Coding Reference Guide Measurement Year 2025
Care for Older Adults (COA)

Measure Description

Members 66 years of age and older who had each of the following during 2025:

1. Medication Review
2. Functional Status Assessment

Definitions

Medication List: A list of the Member's medications in the medical record. The medication list may include medication names only or may include medication names, dosages and frequency, over-the-counter (OTC) medications, and herbal supplemental therapies.

Medication Review: A review of all the Member's medications, including prescription medications, OTC medications, and herbal or supplemental therapies.

Standardized Tool: A set of structured questions that elicit Member information. May include person-reported outcome measures, screening or assessment tools, or standardized questionnaires developed by the health plan to assess risks and needs.

Medication Review

Either of the following meets criteria:

- Both of the following during the same visit during 2025 where the provider type is a prescribing practitioner or clinical pharmacist:
  - At least one medication review and the date when it was performed
  - The presence of a medication list in the medical record or a notation that the Member is not taking any medication and the date when it was noted

  Note: Do not include services provided in an acute inpatient setting or include CPT CAT II modifiers 1P, 2P, 3P, 8P.
- Transitional care management services during 2025

Functional Status Assessment

At least one functional status assessment during 2025.

A functional status assessment limited to an acute or single condition, event, or body system (ex. lower back, leg) does not meet criteria for a comprehensive functional status assessment. The components of the functional status assessment numerator may take place during separate visits within 2025. Notations for a complete functional status assessment must include one of the following:

- Notation that Activities of Daily Living (ADL) were assessed or that at least five of the following were assessed: bathing, dressing, eating, transferring (ex. 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, 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

Note: Do not include services provided in an acute inpatient setting or include CPT CAT II modifiers 1P, 2P, 3P, 8P.

The following codes meet the criteria:	
Medication Review	**CPT:** 90863, 99483, 99605, 99606
	CPT-CAT-II: 1160F
	SNOMED: 719327002, 719328007, 719329004, 461651000124104
Medication List	**CPT-CAT-II:** 1159-F
	HCPCS: G8427
	SNOMED: 428191000124101, 432311000124109
Transitional Care Management Services	**CPT:** 99495, 99496
Functional Status Assessment	**CPT:** 99483
	CPT-CAT-II 1170F
	HCPCS: G0438, G0439

Functional Status Assessment (cont.)	**SNOMED:** 304492001, 385880002, 196681000000107
The following codes will exclude the Member from the measure:	
Hospice Encounter During 2025	**HCPCS:** G9473, G9474, G9475, G9476, G9477, G9478, G9479, Q5003, Q5004, Q5005, Q5006, Q5007, Q5008, Q5010, S9126, T2042, T2043, T2044, T2045, T2046
	SNOMED: 183919006, 183920000, 183921001, 305336008, 305911006, 385765002
	UBREV: 0115, 0125, 0135, 0145, 0155, 0235, 0650, 0651, 0652, 0655, 0656, 0657, 0658, 0659
Hospice Intervention During 2025	**CPT:** 99377, 99378
	HCPCS: G0182
	SNOMED: 170935008, 170936009, 385763009
Members who died any time during 2025	

Tips and Best Practices to Help Improve Performance

MEDICATION REVIEW:

- A medication list in the medical record and evidence of a medication review by a *prescribing practitioner or clinical pharmacist (PharmD)* with the date it was performed is compliant documentation for the medication review sub-measure; or a notation the patient is not taking any medication
- A review of side effects for a single medication at the time of prescription alone is not sufficient Medication lists or medication reviews performed in an acute inpatient setting cannot be used

FUNCTIONAL STATUS ASSESSMENT:

Notations for a complete functional status assessment must include one of the following:

- Notation that ADL were assessed **or** that at least five of the following were assessed: bathing, dressing, eating, transferring, using toilet, walking
- Notation that IADL were assessed **or** at least four of the following were assessed: shopping for groceries, driving, 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

A functional status assessment limited to an acute or single condition, event or body system (e.g., lower back, leg) does not meet criteria for a comprehensive functional status assessment. The components of the functional status assessment may take place during separate visits within the measurement year. Do not include comprehensive functional status assessments performed in an acute inpatient setting.

PAIN ASSESSMENT:

Notations for a pain assessment must include one of the following:

- Documentation that the Member was assessed for pain (may include positive or negative findings)
- Result of assessment using a standardized pain assessment tool
- Do not include pain assessments performed in an acute inpatient setting
- Notation alone of a pain management plan does not meet criteria
- Notation alone of a pain treatment plan does not meet criteria
- Notation alone of screening for chest pain or documentation alone of chest pain does not meet criteria

**The Functional Status Assessment* and *Pain Assessment* do not require a specific setting; services rendered during a telephone visit, e-visit, or virtual check-in also meet criteria. Each may be performed by outpatient providers such as PT, OT, ST, but documentation must be from the same medical record for all sub-measures.