



Learn How to Improve Your HEDIS¹ Rates for the Care for Older Adults Measure

Use this tip sheet to review key details of the Care for Older Adults (COA) measure, exclusions, billing codes, forms, documentation required and best practices.



Measure

This measure assesses the percentage of adults 66 years of age and older who had each of the following documented during the measurement year:

- 1. Medication review.**
- 2. Functional status assessment.**
- 3. Pain assessment.**

Screening of elderly patients is effective in identifying functional decline. This measure ensures that older adults receive the care they need to optimize quality of life.

Exclusions

Patients who meet any of the following criteria are excluded from the measure:

- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year.
- Patients who die any time during the measurement year.

Codes

Use the appropriate service codes when billing for COA

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Medication review

Service type	Codes
Medication review	CPT: 90863, 99483, 99605, 99606 CPT-CAT-II: 1160F
Medication list	CPT-CAT-II: 1159F* HCPCS: G8427
Transition care management services	CPT: 99495, 99496

*Note: Need either medication review or transitional care management services, PLUS medication list code.

¹ HEDIS: Healthcare Effectiveness Data and Information Set.

Codes

Continued,

Functional status assessment

Service type	Codes
Functional status assessment	CPT: 99483 CPT-CAT-II: 1170F HCPCS: G0438, G4439

Pain assessment

Service type	Codes
Pain assessment	CPT-CAT-II: 1125F (pain present) 1126F (no pain present)

Forms

Use a standardized template or assessment form to capture COA components. Providers may use the Annual Care for Older Adults form, available online at www.wellcare.com > California > Providers > Medicare > Quality > HEDIS Measures & Billing Codes.

Documentation required and best practices:

Medication Review

- Documentation must come from the same medical record and must include one of the following:
 - A medication list in the medical record and evidence of a medication review by a prescribing practitioner or clinical pharmacist and the date it was performed.
 - Notation that the member is not taking any medication and the date it was documented.
- A review of side effects for a single medication at the time of prescription alone is not enough. An outpatient visit is not required to meet criteria.
- Medication review conducted in an acute inpatient setting will not meet compliance.

Functional Status Assessment

- Documentation must include evidence of a complete functional status assessment and the date it was performed.
- Notations for a complete assessment must include one of the following:
 - Notation of Activities of Daily Living (ADL) or at least five of the following were assessed:
 - Bathing.
 - Dressing.
 - Eating.
 - Transferring [e.g., getting in and out of chairs].
 - Using toilet.
 - Walking.
 - Notation of Instrumental Activities of Daily Living (IADL) or at least four of the following were assessed:
 - Cooking or meal preparation.
 - Driving or using public transportation.
 - Handling finances.
 - Home repair.
 - Housework.
 - Laundry.
 - Shopping for groceries.
 - Taking medications.
 - Using the phone.

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Functional Status Assessment
Continued,

- Assessment results using a functional status assessment tool:
 - Assessment of Living Skills and Resources.
 - Barthel ADL Index Physical Self-Maintenance Scale.
 - Barthel Index.
 - Bayer ADL Scale.
 - Edmonton Frail Scale.
 - Extended ADL Scale.
 - Groningen Frailty Index.
 - Independent Living Scale.
 - Katz Index of Independence in ADL.
 - Kenny Self-Care Evaluation.
 - Klein-Bell ADL Scale.
 - Kohlman Evaluation of Living Skills .
 - Lawton & Brody’s IADL scales.
 - Patient Reported Outcome Measurement Information System Global or Physical Function Scales.
 - SF-36[®].

- A functional status assessment limited to an acute or single condition, event or body system (e.g., lower back, leg) does not meet criteria for a comprehensive functional status assessment.
- The components of the functional status assessment numerator may take place during separate visits within the measurement year.
- Functional status assessment conducted in an acute inpatient setting will not meet compliance.
- Telehealth visits are acceptable to meet this numerator.

Pain Assessment

- Documentation must include evidence of a pain assessment and the date it was performed. Notations for a pain assessment must include one of the following:
 - Documentation that the patient was assessed for pain (which may include positive or negative findings for pain).
 - Assessment results using a pain assessment tool:
 - Brief Pain Inventory[®].
 - Chronic pain grade.
 - Face, legs, activity, cry consolability scale[®].
 - Numeric rating scales (verbal or written).
 - Pain assessment in advanced dementia scale.
 - Pain thermometer.
 - Pictorial pain scales (Faces Pain Scale, Wong-Baker Faces Pain Scale^{® 2}).
 - PROMIS Pain Intensity Scale[®].
 - Verbal descriptor scales (5–7 word scales, present pain inventory).
 - Visual analogue scale.
- Documentation of pain management or pain treatment plan alone does not meet numerator criteria.
- A pain assessment conducted in an acute inpatient setting will not meet compliance.
- Screening or documentation of chest pain alone does not meet criteria.
- A pain assessment related to a single body part, except for chest, meets compliance.
- A pain assessment may be conducted with the member in various manners (phone, in person, virtually, etc.) and is not limited to being completed by clinicians.

²Proprietary; cost or licensing requirement may be associated with use.