Dual-Eligible Special Needs Plan (D-SNP)

Care of Older Adults (COA) Annual Measurements

As part of the model of care for D-SNP care for older adults (COA), the measurements outlined below (medication review, functional status assessment, and pain assessment) are annual plan requirements. Established by the Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA), these measures represent best practices for those age 66 and older.

	Documentation Required Each Year	Code Options*
Medication Review	Criteria is met if **BOTH** of the following are documented: 1. Evidence of at least one (1) medication review conducted annually by a prescribing practitioner/clinical pharmacist 2. A current medication list in the medical record at the time of the review A medication list signed and dated during the year by the appropriate practitioner type meets these criteria.	**FOR THE MEDICATION REVIEW:** — CPT: 90863, 99605, 99606, 99483 **OR** — CPT II: 1160F **FOR THE MEDICATION LIST:** — CPT II: 1159F **OR** — HCPCS: G8427 (for medication list) **Note:** A medication review code AND a medication list code must be billed together to complete this requirement.
Functional Status Assessment	**At least one (1) completed standardized functional status assessment** with member annually. Many evidence-based tools are available, including but not limited to assessment of: • **Activities of Daily Living (ADLs):** Requires notation that at least five (5) of the following were assessed: bathing, dressing, eating, walking, using toilet, and transferring. • **Instrumental Activities of Daily Living (IADLs):** Requires notation that 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 medications, and handling finances.	— CPT: 99483 **OR** — CPT II: 1170F **OR** — HCPCS: G0438 or G0439
Pain Assessment	**At least one (1) pain assessment conducted annually**	CPT II: — 1125F (for documentation of **no** pain) **OR** — 1126F (for documentation of pain)

*CPT II codes can be used in the procedure code field for reporting purposes only to describe clinical components without a billable charge amount. Typically, these are measured during an annual HEDIS audit and require chart retrieval from offices. These code options for reporting completion of these services is an alternative option to ease the administrative burden of chart review. All of these codes are billable with AWV codes **G0402, G0438, or G0439**.

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