Alameda Alliance Wellness

Measure Tip Sheet

Care for Older Adults (COA)

This tip sheet is part of the *Alliance Medicare Stars Guide: A Resource for Providers and Clinic Staff.* This tip sheet provides measure-specific guidance, coding tips, and documentation strategies to help clinical teams close care gaps and improve performance on HEDIS® measures tied to Medicare Star Ratings.

For questions or more information, please email the Alliance Stars Team at **DeptStarsTeam@alamedaalliance.org**.

Data Collection Methodology: Administrative and hybrid

Measure Description: The percentage of adults 66 years of age and older who had both of the following during the measurement year:

- Medication Review
- Functional Status Assessment

Measure Population (denominator): Members 66 years and older.

Measure Compliance (numerator):

Sub-measure	Description
Medication Review	At least one (1) medication review by a prescribing practitioner or clinical pharmacist and the presence of a medication list in the medical record or transitional care management services during the measurement year. Medical record: Documentation must come from the same medical record and must include one (1) of the following: • A medication list in the medical record and evidence of a medication review by a prescribing practitioner or clinical pharmacist, and the date when it was performed. • Notation that the person is not taking any medication and the date when it was noted. **Please Note:** An outpatient visit is not required to meet criteria; a medication review performed without the person present meets criteria.

Sub-measure	Description
Functional Status Assessment	At least one (1) functional status assessment during the measurement period, as documented through either administrative data or medical record review. Medical record: Documentation in the medical record of evidence of at least one (1) complete functional status assessment during the measurement year and the date performed. An assessment must include one (1) of the following: • Notation that Activities of Daily Living (ADLs) were assessed or that at least five (5) of the following were assessed: bathing, eating, transferring, using the toilet, walking. • Notation that Instrumental Activities of Daily Living (IADLs) were assessed, or at least four (4) 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 medication, handling finances. • Result of assessment using a standardizing 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, Edmonton Frail Scale, Extended ADL (EADL) Scale, Groningen Frailty Index, 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. **Please Note:** The Functional Status Assessment indicator does not require a specific setting. Assessments can occur via all telehealth methods, including audio-only telephone visits, e-visits, and virtual check-ins.

Please Note: Do not include services provided in an acute inpatient setting

Coding Tips:

Value Set	Code		Description
Transitional Care Management Services	CPT	99495	Transitional care management moderate face-to-face 14 day
		99496	Transitional care management high face-to-face 7 day
Functional Status Assessment	CPT	99483	Assessment & care plan patient cognitive impairment
	CPT II	1170F	Functional status assessed
Medication List	CPT II	1159F	Medication list documented in medical record

Value Set	Code		Description
Medication Review	CPT	99483	Assessment & care plan patient cognitive impairment
		99605	Medication therapy management by pharmacist new patient 15 minutes
		99606	Medication therapy management by pharmacist established patient 15 minutes
	CPT II	1160F	Review of all medications by a prescribing practitioner or clinical pharmacist (such as prescriptions, over the counter, herbal therapies, and supplements), documented in the medical record

Please Note: Current Procedural Terminology (CPT) Category (CAT) II codes **are not** reimbursable codes; they are informational codes. The table shows a partial list of value set codes. Additional codes are available upon request.

Exclusions:

- Members who died at any time during the measurement year.
- Members who received hospice services at any time during the measurement year.

How to Improve Your Stars Performance

- Medication review does not require the patient to be present.
- A medication list, signed and dated during the measurement year by the appropriate practitioner type (RNs, LPNs, MAs, or CMAs are not acceptable).
- If the member is not taking any medication, document in the medical record with the date.
- Review the standardized assessment tools, select the one that is most appropriate for your practice, and incorporate to capture these measures for patients 66 years and older in your EMR.
- Notation Activities of Daily Living (ADL) were addressed.
- Notation Instrumental Activities of Daily Living (IADL) were addressed.
- Functional Status Assessment (FSA) can be anytime in the Measurement Year.
- Build preventative care screening alerts in your EHR system.
- Ensure documentation is clear, concise, consistent, complete, and comprehensive.