Please fax completed form to the Gold Kidney Health Plan Quality Department: 1-866-537-0536.

GOLD KIDNEY HEALTH PLAN

Annual Wellness Visit Form

Patient Name:_____ **Date of Service:**_____

Date of Birth:_____ **Age:**_____ **Patient ID:**_____

- ☐ Once-in-a-lifetime Initial Preventive Physical Examination (IPPE) (G0402)
- ☐ Once-in-a-lifetime Initial Annual Wellness Visit (AWV) (G0438)
- ☐ Subsequent AWV (G0439)

General Patient Information

Gender: ☐ Male ☐ Female ☐ Other

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ African American
☐ Native Hawaiian or other Pacific Islander ☐ Caucasian

Are you of Hispanic or Latino origin or descent?
☐ Yes ☐ No *If Yes,* ☐ Hispanic or ☐ Latino

Health Status (in general, how would you rate your overall mental or emotional health?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

How many people live in your household now, including yourself?
☐ 1 Person ☐ 2 to 3 People ☐ 4 or more people

Do you have a hearing impairment?
☐ Yes ☐ No

Tobacco Usage (Do you now smoke (or chew/snuff) tobacco every day, some days, or not at all?
☐ Every day* ☐ Some days* ☐ Not at all
*Please see appendix 1 for information on tobacco cessation.

Alcohol Usage:
☐ Daily ☐ Weekly ☐ Monthly ☐ Never

What is your current marital status?
☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Never married

What language do you mainly speak at home?
☐ English ☐ Spanish ☐ Chinese ☐ Russian ☐ Other
If Other (please specify):_____

Where do you live?
☐ House, apartment, condominium, or mobile home ☐ Nursing home
☐ Assisted living or board and care home ☐ Other
If Other (please specify):_____

Patient Name:_____ **Date of Service:**_____

Date of Birth:_____ **Age:**_____ **Patient ID:**_____

Vital Signs

Height:_____ **Weight:**_____ **BMI:**_____ **BP:**_____ **Pulse 02%:**_____

3008F: BMI

Family History

- ☐ Adopted – I know my family history
- ☐ Adopted – I do NOT know my family history
- ☐ N/A

Condition:	Relationship:	Condition:	Relationship:
☐ Hypertension		☐ Glaucoma	
☐ Stroke		☐ Cancer	
☐ Heart Disease		☐ Alcoholism	
☐ High Cholesterol		☐ Asthma/COPD	
☐ Diabetes		☐ Depression/Suicide	
☐ Chronic Kidney Disease		☐ COVID	
Other:		Other:	

Medical History

- ☐ Anemia
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Atrial Flutter
- ☐ Bipolar Disorder
- ☐ Burn (19% of Body or greater
- ☐ Cardiomyopathy
- ☐ Chronic Bronchitis
- ☐ Chronic Hepatitis
- ☐ Chronic Kidney Disease
  - ☐ *Stage 1 (GFR 90+)*
  - ☐ *Stage 2 (GFR 60-89)*
  - ☐ *Stage 3a (GFR 45-59)*
  - ☐ *Stage 3b (GFR 30-44)*
  - ☐ *Stage 4 (GFR 15-29)*
  - ☐ *Stage 5 (GFR ESRD)*
- ☐ Cirrhosis
- ☐ Congestive Heart Failure
  Ejection Fraction:
- ☐ Constipation
- ☐ COPD
  - ☐ *with exacerbation*
  - ☐ *without exacerbation*
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ CVA
- ☐ Dementia
- ☐ Depression
- ☐ Drug/Alcohol dependence
- ☐ DVT
- ☐ Diabetes Mellitus
  - ☐ *without complications*
  - ☐ *with complications*
  - ☐ *with ophthalmic disease*
  - ☐ *with renal disease*
  - ☐ *with neuropathy*
  - ☐ *with PVD*
  - ☐ *long term use of insulin*
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fracture
  - ☐ *Vertebral*
  - ☐ *Femur*
  - ☐ *Pelvic*
  - ☐ *Wrist*
- ☐ GERD
- ☐ Head/Spinal Injuries

