

Measure #131 (NQF 0420): Pain Assessment and Follow-Up – National Quality Strategy Domain: Communication and Care Coordination

2016 PQRS OPTIONS FOR INDIVIDUAL MEASURE:
CLAIMS, REGISTRY

DESCRIPTION:

Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present

INSTRUCTIONS:

This measure is to be reported **each visit** occurring during the reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. The documented follow-up plan must be related to the presence of pain, example: "Patient referred to pain management specialist for back pain" or "Return in two weeks for re-assessment of pain".

Measure Reporting via Claims:

CPT or HCPCS codes and patient demographics are used to identify visits included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate numerator quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:

CPT or HCPCS codes and patient demographics are used to identify visits included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:

All visits for patients aged 18 years and older

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter

AND

Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 92002, 92004, 92012, 92014, 92507, 92508, 92526, 96116, 96118, 96150, 96151, 97001, 97002, 97003, 97004, 97532, 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, D7140, D7210, G0101, G0402, G0438, G0439

NUMERATOR:

Patient visits with a documented pain assessment using a standardized tool(s) AND documentation of a follow-up plan when pain is present

Definitions:

Pain Assessment – Documentation of a clinical assessment for the presence or absence of pain using a standardized tool is required. A multi-dimensional clinical assessment of pain using a standardized tool may include characteristics of pain; such as: location, intensity, description, and onset/duration.

Standardized Tool – An assessment tool that has been appropriately normed and validated for the population in which it is used. Examples of tools for pain assessment, 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).

Follow-Up Plan – A documented outline of care for a positive pain assessment is required. This must include a planned follow-up appointment or a referral, a notification to other care providers as applicable OR indicate the initial treatment plan is still in effect. These plans may include pharmacologic and/or educational interventions.

Not Eligible – A patient is not eligible if one or more of the following reason(s) is documented:

- Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example, cases where pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status

NUMERATOR NOTE: *The standardized tool used to assess the patient's pain must be documented in the medical record (exception: A provider may use a fraction such as 5/10 for Numeric Rating Scale without documenting this actual tool name when assessing pain for intensity)*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Pain Assessment Documented as Positive AND Follow-Up Plan Documented

(One quality-data code [G8730 or G8731] is required on the claim form to submit this numerator option)

Performance Met: G8730: Pain assessment documented as positive using a standardized tool AND a follow-up plan is documented

OR

Pain Assessment Documented as Negative, No Follow-Up Plan Required

Performance Met: G8731: Pain assessment using a standardized tool is documented as negative, no follow-up plan required

OR

Pain Assessment not Documented Patient not Eligible

(One quality-data code [G8442 or G8939] is required on the claim form to submit this numerator option)

Other Performance Exclusion: G8442: Pain assessment NOT documented as being performed, documentation the patient is not eligible for a pain assessment using a standardized tool

OR

Pain Assessment Documented as Positive, Follow-Up Plan not Documented, Patient not Eligible

Other Performance Exclusion: G8939: Pain assessment documented as positive, follow-up plan not documented, documentation the patient is not eligible

OR

Pain Assessment not Documented, Reason not Given

(One quality-data code [G8732 or G8509] is required on the claim form to submit this numerator option)

Performance Not Met: G8732: No documentation of pain assessment, reason not given

OR

Pain Assessment Documented as Positive, Follow-Up Plan not Documented, Reason not Given

Performance Not Met: G8509:

Pain assessment documented as positive using a standardized tool, follow-up plan not documented, reason not given

RATIONALE:

Chronic pain is defined as pain without biological values that has persisted beyond the normal time and despite the usual customary efforts to diagnose and treat the original condition and injury. If a patient's pain has persisted for six weeks (or longer than the anticipated healing time), a thorough evaluation for the course of the chronic pain is warranted (ICSI, 2013).

Chronic pain affects approximately 100 million adults in the USA. (Gaskin, 2012). It is clear the enormous pain-related costs represent both a great challenge and an opportunity in terms of improving the quality and cost-effectiveness of care (Mayday Fund, 2009).

