



Comprehensive Annual Visit (CAV) EMR Form

Patient Name: _____

Date of Service: ____ / ____ / ____

ATRIO Member ID: _____

Date of Birth: ____ / ____ / ____

Gender: Male Female

Verify the following elements as applicable have been completed and documented in the EMR chart note. Submit claim for face-to-face visit and report quality measure procedure codes. Submit this form and chart note to ATRIO Health Plans (page 2) for incentive compensation.

Patient History

- | | |
|---|--|
| <input type="checkbox"/> Medical history | <input type="checkbox"/> Social history |
| <input type="checkbox"/> Surgical history | <input type="checkbox"/> Alcohol/drug use |
| <input type="checkbox"/> Medical allergies | <input type="checkbox"/> Tobacco use |
| <input type="checkbox"/> Advanced care planning (adults 66 years and older) | <input type="checkbox"/> High-risk lifestyle |
| | <input type="checkbox"/> Physical activity |

Exam

- Vitals: Height, weight, calculated body mass index (BMI), blood pressure and heart rate
- Current medication list (prescriptions, over-the-counter medications and supplements)
 - Specify if review and reconciliation of medications performed
- Physical examination of all systems with notation of findings
- Diagnosis of all active acute and chronic health conditions
 - Diagnosis and ICD-10 code
 - Condition status (e.g. active, improved, worsened, unstable)
 - Treatment plan (e.g. medication, referral, monitor)

Screening/Assessments/Referrals

- Pain screening** (adults 66 years and older)
- Functional status assessment** (adults 66 years and older) – select one of the following:
 - Activities of daily living: bathing, dressing, eating, transferring, using toilet, walking
 - Instrumental activities of daily living: shopping for groceries, driving or using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications, handling finances
 - Result of assessment using standardized functional status assessment tool
 - Assessment of cognitive status, ambulation status, sensory ability, other functional independence
- Breast cancer screening** (women ages 52-74 years old)
 - Date and result of most recent mammogram
 - Indicate if an order was placed for mammogram
- Colorectal cancer screening** (adults 50-75 years old)
 - Date, procedure and result of most recent screening performed
 - Indicate if an order was placed or referral made for screening
- Diabetic care** (patients 18-75 years old diagnosed with diabetes mellitus)
 - HbA1c**
 - Date and result of most recent HbA1c lab test
 - Indicate if an order was placed for HbA1c lab
 - Nephropathy**
 - Date and result of most recent microalbumin or macroalbumin test
 - ACE/ARB therapy medication name
 - Indicate if an order was placed for urine protein lab
 - Eye Care**
 - Date and result of most recent retinopathy screening performed by Optometrist/Ophthalmologist
 - Indicate if a referral was made to Optometrist/Ophthalmologist

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Assessment Statement

By signing this document, you attest to having assessed the patient in a face-to-face visit and reviewed the medical documents to complete the form using the best of your medical knowledge, having placed the completed original of this form in the patient's medical record and having ensured fully documented proof of service of all completed fields is contained in the patient's medical record. If the practice has an electronic medical record system, scan the assessment and attach the image to the electronic record. To the best of my knowledge, information and belief, the information provided regarding diagnoses is truthful and accurate.

Provider name and credentials (printed) _____

Date _____

Compensation Payable To: _____

Office Phone: () -

Provider ID: _____ ID Type: TIN

Office Fax: () -

Mailing Address: _____

City, State, ZIP: _____

Office Manager Name: _____

Email: _____

Submit copy of form and chart note to **ATRIO Health Plans:**
CAV Team Fax: **(866) 255-1032** or Email: **CAV@atriohp.com** *Secure email only*
Email Questions To: QI@atriohp.com

Claim Submission Quality Measure Codes

Please include the following quality procedure and/or diagnosis codes as appropriate on claim submission:

Adult BMI Assessment (adults 18-74 years of age)

ICD-10 Dx	BMI Range	ICD-10 Dx	BMI Range	ICD-10 Dx	BMI Range
<input type="checkbox"/> Z68.10	≤ 19.0	<input type="checkbox"/> Z68.29	29.0-29.9	<input type="checkbox"/> Z68.39	39.0-39.9
<input type="checkbox"/> Z68.20	20.0-20.9	<input type="checkbox"/> Z68.30	30.0-30.9	<input type="checkbox"/> Z68.41	40.0-44.9
<input type="checkbox"/> Z68.21	21.0-21.9	<input type="checkbox"/> Z68.31	31.0-31.9	<input type="checkbox"/> Z68.42	45.0-49.9
<input type="checkbox"/> Z68.22	22.0-22.9	<input type="checkbox"/> Z68.32	32.0-32.9	<input type="checkbox"/> Z68.43	50.0-59.9
<input type="checkbox"/> Z68.23	23.0-23.9	<input type="checkbox"/> Z68.33	33.0-33.9	<input type="checkbox"/> Z68.44	60.0-69.9
<input type="checkbox"/> Z68.24	24.0-24.9	<input type="checkbox"/> Z68.34	34.0-34.9	<input type="checkbox"/> Z68.45	70.0 or greater
<input type="checkbox"/> Z68.25	25.0-25.9	<input type="checkbox"/> Z68.35	35.0-35.9		
<input type="checkbox"/> Z68.26	26.0-26.9	<input type="checkbox"/> Z68.36	36.0-36.9		
<input type="checkbox"/> Z68.27	27.0-27.9	<input type="checkbox"/> Z68.37	37.0-37.9		
<input type="checkbox"/> Z68.28	28.0-28.9	<input type="checkbox"/> Z68.38	38.0-38.9		

Care for Older Adults (ages 66 years and older)

Advance Care Planning

- 1123F Discussed; plan or surrogate decision maker documented in the medical record
- 1124F Discussed; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

Medication Review

Both codes must be reported if service performed

- 1160F Review of all medications by a prescribing practitioner (prescriptions, OTCs, herbal therapies and supplements) documented in medical record
- G8427 Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications

Pain Assessment

- 1125F Pain severity quantified; pain present
- 1126F Pain severity quantified; no pain present

Functional Status Assessment

- 1170F Functional status assessed

Comprehensive Diabetes Care (ages 18-75 years old with diabetes diagnosis)

Blood Pressure Reading

CPT	Systolic	CPT	Diastolic
<input type="checkbox"/> 3074F	< 130 mm Hg	<input type="checkbox"/> 3078F	< 80 mm Hg
<input type="checkbox"/> 3075F	130-139 mm Hg	<input type="checkbox"/> 3079F	80-89 mm Hg
<input type="checkbox"/> 3077F	≥ 140 mm Hg	<input type="checkbox"/> 3080F	≥ 90 mm Hg

HbA1c Level

CPT	HbA1c
<input type="checkbox"/> 3044F	< 7.0%
<input type="checkbox"/> 3045F	7.0-9.0%
<input type="checkbox"/> 3046F	≥ 9.0%

Nephropathy Screening, Monitoring or Treatment

CPT	Test/Treatment
<input type="checkbox"/> 3060F	Positive microalbuminuria test
<input type="checkbox"/> 3061F	Negative microalbuminuria test
<input type="checkbox"/> 3062F	Positive macroalbuminuria test
<input type="checkbox"/> 3066F	Documentation of nephropathy treatment