Care for Older Adults (COA)

Goal: To increase the percentage of adults 66 years and older who had each of the following during the measurement year.

*Members in hospice are excluded from the eligible population
*Services rendered during a Telehealth visit is acceptable for all three indicators

Measurement Requirements:

- **Medication Review**
  - A list of all the member’s medications in the medical record
  - Evidence of a medication review by prescribing provider or clinical pharmacist
  - Date on which medication review was performed

- **Functional Status Assessment**
  - Complete functional status exam
  - Date it was performed

- **Pain Assessment**
  - Pain screening assessment
  - Date it was performed

To achieve this goal, Mercy Care Advantage:

- PCP annual wellness visit letter detailing COA topics
- Annual Wellness Visit webinar with PCP’s
- Member brochure “Getting the most out of your Annual Visit” to improve member compliance and enhance PCP/member relationship
- Provider Newsletter article to improve compliance through provider awareness
- HEDIS Gaps in Care Reports available to providers through Mercy Care Plan website secure provider portal containing a comprehensive list of members needing care
- Member Health and Wellness Calendar to increase member awareness and importance of completing an advanced directive
- Assessment questions on advanced directives in Case Tracker Dynamo completed by the Case Management Staff
- COA supplemental mapping of HEDIS data collection

Tips:

Care for Older Adults has three separate components that require **yearly** documentation.
Medication Review:
Documentation of at least one complete annual review of patient’s medications and the date when it was performed.

Notations for a medication review must include numbers 1 AND 2 OR number 3 alone:

1. Evidence of a medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the date when it was performed
   
   AND
   
2. Presence of a medication list in the medical record
   
   OR
   
3. A notation that the member is not taking any medication and the date when it was noted

Documentation must come from the same medical record and include prescription and non-prescription medications, OTCs, vitamins, and supplements.

<table>
<thead>
<tr>
<th>Medication Review</th>
<th>Presence of a Medication List</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Code System</strong></td>
<td><strong>Code</strong></td>
</tr>
<tr>
<td>CPT II</td>
<td>1159F</td>
</tr>
<tr>
<td>HCPCS</td>
<td>G8427</td>
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</tbody>
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MEDICATION LIST MUST ALSO INCLUDE ONE OF THE MEDICATION REVIEW CODES TO MEET CRITERIA

<table>
<thead>
<tr>
<th>Evidence of a Medication Review</th>
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Functional Status Assessment:
Documentation of at least one complete functional status assessment during the measurement year and the date when it was performed.

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

1. Activities of Daily Living (ADL) were assessed or at least FIVE of the following were assessed, including, but not limited to: bathing, dressing, eating, transferring [e.g., getting in and out of chairs], using toilet, walking.

   OR

2. Instrumental Activities of Daily Living (IADL) were assessed or at least FOUR of the following were assessed, including, but not limited to: shopping for groceries, driving or using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications, handling finances.

   OR

3. Result of an assessment utilizing a standardized functional status assessment tool, including but not limited to:
   - SF-36*
   - Assessment of Living Skills and Resources (ALSAR)
   - Barthel ADL Index Physical Self-Maintenance (ADLS) Scale
   - Bayer ADL (B-ADL) Scale
   - Barthel Index
   - Extended ADL (EADL) Scale
   - Independent Living Scale (ILS)
   - Katz Index of Independence in ADL
   - Karnofsky Performance Status Scale
   - Kenny Self-Care Evaluation
   - Klein-Bell ADL Scale
   - Kohlman Evaluation of Living Skills (KELS)
   - Lawton & Brody’s IADL scales
   - Patient Reported Outcome Measurement Information System (PROMIS) Global or Physical Function Scales

A functional status assessment limited to an acute or single condition, event or body system (e.g., lower back, leg) does not meet criteria for a comprehensive functional status assessment. The various components of the functional status assessment may take place during separate visits within the measurement year.

<table>
<thead>
<tr>
<th>Code System</th>
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<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT II</td>
<td>1170F</td>
<td>Functional status assessed</td>
</tr>
<tr>
<td>HCPCS</td>
<td>G0438</td>
<td>Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit</td>
</tr>
<tr>
<td>HCPCS</td>
<td>G0439</td>
<td>Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit</td>
</tr>
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</table>
Pain Assessment:
Documentation of at least one pain assessment during the measurement year and date when it was performed.

Notations for a pain assessment must include ONE of the following TWO:

1. Documentation that the patient was assessed for pain (which may include positive or negative findings for pain)

   OR

2. Result of assessment using a standardized pain assessment tool, not limited to:
   - Numeric rating scales (verbal or written)
   - Face, Legs, Activity, Cry Consolability (FLACC) scale
   - Verbal descriptor scales (5–7 Word Scales, Present Pain Inventory)
   - Pain Thermometer
   - Pictorial Pain Scales (Faces Scale, Wong-Baker Pain Scale)
   - Visual analogue scale
   - Brief Pain Inventory
   - Chronic Pain Grade
   - PROMIS Pain Intensity Scale
   - Pain Assessment in Advanced Dementia (PAINAD) Scale

Notation of a pain management plan alone does not meet criteria.
Notation of a pain treatment plan alone does not meet criteria.
Notation of screening for chest pain alone or documentation of chest pain alone does not meet criteria.

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<tbody>
<tr>
<td>CPT II</td>
<td>1125F</td>
<td>Pain severity quantified: pain present</td>
</tr>
<tr>
<td>CPT II</td>
<td>1126F</td>
<td>No pain present</td>
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