagnosis changes incorporating conditions that can be linked to immunodeficiency or immunosuppressive condition. Read bullets.



You should note that there are conditions that you can encounter during your HouseCalls visits that you can easily encounter that may have an underlying linkage to immunodeficiency or immunosuppression. The next few slides will introduce you do conditions that can be linked to immunodeficiency. The three main conditions the learn source will present is immunodeficiency with underlying condition, immunodeficiency with medications/drugs and immunodeficiency with external causes. Please note that in addition to this learnsource you will ave access to a JA that will also serve as a resource.

Immunodeficiency with Underlying Condition



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We will now go over Immunodeficiency with Underlying conditions and some of the examples of its manifestations

Documentation Overview

Immunodeficiency due to underlying conditions: Consider when secondary immunodeficiency is due to another medical condition.

- **Metabolic disease***: Uncontrolled diabetes
- **Autoimmune disease:** Rheumatoid arthritis, lupus
- **Malignancies:** Leukemia, lymphoma (Hodgkin's/Non-Hodgkin's), multiple myeloma
- **Hemoglobinopathy:** Sickle cell disease
- **Ulcerative colitis, Crohn's disease**
- **Cirrhosis**
- **Malnutrition***: Severe malnutrition/cachexia (not mild or moderate)
- **Asplenia:** Acquired absence of spleen (surgical history of splenectomy)

***with (or with history of) manifestation of signs and symptoms of immunodeficiency**

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Here we can see you can determine if documentation for Immunodeficiency due to underlying conditions can be documented. Point out some examples

Immunodeficiency with Medications/Drugs



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Immunodeficiency can also be linked to Medications/Drugs

Documentation Overview

Immunodeficiency due to drugs:

Consider when secondary immunodeficiency is due to medications interfering with the immune system.

- **Steroids:** ≥ 20 mg/day of prednisone (or equivalent) for more than 14 days
- **Disease-modifying anti-rheumatic drugs (DMARDs):** Methotrexate, hydroxychloroquine (Plaquenil)
- **Biologic response modifiers (biologics):** Abatacept (Orencia), adalimumab (Humira), entanercept (Enbrel), infliximab (Remicaid), rituximab (Rituxan), tofacitinib (Xeljanz)
- **Medications used to suppress the immune system s/p transplant:** Azathioprine (Imuran), Mycophenolate Mofetil (CellCept), the **calcineurin inhibitors:** cyclosporine (Neoral), tacrolimus (Prograf), sirolimus and rapamycin (Rapamune)
- **Chemotherapeutic agents:** Adriamycin (Doxirubicin) Carboplatin, (Paraplatin), Bleomycin (Blenoxane), Cisplatin (Platinol), Cyclophosphamide (Cytoxan)

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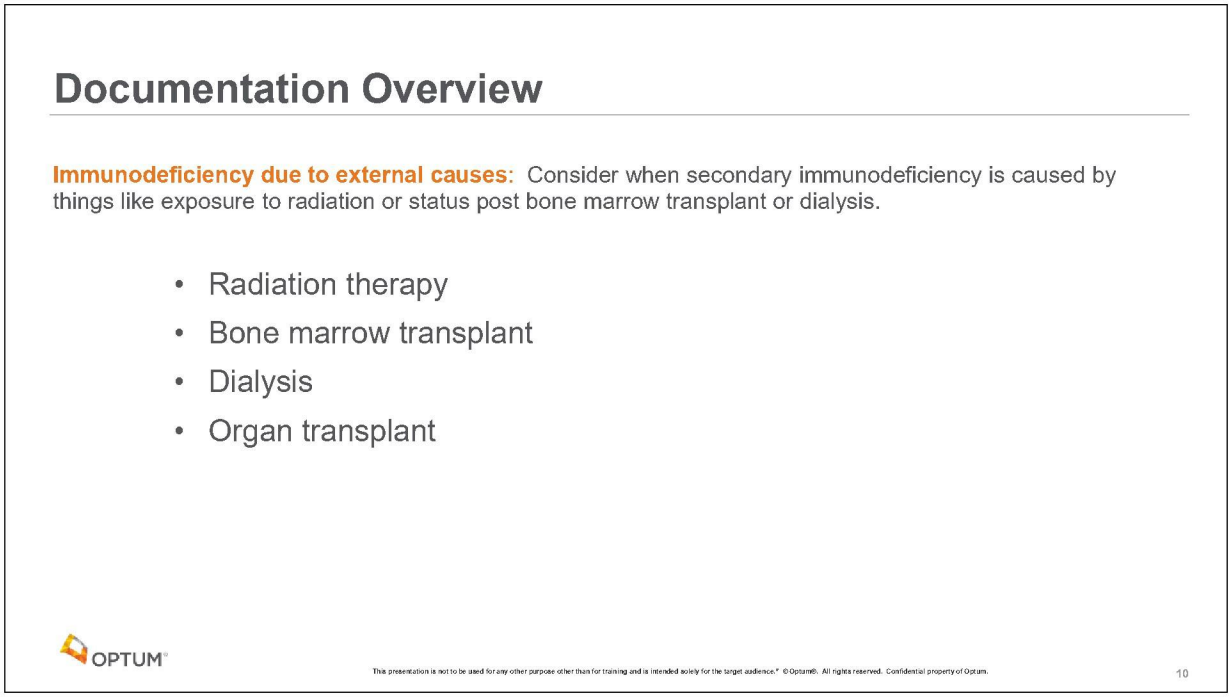
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Here we can see you can determine if documentation for Immunodeficiency due to drugs/medications can be documented. Go over some examples

Immunodeficiency with External Causes



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Here we can see you can determine if documentation for Immunodeficiency due to external causes Go over some examples

eHC Updates & Documentation Requirements



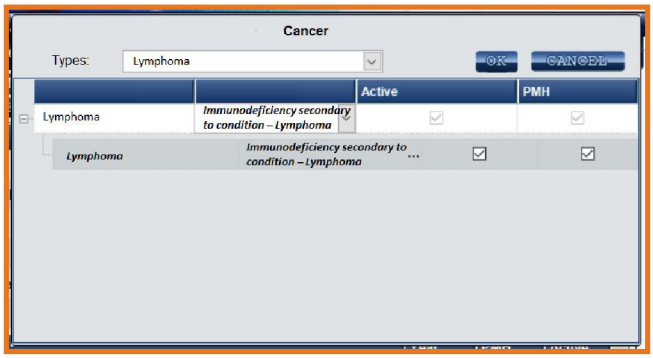
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In this section we will look at the updates and documentation requirements that is accompanying the previously discussed changes on members with immunodeficiency or immunosuppression.

Documentation By Disease Selection

There are ways to add the **NEW** Diagnosis of Immunodeficiency . As you can see below, you will go the PMH Page. The Disease condition is selected and then the Immunodeficiency and subtype is selected.

The example depicted here is for Lymphoma that has been selected in Cancer dropdown; subtype popup displays:



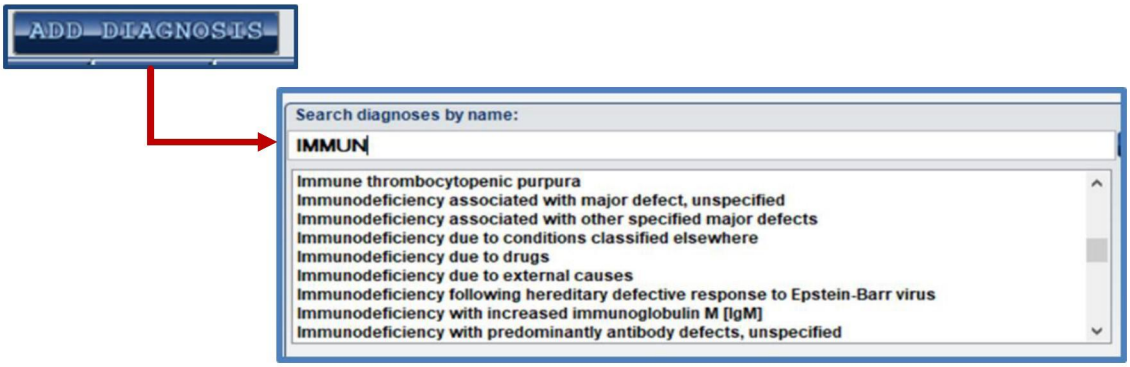
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Review Slide

Documentation by Immunodeficiency Search

The second way is by selecting Immunodeficiency – Using the Drop Down Choice and then select the appropriate the Immunodeficiency type from PMH page 3. You also will document the underlying condition in the NOTES column on the Diagnosis Confirmation Page (page 15)



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You will go to PMH page – Select the Add Diagnosis Tab - You can use the search features to look for Immunodeficiency - select Immunodeficiency, select and Type drop down menu will appear. Also document in notes column should clarifying documentation be warranted.

