PQRS 2016 Pain-Reporting Specifics

In order to meet the quality reporting requirements as specified by CMS in their PQRS program, chiropractors who send claims to Medicare for Chiropractic Manipulative Therapy (CMT) using the codes 98940, 98941, or 98942 must submit a pain-related quality code for each visit during which a CMT is performed. Only one of the pain codes listed below can be included on the form. There is a quality/functional outcome measure that must be reported along with the pain measure. Please refer to the Fact Sheet entitled PQRS Functional Outcome Assessment Reporting Specifics for more information. In all, you must report a quality measure on pain and a quality measure on Functional Outcome Assessments (FOAs) for each active CMT code claim to Medicare.

Definitions:
Examples of Standardized Tools that May Be Used for Pain Assessment (including but 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)
- Visual Analog Scale (VAS)

A patient is not eligible if one or more of the following is documented:

- Severe mental and/or physical incapacity causing the person to be unable to express himself/herself in a manner understood by others. For example, cases in which pain cannot be accurately assessed through use of nationally recognized, standardized pain assessment tools.
- Patient is in an urgent or emergent situation in which time is of the essence, and to delay treatment would jeopardize the patient’s health status (life-threatening).

Follow-Up Plan Definition: Must include a planned follow-up appointment or referral, notification to other care providers, and/or an indication that the initial treatment plan is still in effect.

Why Are There So Many Codes to Choose From?

Although doctors are trained to evaluate whether a patient has pain or not, CMS has developed three categories of tools to systematize that evaluation. There are 300+ measure codes from which providers must choose, and each is divided into outcome-oriented categories. For example, the pain assessment measure is number 131, and the choices for reporting are divided into three sections. You will choose ONLY ONE pain measure code to report on each visit. The only reason for you to note these divisions is that CMS is moving to quality-only outcomes, and you must understand how PQRS reporting can reflect the quality that you provide in your office.

Pain 131:

1. Quality Care Is Demonstrated, Performance Met: (2016 50% or more required)
   - G8730 – Pain assessment was performed using a standardized tool, was positive, and a follow-up plan has been documented.
   - G8731 – Pain assessment was performed using a standardized tool, was negative, and no follow-up is required.
2. Exempt from Quality Care Analysis, Is Not Part of Total Patients
   - G8442 – Pain assessment not performed, patient not eligible for assessment using standardized tool (see not eligible definition above).
G8939 - Pain assessment is positive, but no follow-up plan is documented, patient not eligible (see not eligible definition above).

3. Fails to Show Quality, Performance Not Met (2015 less than 50% required)
   G8732 - No documentation of a pain assessment, reason not given.
   G8509 - Pain Assessment performed using a standardized tool, was positive, but no follow-up plan documented, reason not given.

Remember, only one pain quality code should be reported for a visit on which a CMT (98940, 98941, 98942) is being billed to Medicare. To avoid any confusion, we recommend that you bill each date of treatment on a separate form so that your final Medicare claim for a CMT visit should look something like the example at the end of this document.

<table>
<thead>
<tr>
<th>Examples of Narrative in Documentation</th>
<th>Quality Code to Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>The patient’s pain was assessed using a VAS 7/10. Pain will be reassessed next visit.</td>
<td>G8730</td>
</tr>
<tr>
<td>OR Patient’s pain was 4/5. Reassess in one week or next visit.</td>
<td></td>
</tr>
<tr>
<td>Pain on VAS was 0/10. Patient discharged from active care.</td>
<td>G8731</td>
</tr>
<tr>
<td>OR Pain remains 2/10 for last 2 weeks. Met MMI, discharged from active care.</td>
<td></td>
</tr>
<tr>
<td>Patient is accompanied by caregiver and is nonverbal and unable to communicate pain level.</td>
<td>G8442</td>
</tr>
<tr>
<td>Pain level 7/10 Faces Scale. Patient is unable to understand need to return for care due to mental handicap.</td>
<td>G8939</td>
</tr>
<tr>
<td>Patient can’t identify the pain specifically.</td>
<td>G8732</td>
</tr>
<tr>
<td>OR To be used if there is no pain documentation in record.</td>
<td></td>
</tr>
<tr>
<td>Pain on VAS 6/10.</td>
<td>G8509</td>
</tr>
</tbody>
</table>

NOTE: Documentation showing a scale such as 4/5 does not have to contain the type of standardized tool used for the assessment.

There are more hypothetical situations than we can list here, but using these examples will help you decide which code to report on your claim forms with a CMT code for Medicare patients. Documentation for this pain PQRS coding requirement could look like:

The patient’s pain was assessed using a VAS. Score today was 7/10. Pain will be reassessed next visit.

OR: Pain on VAS 7/10, Reassess next visit.

OR: Pain: 7/10 (VAS) RE-EVAL PN NXT VST.

OR: Pain remains 7/10, referral to (pain management intervention surgical consult, etc.), assess next visit.

**Submitting the Codes**

You can see from the following example that a CMT was performed on a specific date of service. It appears from the dates that this could be the first treatment visit following an evaluation. A pain assessment was performed and a follow-up assessment was planned and noted. This would indicate a G8730 should be reported, and the following was documented in the note for that visit: “Mr. xxxxxx reported pain at 8/10. Will reassess pain each visit during this treatment plan.”
You will also note that an additional G-code is present on this form. Please refer to Fact Sheets PQRS Functional Outcome Assessment Reporting Specifics and PQRS Blood Pressure Screening Reporting Specifics for information on choosing FOA quality codes for your Medicare claims. This claim form does not contain any doctor-specific or practice-specific information. For information on how to fully complete a claim form, please refer to the KMC University website for comprehensive training on claims, documentation, Medicare, and other practice-specific resources.

The following example demonstrates reporting of PQRS as it will appear on a claim to Medicare. All of the procedures should appear under the same date of service and should be on the same claim form “page.” We recommend you verify that your electronic claim forms will be contained to a single “electronic page” for each patient.