MOLINA HEALTHCARE

Medicare & Dual Options

Annual Comprehensive Exam

FAX COMPLETED FORM TO: 877-682-2216

Patient Personal Information

Member Name:		**PCP Name:**	
Date of Birth:	**Age:**		**Case ID:**
HIC#:	**State:**	**Date Of Service:**	_____
MRN#:		**Member Phone#:**	

All fields marked with an * are required to be completed in order to receive payment for the ACE Form, unless indicated otherwise. Please refer to the document titled "ACE Form Instructions" for more detailed instructions.

1. **LOCATION OF VISIT:** ☐ Provider Office Setting ☐ Home Setting

2. **REASON FOR VISIT:** _____

3. **REVIEW OF MEDICATIONS*** ***(3A-3E must all be completed, unless indicated otherwise)***
   - **A.** ☐ **Current medications reviewed with patient (discuss issues/questions)**
   - **B. Note any barriers to medication adherence (indicate N/A if no barriers):**

     _____
   - ***C.*** **Review list of prescriptions and non-prescription medicines, vitamins, home remedies and herbs. Indicate if currently active and if there are changes to quantity dispensed or changes to quantity days supply please populate appropriate columns. If a drug is not indicated as currently active the drug will be treated as member not currently taking such drug. Please list any drugs that are currently active and not already listed. Attach additional page if needed.**

For Claims billing purposes, use BOTH 1159F and 1160F codes, if appropriate for the service rendered. 1159F is usually used to report that the medication list was documented in the medical record and 1160F is usually used to report that the medications were reviewed with patient.

Currently Active	Generic Drug Name	Qty Dispensed	Days Supply	Changes to Qty Dispensed	Changes to Days Supply
☐					
☐					
☐					
☐					
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D. ALLERGIES OR REACTIONS TO MEDICATIONS: _____

E. ☐**Reconciled current medication list with medications prescribed upon hospital discharge (only required if member was hospitalized in the last 30 days)**

For claims billing purposes use CPT 1111F, if appropriate for the services rendered. CPT 1111F is usually used to indicate that discharge medications were reconciled with current medication list.

4. VITAL SIGNS* ***(Required only for the vital signs marked with an *)***

BP* _____ **Temp** _____ **Pulse Ox** _____

Height* _____ **Weight*** _____ **BMI* (*only required for members 21 and over*)** _____

BMI Percentile* (*only required for members 20 and younger*) _____

For claims billing purposes for BMI, use ICD-10 Z68.XX to indicate BMI value/percentile, if appropriate for the services rendered.

5. REVIEW OF SYSTEMS*		
System	**Negative**	**Positive (CIRCLE all applicable symptoms)**
HEENT		Eye pain, ear pain, neck pain, visual problems, masses, hoarseness, **other:**
Respiratory		Cough, wheezing, sputum production, hemoptysis, **other:**
Cardiovascular		Chest pain, SOB, palpitation, orthopnea, **other:**
Gastrointestinal		Abdominal pain, nausea, vomiting, diarrhea, **other:**
Genitourinary		Difficult or painful urination, nocturia, frequency, hematuria, **other:**
Musculoskeletal		Joint pain, swelling, **other:**
Endocrine		Polyuria, heat or cold intolerance, **other:**
Neurological		Disoriented, Paresthesias, weakness, **other:**
Skin		Skin breakdown, rashes, pruritus, **other:**
Psychiatric		Fatigue, hallucinations, anxiety, depressed, **other:**

6. PHYSICAL EXAMINATION*		
General Appearance	**Normal**	**Abnormal (Please document pertinent abnormal symptoms)**
Skin		
Head		
Eyes		
Ears		
Nose		
Throat		

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Neck		
Lungs		
Breast		
Heart		
Abdomen		
Musculoskeletal		
Prostate		
Rectal/GU		
Extremities		
Neurological		

7. ADVANCE DIRECTIVE* (*Only required for members who are 66 years and older*)

For claims billing purposes, use CPT 1158F to report that the Advanced Care Planning was discussed or use CPT 1157F if Advance Directive or similar legal document is present in the medical record, if appropriate for the services rendered.