Documentation Requirements

- There are new documentation requirements that will look at the new changes surrounding immunodeficiency and immunosuppression and the possible corresponding diagnoses
- Immunodeficiency should be documented each time it is a factor in clinical decision-making regardless of clinical manifestations
- The Next Slides will Review Diagnosis that consist of the Following:
  - ✓ **Immunodeficiency – Diabetes Type II**
  - ✓ **Immunodeficiency – Diabetes Type 1**
  - ✓ **Immunodeficiency – Chronic Kidney Disease - ESRD**
  - ✓ **Immunodeficiency – Cancer**
  - ✓ **Immunodeficiency – Rheumatoid Arthritis**
  - ✓ **Immunodeficiency – Due to Condition**
  - ✓ **Immunodeficiency – Due to External Cause**

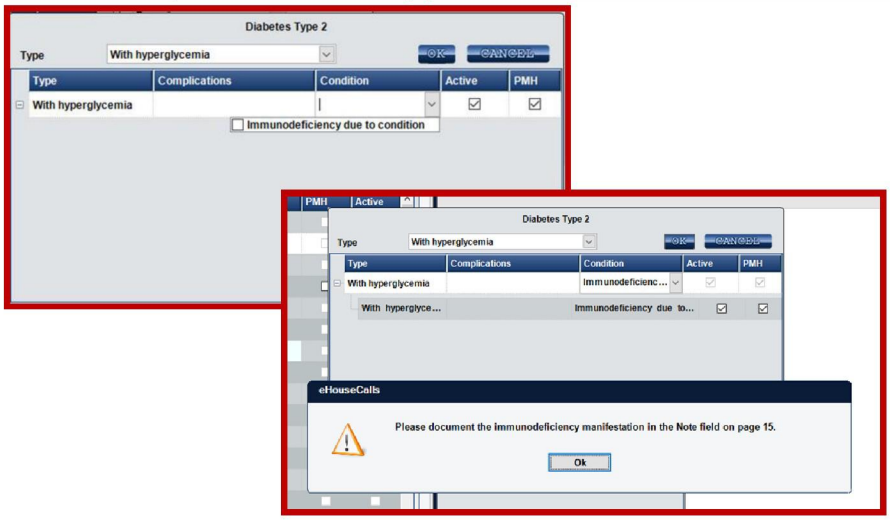
Remember that you can select by first selecting the diagnosis and then adding the immunodeficiency link **OR** you can search for Immunodeficiency and select the type/subtype of the underlying condition.

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Review Slide

Immunodeficiency – Diabetes Type II

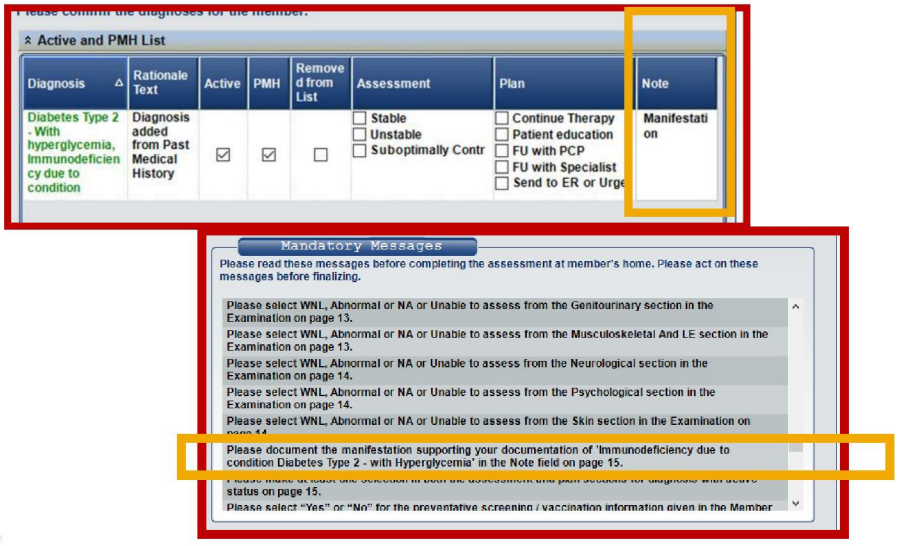


OPTUM

15

Should there be evidence for a diagnosis with immunodeficiency that can be associated with Diabetes Type 2- you will document utilizing the PMH page in the eHC application. As noted on the slide there are specifying drop down boxes where you can indicate the appropriate selection. You will also have a secondary step to do on page 15 – the diagnosis confirmation page you will want to document that Manifestation in the Notes Column of the specified diagnosis. Which we will be able to visualize in the next slide.

Immunodeficiency – Diabetes Type II

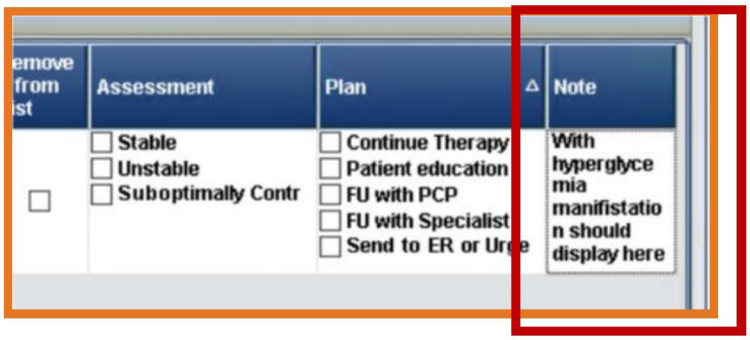


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16

As we had discussed on our previous slide, you can see here for DM2 – the manifestation justification is noted in the Note Column. This is important for you to ensure you note for DM2 with immunodeficiency due to condition. When the chart is reviewed – the clarifying note is an important factor. Additionally on page 18 in the Mandatory messages – you will have an alert populated if this has not been documented on the documentation confirmation page for the diagnosis.

Notes Documentation



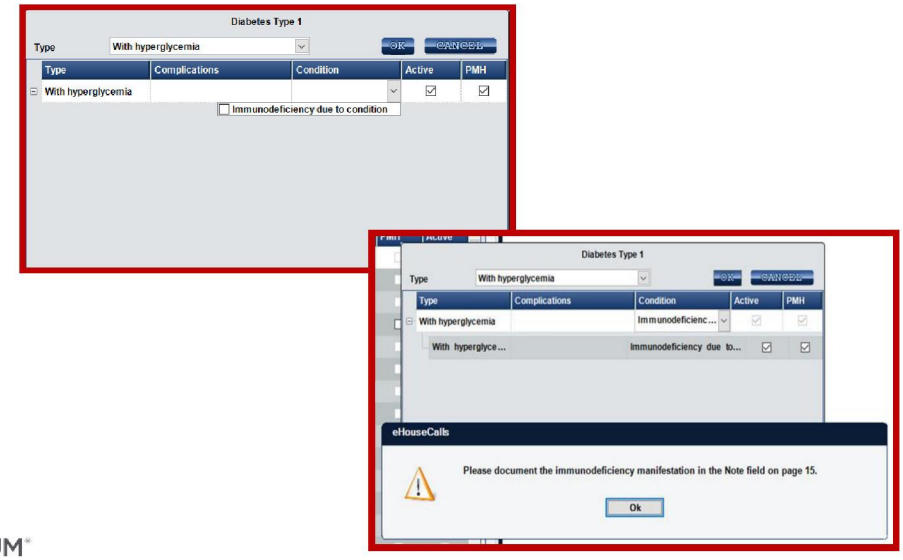
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Documentation in the notes column of the manifestation as highlighted in the previous slide is important to capture. If it is not documented you will have an alert population on the Mandatory Message page.

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Immunodeficiency – Diabetes Type I

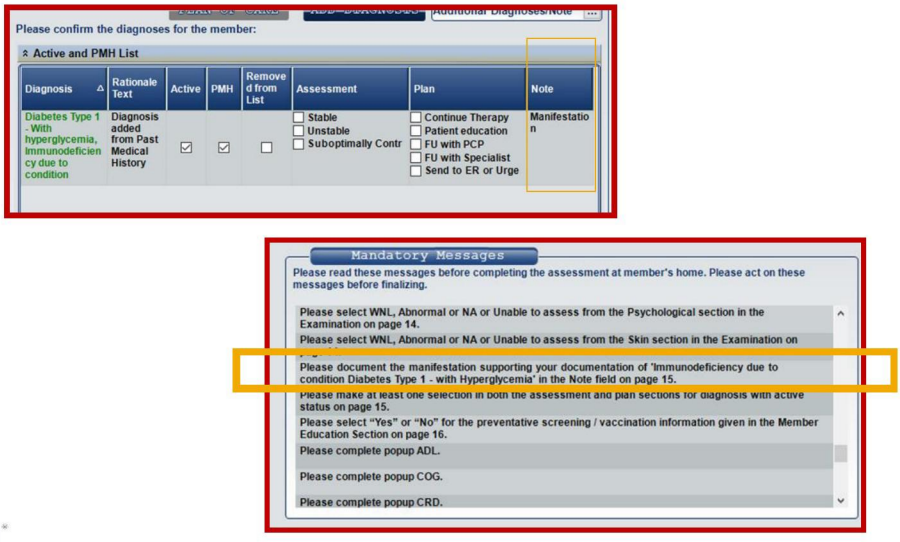


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18

Should there be evidence for a diagnosis with immunodeficiency that can be associated with Diabetes Type 1 - you will document utilizing the PMH page in the eHC application. As noted on the slide there are specifying drop down boxes where you can indicate the appropriate selection. You will also have a secondary step to do on page 15 – the diagnosis confirmation page you will want to document that Manifestation in the Notes Column of the specified diagnosis which we will be able to visualize in the next slide.

