

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

2017 OPTIONS FOR INDIVIDUAL MEASURE:
REGISTRY ONLY

MEASURE TYPE:
Process

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 at each denominator eligible visit occurring during the performance period for patients seen during the performance period. There is no diagnosis associated with this measure. This measure may be reported by eligible clinicians 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:

The listed denominator criteria is used to identify the intended patient population. The numerator options included in this specification are used to submit the quality actions allowed by 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 \geq 18 years on date of encounter

AND

Patient encounter during the **performance period** (CPT or HCPCS): 90791, 90792, 92002, 92004, 92012, 92014, 92507, 92508, 92526, 96116, 96118, 96150, 96151, 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, 97532, 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, D7140, D7210, G0101, G0402, G0438, G0439

WITHOUT

Telehealth Modifier: GQ, GT

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), Patient-Reported Outcomes Measurement Information System (PROMIS).

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, behavioral, physical medicine and/or educational interventions.

Not Eligible (Denominator Exception) – 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 Options:

Performance Met:

Pain assessment documented as positive using a standardized tool AND a follow-up plan is documented (G8730)

OR

Performance Met:

Pain assessment using a standardized tool is documented as negative, no follow-up plan required (G8731)

OR

Denominator Exception:

Pain assessment NOT documented as being performed, documentation the patient is not eligible for a pain assessment using a standardized tool (G8442)

OR

Denominator Exception:

Pain assessment documented as positive, follow-up plan not documented, documentation the patient is not eligible (G8939)

OR

Performance Not Met:

No documentation of pain assessment, reason not given (G8732)

OR

Performance Not Met:

Pain assessment documented as positive using a standardized tool, follow-up plan not documented, reason not given (G8509)

RATIONALE:

Chronic pain affects approximately 100 million adults in the USA. (Gaskin, 2012). According to the American Pain Foundation (2009), pain affects more Americans than diabetes, heart disease and cancer combined. It is the number one reason people seek medical care. In addition, uncontrolled pain is a leading cause of disability and interferes with all activities of daily living (ADLs). It was also noted that under-treated pain drives up healthcare costs and increases hospital stays, Emergency Department visits, and unplanned visits to clinics. 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). The Institute Of Medicine's (IOM) Relieving Pain in America: A Blueprint

for Transforming Prevention, Care, Education and Research (2011) revealed the yearly economic cost (excluding those in institutions/facilities, children, members of the military, and caregivers) of chronic pain in the United States is at least in the \$560-635 billion range. Emotional costs are also excluded from the estimate.

The Institute Of Medicine's (IOM) *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research* (2011) also provided statistics from the National Center for Health Statistics (NCHS) identifying low back pain as the most frequently reported pain condition. The report further states the prevalence of chronic pain is expected to rise due to the aging population, prevalence of obesity, longer survival after a catastrophic injury, undermanaged pain post-surgical procedure, and a better understanding by the public to seek healthcare for chronic pain syndromes.

“Substantial disparities exist in the prevalence, seriousness, and adequate treatment of pain that affect the vulnerable populations of traditional public health concern” [The Institute Of Medicine's (IOM) *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research* (2011, p.5)].

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).

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).

“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).

The 2013 Institute for Clinical Systems Improvement (ICSI) Guideline for the Treatment of Chronic Pain recommends a care plan based on a biopsychosocial model which is defined as “Addressing the whole person in all his/her complexity, including physical and biologic factors, psychological state and beliefs, as well as the family, social and work environment (p.10) Recent research supports a multimodal approach to the treatment of low back pain as well as musculoskeletal disorders of the elbow, forearm, wrist and hand (ICSI, 2013; Sutton et al., 2016).

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)

