*Measure #155: Falls: Plan of Care

2010 PQRI REPORTING OPTIONS FOR INDIVIDUAL MEASURES: CLAIMS, REGISTRY

This is a two-part measure which is paired with Measure #154: Falls: Risk Assessment.
This measure *should* be reported if CPT II code 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.

DESCRIPTION:
Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure is appropriate for use in all non-acute settings (excludes emergency departments and acute care hospitals). This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
All eligible instances when CPT II code 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 reported in the numerator for Measure #154 make up the denominator for this measure. CPT Category II codes are used to report the numerator of the measure.

When CPT II code 1100F is reported with Measure #154, add the appropriate CPT Category II codes OR the CPT Category II code(s) with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

Measure Reporting via Registry:
All eligible instances when patient is reported in the numerator for Measure #154 as screened for future falls risk; documentation of two or more falls in the past year or any fall with injury in the past year are included in the measure's denominator. The numerator options as described in the quality-data codes 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.

NUMERATOR:
Patients with a plan of care for falls documented within 12 months

> Numerator Instructions: All components do not need to be completed during one patient visit, but should be documented in the medical record as having been performed within the past 12 months.

Definitions:
Plan of Care – Must include: 1) consideration of appropriate assistance device AND 2) balance, strength, and gait training.
Consideration of Appropriate Assistance Device – Medical record must include: documentation that an assistive device was provided or considered OR referral for evaluation for an appropriate assistance device
Balance, Strength, and Gait Training – Medical record must include: 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
Fall – 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 sudden onset of paralysis, epileptic seizure, or overwhelming external force

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Plan of Care Documented
CPT II 0518F: Falls plan of care documented

OR

Plan of Care not Documented for Medical Reasons
Append a modifier (1P) to CPT Category II code 0518F to report documented circumstances that appropriately exclude patients from the denominator.
0518F *with* 1P: Documentation of medical reason(s) for no plan of care for falls

OR

Plan of Care not Documented, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 0518F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
0518F *with* 8P: Plan of care not documented, reason not otherwise specified

DENOMINATOR:
All patients aged 65 years and older with a history of falls (history of falls is defined as 2 or more falls in the past year or any fall with injury in the past year)

Denominator Criteria (Eligible Cases):
All eligible instances when CPT II code 1100F (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) is reported in the numerator for Measure #154.

RATIONALE:
Interventions to prevent future falls should be documented for the patient with 2 or more falls or injurious falls.

CLINICAL RECOMMENDATION STATEMENTS:
Among community-dwelling older persons (i.e., those living in their own homes), multifactorial interventions should include:

- gait training and advice on the appropriate use of assistive devices (Grade B)
- review and modification of medication, especially psychotropic medication (Grade B)
- exercise programs, with balance training as one of the components (Grade B)

- treatment of postural hypotension (Grade B)
- modification of environmental hazards (Grade C)
- treatment for cardiovascular disorders (Grade D) (AGS/BGS/AAOS)