



2022 CMS WebInterface

CARE-2 (NQF 0101): Falls: Screening for Future Fall Risk

Measure Steward: NCQA

Contents

INTRODUCTION	3
CMS WEB INTERFACE SAMPLING INFORMATION	4
BENEFICIARY SAMPLING	4
NARRATIVE MEASURE SPECIFICATION	5
DESCRIPTION:	5
IMPROVEMENT NOTATION:	5
INITIAL POPULATION:	5
DENOMINATOR:	5
DENOMINATOR EXCLUSIONS	5
DENOMINATOR EXCEPTIONS	5
NUMERATOR:	5
NUMERATOR EXCLUSIONS	5
DEFINITIONS	5
GUIDANCE	5
SUBMISSION GUIDANCE	6
PATIENT CONFIRMATION	6
SUBMISSION GUIDANCE	7
DENOMINATOR CONFIRMATION	7
SUBMISSION GUIDANCE	8
NUMERATOR SUBMISSION	8
DOCUMENTATION REQUIREMENTS	9
APPENDIX I: PERFORMANCE CALCULATION FLOW	10
APPENDIX II: DOWNLOADABLE RESOURCE MAPPING TABLE	16
APPENDIX III: MEASURE RATIONALE AND CLINICAL RECOMMENDATION STATEMENTS	17
RATIONALE	17
CLINICAL RECOMMENDATION STATEMENTS	17
APPENDIX IV: USE NOTICES, COPYRIGHTS, AND DISCLAIMERS	18
COPYRIGHT	18

INTRODUCTION

There are a total of 10 individual measures included in the 2022 CMS Web Interface targeting high-cost chronic conditions, preventive care, and patient safety. The measures documents are represented individually and contain measure specific information. The corresponding coding documents are posted separately in an Excel format.

The measure documents are being provided to allow organizations an opportunity to better understand each of the 10 individual measures included in the 2022 CMS Web Interface data submission method. Each measure document contains information necessary to submit data through the CMS Web Interface.

Narrative specifications, supporting submission documentation, and calculation flows are provided within each document. Please review all of the measure documentation in its entirety to ensure complete understanding of these measures.

CMS WEB INTERFACE SAMPLING INFORMATION**BENEFICIARY SAMPLING**

For more information on the sampling process and methodology please refer to the 2022 CMS Web Interface Sampling Document, which will be made available during the performance year at CMS.gov.

NARRATIVE MEASURE SPECIFICATION**DESCRIPTION:**

Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period

IMPROVEMENT NOTATION:

Higher score indicates better quality

INITIAL POPULATION:

Patients aged 65 years and older with a visit during the measurement period

DENOMINATOR:

Equals Initial Population

DENOMINATOR EXCLUSIONS:

None

DENOMINATOR EXCEPTIONS:

None

NUMERATOR:

Patients who were screened for future fall risk at least once within the measurement period

NUMERATOR EXCLUSIONS:

Not Applicable

DEFINITION:

Screening for Future Fall Risk: Assessment of whether an individual has experienced a fall or problems with gait or balance. A specific screening tool is not required for this measure, however potential screening tools include the Morse Fall Scale and the timed Get-Up-And-Go test.

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 as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force.

GUIDANCE:

None

SUBMISSION GUIDANCE

PATIENT CONFIRMATION

Establishing patient eligibility for submission requires the following:

- Determine if the patient's medical record can be found
 - If you can locate the medical record select "Yes"
- OR
- If you cannot locate the medical record select "No - Medical Record Not Found"
- OR
- Determine if the patient is qualified for the sample
 - If the patient is deceased, in hospice, moved out of the country or did not have Fee- for-Service (FFS) Medicare as their primary payer select the applicable reason from the provided drop-down menu, and enter the date the patient became ineligible

Guidance**Patient Confirmation**

If "No – Medical Record Not Found" or "Not Qualified for Sample" is selected, the patient is completed but not confirmed. The patient will be "skipped" and another patient must be reported in their place, if available. The CMS Web Interface will automatically skip any patient for whom "No – Medical Record Not Found" or "Not Qualified for Sample" is selected in all other measures into which they have been sampled.

If "Not Qualified for Sample" is selected and the date is unknown, you may enter the last date of the measurement period (i.e., 12/31/2022).

The Measurement Period is defined as January 1 – December 31, 2022.

