Falls — Risk Assessment (Measure 154) and Plan of Care (Measure 155)

*Measure 154 (falls — risk assessment) is to be reported for all patients aged 65 years and older seen by the clinician — a minimum of **once** per reporting period. If patient is identified as at risk for future falls, then paired measure 155 (falls — plan of care) should also be reported.*

Measure description

Measure 154 (falls — risk assessment)

Percentage of patients aged 65 years and older with a history of falls[1] who had a risk assessment[2] for falls completed within 12 months

Measure 155 (falls — plan of care)

Percentage of patients aged 65 years and older with a history of falls[1] who had a plan of care[3] for falls documented within 12 months

What will you need to report for each patient aged 65 years and older for these paired measures?

If you select measures 154 and 155 for reporting, you will report:

- Whether or not the patient is at risk for future falls (ie, there is documentation of two or more falls in the past year or any fall with injury in the past year)

If the patient is at risk for future falls, you will then need to report:

- Whether or not you completed a risk assessment[2] for falls

  AND
- Whether or not you documented a plan of care[3] for falls

If a patient is not at risk for future falls, you do not need to report measure 155 for this patient.

What if these processes or outcomes of care are not appropriate for your patient?

There may be times when it is not appropriate to complete a risk assessment for falls or document a plan of care for falls, due to:

- Medical reasons (eg, not indicated, contraindicated, other medical reason)

In these cases, you will need to indicate that the medical reason applies, and 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]Fall — 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.

[2]Risk Assessment — Comprised of balance/gait AND one or more of the following: postural blood pressure, vision, home fall hazards, and documentation on whether medications are a contributing factor or not to falls within the past 12 months. *NOTE: All components do not need to be completed during one patient visit, but should be documented in the medical record as having been performed within the past 12 months.*

[3]Plan of Care — Must include: 1) consideration of appropriate assistance device AND 2) balance, strength, and gait training. Consideration of Appropriate Assistance Device — Medical record must include: documentation that an assistive device was provided or considered OR referral for evaluation for an appropriate assistance device. Balance, Strength, and Gait Training — Medical record must include: documentation that balance, strength, and gait training/instructions were provided OR referral to an exercise program, which includes at least one of the three components: balance, strength or gait. *NOTE: All components do not need to be completed during one patient visit, but should be documented in the medical record as having been performed within the past 12 months.*

Physician Quality Reporting System 2011 Measures 154 and 155, Effective Date 01/01/2011