

## Measure definition

The percentage of members 66 years and older who had each of the following during the measurement year:

1. Medication review
2. Functional status assessment
3. Pain assessment

Plans(s)	Quality Program(s)	Collection and Reporting
Medicare Special Needs Plans (SNP)	CMS Star Ratings	Administrative/Hybrid Claim/Encounter Data/Medical Record Documentation

## Best practices for quality care

1. Medication Review requirements:
  - Must have evidence of a medication review conducted by a prescribing practitioner or clinical pharmacist and presence of medication list within the medical records.
  - Must include all patient's medications, including prescription and over-the-counter medications and herbal or supplemental therapies. If the patient is not taking any medications, document within medical record with the date.
  - Medication lists must be signed and dated during the measurement year to meet criteria.
2. Functional status assessment requirements:
  - Notation within the medical records that at least five of the following activities of daily living (ADL) were assessed: bathing, dressing, eating, transferring (e.g., getting in and out of chair) using toilet, or walking.
  - Notation within the medical records that at least four of the following instrumental activities of daily living (IADL) were assessed: shopping for groceries, taking medications, using the telephone, home repair, housework, laundry, cooking or meal preparation, driving or using public transportation or handling finances.
3. Pain assessment requirements:
  - Notation within the medical records that the patient was assessed for pain. The notation must include the results (positive or negative) of a standardized pain assessment tool.
  - Notation of a pain treatment plan or complaints of pain from the member does not measure criteria.

## Quality score improvement tips

- For functional status assessments and pain assessments, telephone visits, e-visits or virtual check-ins meet criteria.
- Complete a medication review, functional status assessment, and pain assessment in the same visit when able. If possible complete them during an annual wellness visit.

## Acceptable Screening Tools:

Failure to use one of the screening tools listed below will result in the screening not counting towards this HEDIS measure.

Documentation required for functional status assessment:

- SF-36
- Assessment of Living Skills and Resource (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 report outcome measurement information system (PROMIS) Global or Physical Function Scales

Documentation required for pain assessment:

- Numeric rating scales (verbal or written)
- Face, Leg, Activity, Cry Consolability (FLACC) Scale
- Verbal descriptor scale (5-7 Word scales, Present pain inventory)
- Pain Thermometer
- Pictorial Pain Scales (Faces Pain Scale, Wong-Baker Pain Scale)
- Visual analogue scale
- Brief Pain Inventory
- Chronic Pain Grade
- PROMIS Pain Intensity Scale
- Pain Assessment in Advanced Dementia (PAINAD) Scale

## Exclusions

- Members who used hospice services or elected to use a hospice benefit any time during the measurement year.
- Members who died any time during the measurement year.

## Numerator codes

There is a large list of approved NCQA codes used to identify services included in this measure. The following are the approved codes. For more information, please refer to the American Academy of Professional Coders (AAPC). CPT II codes can be accepted as supplemental data, reducing the need for chart collection and review during the HEDIS hybrid season.

CODES		DESCRIPTIONS
CPT II	1159F	Medication list
CPT II	1160F	Medication review
CPT II	1170F	Functional status assessment
CPT II	1125F	Pain assessment (pain present)
CPT II	1126F	Pain assessment (pain not present)
CPT	90863, 99483, 99605 - 99606	Medication review
CPT	99495 (Transitional Care Management)	Moderate medical complexity requiring a face to face visit within 14 days of discharge
CPT	99496 (Transitional Care Management)	High medical complexity requiring a face to face visit within 7 days of discharge
CPT	99483	Functional status assessment
HCPCS	G8427	Medication list

### How WellSense can help

HEDIS tip sheets are designed to help WellSense providers improve and report the quality of care delivered to WellSense members across key metrics.

If you have questions around HEDIS documentation and quality measures, please email the Quality Team at [WS\\_Quality\\_Dept@wellsense.org](mailto:WS_Quality_Dept@wellsense.org).