Care for Older Adults (COA)

By working together, we can improve health outcomes for your patients, our members. The Healthcare Effectiveness Data and Information Set (HEDIS®) helps us measure many aspects of performance. This tip sheet provides key details of the HEDIS measure for care for older adults.

What is the measure?

The measure looks at the percentage of adults age 66 and older who are in a Special Needs Plan and had each of the following during the measurement year:

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

Exclusions

- Members who receive hospice or use hospice services any time during the measurement year are excluded from the measure.
- Members who died any time during the measurement year

Medication Review *(Applies to Medicare Stars)*

Either of the following meets criteria:

- Medical record documentation of at least one medication review by a prescribing practitioner or clinical pharmacist **and** the presence of a medication list during the same visit, during the measurement year
- Transitional care management services during the measurement year

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

- A signed and dated medication list in the medical record **and** documentation of a medication review done by a prescribing practitioner or a clinical pharmacist including the date it was performed.
- Medical record documentation indicating the member is not taking any medication and the date it was documented.

Note: A review of side effects for a single medication at the time of prescription alone is not sufficient. Do not include medication lists or medication reviews performed in an acute inpatient setting.

Evidence of medication review can also be captured through claims data:

Medication Review
CPT: 90863, 99483, 99605 – 99606
CPT II: 1160F

Transitional Care Management Services
CPT: 99495-99496

Medication List
CPT II: 1159F
HCPCS: G8427

Continued next page

Functional Status Assessment *(Applies to Medicare Stars)*

At least one complete functional status assessment during the measurement year:

- Documentation in the medical record **must** include evidence of a complete functional assessment and the date the assessment was performed

Documentation of a complete functional status assessment must include **ONE** of the following:

- Notation of Activities of Daily Living (ADL) assessment of at least five of the following: bathing, dressing, eating, transferring, using toilet, and walking
- Documentation indicating 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, meal preparation, housework, home repair, laundry, taking medications and handling finances
- Results of an assessment using a standardized functional status assessment tool, not limited to:
  - Medical Outcome Survey 36-Item Short Form (SF-36®)
  - Assessment of Living Skills and Resources (ALSAR)
  - Barthel ADL Index Physical Self-Maintenance (ADLS) Scale
  - Bayer ADL (B-ADL) Scale
  - Barthel Index
  - Edmonton Frail Scale
  - Extended ADL (EADL) Scale
  - Patient-Reported Outcome Measurement Information System (PROMIS®), Global or Physical Function Scales
  - 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 Scale

Note: A functional status assessment limited to an acute or single condition, event or body system 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. Do not include comprehensive functional status assessments performed in an acute inpatient setting.

Evidence of functional status can also be captured through claims data; telehealth visits may be used for compliance:

Functional Status Assessment Codes:

CPT: 99483

CPTII: 1170F

HCPCS: G0438, G0439

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Pain Assessments *(Applies to Medicare Stars)*

Medical record documentation must include at least one pain assessment during the measurement year and the date it was performed. Result may include positive or negative findings for pain.

Documentation must include one of the following:

- Documentation showing the member was assessed for pain
- Results of assessment using a standardized pain assessment tool, not limited to:
  - Numeric rating scales
  - Face, Legs, Activity, Cry, Consolability (FLACC) Scale
  - Verbal descriptor scales (5-7word scales, present pain)
  - Pain Thermometer
  - Pictorial pain scales (Faces pain scale, Wong-Baker pain scale)
  - Visual Analogue Scale
  - Brief Pain Inventory
  - Chronic pain grade
  - PROMIS
  - Pain Assessment in Advanced Dementia (PAINAD) Scale

Note: Documentation of a pain management plan or a pain treatment plan alone does not meet criteria. Documentation of screening for chest pain or documentation of chest pain alone does not meet criteria. Do not include pain assessments performed in an acute inpatient setting.

Evidence of pain assessment can also be captured through claims data; telehealth visits may be used for compliance:

Pain Assessment Codes:
CPT II: 1125F – 1126F

Resources

Florida Blue has case management resources dedicated to members in the Dual-Eligible Special Needs Plan (D-SNP).

Please contact our D-SNP program:

Toll-free number: 866-780-4240

Fax: 904-301-1931

Email: DSNP@FloridaBlue.com