**PQRS SHEET for Medicare Documentation GRID 9-4-15**

Functional Outcome Assessment and follow up plan for people 18 yo and up at EVAL. And each visit, document #3, below, that you already did test. (only specific tests count – call me)

1. Documented using standardized tool and have related POC
2. Documented using standardized tool, no problem, no POC
3. Documented using standardized tool in last 30 days
4. Documented using standardized tool, no care plan, not eligible
5. Not documented, patient not eligible
6. Not documented, reason not given
7. Documented but no POC, reason not given

Pain Assessment and follow up plan EVERY VISIT for people 18 years and up

1. Pain assessment AND follow up plan documented
2. Pain assessment documented as negative, no follow up required
3. Patient not eligible for assessment for documented reasons
4. Pan assessment not documented for unspecified reasons
5. Pain assessment documented as positive but follow up not documented for unspecified reasons

Medications documented in visit note EACH VISIT for people 18 yo and up. Document *current meds with names, dosage, frequency and route*

1. Documented
2. Not documented, patient not eligible
3. Not documented, for reason not specified

Falls Risk Assessment = Assess Balance and gait AND one or more of *postural BP, vision, home assessment, related meds*

1. Falls Risk Assessment completed AND patient screened for future fall risk
2. Unable to assess for mobility issues BUT at risk of falls in the future
3. No fall history, no anticipation of falls
4. Patient not eligible, unspecified reason AND fall status not documented
5. No fall risk assessment competed for other reasons AND still at risk of falls.

Plan of Care for falls (use only if #1,2 or 5 is used in Fall Risk Assessment)

1. Includes assess for assist device and balance, strength, gait training
2. Not documented for Medical reasons
3. Not documented for reasons not specified

NOTE: The following on next page are for OT ONLY…

Depression Screen and Follow up for people 12 years and up (by OT ONLY) (see

1. Positive screen for depression and follow up documented
2. Negative screen and follow up not required
3. NO screen due to patient not eligible/appropriate
4. NO screen for unspecified reasons
5. Screening performed but no follow up plan for reasons not specified

Elder abuse screen and report for people over 65, on eval, using one of three tools (by OT Only) to assess physical, emotional, psychological or sexual abuse; neglect, abandonment, financial or material exploitation and unwarranted control. Also note self-neglect.

1. Screen positive and follow up to APS documented
2. Screen negative and no follow up
3. Screen not documented, patient not eligible – refused or emergency
4. Screen positive, follow up documented but not eligible for follow up plan
5. Screen not documented, reason not given
6. Screen positive, follow up not provided, reason not given

Tobacco use screen and counseling for people 18 and over (by OT Only) at EVAL

1. Screened, is a user and is not counseled
2. Screened and counseled if a user
3. Screened and not a user
4. Not screened for medical reasons such as end of life
5. Not screened for reason unspecified