

Business & Clinical Management Services, Inc. 2009 PQRI Measures & Coding Information- Physical Therapy & Occupational Therapy

Measure # 124 Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)

- Age Criteria: None noted
- Reporting Frequency: Per visit

Nominator:

G8447 Encounter documented using a CCHIT or certified EHR

Or

G8448 Encounter was documented by using a qualified (non-CCHIT) EHR

Denominator: 97001, 97002, 97003, 97004, 97750

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Measure # 126 Diabetic Mellitus: Foot and Ankle Care, Peripheral Neuropathy--Neurological Evaluation

- Age Criteria: Patients with Diabetes Mellitus 18 years or older on date of encounter
- Reporting Frequency: A minimum of once per reporting period
- Documentation Requirement:
 - Assign a Risk Category

Category	Risk Profile	Evaluation Frequency
0	Normal	Annual
1	Peripheral Neuropathy (LOPS)	Semi-Annual
2	Neuropathy, Deformity and/or PAD	Quarterly
3	Previous Ulcer or Amputation	Monthly-Quarterly

Nominator

G8404 Lower Extremity Neurological Exam Performed and Documented

Or

G8406 Lower Extremity Neurological Exam not Performed for Documented Reasons (clinician documented that the patient was not an eligible candidate for a lower extremity neurological exam measure)

Or

G8405 Lower Extremity Neurological Exam Not Performed

Denominator: 97001 or 97002

Diagnosis for Diabetes (line-item ICD-9 CM): 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93

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Measure #127: Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention--Evaluation of Footwear

- Age Criteria: Patients with Diabetes Mellitus 18 years or older on date of encounter
- Reporting Frequency: A minimum of once per reporting period
- Evaluation Requirement
 - Examination and documentation of vascular, neurological, dermatological and structural/biomechanical findings. The foot should be measured using a standard measuring device and counseling on appropriate foot wear should be based on the risk categorization noted in Measurement 126

Nominator:

G8410 Footwear Evaluation Performed and Documented

Or

G8416 Footwear Evaluation not Performed for Documented Reasons

Or

G8415 Footwear Evaluation Was not Performed

Denominator: 97001 or 97002:

Diagnosis for Diabetes (line-item ICD-9 CM): 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93

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Measure # 128 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow Up

- Age Criteria: 65+ BMI ≥ 30 or < 20 ; or Age 18-64 BMI ≤ 25 or < 18.5)
- Reporting Frequency: A minimum of once per reporting period
- Measure Requirement: Both height and weight must be actually measured unless obtained within 6 months from authentic clinical records.

Nominator:

G8420 BMI Calculated, No Follow-up Plan Needed or BMI Calculated, Follow-up Plan Documented (BMI within normal parameters)

Or

G8417 The Patient's BMI was Taken and Calculated, and was Above the Upper Parameters and a Follow-up Plan was Documented in the Medical Record

Or

G8418 The Patient's BMI was Taken and Calculated, was Below the Lower Parameter and a Follow-Up Plan was Documented in the Medical Record

Or

G8419 The Patient's Calculated BMI Outside Normal Parameters, No Follow-up Plan Documented in the Medical Record

Or

G8421 BMI was not Calculated

Or

G8422 The Patient was not Eligible for BMI Calculation for Documented Reasons:

- Diagnosed with a disease (terminal) that could impact weight gain or loss
- Previously diagnosed with a weight problem & managed by another provider
- Patient refuses BMI measures
- Patient is in urgent or emergency situation and could not obtain data
- Another reason was documented in the medical record by the provider explaining why BMI measurement was not appropriate

Example of Follow Up Plan:

- Included the BMI scores in the evaluation for physician's intervention
- Provided the patient with information health risks based on weight (education)
- Attempted to provide the patient with information, but the patient declined to be informed or accept any information

Denominator: 97001 and 97003

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Measure #130 Documentation & Verification of Current Medications in the Medical Record

- Age Criteria: Patients 18 years or older
- Reporting Frequency: Each visit
- Medication Reporting Includes: List of current medications with dosages (includes prescriptions, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) and verification with the patient or authorized representative documented by the provider

