Neighborhood Health Plan OF RHODE ISLAND™

910 Douglas Pike, Smithfield, RI 02917

HEDIS® CARE FOR OLDER ADULTS (COA) MEASURE CRITERIA

MEDICARE-MEDICAID PLAN (MMP)

Q: WHICH MEMBERS ARE INCLUDED IN THE SAMPLE?

A: Adults 66 years and older who had each of the following within the calendar year:

- ✓ Advance care planning
- ✓ Medication review
- ✓ Functional status assessment
- ✓ Pain assessment

Q: WHAT DOCUMENTATION IS NEEDED IN THE MEDICAL RECORD?

A:

- ✓ Advanced Care Planning – evidence must include either the presence of advanced care plan in the medical record or documentation of advance care planning discussion with the provider and the date when it was discussed.
- ✓ Evidence of Medication Review – must include medication list in the medical record, and evidence of a medication review and the date when it was performed or notation that the member is not taking any medication and the date when it was noted.
- ✓ Evidence of Functional Status Assessment – documentation must include evidence of functional status assessment and the date when it was performed.
- ✓ Evidence of Pain Assessment – documentation must include evidence of a pain assessment (may include positive or negative findings for pain) and the date when it was performed.

Q: WHAT TYPE OF MEDICAL RECORD IS ACCEPTABLE?

A: **Advance Care Planning**

- ✓ Advance Directives
- ✓ Actionable medical orders
- ✓ Copy of Living Wills
- ✓ Copy of documentation of surrogate decision maker
- ✓ Evidence of oral statements noted in the medical record in the calendar year

Medication Review

- ✓ Current medication list in the calendar year
- ✓ Notation of medication review in the calendar year
- ✓ Date and notation that the member is not taking any medication in the calendar year

Functional Status Assessment

- ✓ Progress notes, IHSS forms, HRA forms, AWE form
- ✓ Notation that Activities of Daily Living (ADL) were assessed or that at least 5 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 4 of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications, handling finances.
- ✓ Result of assessment using a standardized functional status assessment tool
- ✓ Notation of cognitive status, ambulation status, sensory ability (hearing, vision and speech) and, other functional independence (e.g., exercise).

Pain Assessment

- ✓ Progress notes – notation of a pain assessment (which may include positive or negative findings for pain)
- ✓ Result of assessment using a standardized pain assessment tool
- ✓ Numeric rating scales (verbal or written)
- ✓ Pain Thermometer
- ✓ Pictorial Pain Scales
- ✓ Visual analogue scale
- ✓ Brief Pain Inventory
- ✓ Chronic Pain Grade
- ✓ PROMIS Pain Intensity Scale
- ✓ Pain Assessment in Advanced Dementia (PAINAD) Scale

Q: HOW CAN WE IMPROVE OUR RATE FOR THIS HEDIS® MEASURE?

A:

- ✓ Use of complete and accurate Value Set Codes (see page 2)
- ✓ Timely submission of claims and encounter data
- ✓ Ensure complete and appropriate documentation in medical record

Care for Older Adults (COA) Assessment Codes and Descriptions

Measure	Code	Type	Description/Notes	Compliance Criteria
Advance Care Planning	99497	CPT	Advance care planning including the explanation and discussion of advance directives, including the use (and completion) of standard forms, by the physician or other qualified health care professional; first 30 minutes, face-to-face with patient, family and/or surrogate. Code 99498 can be used for each additional 30 minutes.	Any one of these codes.
	1157F	CPT II	Advance care plan or similar legal document present in the medical record.	
	1158F	CPT II	Advance care planning discussion documented in the medical record.	
	S0257	HCPCS	Counseling and discussion regarding advance directives or end of life care planning and decisions, with patient and/or surrogate.	
	1123F	CPT II	Advance care planning discussed and documented. Advance care plan or surrogate decision maker documented in the medical record.	
	1124F	CPT II	Advance care planning discussed and documented in the medical record. Patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	
	99483	CPT	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient setting, home or domiciliary or rest home, with a list of specific required elements.	
	Z66	ICD10CM	Do not resuscitate	
Functional Status Assessment	1170F	CPT II	Functional status assessed.	Any one of these codes
	99483	CPT	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient setting, home or domiciliary or rest home, with a list of specific required elements.	
	G0438	HCPCS	Annual wellness visit; includes personalized prevention plan of service; first visit.	
	G0439	HCPCS	Annual wellness visit; includes personalized prevention plan of service; subsequent visit.	
Medication Review	1159F	CPT II	Medication list documented in medical record.	Either of these codes, AND
	G8427	HCPCS	Eligible clinician attests to documenting in the medical record they obtained, updated or reviewed the patient's current medications.	
	1160F	CPT II	Review of all medications (such as prescriptions, OTCs, herbal therapies and supplements) by a prescribing practitioner or clinical pharmacist documented in the medical record.	Any one of these codes.
	90863	CPT	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services.	
	99483	CPT	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient setting, home or domiciliary or rest home, with a list of specific required elements.	
	99495, 99496	CPT	Transitional care management services following hospital discharge with the following required elements: • Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge • Medical decision making of at least moderate (99495) or high (99496) complexity during the service period • Face-to-face visit within 14 (99495) or 7 (99496) calendar days of discharge	
	99605, 99606	CPT	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, new patient.	
Pain Assessment	1125F	CPT II	Pain severity quantified; pain present.	Either of these codes.
	1126F	CPT II	Pain severity quantified; no pain present.	