Immunodeficiency – Diabetes Type I

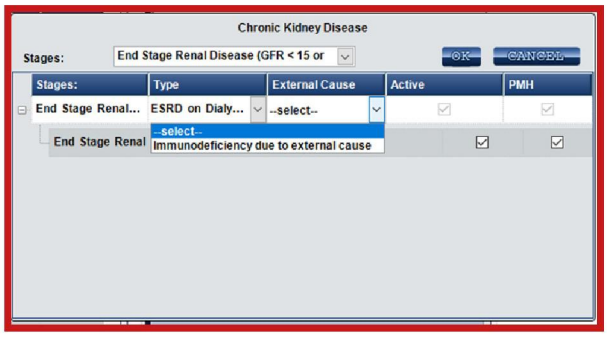


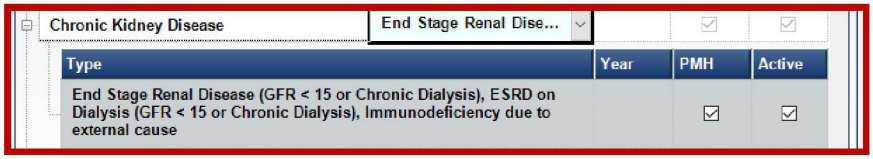
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19

As we had discussed on our previous slide, you can see here for DM1 – the manifestation justification is noted in the Note Column. This is important for you to ensure you note for DM1 with immunodeficiency due to condition. When the chart is reviewed – the clarifying note is an important factor. Additionally on page 18 in the Mandatory messages – you will have an alert populated if this has not been documented on the documentation confirmation page for the diagnosis.

Immunodeficiency – Chronic Kidney Disease - ESRD



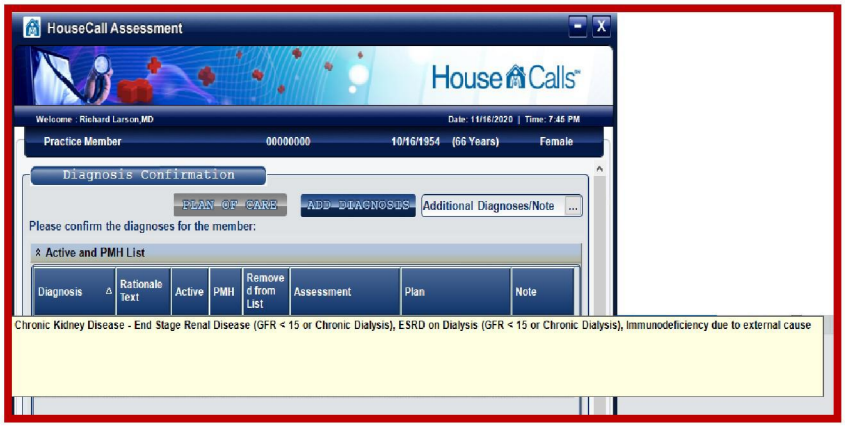


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Should there be evidence for a diagnosis with immunodeficiency that can be associated with ESRD you will document utilizing the PMH page in the eHC application. Only ESRD on dialysis may be selected not CKD in general. Also status either PMH or Active and PMH once you have selected the disease condition and then specified the type/subtype.

Immunodeficiency – Chronic Kidney Disease-ESRD

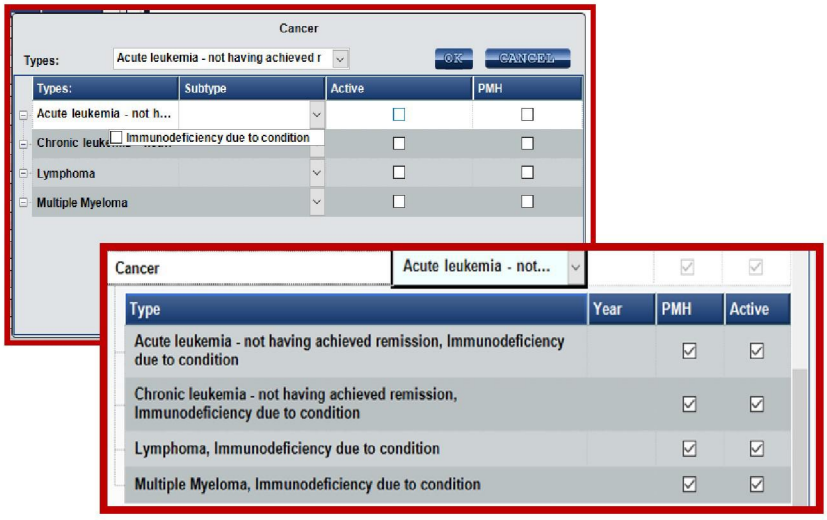


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As seen on the previous slide, the capture can be documented on PMH page. It will also be noted on the Diagnosis Confirmation page. You should only select ESRD on dialysis. Ensure that it has a substantiated status. Ensure that you are able to capture the evidentiary support. The note column can be utilized for additional documentation for clarification.

Immunodeficiency – Cancer

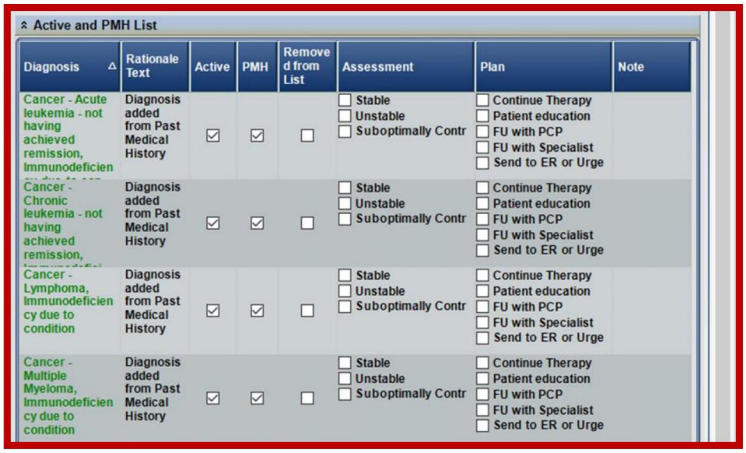


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22

Should there be evidence for a diagnosis with immunodeficiency due to cancer you will document utilizing the PMH page in the eHC application. As noted on the slide there are specifying drop down boxes where you can indicate the appropriate selection. In this example, the disease condition was selected, the the type and then the subtype. Remember the importance of multi-level diagnosing.

Immunodeficiency – Cancer

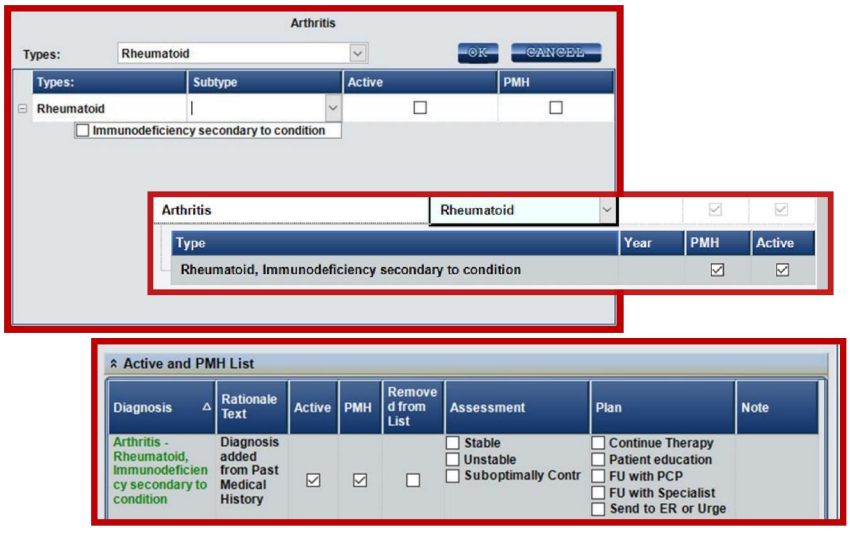


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23

Should there be evidence for a diagnosis with immunodeficiency due to cancer you will document utilizing the PMH page in the eHC application. As noted on the slide there are specifying drop down boxes where you can indicate the appropriate selection.

