DRAFT MEASURE #8: Patient Queried about Pain and Pain Interference with Function

MUSCULAR DYSTROPHY

Measure Description
All visits for patients diagnosed with a muscular dystrophy where the patient was queried about pain and pain interference with function using a validated and reliable instrument*.

Measure Components

<table>
<thead>
<tr>
<th>Numerator Statement</th>
<th>Patient visits where the patient was queried about pain and pain interference with function using a validated and reliable instrument*.</th>
</tr>
</thead>
</table>

*(Note: Pain can be assessed using one of a number of available valid and reliable instruments available from medical literature. Examples, include, but are not limited to:  
- Numeric Rating Scale for Pain¹  
- Faces Pain Scale²  
- Graded Chronic Pain Scale³  
- Visual Analogue Scale⁴  
- McGill Pain Questionnaire⁵  
- Short-Form McGill Pain Questionnaire⁶)


Denominator Statement
All visits for patients diagnosed with a muscular dystrophy.

Denominator Exceptions
Exceptions:  
- Medical reason for not querying about pain and pain interference with function (eg patient is cognitively impaired and unable communicate)  
- Patient reason for not querying about pain and pain interference with function (eg patient declines to respond to questions)

Supporting Guideline & Other References
- Routine pain evaluation should be part of standard clinical assessment in all children and young people with neuromuscular disorders. [Level D]¹  
- C6. Treating physicians should routinely inquire about pain in patients with FSHD.²

Do Not Cite. For Public Comment Period

<table>
<thead>
<tr>
<th>Measure Designation</th>
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<tbody>
<tr>
<td><strong>Measure purpose</strong></td>
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<tr>
<td><strong>Type of measure</strong></td>
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<tr>
<td><strong>Level of</strong></td>
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Rationale for the Measure
Between 68-82% of patients with muscular dystrophies live in pain.1 Pain is a common feature of some MDs, notably myotonic dystrophy and FSHD, but also many of the LGMDs. Pain interferes with physical and psychological functioning in these patients. Lower extremity pain intuitively affects ambulation.2,3 Pain and fatigue are independent predictors of lower physical functioning and greater depression.4 Thus identification and treatment of pain is important to improve the care of patients with MD

Gap in Care:
Pain in the back and the legs is most commonly reported. Most patients do not receive optimal and effective treatments.3 One paper reported that pain is multifactorial and can be a significant and under recognized problem in congenital muscular dystrophy.5 Effective management begins with a comprehensive assessment of acute and chronic pain to determine the presence, frequency, and duration of painful episodes and to identify alleviating or exacerbating factors.6,7

Opportunity for Improvement:
A multitude of treatment modalities are available to control or relieve the pain using non-pharmacological, pharmacological, and interventional approaches in this patient group. Access to these treatments could improve the quality of life. Adequate assessment of pain using validated and easy-to-use tools to measure pain is a key step to bridge this gap. The Numeric Rating Scale for Pain and Faces Pain Scale are such tools and the compliance with measurement task is high.

Measurement

**Care setting**
- Outpatient visits
- Nursing homes
- Home services
- Rehabilitation

**Data source**
- Electronic health record (EHR) data
- Administrative Data/Claims (inpatient or outpatient claims)
- Administrative Data/Claims Expanded (multiple-source)
- Paper medical record

**Technical Specifications: Administrative/Claims Data (Under Development)**

Administrative claims data collection requires users to identify the eligible population (denominator) and numerator using codes recorded on claims or billing forms (electronic or paper). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.

The specifications listed below are those needed for performance calculation.

<table>
<thead>
<tr>
<th>Denominator (Eligible Population)</th>
<th>ICD-9 and ICD-10 Diagnosis Codes:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ICD-9 Code</td>
</tr>
<tr>
<td>359 Muscular dystrophies and other myopathies</td>
<td>G71.2 Congenital myopathies</td>
</tr>
<tr>
<td>359.0 Congenital hereditary muscular dystrophy</td>
<td>G71.0 Muscular dystrophy</td>
</tr>
<tr>
<td>359.1 Hereditary progressive muscular dystrophy</td>
<td>G71.1 Muscular dystrophy</td>
</tr>
<tr>
<td>359.2 Myotonic disorders</td>
<td>G71.11 Myotonic muscular dystrophy</td>
</tr>
<tr>
<td>359.21 Myotonic muscular dystrophy</td>
<td>G71.12 Myotonia congenital</td>
</tr>
<tr>
<td>359.22 Myotonia congenita</td>
<td>G71.13 Myotonic chondrodystrophy</td>
</tr>
<tr>
<td>359.8 Other myopathies</td>
<td>G72.89 Other specified myopathies</td>
</tr>
<tr>
<td>359.89 Other myopathies</td>
<td>G72.9 Myopathy, unspecified</td>
</tr>
<tr>
<td>359.9 Myopathy, unspecified</td>
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</tbody>
</table>

AND

CPT E/M Service Code:
99201, 99202, 99203, 99204, 99205 (Office or other outpatient visit-New Patient);
99211, 99212, 99213, 99214, 99215 (Office or other outpatient visit-Established Patient);
99241, 99242, 99243, 99244, 99245 (Office or Other Outpatient Consultation-New or Established Patient);99304, 99305, 99306 (Initial Nursing Facility Care);99307, 99308, 99309, 99310 (Subsequent Nursing Facility Care);
99319 (Other Nursing Facility Services);99324, 99325, 99326, 99327, 99328 (Domiciliary, Rest Home, or Custodial Care Services-New Patient);
99334, 99335, 99336, 99337 (Domiciliary, Rest Home, or Custodial Care Services-Established Patient);
99339, 99340 (Domiciliary, Rest Home, or Home Care Plan Oversight Services);
99341, 99342, 99343, 99344, 99345 (Home Services-New Patient);
99347, 99348, 99349, 99350 (Home Services-Established Patient).
97001, 97002, 97003, 97004 (PT/OT evaluation)