Patient Name: _____ **Date of Service:** _____

Date of Birth: _____ **Age:** _____ **Patient ID:** _____

Medical History *continued*

- ☐ HIV
- ☐ Hyperlipidemia
- ☐ Hypertension
  - ☐ *with CHF*
  - ☐ *with Kidney Disease*
- ☐ Insomnia
- ☐ Malignancy
  Specify:
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteomyelitis
- ☐ Osteoporosis
- ☐ Pancreatitis
- ☐ Paralysis
- ☐ Pituitary Disease
- ☐ Pneumonia
- ☐ Pressure Ulcer
  Site:
- ☐ Prior Myocardial Infraction
- ☐ PUD
- ☐ PVD
- ☐ Rheumatoid Arthritis
- ☐ Schizophrenia
- ☐ Seizure Disorder
- ☐ SLE
- ☐ Ulcerative Colitis

Surgical History

- ☐ Amputation
  Service Date:
- ☐ Appendectomy
  Service Date:
- ☐ Breast biopsy
  Service Date:
- ☐ Carotid endarterectomy
  Service Date:
- ☐ Cataract surgery
  Service Date:
- ☐ Cholecystectomy
  Service Date:
- ☐ Coronary artery bypass graft
  Service Date:
- ☐ Coronary stents
  Service Date:
- ☐ Hernia repair
  Service Date:
- ☐ Implantable defibrillator
  Service Date:
- ☐ Organ transplant
  Service Date:
- ☐ Pacemaker
  Service Date:

Other:

Medications (list all known medications and supplements)

- ☐ Allergies:
- ☐ No known allergies
- ☐ Patient does not know

Provider Initials: **Date:**

Medication Follow-up Questions

Do you have any questions, or are you having any issues with medications you are taking?

Reporting CPT II codes (both codes must be used):
1159F: Medication list documented in medical record | 1160F: Review of all medications by prescriber documented in medical record

Patient Name: _____ **Date of Service:** _____

Date of Birth: _____ **Age:** _____ **Patient ID:** _____

Medical Care: List all physicians or suppliers who provided medical care to the patient

Physician Name:	Date:	Condition:

Physician Follow-up Questions

Are you having any issues receiving needed services such as an appointment with a specialist, a referral, etc.?

☐ Yes ☐ No

Are you experiencing any delays, or do you have any questions about the tests, treatments and/or services you are receiving?

☐ Yes ☐ No

ASSESSMENTS

Pain Assessment: Assess level of pain, if present

No Pain | Pain Present

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Location of pain if present: _____

Condition Confirmation

ICD-10 *(check all that apply):*

- ☐ 0521F - Plan of care documented
- ☐ 1125F - Pain severity quantified, pain present
- ☐ 1126F - Pain severity quantified, no pain present

Condition: _____

Status: ☐ Stable ☐ Unstable ☐ Asymptomatic ☐ Symptomatic ☐ Unknown

Plan: ☐ Continue ☐ Change ☐ Monitor ☐ Workup

Findings: _____

Patient Name: _____ **Date of Service:** _____

Date of Birth: _____ **Age:** _____ **Patient ID:** _____

Assessments (complete the following assessments)

Physical activity assessment*

Are you having any pain that is limiting your physical activity? How many times a week are you active, with increased heart rate at least 30minutes?

☐ Start exercise ☐ Increase exercise ☐ Maintain current level of physical activity

Fall Risk assessment*

Have you had a fall in the past year or are you having any trouble with balance?

☐ Patient did not have any falls or only had 1 fall in the past year

☐ Patient had 2 or more falls in the past year

Urinary Incontinence

Have you had any problems controlling your bladder in the past six months?

☐ Patient is NOT incontinent

☐ If so how often? When does the problem occur?

Condition Confirmation

ICD-10 *(check all that apply):*

☐ 1090F - Urinary incontinence refers to the leakage of urine due to lack of bladder control. The provider assesses a female patient of 65 years or older for the presence or absence of urinary incontinence within a 12-month period.

☐ 1100F - Patient screened for future fall risk.

☐ 1101F - Patient screened for future fall risk; documentation of no falls in the past year or only one fall without injury in the past year.

☐ R32 - Unspecified urinary incontinence.

☐ R39.81 - Functional urinary incontinence.

☐ F98.0 - Non-organic enuresis.

☐ N39.3-39.4 - Stress incontinence and other specified urinary incontinence.

☐ R39.81 - Urinary incontinence associated with cognitive impairment.

