Getting Started With PQRS

The Patient Protection and Affordable Care Act made participation in Medicare's Physician Quality Reporting System (PQRS) program *mandatory beginning in 2015*.

Measure #131 Pain Assessment and Follow-Up

The provider should report one of the quality-data codes (G-codes) below on line **24 D of a paper claim or on service line 24 of an electronic claim; and price reach G code at $0.01.**

Examples of standardized pain assessment tools include, but are not limited to:

Brief Pain Inventory(BPI), Faces Pain Scale (FPS), McGill Pain Questionnaire (MPQ), Multidimensional Pain Inventory (MPI), Neuropathic Pain Scale (NPS), Numeric Rating Scale (NRS), Oswestry Disability Index (ODI), Roland Morris Disability Questionnaire (RMDQ), Verbal Descriptor Scale (VDS), Verbal Numeric Rating Scale (VNRS), and Visual Analog Scale (VAS).

The following depicts the when each G-code should be reported for Measure #131:

Please use these Codes

G8730: Reported Pain assessment documented as positive using a standardized tool AND a follow-up plan is documented. The provider assessed the patient for pain using a standardized tool, documented a positive assessment (pain was present), and also documented a follow-up plan that specifically stated a planned reassessment of pain, a referral, or that the initial plan is still in effect..

G8731: Pain assessment using a standardized tool is documented as negative, no follow-up plan required. The provider assessed the patient for pain, documented a negative assessment (absence of pain), so no additional documentation was required.

G8442: Pain assessment NOT documented as being performed, documentation the patient is not eligible for a pain assessment using a standardized tool. The provider documented that the patient was not eligible for a pain assessment. Patients are not eligible only if one or more of the following reason(s) are documented: *Severe mental and/or physical incapacity where the patient is unable to express himself/herself in a manner understood by others*

Please use these Codes

Sparingly

G8939: Pain assessment documented as positive, follow-up plan not documented, documentation the patient is not eligible. The provider assessed the patient for pain using a standardized tool, documented a positive assessment (pain was present), did not document a follow-up plan because the patient was deemed ineligible. Patients are not eligible only if one or more of the following reason(s) are documented: *Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others*

G8732: No documentation of pain assessment, reason not given. The provider did not assess the patient for pain and there is no documentation the patient was not eligible (see G8939 or G8442 for non-eligibility reasons).

G8509: Pain assessment documented as positive using a standardized tool, follow-up plan not documented, reason not given. The provider assessed the patient for pain, documented a positive assessment (pain was present), but did not document a follow-up plan or a reason the patient was not eligible (see G8442 or G8939 for non-eligibility reasons).

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Measure #182 Functional Outcome Assessment

Examples of standardized functional outcome assessment tools include

Oswestry Disability Index (ODI), Neck Disability Index (NDI), Roland Morris Disability/Activity Questionnaire (RM)Low Back Disability Index (LBDI), Physical Mobility Scale (PMS), Disabilities of the Arm, Shoulder and Hand (DASH), Knee Outcome Survey Activities of Daily Living Scale (KOS-ADL).

The intent of the measure is for the functional outcome assessment tool to be utilized at a minimum of every **30 days or 12-15 Visits**

The provider should report one of the quality-data codes (G-codes) below on line **24 D of a paper claim or on service line 24 of an electronic claim; and price reach G code at $0.01.**

Please use these Codes

G8539: Reported Functional outcome assessment documented as positive using a standardized tool AND a care plan based, on identified deficiencies on the date of the functional outcome assessment, is documented. The provider performed a functional outcome assessment, using a standardized tool, and documented a care plan which included goals based on the deficiencies found.(**First visit and re-exams)**

G8542: Functional outcome assessment using a standardized tool is documented; no functional deficiencies identified, care plan not required. The provider performed a functional outcome assessment, using a standardized tool, but a care plan is not required because no functional deficiencies were identified. (**Every Visit in Between)**

G8942: Functional outcome assessment using a standardized tool is documented within the previous 30 days and care plan, based on identified deficiencies on the date of the functional outcome assessment, is documented. The provider has documented a functional outcome assessment, using a standardized tool, and a care plan which included goals based on the deficiencies found, within the last 30 days. **(Discharge Visit)**

Please use these Codes Sparingly

G8540: Functional Outcome Assessment NOT documented as being performed, documentation the patient is not eligible for a functional outcome assessment using a standardized tool. The provider documented the patient was not eligible for a functional outcome assessment. Patients are not eligible only if one or more of the following reason(s) are documented: The patient refuses to participate, The patient is unable to complete the questionnaire

G9227: Functional outcome assessment documented, care plan not documented, documentation the patient is not eligible for a care plan. The provider performed a functional outcome assessment, using a standardized tool, and found functional deficiencies, did not document a follow-up plan because the patient was deemed ineligible. Patients are not eligible only if one or more of the following reason(s) are documented: Patient refuses to participate, Patient unable to complete questionnaire.

G8541 Functional outcome assessment using a standardized tool not documented, reason not given. The provider did not perform a functional outcome assessment and there is no documentation the patient was not eligible.

G8543: Documentation of a positive functional outcome assessment using a standardized tool; care plan not documented, reason not given. The provider performed a functional outcome assessment, using a standardized tool, and found functional deficiencies, but did not document a care plan. In addition, there is no documentation the patient was not eligible.

Any Questions please contact Dr. Anderson with the contact page at www.AskDrAnderson.com

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Please Consult the ChiroCode Deskbook

http://www.chirocode.com/