Immunodeficiency – Rheumatoid Arthritis

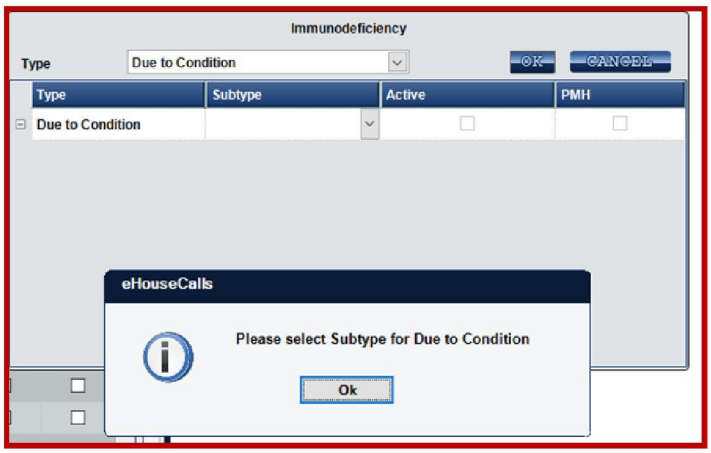


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Should there be evidence for a diagnosis with immunodeficiency that can be associated with Rheumatoid Arthritis you will document utilizing the PMH page in the eHC application. As noted on the slide there are specifying drop down boxes where you can indicate the appropriate selection. If Systemic lupus erythematosus, unspecified is selected then subtype dropdown should display

Immunodeficiency – Due to Condition

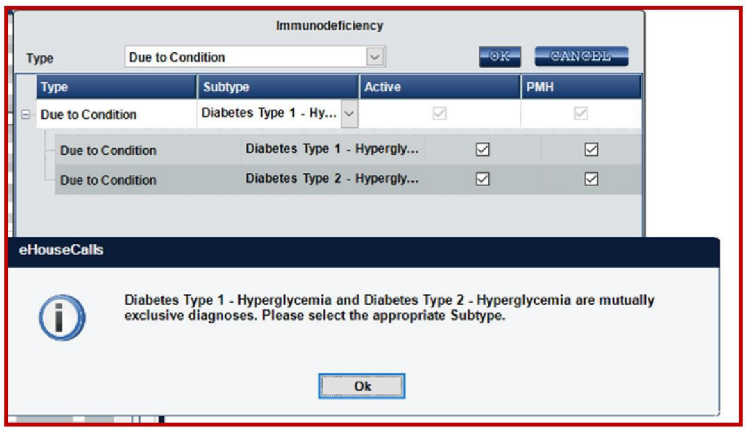


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25

In the PMH page, when selecting Immunodeficiency due to condition, ensure that you are selecting the appropriate subtype for due to condition.

Immunodeficiency – Due to Condition

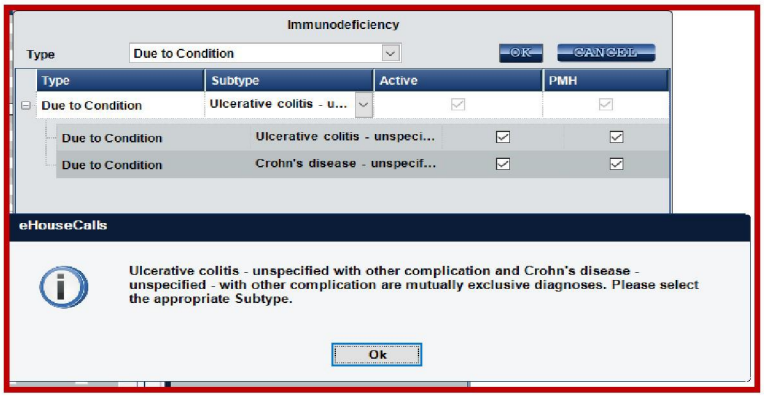


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26

Here we can see the request for clarification between DM1 and DM2. Clinical pearls will be for you to code the underlying condition that you have evidentiary support for.

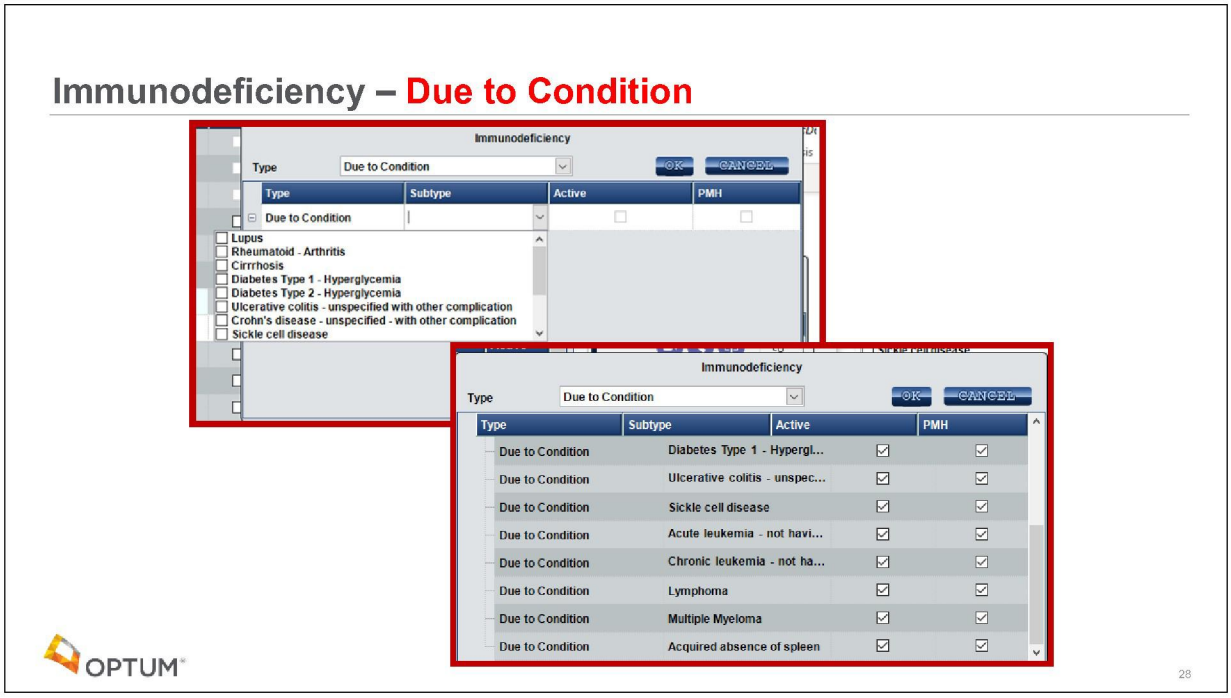
Immunodeficiency – Due to Condition



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When you utilize the drop down arrow to enable the subtype, you will see multiple choices to specify. If there is any ambiguity or duplication, there will be an alert as noted on the slide to select the most appropriate Subtype.



Should there be evidence for a diagnosis with immunodeficiency due to condition you will document utilizing the PMH page in the eHC application. As noted on the slide there are specifying drop down boxes where you can indicate the appropriate selection.

