

Falls: Screening for Future Fall Risk (CMS139)

The following is for educational purposes only and is not intended to be clinical or legal advice. The information provided in the Measure Details section is based on specification published by CMS at <https://ecqi.healthit.gov/ecqm/ec/2023/cms139v11>

Measure Details

Description *

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

Initial Population

Patients aged 65 years and older **at the start of the measurement period** with a visit during the measurement period

Denominator

Equals Initial Population

Numerator

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

Denominator Exclusion

Exclude patients who are in hospice care for any part of the measurement period

Numerator Exclusion

NA

Overview

| What is Documented | When is it Documented | Where in QMER |
|----------------------|----------------------------------|-----------------|
| Qualifying Encounter | During Measurement Period (2023) | Coded SOAP Note |
| Fall Risk Screening | During Measurement Period (2023) | History Module |

| Exclusions/Exceptions | Where in QEMR |
|---|----------------|
| Patients who are in hospice care for any part of the measurement period | History Module |

| 2022 to 2023 Changes |
|----------------------|
| N/A |

Set Up

All codification shown is an example for incrementation, for a full list of accepted codes please visit [Value Set Authority Center](#).

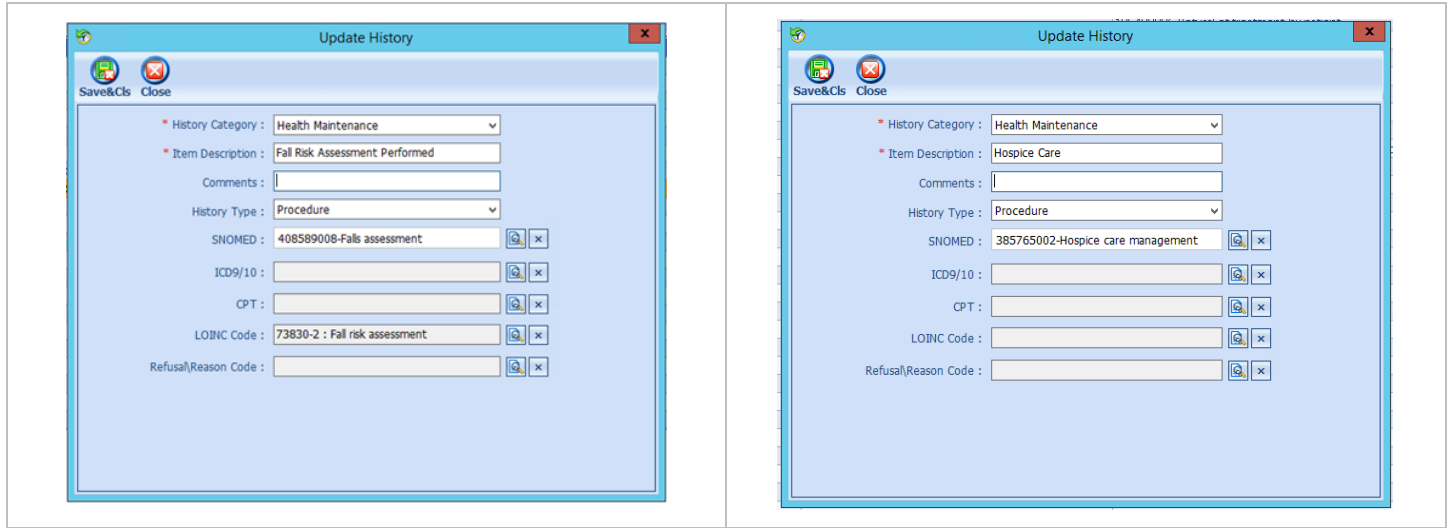
Qualifying Encounter

No set up required

Building History Items

Build the history items below:

1. Log into **QEMR** > Navigate to **Edit > History**
2. Highlight **desired History Category** list on left side bar
3. Click **New** hot button
4. **Complete the Update History** Screen as seen below
5. Click **Save & Close** hot button



Workflow

Qualifying Encounter

Following standard office workflow, document patient visit(s) via SOAP notes and code with CPT and diagnosis codes using either Dx/CPT, SmartDx or Smart CPT modules.

Document Fall Risk Assessment or Hospice Care

Smoking Status

To document smoking status, follow steps below:

1. Navigate to **History** Module > **Health Maintenance** category
 - a. Double-click Fall Risk Assessment Performed OR Hospice Care
 - b. Enter **Occur Date**

| Category | Item | Comments | Smoking Status | Active | Occur Date | Date Entered | Source |
|------------------------------|--------------------------------|----------|----------------|--------|------------|--------------------|--------|
| Health Maintenance Screening | Fall Risk Assessment Performed | | | | 01/18/2022 | 1/18/2022 11:06 AM | gloEMR |

| Category | Item | Comments | Smoking Status | Active | Occur Date | Date Entered | Source |
|------------------------------|--------------|----------|----------------|--------|------------|-------------------|--------|
| Health Maintenance Screening | Hospice Care | | | | 01/19/2022 | 1/19/2022 9:21 AM | gloEMR |

Incrementing Details

Occur Dates

To increment ANY measure using the History Module the Occur Dater MUST be documented using appropriate date based upon Measure Description.

Exam Coding

If exam notes (Past Exams) are not coded with Diagnosis Code and CPT code measures will not increment.

Measure Specific Codes

The codification shown in this document are examples of qualifying documentation. To see a full list please visit [Value Set Authority Center](#).

CMS Guidance *

This eCQM is a patient-based measure.