Physician Quality Reporting System (PQRS)

Measure 154
Falls: Risk Assessment

- Reported a minimum of once per reporting period (per year) per patient
- No specific diagnosis code (ICD-10) requirements
- All patients aged 65 years and older with Medicare as their primary insurance
- Does not include Medicare Advantage Plans
- Each provider must report on at least 50% of eligible patients per year
CPT Codes

- Measure #154 must be reported when billing the following CPT codes that are relevant to audiology:
  - 92540: Basic Vestibular Evaluation (which includes 92541, 92542, 92544, & 92545)
  - 92541: Spontaneous nystagmus (with recording)
  - 92542: Positional nystagmus (4 positions with recording)
  - 92548: Computerized Dynamic Posturography

Important CMS Definitions

- Fall: 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 a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force
- Injury: Requiring medical attention
Fall Risk Assessment

Comprised of balance/gait evaluation:

- including documentation of observed transfer and walking
- OR use of a standardized scale (e.g., Timed Up and Go, CTSIB, Functional Reach, Berg, Tinetti)
- OR documentation of referral for assessment of balance/gait

AND one or more of the following:

- Postural blood pressure: Documentation of blood pressure values in supine and then standing positions
- Vision Assessment: Documentation that the patient is or is not functioning well with vision based on discussion with the patient OR documentation of referral for vision assessment
- Home fall hazards: Documentation of counseling on home falls hazards OR referral for evaluation of home falls hazards
- Documentation on whether medications are contributory or not to falls within past 12 months
Measure 154
CPT II Codes

• 1101F: Patient is not eligible for this measure because no falls or only one fall without injury have occurred within the past 12 months

• If this is reported, no further CPT II Codes are necessary to report for measures 154 or 155

Measure 154
CPT II Codes

• 1100F: Two or more falls are documented within the past 12 months OR any fall with injury within the past 12 months

• 1100F-1P: Documentation of medical reason(s) for not completing fall risk assessment

• Patient is non-ambulatory, bed ridden, immobile, wheelchair bound

• 1100F-8P: No documentation of falls status
Measure 154
CPT II Codes

- 3288F: Fall Risk Assessment documented
- 3288F-1P: Fall Risk Assessment unable to assess due to limited mobility/non-ambulatory status
- 3288F-8P: Falls Risk Assessment not completed, reason otherwise unspecified
  - Performance not met; Negative reporting

Measure 154
CPT II Codes

- When reporting for Measure 154, if the patient has fallen twice in the past year or any fall has had injury, you will need to report 2 CPT II codes
- Example: Patient has fallen twice in the past year and a Falls Risk screening is performed and documented on the same day as VNG testing. CPT II Codes reported should include 1100F and 3288F.
Measure 155
Falls: Plan of Care

• Second part of the 2-part measure paired with Measure #154

• Reported if Measure #154 includes CPT II Code 1100F: Patient screened for future falls risk; documentation of two or more falls in the past year or any fall with injury in the past year

• Same reporting criteria as Measure #154

• Rationale: Interventions to prevent future falls should be documented for the patient with 2 or more falls or injurious falls

Important CMS Definitions

• Plan of Care: Must include BOTH of the following:

  1. Vitamin D supplementation
     • Patient referred to his/her physician for vitamin D supplementation advice OR
     • Documentation that supplementation was advised or considered

  2. Balance, strength, and gait training
     • Instructions provided OR
     • Recommendation/referral for exercise program OR
     • Recommendation/referral for Physical Therapy
Measure 155
CPT II Codes

- 0518F: Falls Plan of Care Documented
- 0518F-1P: Medical Reason for no plan of care documented
  - Patient is non-ambulatory, bed ridden, immobile, wheelchair bound
- 0518F-8P: Plan of care not documented; reason not otherwise specified
  - Performance not met; Negative reporting

Balance Screening Protocols

- Timed Up and Go (TUG)
- Functional Reach Test (FRT)
- Clinical Test of Sensory Integration of Balance (mCTSIB)
The Timed "Up & Go": A Test of Basic Functional Mobility for Frail Elderly Persons

