COA (Care for Older Adults)
PAIN ASSESSMENT

Members 66 years and older as of 12/31/2024 who had at least one pain assessment during the measurement year.

This checklist specifies all required elements that need to be present for measure compliance when uploaded to the Provider Portal.

Please use name convention for uploads:
Patient Last Name, Patient First Name_Measure ID_Clinic Name

#	Required Element	Example(s)	Notes
1	Patient name DOB	"Jane Jones" "1/1/1959"	Two patient identifiers needed for all chart notes.
2	**At least one pain assessment during the measurement year**		
	Notations for a pain assessment must include one of the following:		Documentation in the medical record must include evidence of a pain assessment and the date when it was performed.
	· Documentation that the patient was assessed for pain (which may include positive or negative findings for pain).	**"Pain Screening** Patient DOES NOT have complaints at this time." "Patient is experiencing back pain."	
	· Result of assessment using a standardized pain assessment tool, not limited to:	"Pain Scale = 5 (moderate pain; interferes with concentration)"	• 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
To Note:	• Do not include pain assessments performed in an acute inpatient setting. • Notation of a pain management or treatment plan alone does not meet criteria. • Notation alone of screening for chest pain or documentation alone of chest pain does not meet criteria.		

COA (Care for Older Adults)
MEDICATION REVIEW

Members 66 years and older as of 12/31/2024 who had either a medication review and a medication list or a transitional care management visit during the measurement year.

This checklist specifies all required elements that need to be present for measure compliance when uploaded to the Provider Portal.

Please use name convention for uploads:
Patient Last Name, Patient First Name_Measure ID_Clinic Name

#	Required Element	Example(s)	Notes	
1	Patient name DOB	"Jane Jones" "1/1/1959"	Two patient identifiers needed for all chart notes.	
Both a medication list & medication review or a TCM visit are required:				
2	Medication List	**"Medication List** Name Amlodipine 5 mg oral tablet Triamterene-hydrocholothiazid oral Viagra 100 mg oral tablet"	• A list of the member's medications in the medical record. The medication list may include medication names only or may include medication names, dosages and frequency, over the counter (OTC) medications and herbal or supplemental therapies.	An outpatient visit is not required; however, documentation must come from the same medical record.
3	Medication Review	• "Medications have been reviewed. Electronically signed by: David, DO on March 30, 2024 10:00:13 AM" • "Patient is not taking any medication. Electronically signed by: David, DO on March 30, 2024 10:00:13 AM"	• A review of the member's medications and signed by a prescribing practitioner such as M.D., D.O., Physician Assistant, Nurse Practitioner, or clinical Pharmacist and the date it was performed. If the patient is not taking any medications a notation and the date it was noted. • A review of all a member's medications, including prescription medications, OTC medications and herbal or supplemental therapies.	
4	Transitional Care Management Visit	"Discharge medications from recent hospitalization have been reviewed"		
To Note:	• Exclude services provided in an acute inpatient setting. • Review of side effects for a single medication at the time of prescription alone is not sufficient.			