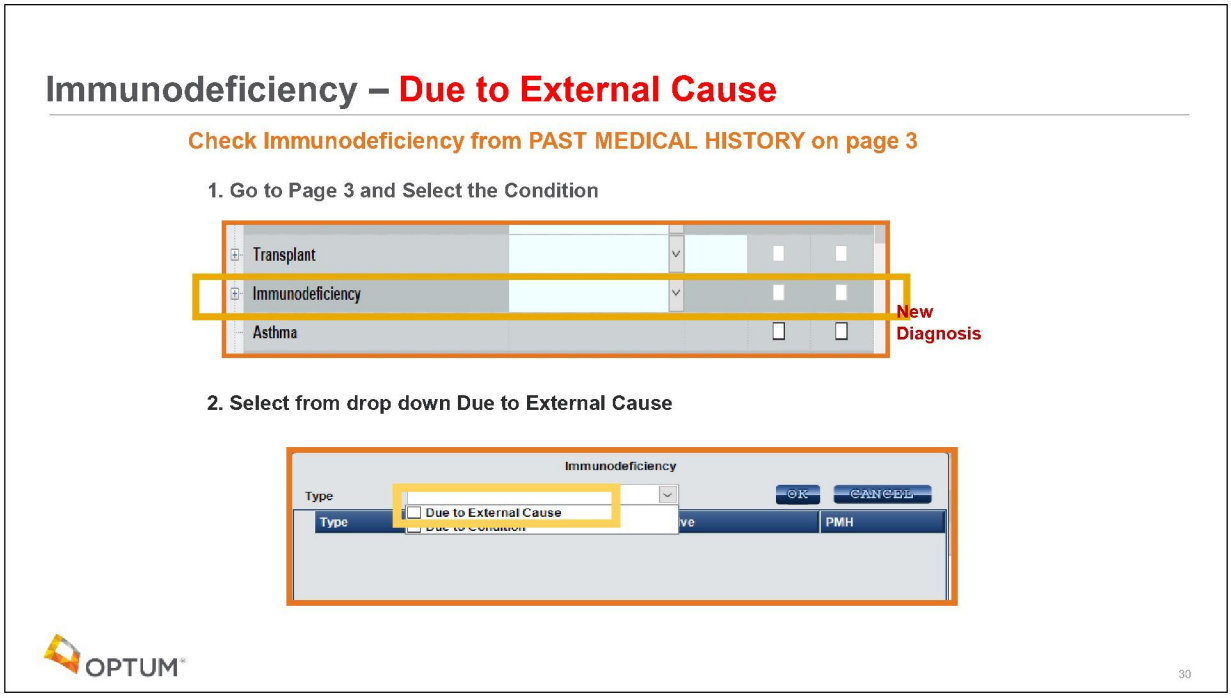
Immunodeficiency – Due to Condition



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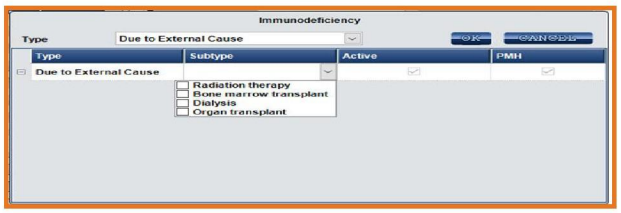
As you can see – these are the multiple diagnoses that can be linked to immunodeficiency – please remember to utilize every aspect of your assessment PMH, Medications, ROS to substantiate the capture of the appropriate diagnosis to the highest specificity



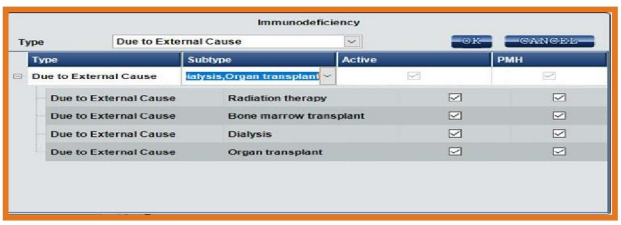
To document and select Immunodeficiency due to external cause the APC will go to Page 3 – PMH and go to the diagnosis line. Use the drop down menu to select the appropriate type of it is due to external cause. As noted on the slide there are specifying drop down boxes where you can indicate the appropriate selection.

Immunodeficiency – Due to External Cause

3. Check the External Cause from drop down box



4. Mark those that are applicable

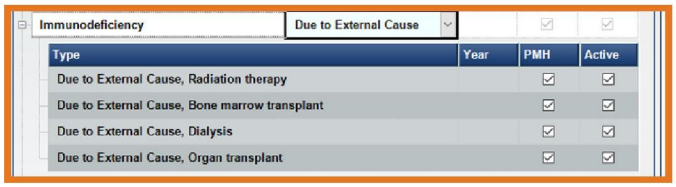


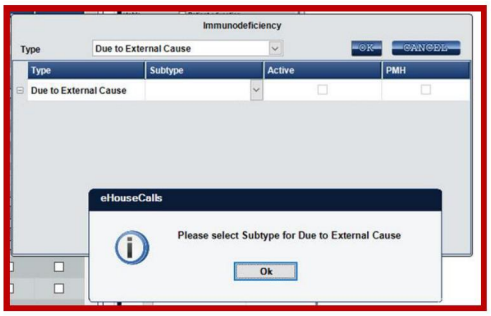
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Once the drop down box has been enabled you want to select all applicable diagnoses that can be linked to the condition. As you can see , Due to external Cause was selected and then the related subtype can be selected.

Immunodeficiency – Due to External Cause



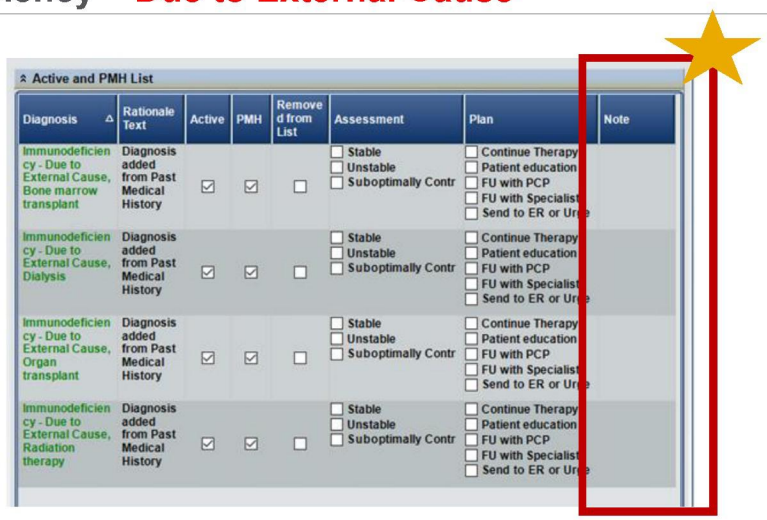


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Here we see the correlation between our documentation in PMH and/or medication condition that can be selected. Also note that if you do not complete the documentation thoroughly after enabling the drop down you will get an alert as depicted on this slide.

Immunodeficiency – Due to External Cause



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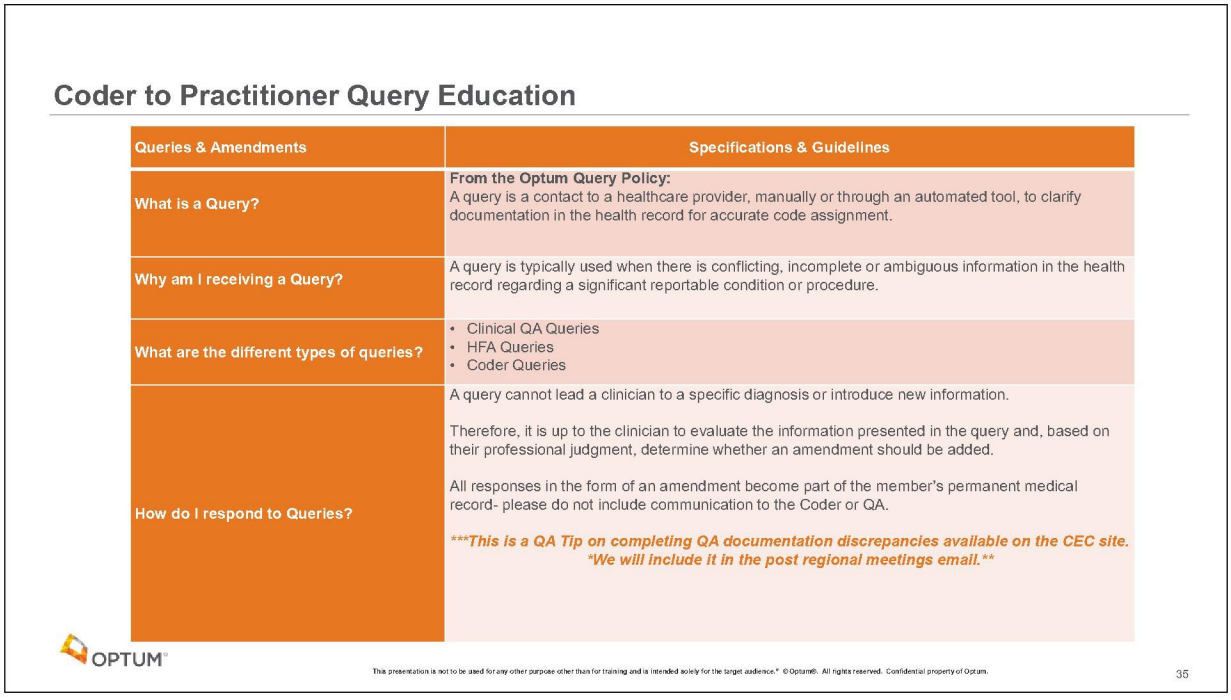
33

The diagnoses noted on page 15 which is the Diagnosis Confirmation page is important for you to review in detail. Understand the importance to utilize the evidentiary support to substantiate the status that you are selecting. Utilize the notes column to ensure you document the underlying manifestation and any clarifying justification for your clinical judgment. Coding is specifically going to look for notes to understand the reasoning behind the justification for the capture of the underlying diagnosis for immunodeficiency or immunosuppression.

