SUBMITTING PROGRESS NOTES OR EMR

You may use your own progress notes or Electronic Medical Record (EMR) to document the annual comprehensive examination. The EMR must include the elements indicated below and a sample copy of the EMR must be sent to and approved by RAMP@MolinaHealthcare.com before an EMR record can be submitted. If RAMP@MolinaHealthcare.com does not approve the EMR, RAMP@MolinaHealthcare.com will indicate what is missing from the EMR, and provider can update the EMR or use the ACE Form to complete the fields that are missing from the EMR.

1. **Every page of the EMR document must include:**
    a. Member Name
    b. Patient Identifiers (i.e. Date of Birth)
    c. Date of Service

2. **The document must include elements for:**
    a. Review of Medications
    b. Vital Signs (BP, Height, Weight, BMI or BMI percentile depending on age)
    c. Review of Systems
    d. Physical Examination
    e. Advance Directive
    f. Preventive Health Counseling
    g. Pain Scale
    h. Functional Assessment
    i. Depression Screening/PHQ-9
    j. Preventive Health Review
    k. Assessment and Treatment Plan for any diagnoses
    l. Risk for Hospitalization and Case Management

3. **The Progress Notes must include:**
    a. Provider printed name
    b. Signature
    c. Credentials
    d. NPI Number

4. **EMRs must also include:**
    a. Signature with CMS approved authentication
    b. Provider's full name
    c. Provider credentials
    d. Date stamp

    Examples:
    a. Authenticated by: John Doe, MD MM/DD/YYYY
    b. Signed by: Jane Doe, PA MM/DD/YYYY
    c. Electronically signed by: John Doe, DO MM/DD/YYYY
    d. Finalized by: Jane Doe, NP MM/DD/YYYY

ACE FORM INSTRUCTIONS

Section	Details	Required for ACE Incentive
1: Location of visit	Check off the appropriate box to indicate where the assessment was completed.	
2: Reason for Visit	Note the reason the member is being seen.	
3: Review of Medications	A. Check off the box to show that you have reviewed the information with member. B. Indicate if there are barriers to medication adherence and what those challenges are. C. Check off if the Medications listed are currently active and being used by the member as of the Date of Service. Indicate if there are any changes to the quantity dispensed and the days supply. List any additional medications the member is currently taking. A separate medication list may be attached and must include the member's Name, DOB, DOS and provider signature. D. Note any allergies or reactions to medications. E. If the member was hospitalized during the last 30 days, reconcile the current medication list with the medications prescribed upon hospital discharge and check off the box to indicate this has been completed.	☑
4: Vital Signs	Complete all the required information indicated by the asterisks (*), which include: ➢ Blood Pressure ➢ Weight ➢ Height ➢ BMI (only required for members 21 and older). If BMI is higher than 40, document Morbid Obesity in Section 13, Assessment and Treatment Plan, if appropriate. ➢ BMI Percentile (only required for members 20 and younger)	☑
5: Review of Systems	Perform a full review of systems for the member and circle any positive symptoms.	☑
6: Physical Examination	Document any abnormal or negative findings for affected body systems. Only document **Normal** for asymptomatic body systems.	☑
7: Advanced Directives	Only required if member is 66 years or older. Select appropriate box.	☑
8: Preventive Health Counseling	Indicate N/A, Yes or No to each question.	☑
9: Pain Scale	Only required if member is 66 years or older. A. 9A--Describe Type of Pain and Location, Indicate N/A if no pain. B. 9B--Place check mark on face that best describes pain level.	☑
10: Functional Assessment	Only required if member is 66 years or older. Assess, score all functional activities, and add up the Total Score. If member received a score of 0 for continence or mobility/transferring indicate if	☑

	patient has been counseled.	
11: Psychosocial Assessment (PHQ-9)	1. For each question, circle the appropriate number corresponding to the member's answers. 2. Add up the member's score and total 3. For any score higher than 0, ask the member to indicate their level of difficulty in completing certain tasks. 4. Circle the appropriate depression severity indicator 5. Include any additional comments that are pertinent	☑
12: Preventive Health Review	Complete each section for the Required Population. Include Procedure Report for preventive health service for each item. 1. Colon Cancer Screening: • Required for members between the ages of 50-75. • One box must be checked for question A. Answer appropriate questions based on the box checked. • One box must be checked for question B. If applicable, answer appropriate question based on the box checked. 2. Bilateral Mammogram for breast cancer screening • Required for female members between the ages of 50-74 • One box must be checked for letter A. Answer appropriate questions based on the box checked. 3. Diabetes. Must indicate whether member has diabetes or not. If Member has diabetes, must complete 3A-3D. • One box must be checked for question A. Answer appropriate questions based on the box checked. • One box must be checked for question B. Answer appropriate questions based on the box checked. • One box must be checked for question C. Answer appropriate questions based on the box checked. • Diabetic foot exam must be completed within the required timeframe to receive credit. Indicate the date the diabetic foot exam was completed and if diagnosed with diabetic neuropathy. 4. Rheumatoid Arthritis • One box must be checked for question A. • If yes was chosen for 4A, please complete all required sections for 4B. 5. Bone Mineral Density Testing for Osteoporosis Management • Required for female members 65 years and older. • One box must be checked for question A. Answer appropriate questions based on the box checked. • One box must be checked for question B. If applicable, answer appropriate questions based on the box checked. 6. Influenza vaccine • One box must be checked for question A. Yes, must be chosen in order to receive payment for ACE Form.	☑

