

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

**2018 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 submitted 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 submitted 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 Submission:**

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 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 NOTE:*** \*Signifies that this CPT Category I code is a non-covered service under the Medicare Part B Physician Fee Schedule (PFS). These non-covered services should be counted in the denominator population for registry-based measures

**Denominator Criteria (Eligible Cases):**

Patients aged ≥ 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, 97127\*, 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, , 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99234, 99235, 99236, 99238, 99239, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, D7140, D7210, G0101, G0402, G0438, G0439

**WITHOUT**

**Telehealth Modifier:** GQ, GT, 95, POS 02

**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, interventional therapies, 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 at the time of the encounter:

- 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 at the time of the encounter  
**(G8442)**

**OR**

**Denominator Exception:**

Pain assessment documented as positive, follow-up plan not documented, documentation the patient is not eligible at the time of the encounter  
**(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 reportedly has affected approximately 116 million adults in the USA and has accounted for more than 70 million annual visits to healthcare providers (IOM Relieving Pain in America, 2011).

The cost for treatment and loss of productivity related to chronic pain exceeds \$600 million/year, not inclusive of the intangible costs of stress to patient and family and decreased quality of life (IOM, 2011; Kim, H. J., et al., 2017; & Park, P. W., 2015). According to Grol-Prokopczyk (2017), the prevalence of chronic pain has increased from 27.3% in 1998 to 36.6% in 2010. Low back pain is the most common reason stated for visiting a healthcare provider with 80% of population experiencing at least one episode in their lifetime (Wong, J. J., et al., 2016) and according to the statistics provided by the National Center for Health Statistics (NCHS) it is identified as the most frequently reported pain condition. Blanchette, M. A., et al. (2016) also noted that low back pain is the most common occupational injury reported (IOM: Relieving Pain in America, 2011). The Institute Of Medicine's (IOM) Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research (2011) 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.

Neck pain and associated disorders were noted to be experienced by greater than 80% of the population, at some point in their lives, accounting for approximately 10.2 million annual healthcare visits (Blanchette, M. A., et al., 2016). Management of neck and low back pain account for decreased quality of life and productivity, limitation of daily activities, and increased utilization of healthcare resources (Blanchette, M. A., et al., 2016; Cote, P., et al., 2016, and Wong, et al., 2016).

“Substantial disparities exist in the prevalence, seriousness, and adequacy of the 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). Grol-Prokopczyk (2017) found that non-Hispanic whites reported pain more often than non-Hispanic blacks or Hispanics (p. 313). 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 socioeconomic status (SES) and race plays a role in pain outcomes beyond SES (Green, 2012). Kim (2017) noted that those with a lower socioeconomic status, lack of or inadequate health insurance, limited access to treatment, lower education levels, and communication issues with health care professionals have been associated with higher racial/ethnic chronic pain disparities.

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). Women experience pain 38% more than men, have an increased number of pain sites, do not communicate pain related issues as well as men, and are more likely to request advice than mechanical treatment (Grol-Prokopczyk, H., 2017). “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).

## **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 biological, psychological, social, and environmental factors, as well as spiritual and cultural issues. It is important to have a multidisciplinary team approach which includes the primary care physician as well as specialty areas of psychology and physical rehabilitation (Ernstzen, D. V., 2017; and Kurlinsky, S., 2016).

The 2016 Institute for Clinical Systems Improvement (ICSI) Pain: Assessment, Non-Opioid Treatment Approaches and Opioid Management Guidelines (Hooten, et al., 2016) suggest that the patient be an active member of the care team and that a multidisciplinary approach to care is recommended due to the complexity of pain. The clinician should use a validated pain tool to assess the patient's pain intensity, functional limitations, and effects of pain on quality of life. A comprehensive medical assessment should be performed initially, at periodic intervals, and when there is lack of progress noted to assess effectiveness of plan and modify as needed (Hooten, et al., 2016).