☐**Patient has an active Advance Directive in place** **OR** ☐**End-of- life care was discussed at this visit**

8. PREVENTIVE HEALTH COUNSELING*

1.	Improving and maintaining physical activity		Yes [ ]	No [ ]
2.	Bladder control issues and treatment options	N/A [ ]	Yes [ ]	No [ ]
3.	Fall risks and fall prevention		Yes [ ]	No [ ]
4.	Improving and maintaining physical health		Yes [ ]	No [ ]
5.	Improving and maintaining mental health		Yes [ ]	No [ ]

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9. PAIN SCALE* (*Only required for members who are 66 years and older*)

For claims billing purposes, use CPT 1125F if pain level is 1 to 10, or CPT 1126F if pain level is 0, if appropriate for the service rendered. Indicate which below best describes pain level and describe the type of pain and location.

A. Describe Type of Pain and Location:

_____

B. Place check mark on face that best describes pain level

0	2	4	6	8	10
No hurt	Hurts little bit	Hurts little more	Hurts even more	Hurts whole lot	Hurts worst
[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

10. FUNCTIONAL ASSESSMENT* (*Only required for members who are 66 years and older*)

Please indicate either"1" or "0" in score field for <u>each</u> activity and whether member has counseled, if applicable. Please total score in the space provided for the Total Functional Score. For claims billing confirmation, use CPT 1170F to report that the functional assessment was completed, if appropriate for the service rendered.

Activity	Score	Comments
CONTINENCE 0 = incontinent (or catheterized and unable to manage alone) 1 = independent		If 0, has patient been counseled?
MOBILITY/TRANSFERRING 0 = unable, needs help in moving from bed to chair or requires complete transfer, uses wheelchair 1 = moves in and out of bed unassisted (mechanical aids are acceptable)		If 0, has patient been counseled?
FEEDING 0 = needs partial or total help with feeding or requires parenteral feeding 1 = gets food from plate into mouth independently, prep of food may be done by another person		
BATHING 0 = needs help with bathing or getting in and out of the shower 1 = independent (bathes self completely, disabled extremity)		
DRESSING 0 = needs help with dressing self or needs to be completely dressed 1 = gets clothes from closet and puts on clothes complete with fasteners		
TOILET USE 0 = needs help transferring to the toilet, unable to clean self, uses bed pan or commode 1 = goes to toilet, gets on and off, cleans genital area without help		
WALKING 0 = needs help from another person with walking or completely unable to walk 1 = independent (able to walk by themselves or cane or other assistive devices)		

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TOTAL functional score (0-7)	_____	

11. **DEPRESSION SCREENING (PHQ-9)***

For claims billing purposes use the codes indicated below if appropriate for the service rendered:

- ***Use HCPCS G8431 if positive screen for clinical depression and follow-up plan is documented.***
- ***Use HCPCS G8510 if negative screen for clinical depression and patient not eligible for follow up plan.***
- ***Use HCPCS G8433 if screening for clinical depression not documented, patient not eligible/appropriate.***
- ***Use HCPCS G8940 if screening for clinical depression documented, follow up plan not documented, patient not eligible/ appropriate.***

Over the last 2 weeks, how often has the patient been bothered by the following problems?	**Not at all**	**Several Days**	**More than half the days**	**Nearly every day**
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 or staying asleep, or 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 and/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 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 thoughts of hurting yourself in some way	**0**	1	2	3
Scoring:	**0**	+ _____	+ _____	+ _____
TOTAL SCORE :	_____			

10. If the patient checked off any problems, how difficult have those problems made it for him/her to do work, take care of things at home, or get along with other people?

☐No difficult at all ☐ Somewhat difficult ☐Very difficult ☐Extremely difficult

Consider total score as possible indicator of level of depression. Circle the appropriate score/severity indicator	
	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression

ADDITIONAL COMMENTS:

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20-27	Severe depression
Q.10 - a non-scored question used to assign weight to the degree to which depressive problems have affected the patient's level of function.	

