2024 COA-Pain
Care for Older Adults, Pain

Care for Older Adults, Pain (COA-Pain)

Care for Older Adults

Appropriate screening and evaluation can keep the patient out of the Emergency Room.

As the population ages, physical and cognitive function can decline and pain becomes more prevalent

Screening of elderly patients is effective in identifying functional decline

This measure ensures that older adults receive the care they need to optimize quality of life.

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Measure Description

The percentage of adults 66 years of age and older who were assessed for pain anytime during the current performance period.

Patients 66 years of age and older

Had an appropriate screening for pain anytime during the current performance period

X1

Single Weighted Star Measure (subset measure of COA)

Measure Steward: National Committee for Quality Assurance (NCQA)

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Required Exclusions

These exclusions can be verified via claims **or** supplemental data submissions.

- Patients in **hospice** or using hospice services any time during the current performance period
- Patients who **pass away** any time during the current performance period

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COA Documentation and Submission

Documentation must include an assessment for pain anytime during 2024. The assessment may have positive or negative findings.

A standardized tool may be used to assess the patient's pain.

All documentation or tools used must contain the date the assessment was completed.

Pain can be assessed from an acute condition, such as a sore throat, abdominal pain, etc.

Pain assessment may be documented in the Review of Systems (ROS) and be related to a single body part, **except for the chest .** Ex. GI Assessment: No pain or tenderness, normal bowel sounds, denies diarrhea and constipation

Pain scales, using numbers or faces, used in the current performance period do meet numerator compliance.

Pain may be assessed during an in person, telephonic or virtual visit and is **not** limited to a specified clinician assessment.

Use CPT II codes to lessen the administrative burden of manual chart reviews.

Compliant Chart Documentation

We are going to assume this documentation comes from an outpatient visit in 2024, two patient identifiers (Name and DOB) are present, and the physician signed the visit note. In this example, we can see that pain has been addressed. Pain can be extracted from an acute condition, chronic condition, assessment scale/faces or even during the review of systems.

Subjective:

Chief Complaints:

1. Ov/disability.

HPI:

General:

patient is here today to have her disability paper work completed.

Wrist/Hand:

duration chronic. Wrist pain bilateral hands. Hand pain swelling bilateral. Finger(s) stiffness. Stiffness that is constant. Surgery Carpal tunnel release 1989. She can pick anything up and immediately drop it.

Patient was diagnosed with Carpal Tunnel in 1989,from consistant motion working in the chicken plant.

*Patient identifiers and provider name have been altered for HIPAA confidentiality reasons.

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Non-compliant Documentation Hints

Documentation of **pain management alone or pain treatment** alone does not meet numerator criteria.

A pain assessment performed in an **acute inpatient setting** does not meet numerator criteria.

Screening or documentation of **chest pain** will not meet numerator compliance.

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Code one of these to reduce the need for chart review!

Common Codes

1125F- Pain Severity quantified, pain present

1126F- Pain Severity quantified, no pain present

Thank You!