Banner Plans & Networks

Frail & Elderly Toolkit

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These guidelines serve to assist in the management, documentation, and coding of clinical diagnoses. The intent of this document is to supplement, but not replace, the provider's clinical judgement.

Frail & Elderly Best Practices

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Frail & Elderly - Provider One Pager

POP
Provider One Pager

The Frail & Elderly (F&E) population segment drives a disproportionate amount of total medical spend. The F&E population is defined as being 65 or older and having 2 or more conditions indicating frailty or 1 condition with utilization of durable medical equipment (DME).

Link to Frail & Elderly Indicators List.

The avoidable spend may be prevented in the following ways:

- **Frequent PCP visits**: Goal – direct impact on reducing ED & hospital utilization
- Referral to BPN care management teams or other supports as appropriate. High touch patient assistance managing their health care needs across the continuum.
- Refer to In Home Providers or Palliative Care as appropriate.

A list of your F&E members can be pulled by your office staff. These members will likely need to be seen more frequently and may require additional coordination of care or other services to help manage symptoms, complex needs and reduce ED and inpatient utilization. (Link to F&E member list instructions.) Please note: The F&E list is based on an algorithm and will have a bell curve of patients with varying levels of acuity.

Care Team Impact on F&E Patients

Care for All F&E Patients	Additional Care for High Acuity F&E Patients

• Annual wellness visit
  • Optimize care gap closure
  • Depression screening
  • Vaccinations
  • Other routine screenings
  • Medication review
  • SDoH Evaluation
• Appropriate interventions based on frailty indicator
• Appropriate documentation of disease burden
• Provide patient with a "sick day plan" based on chronic conditions
  • What to do if their condition worsens
  • Help to avoid unnecessary ED and IP utilization
	• 8-12 primary care visits per year (2-3 times per quarter recommended)
	  • Visits may be via telehealth, video or in person
	  • Visits may be with non-PCP members of the care team, such as APPs or Pharmacists
	• Advanced Care Planning (ACP) and documentation
	• Refer to other support teams or services as appropriate

Support Teams & Services		
Care Management Services include: Community resources Disease & lifestyle education Post discharge assistance End of life planning and much more Care Management Referral Form	**In Home Providers** Services include: Home NP/PCP visits Mobile Labs/X-ray Home Providers	**Palliative Care** Services include: Home visits Patient centered treatment goals & condition management Extra support Coordination with PCP office Palliative Care Provider List

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Frail/Elderly Population Description

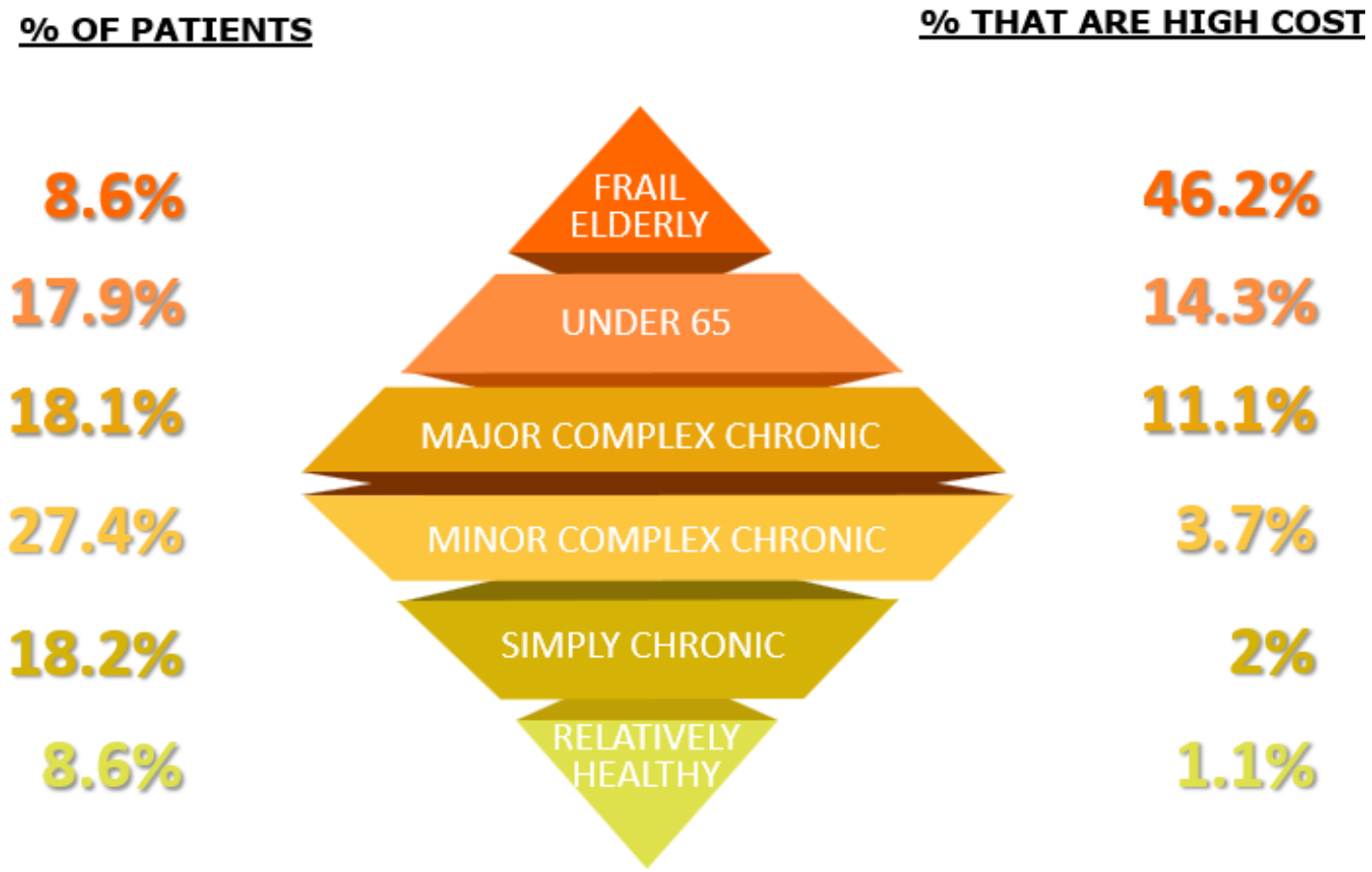
Frail/elderly patients account for nearly half of all potentially preventable health care costs due to admissions for ambulatory care-sensitive conditions and avoidable emergency department visits. A particularly high amount of ambulatory care-sensitive conditions are derived from heart failure, pneumonia, chronic obstructive disease, asthma and urinary tract infections.