Query Amendments & Documentation



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Coder to Practitioner Query Education

Queries & Amendments	Specifications & Guidelines
What is a Query?	**From the Optum Query Policy:** A query is a contact to a healthcare provider, manually or through an automated tool, to clarify documentation in the health record for accurate code assignment.
Why am I receiving a Query?	A query is typically used when there is conflicting, incomplete or ambiguous information in the health record regarding a significant reportable condition or procedure.
What are the different types of queries?	• Clinical QA Queries • HFA Queries • Coder Queries
How do I respond to Queries?	A query cannot lead a clinician to a specific diagnosis or introduce new information. Therefore, it is up to the clinician to evaluate the information presented in the query and, based on their professional judgment, determine whether an amendment should be added. All responses in the form of an amendment become part of the member's permanent medical record- please do not include communication to the Coder or QA. ******This is a QA Tip on completing QA documentation discrepancies available on the CEC site. *We will include it in the post regional meetings email.*****

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Let's review some facts, guidelines and some specifications concerning guidelines when looking at queries. It is not a punitive form of communication but utilized for clarification and understanding. Should there be any ambiguous information with regards to documentation or diagnosis - clarification can be sought out via the query process. Keep an open mind and reevaluate your documentation utilizing the job aide and the available resources to best look at diagnosis specificity. Review some points on the different types of queries and how to respond
Then state on the next few slides we will see some examples of some queries and how to respond

Example of a QA Query
Immunodeficiency Assessed With Underlying Condition

Query Example

Your HouseCalls visit documents Immunodeficiency due to conditions classified elsewhere in the Assessment. Can you please provide clarification on which diagnosis most accurately represents the patient's underlying condition for this date of service?

Appropriate Amendment Response



- Review your documentation in sections in the assessment PDF
- Respond YES or NO if the underlying condition can be linked to the presenting diagnosis

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This example looks at responding to clarification on diagnosis with immunodeficiency assessed with an underlying condition. Go over the example and how to best response

Example of a QA Query
Immunodeficiency Assessed With Cause-and-Effect Relationship

Query Example

Your HouseCalls visit documents Diabetes Type 2 – With hyperglycemia and Immunodeficiency otherwise classified elsewhere in your Assessment. Based on your documentation and professional judgement can the relationship between these two diagnoses be further specified?

Appropriate Amendment Response



- Review your documentation in sections in the assessment PDF
- Respond YES or NO if the underlying condition can be linked to the presenting diagnosis

OPTUM

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This example looks at responding to clarification on diagnosis with immunodeficiency assessed with a cause and effect relationship. Go over the example and how to best response

Example of a QA Query
Immunodeficiency Clinical Indicators and Treatment

Query Example

Your HouseCalls visit documents the member undergoing (insert treatment) and (insert other clinical indicator(s)). Based on the documentation and your professional judgment can an associated diagnosis be documented?

Appropriate Amendment Response



- Review your documentation in sections in the assessment PDF
- Respond YES or NO if the underlying condition can be linked to the presenting diagnosis
- Select the most appropriate choice as noted below if evidentiary support is found:
  - Immunodeficiency due to (insert treatment)
  - Immunodeficiency due to other cause (document other cause)
  - Findings of no clinical significance
  - Unknown/Unable to determine

OPTUM

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This example looks at responding to clarification on diagnosis with immunodeficiency clinical indicators and treatment as an underlying condition. Go over the example and how to best response

Example of a QA Query
Immunodeficiency Clinical Indicators and Transplant

Query Example

Your HouseCalls visit documents the member to have a transplant of the (insert organ) and is (insert medication and/or other clinical indicator (s)). Based on the clinical indicators and your professional judgment, can an associated diagnosis be documented?

Appropriate Amendment Response



- ❑ **Review your documentation in sections in the assessment PDF**
- ❑ **Respond YES or NO if the underlying condition can be linked to the presenting diagnosis**
- ❑ **Select the most appropriate choice as noted below if evidentiary support is found:**
  - Immunodeficiency due to (insert organ transplant)
  - Immunodeficiency due to other cause (document other cause)
  - Findings of no clinical significance
  - Unknown/Unable to determine

OPTUM

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This example looks at responding to clarification on diagnosis with immunodeficiency indicators and transplant as an underlying factor. Go over the example and how to best response

Example of a QA Query
Immunodeficiency Assessed With No Underlying Disease

Query Example

Your HouseCalls visit documents (Select disease) and (Insert Disease). Based on the documentation and your professional judgment can this diagnosis be further specified?

Appropriate Amendment Response



- ❑ **Review your documentation in sections in the assessment PDF**
- ❑ **Respond YES or NO if the underlying condition can be linked to the presenting diagnosis**
- ❑ **Select the most appropriate choice as noted below if evidentiary support is found:**
  - Immunodeficiency due to (document condition)
  - Immunodeficiency due to other cause (document other cause)
  - Unknown/Unable to determine

OPTUM

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This example looks at responding to clarification on diagnosis with immunodeficiency assessed with no underlying condition. Go over the example and how to best response

Example of a QA Query
Immunodeficiency Assessed With No Underlying Medication Cause

Query Example

Your HouseCalls visit documents (Select disease) and (Insert medication). Based on the documentation and your professional judgment can this diagnosis be further specified and/or an associated diagnosis be documented?

Appropriate Amendment Response



- ❑ **Review your documentation in sections in the assessment PDF**
- ❑ **Respond YES or NO if the underlying condition can be linked to the presenting diagnosis**
- ❑ **Select the most appropriate choice as noted below if evidentiary support is found:**
  - Immunodeficiency due to (insert medication)
  - Immunodeficiency due to other cause (document other cause)
  - Unknown/Unable to determine

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41

This example looks at responding to clarification on diagnosis with immunodeficiency assessed with no underlying medication cause. Go over the example and how to best response

Example of a QA Query
Immunodeficiency Generic

Query Example

Your HouseCalls visit documents the member with (insert disease) and (insert medication or other clinical indicator(s)). Based on the clinical indicators and your professional judgment can an associated diagnosis be documented?

Appropriate Amendment Response



- ❑ **Review your documentation in sections in the assessment PDF**
- ❑ **Respond YES or NO if the underlying condition can be linked to the presenting diagnosis**
- ❑ **Select the most appropriate choice as noted below if evidentiary support is found:**
  - Immunodeficiency due to (insert disease)
  - Immunodeficiency due to other cause (document other cause)
  - Findings of no clinical significance
  - Unknown/Unable to determine

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This example looks at responding to clarification on diagnosis with immunodeficiency assessed without a specific underlying condition i.e. a generic or unspecified cause. Go over the example and how to best response

