### Measure #128

**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up**

Medicare patients 18+ years of age, screened for BMI

- **Normal:** Age 65 years and older BMI ≥ 23 and < 30
  - Age 18 to 64 years BMI ≥ 18.5 and < 25

Height and weight must be taken by professional or their staff. If the BMI falls outside of the normal parameters develop a follow up plan which can include by is not limited to:

- Documentation education,
- A referral (e.g., a registered dietician, nutritionist, occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professional, or surgeon),
- Pharmacological interventions,
- Dietary supplements,
- Exercise counseling,
- Nutrition counseling.

Reportable once per reporting period when you bill 97001

- **G8420:** BMI is documented within normal parameters and no follow-up plan is required
  - Normal: Age 65 years and older BMI ≥ 23 and < 30
  - Age 18 to 64 years BMI ≥ 18.5 and < 25

- **G8417:** BMI is documented above normal parameters and a follow-up plan is documented
  - Above: Age 65 years and older BMI > 30
  - Age 18 to 64 years BMI > 25

- **G8418:** BMI is documented below normal parameters and a follow-up plan is documented
  - Below: Age 65 years and older BMI < 23
  - Age 18 to 64 years BMI < 18.5

- **G8422:** BMI not documented, documentation the patient is not eligible (*patient is receiving palliative care, pregnant, refuses BMI measurement - refuses height and/or weight, any other reason documented in the medical record by the provider why BMI calculation or follow-up plan was not appropriate, OR patient is in an urgent or emergent medical situation where time is of the essence, and to delay treatment would jeopardize the patient's health status) for BMI calculation

- **G8938:** BMI is documented as being outside of normal limits, follow-up plan is not documented, documentation the patient is not eligible*

- **G8421:** BMI not documented and no reason is given

- **G8419:** BMI documented outside normal parameters, no follow-up plan documented, no reason given

### Helpful Tips:

This measure is reported once per calendar year when you bill a 97001. If a patient returns for a second episode of therapy during the year, you may report this measure again; however, you are not required to do so.

APTA has resources available on body mass [http://www.apta.org/PatientScreenings/](http://www.apta.org/PatientScreenings/)
**Measure #130**

**Documentation of Current Medications in the Medical Record**

Medicare patients 18+ years of age, documentation of current medications including prescription, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements. Information must include:

- Name,
- Dosage,
- Frequency, and
- Route of administration

Reportable on each visit in which you bill 97001, 97002, 97110, 97140, or 97532.

- **G8427**: Eligible professional attests to documenting in the medical record they obtained, updated, or reviewed the patient’s current medications.
- **G8430**: Eligible professional attests to documenting in the medical record the patient is not eligible (patient is in an urgent or emergent medical situation where time is of the essence, and to delay treatment would jeopardize the patient’s health status) for a current list of medications being obtained, updated, or reviewed by the eligible professional.
- **G8428**: Current list of medications not documented as obtained, updated, or reviewed by the eligible professional, reason not given.

**Helpful Tips:**

This measure is to be reported on every visit in which you bill a 97001, 97002, 97110, 97140, or 97532.

Please note that this measure now requires reporting on 97110, 97140, 97532 in addition to 97001 and 97002.

If you are missing any of the required medication information as listed above, you should report G8428 and attempt to get the completed list of medications on the next visit.

Once you have a full medication list in the chart, you can make an attestation statement on each eligible visit acknowledging that the list was reviewed with the patient and remains accurate (or note any new changes).

APTA has a podcast on this measure [www.apta.org/PQRS](http://www.apta.org/PQRS)
<table>
<thead>
<tr>
<th>Measure #131</th>
<th>Pain Assessment and Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare patients 18+ years of age, 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. A standardized assessment tool is one that has been appropriately normalized and validated for the population in which it is used (examples include but are not limited to: McGill Pain Questionnaire (MPQ), Oswestry Disability Index (ODI), Verbal Numeric Rating Scale (VNRS), and Visual Analog Scale (VAS)). Reportable on each visit in which you bill 97001, 97002, or 97532</td>
<td></td>
</tr>
<tr>
<td>• <strong>G8730</strong>: Pain assessment documented as positive using a standardized tool AND a follow-up plan is documented</td>
<td></td>
</tr>
<tr>
<td>• <strong>G8731</strong>: Pain assessment using a standardized tool is documented as negative, no follow-up plan required</td>
<td></td>
</tr>
<tr>
<td>• <strong>G8442</strong>: Pain assessment NOT documented as being performed, documentation the patient is not eligible (*severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others, cases where pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools, or 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) for a pain assessment using a standardized tool</td>
<td></td>
</tr>
<tr>
<td>• <strong>G8939</strong>: Pain assessment documented as positive, follow-up plan not documented, documentation the patient is not eligible*</td>
<td></td>
</tr>
<tr>
<td>• <strong>G8732</strong>: No documentation of pain assessment, reason not given</td>
<td></td>
</tr>
<tr>
<td>• <strong>G8509</strong>: Pain assessment documented as positive using a standardized tool, follow-up plan not documented, reason not given</td>
<td></td>
</tr>
</tbody>
</table>