Condition: _____

Status: ☐ Stable ☐ Unstable ☐ Asymptomatic ☐ Symptomatic ☐ Unknown

Plan: ☐ Continue ☐ Change ☐ Monitor ☐ Workup

Findings: _____

Patient Name: _____ **Date of Service:** _____

Date of Birth: _____ **Age:** _____ **Patient ID:** _____

Functional Status Assessment: Select the appropriate answer for each activity list below

Activity	Independent	Needs Some Assistance	Dependent on Others
Bathing *Do you have difficulty bathing?*	☐ Patient can bathe themselves regularly	☐ Patient needs handrails in the shower or bathtub	☐ Patient needs another person to help them bathe/ shower
Dressing *Do you have difficulty dressing?*	☐ Patient can dress themselves	☐ Patient struggles a bit when getting dressed	☐ Patient needs someone else to help them get dressed
Eating	☐ Patient can eat and prepare food by themselves	☐ Patient needs some assistance in preparing or eating food	☐ Patient is dependent on others for preparing food and feeding them
Transferring	☐ Patient can get in and out of bed without a problem	☐ Patient needs the assistance of guard rails to get out of bed	☐ Patient needs another person's assistance to get in and out of bed
Walking *Do you have serious difficulty walking or climbing stairs?*	☐ Patient can walk without the use of mobility aids	☐ Patient needs mobility aids to walk	☐ Patient is wheelchair bound
Toilet	☐ Patient can go to the toilet by themselves	☐ Patient needs guardrails or grab bars when going to the toilet	☐ Patient is dependent on others when going to the toilet

Additional Functional Assessment Question

Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?

☐ Yes ☐ No ☐ N/A

Condition Confirmation

ICD-10 *(check all that apply):*

☐ 1170F - The provider assesses the functional status of a patient with rheumatoid arthritis, or RA. The assessment may evaluate the patient's level of activities of daily living, or ADL, and or status of instrumental activities of daily living, or IADL.

Condition: _____

Status: ☐ Stable ☐ Unstable ☐ Asymptomatic ☐ Symptomatic ☐ Unknown

Plan: ☐ Continue ☐ Change ☐ Monitor ☐ Workup

Findings: _____

Patient Name: _____ **Date of Service:** _____

Date of Birth: _____ **Age:** _____ **Patient ID:** _____

Patient Health Questionnaire: Select answers that apply to current situation
Over the last two weeks, how often have you been bothered by any of the following problems?

Questions	Not at all	Several days	More than half the days	Nearly everyday
Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3
Feeling down depressed or hopeless	☐ 0	☐ 1	☐ 2	☐ 3
Trouble falling or staying asleep or sleeping too much	☐ 0	☐ 1	☐ 2	☐ 3
Feeling tired or having little energy	☐ 0	☐ 1	☐ 2	☐ 3
Poor appetite or overeating	☐ 0	☐ 1	☐ 2	☐ 3
Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐ 0	☐ 1	☐ 2	☐ 3
Trouble concentrating on things such as reading the newspaper or watching television	☐ 0	☐ 1	☐ 2	☐ 3
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
Thoughts that you would be better off dead, or hurting yourself in some way	☐ 0	☐ 1	☐ 2	☐ 3
			Add Totals:	

Condition Confirmation

ICD-10 *(check all that apply):*

☐ 96160 - The provider administers a questionnaire aimed at helping to identify a specific health risk to a patient, analyzes the results, assigns a score, and documents the findings. Use this code for each standardized survey questionnaire (criteria established and agreed upon by a group of experts).

Condition: _____

Status: ☐ Stable ☐ Unstable ☐ Asymptomatic ☐ Symptomatic ☐ Unknown

Plan: ☐ Continue ☐ Change ☐ Monitor ☐ Workup

Findings: _____

Patient Name: _____ **Date of Service:** _____

Date of Birth: _____ **Age:** _____ **Patient ID:** _____

Six-Item Cognitive Impairment Test

Questions	Scoring System		
What year is it?	☐ Correct (0pts)	☐ Incorrect (4pts)	
What month is it?	☐ Correct (0pts)	☐ Incorrect (3pts)	
Give the patient an address phrase to remember with five components (example John, Doe, 24, sunset Blvd Los Angeles).			
About what time is it within one hour?	☐ Correct (0pts)	☐ Incorrect (3pts)	
Count backwards from 20 to 1.	☐ Correct (0pts)	☐ 1 Error (2pts)	☐ More than one error (4pts)
Say the months of the year in reverse.	☐ Correct (0pts)	☐ 1 Error (2pts)	☐ More than one error (4pts)
Repeat address phrase.	☐ Correct (0pts) ☐ 1 Error (2pts)	☐ 2 Errors (4pts) ☐ 3 Errors (6pts)	☐ 4 Errors (8pts) ☐ All wrong (10pts)

Total Score: _____

Scoring: ☐ 0-7 normal ☐ 8-9 probably significant cognitive impairment (consider referral)
☐ 11-50 significant cognitive impairment (refer)

Condition Confirmation

ICD-10 *(check all that apply):*

☐ 96116 - A physician or other qualified healthcare professional performs a face–to–face assessment of a patient's thinking, reasoning, and judgment. Report this code for the first hour of face–to–face clinical assessment as well as the time spent interpreting the results and preparing a report.