The 2016 ICSI guidelines also recommend the clinician use a biophysical approach which views pain as "...a complex and dynamic interaction among physiological, psychological, and social factors that can perpetuate or worsen the clinical presentation" (Hooten, et al., 2016, p.35). The multidisciplinary treatment plan should take into consideration the following: severity of pain, effects of pain on patient's quality of life and functional status, pain diagnosis, co-morbidities, patient goals for treatment, options available for treatment, patient capacity to follow plan, and any barriers to treatment that may exist for the patient (Hooten, et al., 2016). It is recommended that first line treatment should consist of non-pharmacologic pain management strategies and if pharmacologic treatments are required, the clinician should determine if the benefits of pharmacologic treatment outweighs the risk of polypharmacy, addiction, and other potential adverse events (Hooten, et al., 2016).

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 (Sutton et al., 2016).

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.

The American College of Physicians (ACP) discussed in the clinical guidelines for Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline from the American College of Physicians (2017) that clinicians should utilize a shared decision approach with patients as they formulate the follow up and treatment plan. Clinicians should educate patients on prognosis, treatment, and encourage activity. Non-pharmacologic interventions should be the first line treatment and have been shown effective for improving pain and functionality in patients with acute or sub-acute low back pain. If no improvement seen with non-pharmacologic treatment clinicians and patients should consider nonsteroidal anti-inflammatory drugs (NSAIDs). Opioids should only be considered as a treatment option when all other therapies have failed due to the associated potential harms. The ACP (2017) noted that due to a lack of advantage for a particular therapy, the clinician should first select the therapies that have the fewest harms and lowest cost and should avoid prescribing costly therapies with substantial potential harms.

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). ). Utilization of a standardized pain tool assists to improve communication amongst the provider and client, to enhance the decision making process, improves patient engagement, and assists the provider in evaluating and adjusting the plan of care (Holmes, M. M., 2016).

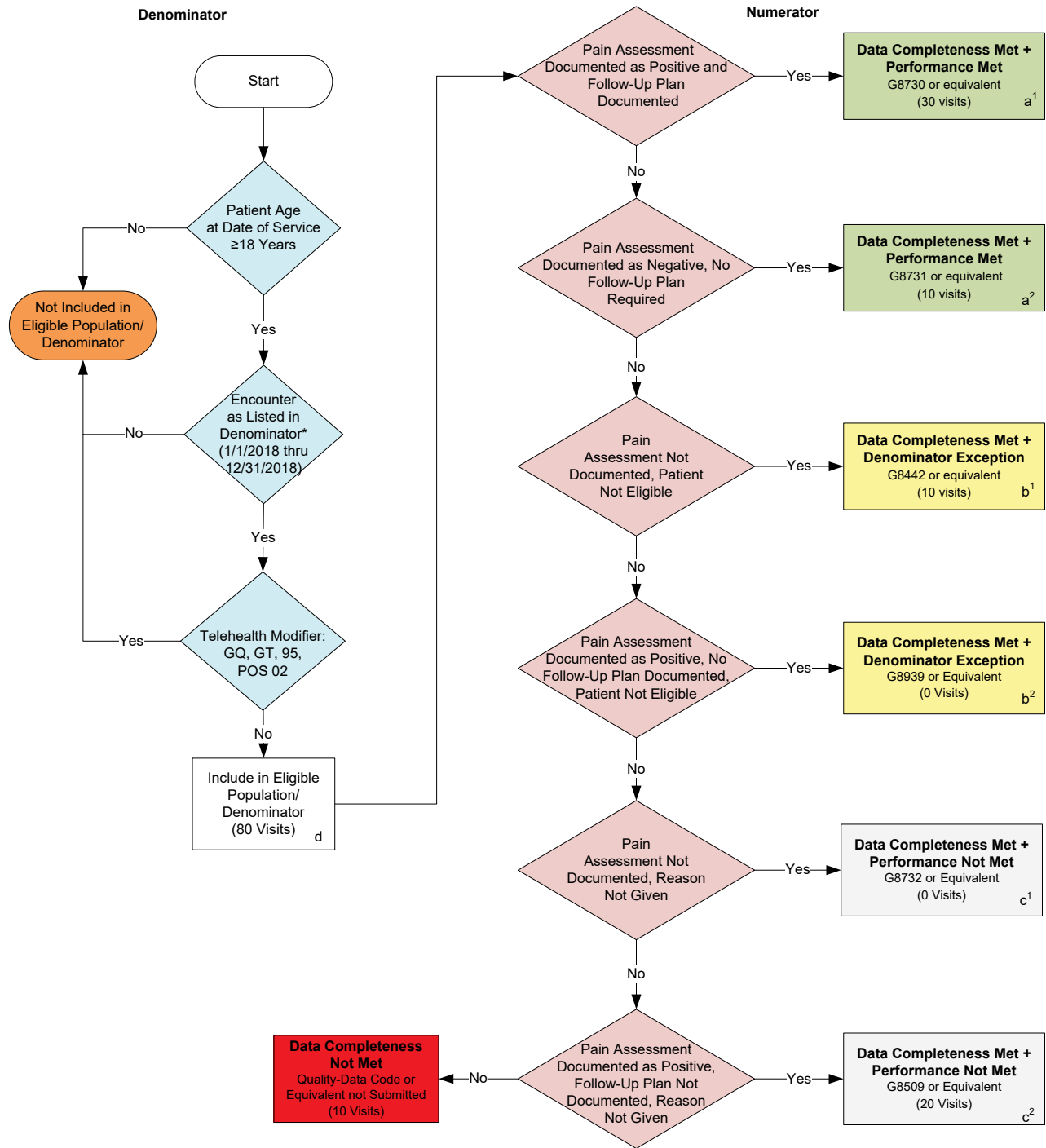
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## 2018 Registry Flow for Quality ID #131 NQF #0420: Pain Assessment and Follow-Up