12. PREVENTIVE HEALTH REVIEW* (*Only required for the Required Population indicated. If a Required Population is not indicated, then required for all members. All applicable answers must be completed.)*

IMPORTANT: Please include procedure report for preventive health services listed below

1. Colon Cancer Screening
(***Required Population***: Members between the ages of 50-75)

A. Check the appropriate box and answer related questions:

☐ Ordered FIT/iFOBT (at least once per current calendar year)
OR
☐ Ordered Flexible Sigmoidoscopy (at least once in current or preceding 4 calendar years)
OR
☐ Ordered Colonoscopy – (at least once in current or preceding 9 calendar years)
OR
☐ Referred to a Specialist
OR
☐ Member has already received one of the following screenings within the required timeframes indicated in 1A (check appropriate screening below):
☐ FIT/iFOBT test (at least once per current calendar year)
OR
☐ Flexible Sigmoidoscopy (at least once in current or preceding 4 calendar years)
OR
☐ Colonoscopy (at least once in current or preceding 9 calendar years)
OR
☐ Member had total colectomy and does not need to be screened

Date colon screening ordered: _____

Specialist name: _____
Date referred to specialist: _____

Date colon screening completed: _____
Result: _____

Date of total colectomy: _____

B. Does member have history of colon cancer?
☐ Yes -- If yes, date member was diagnosed: _____ ☐ No

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2. Bilateral mammogram for breast cancer screening
(**Required Population**: female members between the ages of 50-74,
Required timeframe: At least once in current or preceding calendar year.)

A. Check the appropriate box and answer related questions:

☐ Ordered breast cancer screening

OR

☐ Member has already completed bilateral mammogram within required timeframe

OR

☐ Member has had a bilateral mastectomy and does not need to be screened

Date bilateral mammogram ordered: _____

Date bilateral mammogram completed: _____
Result: _____

Date of bilateral mastectomy: _____

3. Diabetes
Does member have diabetes?
☐ Yes (complete 3A-3D) ☐ No (skip to 4A)

A. HbA1c (**Required timeframe:** at least once per current calendar year)

Check the appropriate box and answer related questions:

☐ Ordered Hba1c

OR

☐ Referred to a specialist

OR

☐ Member has already received Hba1c test within required timeframe (include the latest test result from the current calendar year)

Date HbA1c test ordered: _____

Name of specialist: _____
Date referred to specialist: _____

Date Test Completed: _____
Result: _____

B. Diabetic Retinal or Dilated Eye Exam (**Required timeframe:** once in current calendar year if previously diagnosed with retinopathy or once in current or previous calendar year if not previously diagnosed with retinopathy)

Check the appropriate box and answer related questions:

☐ Referred to a specialist for eye exam

OR

☐ Member has already completed diabetic retinal or dilated eye exam within required timeframe

Date referred to specialist or optometrist:
_____

Date diabetic eye exam completed: _____
Result (check one):
☐ No retinopathy ☐ Diabetic retinopathy

Name and location of Vision Care Provider
_____

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C. Attention to nephropathy
(**Required timeframe:** at least once per current calendar year)

Check the appropriate box and answer applicable related question:

☐ Ordered nephropathy screening or monitoring test — Date test ordered: _____
OR
☐ Member received nephropathy test within required timeframe — Date nephropathy test completed: _____ Result: _____
OR
☐ Referred to Nephrologist — Name of Nephrologist: _____ Date Referred to Nephrologist:_____
OR
☐ Member is currently on ACE/ARB therapy — Name of ACE/ARB medication: _____
OR
☐ Member has diagnosis of ESRD — Date of ESRD diagnosis: _____

D. Diabetic foot exam (**Required timeframe:** at least once per current calendar year)

☐ Diabetic foot exam completed within required timeframe — Date completed: _____
Member diagnosed with Diabetic Neuropathy:
☐Yes ☐No

4. Rheumatoid arthritis

A. Does member have rheumatoid arthritis?
☐ Yes (complete 4B) ☐ No (skip to 5A)

B. Was disease-modifying anti-rheumatic drug (DMARD) dispensed (**Required timeframe:** at least once per current calendar year)
☐ Yes ☐ No
If No, please indicate reason: _____