Research also shows gender differences in the experience and treatment of pain. Most chronic pain conditions are more prevalent among women; however, women's pain complaints tend to be poorly assessed and undertreated (Green, 2003; Chronic Pain Research Alliance 2011, Weimer 2013). Although women may have higher baseline pain, differences in pain levels may not persist at one month (Peterson, 2012).

A growing body of research reveals even more extensive gaps in pain assessment and treatment among racial and ethnic populations, with minorities receiving less care for pain than non-Hispanic whites (Burgess, 2013; Green, 2003; Green, 2007; Green et al., 2011; Todd et al., 2004; Todd et al., 2007). Differences in pain care occur across all types of pain (e.g., acute, chronic, cancer-related) and medical settings (e.g., emergency departments and primary care) (Green, 2003; Green, 2007; Todd et al., 2007). Even when income, insurance status and access to health care are accounted for, minorities are still less likely than whites to receive necessary pain treatments (Green, 2003; Green, 2007; Paulson et al., 2007). Black race is associated with neighborhood socio-economic status (SES) and race plays a role in pain outcomes beyond SES (Green, 2012)

"When assessing and treating pain, practitioner sex, race, age, and duration of experience were all significantly associated with pain management decisions. These findings suggest that pain assessment and treatment decisions may be impacted by the health care providers' demographic characteristics, effects which may contribute to pain management disparities."(Bartley et al., 2015).

"A standard minimum pain assessment for back-pain patients should integrate pain intensity (e.g. VAS/NRS), pain affect (e.g. five-point VRS) and pain-related disability. Depending on more detailed research questions, more sophisticated questionnaires on pain affect (e.g. MPQ), coping strategies and fear-avoidance behavior should be used. This allows for a more comprehensive assessment of pain and factors influencing pain perception." (Haefeli M., Elfiring. A.,2005).

The American Pain Foundation (2009) identified pertinent facts related to the impact of pain as follows:

- Approximately 76.5 million Americans suffer from pain.
- Pain affects more Americans than diabetes, heart disease and cancer combined. It is the number one reason people seek medical care.
- Uncontrolled pain is a leading cause of disability and diminishes quality of life for patients, survivors, and their loved ones. It interferes with all aspects of daily activity, including sleep, work, social and sexual relations.
- Under-treated pain drives up costs – estimated at \$100 billion annually in healthcare expenses, lost income, and lost productivity– extending length of hospital stays, as well as increasing emergency room trips and unplanned clinic visits.
- Medically underserved populations endure a disproportionate pain burden in all health care settings.

- Disparities exist among racial and ethnic minorities in pain perception, assessment, and treatment for all types of pain, whether chronic or acute.

The Institute Of Medicine's (IOM) *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research* (2011) report suggests that chronic pain rates will continue to increase as a result of:

- More Americans will experience a disease in which chronic pain is associated (diabetes, cardiovascular disease, etc.).
- Increase in obesity which is associated with chronic conditions that have painful symptoms.
- Progress in lifesaving techniques for catastrophic injuries for people who would have previously died leads to a group of young people at risk for lifelong chronic pain.
- Surgical patients are at risk for acute and chronic pain.
- The public has a better understanding of chronic pain syndromes and new treatments and therefore may seek help when they may not have sought help in the past.

There are no current estimates of the total cost of poorly controlled pain in today's dollars. Viewed from the perspective of health care inflation at levels of more than 40% during the past decade (President's Council of Economic Advisors, 2009), the cost of health care due to pain is estimated to be between \$261 to \$300 billion. The value of lost productivity based on estimates of days of work missed is \$11.6 to 12.7 billion, hours of work lost is 95.2 to \$96.5 billion and lower wages is \$190.6 to \$226.3 billion.

CLINICAL RECOMMENDATION STATEMENTS:

Chronic pain assessment should include determining the mechanisms of pain through documentation of pain location, intensity, quality and onset/duration; functional ability and goals; and psychological/social factors such as depression or substance abuse.

A patient-centered, multifactorial, comprehensive care plan is necessary; one that includes biopsychosocial factors, as well as spiritual and cultural issues. It is important to have an interdisciplinary team approach which includes the primary care physician and specialty areas of psychology and physical rehabilitation.