Simple interventions in the outpatient setting, such as close management of heart failure and prevention of urinary tract infections may have a positive impact on the cost of care.[i]

It is a common belief that most high-need, high-cost patients are near the end of life. In fact, the population is clinically diverse. Some have multiple chronic conditions that are stable with treatment and will persist for years. Others have extreme functional limitations.[ii]

Patient Segmentation

The segmentation diamond below is an illustration of the peer-reviewed patient segmentation methodology that identified the "frail/elderly" as the largest proportion of high-cost patients.



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Frail & Elderly Indicators

Criteria for Frail/Elderly Classification[iii]:

- 65 years or older
- Two or more indicators are needed to be classified as "Frail/Elderly"
- One indicator plus durable medical equipment

Abnormalities of Gait; Debility

ICD-10	Description
R26.-	Abnormalities of gait and mobility
R26.0	Ataxia gait
R26.1	Paralytic gait
R26.2	Difficulty in walking, NEC
R26.81	Unsteadiness on feet
R26.89	Other abnormalities of gait and mobility
R26.9	Unspecified abnormalities of gait and mobility
R53.81	Other malaise
Z91.81	History of fall

Failure to Thrive; Feeding Difficulties; Cachexia

ICD-10	Description
R62.51	Failure to thrive (child)
R62.7	Adult failure to thrive
R63.4	Abnormal weight loss
R63.6	Underweight; Use additional code to identify the BMI (Z68.-)
R64	Cachexia (wasting syndrome; underlying condition coded first)
Z68.1	BMI 19 or less, adult

Malnutrition; Protein-Calorie Malnutrition; Severe Morbid Obesity

ICD-10	Description
E40	Kwashiorkor
E41	Nutritional Marasmus
E42	Marasmic kwashiorkor
E43	Unspecified severe protein-calorie malnutrition
E44.0	Moderate protein-calorie malnutrition
E44.1	Mild protein-calorie malnutrition
E46	Unspecified protein-calorie malnutrition
E66.01	Morbid (severe) obesity due to excess calories

Muscle Wasting/Atrophy/Weakness; Pressure Ulcer; Senile Degeneration

ICD-10	Description
M62.50	Muscle wasting and atrophy, not elsewhere classified, unspecified site
M62.81	Muscle weakness (generalized)
L89.-	Pressure ulcer (all L89 codes)
G31.1	Senile degeneration of brain, not elsewhere classified

Durable Medical Equipment (DME)

HCPCS	Description
E01.0-E80.02	DME

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Care Strategies

- Utilize Innovaccer's Frail & Elderly List to view or download a list of Frail & Elderly patients who would benefit from outreach and follow-up
- Schedule recurring appointments (6-8 appointments every year/2 times per quarter recommended) with interdisciplinary health care team (PCP, NP, PA, Dietician, Pharmacy, etc.)
- Perform Annual Wellness Visits and optimize care gaps
    - Complete evaluation for chronic conditions once per year (minimum)
- Refer to Care Management if a further need for clinical support has been identified for the following plans: UHC MA, Humana MA, Banner MA-Dual, Banner MA-Plus, Banner MA-Prime, Medicare-MSSP, Banner|Aetna, BUFC-ACC, BUFC-ALTCS (Link: Care Management Referral Form)
    - Care Management offerings:
        - Assistance with patients who've had multiple ED visits or inpatient admissions
        - Post-discharge assistance
        - Medication assistance (education, cost barriers, adherence & polypharmacy)
        - Non-adherence to PCP treatment plan/missed appointments
        - Chronic condition(s) or newly diagnosed condition(s)/Disease education
        - Mental Health needs (i.e., dementia, Alzheimer's, depression, substance abuse)
        - Home safety concerns
        - Advance Directives/End-of-life planning
        - Community resources (i.e., financial needs, transportation, caregiver support, support groups)
- Chronic Care Management (CCM)
    - Care management services provided by the provider office are reimbursable; please see the Chronic Care Management Toolkit for more information: CCM Toolkit
- Evaluate for Social Determinants of Health
    - Social Determinants of Health Evaluation Example: SDoH evaluation

Palliative Care

Early palliative care, also known as supportive care, has been shown to improve quality of life, symptom management and satisfaction in patients with advanced stages of disease. Currently there is a stigma associated with palliative care, which may be a barrier to timely referral depriving patients and caregivers of the full benefits of palliative care.[iv]

Palliative care is NOT synonymous with hospice care

Palliative care is supportive care at any point in a disease journey. It is not necessarily a pathway to hospice. Palliative care provides support beyond treatment of disease, leading to improved quality of life for patients and caregivers.[v]

Palliative care focuses on:

- Specialized medical care for people living with serious illness
- Relief from symptoms & stress of serious illness
- Improving quality of life for patient & family
- Care based on patients' needs, not on patients' prognosis
- Working in partnership with primary care physicians and specialists

Hospice care focuses on the care and comfort at the end of life.

Determining Appropriateness for Palliative Care

Palliative care is for any individual with a serious illness, regardless of life expectancy or prognosis. This would include patients with advanced chronic illness that have received maximum medical therapy and are at risk of using the hospital for decompensation.