☐ 96125 - In this procedure, the provider performs standardized cognitive performance testing, which is a functional assessment test for a person with memory loss.

Condition: _____

Status: ☐ Stable ☐ Unstable ☐ Asymptomatic ☐ Symptomatic ☐ Unknown

Plan: ☐ Continue ☐ Change ☐ Monitor ☐ Workup

Findings: _____

Patient Name: _____ **Date of Service:** _____

Date of Birth: _____ **Age:** _____ **Patient ID:** _____

PREVENTATIVE SCREENINGS

Immunization

Influenza Vaccination

Have you had a flu shot since July 1, 2022?

- ☐ Vaccine administered during today's visit (G0008) Date Completed:
- ☐ Vaccine administered previously (4037F) Date Completed:

Pneumococcal Vaccination

Have you ever had one or more pneumonia shots? Two shots are usually given in a person's lifetime, and these are different from a flu shot. It is also called the pneumococcal vaccine.

- ☐ Vaccine administered during today's visit (G0009) Date Completed:
- ☐ Vaccine administered previously (4040F) Date Completed:

Colorectal Screening and Counseling

Colorectal Cancer Screening

Patients aged 50-75 years must complete any one of the following screenings for colorectal cancer:

- ☐ Colonoscopy (every 10 years) Date Completed:
- ☐ Flexible sigmoidoscopy (every 5 years) Date Completed:
- ☐ CT Colonography (every 5 years) Date Completed:
- ☐ FIT-DNA (every 3 years) Date Completed:
- ☐ Fecal Occult Blood Test (every year) Date Completed:
- ☐ N/A

Condition Confirmation

ICD-10 *(check or add any applicable codes):*

- ☐ 3017F - Colorectal cancer screening includes radiologic, endoscopic, and laboratory tests to assess the colon, or lower part of the large intestine, and the rectum for cancer in individuals at age 50 or older. The code includes the interpretation of the results of the procedure by the provider and its documentation. Unlike diagnostic tests, there do not need to be signs, symptoms, or history of colon disease in order to cover a screening exam.
- ☐ 82270 - The lab analyst uses a peroxidase activity method to perform a colorectal cancer screening test for the presence of hidden blood in a fecal specimen that the patient collects from three consecutive bowel movements. Clinicians commonly call the test a fecal occult blood test (FOBT).

Condition: _____

Status: ☐ Stable ☐ Unstable ☐ Asymptomatic ☐ Symptomatic ☐ Unknown

Plan: ☐ Continue ☐ Change ☐ Monitor ☐ Workup

Findings: _____

Patient Name: _____ **Date of Service:** _____

Date of Birth: _____ **Age:** _____ **Patient ID:** _____

Breast Cancer Screening and Counseling

Breast cancer screening **women aged 50-75 years** must complete a mammogram every two years.

- ☐ Mammography performed 27 months prior to December 31st period of the current measurement year. Date Completed:
- ☐ Excluded due to bilateral mastectomy. Date Completed:
- ☐ Excluded due to two unilateral mastectomies with service dates 14 days or more apart. Date Completed:
- ☐ Excluded due to unilateral mastectomy with bilateral modifier. Date Completed:
- ☐ N/A

Condition Confirmation

ICD-10 *(check all that apply):*

- ☐ 3315F - The provider assesses the presence of estrogen or progesterone receptors, cell proteins that bind to specific molecules, within tumor cells in female patients, 18 years of age or older. A tumor that is estrogen or progesterone receptor positive (ER+ or PR+) responds to medications that interfere with the production or utilization of estrogen.

Condition: _____

Status: ☐ Stable ☐ Unstable ☐ Asymptomatic ☐ Symptomatic ☐ Unknown

Plan: ☐ Continue ☐ Change ☐ Monitor ☐ Workup

Findings: _____

Cervical Cancer Screening and Counseling

Cervical Cancer

- ☐ **Women aged 24-64 years** must complete a cervical cytology every 3 years. Date Completed:
- ☐ **Women aged 30-64** years must complete a cervical high-risk HPV testing every 5 years. Date Completed:
- ☐ N/A

Condition Confirmation

ICD-10 *(check or add any applicable codes):*

- ☐ 3015F - Diagnostic/screening processes.