Nominator:

G8427 Medication with Dosages and Verification Documented
or

G8507 Current Medications with Dosages Documented, Patient Verification not Documented, Patient not Eligible

Or

G8428 Current Medications with Dosages Documented, Patient Verification not Documented, Reason not Specified

Or

G8429 Current Medications with Dosages not Documented, Reason not Specified

Or

G8430 Current Medications with Dosages not Documented, Patient not Eligible

- Patient refuses to participate
- Patient is cognitively impaired and no authorized representative available
- Patient is in an urgent or emergency situation where time is of the essence

Denominator: 97001, 97002, 97003 and 97004

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Measure #131 Pain Assessment Prior to Physical Therapy & Follow-up Plan:

- Age Criteria: Patients 18 or older
- Reporting Frequency: Upon evaluation, prior to treatment initiation
- Reporting Requirements:
 - Pain assessment must include location, intensity and description with a follow-up plan that includes reassessment of pain, education, interventions, future appoints, etc.
 - Pain assessment that demonstrates the lack of pain must include documentation that states:
 - Absence of pain on assessment
 - Diagnosis/condition/illness if not typically related to pain

G8440 Pain Assessment Documented and Follow-up Plan Documented

Or

G8441 Pain Assessment not Documented, Reason not Specified

Or

G8442 Pain Assessment not Document, Patient not Eligible

- Patient refuses to participate
- Patient has mental and/or physical incapacities that would limit his/her ability to respond or be understood
- Patient is in an urgent or emergency situation

Or

G8508 Pain Assessment Documented, Follow-up Plan not Documented, Patient not Eligible

Or

G8809 Pain Assessment Documented, Follow-up Plan not Documented, Reason not Specified

Denominator: 97001 and 97003

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Measure # 154: Falls: Risk Assessment (Two Part Measure)

- Age Criteria: 65 years or older
- Reporting Frequency: Once per reporting period
- Reporting Requirements; If the falls risk assessment indicates that the patient has documentation of two or more falls in the past year or any fall with an injury in the past year the Falls: Plan of Care # 155 measure should also be reported
- Fall Definition: A sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor or the ground, other than as a consequence of a sudden onset of paralysis, epileptic seizure or overwhelming external force
- Risk Assessment Components: Balance/Gait & one or more of the following: Postural blood pressure, Vision, Home Fall Hazards or documentation on whether medications are a contributing factor or not to falls within the past 12 months

Numerator: (Two CPT II Codes are Required Where Noted by AND)

3288F Falls Risk Assessment Documented

and

1100F Patient Screened for Future Fall Risk; Documentation of Two or More Falls in the Past Year or any Fall with an Injury in the Past Year

Or

3288-1P Risk Assessment for Falls not Completed for Medical Reasons

and

1100F Patient Screened for Future Falls Risk; Documentation of Two or More Falls in the Past Year or any Fall with an Injury in the Past Year

Or

1101F Patient not at Risk for Falls (Documentation of no falls or an injury due to a fall in the past year)

Or

1101F-8P Fall Status not Documented (patient is not eligible)

Or

3288F-8P Risk Assessment for Falls not Completed, Reason not Specified

and

1100F Patient Screened for Falls; Documentation of 2 or more Falls

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Denominator: 97001, 97002, 97003 and 97004

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Measure # 155: Falls: Plan of Care (Two Part Measure)

- Age Criteria: 65 years or older
- Reporting Frequency: Once per reporting period
- Reporting Requirements; If the Falls Risk Assessment Measure # 154 indicates that the patient has documentation of two or more falls in the past year or any fall with an injury in the past year the Falls: Plan of Care Measure # 155 measure should also be reported. Both measures must be recorded on the same claim form
- Plan of Care Requirements: Consideration or provision of an appropriate assistive device and balance, strength and gait training instructions and/or plans for intervention

Numerator:

0518F Falls Plan of Care Documented

Or

0518F-1P Falls Plan of Care not Documented for Medical Reasons

Or

0518F-8P Falls Plan of Care not Documented, Reason not Specified

Denominator: All eligible instances when CPT II code 1100F is reported in the numerator for Measure #154