Advanced Chronic Disease
Cancer
COPD
Liver Failure
Heart Failure
Kidney Failure
Advanced Dementia or Alzheimer's
Advanced Neuromuscular Disease
Other (previous traumatic injury, multi organ failure)

Additional Health Indicators
1+ Hospitalization or ED visit in past 6 months
High DME Need (Oxygen, lift, hospital bed, scooter, etc.)
Complex social dynamics
Lack of clarity regarding goals of care
Difficult to control symptoms (pain, nausea, dyspnea, etc.)
Complex care requirements (ventilator dependent, long-term antibiotics, long-term feeding tube, etc.)
Decline in function or failure to thrive (weight loss >10%, low albumin, reduction of ability to complete ADLs)
Declining cognitive status, decreasing alertness, withdrawal, increased sleeping, or mental confusion
History of need for home health or wound care

Link to: Palliative Care Providers List

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Frailty Best Practices

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Frailty - Provider One Pager

POP
Provider One Pager

Patients assessed with frailty experience increased vulnerability and functional impairment[vi]. Frailty may lead to poor health outcomes, a reduced ability to recover from acute stress, and include the following:

- Loss of muscle mass and strength
- Reduced energy and exercise tolerance
- Cognitive impairment
- Decreased physiological reserve

The FRAIL scale is a brief screening tool to evaluate patients for frailty. Link: Frailty Tools

Frailty Assessment and Management Pathway

Benefits of Early Assessment	

• Preventive and rehabilitative actions to:
  • Delay decline in health
  • Prevent deterioration of condition
  • Reverse progression of illness
• Polypharmacy evaluation to prevent overmedication and other complications
• Refer to other support teams or services as appropriate
	• Management in the primary care setting through supportive network:
	  • Family
	  • Caregivers
	  • Community care providers
	• Development of a care plan
	• Advanced care planning

Support Teams & Services		
Care Management Services include: Community resources Disease & lifestyle education Post discharge assistance End of life planning & much more	**In Home Providers** Services include: Home NP/PCP visits Mobile Labs/X-ray Home Providers	**Palliative Care** Services include: Home visits Patient-centered treatment Goals & condition management Extra support Coordination with PCP office Palliative Care Providers

Frailty and Exclusion from HEDIS Quality Measures

HEDIS Quality Measures are valuable for populations who would benefit from preventive screenings. For patients assessed with frailty or advanced illness, coordinated care to support maintaining function and quality of life in the face of declining health may outweigh the benefits of preventive screenings. As a result, a set of exclusions has been implemented to remove those with frailty or advanced illness from selected HEDIS quality measure reporting.

A listing of HEDIS Advanced Illness and Frailty Exclusions criteria can found in the Appendix: HEDIS Advanced Illness and Frailty Exclusions

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Frailty Tools

FRAIL Scale[vii]

Frailty has been associated with increased length of stay, complications after surgery and discharge to rehabilitation facility in geriatric fracture patients.

FRAIL Scale

For Patient:

Have you felt fatigued?	**Yes**	**No**
If yes – *Most or all of the time over the past month?*	**Yes (1)**	**No**
Do you have difficulty climbing a flight of stairs?	**Yes (1)**	**No**
Do you have difficulty walking one block?	**Yes (1)**	**No**

For Care Team:

Does the patient have any of these illnesses: Hypertension, diabetes, cancer (other than a minor skin cancer), chronic lung disease, heart attack, congestive heart failure, angina, asthma, arthritis, stroke or kidney disease?	**Five or more (1)**	**Fewer than five**
Has the patient lost more than 5 percent of their weight in the past year? **Calculate:** • Weight 1 year ago _____ x 0.95 = _____ (A) • Current weight _____ (B) • If A > B, answer "Yes." If A < B, answer "No."	**Yes (1)**	**No**

Score:_____
Interpretation:
0 = Not Frail
1-2 = Pre-Frail
3-5 = Frail

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Pharmacy Considerations

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Pharmacy Considerations

The use of medication and normal body changes caused by aging can increase the chance of unwanted or maybe even harmful drug interactions.

American Geriatrics Society (AGS) Beers Criteria:

- The intention of the AGS Beers Criteria is to:
  - Reduce older adults' exposure to potentially inappropriate medications (PIMs) by improved medication selection
  - Educate clinicians and patients
  - Serve as a tool for evaluating the quality of care, cost and patterns of drug use in older adults
- The target audience for the 2023 AGS Beers Criteria is practicing clinicians and others who utilize the criteria including healthcare consumers, researchers, pharmacy benefits managers, regulators and policymakers.
- The criteria are intended to be applied to adults 65 years old and older in all ambulatory, acute and institutionalized settings of care, except hospice and end-of-life care setting
- American Geriatrics Society 2023 updated AGS Beers Criteria®

Medications to Avoid in Older Adults:

Medications Best Avoided		
Antihistamines	• Brompheniramine • Chlorpheniramine • Cyproheptadine • Dimenhydrinate • Diphenhydramine	• Doxylamine • Hydroxyzine • Meclizine • Promethazine • Triprolidine
Antidepressants	• Amitriptyline • Amoxapine • Clomipramine • Desipramine • Doxepin>6mg/day	• Impramine • Nortriptyline • Paroxetine
Antiemetics	• Prochlorperazine	• Promethazine
Antimuscarinics	• Darifenacin • Fesoterodine • Flavoxate • Oxybutynin	• Solifenacin • Tolterodine • Trospium
Antiparkinson	• Benztropine	• Trihexyphenidyl
Antipsychotics	• Chlorpromazine • Clozapine • Olanzapine	• Perphenazine • Quetiapine
Antispasmodics	• Atropine • Dicyclomine	• Hyoscyamine • Scopolamine
Muscle Relaxants	• Carisoprodol • Cyclobenzaprine • Methocarbamol	• Orphenadrine • Tizanidine

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Tool Kit Survey

To help us continuously improve our tool kits, education, and communication with providers, please take this short survey regarding the Frail and Elderly Toolkit by scanning the QR code with your mobile device or visiting https://forms.office.com/r/LnjuXPjJ5L

Thank you so much for your feedback!

Appendix

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Methodology

Population segmentation criteria:

Age over-65 and the presence of at least two conditions indicative of frailty (gait abnormality, malnutrition, failure to thrive, cachexia, debility, difficulty walking, history of fall, muscle wasting, muscle weakness, decubitus ulcer, senility, or durable medical equipment use)

The under-65 Medicare population, which consists of those qualifying for Medicare, based on the presence of end-stage renal disease (ESRD) or disability as determined by the Social Security Administration

Two or more complex conditions or at least six non-complex conditions

Only one complex condition and less than 6 non-complex conditions

1-5 non-complex chronic conditions

All others not captured by the above five categories

*Note: The researchers started with the list of 29 key chronic diseases outlined by CMS in their measure for unplanned admissions for patients with multiple chronic conditions. They defined 9 conditions as "complex conditions:" Acute Myocardial Infarction / Ischemic Heart Disease, Chronic Kidney Disease, Congestive Heart Failure, Dementia, Chronic Lung Disease, Psychiatric Disease, Specified Heart Arrhythmias, Stroke, and Diabetes. They defined the remaining 20 conditions as "other non-complex conditions."

