

2011 AAOS PQRS WORKSHEET, No. 4
Coding – CPT Level II with Modifiers and G-Codes

0518F: Falls plan of care documented.

1P: Documentation of medical reason(s) for no plan of care for falls.

8P: Plan of care not documented, reason not otherwise specified.

0526F: Subsequent visit for the episode. (MEASURE GROUP ONLY).

1006F: Osteoarthritis symptoms and functional status assessed (may include the use of a standardized scale or the completion of an assessment questionnaire, such as the SF-36, AAOS Hip & Knee Questionnaire).

8P: Osteoarthritis symptoms and functional status not assessed, reason not otherwise specified.

1007F: Use of anti-inflammatory or analgesic over the counter (OTC) medications for symptom relief assessed.

8P: Use of anti-inflammatory or analgesic OTC medications not assessed, reason not otherwise specified.

1100F: Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year.

1101F: Patient screened for future fall risk; documentation of no falls in the past year or only one fall without injury in the past year.

8P: No documentation of falls status.

1130F: Back pain and function assessed, including all of the following: Pain assessment AND functional status AND patient history, including notation of presence or absence of “red flags” (warning signs) AND assessment of prior treatment and response, AND employment status. (MEASURE GROUP ONLY).

8P: Back pain and function was not assessed during the initial visit, reason not otherwise specified.

2028F: Foot examination performed (includes examination through visual inspection, sensory exam with monofilament, and pulse exam – report when any of the 3 components are completed).

1P: Documentation of medical reason for not performing foot exam (i.e., patient with bilateral foot/leg amputation).

8P: Foot exam was not performed, reason not otherwise specified.

2040F: Physical examination on the date of the initial visit for low back pain performed, in accordance with specifications. (MEASURE GROUP ONLY).

8P: Physical exam was not performed during the initial visit, reason not otherwise specified.

3095F: Central Dual-energy X-Ray Absorptiometry (DXA) results documented.

1P: Documentation of medical reason(s) for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement.

2P: Documentation of patient reason(s) for not ordering or performing central dual energy X-ray absorptiometry (DXA) measurement.

3P: Documentation of system reason(s) for not ordering or performing central dual energy X-ray absorptiometry (DXA) measurement.

8P: Central dual energy X-ray absorptiometry (DXA) measurement was not ordered or performed, reason not otherwise specified.

3096F: Central Dual-energy X-Ray Absorptiometry (DXA) ordered.

1P: Documentation of medical reason(s) for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement.

2P: Documentation of patient reason(s) for not ordering or performing central dual energy X-ray absorptiometry (DXA) measurement.

3P: Documentation of system reason(s) for not ordering or performing central dual energy X-ray absorptiometry (DXA) measurement.

8P: Central dual energy X-ray absorptiometry (DXA) measurement was not ordered or performed, reason not otherwise specified.

3288F: Fall assessment risk documented AND 1100F above.

1P: Documentation of medical reason(s) for not completing a risk assessment for falls.

8P: Falls risk assessment not completed, reason not otherwise specified.

3570F: Final report for bone scintigraphy study includes correlation with existing relevant imaging studies (e.g., x-ray, MRI, CT) corresponding to the same anatomical region in question.

3P: Documentation of system reason(s) for not documenting correlation with existing relevant imaging studies in final report (e.g. no existing relevant imaging study available, patient did not have a previous relevant imaging study). **Note:** Correlative studies are considered to be unavailable if relevant studies (reports and/or actual examination material) from other imaging modalities exist but could not be obtained after reasonable efforts to retrieve the studies are made by the interpreting physician prior to the finalization of the bone scintigraphy report.

8P: Bone scintigraphy report not correlated, reason not otherwise specified.

4005F: Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed.

1P: Documentation of medical reason(s) for not prescribing pharmacologic therapy for osteoporosis.

2P: Documentation of patient reason(s) for not prescribing pharmacologic therapy for osteoporosis.

3P: Documentation of system reason for not prescribing pharmacologic therapy for osteoporosis.

8P: Pharmacologic therapy for osteoporosis was not prescribed, reason not otherwise specified.

4041F: Documentation of order for cefazolin OR cefuroxime for antimicrobial prophylaxis.

1P: Documentation of medical reason(s) for not ordering cefazolin OR cefuroxime for antimicrobial prophylaxis.

8P: Order for cefazolin OR cefuroxime for antimicrobial prophylaxis was not documented, reason not otherwise specified.

4042F: Documentation that prophylactic antibiotics were neither given within 4 hours prior to surgical incision nor given intraoperatively.

4044F: Documentation that an order was given for venous thromboembolism (VTE) prophylaxis to be given within 24 hours prior to incision time or 24 hours after surgery end time.

1P: Documentation of medical reason(s) for patient not receiving any form of VTE prophylaxis (LMWH, LDUH, adjusted-dose warfarin, fondaparinux or mechanical prophylaxis) within 24 hours prior to incision time or 24 hours after surgery end time.

