

Medicare 2007 Physician Quality Reporting Initiative (PQRI): Falls Work Sheet

Has patient been screened for future fall risk? Conduct screen if patient \geq 65 years old on date of encounter, hasn't been screened within 12 mos or the reporting period, and for **non-acute settings** (excludes ED and acute care hospitals). Circle all that apply and be sure to document reasons for exclusions.

Date of Service: _____ Physician NPI: _____ Patient: _____ \geq 65 yo no scrn w/n 12 mos or rpt pd

Screening for Future Fall* Risk		
<p>CPT E/M service codes: A CPT E/M service code to identify patients aged 65 years and older who were seen by the clinician is required for denominator inclusion.</p> <ul style="list-style-type: none"> - 97001-97004 Physical medicine and rehabilitation - 99201-99205 New patient office or other outpatient visit; levels 1-5 - 99212-99215 Established patient office or other outpatient visit; levels 2-5 - 99304-99310 Initial nursing facility care, per day; Subsequent nursing facility care, per day - 99324-99328 New patient domiciliary or rest home visit; levels 1-5 - 99334-99337 Established patient domiciliary or rest home visit; levels 1-4 - 99341-99345 New patient home visit; levels 1-5 - 99347-99350 Established patient home visit; levels 1-4 - 99387 New patient initial comprehensive preventive medicine; 65 years and older - 99397 Established patient periodic comprehensive preventive medicine re-evaluation; 65 years and older - 99401-99404 Preventive medicine counseling and/or risk factor reduction; approx. 15 minutes, approx. 30 minutes, approx. 45 minutes, approx. 60 minutes <p>*Definition: A fall is defined as a sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force (Tinetti).</p>		
Patient Screened for Future Fall Risk?		
Yes, patient screened for future fall risk.		No, due to exception
Yes, documentation of 2 or more falls in the past year or fall with injury	Yes, documentation of no falls in the past or only one fall without injury in the past year	1100F (\geq 2 falls) + 1P modifier (medical reason) OR 1101F (<1 fall) + 1P modifier (medical reason) OR 1100F8P (reason not otherwise specified)
1100F	1101F	
<p><i>The "P" modifiers listed for the measure are the only allowable reasons for exclusion. The reason must be documented in the medical record.</i></p>		