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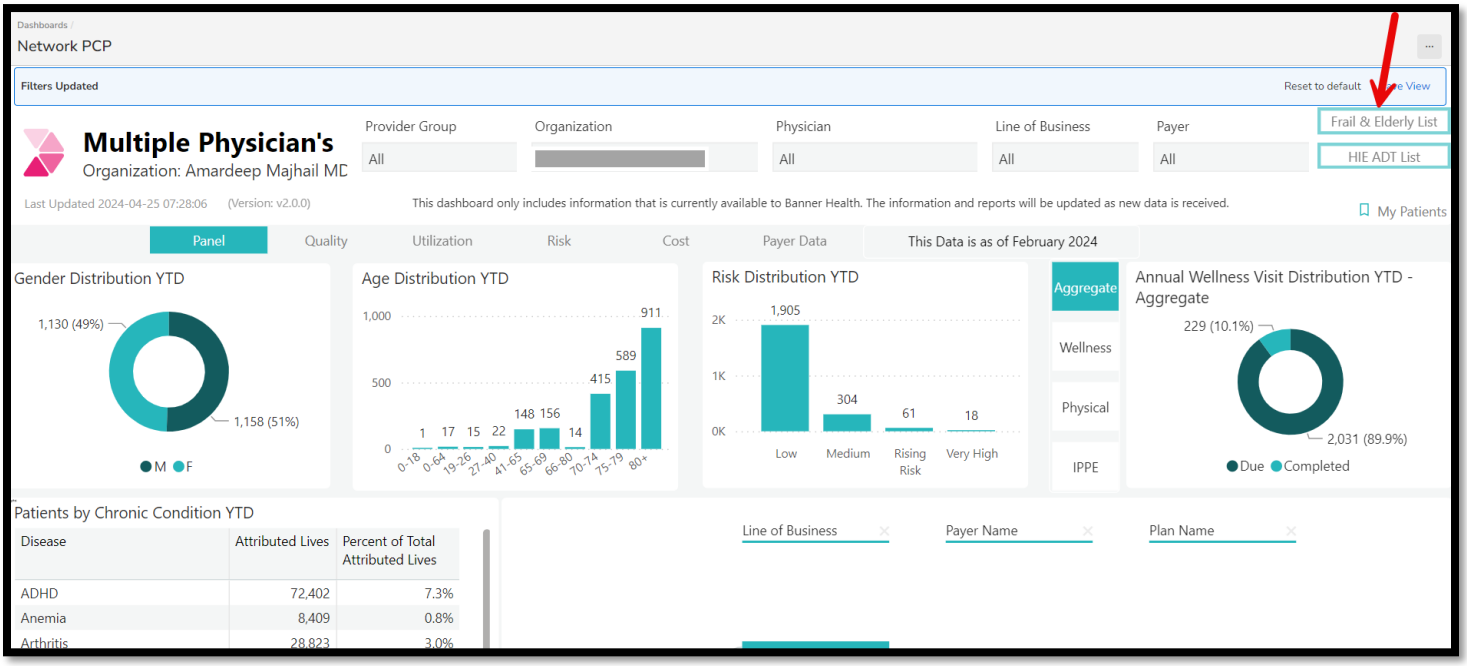
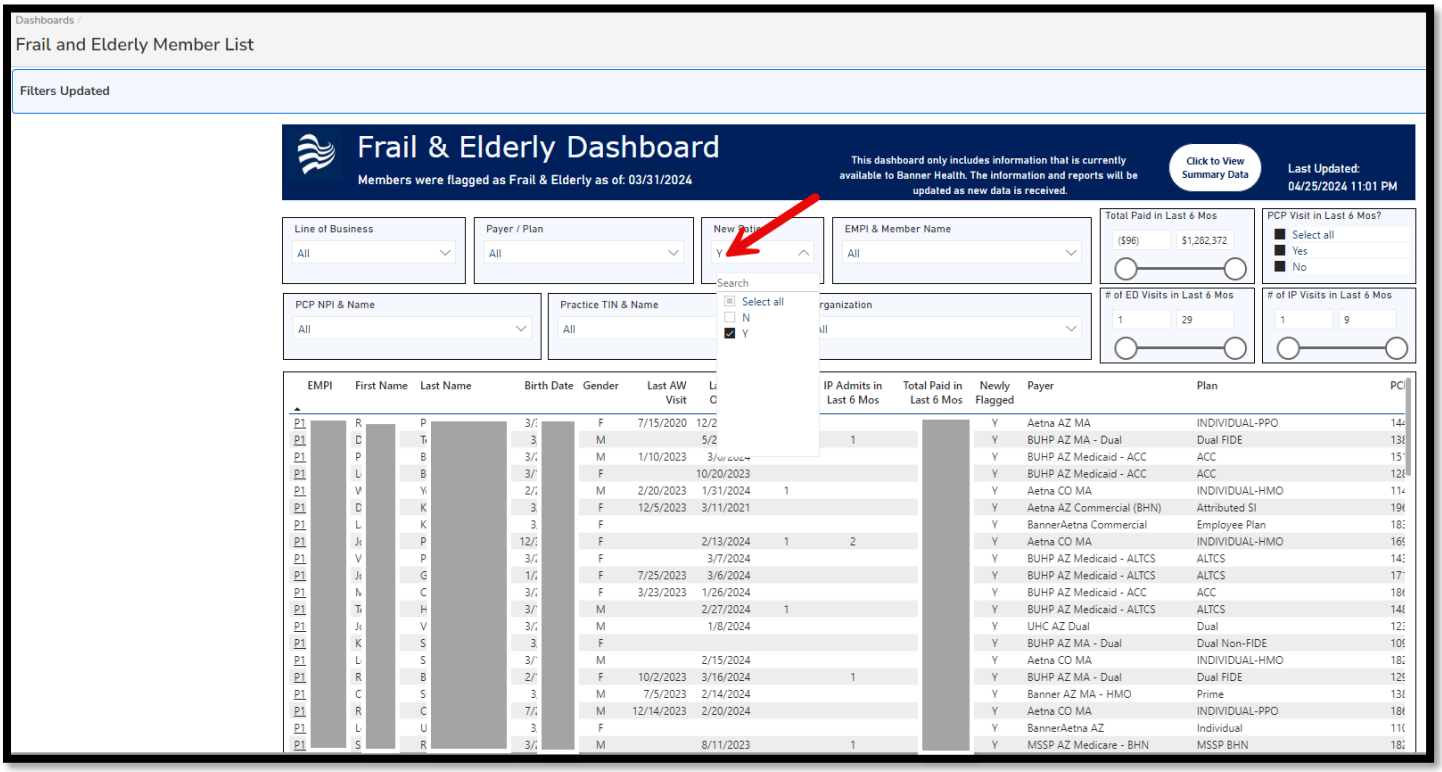
Innovaccer—InNote & InGraph