8P: Order was not given for venous thromboembolism (VTE) prophylaxis to be given within 24 hours prior to incision time or 24 hours after surgery end time, reason not otherwise specified.

4046F: Documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or given intraoperatively.

4049F: Documentation that order was given to discontinue prophylactic antibiotics within 24 hours of surgical end time, non-cardiac procedure.

1P: Documentation of medical reason(s) for not discontinuing prophylactic antibiotics within 24 hours of surgical end time.

8P: Order was not given to discontinue prophylactic antibiotics within 24 hours of surgical end time, non-cardiac procedure, reason not otherwise specified.

4245F: Patient counseled during the initial visit to maintain or resume normal activities. (MEASURE GROUP ONLY)

8P: Advice for normal activities was not performed during the initial visit, reason not otherwise specified.

4248F: Patient counseled during the initial visit for an episode of back pain against bed rest lasting 4 days or longer. (MEASURE GROUP ONLY)

8P: Advice against bed rest was not performed during the initial visit, reason not otherwise specified.

5015F: Documentation of communication that a fracture occurred and that the patient was or should be tested or treated for osteoporosis.

1P: Documentation of medical reason(s) for not communicating with physician managing ongoing care of patient that a fracture occurred and that the patient was or should be tested or treated for osteoporosis.

2P: Documentation of patient reason(s) for not communicating that a fracture occurred and that the patient was or should be tested or treated for osteoporosis with physician managing ongoing care of patient.

8P: No documentation of communication that a fracture occurred and that the patient was or should be tested or treated for osteoporosis, reason not otherwise specified.

G8399: Patient with central Dual-energy X-Ray Absorptiometry (DXA) results documented or ordered or pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed. No Modifier Applicable.

G8400: Patient with central Dual-energy X-Ray Absorptiometry (DXA) results not documented or not ordered or pharmacologic therapy (other than minerals/vitamins) for osteoporosis not prescribed. No Modifier Applicable.

G8401: Clinician documented that patient was not an eligible candidate for screening or therapy for osteoporosis for women measure. No Modifier Applicable.

G8404: Lower extremity neurological exam performed and documented. No Modifier Applicable.

G8405: Lower extremity neurological exam not performed. No Modifier Applicable.

G8406: Clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure. No Modifier Applicable.

G8410: Footwear evaluation performed and documented. No Modifier Applicable.

G8415: Footwear evaluation was **not** performed. No Modifier Applicable.

G8416: Clinician documented that patient was not an eligible candidate for footwear evaluation measure. No Modifier Applicable.

G8427: List of current medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) documented by the provider, including drug name, dosage, frequency and route. No Modifier Applicable.

G8428: Current medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) with drug name, dosage, frequency and route not documented by the provider, reason not specified. No Modifier Applicable.

G8430: Provider documentation that patient is not eligible for medication assessment. No Modifier Applicable.

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. No Modifier Applicable.

G8441: No documentation of pain assessment (including location, intensity and description) prior to initiation of treatment. No Modifier Applicable.

G8442: Documentation that patient is not eligible for a pain assessment. No Modifier Applicable

G8447: Patient encounter was documented using an EHR system that has been certified by an Authorized Testing and Certification Body (ATCB). No Modifier Applicable.

G8448: Patient encounter was documented using a Physician Quality Reporting System qualified EHR or other acceptable systems. No Modifier Applicable.

G8492: Intend to report the Perioperative Care Measures Group. No Modifier Applicable.

G8493: Intend to report the Back Pain Measures Group. No Modifier Applicable.

G8501: All quality actions for the applicable measures in the Perioperative Care Measures Group have been performed for this patient. No Modifier Applicable.

G8502: All quality actions for the applicable measures in the Back Pain Measures Group have been performed for this patient. No Modifier Applicable.

G8508: Documentation of pain assessment (including location, intensity and description) prior to initiation of treatment 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. No Modifier Applicable.

G8509: Documentation of pain assessment (including location, intensity and description) prior to initiation of treatment 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. No Modifier Applicable.

G8629: Documentation of order for prophylactic parenteral antibiotics to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required). No Modifier Applicable.

G8630: Documentation that administration of prophylactic parenteral antibiotics was initiated within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required), as ordered. No Modifier Applicable.

G8631: Clinician documented that patient was not an eligible candidate for ordering prophylactic parenteral antibiotics to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required). No Modifier Applicable.

G8632: Prophylactic parenteral antibiotics were not ordered to be given or given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required), reason not otherwise specified. No Modifier Applicable.

G8633: Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed. No Modifier Applicable.

G8634: Clinician documented patient not an eligible candidate to receive pharmacologic therapy for osteoporosis. No Modifier Applicable.

G8635: Pharmacologic therapy for osteoporosis was not prescribed, reason not otherwise specified. No Modifier Applicable.