

## Communication with the Physician Managing Ongoing Care Post Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older

### PQRI Data Collection Sheet

Patient's Name	Practice Medical Record Number (MRN)	Birth Date (mm/dd/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
National Provider Identifier (NPI)		Date of Service	

#### Clinical Information

#### Billing Information

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

	Yes	No	Code Required on Claim Form
Patient is aged 50 years and older on date of encounter.	<input type="checkbox"/>	<input type="checkbox"/>	Verify date of birth on claim form.
Patient has a line item diagnosis of fracture of the hip, spine or distal radius AND a CPT Code for this visit OR Patient has a line item diagnosis of fracture of the hip, spine or distal radius and there is a CPT Procedure Code.	<input type="checkbox"/>	<input type="checkbox"/>	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.
If <b>No</b> is checked for any of the above, STOP. Do not report a CPT category II code.			

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

Post-Fracture Care	Yes	No	Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)
Communicated <sup>1</sup>	<input type="checkbox"/>	<input type="checkbox"/>	5015F
Not communicated for one of the following reasons:			
• Medical (eg, not indicated, contraindicated, other medical reason)	<input type="checkbox"/>	<input type="checkbox"/>	5015F-1P
• Patient (eg, patient declined, economic, social, religious, other patient reason)	<input type="checkbox"/>	<input type="checkbox"/>	5015F-2P
Document reason here and in medical chart. _____ _____ _____			If <b>No</b> is checked for <b>all</b> of the above, report 5015F-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.)

Note: This measure should be reported at one of the following two instances if communication post fracture has occurred or is planned within 3 months of fracture.

- 1) During an office visit with ICD-9-CM diagnosis code for fracture of hip, spine or distal radius OR
- 2) At the time of a procedure to repair a fracture

<sup>1</sup>Communication may include: Documentation in the medical record indicating that the clinician treating the fracture communicated (eg, verbally, by letter, DXA report was sent) with the clinician managing the patient's ongoing care OR a copy of a letter in the medical record outlining whether the patient was or should be treated for osteoporosis.