HEDIS Hints

Care for Older Adults (COA)

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- What is NCQA's Care for Older Adults (COA) of Measure?
- Examples of Best Practices Documentation
- Coding to Improve this HEDIS Measure
- Questions

What is NCQA's COA Measure?

- The COA measures the percentage of adults 66 years of age and older who had each of the following during the Measurement Year (MY):
  - Medication Review
  - Functional Status Assessment
  - Pain Assessment

- The look back period is January 1 through December 31 of the MY.

- This measure looks for the date of service the service was completed.
  - Each service may have a different date of service

What is NCQA's COA Measure?

- This measure is a hybrid measure, meaning it can come from chart review or codes submitted on claims.
- All services must be found in the same chart for the chart review.
- All documentation from a medical record must be dated and have a signature.
- Visits may be face-to-face, e-visit or telehealth.
- Exclusions are members in hospice anytime during the MY.

Medication Review

Medication Review: At least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record.

Documentation must come from the same medical record **and** must include **one** of the following:

- A medication list in the medical record; evidence of a medication review by a prescribing practitioner or clinical pharmacist; and the date when it was performed.
- Notation that the member is not taking any medication and the date when it was noted.

Functional Status Assessment

Functional Status Assessment: At least one functional status assessment during the measurement year, as documented through either administrative data or medical record review.

Documentation in the medical record must include evidence of a complete functional status assessment and the date when it was performed.

Notations for a complete functional status assessment must include one of the following:

- Notation that Activities of Daily Living (ADL) were assessed or that at least five of the following were assessed: bathing, dressing, eating, transferring (e.g., getting in and out of chairs), using toilet, walking.
- Notation that Instrumental Activities of Daily Living (IADL) were assessed or at least four of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, cooking or meal preparation, housework, home repair, laundry, taking medications, handling finances.
- Result of an assessment using a standardized functional status assessment tool

Functional Status Assessment

Some examples of standardized functional status assessment tools:

- Assessment of Living Skills and Resources (ALSAR)
- Barthel ADL Index Physical Self-Maintenance (ADLS) Scale
- Bayer ADL (B-ADL) Scale
- Barthel Index. (The Barthel Index)
- Edmonton Frail Scale
- Extended ADL (EADL) Scale
- Functional Independence Measure (FIM)
- Katz Index of Independence in ADL. (Katz Index of Independence in ADLs)
- Kenny Self-Care Evaluation
- Klein-Bell ADL Scale
- Kohlman Evaluation of Living Skills (KELS)
- Lawton & Brody's IADL scales (LAWTON - BRODY Instrumental Activities of Daily Living Scale (IADL))

Pain Assessment

Pain Assessment: At least one pain assessment during the measurement year, as documented through either administrative data or medical record review.

Documentation in the medical record must include evidence of a pain assessment and the date when 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)
- Documentation of the use of a standardized pain assessment tool such as:
  - Numeric rating scales (verbalized or written)
  - Pictorial Pain Scales (Wong-Baker Pain Scale, Faces Pain Scale)
- Pain assessment **cannot** be:
  - Chest pain alone
  - Taken from inpatient or Emergency Department notes

Examples of Best Practices Documentation

- Use the appropriate Codes for claims whenever possible.
- Conduct Medication Reviews at each visits.
- Utilize your Electronic Medical Records (EMR) medication list.
- Document at least annually that Activities of Daily Living (ADLs) have been assessed and issues have been addressed.
- Utilize the same standardized functional assessment tool consistently and if possible, incorporate it into the EMR system.
- Assess your patient for pain at every visit and document pain and/or the lack of pain.
- Always include the date an assessment was completed and a signature of the provider who completed or supervised the assessment.
- Remember that assessments completed in an inpatient, emergency department or an urgent care settings are **cannot** be used to satisfy this measure.

Coding to Improve this HEDIS Measure

- **CPT:**
  - Medication Review: 90863, 99486, 99605, 99606
  - Functional Status Assessment: 99483
- **CPT II:**
  - Medication Review: 1160F
  - Medication List: 1159F
  - Functional Statues Assessment: 1170F
  - Pain Assessment : 1125F, 1126F
- **HCPCS:**
  - Medication List: G8427
  - Functional Statues Assessment: G0438, G0439

References

- **Functional Status Assessments:**

  - Best Practices in Nursing Care to Older Adults, The Hartford Institute for Geriatric Nursing, New York University, College of Nursing, www.hartfordign.org.
  - Mahoney FI, Barthel D. “Functional evaluation: the Barthel Index.” Maryland State Med Journal 1965;14:56-61. Used with permission.

Questions?

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