pa health & wellness

HEDIS® 2021 (MY 2020)

Care for Older Adults (COA)

We are committed to working with you to improve the quality of care and health outcomes for your patients, our members. The Healthcare Effectiveness Data and Information Set (HEDIS®) tool is used to measure many aspects of performance. This tip sheet details some of the key features of the HEDIS® measures for Care for Older Adults.

Measure Definition	The COA measure evaluates the percentage of adults ages 66 and older who had each of the following during the measurement year: • Advance care planning • Medication review • Functional status assessment • Pain assessment

Lines of Business	Medicare

HEDIS 2021 Updates	• Medication review does not require the member to be present • Services rendered during a telephone visit, e-visit or virtual check-in meet criteria for the Advance Care Planning, Functional Status Assessment and Pain Assessment Indicators

Required Documentation: 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

Required Documentation: Medication Review	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 • Medication Review does not require the member to be present

Required Documentation: Functional Status Assessment	• 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 • Result of assessment using a standardized functional status assessment tool, such as *(but not limited to): SF-36, ALSAR, ADLS Scale, B-ADL Scale, Barthel Index, Edmonton Frail Scale, ILS, KELS, or PROMIS*

Required Documentation: Pain Assessment	• 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

Required Documentation: Exclusions	• Members receiving palliative care during the measurement year • Members who use hospice services or elect to use a hospice benefit, regardless of when the services began in the measurement year

Best Practices: Improving HEDIS Scores	• Check the EMR for open care gaps • Work with your PHW Provider Relations Representative to understand your COA metrics and how to address care gaps • Remember the medication review measure requires medications are listed in the chart, plus the review • Incorporate a standardized template to capture these measures for members 66 years and older • Document that you ***discussed*** the advance care plan, documentation stating only that the patient does not have a care plan is not adequate • Use of Value Set Codes *(Common Codes listed immediately below)* • Timely submission of Claims and Encounter Data

Common Codes*

Description	Codes
Advanced Care Planning	**CPT:** 99483, 99497 **CPT-CAT-II:** 1123FD, 1124F, 1157F, 1158F **HCPCS:** S0257 **ICD-10:** Z66
Medication Review	**CPT:** 90863, 99483, 99605, 99606 **CPT-CAT-II:** 1160F
Medication List	**CPT-CAT-II:** 1159F **HCPCS:** 1160F
Transitional Care Management Services	**CPT:** 99495, 99496
Acute In-patient	**CPT:** 99221-99223, 99231-99233, 99251-99255
Functional Status Assessment	**CPT:** 99483 **CPT-CAT-II:** 1170F **HCPCS:** G0438, G0439
Pain Assessment	**CPT-CAT-II:** 1125F, 1126F

*codes subject to change