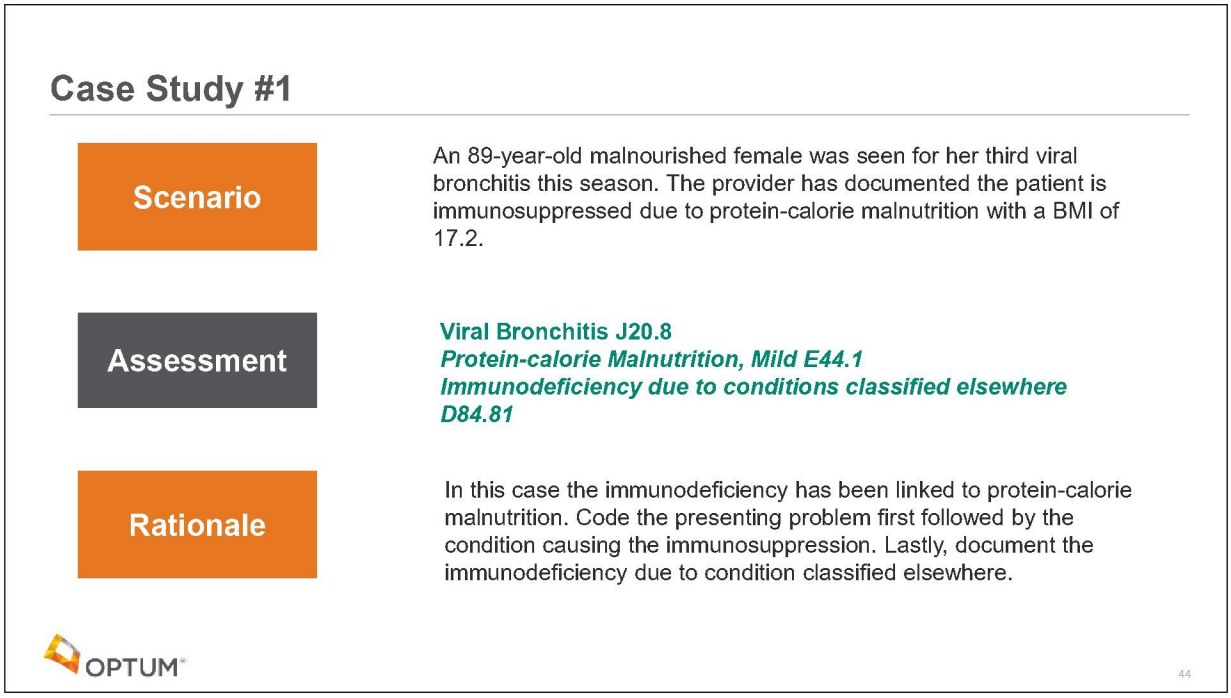
Case Study Presentations



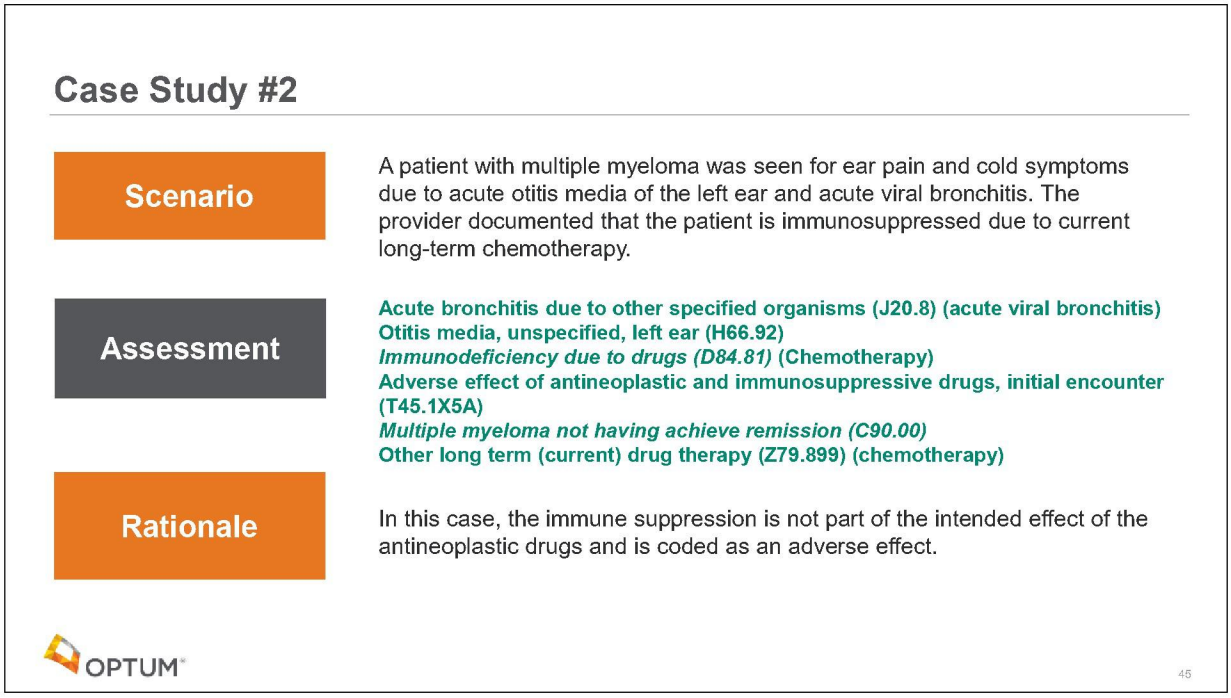
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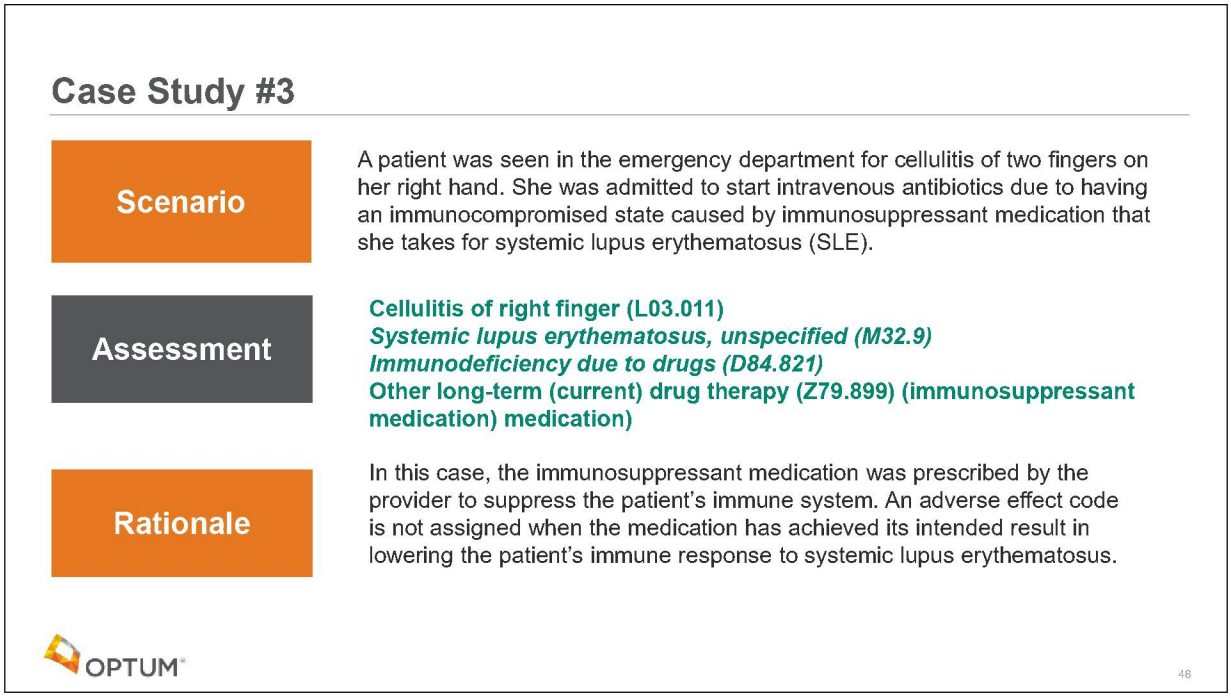
Lets review some case studies that can serve as examples as the possible scenarios you may see as you are doing visits.



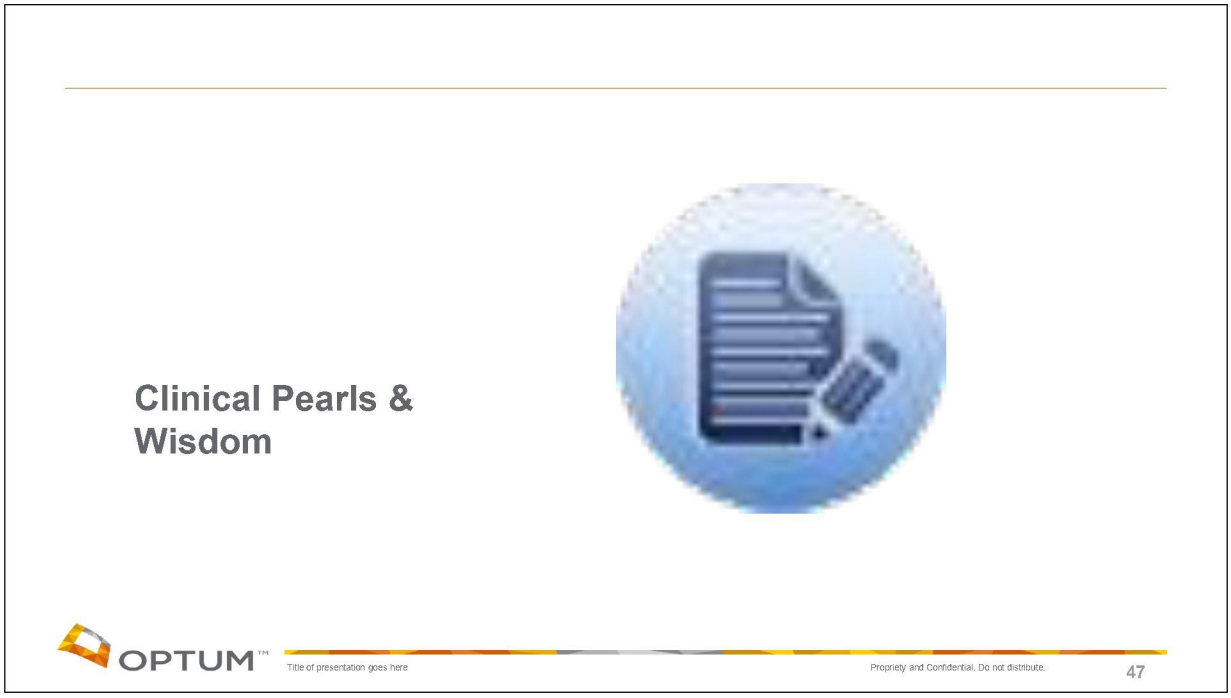
Lets take a look and review our first case study. You see an elderly malnourished female that is have a third viral episode. Underlying conditions consist of protein calorie malnutrition; you know she's immunocompromised because this is her third viral infection in a short period of time. She is underweight and you have evidentiary support because you have weighed and measured her height. Utilizing her BMI, constitutional appearance, history of past and current viral infection – you can capture and substantiate the connection between immunodeficiency and protein calorie malnutrition.



