Communication with the Physician Managing Ongoing Care Post Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older

*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 men and women aged 50 years and older. It is anticipated that clinicians who treat the hip, spine, or distal radial fracture will submit this measure.*

Measure description

Percentage of patients aged 50 years and older treated for a hip, spine or distal radius fracture with documentation of communication[1] 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[1] to the clinician managing the ongoing 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, 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).

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-CM 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 ongoing care OR a copy of a letter in the medical record outlining whether the patient was or should be treated for osteoporosis.