OPNS Advanced Illness and Frailty Webinar
Questions and Answers

What is the overall purpose of understanding and coding for advanced illness and frailty?

- To be able to identify and remove patients from various quality measures, such as blood pressure, colonoscopy, HgB A1C, when clinically appropriate so the patients are not counted 'against your score'

Since we are very busy in the office, we need some type of cheat sheet that will help us identify patients as we see them for appointments. Can we have a one-pager of something along those lines?

- Yes, I have a cheat sheet created that I will plan to share along with the presentation. There are 3-4 codes that are most used when coding for frailty. The frailty codes are the most common codes that are missing when trying to remove patients from your numbers

It's important to note that CMS, Centers for Medicaid and Medicare, came up with these codes back in 2018 or 2019 and once my providers were aware of these codes, our performance scores increased significantly once they were implemented and coded correctly.

Advanced Illness and frailty codes must be submitted on claims. It cannot be reported to the health payers by supplemental data.

Does this affect individual providers' incentives? Or does it affect incentives at a practice level?

- These codes aren't directly tied to an incentive per se, but it also depends on the contract you have with the particular payer. If you are participating in a full risk model, through Honest Health, for example, when you use these codes, you are removing them from your denominator and your quality score may improve as an individual provider, but full risk means taking everything else into consideration, like readmissions, and your performance will be at the practice and PO level. Other contracts may be a fee for service, you are being incentive based on the individual providers quality score

To be clear, with these codes for advanced illness and frailty, it means that patients don't need regular eye exams, urine analysis, HgB A1C's under 8%, etc.?

- Yes, but only if it's a Medicare patient who is 66 or older, and they meet the criteria for **both** frailty and advanced illness it will remove them from that particular measure. So that could include blood pressure control, breast cancer screening, colorectal screening, HgB A1C, KED, diabetic eye exams

Can you clarify why these codes are pertinent to specialists? Specifically, cardiologists? It seems to be more geared toward primary care providers, but this was mandatory for specialists?

- This pertains to cardiologists from a blood pressure perspective
- This webinar was made mandatory for specialists who may have an impact on quality scores. This includes, cardiologists, gastroenterologists, endocrinologists, etc. Health payers loot at the last

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Questions and Answers

A1C reading of the year and the last blood pressure reading of the year. This all ties into how we perform as a network. Specialists' value-based care (VBR) uplifts are directly tied to how our primary care providers (PCP's) perform. The VBR for specialists will change every spring and PCP's will change every fall.

- It's important that specialists who can have a direct impact on quality understand that they can also report advanced illness and frailty codes on claims when appropriate

To clarify, we are just talking about a small population of patients, those age 66 and older, correct? Because if I'm seeing my typical 80-year old patient in the office, I'm not going to worry about them being in the colonoscopy or mammogram denominator.

- Yes, but if the patient is still diabetic, they will still be in your 'diabetic' denominator-A1C, diabetic eye exam, KED, etc.

So, you're saying, once they hit 80, preventative measures are no longer necessary because of age?

- Correct

So, they wouldn't be counted in the denominator if they aged out as long as I document that?

- Right, I do have a one-pager that reviews what preventative care screenings patients can age out of, but they are still included in denominators such as blood pressure, KED, osteoporosis, etc.

What happens if you only see them once in a year and not twice?

- They would remain in your denominator

Do the codes have to come from the same provider or can two different providers code for frailty if it's within the same year?

- No, the codes do not have to come from the same provider. It's all based on claims.
- That is why it's so important that specialists understand why these codes are so important. If a patient comes to see a cardiologist, and they code that the patients is in a wheelchair, and then the patients goes to see their PCP and they also code that they are in a wheelchair, that counts as two different dates of service within the calendar year.

What is the significance between two vs one?

- It's the criteria that CMS came up with.
- Two frailty codes are needed within the same measurement year. So if the patient only has one frailty code, they met the advanced illness code, they are still missing one frailty code so they will remain in the denominator

Oakland Physician Network Services

OPNS Advanced Illness and Frailty Webinar
Questions and Answers

Is there a frailty sheet that can be provided to the providers on a quarterly basis just like we receive sheets on chronic conditions that we need to code for on an annual basis? Can one be provided so we know which frailty codes can be or used to be captured?

- Not currently, however, it's important to note that the best way to capture these potential codes is to focus on your annual wellness visits. During these visits, you will review functional status with your Medicare population. Since it's the beginning of 2026, you should focus on your non-compliant patients who were not seen in 2025. Your OPNS contact should have sent you a list of non-compliant patients. Focus on your Medicare patients regardless of insurance, straight Medicare, Humana Medicare, Blue Cross Medicare, etc.
- You can run a report on high-risk patients on HealthFocus that will indicate who could be a good candidate for these codes. The higher the patients risk score, the more likely they are to be re-admitted to the hospital.

It was suggested during the call to add a line item to an annual wellness checklist regarding frailty to remind the providers about the frailty and advanced illness codes.

What codes in paid claims are flagging that the patient has an advanced illness or frailty code?

- Mostly diagnosis codes that are associated with Z-Codes. A copy of the presentation and frailty ICD 10 codes will be emailed out to the network

If you have a patient that meets both criteria and they end up being excluded for the year, is it safe to say that they are put back in the denominator again the following year, or once they meet criteria they are off for good? Specifically for the patients who are not going to age out.

- Yes, they will be put back in the denominator the following year. They need to have two frailty codes submitted every year

It would take a bit of work, but if you are tracking the patients who are excluded, you will just have to make sure to code them correctly the following year. Once you start coding for those patients appropriately, it should be easier to track moving forward.

- OPNS will work with HealthFocus to potentially display advanced illness and frailty codes and to indicate them somehow. However, it's important to note that HealthFocus will not be able to display any associated codes until the codes have been submitted on previous claims. Therefore, if the codes are initiated this year (2026) on claims, we can potentially show them on claims in 2027.

This is a lot of work; we're wearing so man different hats. Isn't this something a care manager can do?

- Yes, exactly. This is why we keep talking about care managers and how important they can be for our providers within our network

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OPNS Advanced Illness and Frailty Webinar
Questions and Answers

Can a care manager help with these codes?

- Yes

What about those patients who live in a long term care facility long term? They go back to the hospital, home, back to the hospital, back to SNF, they will still be attributed and counted against the provider?

- If they are 66 years and/or older they will be excluded from your attribution because they are enrolled in an institution as a long-term care resident. The health payers will know this based on claims they receive from the facility. Typically patients are enrolled at the facility for at least 90-days.

How are dementia medications captured?

- It is captured through pharmacy claims when the patient fills the prescription