Helpful Tips:

This measure is to be reported on every visit in which you bill a 97001, 97002, or 97532.

Please note that this measure now requires reporting on 97002, 97532 in addition to 97001.

APTA has a podcast on this measure [www.apta.org/PQRS](http://www.apta.org/PQRS)
### Measures #154 and #155 is a Paired Measure Set

<table>
<thead>
<tr>
<th>Measure #154</th>
<th>Falls: Risk Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months. History of falls is defined as 2 or more falls in the past year or any fall with injury in the past year. If the patient has a positive history, then a risk assessment must be completed. A risk assessment is comprised of balance/gait AND one or more of the following: postural blood pressure, vision, home fall hazards, and documentation on whether medications are a contributing factor or not to falls within the past 12 months. <strong>If the falls risk assessment indicates the patient has documentation of two or more falls in the past year or any fall with injury in the past year (CPT II code 1100F is submitted), #155 should also be reported.</strong></td>
<td></td>
</tr>
<tr>
<td>Reportable once per reporting period when you bill</td>
<td>97001 or 97002</td>
</tr>
<tr>
<td>• 3288F AND 1100F: Falls risk assessment documented AND patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year</td>
<td></td>
</tr>
<tr>
<td>• 3288F with 1P AND 1100F: Documentation of medical reason(s) for not completing a risk assessment for falls (ie, reduced mobility, bed ridden, immobile, confined to chair, wheelchair bound, dependent on helper pushing wheelchair, independent in wheelchair or minimal help in wheelchair) AND patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year</td>
<td></td>
</tr>
<tr>
<td>• 1101F: Patient screened for future fall risk; documentation of no falls in the past year or only one fall without injury in the past year</td>
<td></td>
</tr>
<tr>
<td>• 1101F with 8P: No documentation of falls status</td>
<td></td>
</tr>
<tr>
<td>• 3288F with 8P AND 1100F: Falls risk assessment not completed, reason not otherwise specified AND patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year</td>
<td></td>
</tr>
</tbody>
</table>

### Helpful Tips:

- This measure is reported once per calendar year when you bill a 97001 or 97002. If a patient returns for a second episode of therapy during the year, you may report this measure again; however, you are not required to do so.

Measure #154 is a paired measure with measure #155. If you choose to report measure #154, you must report #155.

Patients only qualify for measure #155 if they have a positive history of falls which is defined as 2 or more falls in the past year or any fall with injury in the past year. You may still perform a risk assessment on a patient if you feel that they are at risk for falls but have a negative falls history, however, for the purposes of reporting this measure, if the falls history is not positive you will report 1101F only and you will not report #155.

APTA has a podcast on this measures [www.apta.org/PQRS](http://www.apta.org/PQRS)
Measures #154 and #155 is a Paired Measure Set

<table>
<thead>
<tr>
<th>Measure #155</th>
<th>Falls: Plan of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>This measure should be reported if 1100F “Patient screened for future falls risk; documentation of two or more falls in the past year or any fall with injury in the past year” is submitted for Measure #154.</td>
<td></td>
</tr>
</tbody>
</table>

Medicare patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months. Falls plan of care must include:

- Consideration of vitamin D supplementation:
  - Documentation that vitamin D supplementation was advised or considered or documentation that patient was referred to his/her physician for vitamin D supplementation advice, AND
- Balance, strength, and gait training:
  - Documentation that balance, strength, and gait training/instructions were provided OR referral to an exercise program, which includes at least one of the three components: balance, strength or gait OR referral to physical therapy.