Pull Frail & Elderly patient list from Innovaccer

- Select **Frail & Elderly List** in Network PCP Dashboard:



- Default to **All** under **New Patient section** or select **Y** to pull new patients only:



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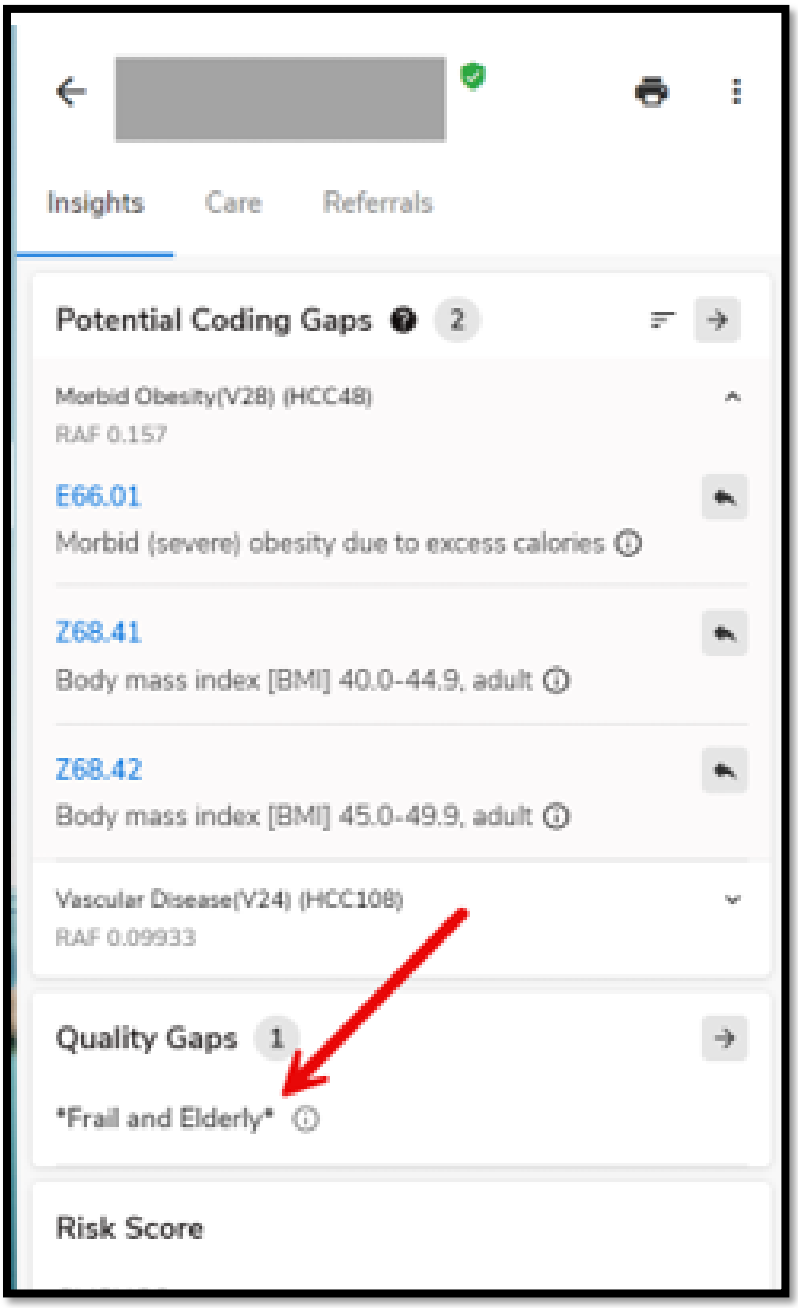
Identify Frail & Elderly patients in InNote

- Frail & Elderly patients will be identified under Quality Gaps:



Social Determinants of Health (SDoH)

Identifying and Addressing Social Determinants of Health

An SDoH screening tool is a questionnaire that gathers data from patients, providing insight into which patients might need support with a specific social need and the level of that need. See example below:

Section 1: Social Need Screening

1. Are you worried about losing your housing?
   ☐ Yes ☐ No
2. 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?
   ☐ Childcare ☐ Utilities (heating/cooling) ☐ Utilities (water)
   ☐ Utilities (electricity) ☐ Clothing ☐ Food
   ☐ Phone ☐ Medicine or any health care ☐ Other _____
   ☐ None ☐ I choose not to answer this question
3. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?
   ☐ Yes, kept from getting to medical appt/getting medications
   ☐ Yes, kept from non-medical meetings, work or necessities
   ☐ No ☐ Other ☐ I choose not to answer this question
4. How often do you see or talk to people you care about and feel close to? (For example, talking to friends on the phone or visiting friends or family, going to church or club meeting.)
5. ☐ Less than once a week ☐ 1 or 2 times a week 3 to 5 times a week
   ☐ More than 5 times a week ☐ I choose not to answer this question

Section 2: Intervention Summary (select all that apply)

☐ No interventions needed at this time (no risk factors identified)
☐ Referred to CM/CM to address
☐ Referred to community programs
☐ Notes: _____

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Frailty – Star Measure Exclusion Criteria

An exclusion will remove a member from the measure denominator based on information captured on claims, encounter, pharmacy and/or enrollment data. A "Frailty with Advanced Illness Exclusion" is applicable for members ages 66 and older as of Dec. 31 of the measurement year with frailty and advanced illness during the measurement year.

- Claims with Advanced Illness diagnosis on two different dates of service in the prior year or measurement year (link to Advanced Illness codes)
  AND
- Claim with Frailty encounter (CPT/HCPCS) or Frailty indicator (ICD10) in the measurement year (link to Frailty codes)

Exclusions for hospice, palliative care, advanced illness, frailty, and long-term nursing home residence exclusions are specified in HEDIS measures where the services being captured may not be of benefit for this population or may not be in line with patients' goals of care.