NOTE:

- **In Hospice:** Select this option if the patient is not qualified for sample due to being in hospice care at any time during the measurement period (this includes non-hospice patients receiving palliative goals or comfort care)
- **Moved out of Country:** Select this option if the patient is not qualified for sample because they moved out of the country any time during the measurement period
- **Deceased:** Select this option if the patient died during the measurement period
- **Non-FFS Medicare:** Select this option if the patient was enrolled in Non-FFS Medicare at any time during the measurement period (i.e., commercial payers, Medicare Advantage, Non-FFS Medicare, HMOs, etc.) This exclusion is intended to remove beneficiaries for whom Fee-for-Service Medicare is not the primary payer.

SUBMISSION GUIDANCE

DENOMINATOR CONFIRMATION

- Determine if the patient is qualified for the measure.
 - If the patient is qualified for the measure select "Yes"
- OR
- If there is an "other" CMS approved reason for patient disqualification from the measure select "No - Other CMS Approved Reason"

Guidance**Denominator**

If "No – Other CMS Approved Reason" is selected, the patient will be "skipped" and another patient must be reported in their place, if available. The patient will only be removed from the measure for which one of these options was selected, not all CMS Web Interface measures.

Other CMS Approved Reason is reserved for unique cases that are not covered by any of the above stated skip reasons. To gain CMS approval, submit a skip request by selecting Request Other CMS Approved Reason in the patient qualification question for the measure. Note that skip requests can only be submitted manually through the CMS Web Interface.

To submit a skip request, follow these steps:

1. After confirming the beneficiary for the sample, scroll to the measure you would like to skip.
2. When confirming if the beneficiary is qualified for the measure, select Request Other CMS Approved Reason.
3. In the skip request modal, review the organization you are reporting for and provide the submitter's email address. CMS uses this email to send status updates and/or reach out if further information is needed to resolve the skip request. You also need to provide specific information about the beneficiary's condition and why it disqualifies the beneficiary from this measure. Never include Personally Identifiable Information (PII) or Protected Health Information (PHI) in the case.

Beneficiaries remain incomplete until CMS resolves the skip request. The CMS Web Interface automatically updates the resolution of a skip request, either approved or denied. Beneficiaries for whom a CMS Approved Reason is approved are marked as Skipped and another beneficiary must be reported in their place, if available.

By selecting "No - Other CMS Approved Reason", the patient is only removed from the measure for which the reason was requested, not all CMS Web Interface measures.

SUBMISSION GUIDANCE

NUMERATOR SUBMISSION

- Determine if patient was screened for future fall risk at least once during the measurement period
 - If patient was screened for future fall risk select “Yes”
- OR**
- If patient was Not screened for future fall risk select “No”

Numerator codes can be found in the 2022 CMS Web Interface CARE Coding Document. The Downloadable Resource Mapping Table can be located in Appendix II of this document.

Guidance	Numerator
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NOTE:

- ***A clinician*** with appropriate skills and experience may perform the screening
- ***Setting of screening*** is not restricted to an office setting
- ***Documentation*** of no falls is sufficient
- ***Medical record*** must include documentation of screening performed
- ***Any history of falls*** screening during the measurement period is acceptable as meeting the intent of the measure
- ***A gait or balance*** assessment meets the intent of the measure
- ***Screening for future fall risk*** may be completed during a telehealth encounter

DOCUMENTATION REQUIREMENTS

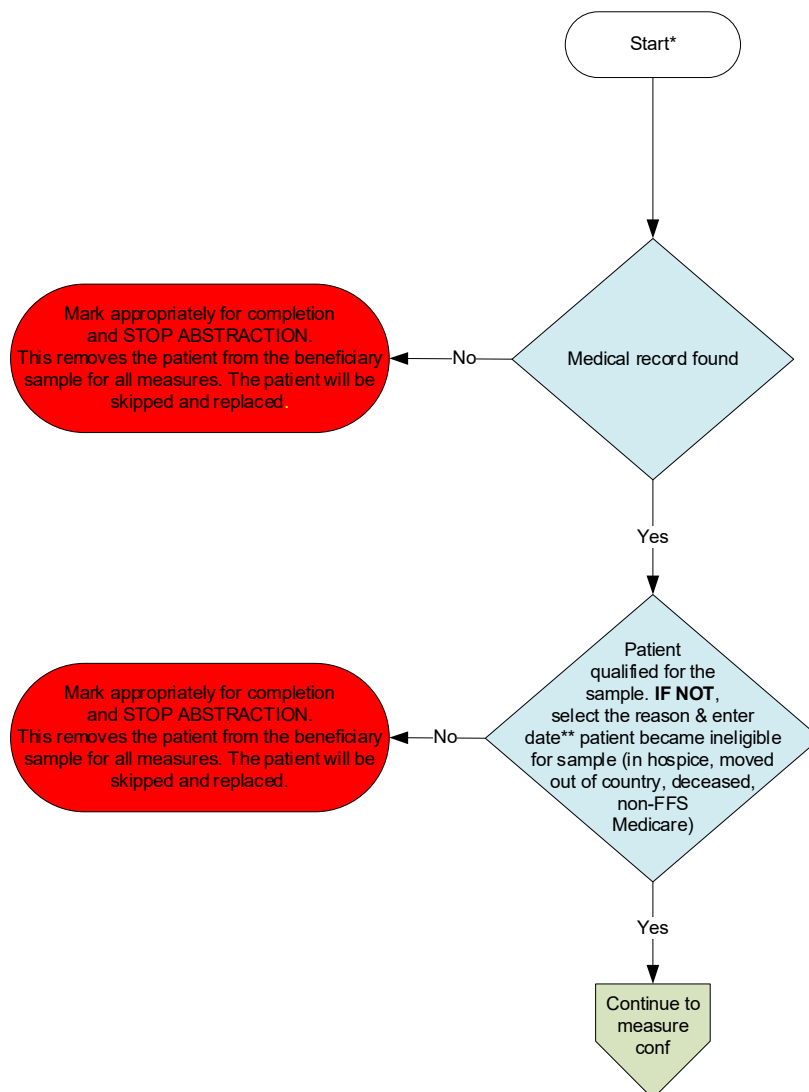
When submitting data through the CMS Web Interface, the expectation is that medical record documentation is available that supports the action reported in the CMS Web Interface i.e., medical record documentation is necessary to support the information that has been submitted.

Appendix I: Performance Calculation Flow

Disclaimer: Refer to the measure submission document for specific coding and instructions to submit this measure.

Patient Confirmation Flow

For 2022, confirmation of the "Medical Record Found", or indicating the patient is "Not Qualified for Sample" with a reason of "In Hospice", "Moved out of Country", "Deceased", or "Non-FFS Medicare", will only need to be done **once** per patient.

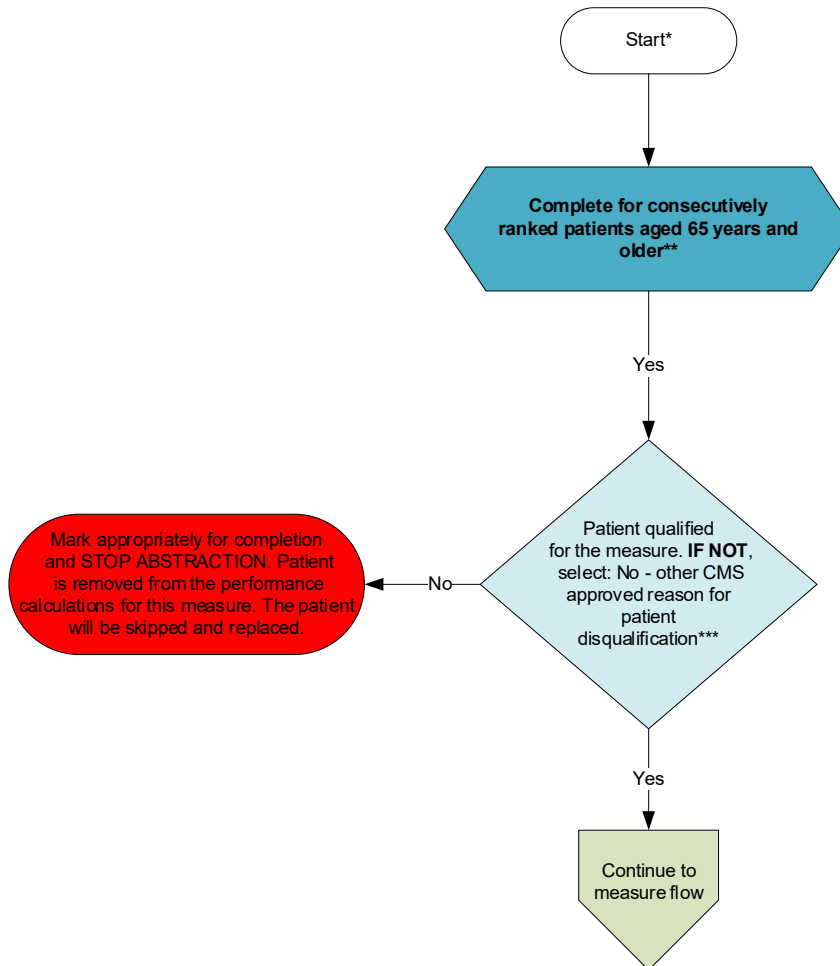


*See the posted measure submission document for specific coding and instructions to submit this measure.