Rx Name: _____ Date dispensed: _____

5. Bone Mineral Density Testing for Osteoporosis Management (**Required timeframe:** At least one time after member is 65 years or older. **Required population:** female members 65 years and older)

A. Bone mineral density testing

☐ Ordered bone mineral density test — Date Test Ordered: _____
OR
☐ Member has already received bone mineral test — Date of last bone mineral density test: _____ Result: _____
OR
☐ Member has current diagnosis of osteoporosis (currently on osteoporosis medication) — Name of prescription: _____ Date prescribed: _____

B. If post non-traumatic fracture, was bone density test or osteoporosis prescription ordered within 3 months?
☐ Yes, Date of fracture: _____ Date of bone density test: _____ Name of prescription: _____
☐ No Date prescribed: _____
☐ N/A, member has not had post non-traumatic fracture

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6. Influenza vaccine (**Required timeframe:** current calendar year):

A. Counseled member on importance of influenza vaccine (required to counsel member for payment of ACE form)
☐ Yes ☐ No

B. Has member received influenza vaccine?
☐ Yes If yes: Date influenza vaccine administered:_____
☐ No

7. Pneumococcal vaccine (**Required population:** members 65 years and older or any member that is considered high risk, **Required timeframe:** current calendar year):

A. Counseled member on importance of Pneumococcal vaccine (required to counsel member for payment of ACE form)
☐ Yes ☐ No

B. Has member received pneumococcal vaccine?
☐ Yes If yes: Date PCV13 given: _____ Date PPSV23 given_____
☐ No

13. ASSESSMENT AND TREATMENT PLAN* (Please populate any diagnoses made and document current status and treatment plan)	
Diagnosis Description	**Status and Treatment Plan (check 1 only)**
	Indicate the status of assessed diagnosis: [ ]Stable [ ]Unstable [ ]In Remission **Treatment Plan (please provide any relevant support for new diagnoses):**
	Indicate the status of assessed diagnosis: [ ]Stable [ ]Unstable [ ]In Remission **Treatment Plan (please provide any relevant support for new diagnoses):**

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	Indicate the status of assessed diagnosis: [ ]Stable [ ]Unstable [ ]In Remission **Treatment Plan (please provide any relevant support for new diagnoses):**
	Indicate the status of assessed diagnosis: [ ]Stable [ ]Unstable [ ]In Remission **Treatment Plan (please provide any relevant support for new diagnoses):**
	Indicate the status of assessed diagnosis: [ ]Stable [ ]Unstable [ ]In Remission **Treatment Plan (please provide any relevant support for new diagnoses):**
	Indicate the status of assessed diagnosis: [ ]Stable [ ]Unstable [ ]In Remission **Treatment Plan (please provide any relevant support for new diagnoses):**
	Indicate the status of assessed diagnosis: [ ]Stable [ ]Unstable [ ]In Remission **Treatment Plan (please provide any relevant support for new diagnoses):**

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	Indicate the status of assessed diagnosis: [ ]Stable [ ]Unstable [ ]In Remission **Treatment Plan (please provide any relevant support for new diagnoses):**
	Indicate the status of assessed diagnosis: [ ]Stable [ ]Unstable [ ]In Remission **Treatment Plan (please provide any relevant support for new diagnoses):**
	Indicate the status of assessed diagnosis: [ ]Stable [ ]Unstable [ ]In Remission **Treatment Plan (please provide any relevant support for new diagnoses):**

14. Risk for Hospitalization and Case Management*

Based on your evaluation:

Do you think the member is at risk for hospitalization? [ ] Yes [ ] No

Would you like to refer the member to Case Management? [ ] Yes [ ] No

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15. COMPLETED BY* (*only fields marked with an * are required to be completed*): Provider warrants that by signing below, all the information contained in this document is truthful and accurate. Molina Healthcare reserves the right to validate and code any diagnosis made by the Provider.

Mark credential*:
☐**MD** ☐**DO** ☐**NP**
☐**PA**

_____ _____
Print Provider Name* **Provider Signature***

_____ _____
Provider NPI Number* **Date***

_____ ( ) - _____
Clinic or Vendor Name **Phone**