- The below exclusions are calculated by the software based on administrative data. Supplemental or medical record data may not be used for these exclusions
  - FRAILTY: Members ages 81 and older as of Dec. 31 of the measurement year who had a diagnosis of frailty in the measurement
  - FRAILTY AND ADVANCED ILLNESS: Members 66 years of age and older as of Dec. 31 of the measurement year (all product lines) with frailty and advanced illness. Members must meet BOTH of the following frailty and advanced illness criteria to be excluded:
    - Frailty: At least two indications with different dates of service during the measurement year
    - Advanced illness is indicated by one of the following:
    - Two or more outpatient, observation, emergency (ER) or non-acute inpatient encounters or discharges on separate dates of service with a diagnosis of advanced illness
    - One or more acute inpatient encounter(s) with a diagnosis of advanced illness
    - One or more acute inpatient discharge(s) with a diagnosis of advanced illness on the discharge claim
    - NOTE: Advanced illness diagnosis must occur in the measurement year or year prior
    - Dispensed a dementia medication: Donepezil, Galantamine, Rivastigmine, Memantine or Donepezil-memantine
    - Long Term Care: Medicare members ages 66 and older as of Dec. 31 of the measurement year who are either:
      - Enrolled in an Institutional Special Needs Plan (I-SNP)
      - Living long term in an institution
  - HEDIS Measures and Qualifying Exclusions

Exclusion	Measure
Patients aged 66 and older with both advanced illness and frailty	Breast Cancer Screening (BCS) Colorectal Cancer Screening (COL) Hemoglobin A1c Control for Patients with Diabetes (HBD) Eye Exam for Patients with Diabetes (EED) Kidney Health Evaluation for Patients with Diabetes (KED) Blood Pressure Control for Patients with Diabetes (BPD) Statin Therapy for Patients with Diabetes (SPD) Statin Therapy for Patients with Cardiovascular Disease (SPC) Use of Imaging Studies for Low Back Pain (LBP)

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Exclusion	Measure
Patients aged 66-80 with both advanced illness and frailty	Controlling Blood Pressure (CBP)
Patients aged 67-80 with both advanced illness and frailty	Osteoporosis Management in Women Who Had a Fracture (OMW)
Patients aged 81 and older with frailty alone	Controlling Blood Pressure (CBP) Osteoporosis Management in Women Who Had a Fracture (OMW)

Frailty Coding

Coding for a Frailty Encounter[viii] & [ix]:

Code Type	Code	Brief Description
CPT®	99504	Home visit for mechanical ventilation care
CPT®	99509	Home visit for assistance with activities of daily living and personal care
HCPCS	G0162	Skilled services by a registered nurse (RN) in the delivery of management & evaluation of the plan of care; each 15 minutes
HCPCS	G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting; each 15 minutes
HCPCS	G0300	Direct skilled nursing services of a licensed practical nurse (LPN) in the home health or hospice setting; each 15 min.
HCPCS	G0493	Skilled services of a registered nurse (RN) for the observation and assessment of the patient's condition; each 15 min (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting)
HCPCS	G0494	Skilled services of a licensed practical nurse (LPN) for the observation and assessment of the patient's condition; each 15 min (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting)
HCPCS	S0271	Physician management of patient home care; hospice monthly case rate (per 30 days)
HCPCS	S0311	Comprehensive management and care coordination for advanced illness per calendar month
HCPCS	S9123	Nursing care, in the home; by registered nurse (RN); per hour (use for general nursing care only, not to be used when CPT codes 99500-99602 can be used)
HCPCS	S9124	Nursing care, in the home; by licensed practical nurse (LPN); per hour
HCPCS	T1000	Private duty/independent nursing service(s); licensed; up to 15 minutes
HCPCS	T1001	Nursing assessment/evaluation
HCPCS	T1002	Registered nurse (RN) services; up to 15 minutes
HCPCS	T1003	Licensed practical nurse (LPN) /licensed vocational nurse (LVN) services; up to 15 minutes
HCPCS	T1004	Services of a qualified nursing aide; up to 15 minutes

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Healthcare Common Procedure Coding System

HCPCS Codes	Brief Description
T1005	Respite care services; up to 15 minutes
T1019	Personal care services; per 15 minutes, not for inpatient or resident of hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)
T1020	Personal care services; per diem, not for inpatient or resident of hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)

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HCPCS Codes	Brief Description
T1021	Home health aide or certified nurse assistance; per visit
T1022	Contracted home health agency services; all services provided under contract, per day
T1030	Nursing care, in the home, by registered nurse (RN); per diem
T1031	Nursing care, in the home, by licensed practical nurse (LPN); per diem

ICD-10 Frailty Coding:

ICD-10 Codes	Description	ICD-10 Codes	Description
L89.xxx	Pressure ulcer	Y92.199	Unspecified place in other specified residential institution as the place of occurrence of the external cause
M62.50	Muscle wasting and atrophy, not elsewhere classified, unspecified site	Z59.3	Problems related to living in residential institution
M62.81	Muscle weakness (generalized)	Z73.6	Limitation of activities due to disability
M62.84	Sarcopenia	Z74.01	Bed confinement status
R26.2	Difficulty in walking, not elsewhere classified	Z74.09	Other reduced mobility
R26.89	Other abnormalities of gait and mobility	Z74.1	Need for assistance with personal care
R53.1	Weakness	Z74.2	Need for assistance at home and no other household member able to render care
R54	Age-related physical debility	Z74.3	Need for continuous supervision
R62.7	Adult failure to thrive	Z74.8	Other problems related to care provider dependency
R63.4	Abnormal weight loss	Z74.9	Problem related to care provider dependency, unspecified
R63.6	Underweight	Z91.81	History of falling
R64	Cachexia	Z99.11	Dependence on respirator [ventilator] status
W01.0XXA	Fall on same level from slipping, tripping and stumbling without subsequent striking against object, initial encounter	Z99.3	Dependence on wheelchair
W19.XXXA	Unspecified fall, initial encounter	Z99.81	Dependence on supplemental oxygen
W19.XXXD	Unspecified fall, subsequent encounter	Z99.89	Dependence on other enabling machines and devices
W19.XXXS	Unspecified fall, sequela		