The Institute for Clinical Systems Improvement (ICSI, 2013) *Assessment and Management of Chronic Pain Guideline, Sixth Edition* is based on a very broad foundation of evidence addressing a wide range of clinical conditions. It was chosen because it addresses the key factors of the comprehensive plan of care which incorporates self-management and active input from the patient and primary care clinician, pain assessment outcomes and referral to a pain medicine specialist or pain medicine specialty clinic.

The Institute for Clinical Systems Improvement (ICSI, 2012) *Adult Acute and Subacute Low Back Pain guideline* provides guidelines for physical therapists for low back pain assessment criteria, reducing or eliminating imaging for diagnosis of non-specific low back pain in patients 18 years and older, first-line treatment which emphasizes patient education and a core treatment plan that includes encouraging activity, use of heat, no imaging, cautious and responsible use of opioids, anti-inflammatory and analgesic over-the-counter medications and return to work assessment, advising patients with acute or subacute low back pain to stay active and the use of opioids.

Low Back Pain: Clinical Guidelines Linked to the International Classification of Functioning, Disability, and Health from the Orthopedic Section of the American Physical Therapy Association (Delitto, 2012) provides evidence to classify musculoskeletal conditions, specify interventions and identify appropriate outcome measures.

"Initial physical therapy management was not associated with increased health care costs or utilization of specific services following a new primary care LBP consultation" (Fritz, 2013, p. 1).

Anchored numerical scales are recommended for tracking routine progress, particularly pain interference with important activities. Regional or condition functional outcome scales should be routinely used at baseline and

periodic follow-ups. More frequent follow-up is recommended with higher frequency care. (Washington State Department of Labor and Industries, 2014)

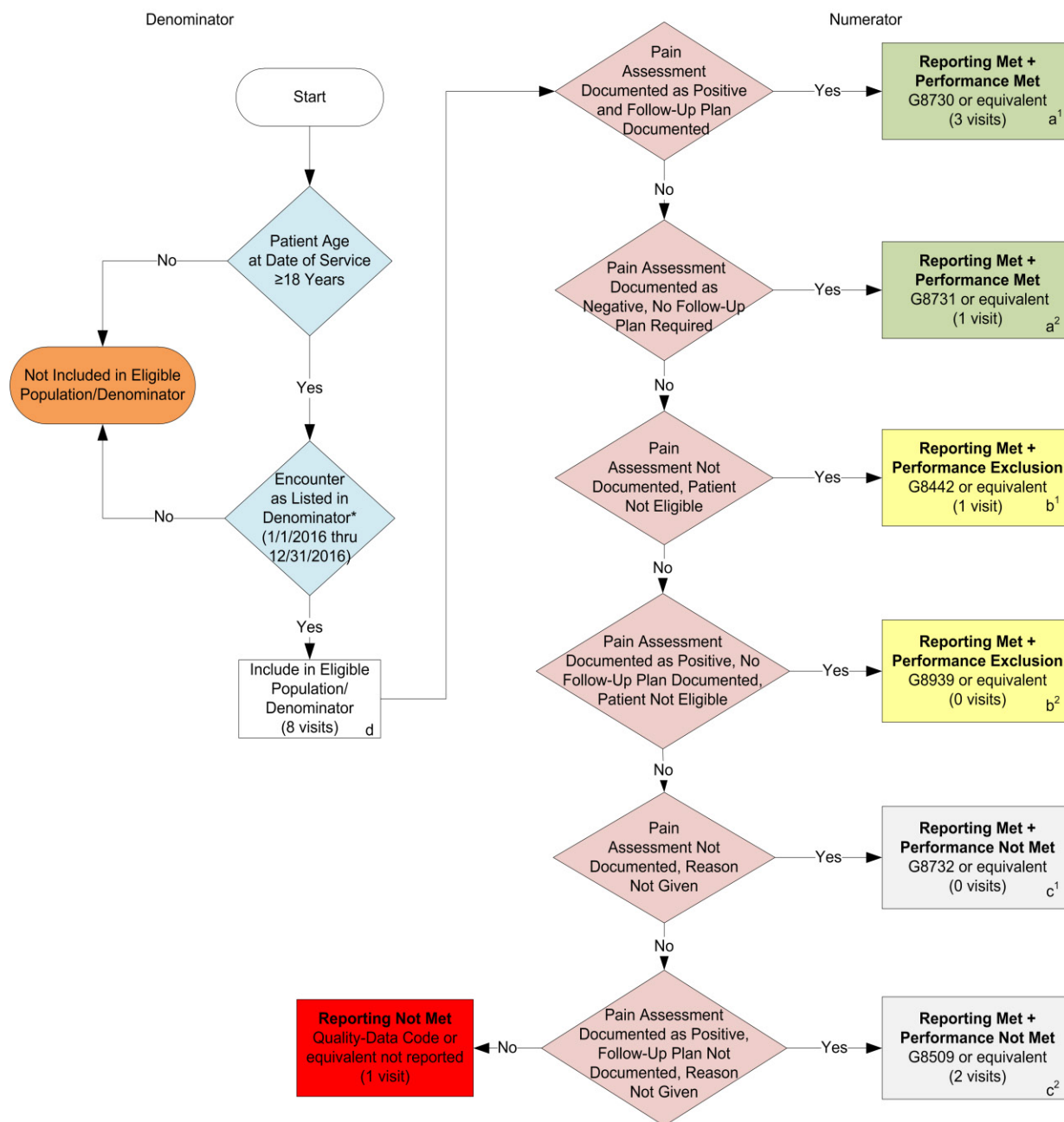
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2016 Claims/Registry Individual Measure Flow PQRS #131 NQF #0420: Pain Assessment and Follow-Up



