Dual-Eligible Special Needs Plan (D-SNP)
Care of Older Adults Annual Measurements

As part of the model of care for D-SNP care for older adults (COA), the measurements outlined below (advance care planning, medication review, functional status assessment, and pain assessment) are annual plan requirements. Established by the Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA), these measures represent best practices for those age 66 and older.

	Documentation Required Each Year	Code Options*
Advance Care Planning	**At least one (1) of the following:** 1. Copy of an active advance care plan in the medical record (e.g., advance directive, actionable medical orders,living will, power of attorney, surrogate decision maker, etc.) 2. Documentation of advance care planning discussion between provider and member including date of discussion during the last year. **NOTE**: – If when asked by the provider, the member indicated a plan was not in place, more documented discussion would be required to meet criteria. – If the member declined to discuss advance care planning when the provider initiated such a discussion, criteria would be met. 3. Note in the medical record, dated during the current year, indicating that the member previously executed an advance care plan	**CPT: 99497** (for 30 min. discussions) **CPT II:** • **1123F** (documentation in the medical record) • **1124F** (patient refused to discuss), • **1157F** (ACP already in medical record) • **1158F** (documenting discussion) **ICD 10:** Z66 (for patients with DNR)
Medication Review	Criteria is met if **BOTH** of the following are documented: 1. Evidence of at least one (1) medication review conducted annually by a prescribing practitioner/clinical pharmacist 2. A current medication list in the medical record at the time of the review A medication list signed and dated during the year by the appropriate practitioner type meets these criteria.	**CPT: 90863, 99605, 99606** **CPT II: 1160F** (for the medication review) that must be billed alongside either: • **1159F** (for medication list) **OR** • **HCPCS: G8427** (for medication list)
Functional Status Assessment	**At least one (1) completed standardized functional status assessment** with member annually. Many evidence-based tools are available, including but not limited to assessment of: • **Activities of Daily Living (ADLs):** Requires notation that at least five (5) of the following were assessed: bathing, dressing, easting, walking, using toilet, and transferring. • **Instrumental Activities of Daily Living (IADLs):** Requires notation that at least four (4) 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, and handling finances.	**CPT II: 1170F** (for functional assessments)
Pain Assessment	**At least one (1) pain assessment conducted annually**	**CPT II:** • **1125F** (for documentation of **no** pain) • **1126F** (for documentation of pain)

* CPT II codes can be used in the procedure code field for reporting purposes only to describe clinical components without a billable charge amount. Typically, these are measured during an annual HEDIS audit and require chart retrieval from offices. These code options for reporting completion of these services is an alternative option to ease the administrative burden of chart review. All of these codes are billable with AWV codes **G0402**, **G0438**, or **G0439**.

selecthealth