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.

Medication Review		
Presence of a Medication List		
Code System	**Code**	**Definition**
CPT II	1159F	Medication list documented in medical record
HCPCS	G8427	Eligible professional attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications
MEDICATION LIST MUST ALSO INCLUDE ONE OF THE MEDICATION REVIEW CODES TO MEET CRITERIA		
Evidence of a Medication Review		
Code System	**Code**	**Definition**
CPT II	90863	Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
CPT II	99605	Medication therapy management service(s) provided by a PCP or clinical pharmacist face to face with a patient, with assessment and intervention if provided; initial 15 minutes, new patient
CPT II	99606	Initial 15 minutes, established patient
CPT II	1160F	Review of all medications by a prescribing practitioner or clinical pharmacist (such as, prescriptions, OTCs, herbal therapies, and supplements) documented in the medical record

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.

Functional Status Assessment		
Code System	**Code**	**Definition**
CPT II	1170F	Functional status assessed
HCPCS	G0438	Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit
HCPCS	G0439	Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit

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 Pain 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.

Pain Assessment		
Code System	**Code**	**Definition**
CPT II	1125F	Pain severity quantified: pain present
CPT II	1126F	No pain present