Care for Older Adults – COA 2020-21 Coding and Documentation Guide

Eligible:

- The percentage of adults 66 years and older who had each of the following during the measurement year:
 - o Functional status assessment.
 - o Medication review.
 - Pain assessment.
- For members in a Medicare SNP (Special Needs Plan) and MMP (Medicare-Medicaid Plans).
- Components can be completed at any visit and telehealth can be used (see below).
- Annual Wellness Exam (AWE) visits are the most common and best way to complete this measure. Make sure the AWE forms are completed correctly and include the COA CPT II codes.
- Document all 3 components every year.
- Exclude services provided in an acute inpatient setting.

Component	CPT II Coding	Medical Record
Functional Status Assessment	1170F Functional status assessed.	 Documentation in the medical record must include evidence of a complete functional status assessment and the date when it was performed. Notations for a complete functional status assessment must include one of the following: Notation that Activities of Daily Living (ADL) were assessed or at least five of the following were assessed: bathing, dressing, eating, transferring [e.g., getting in and out of chairs], using toilet, walking. Notation 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, cooking or meal preparation, housework, home repair, laundry, taking medications, handling finances. Result of assessment using a standardized functional status assessment tool (see Tech Specs for compliant tools). Note that nurses and trained medical assistants can complete standardized assessment tools under the general supervision of the provider. Telehealth: Functional status may be conducted over the phone by any care provider
Medication Review Tip: If performing discharge med reconciliation (1111F), also code for COA Med Review (1159F and 1160F).	1159F Medication list documented in the medical record. and 1160F Review of all medications by a prescribing practitioner or clinical pharmacist documented in the medical record.	 type including registered nurses and medical assistants. Medical record must include both current medication list in 2020 and notation of medication review in 2020. The 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. Evidence of a medication review and the date when it was performed <i>or</i> notation that the member is not taking any medication in 2020 and the date when it was noted must be present. Review can be conducted by prescribing practitioner or clinical pharmacist. Telehealth: A registered nurse can collect the list of current medications from the member during a call, but there must be evidence that the prescribing clinician or clinical pharmacist reviewed the list. An electronic signature with credentials on the medication list is evidence the medications were reviewed.
Pain Assessment	1125F Pain Present. or 1126F Pain not present.	 Progress notes – notation of a pain assessment (which may include positive or negative findings for pain) and date when it was performed. Result of assessment using a standardized pain assessment tool . Numeric rating scales (verbal or written) 0-10 is most common. <u>Telehealth</u>: A pain assessment may be conducted over the phone by any care provider type including registered nurses and medical assistants.
Telehealth	Use POS (Place of Service) code 02 with modifier 95 (audiovisual visit).	 If a practitioner or other health plan staff contacts a member by phone to just gather information for HEDIS® data collection, a service isn't being rendered and will not meet criteria. For common ICD-10 and CPT codes, see https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet.