Osteoporosis

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

Physician Quality Reporting System 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

Step 1 Is patient eligible for this measure?

	Yes	No
Patient is aged 50 years and older on date of encounter.	☐	☐
Patient has a diagnosis of fracture of the hip, spine or distal radius AND a CPT Code for this visit OR Patient has a diagnosis of fracture of the hip, spine or distal radius and there is a CPT Procedure Code.	☐	☐
If **No** is checked for any of the above, STOP. Do not report a CPT category II code.		

Billing Information

Code Required on Claim Form

Verify date of birth on claim form.

Refer to coding specifications document for list of applicable codes. Codes determining a patient's eligibility must be reported on the same claim as the quality code(s) identified below.

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-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.

Physician Quality Reporting System 2011 Measure 24, Effective Date 01/01/2011