**Care for Older Adults: Functional Status Assessment (COA)**

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

**Why:** A yearly assessment of how well patients are able to perform activities of daily living and/or instrumental activities of daily living provides insight into their ability to care for one’s self, including personal care, mobility, eating, managing finances or medications. This is very important in the aging population because a decline in 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:** This measure can be satisfied with a CPT code or medical record review during HEDIS review.

Any outpatient visits, including seen by a CMA, nurse, OT/PT, Social Worker, Pharmacist or Provider. The patient, family member, or caregiver can fill out the functional status assessment at the Medicare Wellness visit which is then reviewed by the clinic staff/provider.

Evidence of complete functional status assessment and date the assessment was performed and documented in the medical record or claim with the CPT code listed below.

*Complete status assessment tools include:* at least five ADLs assessed; at least four IADLs assessed; or using one of the standardized functional status assessment tools listed in the HEDIS technical specifications.

**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: 1170F
Care for Older Adults: Functional Status Assessment (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.

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.

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

A: A questionnaire or checklist that incorporates one or more of the standard assessment tools.