Care for Older Adults (COA)

We are committed to working with you to improve the quality of care and health outcomes for our members, your patients. The Healthcare Effectiveness Data and Information Set (HEDIS®) is one tool we use to measure many aspects of performance. This tip sheet details some of the key features 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, in a Special Needs Plan, who had each of the following during the measurement year:

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

Medication Review (Applies to Medicare Stars)

Medical record documentation of at least one medication review by a prescribing practitioner or clinical pharmacist during the measurement year **and** the presence of a medication list:

- 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.
  - Documentation in the medical record that 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.

An outpatient visit is not required to meet criteria.

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

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

Medication List
CPT II: 1159F
HCPCS: G8427

Transitional Care Management Services
CPT: 99495, 99496

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Functional Status Assessment **(Applies to Medicare Stars)**

At least one functional status assessment during the measurement year.

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

Documentation of 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, using toilet, and walking
- Documentation 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, 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
- Documentation that at least three of the following four components were assessed:
  - Cognitive status
  - Ambulation status
  - Hearing, vision and speech
    - Documentation of assessment of cranial nerves corresponding specifically to hearing (cranial nerve VIII), vision (cranial nerve II) and speech (cranial nerve XII) with a result or finding meets criteria for this component.

      Note: *Notation alone that cranial nerves were assessed does not meet criteria for the sensory ability component.*
  - Other functional Independence (e.g., exercise, ability to perform their job)

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.

Evidence of functional status can also be captured through claims data.

Functional Status Assessment

CPT: 99483 **CPTII:**1170F **HCPCS:** G0438, G0439

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Pain Assessments **(Applies to Medicare Stars)**

Documentation in the medical record of 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 evidence of a pain assessment tool, not limited to:

- Numeric rating scales
- Face, Legs, Activity, Cry, Consolability (FLACC) Scale
- Verbal descriptor scales (5-7 word 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.

Evidence of pain assessment can also be captured administratively through claims data:

Pain Assessment:
CPT II: 1125F, 1126F

Advanced Care Planning

Advance care planning is a discussion about the member's preferences for resuscitation, life sustaining treatment and end of life care.
One of the following must be included as evidence of advance care planning:

- Presence of an advance care plan in the medical record during the measurement year
- Documentation during the measurement year of an advance care planning *discussion* with the provider and the date it was discussed. The notation must be dated during the measurement year.
- Notation that the member previously executed an advance care plan. The notation must be dated during the measurement year.

Examples of an advance care plan include:

- Advance directive
- Actionable medical orders
- Living will
- Surrogate decision-maker

Evidence of advance care planning can also be captured administratively through claims data:
Advance Care Planning
CPT: 99483, 99497 **CPT II:** 1123F, 1124F, 1157F, 1158F **HCPCS:** S0257 **ICD-10**: Z66

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Exclusions

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

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

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