**If date is unknown, enter 12/31/2022

Measure Confirmation Flow for CARE-2

For 2022, measure specific reasons a patient is "Not Confirmed" or excluded for "Denominator Exclusion" or "Other CMS Approved Reason" will need to be done for each measure where the patient appears.

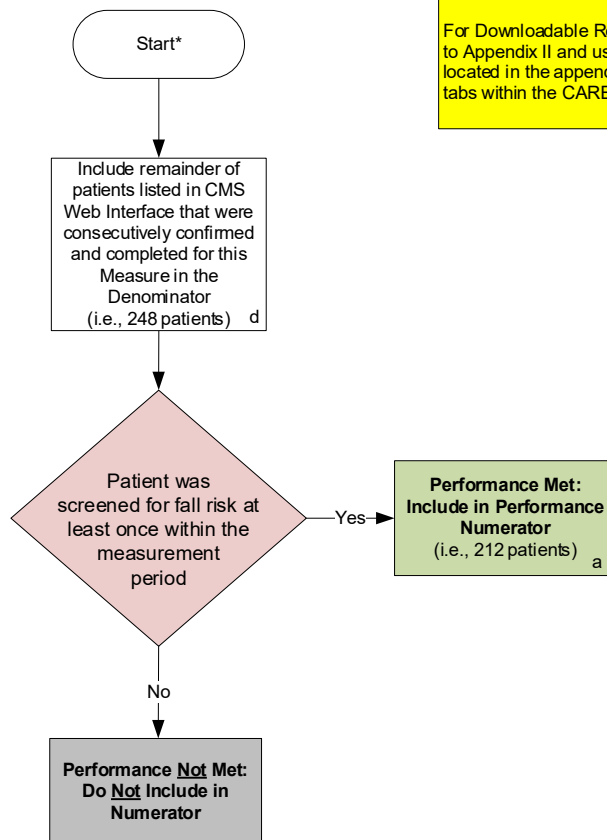


*See the posted measure submission document for specific coding and instructions to submit this measure.

**Further information regarding patient selection for specific disease and patient care measures can be found in the CMS Web Interface Sampling Methodology Document. For patients who have the incorrect date of birth listed, a change of the patient date of birth by the abstractor may result in the patient no longer qualifying for the CARE-2 measure. If this is the case, the system will automatically remove the patient from the measure requirements.

***"Other CMS Approved Reason" may only be selected if the CMS Web Interface updated the resolution of the skip request to be "Approved".

Measure Flow for CARE-2

**SAMPLE CALCULATION:****Performance Rate=**

$$\frac{\text{Performance Met (a=212 patients)}}{\text{Denominator (d=248 patients)}} = \frac{212 \text{ patients}}{248 \text{ patients}} = 85.48\%$$

CALCULATION MAY CHANGE PENDING PERFORMANCE MET ABOVE

*See the posted measure submission document for specific coding and instructions to submit this measure.

Patient Confirmation Flow

For 2022, confirmation of the “Medical Record Found”, or indicating the patient is “Not Qualified for Sample” with a reason of “In Hospice”, “Moved out of Country”, “Deceased”, or “Non-FFS Medicare”, will only need to be done **once** per patient.

1. Start Patient Confirmation Flow.
2. Check to determine if Medical Record can be found.
 - a. If no, Medical Record not found, mark appropriately for completion and stop abstraction. This removes the patient from the beneficiary sample for all measures. The patient will be skipped and replaced. Stop processing.
 - b. If yes, Medical Record found, continue processing.
3. Check to determine if Patient Qualified for the sample.
 - a. If no, the patient does not qualify for the sample, select the reason why and enter the date (if date is unknown, enter 12/31/2022) the patient became ineligible for sample. For example; In Hospice, Moved out of Country, Deceased, Non-FFS Medicare. Mark appropriately for completion and stop abstraction. This removes the patient from the beneficiary sample for all measures. The patient will be skipped and replaced. Stop processing.
 - b. If yes, the patient does qualify for the sample; continue to the Measure Confirmation Flow for CARE-2.