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

NOTE: Submission Frequency: Visit

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## 2018 Registry Flow for Quality ID #131 NQF #0420: Pain Assessment and Follow-Up

### SAMPLE CALCULATIONS:

#### **Data Completeness=**

$$\frac{\text{Performance Met (a}^1\text{+a}^2\text{=40 visits) + Denominator Exception (b}^1\text{+b}^2\text{=10 visits) + Performance Not Met (c}^1\text{+c}^2\text{=20 visits)}}{\text{Eligible Population / Denominator (d=80 visits)}} = \frac{70 \text{ visits}}{80 \text{ visits}} = 87.50\%$$

#### **Performance Rate=**

$$\frac{\text{Performance Met (a}^1\text{+a}^2\text{=40 visits)}}{\text{Reporting Numerator (70 visits) – Denominator Exception (b}^1\text{+b}^2\text{=10 visits)}} = \frac{40 \text{ visits}}{60 \text{ visits}} = 66.67\%$$

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

NOTE: Submission 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.

**2018 Registry Flow for Quality ID  
#131 NQF #0420: Pain Assessment and Follow-Up**

Please refer to the specific section of the Specification to identify the denominator and numerator information for use in submitting this Individual Specification. This flow is for registry data submission.

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 Performance 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 Performance 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 80 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 a<sup>1</sup> equals 30 visits in the 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 a<sup>2</sup> equals 10 visit in the 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 b<sup>1</sup> equals 10 visit in the 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 b<sup>2</sup> equals 0 visits in the 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 c<sup>1</sup> equals 0 visits in the 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 c<sup>2</sup> equals 20 visits in the 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 submitted. 10 visits have been subtracted from the Data Completeness Numerator in the Sample Calculation.

**SAMPLE CALCULATIONS:**

**Data Completeness=**

$$\frac{\text{Performance Met (a}^1\text{+a}^2\text{=40 visits) + Denominator Exception (b}^1\text{+b}^2\text{=10 visits) + Performance Not Met (c}^1\text{+c}^2\text{=20 visits)}}{\text{Eligible Population / Denominator (d=80 visits)}} = \frac{70 \text{ visits}}{80 \text{ visits}} = \mathbf{87.50\%}$$

**Performance Rate=**

$$\frac{\text{Performance Met (a}^1\text{+a}^2\text{=40 visits)}}{\text{Reporting Numerator (70 visits) - Denominator Exception (b}^1\text{+b}^2\text{=10 visits)}} = \frac{40 \text{ visits}}{60 \text{ visits}} = \mathbf{66.67\%}$$