

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 SAME CLAIM

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 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 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 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
- **G8441:** No documentation of pain assessment (including location, intensity and description) prior to initiation of treatment
- **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