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Advanced Illness Coding

ICD-10 Advanced Illness Coding:

ICD-10 Codes	Description	ICD-10 Codes	Description
A81.-	Creutzfeldt-Jakob disease	C79.7-	Secondary malignant neoplasm adrenal gland
C25.-	Malignant neoplasm of pancreas	C79.81	Secondary malignant neoplasm breast
C71.-	Malignant neoplasm of brain	C79.89	Secondary malignant neoplasm other specified sites
C77.-	Secondary and unspecified malignant neoplasm of lymph nodes	C79.9	Secondary malignant neoplasm unspecified site
C78.0-	Secondary malignant neoplasm lung	C91.0-	Acute lymphoblastic leukemia [ALL]
C78.1	Secondary malignant neoplasm of mediastinum	C92.0-	Acute myeloblastic leukemia
C78.2	Secondary malignant neoplasm of pleura	C93.0-	Acute monoblastic/monocytic leukemia
C78.3-	Secondary malignant neoplasm respiratory organ other, unspecified	C93.9-	Monocytic leukemia, unspecified
C78.4	Secondary malignant neoplasm small intestine	C93.Z0	Other monocytic leukemia, not having achieved remission
C78.5	Secondary malignant neoplasm large intestine and rectum	C93.Z2	Other monocytic leukemia, in relapse
C78.6	Secondary malignant neoplasm retroperitoneum and peritoneum	C94.3-	Mast Cell Leukemia
C78.7	Secondary malignant neoplasm liver and intrahepatic bile duct	F01.5-	Vascular dementia
C78.8-	Secondary malignant neoplasm digestive organ, other and unspecified	F02.80	Dementia in other diseases classified elsewhere without behavioral disturbance
C79.0-	Secondary malignant neoplasm kidney and renal pelvis	F02.81	Dementia in other diseases classified elsewhere with behavioral disturbance
C79.1-	Secondary malignant neoplasm urinary organs, other and unspecified	F03.90	Unspecified dementia without behavioral disturbance
C79.2	Secondary malignant neoplasm skin	F03.91	Unspecified dementia with behavioral disturbance
C79.3-	Secondary malignant neoplasm brain and meninges	F04	Amnestic disorder due to known physiological condition
C79.4-	Secondary malignant neoplasm nervous system, other and unspecified	F10.27	Alcohol dependence with alcohol-induced persisting dementia
C79.5-	Secondary malignant neoplasm bone and bone marrow	F10.96	Alcohol use, unspecified with alcohol-induced persisting amnestic disorder
C79.6-	Secondary malignant neoplasm ovary	F10.97	Alcohol use, unspecified with alcohol-induced persisting dementia

ICD-10 Codes	Description	ICD-10 Codes	Description
C79.7-	Secondary malignant neoplasm adrenal gland	F10.97	Alcohol use, unspecified with alcohol-induced persisting dementia
C79.81	Secondary malignant neoplasm breast	G10	Huntington's disease
C79.89	Secondary malignant neoplasm other specified sites	G12.21	Amyotrophic lateral sclerosis [ALS]
C79.9	Secondary malignant neoplasm unspecified site	G20.-	Parkinson's disease
C91.0-	Acute lymphoblastic leukemia [ALL]	G30.0-	Alzheimer's disease
C92.0-	Acute myeloblastic leukemia	G31.0-	Frontotemporal dementia
C93.0-	Acute monoblastic/monocytic leukemia	G31. 83	Neurocognitive disorder with Lewy bodies
C93.9-	Monocytic leukemia, unspecified	I09.81	Rheumatic heart failure
C93.Z0	Other monocytic leukemia, not having achieved remission	I11.0	Hypertensive heart disease with heart failure
C93.Z2	Other monocytic leukemia, in relapse	I12.0	Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end-stage renal disease
C94.3-	Mast Cell Leukemia	I13.0	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
F01.5-	Vascular dementia	I13.11	Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease, or end-stage renal disease
F02.80	Dementia in other diseases classified elsewhere without behavioral disturbance	I13.2	Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end-stage renal disease
F02.81	Dementia in other diseases classified elsewhere with behavioral disturbance	I50.-	Heart failure
F03.90	Unspecified dementia without behavioral disturbance	N18.5	Chronic kidney disease, stage 5
F03.91	Unspecified dementia with behavioral disturbance	N18.6	End-stage renal disease
F04	Amnestic disorder due to known physiological condition	J43.-	Emphysema
F10.27	Alcohol dependence with alcohol-induced persisting dementia	J68.4	Chronic respiratory conditions due to chemicals, gases, fumes and vapors
F10.96	Alcohol use, unspecified with alcohol-induced persisting amnestic disorder	J84.10	Pulmonary fibrosis, unspecified

ICD-10 Codes	Description	ICD-10 Codes	Description
J84.10	Pulmonary fibrosis, unspecified	K74.0	Hepatic fibrosis
J84.112	Idiopathic pulmonary fibrosis	K74.1-	Hepatic sclerosis
J84.17-	Other interstitial pulmonary diseases with fibrosis in diseases classified elsewhere	K74.2	Hepatic fibrosis with hepatic sclerosis
J96.1-	Chronic respiratory failure	K74.4	Secondary biliary cirrhosis
J96.2-	Acute and chronic respiratory failure	K74.5	Biliary cirrhosis, unspecified
J98.2	Interstitial emphysema	K74.6-	Unspecified cirrhosis of liver
J98.3	Compensatory emphysema		

Banner Plans & Networks

Advanced Illness & Frailty Pocket Guide

Billing Criteria

Claims with advanced illness diagnosis on two different dates of service in the prior year or measurement year and two diagnoses of frailty claims on different dates in the measurement year, as well as measure-specific ages. Codes must be billed in the measurement year or the year prior to exclude the patient from the star measures.

Metric Exclusion Criteria

CBP	COL	HBD
66-80yo + Advanced Illness + Frailty Indicator **OR** ≥81yo + Frailty Indicator	≥66yo + Advanced Illness + Frailty Indicator	≥66yo + Advanced Illness + Frailty Indicator

BCS	SPC	OMW
≥66yo + Advanced Illness + Frailty Indicator	≥66yo + Advanced Illness + Frailty Indicator	≥67-80yo + Advanced Illness + Frailty Indicator **OR** ≥81yo + Frailty Indicator

These guidelines serve to assist in the management, documentation, and coding of clinical diagnoses. The intent of this document is to supplement, but not replace, the provider's clinical judgement.