We now will look at a member that you may see who has a blood cancer with an acute ear and bronchial infection. Due to a condition that is linked to a depressed immune system, other conditions may develop due to the cancer that is an underlying condition that can be tied to the immunosuppression. Do not forget your pathophysiology. Use the evidence that you see during your visit and tie your conditions when applicable.



We now have a member with an acute case of cellulitis who has a chronic condition of SLE. If we remember our patho, we will remember that an underlying condition of immunosuppression is evident in this particular case. The medication utilized to control the condition of SLE is lowering the patients immune system – thus leading the member to have other infections i.e. the cellulitis we see in this particular case study.



Lets review some case studies that can serve as examples as the possible scenarios you may see as you are doing visits.

Documentation Tips



- When there is an immunocompromised state is the intended or unintended result of a drug regimen (e.g., prednisone, chemo, etc.) treatment (e.g., radiation, radiological procedure, etc.) utilize that evidence to specify diagnosis
- When there is an underlying medical condition (e.g., malnutrition, malignancy, prolonged hyperglycemia, etc.), it is important to clearly document and code the cause of the immunocompromised state and link to any underlying condition
- When there is a defining criterion of a primary immunodeficiency disease, simply use the specific disease diagnosis
- Utilize the Notes Column on the Diagnosis Confirmation Page for further clarification for certain underlying conditions (i.e. DM, Cancer, Manifestation, Etiology)

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Review bullet points on Slide

Important to Remember



- It is important to use and document your clinical judgement
- You must ask the pertinent probing questions and obtain a thorough history
- When examining your patient, rarely is there lab work that will assist you in diagnosing secondary immunodeficiency
- Carefully review the surgical history, past medical history and medication list
- Pay attention to what other providers/specialists that are providing care for the member

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Read Bullets

Questions? Clarifications?



If you have any questions or require clarification:

- ✓ Refer to JA on the CEC
  - Immunodeficiency_JobAid.11.11.2020
- ✓ Speak to your CTM
- ✓ Email Clinical Education Team at: housecallspractitionertraining@optum.com

Any issues obtaining access into the Clinical Education Center (CEC) email onlinecommunity@optum.com

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Read Slide



We want to thank you for all that you are doing and will continue to do to make our members healthier and make the healthcare system work better for everyone.

References

1. The amount of systemically absorbed corticosteroids and the duration of administration needed to suppress the immune system of an otherwise immunocompetent person are not well defined. Although the immunosuppressive effects of steroid treatment vary, the majority of clinicians consider a dose equivalent to either ≥2 mg/kg of body weight or ≥20 mg/day of prednisone or equivalent for persons who weigh >10 kg when administered for ≥14 consecutive days as sufficiently immunosuppressive to raise concern about the safety of vaccination with live-virus vaccines (37). This dosage is referred to as "high-dose corticosteroids". Source: https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html
2. "This wide range of immune defects renders the patient susceptible to viral, bacterial, and fungal infections, according to the degree of immunosuppression and the administration route. Examples of these are oral candidiasis, a frequent complication of the use of inhaled steroids, and herpes zoster disease, which often presents with chronic use of systemic corticosteroids" Source : https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6151868/pdf/nihms-988872.pdf
3. "Common DMARDs include methotrexate (Rheumatrex, Trexall, Otrexup, Rasuvo), leflunomide (Arava), hydroxychloroquine (Plaquenil) and sulfasalazine (Azulfidine).
4. Gold is an older DMARD that is often given as an injection into a muscle (such as Myochrysine), but can also be given as a pill — auranofin (Ridaura). The antibiotic minocycline (Minocin) also is a DMARD, as well as azathioprine (Imuran) and cyclosporine (Neoral, Sandimmune, Gengraf). These three drugs and gold are rarely prescribed for RA these days, because other drugs work better or have fewer side effects.
5. Patients with more serious disease may need medications called biologic response modifiers or "biologic agents." They can block immune system chemical signals that lead to inflammation and joint/tissue damage. FDA-approved drugs of this type include abatacept (Orencia), adalimumab (Humira), anakinra (Kineret), certolizumab (Cimzia), etanercept (Enbrel), golimumab (Simponi) infliximab (Remicade), rituximab (Rituxan, MabThera), sarilumab (Kevzara) and tocilizumab (Actemra). Most often, patients take these drugs with methotrexate, as the mix of medicines is more helpful.
6. **Pasternack MS. Approach to the adult with recurrent infections. *UpToDate*. Published online November 12, 2019. www.uptodate.com/contents/approach-to-the-adult-with-recurrent- infections. Accessed 12 Oct. 2020**
7. **Immunodeficiency Status. *AHA Coding Clinic for ICD-10-CM and ICD-10-PCS*. Fourth Quarter 2020;7(4):10. quantim.ahima.org:8080/topaz/reference/latest_issue_codingclinic_icd10.pdf**
8. **ACIP Altered Immunocompetence Guidelines for Immunizations. https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html. Published September 28, 2020. Accessed November 6, 2020.**
9. For additional coding information please refer to the current ICD-10-CM Official Guidelines for Coding and Reporting and ICD-10-CM code set at http://www.cdc.gov/nchs/icd/icd10cm.htm

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Substance Use Disorders (Opioids)

Objective: To assist provider in properly assessing, diagnosing and documenting opioid abuse and opioid dependence during a HouseCalls visit.

Opioids

Opioids are a class of drugs that are chemically related and interact with opioid receptors on nerve cells and the brain. Opioids are generally safe when used short term for pain relief; however, the euphoric affect produced in addition to pain relief increases the risk of misuse.

Definition:

- **Physiological Dependence:** Development of a drug tolerance where an increased amount is required to achieve a certain effect; may also display withdrawal symptoms if the drug is ceased abruptly
- **Addiction:** Compulsive drug seeking and inability to stop drug usage despite harmful consequences
- **Psychological Dependence:** An emotional need for a substance without any underlying physical need

NOTE: Physiological and psychological dependency while they have different definitions both map to the same ICD-10 code F11.20.

Criteria for differentiating between dependence and abuse:

Dependence (3 or more in a 12 month period)	Abuse (1 or more in a 12 month period)
• Tolerance (increased amount of substance is required to produce the same effect) • Substance is taken to relieve withdrawal symptoms • Presence of withdrawal symptoms when the medication is stopped • Unsuccessful attempts to quit, despite a desire to quit • Increased amount of time to obtain substance or to recover from its use • Neglecting important social, occupational or recreational activities • DSM IV TR Criteria for substance abuse and dependency: continued use despite awareness of negative consequences.[2]	• Usage results in an inability to fulfill major life obligations (work, home, school) • Recurrent use in physically hazardous situation • Repetitive substance-related legal problems • Continued use despite repeated social and interpersonal harm[2]

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Assessing Opioid Use

Probing questions

- Does the member have a history of overdose or substance abuse use disorder?
- Is the member on a concurrent benzodiazepine?[1]
- Is the member taking more than the prescribed dosage? Or running out early?
- Has opioid usage impacted their job or home life?
- Has anyone told them they should cut down on their opioid usage?
- Does the member substitute street medication when out of their prescription medications?
- Physiological dependence
  - Does the member need an increased dosage to achieve pain relief?
  - Does the member get signs of withdrawal with abruptly stopping the medication?
- Psychological dependence
  - Is the member using the drug in a different route than prescribed?

Past medical history

- Active or past medical history of opioid use disorder

Medication

- Medication addiction (irresistible urges to use opioid or negative consequences of medication usage) (I.e. Impact on family and work)
- List the appropriate diagnosis under the indication section (I.e. Opioid dependence, Opioid abuse)



- Concurrent Opioid and Benzodiazepine prescription which may increase the patient risk of overdose
- Document any relevant information under the comment section
- Medication misuse
  - Taking more medication than prescribed
  - Usage of different route than the prescribed route
  - Referring to street name to described the medications
- Medication used to treat opioid addiction, and overdose
  - Medications that are used to effectively to treat opioid use disorder include: *methadone, buprenorphine and naltrexone* (alone or in combination).[5]
  - Naloxone (Narcan) is the reversal agent used to treat opioid overdone[5]
- Common Opioid Drugs-
  - Fentanyl (Duragesic)
  - Hydrocodone (Norco, Vicodin, Lortab)
  - Hydromorphone (Dilaudid, Exalgo)
  - Oxymorphone (Opana)
  - Morphine
  - Oxycodone (OxyContin, Percocet)
  - Tramadol (Ultram)
  - Codeine (Tylenol #1-4)
  - Heroin

Social History – Drug Use

Drug Use? Yes or no:

- This question applies to recreational drug use or use of a psychoactive drug without medical justification. The most common opioid drug abused is heroin.
- If answer is 'yes' clarification of the drug and pattern of use (frequency/amount) must be documented in an assessment note.

ROS

- Assess for signs of opioid withdrawal
- Insomnia or sedation
- Mental disorder, depression and antisocial personality
- Dry mouth
- Warm flushing of the skin
- Heavy feeling in the arm and legs

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