

## Care for Older Adults (COA): Pain Assessment

Performance Measure Set:  CCO Incentive Metric  Medicare Stars Measure  
Quality Measurement Type:  Structure  Process  Outcome  Patient Experience  
Data Type:  Claims  Chart Documentation  eCQM  Survey  Other  
HEDIS Benchmarks Nat'l Percentile: 98.54% (75<sup>th</sup>), 99.71% (90<sup>th</sup>)

**Who:** Adults 66 years of age or older as of December 31 of the measurement year.

**Why:** As the population ages physical and cognitive function can decline, and pain becomes more prevalent. This is one of four important measures to help ensure that older adults receive the care they need to optimize quality of life.

**What:** Percentage of patients with a pain assessment and pain management plan during the measurement year.

Update for MY 2020 & MY 2021: Please note that services provided during a telephone visit, e-visit, or virtual check-in meet criteria for Pain Assessment indicators.

**How:** This measure can be satisfied using CPT codes or through medical record review during HEDIS review.

At least one pain assessment or pain management plan documented with the date the assessment was performed in the medical record.

*Standardized pain assessment tools include:* Numeric rating scales (verbal or written); Face, Legs, Activity, Cry, Consolability (FLACC) scale; Verbal descriptor scales (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:** Patients in hospice or using hospice services during the measurement year. Services provided in an acute inpatient setting are excluded.

**Coding:** CPT-CAT-II: 1125F, 1126F

## Care for Older Adults (COA): Pain Assessments FAQs

**Q: Will notation of a pain management plan or pain treatment plan alone in the record meet criteria?**

**A:** No. Documentation in the medical record must include evidence of a pain assessment and the date when it was performed.

**Q: Does screening for chest pain or documentation in the medical record of chest pain alone meet criteria?**

**A:** No. Patients coming in for chest pain or who have chest pain as a chief complaint typically get elevated to a more specific level of systems assessment that could potentially lead to something more serious.

**Q: Do I need to document negative findings when screening for pain?**

**A:** Yes. To meet criteria, documentation must include that the patient was assessed for pain and the results, positive or negative.

**Q: Who can document the pain assessment?**

**A:** CMA, RN, PT/OT, Pharmacist, and Provider.

**Q: Does whole body pain need to be assessed?**

**A:** No. Pain assessment can originate from a chief complaint, reason for visit, or question of overall how well the patient is feeling.

**Q: Is an outpatient visit required to meet criteria?**

**A:** No. A CMA, nurse clinical pharmacist, or provider can assess pain with a patient via a phone conversation. For example: asking how the patient is feeling or asking follow-up questions from a previous visit for leg pain, etc.