Condition: _____

Status: ☐ Stable ☐ Unstable ☐ Asymptomatic ☐ Symptomatic ☐ Unknown

Plan: ☐ Continue ☐ Change ☐ Monitor ☐ Workup

Findings: _____

Patient Name: _____ **Date of Service:** _____

Date of Birth: _____ **Age:** _____ **Patient ID:** _____

Controlling Blood Pressure

Hypertension

☐ **Members 18-85 years old** whose blood pressure BP was adequately controlled (less than 140/90). BP reading during the current measurement year on or after the second diagnosis of hypertension. Most recent reading in the current measurement year must have a representative systolic BP less than 140 mmHg and a representative diastolic BP less than 90 mmHg.

Date Completed:

☐ N/A

Condition Confirmation

ICD-10 *(circle or add any applicable codes):*

☐ 3074F: SBP ≤ 130 mmHg
☐ 3075F: SBP 130-139 mmHg
☐ 3077F: SBP ≥ = 140 mmHg
☐ 3078F: DBP ≤ 80 mmHg
☐ 3079F: DBP 80-89 mmHg
☐ 3080F: DBP ≥ = 90 mmHg

Condition: _____

Status: ☐ Stable ☐ Unstable ☐ Asymptomatic ☐ Symptomatic ☐ Unknown

Plan: ☐ Continue ☐ Change ☐ Monitor ☐ Workup

Findings: _____

Patient Name: _____ **Date of Service:** _____

Date of Birth: _____ **Age:** _____ **Patient ID:** _____

Diabetes Screening and Counseling

Diabetes Screenings

Diabetic patients aged 18-75 years must complete the following screenings:

- ☐ Hemoglobin A1C screening at least once a year. Date Completed:
  - A1C results:
    - ☐ A1C less than 7%
    - ☐ A1C greater than 7% and less than 8%
    - ☐ A1C greater than 8% and less than 9%
- ☐ Dilated or retinal eye exam every year. If patient had a negative result in the year prior, patient may complete eye exam every two years. Date Completed:
- ☐ Bilateral eye enucleation any time during the member's history or current measurement year. Date Completed:
- ☐ Micro albumin screening every year. Date Completed:
- ☐ Foot exam completed by a podiatrist, as needed. Date Completed:
- ☐ N/A

Condition Confirmation

ICD-10 *(check or add any applicable codes):*

HbA1C (83036, 83037)

- ☐ 3044F ≤ 7.0%
- ☐ 3051F ≥=7.0% and ≤8.0%
- ☐ 3052F ≥8.0% and ≤=9.0%
- ☐ 3046F ≥9.0%
- ☐ uACR (82043)
- ☐ Urine Creatine Test (82570)
- ☐ eGFR (81000-81005, 82043, 82044)

Reporting CPT II Codes: 2023F, 2025F, or 2033F for negative retinopathy, 2022F, 2024F, or 2026F for positive/unknown

Condition: _____

Status: ☐ Stable ☐ Unstable ☐ Asymptomatic ☐ Symptomatic ☐ Unknown

Plan: ☐ Continue ☐ Change ☐ Monitor ☐ Workup

Findings: _____

Patient Name: _____ **Date of Service:** _____

Date of Birth: _____ **Age:** _____ **Patient ID:** _____

Kidney Health Evaluation for Patients with Diabetes Screening and Counseling

Kidney Health Evaluation for Patients with Diabetes

☐ **Members 18-85 years old** with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin creatinine ratio (uACR) during the measurement year. Date Completed:

☐ N/A

Condition Confirmation

ICD-10 *(check all that apply):*

☐ 90947 - Report 90947 if the procedure requires repeated physician evaluations, with or without substantial revision of a dialysis prescription.

Condition: _____

Status: ☐ Stable ☐ Unstable ☐ Asymptomatic ☐ Symptomatic ☐ Unknown

Plan: ☐ Continue ☐ Change ☐ Monitor ☐ Workup

Findings: _____

Osteoporosis Cancer Screening and Counseling

Osteoporosis Screening

☐ **Women aged 67-85 years** who had a fracture must complete a bone mineral density test or be dispensed osteoporosis medication within six months of the fracture date. Date Completed:

☐ N/A

Condition Confirmation

ICD-10 *(check all that apply):*

☐ Z13 - Screening is the testing for disease or disease precursors in asymptomatic individuals so that early detection and treatment can be provided for those who test positive for the disease.

