Back Pain Measures Group

Physician Quality Reporting System Data Collection Sheet*

Patient's Name	Practice Medical Record Number (MRN)	Birth Date (mm/dd/yyyy) / /	☐ Male ☐ Female
National Provider Identifier (NPI)		Date of Encounter	

Step 1 Preliminary reporting requirements

You must identify your intent to report the Back Pain Measures Group by submitting the G-code specified for this measures group on the first patient claim (G8493: I intend to report the Back Pain Measures Group). You do not need to resubmit the measures group-specific G-code on more than one claim.

Step 2 Determine patient eligibility

*(Codes determining a patient's eligibility must be reported on the **same claim** as the quality code(s) identified in Step 3 below.)*

	Yes	No	
Patient is aged 18 through 79 on date of encounter.	☐	☐	Refer to date of birth listed above or on claim form.
If **No** is checked for the above, STOP. This patient is not eligible for reporting on this measures group. Do not report a CPT category II code or G-code.			
Patient has a diagnosis indicating back pain AND a CPT Code for an office visit or physical therapy evaluation.	☐	☐	721.3 721.41, 721.42, 721.90, 722.0, 722.10, 722.11, 722.2, 722.30, 722.31, 722.32, 722.39, 722.4, 722.51, 722.52, 722.6, 722.70, 722.71, 722.72, 722.73, 722.80, 722.81, 722.82, 722.83, 722.90, 722.91, 722.92, 722.93, 723.0, 724.00, 724.01, 724.02, 724.09, 724.2, 724.3, 724.4, 724.5, 724.6, 724.70, 724.71, 724.79, 738.4, 738.5, 739.3, 739.4, 756.12, 846.0, 846.1, 846.2, 846.3, 846.8, 846.9, 847.2 AND 97001, 97002, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215
OR	**OR**		**OR**
There is a CPT Code for back surgery.	☐	☐	22210, 22214, 22220, 22222, 22224, 22226, 22532, 22533, 22534, 22548, 22554, 22556, 22558, 22585, 22590, 22595, 22600, 22612, 22614, 22630, 22632, 22818, 22819, 22830, 22840, 22841, 22842, 22843, 22844, 22845, 22846, 22847, 22848, 22849, 63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63035, 63040, 63042, 63043, 63044, 63045, 63046, 63047, 63048, 63055, 63056, 63057, 63064, 63066, 63075, 63076, 63077, 63078, 63081, 63082, 63085, 63086, 63087, 63088, 63090, 63091, 63101, 63102, 63103 , 63170, 63172, 63173, 63180, 63182, 63185, 63190, 63191, 63194, 63195, 63196, 63197, 63198, 63199, 63200
If **No** is checked for both of the above, STOP. This patient is not eligible for reporting on this measures group. Do not report a CPT category II code or G-code.			

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*For additional information on the Physician Quality Reporting System program and reporting on measures groups, please visit the CMS Web site at http://www.cms.hhs.gov/pqri.

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Determine if patient meets additional eligibility criteria			
	Yes	**No**	
Is this the first visit[1] to the clinician for a new episode[2] of back pain (ie, a new or recurrent episode of back pain that has not been seen or treated by this practitioner during the four preceding months)?	☐	☐	If **No,** report 0526F once for this patient AND STOP. If Yes, proceed to Step 3.

