# Screening for Future Fall Risk

*This measure is to be reported for all patients aged 65 years and older seen by the clinician — a minimum of **once** per reporting period.*

## Measure description

Percentage of patients aged 65 years and older who were screened for future fall[1] risk (patients are considered at risk for future falls if they have had 2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months

## What will you need to report for each patient aged 65 years and older for this measure?

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

- Whether or not you screened the patient for future fall risk. Patients will fall into one of two categories described below:
  - At risk — Documentation of two or more falls in the past year or any fall with injury in the past year OR
  - Not at risk — Documentation of no falls in the past year or only one fall without injury in the past year

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

There may be times when it is not appropriate to screen the patient for future fall risk, due to:

- Medical reasons (eg, patient is not ambulatory)

In these cases, you will need to indicate that the medical 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).

[1]A fall is defined as 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 (Tinetti et al., 1997).

# Geriatric Care

## Screening for Future Fall Risk

### PQRI Data Collection Sheet

| | | | |
|---|---|---|---|
| | | / / | ☐ Male ☐ Female |
| Patient's Name | Practice Medical Record Number (MRN) | Birth Date (mm/dd/yyyy) | Gender |
| National Provider Identifier (NPI) | | Date of Service | |

## Clinical Information

### Step 1 Is patient eligible for this measure?

| | Yes | No |
|---|---|---|
| Patient is aged 65 years and older. | ☐ | ☐ |
| There is a CPT E/M Service Code for this visit. | ☐ | ☐ |

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?

| Screening for Future Fall[1] Risk | Yes | No |
|---|---|---|
| Performed — Patient is at risk (documentation of two or more falls in the past year or any fall with injury in the past year) | ☐ | ☐ |
| Performed — Patient is not at risk (documentation of no falls in the past year or only one fall without injury in the past year) | ☐ | ☐ |
| Not performed for the following reason:<br>• Medical (eg, patient is not ambulatory) | ☐ | ☐ |

Document reason here and in medical chart.

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## Billing Information

| Code Required on Claim Form |
|---|
| Verify date of birth on claim form. |
| Refer to coding specifications document for list of applicable codes. |

| Code to be Reported on Line 24D of Paper Claim Form, if *Yes* (or Service Line 24 of Electronic Claim Form) |
|---|
| 1100F |
| 1101F |
| 1100F–1P or 1101F–1P |
| If **No** is checked for **all** of the above, report 1100F–8P (Patient was not screened for future fall risk, reason not otherwise specified.) |

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## Coding Specifications

Codes required to document a visit occurred:

- A CPT E/M service code is required to identify patients to be included in this measure.

**CPT E/M service codes**

- 97001, 97002, 97003, 97004 (physical medicine and rehabilitation),
- 99201, 99202, 99203, 99204, 99205 (office-new patient),
- 99212, 99213, 99214, 99215 (office-established patient),
- 99304, 99305, 99306, 99307, 99308, 99309, 99310 (nursing facility),
- 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337 (domiciliary),
- 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350 (home visit)
- 99387 (preventive medicine services — new patient),
- 99397 (preventive medicine services — established patient),
- 99401, 99402, 99403, 99404 (preventive medicine services — individual counseling)

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 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
- ***CPT II 1101F:*** Patient screened for future fall risk; documentation of no falls in the past year or only one fall without injury in the past year
- ***CPT II 1100F–1P*** OR ***1101F–1P:*** Documentation of medical reason(s) for not screening for future fall risk (eg, patient is not ambulatory)
- ***CPT II 1100F–8P:*** Patient was not screened for future fall risk, reason not otherwise specified