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

Coding Specifications

Codes required to document a visit occurred:

A CPT code is required to identify patients to be included in this measure.

All measure specific coding should be reported on the claim(s) representing the eligible encounter.

CPT codes

- 90801
- 90802
- 96116
- 96150
- 97001
- 97003
- 98940, 98941, 98942

Quality codes for this measure:

G-code descriptors

(Data collection sheet should be used to determine appropriate code.)

- ***G8440:*** Documentation of pain assessment (including location, intensity and description) prior to initiation of therapy or documentation of the absence of pain as a result of assessment through discussion with the patient including the use of a standardized tool AND a follow-up plan is documented
- ***G8442:*** Documentation that patient is not eligible for pain assessment
- ***G8508:*** Documentation of pain assessment (including location, intensity and description) prior to initiation of therapy or documentation of the absence of pain as a result of assessment through discussion with the patient including the use of a standardized tool; no documentation of a follow-up plan, patient not eligible
- ***G8441:*** No documentation of pain assessment (including location, intensity and description) prior to initiation of therapy
- ***G8509:*** Documentation of pain assessment (including location, intensity and description) prior to initiation of therapy or documentation of the absence of pain as a result of assessment through discussion with the patient including the use of a standardized tool; no documentation of a follow-up plan, reason not specified

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Physician Quality Reporting System 2011 Measure 131, Effective Date 01/01/2011
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