HEDIS MEASURE OVERVIEW

Care for Older Adults (COA)

Please note that the information offered in this flyer is based on Healthcare Effectiveness Data and Information Set (HEDIS®) technical specifications. It is not meant to preclude your clinical judgment.

What are the COA measures?

The Care for Older Adults (COA) measures evaluate the percentage of adults 66 years of age and older who had each of the following during the measurement year: Advance Care Planning,* Functional Status Assessment, Medication Review and Pain Screening.†

Who is included in the COA measures?

Patients 66 years of age and older who are enrolled in a Medicare Special Needs Plan (SNP) are eligible for the COA measures. SNPs provide healthcare for patients with specific medical needs and are available for patients who:

- Have certain chronic diseases or conditions
- Have both Medicare and Medicaid benefits (also known as “dual eligible”)
- Live in an institution such as a nursing home

Exclusion

Patients in hospice or using hospice services

* Advance Care Planning is not a measure in the Star Rating Program; however, it is a National Committee for Quality Assurance (NCQA) quality measure.
† Pain Screening is retired from the Star Rating Program and from the National Committee for Quality Assurance’s Healthcare Effectiveness Data and Information Set (HEDIS®) as of Dec. 31, 2024. We anticipate this submeasure will be restructured and will return in the future.

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Service needed

Advance Care Planning

Completion of any one of the following:

- An advance care plan with a dated notation in the medical record in the current measurement year
- Discussion about advance care planning in the current measurement year with a dated notation in the patient's medical record
- Documentation that the patient previously executed an advance care plan with a dated notation in the patient's medical record in the current measurement year

Functional Status Assessment

At least one complete functional status assessment performed in an outpatient setting in the current measurement year with dated notation in the patient's medical record, which may include:

- Assessment of instrumental activities of daily living (IADL) or activities of daily living (ADL)
- Results using a standardized functional assessment tool

Medication Review

Both of the following services must be included along with the appropriate Current Procedural Terminology (CPT®) Category II codes:

- **CPT II 1160F** – At least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record, as documented through either administrative data or medical record review.
- **CPT II 1159F** – A medication list signed and dated during the measurement year by the appropriate practitioner type (prescribing practitioner or clinical pharmacist). The practitioner's signature is considered evidence that the medications were reviewed.

Pain Screening

Completion of at least one pain assessment during the measurement year with a dated notation in the patient's medical record. Exclude services provided in an acute inpatient setting.

Measure best practices

- Complete the COA assessment form annually with eligible patients or as part of an annual wellness exam. Completed forms can then be submitted as supplemental data.
- If a patient is not taking any medicine, the measure can be addressed by creating a dated notation in the medical record.
- A medication review and medication list code must be billed simultaneously for a patient to be compliant. A review of side effects for a single medication at the time of prescription alone is not sufficient.
- Discuss the following types of advance care plans with your patients during visits and include a dated notation in their medical record documenting:
  - Advance directive or living will
  - Power of attorney
  - Healthcare proxy
  - Actionable medical or surrogate decision-maker

Coding guidance

The table below contains the codes used to reflect completion of the assessments.

COA – Advance Care Planning (ACP)		
Code	**Code type**	**Definition**
99483	CPT	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with required elements: cognition-focused evaluation, medical decision making of moderate or high complexity, functional assessment, use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]), medication reconciliation and review for high-risk medications, evaluation for neuropsychiatric and behavioral symptoms, evaluation of safety including motor vehicle operation, identification of caregiver(s); caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; development, updating or revision, or review of an advance care plan and creation of a written care plan
99497	CPT	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified healthcare professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
1123F	CPT II	Advance care planning discussed; advance care plan or surrogate decision maker documented in the medical record (DEM) (GER, Pall Cr)
1124F	CPT II	Advance care planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan (DEM) (GER, Pall Cr)
1157F	CPT II	Advance care plan or similar legal document present in the medical record
1158F	CPT II	Advance care planning discussion documented in the medical record
S0257	HCPCS	Counseling and discussion regarding advance 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)
Z66	ICD-10	Do not resuscitate
COA – Functional Status Assessment (FSA)		
99483	CPT	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with required elements: cognition-focused evaluation, medical decision making of moderate or high complexity, functional assessment, use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]), medication reconciliation and review for high-risk medications, evaluation for neuropsychiatric and behavioral symptoms, evaluation of safety including motor vehicle operation, identification of caregiver(s); caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; development, updating or revision, or review of an advance care plan and creation of a written care plan
1170F	CPT II	Functional status assessed
G0438	HCPCS	Annual Wellness Visit; includes a personalized prevention plan of service (PPS), initial visit
G0439	HCPCS	Annual Wellness Visit, includes a personalized prevention plan of service (PPS), subsequent visit

COA – Medication Review (MDR)		
Code	**Code type**	**Definition**
90863	CPT	Pharmacologic management, including prescription, use and review of medication with no more than minimal medical psychotherapy
99483	CPT	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with required elements: cognition-focused evaluation, medical decision making of moderate or high complexity, functional assessment, use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]), medication reconciliation and review for high-risk medications, evaluation for neuropsychiatric and behavioral symptoms, evaluation of safety including motor vehicle operation, identification of caregiver(s); caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; development, updating or revision, or review of an advance care plan and creation of a written care plan
99495	CPT	Transitional care management services with the following required elements: communication (direct contact, telephone or electronic) with the patient and/or caregiver within two business days of discharge, medical decision-making of at least moderate complexity during the service period, face-to-face visit within 14 calendar days of discharge
99496	CPT	Transitional care management services with the following required elements: communication (direct contact, telephone or electronic) with the patient and/or caregiver within two business days of discharge, medical decision-making of high complexity during the service period, face-to-face visit within seven calendar days of discharge
99605	CPT	Medication therapy management service(s) provided by a pharmacist, face-to-face with patient, with assessment and intervention if provided, initial 15 minutes, new patient
99606	CPT	Medication therapy management service(s) provided by a pharmacist, face-to-face with patient, with assessment and intervention if provided, initial 15 minutes, established patient
1159F	CPT II	Medication list documented in medical record
1160F	CPT II	Review of all medications by a prescribing practitioner or clinical pharmacist documented in the medical record
G8427	HCPCS	List of current medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) documented by the provider, including drug name, dosage, frequency and route
COA – Pain Screening (PNS)		
Code	**Code type**	**Definition**
1125F	CPT II	Pain severity quantified; pain present
1126F	CPT II	Pain severity quantified; no pain present

CPT – Current Procedural Terminology (CPT®)
HCPCS – Healthcare Common Procedure Coding System
ICD-10 – International Classification of Diseases, 10th Revision

The coding information in this document is subject to changing requirements and should not be relied on as official coding or legal advice. All coding should be considered on a case-by-case basis and supported by medical necessity and appropriate documentation in the medical record.

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