

♣ Measure #131: Pain Assessment and Follow-Up

2012 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES: CLAIMS, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older with documentation of a pain assessment through discussion with the patient including the use of 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 for 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.

Measure Reporting via Claims:

CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

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

Measure Reporting via Registry:

CPT codes and patient demographics are used to identify patients who 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.

DENOMINATOR:

All 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): 90801, 90802, 96116, 96150, 97001, 97003, 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0101, G0402, G0438, G0439

NUMERATOR:

Patient's pain assessment is documented through discussion with the patient including the use of a standardized tool(s) AND a follow-up plan is documented when pain is present.

Definitions:

Pain Assessment- A clinical assessment of pain through discussions with the patient and use of a standardized tool(s) for the presence and characteristics of pain which may include location, intensity, quality, and onset/duration

Standardized Tool – An assessment tool that has been appropriately normalized 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 – Proposed outline of treatment to be conducted as a result of pain assessment. Follow-up ***must*** include a planned reassessment of pain and may include documentation of future appointments, education, referrals, pharmacological intervention, or notification of other care providers as applicable.

Not Eligible – A patient is not eligible for pain assessment and/or follow-up if the following reason exists:

- Patient refuses to participate
- 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
- Diagnosis/condition/illness is not situationally related to pain

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Pain Assessment Documented as Positive AND Follow-Up Plan Documented

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

OR

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

G8731: Pain assessment documented as negative, no follow-up plan required

OR

Patient not Eligible for Pain Assessment for Documented Reasons

G8442: Documentation that patient is not eligible for a pain assessment

OR

Pain Assessment not Documented, Reason not Specified

G8732: No documentation of pain assessment

OR

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

G8509: Documentation of positive pain assessment; no documentation of a follow-up plan, reason not specified

RATIONALE:

Several provisions from the National Pain Care Policy Act (H.R. 756/S. 660) have been included in the the Affordable Care Act (ACA) of 2010 to Improve pain care. The legislation includes:

- Mandating an Institute on Medicine conference on pain to address key medical and policy issues affecting the delivery of quality pain care
- Establishing a training program to improve the skills of health care professionals to assess and treat pain
- Enhancing the pain research agenda for the National Institute of Health (NIH)

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

- 76.5 million Americans suffering 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.

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 annual costs associated with pain are probably at least as high as the estimated annual cost of \$174 billion that is attributed to diabetes and not including other diseases/conditions or sources of pain. More needs to be known about the economic impact of chronic pain. Chronic pain—commonly defined as pain persisting longer than six months—affects an estimated 70 million Americans and is a tragically overlooked public health problem (USDHHS, 2006). But even in the absence of adequate data, 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 (The Mayday Fund, 2009).

The prevalence of pain has a tremendous impact on business, with an estimated annual cost of \$61.2 billion in lost productive time. Studies show that most of the pain-related lost productive time occurs while employees are at work and is in the form of reduced performance. The cost of pain is an enormous burden on today's society, particularly to employers (American Academy of Pain Medicine, 2010). Stewart et al (2003) identified almost thirteen percent of the total workforce experienced a loss in productive time during a two-week period due to a common pain condition:

5.4% for headache; 3.2% for back pain; 2.0% for arthritis pain; 2.0% for other musculoskeletal pain.

Green (2003) identified pain to be widely recognized as an undertreated health problem in the general population. Failure to assess pain is a critical factor leading to undertreatment. In September 2008, the World Health Organization (WHO) estimated that approximately 80 percent of the world population has either no or insufficient access to treatment for moderate to severe pain.

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).

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 (Green, 2003; Green, 2006; 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, 2006; 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, 2006; Paulson, et al, 2007).

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 addressing biopsychosocial factors, spiritual and cultural issues are also important. It is important to have a multidisciplinary team approach coordinated by the primary care physician to lead a team including specialty areas of psychology and physical rehabilitation.

The Institute for Clinical Systems Improvement (ICSI, 2009) *Assessment and Management of Chronic Pain Guideline, Fourth Edition* was chosen because it address the key factors of the plan of care, pain assessment, and outcomes, and is based on a very broad foundation of evidence, and addresses a wide range of clinical conditions.