This study evaluated a modified, timed version of the "Timed Up and Go" (TUG) test. Mitchell, et al., 1988. 40 persons referred to a Geriatric Day Hospital (mean age 73.3 years). The patient is seated and timed while he or she stands from an armchair, walks 3 meters, turns, walks back, and sits down again. The results indicate that the test is quick and easy to perform and correlated well with grip strength scores on the Berg Balance Scale ($r = 0.82$), gait speed ($r = 0.41$) and Berg Balance Scale ($r = 0.79$) and also appears to predict the patient's ability to go outside alone safely. These data suggest that the timed "Up & Go" test is a reliable and valid test for quantifying functional mobility that may be also useful in following clinical change over time. The test is quick, requires no special equipment or training, and is easily administered to a variety of normal and abnormal medical conditions. J Am Geriatr Soc 39:142-148, 1991
Timed Up and Go (TUG)

- **Purpose:** Assesses mobility, balance, walking ability, and fall risk in older adults
- **Equipment needed:** Standard armchair and a stop watch
- **Length of time:** 5 minutes or less

**TUG: How to Perform**

- The patient sits in a chair with his/her back against the chair back
- On the practitioner’s command, the patient rises from the chair, walks 3 meters (about 10 feet) at a comfortable and safe pace, turns, walks back to the chair, and sits down
- The timer starts when the patient begins to rise from the chair, and the timer stops when the patient sits down
- Three trials should be completed; the first trial is considered practice and not scored. Use the best score of the second and third trials
- Patient should wear their regular footwear and use their assistive device, if they have one
- For patients with acute onset vestibulopathy, to ensure test reliability, it should be administered with both a right and left turn
TUG: Scoring

- An older adult who takes 12 seconds or more to complete the task is at a high risk of falling
- Sensitivity and Specificity are 87%
- Strong correlation with functional mobility
- The longer the patient takes to perform the task has a direct correlation with dependence in Activities of Daily Living (ADLs)

Functional Reach Test
Functional Reach Test (FRT)

- **Purpose:** Assesses a patient’s stability by measuring the maximum distance an individual can reach forward while standing in a fixed position

- **Equipment Needed:** Yardstick attached to wall in a horizontal position

- **Length of Time:** 5 minutes or less
FRT: How to Perform

- Patient is instructed to stand close to a wall without touching it
- The arm closest to the wall is positioned at 90 degrees of shoulder flexion with a closed fist
- Record the starting position at the knuckle of middle finger (3rd metacarpal head) on the yardstick
- Instruct the patient to “reach as far as you can forward without taking a step”
- Watch that the patient does not lift their heels off the ground
- Record the position of the knuckle on the yardstick

FRT: Scoring

- The score is the difference between the start and end position of the knuckle is the reach distance, usually measured in inches
- Patient may need one or two trial runs that are not scored
- The average of three runs is the final score in inches
- FRT score of greater than 10 inches is considered normal
- FRT score of less than 6 inches is considered high risk for falls
Modified Clinical Test of Sensory Integration of Balance (mCTSIB)

Assessing the Influence of Sensory Interaction on Balance
Suggestion from the Field

ANNE SHUMWAY-COOK
and FAY BAILING HORAK
Modified CTSIB (mCTSIB)

- Purpose: Assess the patient’s balance under various sensory conditions
- Equipment Needed: Standardized foam
- Length of Time: Less than 10 minutes

mCTSIB: How to Perform

- For all Conditions: The patient is standing with their feet comfortably apart (about shoulder width) and their arms at their sides
- Condition 1: Patient stands on a firm surface with their eyes open
  - Sensory information: all three sensory inputs: visual, vestibular, and somatosensory
- Condition 2: Patient stands on a firm surface with their eyes closed
  - Sensory information: vestibular and somatosensory
- Condition 3: Patient stands on an unstable surface (foam) with eyes open
  - Sensory information: vision and vestibular
- Condition 4: Patient stands on an unstable surface (foam) with eyes closed
  - Sensory information: vestibular
mCTSIB: Scoring

- Condition 1 is considered a baseline
- Condition 2: inability to perform or significant sway indicates a visual dependence
- Condition 3: inability to perform or significant sway indicates somatosensory dependent
- Condition 4: inability to perform or significant sway indicates vestibular disruption likely (with 90% sensitivity)
- If the patient moves their arms (Parachute Reflex) or their feet, this is considered a Fall on that condition

Summary

- Audiologists have an excellent opportunity and responsibility to become important stakeholders in Fall Risk and Fall Management of older adults.
- This role may be accomplished through patient education, referrals and triage or actual balance screenings.
- With 10,000 baby boomers turning 65 years old each day for the next 18 years, there will be a growing population requiring the audiologist’s expertise and care.
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References


