

Care of Older Adults (COA): Functional Status Assessment



Who: Adult patients 66 years of age or older as of December 31 of the measurement year. (Measurement year: the 12-month timeframe between January 1st - December 31st in which the service was rendered).

Why: A yearly assessment of how well patients perform activities of daily living and/or instrumental activities of daily living provides insight into one’s ability to care for oneself. Each ADL/iADL functional limitation should be addressed and documented clearly in the clinical note. This is very important in the aging population because a decline in instrumental activities of daily living is often the first sign of a decline in cognition, overall health and/or the ability to continue living independently.

What: The percentage of adults over 66 years with at least one functional status assessment during the measurement year, as documented through either claim or medical record review.

How: Functional status assessment is identified through claims and with chart review. Complete functional status assessments must include **one of the following:**

- Notation of **at least five** of the Activities of Daily Living (ADL) bathing, dressing, eating, transferring, using toilet, walking Note-“incontinence” does not count
- Notation of **at least four** Instrumental Activities of Daily Living (IADL) 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 an assessment using a standardized functional assessment tool.

Examples include, but not limited to:

ECOG, RAPID3, PROMIS, Katz & Lawton, DASI (Duke Activity Status Index), Barthel Index, Bayer ADL scale, Klein-Bell ADL scale, Edmonton Frail Scale, Independent Living Scale (ILS),

Exclusions:

- Members in hospice or using hospice services during the measurement year.
- Members who died during the measurement year.
- Services provided in an acute inpatient setting.

Coding: Functional status assessments are identified through claims with at least one of the following codes, or through chart review.

CPT-CAT-II	1170F	Functional Assessment
CPT	99483	Care Planning Visit (includes functional assessment)
HCPCS	G0438	Initial Medicare AWV (includes functional assessment)
HCPCS	G0439	Subsequent Medicare AWV (includes functional assessment)

Cut Points: Cut points demonstrate the rates that need to be reached to achieve the specific star rating.

1 Star: Less than 44%

2 Star: 44% to less than 66%

3 Star: 66% to less than 79%

4 Star: 79% to less than 89%

5 Star: Greater than or equal to 89%

Data info:

Performance Measure Set: Medicare Star Measure

Quality Measurement Type: Process

Data Type: Claims, Chart Documentation

CMS National Average: 79%

Tips for Success:

- Implement the use of a standardized functional assessment tool (see above examples):
 - If you have an assessment tool or format you wish to use, we will be happy to check with our CMS Auditor for approval
 - Most EMR systems have functionality to set these up for easy use in flowsheets &/or the chart note
- Schedule patients for yearly Medicare Wellness Visits to include a functional assessment

Care for Older Adults: Functional Assessment Review (COA) FAQs

Q: Does the functional assessment need to be done in an office visit?

A: No, the assessment can be done telephonically, if the assessment is documented in the medical record. The patient or family member may also fill out the assessment form and send back to the clinic. Please make sure the assessment form has a date on it.

Q: How often should a clinic do a functional assessment on a patient?

A: At least once a year and after a significant event for example: a fracture, MI, or CVA, etc.

Q: What is an example of an acceptable non-standard assessment tool?

A: A questionnaire or checklist that reviews and addresses the list of ADLs &/or iADLs.

Q: Is there another way to document a functional assessment without using an assessment tool?

A: Under the physical exam, document a header that indicates all ADLs or iADLs have been addressed, and that member is independent or otherwise.

- ADLs-independent
- iADLs-independent except needs help with cooking