

Communication with the Physician Managing Ongoing Care Post Fracture

*This measure is to be reported after **each occurrence** of a fracture of the hip, spine or distal radius during the reporting period for all patients aged 50 years and older.*

Measure description

Percentage of patients aged 50 years and older treated for a hip, spine or distal radial fracture with documentation of communication with the physician managing the patient's ongoing care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis

What will you need to report for each occurrence of a fracture of the hip, spine or distal radius for this measure?

If you select this measure for reporting, you will report:

- Whether or not you communicated to the clinician managing the patient's ongoing care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis

Documentation must indicate that communication to the clinician managing the on-going care of the patient occurred within three months of treatment for the fracture.

What if this process or outcome of care is not appropriate for your patient?

There may be times when it is not appropriate to communicate post-fracture care, due to:

- Medical reasons (eg, not indicated, contraindicated, other medical reason) OR
- Patient reasons (eg, patient declined, economic, social, religious, other patient reason)

In these cases, you will need to indicate which reason applies, specify the reason on the worksheet and in the medical chart. The office/billing staff will then report a code with a modifier that represents these valid reasons (also called exclusions).

Note: This measure should be reported at one of the following two instances if communication post fracture has occurred or is planned within 3 months of fracture.

- 1) *During an office visit with ICD-9 diagnosis code for fracture of hip, spine or distal radius OR*
- 2) *At the time of a procedure to repair a fracture*

¹Communication may include: Documentation in the medical record indicating that the clinician treating the fracture communicated (eg, verbally, by letter, DXA report was sent) with the clinician managing the patient's on-going care OR a copy of a letter in the medical record outlining whether the patient was or should be treated for osteoporosis.

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PQRI Data Collection Sheet

Patient's Name	Practice Medical Record Number (MRN)	Birth Date (mm/dd/yyyy) / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
National Provider Identifier (NPI)		Date of Service	

Clinical Information

Billing Information

Step 1 Is patient eligible for this measure?

	Yes	No	Code Required on Claim Form
Patient is aged 50 years and older.	<input type="checkbox"/>	<input type="checkbox"/>	Verify date of birth on claim form.
Patient has a diagnosis of fracture of the hip, spine or distal radius AND a CPT E/M Service Code for this visit OR There is a CPT Procedure Code.	<input type="checkbox"/>	<input type="checkbox"/>	Refer to coding specifications document for list of applicable codes.
If No is checked for any of the above, STOP. Do not report a CPT category II code.			

Step 2 Does patient meet or have an acceptable reason for not meeting the measure?

Post-Fracture Care	Yes	No	Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)
Communicated ¹	<input type="checkbox"/>	<input type="checkbox"/>	5015F
Not communicated for one of the following reasons:			
• Medical (eg, not indicated, contraindicated, other medical reason)	<input type="checkbox"/>	<input type="checkbox"/>	5015F-1P
• Patient (eg, patient declined, economic, social, religious, other patient reason)	<input type="checkbox"/>	<input type="checkbox"/>	5015F-2P
Document reason here and in medical chart. _____ _____			If No is checked for all of the above, report 5015F-8P (No documentation of communication that a fracture occurred and that the patient was or should be tested or treated for osteoporosis, reason not otherwise specified.)

Note: This measure should be reported at one of the following two instances if communication post fracture has occurred or is planned within 3 months of fracture.

- 1) During an office visit with ICD-9 diagnosis code for fracture of hip, spine or distal radius OR
- 2) At the time of a procedure to repair a fracture

¹Communication may include: Documentation in the medical record indicating that the clinician treating the fracture communicated (eg, verbally, by letter, DXA report was sent) with the clinician managing the patient's on-going care OR a copy of a letter in the medical record outlining whether the patient was or should be treated for osteoporosis.

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Coding Specifications

Codes required to document patient has fracture of the hip, spine or distal radius and a visit or procedure occurred:

An ICD-9 diagnosis code for fracture of the hip, spine or distal radius and a CPT E/M service code OR a CPT procedure code are required to identify patients to be included in this measure.

Note: This measure should be reported at one of the following two instances if communication post fracture has occurred or is planned within 3 months of fracture.

- 1) During an office visit with ICD-9 diagnosis code for fracture of hip, spine or distal radius OR
- 2) At the time of a procedure to repair a fracture

Fracture of the hip, spine or distal radius ICD-9 diagnosis codes

- 733.12, 733.13, 733.14 (pathologic fracture),
- 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.10, 805.11, 805.12, 805.13, 805.14, 805.15, 805.16, 805.17, 805.18 (cervical fracture),
- 805.2 (dorsal- thoracic fracture),
- 805.4 (lumbar fracture),
- 805.6, 805.8 (sacrum and coccyx fracture),
- 813.40, 813.41, 813.42, 813.44, 813.45, 813.50, 813.51, 813.52, 813.54 (radius and ulna fracture),
- 820.00, 820.01, 820.02, 820.03, 820.09, 820.10, 820.11, 820.13, 820.20, 820.21, 820.22, 820.8, 820.9 (femur fracture)

AND

CPT E/M service codes

- 99201, 99202, 99203, 99204, 99205 (office — new patient),
- 99212, 99213, 99214, 99215 (office — established patient),
- 99241, 99242, 99243, 99244, 99245 (outpatient consult),

OR

CPT procedure codes

- 22305, 22310, 22315, 22318, 22319, 22325, 22326, 22327, 22520, 22521, 22523, 22524 (vertebral procedure),
- 25600, 25605, 25606, 25607, 25608, 25609 (radial procedure),
- 27230, 27232, 27235, 27236, 27238, 27240, 27244, 27245, 27246, 27248 (femoral procedure)

Quality codes for this measure (one of the following for every eligible patient):

CPT II Code descriptors

(Data Collection sheet should be used to determine appropriate combination of codes.)

- **CPT II 5015F:** Documentation of communication that a fracture occurred and that the patient was or should be tested or treated for osteoporosis
- **CPT II 5015F-1P:** Documentation of medical reason(s) for not communicating with physician managing ongoing care of patient that a fracture occurred and that the patient was or should be tested or treated for osteoporosis
- **CPT II 5015F-2P:** Documentation of patient reason(s) for not communicating that a fracture occurred and that the patient was or should be tested or treated for osteoporosis with physician managing ongoing care of patient
- **CPT II 5015F-8P:** No documentation of communication that a fracture occurred and that the patient was or should be tested or treated for osteoporosis, reason not otherwise specified

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