	• One box must be checked for question B. If applicable, answer appropriate questions based on the box checked. 7. Pneumococcal vaccine • Required for members 65 years or older or any member that is considered high risk. • One box must be checked for question A. Yes, must be chosen in order to receive payment for ACE Form. • One box must be checked for question B. If applicable, answer appropriate questions based on the box checked.	
13: Assessment and Treatment Plan	1. Document any conditions diagnosed for member. Documentation must include: • Diagnosis description • Choosing the appropriate box for the assessed diagnosis • Providing a treatment plan 2. Review the "Member Information Profile". Each family of conditions listed under "HCC History", must be assessed by: 1) documenting it on the ACE Form, under question 13, as a diagnosed condition, if the member has such condition; OR 2) documenting on the "Never Existed and Resolved Conditions" if the condition is Resolved, Never Existed, or practitioner is unable to make diagnosis. 3. Review The "Member Information Profile". For each family of conditions listed under "List of Suspect Conditions" that is neither documented on the ACE form as a diagnosed condition OR documented on the "Never Existed and Resolved Conditions" page, please complete question 2 on the "Never Existed and Resolved Conditions" page. Yes, must be chosen in order to receive payment for the ACE Form in order to show that a comprehensive exam was performed.	☑
14. Risk for Hospitalization and Case Management	Indicate "yes" or "no" for the two questions that are part of question 14.	☑
15: Completed By	Enter information of rendering provider. The following information is required: ➢ Rendering provider name ➢ Provider Signature ➢ Provider NPI Number ➢ Date ➢ Credential	☑

REMINDERS

- If additional space is needed for diagnosed conditions or review of medications, please document on a separate sheet of paper and attach to the form when faxing it.
- Any attachments must have member's name, DOB, DOS, provider signature and credentials on each sheet.
- If the PCP Name at the top of the form is incorrect, the Completed By section (Section 15 of the Ace Form) must include the information for the office completing the assessment.

FORM REJECTION REASONS

An ACE Form, Progress Note, or EMR submitted for the ACE Program will be rejected if these elements are not documented:

- Fields in the Patient Personal Information are not completed for each page submitted
- Portions stated as "Required" are not completed in their entirety.

CODING THE CLAIM FORM

If appropriate for the service provided, please use the following CPT (or ICD-10) codes in your claim form. The CPT and ICD-10 codes listed below are not exhaustive. The ACE form is not a template for CPT or ICD-10 Code selection. Please ensure to follow E&M and CPT guidelines.

OUTPATIENT VISIT	CODE RANGE
New Patient	99201-99205
Established Patient	99211-99215

PROCEDURE	CODE	PROCEDURE	CODE	PROCEDURE	CODE
Medication List	1159F	Functional Status Assessment	1170F	HbA1C<7.0%	3044F
Medication Review	1160F	Positive Screen for Clinical Depression and Follow-up Plan Documented	G8431	HbA1c is 7.0-9.0%	3045F
Medication Reconciliation – 30 days post hospitalization	1111F	Negative Screen for Clinical Depression	G8510	HbA1C>9.0%	3046F
Advanced Care Plan – present in medical record	1157F	Screening for Clinical Depression Not Documented, Patient Not Eligible	G8433	Positive Urine Microalbumin	3060F
Pain Scale level 0	1126F	Screening for Clinical Depression Documented, Follow up Plan Not Documented, Patient Not Eligible	G8940	Negative Urine Microalbumin	3061F
Pain Scale level 1-10	1125F	Diabetes Foot Exam	G9226 or 2028F	Positive Urine Macroalbumin	3062F

PROCEDURE	CODE	PROCEDURE	CODE	PROCEDURE	CODE
Advance Care Planning discussed	1158F	BMI Assessment	ICD-10: Z68.1, Z68.20-Z68.45, Z68.51-Z68.54	Urine Protein Test completed	81000-81003, 81005, 82042-82044, 84156
Influenza Vaccine	90630, 90653, 90654, 90656, 90660, 90661, 90662, 90672, 90673, 90686, 90688 with Z23 diagnosis code	Pneumococcal Vaccine	90670 or 90732 with Z23 diagnosis code	Bone Mineral Density Tests	76977, 77078, 77080, 77081, 77082, 77085, G0130