Measure Specific Guidelines for Care for Older Adults (COA)

Description: Members age 66 years of age and older who had at least one complete annual review.
To include **EACH** of the **FOUR** following sub measures in 2019:

- **Medication Review:**
  1. Medication listin chart
  2. Evidence of a medication review by a prescribing provider or clinical pharmacist
  3. Date on which the medication review was performed in 2019
- **Functional Status Assessment**
  1. Complete functional status exam: Cognitive, Ambulation status, Sensory ability Functional Independence
  2. Date it was performed in 2019
- **Pain Assessment**
  1. Pain screening assessment
  2. Date it was performed in 2019
- **Advanced Care Planning**
  1. Presence of advanced care plan in record on or before 12/31/2019
     OR
  2. Documentation of advanced care planning **discussion or initiation of discussion** ***and*** date it was performed in 2019
     OR
  3. Notation of previously executed advanced care plan in 2019 on or before 12/31/2019

Documentation guidelines:

- Documentation of a **Medication Review** in 2019 as evidenced by **ONE** of the following:
  - **Medication list** in chart to include prescription and non-prescription medications, vitamins and supplements
  - **Signature** of a prescribing provider or clinical pharmacist that a medication review wascompleted
  - **Date** on which the medication review was performed in 2019

  OR
  - **Notation** that the member is not taking any medication
  - **Date** when it was noted in 2019

- Documentation of a complete **Functional Status Assessment** in 2019 as evidenced by **ONE** of the following **FOUR OPTIONS** AND **DATE** it was performed:
    - Notation that 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

    - Notation that 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
        - ✓ cooking or meal preparation
        - ✓ housework
        - ✓ home repair
        - ✓ laundry
        - ✓ taking medications
        - ✓ handling finances

    OR

    - Notation that at least **THREE** of the following four components were assessed:
        - ✓ Cognitive status,
        - ✓ Ambulation status
        - ✓ Hearing, vision and speech (i.e., sensory ability; ***all three areas must be assessed***).
        - ✓ Other functional independence (e.g., exercise, ability to perform job)

    OR

    - Result of assessment using at least **ONE** of the following standardized functional status assessment tools, 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
        - ✓ 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

- Documentation of a **Pain Assessment** in 2019 as evidenced by **ONE** of the following AND **DATE** it was performed:
    - Documentation that the patient was assessed for pain (which may include positive or negative findings for pain)

  OR

    - 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.

- Documentation of **Advanced Care Planning** with evidence of **<u>ONE</u>** of the following:
    - Presence of advanced care plan in record such as:
        - **Advanced Directive**: *Directive about treatment preferences or the designation of a surrogate who can make medical decisions for a patient who is unable to make them (e.g., Living Will, Healthcare power of attorney, health care proxy)*
        - **Actionable medical orders**: *Written instructions initiating, continuing withholding or withdrawing specific forms of life-sustaining treatment: (e.g., Physicians Orders for Life sustaining Treatment (POLST), Five Wishes)*
        - **Living Will:** *Legal document denoting preferences for life sustaining treatment and end of life care*
        - **Name of surrogate decision maker***: Written document designating someone other than the member to make future medical treatment choices*

  OR

    - Documentation of an advanced care planning **<u>discussion</u>** with the provider **and** <u>date</u> it was discussed in 2019. Examples of discussion are:
        - ✓ **Notation of a <u>discussion</u> *or <u>initiation of a discussion</u>*** *by a provider*
          - Documentation that a member declined to discuss advanced care planning is considered evidence that the provider initiated a discussion meets criteria
          - Documentation that a provider asked the member if an advance care plan was in place and the member indicated a plan was not in place is not considered a discussion or initiation of a discussion
        - ✓ **Oral statements**: *Conversations with relatives or friends about life-sustaining treatment and end-of-life care,* ***or*** *patient designation of an individual who can make decisions on behalf of the patient.*
          ****Evidence of oral statements must be noted in the medical record in 2019***

  OR

    - Notation that a member previously executed advanced care plan in 2019 on or before 12/31/2019

Tips:

- *Medication List may include medication names only or may include medication names, dosages and frequency, over-the-counter (OTC) medications and herbal or supplemental therapies*
- *Medication Review of **all** member's medications, including prescription medications, OTC medications and herbal or supplemental therapies.*
- *A functional status documentation of the 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*
- *Notation of a pain management plan alone does not meet criteria.*
- *Notation of a pain treatment plan alone does not meet criteria.*
- *Advanced Care Planning documentation that a provider asked the member if an advance care plan was in place and the member indicated a plan was not in place is not considered a discussion or initiation of a discussion*
- Claim submission with ICD-10 coding can be used to make a member compliant without a chart review

CODES FOR TRACKING PERFORMANCE MEASURES

MEETS SCREENING CRITERIA		
Advanced Care Planning		
Code System	**Code**	**Definition**
CPT	99497	Advanced care planning including the explanation and discussion of advanced directives such as standard forms (with completion of such forms) when performed by the physician or other qualified health care professional: first 30 minutes, face to face with the patient, family member(s), and/or surrogate. The service carries an eligible charge, and also a co-payment for the patient unless performed as part of an Annual Wellness Visit
CPT II	1123F	Advanced care planning discussed and documented: advanced care plan or surrogate decision marker documented in the medical record
CPT II	1124F	Advanced care planning discussed and documented: patient did not wish or was not able to name a surrogate decision maker or provide and advance care plan
CPT II	1157F	Advanced care plan or similar legal document present in the medical record
CPT II	1158F	Advanced care planning discussion documented in the medical record
HCPCS	S0257	Counseling and discussion regarding advanced directives or end of life care planning and decisions, with patient and/or surrogate (list separately in addition to code for appropriate evaluation and management service)
ICD10CM	Z66	Do not resuscitate
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		
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

Transitional Care Management alone meets Medication Review compliance		
Code System	**Code**	**Definition**
CPT	99495	Transitional Care Management 14 Day
CPT	99496	Transitional Care Management 7 Day
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		
Code System	**Code**	**Definition**
CPT II	1125F	Pain severity quantified: pain present
CPT II	1126F	No pain present