Osteoporosis

Communication with the Physician Managing Ongoing Care Post Fracture

PQRI Data Collection Sheet

Patient's Name	Practice Medical Record Number (MRN)	Birth Date (mm/dd/yyyy)	Gender
		/ /	☐ Male ☐ 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.	☐	☐	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.	☐	☐	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]	☐	☐	5015F
Not communicated for one of the following reasons: • Medical (eg, not indicated, contraindicated, other medical reason)	☐	☐	5015F–1P
• Patient (eg, patient declined, economic, social, religious, other patient reason)	☐	☐	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 occured 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 occured 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

[1]Communication 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.