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:

- ✓ Medication review
- ✓ Functional status assessment
- ✓ Pain assessment

Q: WHAT DOCUMENTATION IS NEEDED IN THE MEDICAL RECORD?

A:

- ✓ Evidence of Medication Review – must include medication list in the medical record, and evidence of a medication review by a prescribing provider 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: **Medication Review**

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

Functional Status Assessment

- ✓ 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
- ✓ Progress notes, IHSS forms, HRA forms, AWE form

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
- ✓ Ensure all medication reviews are signed by a prescribing provider
- ✓ Ensure all ADL/IADL assessments are completed and documented every year

Care for Older Adults (COA) Assessment Codes and Descriptions

Measure	Code	Type	Description/Notes	Compliance Criteria
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** Any one of these codes.
	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.	
	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.	