Reportable once per reporting period when you bill 97001 or 97002

- **0518F**: Falls plan of care documented
- **0518F with 1P**: Documentation of medical reason(s) for no plan of care for falls
- **0518F with 8P**: Plan of care not documented, reason not otherwise specified

Helpful Tips:

This measure is reported once per calendar year when you bill a 97001 or 97002. If a patient returns for a second episode of therapy during the year, you may report this measure again; however, you are not required to do so.

You will only complete this measure if you have submitted 1100F for measure #154 indicating that the patient has a history of falls is defined as 2 or more falls in the past year or any fall with injury in the past year.

Consideration of vitamin D supplementation for the plan of care is new for this measure in 2014.

APTA has a podcast on this measures [www.apta.org/PQRS](http://www.apta.org/PQRS)
### Functional Outcome Assessment

- **Measure #182**

Medicare patients 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies. A standardized tool is a tool that has been normalized and validated (examples include but are not limited to: Oswestry Disability Index (ODI), Roland Morris Disability/Activity Questionnaire (RM), Neck Disability Index (NDI), and Patient-Reported Outcomes Measurement Information System (PROMIS)).

<table>
<thead>
<tr>
<th>Reportable on each visit in which you bill</th>
<th>97001 or 97002</th>
</tr>
</thead>
<tbody>
<tr>
<td>• G8539: 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</td>
<td></td>
</tr>
<tr>
<td>• G8542: Functional outcome assessment using a standardized tool is documented; no functional deficiencies identified, care plan not required</td>
<td></td>
</tr>
<tr>
<td>• 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</td>
<td></td>
</tr>
<tr>
<td>• G8540: Functional Outcome Assessment NOT documented as being performed, documentation the patient is not eligible (*patient refuses to participate, patient unable to complete questionnaire, or patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient’s health status) for a functional outcome assessment using a standardized tool</td>
<td></td>
</tr>
<tr>
<td>• G9227: Functional outcome assessment documented, care plan not documented, documentation the patient is not eligible* for a care plan</td>
<td></td>
</tr>
<tr>
<td>• G8541: Functional outcome assessment using a standardized tool not documented, reason not given</td>
<td></td>
</tr>
<tr>
<td>• G8543: Documentation of a positive functional outcome assessment using a standardized tool; care plan not documented, reason not given</td>
<td></td>
</tr>
</tbody>
</table>

### Helpful Tips:

This measure is to be reported on every visit in which you bill a 97001 or 97002.

There is a lot of confusion with this measure as the measure specification includes a numerator note which reads “The intent of this measure is for a functional outcome assessment tool to be utilized at a minimum of every 30 days but reporting is required at each visit due to coding limitations.” Due to the CPT code requirements for the measure, PTs can only report when billing a 97001 or 97002. In many instances you may only report this measure on evaluation (if you do not bill 97002 during the episode) - *this is considered successful reporting.*

You should not submit a 97002 for the sole purpose of re-reporting this measure.

Of note, although similar, do not confuse this measure with the Functional Limitation Reporting (FLR) requirements, which is a separate program. [www.apta.org/FLR](http://www.apta.org/FLR)
Measure #245  Chronic Wound Care: Use of Wound Surface Culture Technique in Patients with Chronic Skin Ulcers (Overuse Measure)

Medicare patients 18 years and older with a diagnosis of chronic skin ulcer without the use of a wound surface culture technique.

Requires ICD9: 454.0, 454.2, 459.11, 459.13, 459.31, 459.33, 707.00, 707.01, 707.02, 707.03, 707.04, 707.05, 707.06, 707.07, 707.09, 707.10, 707.11, 707.12, 707.13, 707.14, 707.15, 707.19, 707.8, 707.9

Reportable on each visit in which you bill 97001 or 97002

- **4261F**: Technique other than surface culture of the wound exudate used (eg, Levine/deep swab technique, semiquantitative or quantitative swab technique) OR wound surface culture technique not used
- **4260F with 1P**: Documentation of medical reason(s) for using a wound surface culture technique (eg, surface culture for methicillin-resistant staphylococcus aureus [MRSA] screening)
- **4260F**: Wound surface culture technique used

Helpful Tips:

This measure is to be reported on every visit in which you bill a 97001 or 97002.

This measure must be reported with one of the eligible ICD9 codes as well as one of the eligible CPT codes as this is a diagnosis specific measure.