Pain Management

Pain Assessment 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 seen during the reporting period.

Measure description

Percentage of visits for patients aged 18 years and older with documentation of a pain assessment\(^1\) through discussion with the patient including the use of a standardized tool(s)\(^2\) on each visit AND documentation of a follow-up plan\(^3\) when pain is present

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(s)\(^2\) AND documented a follow-up plan when pain is present

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 or document a follow-up plan, due to:

- Documented reasons (e.g., severe mental and/or physical incapacity; patient is in urgent or emergent situation and to delay treatment would jeopardize the patient’s health status)

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 exceptions).

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\(^1\)Pain assessment — A clinical assessment of pain using a standardized tool for the presence and characteristics of pain; characteristics may include location, intensity, quality, and onset/duration.

\(^2\)Standardized tool — An assessment tool that has been appropriately normalized and validated for the population in which it is used. Examples of tools for pain assessment include, but are not limited to: Brief Pain Inventory (BPI), Faces Pain Scale (FPS), McGill Pain Questionnaire (MPQ), Multidimensional Pain Inventory (MPI), Neuropathic Pain Scale (NPS), Numeric Rating Scale (NRS), Oswestry Disability Index (ODI), Roland Morris Disability Questionnaire (RMDQ), Verbal Descriptor Scale (VDS), Verbal Numeric Rating Scale (VNRS), Visual Analog Scale (VAS).

\(^3\)Follow-Up Plan — Proposed outline of treatment to be conducted as a result of pain assessment. Follow-up must include a planned reassessment of pain and may include documentation of future appointments, education, referrals, pharmacological intervention, or notification of other providers as applicable.
Coding Specifications
Codes required to document a visit occurred:

A CPT or HCPCS 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 or HCPCS codes
- 90791, 90792
- 92507, 92508
- 92526
- 96116
- 96150
- 97001
- 97003
- 97532
- 98940, 98941, 98942
- 99201, 99202, 99203, 99204, 99205
- 99212, 99213, 99214, 99215
- G0101
- G0402
- G0438, G0439

Quality codes for this measure:

G-code descriptors
(Data collection sheet should be used to determine appropriate code.)
- G8730: Pain assessment documented as positive utilizing a standardized tool AND a follow-up plan is documented
- G8731: Pain assessment documented as negative, no follow-up plan required
- G8939: Pain assessment documented, follow-up plan not documented, patient not eligible/appropriate\(^1\)
- G8442: Documentation that patient is not eligible\(^1\) for a pain assessment
- G8732: No documentation of pain assessment, reason not given
- G8509: Documentation of positive pain assessment; no documentation of a follow-up plan, reason not given

\(^1\)Not eligible — A patient is not eligible if one or more of the following reasons exist: severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others (for example, cases where pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools); patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient’s health status.

Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. Quality Insights of Pennsylvania disclaims all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications. CPT contained in the Measure specifications is copyright 2004-2012 American Medical Association. All Rights Reserved. These performance measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.

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### Step 1  Is patient eligible for this measure?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Code Required on Claim Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>Verify date of birth on claim form.</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>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.</td>
</tr>
</tbody>
</table>

### Step 2  Does patient meet or have an acceptable reason for not meeting the measure?

#### Pain Assessment

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>G8730</td>
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<tr>
<td>☐</td>
<td>☐</td>
<td>G8442</td>
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<tr>
<td>☐</td>
<td>☐</td>
<td>G8731</td>
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<tr>
<td>☐</td>
<td>☐</td>
<td>G8939</td>
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<tr>
<td>☐</td>
<td>☐</td>
<td>G8732 (No documentation of pain assessment, reason not given)</td>
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<tr>
<td>☐</td>
<td>☐</td>
<td>G8509 (Documentation of positive pain assessment, no documentation of a follow-up plan, reason not given)</td>
</tr>
</tbody>
</table>

1Follow-Up Plan — Proposed outline of treatment to be conducted as a result of pain assessment. Follow-up must include a planned reassessment of pain and may include documentation of future appointments, education, referrals, pharmacological intervention, or notification of other providers as applicable.