☐ R54 - Age-related physical debility.

Condition: _____

Status: ☐ Stable ☐ Unstable ☐ Asymptomatic ☐ Symptomatic ☐ Unknown

Plan: ☐ Continue ☐ Change ☐ Monitor ☐ Workup

Findings: _____

Patient Name: _____ **Date of Service:** _____

Date of Birth: _____ **Age:** _____ **Patient ID:** _____

Statin Therapy Screening and Counseling

Statin Therapy for Cardiovascular Disease

☐ **Patients aged 40-75 years** who are diagnosed with CVD must be prescribed with moderate to high intensity statin medication. Date Completed:

☐ N/A

Statin Therapy for Diabetes

☐ **Patients aged 40-75 years** who are diagnosed with Diabetes must be prescribed with statin medication. Date Completed:

☐ N/A

Condition Confirmation

ICD-10 *(check or add any applicable codes):*

☐ 4013F - A provider uses this code to report that the provider prescribes or the patient is currently taking a statin therapy. Statins are drugs that lower the level of cholesterol in blood as it reduces its production in liver. The provider may adjust the patient's statin therapy depending on his condition.

Condition: _____

Status: ☐ Stable ☐ Unstable ☐ Asymptomatic ☐ Symptomatic ☐ Unknown

Plan: ☐ Continue ☐ Change ☐ Monitor ☐ Workup

Findings: _____

Case Management and Screenings

☐ Have you been in contact with your case manager?

☐ Has your case manager discussed screening/prevention for the next five to ten years?

☐ Inquiry…

Advanced care planning services

☐ Encourage member to inform others about care preferences and future care decisions

☐ Explain advanced directives may require completion of standard forms

☐ Member did not wish to discuss any of the above at this time

Provider Name: _____

Provider Signature: _____ Date: _____

Gold Kidney Health Plan is an HMO, HMO C-SNP, HMO-POS C-SNP with a Medicare contract.
Enrollment in Gold Kidney Health Plan depends on contract renewal.

GOLD KIDNEY HEALTH PLAN

ANNUAL VISIT FORM (AWV) | FREQUENTLY ASKED QUESTIONS

What is the Gold Kidney AWV?

The Gold Kidney Annual Wellness Visit form (AWV) is intended to guide a comprehensive health assessment. The form consists of elements from the Annual Wellness Visit, a physical exam and Healthcare Effectiveness Data and Information Set (HEDIS®) measures. The form can be used by physicians and other healthcare providers to help document vital information for Gold Kidney Medicare Advantage-covered patients during an annual face-to-face examination or telehealth visit. The Gold Kidney AWV is a stand-alone medical record, which should include supporting documentation for all services billed to capture the true health status of the patient.

Why should I complete the AWV?

The AWV serves as a concise template that helps to ensure all the elements of a comprehensive health and quality assessment are documented, while assisting in HEDIS measurement closure.

Completion of the form enhances complete and accurate medical record documentation, which allows diagnosis coding to the highest level of specificity and identifies opportunities to positively impact patient care with HEDIS® and CMS STAR Ratings measures. It will help improve coordination of care and help patients access applicable Gold Kidney Health Pan Care Management programs.

How do I complete the AWV?

- Ensure you are using the most updated AWV form. The current version of the AWV form can be found at www.goldkidney.com/forms/
- Contact your assigned Gold Kidney-covered patient to schedule an appointment.
- Complete the Gold Kidney AWV during a face-to-face encounter between a patient and
- a licensed medical doctor (MD), doctor of osteopathy (DO), physician assistant (PA) or nurse practitioner (NP).
- Examine, evaluate and treat the patient as you normally would, being sure to assess all of his or her chronic health conditions, if any, as well as any acute conditions that may be present.
- Ensure that the assessment form is completed in its entirety and signed by the rendering healthcare provider.
- Place the completed assessment form in the patient's medical record.
- Submit the completed assessment form to Gold Kidney by faxing all completed forms to the Quality Assurance line at 1-866-537-0536.

Do I have to submit a claim?

A claim must be submitted with Current Procedural Terminology (CPT®) code G0438 for initial visit and G0439 for subsequent visit and/or G0402 for initial preventive physical examination.

If you have additional questions, please contact the Quality Department: quality@goldkidney.com