Pain Assessment Prior to Initiation of Patient Therapy and Follow-Up

*This measure is to be reported for **each** visit occurring during the reporting period for all patients aged 18 years and older.*

Measure description

Percentage of patients aged 18 years and older with documentation of a pain assessment (if pain is present, including location, intensity and description) through discussion with the patient including the use of a standardized tool[1] on each visit prior to initiation of therapy AND documentation of a follow-up plan[2]

What will you need to report for each visit for patients aged 18 years and older for this measure?

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

- Whether or not you assessed for pain using a standardized tool prior to initiation of therapy AND documented a follow-up plan, if appropriate

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

There may be times when it is not appropriate to assess for pain prior to initiation of therapy, due to:

- Documented reasons (eg, patient refuses to participate; severe mental and/or physical incapacity; patient's motivation to improve may impact accuracy of results; patient is in urgent or emergent situation and to delay treatment would jeopardize the patient's health status)

There may be times when it is not appropriate to document a follow-up plan, due to:

- Documented reasons (eg, absence of pain on assessment, diagnosis/condition/illness if not situationally related to pain)

In these cases, you will need to indicate that a documented reason applies, and specify the reason on the worksheet and in the medical chart. The office/billing staff will then report the G-code that represents these valid reasons (also called exclusions).

[1]A standardized tool is a test or measure administered and scored in a consistent manner and supported by psychometric literature. Examples of tools for pain assessment include, but are not limited to, Multidimensional Pain Score and McGill Pain Questionnaire.

[2]Such follow-up must include a reassessment of pain and may include documentation of a future appointment, education, referral, notification of primary care provider, etc.