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Common Frailty Indicator*	Advanced Illness*
Limitation of activities due to disability (Z73.6)	Alzheimer's Disease (G30.0, G30.1, G30.8, G30.9)
Difficulty in walking (R26.2)	Dementia (F01.50)
Muscle weakness/Weakness (M62.81/R53.1)	Parkinson's disease (G20)
Age related physical debility (R54)	Heart Failure to include (150.9 - pre-CHF)
History of fall (Z91.81)	CKD Stage 5 (N18.5)
Other Fatigue (R53.83)	End Stage Renal disease (N18.6)
Other Malaise (R53.81)	Emphysema (J43.0)
Age related cognitive decline (R41.81)	Leukemias (C91-94)
Underweight (R63.6)	Respiratory failure (J96.11)
Pressure ulcers (L89.0-9)	Pulmonary Fibrosis (J84.10)
Abnormalities of gait/mobility (R26.89)	Alcoholic Hepatic disease/cirrhosis (K70.30)
Muscle wasting/atrophy (M62.50)	Unspecified cirrhosis of liver (K74.60)
Dependence of supplemental oxygen (Z99.81)/Use of oxygen (E0424)	Pressure ulcers (L89.0-9)
Dependence on wheelchair (Z99.3)/Use of wheelchair (E1130)	Malignant neoplasm of pancreas (C25.0-4)
Use of a cane (E0100)/Use of a walker(E0130)	Malignant neoplasm of brain (C71.0-9)
Use of commode chair (E0163)	Almost all secondary malignant neoplasms (C77-79)
Use of hospital bed (E0250)	Acronyms BCS: Breast Cancer Screening CBP: Controlling Blood Pressure COL: Colorectal Cancer Screening HBD: Hemoglobin A1c Control OMW: Osteoporosis Management SPC: Statin Use
Physician management of patient home care (S0271)	
Management and coordination for advanced illness (S0311)	
Limitation of activities due to disability (Z73.6)	

**Codes provided are not all inclusive.*

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Palliative Care Providers

Palliative Care			LOB								
Provider Name	**Webpage**	**Service Areas**	Banner MA HMO/PPO	Banner MA DUAL	Aetna MA	BCBS MA	UHC MA	Humana MA	BUHP ACC	BUHP ALTCS	Banner Aetna
Geriatric Solutions 602-954-0444 1510 E Flower St. Phoenix, AZ 85014	www.geriatricsolutions.org	Phoenix Metro		x					x	x	
Doctor Care 480-575-057 7010 E Acoma Drive Ste 102 Scottsdale, AZ 85254	https://doctorcareaz.com/about.php	Phoenix Metro	x	x					x	x	
Casa de la Luz (formerly East Valley Palliative Care) 480-801-2416 2152 S Vineyard Ste 118 Mesa, AZ 85210	www.lhcgroup.com	Phoenix Metro					x	x			
Arizona Supportive Care by Hospice of the Valley 602-530-6900 1510 E Flower St. Phoenix, AZ 85014	www.hov.org	Phoenix Metro		x		x	x		x	x	
Sage Primary & Palliative Care 480-771-3400 3030 N Central Ave Ste 1200 Phoenix, AZ 85012	www.sagefoc.com	Maricopa, Pinal & Pima	x	x					x	x	x
Frances E Davison DBA Southwestern Palliative Cre 928-366-1067 1950 W 3rd St Yuma, AZ 85364	www.swpchospice.com	Yuma	x	x					x	x	x
Wings of Hope 602-971-0304 11022 N 28th Drive Ste 205 Phoenix AZ 85029	https://wohhospice.com/	Phoenix Metro							x	x	
Harmony Hospice of Tucson 520-284-9334 310 S. Williams Blvd STE 210 Tucson AZ 85715	https://www.harmonyhospice.org/	Tucson	x	x					x	x	
Eternity Hospice & Palliative 602-374-68781 4122 W McDowell Rd # 204 Goodyear, AZ 85395	www.eternityhospicepalliativecare.com	Phoenix Metro	x	x					x	x	
Savior Palliative Care 480-320-4733 4530 E Shea Blvd Ste 175 Phoenix, AZ 85028	www.saviorhospice.org	Phoenix Metro			x						

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Home Care Providers

Home Providers											
Provider Information	**Webpage**	**Service Areas**	**Banner MA HMO/PPO**	**Banner MA DUAL**	**Aetna MA**	**BCBS MA**	**UHC MA**	**Humana MA**	**BUHP ACC**	**BUHP ALTCS**	**Banner Aetna**
My Doctor Now 480-677-4663 Multiple Locations	www.mydrnow.com	Phoenix Metro		X			X				
Curana Health - Previously The Doctor Is In 480-626-6318 1610 W Glendale Rd Phoenix, AZ 85021	www.curanahealth.com	Phoenix Metro	X	X				X			
ASAP Health Solutions 602-996-5595 29455 N Cave Creek Rd #118 Cave Creek, AZ 85331	www.asaphealthsolutions.com	Phoenix Metro		X							
Southwest Geriatric 520-314-3412 6890 E Sunrise Dr Tucson, AZ 85750Tucson	www.swgeriatrics.com	Tucson	X	X					X	X	
Dispatch Health Urgent Care at Home 480-351-3918 Multiple locations	www.dispatchhealth.com	Phoenix Metro	X	X			X		X	X	

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References

References

Coding references:

2024 ICD-10-CM Coding Book

2024 CPT Coding Book

2024 HCPCS Coding Book

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[ii] Caring for High-Need, High-Cost Patients — An Urgent Priority | New England Journal of Medicine (nejm.org)
[iii] 2024 ICD-10-CM Coding Book
[iv]https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4938678/#:~:text=Similarly%2C%20oncology%20health%20care%20professionals,as%20a%20barrier%20to%20referral.&text=In%20response%20to%20these%20findings,themselves%20as%20supportive%20care%20services
[v] https://www.medpagetoday.com/opinion/second-opinions/108848
[vi] https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines/frailty#Scope
[vii] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6611671/
[viii] 2024 CPT Coding Book
[ix] 2024 HCPCS Coding Book