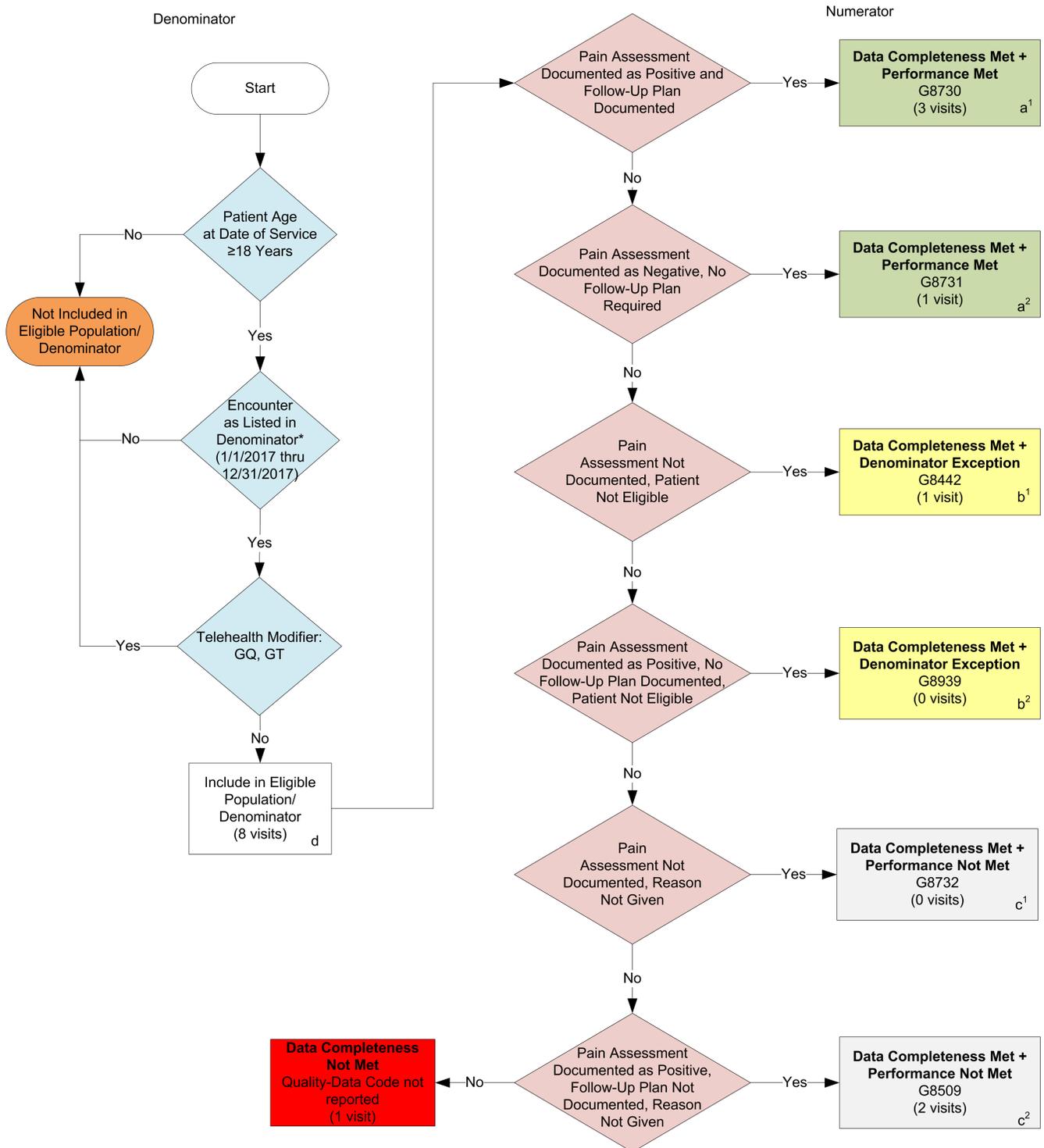
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2017 Registry Individual Measure Flow #131 NQF #0420: Pain Assessment and Follow-Up



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

NOTE: Reporting Frequency: Visit

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v1

**2017 Registry Individual Measure Flow
#131 NQF #0420: Pain Assessment and Follow-Up**

SAMPLE CALCULATIONS:

Data Completeness=

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

Performance Rate=

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

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

NOTE: Reporting Frequency: Visit

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v1

2017 Registry Individual Measure Flow
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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, proceed to check Telehealth Modifier.
4. Check Telehealth Modifier
 - a. If Telehealth Modifier as Listed in the Denominator equals Yes, do not include in Eligible Patient Population. Stop Processing.
 - b. If Telehealth Modifier as Listed in the Denominator equals No, include in the Eligible Patient Population.
5. 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.
6. Start Numerator
7. 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 Data Completeness Met and Performance Met.
 - b. Data Completeness Met and Performance Met letter is represented as Data Completeness 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.
8. 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 Data Completeness Met and Performance Met.

- b. Data Completeness Met and Performance Met letter is represented as Data Completeness 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.
9. Check Pain Assessment Not Documented, Patient Not Eligible:
- a. If Pain Assessment Not Documented, Patient Not Eligible equals Yes, include in Data Completeness Met and Denominator Exception.
 - b. Data Completeness Met and Denominator Exception letter is represented as Data Completeness 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.
10. 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 Data Completeness Met and Denominator Exception.
 - b. Data Completeness Met and Denominator Exception letter is represented as Data Completeness 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.
11. Check Pain Assessment Not Documented, Reason Not Given:
- a. If Pain Assessment Not Documented, Reason Not Given equals Yes, include in Data Completeness Met and Performance Not Met.
 - b. Data Completeness Met and Performance Not Met letter is represented as Data Completeness 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.
12. 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 Data Completeness Met and Performance Not Met.
 - b. Data Completeness Met and Performance Not Met letter is represented as Data Completeness 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 Data Completeness Not Met.
13. Check Data Completeness Not Met:

- a. If Data Completeness Not Met equals No, Quality Data Code or equivalent not reported. 1 visit has been subtracted from the data completeness numerator in the sample calculation.

SAMPLE CALCULATIONS:

Data Completeness=

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

Performance Rate=

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