SAMPLE CALCULATIONS:

Reporting Rate=
 Performance Met ($a^1+a^2=4$ visits) + Performance Exclusion ($b^1+b^2=1$ visit) + Performance Not Met ($c^1+c^2=2$ visits) = $\frac{7 \text{ visits}}{8 \text{ visits}} = 87.50\%$

Performance Rate=
 $\frac{\text{Performance Met } (a^1+a^2=4 \text{ visits})}{\text{Reporting Numerator } (7 \text{ visits}) - \text{Performance Exclusion } (b^1+b^2=1 \text{ visit})} = \frac{4 \text{ visits}}{6 \text{ visits}} = 66.67\%$

*See the posted Measure Specification for specific coding and instructions to report this measure.

NOTE: Reporting Frequency: Visit

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 The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

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2016 Claims/Registry Individual Measure Flow
PQRS #131 NQF #0420: Pain Assessment and Follow-Up

Please refer to the specific section of the Measure Specification to identify the denominator and numerator information for use in reporting this Individual Measure.

1. Start with Denominator
2. Check Patient Age:
 - a. If the Age is greater than or equal to 18 years of age on Date of Service and equals No during the measurement period, do not include in Eligible Patient Population. Stop Processing.
 - b. If the Age is greater than or equal to 18 years of age on Date of Service and equals Yes during the measurement period, proceed to check Patient Encounter
3. Check Encounter Performed:
 - a. If Encounter as Listed in the Denominator equals No, do not include in Eligible Patient Population. Stop Processing.
 - b. If Encounter as Listed in the Denominator equals Yes, include in the Eligible population.
4. Denominator Population:
 - a. Denominator population is all Eligible Patients in the denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 8 visits in the sample calculation.
5. Start Numerator
6. Check Pain Assessment Documented as Positive and Follow-Up Plan Documented:
 - a. If Pain Assessment Documented as Positive and Follow-Up Plan is Documented equals Yes, include in Reporting Met and Performance Met.
 - b. Reporting Met and Performance Met letter is represented in the Reporting Rate and Performance Rate in the sample calculation listed at the end of this document. Letter a1 equals 3 visits in Sample Calculation.
 - c. If Pain Assessment Documentation is Positive and Follow-Up Plan is Documented equals No, proceed to Pain Assessment Documented as Negative, No Follow-Up Plan Required.
7. Check Pain Assessment Documented as Negative, No Follow-Up Plan Required:
 - a. If Pain Assessment Documented as Negative and No Follow-Up Plan is Required equals Yes, include in Reporting Met and Performance Met.
 - b. Reporting Met and Performance Met letter is represented in the Reporting Rate and Performance Rate in the sample calculation listed at the end of this document. Letter a2 equals 1 visit in Sample Calculation
 - c. If Pain Assessment Documented as Negative and No Follow-Up Plan is Required equals No, proceed to Pain Assessment Not Documented, Patient Not Eligible.
8. Check Pain Assessment Not Documented, Patient Not Eligible:

