Care for Older Adults (COA) Assessment Form

This form can help you address the COA Healthcare Effectiveness Data and Information Set (HEDIS®) care opportunity for your patients who are UnitedHealthcare Medicare plan members. This form is intended to be utilized as a guide by external Healthcare Providers that do not have a COA template built within their Electronic Medical Record. COA Assessments may be conducted over the phone by any care provider type including registered nurses and medical assistants, but there must be evidence that the appropriate practitioner reviewed the list. If a practitioner or other health plan staff contacts a member by phone to gather information for HEDIS® data collection, a service isn't being rendered and will not meet criteria.

Patient Name (Last, First)	DOB	Member ID	Date Assessment Completed:

Height: FT._____ IN. _____ Weight: LBS. _____ BMI Value: _____	BMI ICD-10-CM Diagnosis Codes (Z68.1, Z68.20-Z68.39, Z68.41-Z68.45 – Please reference Page 2 for the full list of codes.)	Language Needs: English, Spanish or Other

Description of allergies, if applicable:	Drug Allergies? Yes No	Food Allergies? Yes NO

Care of Older Adults (COA) – Advanced Care Planning

Does the patient have an advanced directive?   Yes   No   **Has the patient been provided verbal discussion of an Advanced Directive? Yes No**
Has the patient discussed end of life care during this visit? Yes No   **Does the patient have a Health Care Surrogate/Proxy? Yes   No**
Date of discussion or refusal by member to discuss Advanced Directive: _____/_____/_____

Category II Codes: 99483, 99497, 1123F-24F, 11157F -58F. ICD 10 Diagnosis code Z66 – Do not resuscitate. Documentation of a conversation between a care provider and a member where the member declines to talk about advanced care planning shows the care provider initiated a discussion and meets compliance.

Care of Older Adults (COA) - Medication Review

Category II Codes: Medication List 1159F, 99483 | Medication Review 99605-06, 90863, 1160F | Transitional care Management 99495-96 Medication Review conducted in an acute inpatient setting will not meet compliance. Medication list must be included in the medical record and medication review must be completed by a prescribing provider or clinical pharmacist. If a medication list is attached, please be sure the list and this form have the same date and are both signed.

Medication Name	Prescription	OTC	Dosage
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

Care of Older Adults (COA) – Functional Status Assessment

Category II Codes: 1170F, 99483. "Continence" is not an acceptable Activity of Daily Living (ADL) for documentation of functional status assessment and an FSA provided in an acute inpatient setting will not meet compliance.

| **ADL/IADL**	☐Dressing	☐ Toilet Use	☐ Housework	☐ Shopping	☐ Eating	☐ Walking	☐ Bathing	☐ Transferring
Ambulatory Status	☐ Excellent	☐ Good	☐ Fair	☐ Relies on other person	☐ Uses a cane or walker	☐ Uses wheelchair or scooter	☐ Amputation R/L AKA BKA	☐ Prosthetics
Cognitive Status	☐ Excellent	☐ Diminished	☐ Dementia	☐ Alzheimer's	☐ Alert and oriented			
Sensory Hearing	☐ Excellent	☐ Good	☐ Poor	☐ Deaf	☐ Hearing aids or device			
Sensory Speech	☐ Excellent	☐ Good	☐ Poor	☐Stutter	☐ Mute	☐ Slurred	☐ Normal	
Sensory Vision	☐ Excellent	☐ Good	☐ Poor	☐ Glasses	☐ Contacts	☐ Cataract(s)	☐ Glaucoma	
	☐ DM Retinopathy							

Care of Older Adults (COA) – Pain Assessment

Category II Codes: 1125F-26F Pain assessments conducted in an acute inpatient setting will not meet compliance.

Intensity: On a scale of 0 to 10, with 0 being no pain and 10 being the worst pain you can imagine, how does it hurt right now?

Please mark one of the options above. N/A is not a valid response.
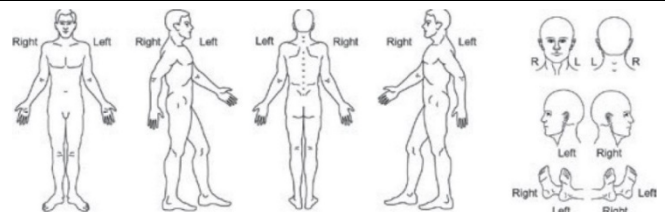
Is the pain constant? YES or NO	Type of pain (Example: ache, deep, sharp, hot, cold, sensitive skin):
Onset, duration and variations:	What relieves the pain?
By signing below, I attest that this document is part of the Patient's medical record. Signature:	Date: _____/_____/_____ *Important Note: Please be sure the date of the assessment and the date the form is signed are the same date.*

Documentation in the medical record must include the date the discussion took place by phone with accompanying progress note for date of telephonic visit if this form is submitted via the UHCCareConnect Tool.

PREFERRED CARE NETWORK
A UnitedHealthcare Company

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Assessment Codes and Descriptions

CPT Category II Code	HEDIS Measure Description
1170F	Functional status assessment: To address this care opportunity, a member's functional status must be assessed with one of the following during the measurement year: • Activities of Daily Living (ADL)/Instrumental Activities of Daily Living (IADL) • Standardized functional status assessment tool and results • Body systems assessment that includes three of these four components: ambulation status, cognitive status, functional independence or sensory ability A notation showing the assessment was done must be included in a member's medical record for completion.
1125F	**Pain screening:** To address this care opportunity, a member must have a comprehensive pain screening or pain management plan done at least one time during the measurement year.
1126F	**Pain screening:** To address this care opportunity, a member must have a comprehensive pain screening or pain management plan done at least one time during the measurement year.
1157F	**Advance care planning:** This care opportunity is addressed with evidence a member's had an advance care plan discussion during the measurement year. The discussion should cover a member's preferences for resuscitation, life-sustaining treatment and end of life
1158F	**Advance care planning**: This care opportunity is addressed with evidence a member's had an advance care plan discussion during the measurement year. The discussion should cover a member's preferences for resuscitation, life-sustaining treatment and end of life
1159F	**Medication list:** To address this care opportunity, a member's list of medications must be documented in their medical record during the measurement year.
1160F	**Medication review:** This care opportunity is addressed when a member's medications are reviewed by a prescribing practitioner or clinical pharmacist during the measurement year. A medication list must be included in the member's medical record for completion.

For your quick reference, here are the ICD-10-CM codes for body mass index (BMI). This reading is required to address the Adult Body Mass Index (ABA) care opportunity.

BMI	ICD-10-CM Code
≤ 19	Z68.1
20 – 20.9	Z68.20
21 – 21.9	Z68.21
22 – 22.9	Z68.22
23 – 23.9	Z68.23
24 – 24.9	Z68.24
25 – 25.9	Z68.25
26 – 26.9	Z68.26
27 – 27.9	Z68.27
28 – 28.9	Z68.28
29 – 29.9	Z68.29
30 – 30.9	Z68.30
31 – 31.9	Z68.31
32 – 32.9	Z68.32
33 – 33.9	Z68.33
34 – 34.9	Z68.34
35 – 35.9	Z68.35
36 – 36.9	Z68.36
37 – 37.9	Z68.37
38 – 38.9	Z68.38
39 – 39.9	Z68.39
40 – 44.9	Z68.41
45 – 49.9	Z68.42
50 – 59.9	Z68.43
60 – 69.9	Z68.44
≥ 70	Z68.45

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