Step 3 Complete individual measures

Comprehensive Initial Assessment *(including pain assessment, functional status, patient history, assessment of prior treatment and response, and employment status)*	Report one code for comprehensive assessment OR one code for NOT completed.	
Physician Quality Reporting System Measure #148 • *reporting frequency: comprehensive assessment must be completed and reported at the initial visit* • *preferred standardized assessment tools for pain and functional assessment include: SF-36, Oswestry Low Back Pain Disability Questionnaire, Roland-Morris Disability Questionnaire, Quebec Pain Disability Scale, Sickness Impact Profile, Multidimensional Pain Inventory)* • *warning signs include: history of cancer or unexplained weight loss, current infection or immunosuppression, fracture or suspected fracture, cauda equina syndrome or progressive neurologic deficit* • *preferred standardized assessment tools for employment status assessment include: Sickness Impact Profile, Multidimensional Pain Inventory* • *variables of an employment assessment include: type of work; work status; length of time for work limitations, if applicable; workers' compensation or litigation involvement*	Pain assessment completed using one of the preferred standardized tools or an acceptable alternative	☐ 1130F
	Functional assessment completed using one of the preferred standardized tool or assessment of activities of daily living	
	Patient history completed including notation of presence or absence of warning signs	
	Assessment of prior back pain episodes completed and if applicable, associated treatment and response	
	Employment status assessment completed using one of the preferred standardized tools or an assessment of specified variables	
	Comprehensive assessment NOT completed, patient not eligible, subsequent visit for episode	☐ 0526F
	OR	
	Comprehensive assessment NOT completed	☐ 1130F–8P
Physical Exam	Report the following code for physical exam OR one code for NOT performed.	
Physician Quality Reporting System Measure #149 • *reporting frequency: physical exam must be performed and reported at the initial visit* • *for patients with radicular symptoms, physical exam must include: straight leg raise test AND notation of completion of neurovascular exam* • *for patients without radicular symptoms, physical exam must include: straight leg raise test AND either neurovascular exam or clear notation of absence or presence of neurologic deficits*	Performed	☐ 2040F
	Comprehensive assessment NOT completed, patient not eligible, subsequent visit for episode	☐ 0526F
	OR	
	Physical exam NOT performed	☐ 2040F–8P

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[1]Initial Visit — First visit to the clinician during an episode of back pain. There can only be one initial visit with each clinician, but there can be more than one initial visit for a patient, if multiple clinicians evaluate or treat the patient for the back pain episode. Report the appropriate Quality Data Codes on the claim for each initial visit. For each subsequent encounter after the initial visit with that clinician, or if the initial visit with that clinician occurred prior to the start of the reporting period, then report 0526F.

[2]Episode — Patient with back pain who has not been seen or treated for back pain by any practitioner during the four months prior to the first clinical encounter with a diagnosis of back pain. If a patient has a four-month period without treatment, and then sees both a primary care physician and a specialist, both visits are considered the initial visit with that clinician. A new episode can either be a recurrence for a patient with prior back pain or a patient with a new onset of back pain. The first clinical encounter after the four months without being seen or treated for back pain is considered the beginning of the new episode.

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Advice for Normal Activities	Report the following code for advice for normal activities or one code for NOT provided.	
Physician Quality Reporting System Measure #150 • *reporting frequency: advice for normal activities must be provided and reported at the initial visit*	Advice provided to maintain or resume normal activities	☐ 4245F
	Comprehensive assessment NOT completed, patient not eligible, subsequent visit for episode	☐ 0526F
	OR	
	Advice NOT provided	☐ 4245F–8P
Advice Against Bed Rest	Report the following code for advice against bed rest or one code for NOT provided.	
Physician Quality Reporting System Measure #151 • *reporting frequency: advice against bed rest must be provided and reported at the initial visit*	Advice provided against bed rest lasting four days or longer	☐ 4248F
	Comprehensive assessment NOT completed, patient not eligible, subsequent visit for episode	☐ 0526F
	OR	
	Advice NOT provided	☐ 4248F–8P

Step 4 Reporting Instructions

This measure can be reported for each eligible patient in one of two ways:

1. Report the corresponding CPT category II code(s) as selected above for each of the four measures in the Back Pain Measures Group.

   OR

2. If **all** quality actions for the patient have been performed for each of the four measures in the Back Pain Measures Group, **G8502** may be reported. *Note: G8502 is not appropriate for this patient if any CPT category II codes with the 8P modifier have been selected from Step 3.*