- a. If Pain Assessment Not Documented, Patient Not Eligible equals Yes, include in Reporting Met and Performance Exclusion.
 - b. Reporting Met and Performance Exclusion letter is represented in the Reporting Rate and Performance Rate in the sample calculation listed at the end of this document. Letter b1 equals 1 visit in Sample Calculation.
 - c. If Pain Assessment is Not Documented, Patient Not Eligible equals No, proceed to Pain Assessment Documented as Positive, No Follow-Up Plan Documented, Patient Not Eligible.
9. Check Pain Assessment Documented as Positive, No Follow-Up Plan Documented, Patient Not Eligible:
- a. If Pain Assessment Documented as Positive, No Follow-Up Plan Documented, Patient Not Eligible equals Yes, include in Reporting Met and Performance Exclusion.
 - b. Reporting Met and Performance Exclusion letter is represented in the Reporting Rate and Performance Rate in the sample calculation listed at the end of this document. Letter b2 equals 0 visits in Sample Calculation.
 - c. If Pain Assessment Documented as Positive, No Follow-Up Plan Documented, Patient Not Eligible equals No, proceed to Pain Assessment Not Documented, Reason Not Given.
10. Check Pain Assessment Not Documented, Reason Not Given:
- a. If Pain Assessment Not Documented, Reason Not Given equals Yes, include in Reporting Met and Performance Not Met.
 - b. Reporting Met and Performance Not Met letter is represented in the Reporting Rate and Performance Rate in the sample calculation listed at the end of this document. Letter c1 equals 0 visits in Sample Calculation.
 - c. If Pain Assessment Not Documented, Reason Not Given equals No, proceed to Pain Assessment Documented as Positive, Follow-Up Plan Not Documented, Reason Not Given.
11. Check Pain Assessment Documented as Positive, Follow-Up Plan Not Documented, Reason Not Given:
- a. If Pain Assessment Documented as Positive, Follow-Up Plan Not Documented, Reason Not Given equals Yes, include in Reporting Met and Performance Not Met.
 - b. Reporting Met and Performance Not Met letter is represented in the Reporting Rate and Performance Rate in the sample calculation listed at the end of this document. Letter c2 equals 2 visits in Sample Calculation.
 - c. If Pain Assessment Documented as Positive, Follow-Up Plan Not Documented, Reason Not Given equals No, proceed to Reporting Not Met.
12. Check Reporting Not Met:
- a. If Reporting Not Met equals No, Quality Data Code or equivalent not reported. 1 visit has been subtracted from the reporting numerator in the sample calculation.

SAMPLE CALCULATIONS:

Reporting Rate=

$$\frac{\text{Performance Met (a}^1\text{+a}^2\text{=4 visits) + Performance Exclusion (b}^1\text{+b}^2\text{=1 visit) + Performance Not Met (c}^1\text{+c}^2\text{=2 visits)}}{\text{Eligible Population / Denominator (d=8 visits)}} = \frac{7 \text{ visits}}{8 \text{ visits}} = \mathbf{87.50\%}$$

Performance Rate=

$$\frac{\text{Performance Met (a}^1\text{+a}^2\text{=4 visits)}}{\text{Reporting Numerator (7 visits) – Performance Exclusion (b}^1\text{+b}^2\text{=1 visit)}} = \frac{4 \text{ visits}}{6 \text{ visits}} = \mathbf{66.67\%}$$