**HEDIS® Tip Sheet**

Effectiveness of Care Measure

wellcare By health net

# Learn How to Improve Your HEDIS[1] 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 documentation during the measurement year. 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.

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

## Exclusions

Patients who meet the following criteria:

- Enrolled in hospice or using hospice services during the measurement year.
- Died during the measurement year.

## Codes

### Use the appropriate service codes when billing for COA



### Medication review

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

*Note: Need both Medication Review/Transition Care Management Services AND Medication List code.

[1]HEDIS: Healthcare Effectiveness Data and Information Set.

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**Codes**
*Continued,*

**Functional status assessment**

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

**Pain assessment**

| Service type | Codes |
|---|---|
| Pain assessment | CPT-CAT-II:<br>1125F (pain present)<br>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 in the Provider Library on Health Net's provider portal at provider.healthnetcalifornia.com > *Provider Library under Forms and References*, or go directly to providerlibrary.healthnetcalifornia.com.

**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 telephone.

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**Functional Status Assessment** *Continued,*

- Assessment results using a functional status assessment tool:
  - Assessment of Living Skills and Resources (ALSAR).
  - Barthel ADL Index Physical Self-Maintenance (ADLS) Scale.
  - Barthel Index.
  - Bayer ADL (B-ADL) Scale.
  - Edmonton Frail Scale.
  - Extended ADL (EADL) Scale.
  - Groningen Frailty Index.
  - Independent Living Scale (ILS).
  - Katz Index of Independence in ADL.
  - Kenny Self-Care Evaluation.
  - Klein-Bell ADL Scale.
  - Kohlman Evaluation of Living Skills (KELS).
  - Lawton & Brody's IADL scales.
  - Patient Reported Outcome Measurement Information System (PROMIS) 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 (FLACC) scale.
    - Numeric rating scales (verbal or written).
    - Pain assessment in advanced dementia (PAINAD) scale.
    - Pain thermometer.
    - Pictorial pain scales (faces pain scale, Wong-Baker pain scale).
    - 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.