Measure Confirmation Flow for CARE-2

For 2022, measure specific reasons a patient is “Not Confirmed” or excluded for “Denominator Exclusion” or “Other CMS Approved Reason” will need to be done for each measure where the patient appears.

1. Start Measure Confirmation Flow for CARE-2. Complete for consecutively ranked patients aged 65 years and older. Further information regarding patient selection for specific disease and patient care measures can be found in the CMS Web Interface Sampling Methodology Document. For patients who have the incorrect date of birth listed, a change of the patient date of birth by the abstractor may result in the patient no longer qualifying for the CARE-2 measure. If this is the case, the system will automatically remove the patient from the measure requirements.
2. Check to determine if the patient qualifies for the measure (Other CMS Approved Reason).
 - a. If no, the patient does not qualify for the measure select: No – Other CMS Approved Reason for patient disqualification. Mark appropriately for completion and stop abstraction. Patient is removed from the performance calculations for this measure. The patient will be skipped and replaced.

“Other CMS Approved Reason” may only be selected by if the CMS Web Interface updated the resolution of the skip request to be “Approved”. Stop processing.
 - b. If yes, the patient does qualify for the measure, continue to the CARE-2 measure flow.

Measure Flow for CARE-2

For Downloadable Resource Mapping Table, go to Appendix II and use the Variable Names located in the appendix along with the applicable tabs within the CARE Coding Document.

1. Start processing 2022 CARE-2 (NQF 0101) Flow for the patients that qualified for sample in the Patient Confirmation Flow and the Measure Confirmation Flow for Care-2. **Note:** Include remainder of patients listed in the CMS Web Interface that were consecutively confirmed and completed for this measure in the denominator. For the sample calculation in the flow these patients would fall into the 'd' category (eligible denominator, i.e. 248 patients).
2. Check to determine if the patient was screened for future fall risk at least once during the measurement period.
 - a. If no, the patient was not screened for future fall risk at least once during the measurement period, performance is not met and the patient should not be included in the numerator. Stop processing.
 - b. If yes, the patient was screened for future fall risk at least once during the measurement period, performance is met and the patient will be included in the numerator. For the sample calculation in the flow these patients would fall into the 'a' category (numerator, i.e. 212 patients). Stop processing.

Sample Calculation:

Performance Rate equals Performance Met (a equals 212 patients) divided by Denominator (d equals 248 patients). All equals 212 patients divided by 248 patients. All equals 85.48 percent.

CALCULATION MAY CHANGE PENDING PERFORMANCE MET ABOVE.

Appendix II: Downloadable Resource Mapping Table

Each data element within this measure's denominator or numerator is defined as a pre-determined set of clinical codes. These codes can be found in the 2022 CMS Web Interface CARE Coding Document.

***CARE-2: Falls: Screening for Future Fall Risk**

Measure Component/Excel Tab	Data Element	Variable Name	Coding System(s)
Numerator/Numerator Codes	Falls Screening	FALLS_SCREEN_CODE	LN

**For EHR mapping, the coding within CARE-2 is considered to be all inclusive*

Appendix III: Measure Rationale and Clinical Recommendation Statements**RATIONALE:**

As the leading cause of both fatal and nonfatal injuries for older adults, falls are one of the most common and significant health issues facing people aged 65 years or older (Schneider, Shubert and Harmon, 2010). Moreover, the rate of falls increases with age (Dykes et al., 2010). Older adults are five times more likely to be hospitalized for fall-related injuries than any other cause-related injury. It is estimated that one in every three adults over 65 will fall each year (Centers for Disease Control and Prevention 2015). In those over age 80, the rate of falls increases to fifty percent (Doherty et al., 2009). Falls are also associated with substantial cost and resource use, approaching \$30,000 per fall hospitalization (Woolcott et al. 2011). Identifying at-risk patients is the most important part of management, as applying preventive measures in this vulnerable population can have a profound effect on public health (al-Aama, 2011). Family physicians have a pivotal role in screening older patients for risk of falls, and applying preventive strategies for patients at risk (al-Aama, 2011).

CLINICAL RECOMMENDATION STATEMENTS:

All other persons who are under the care of a health professional (or their caregivers) should be asked at least once a year about falls. (AGS/BGS/AAOS, 2010)

Older persons who present for medical attention because of a fall, report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should have a fall evaluation performed. This evaluation should be performed by a clinician with appropriate skills and experience, which may necessitate referral to a specialist (e.g., geriatrician). (AGS/BGS/AAOS, 2010)

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