Quality ID #024: Communication with the Physician or Other Clinician Managing On-Going Care Post-Fracture for Men and Women Aged 50 Years and Older

2026 COLLECTION TYPE:
MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) CLINICAL QUALITY MEASURE (CQM)

MEASURE TYPE:
Process – High Priority

DESCRIPTION:
Percentage of patients aged 50 years and older treated for a fracture with documentation of communication, between the physician treating the fracture and the physician or other clinician managing the patient's on-going care, that a fracture occurred and that the patient was or should be considered for osteoporosis treatment or testing. This measure is submitted by the physician who treats the fracture and who therefore is held accountable for the communication.

INSTRUCTIONS:

Reporting Frequency:
This measure is to be submitted after each occurrence for denominator eligible cases as defined in the denominator criteria. Each occurrence of a fracture is identified by either an ICD-10-CM diagnosis code for fracture or osteoporosis and a CPT service code OR an ICD-10-CM diagnosis code for fracture or osteoporosis and a CPT procedure code for surgical treatment of a fracture.

Intent and Clinician Applicability:
The intent of this measure is to ensure communication of the osteoporosis treatment plan between the physician treating the fracture and the physician or other clinician managing on-going care of the patient diagnosed with a fracture. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions as defined by the numerator based on the services provided and the measure-specific denominator coding.

Measure Strata and Performance Rates:
This measure contains one strata defined by a single submission criteria.
This measure produces a single performance rate.

Implementation Considerations:
For the purposes of MIPS implementation, this episode measure is submitted once for each occurrence of a particular illness or condition during the performance period. Patients with a fracture should have documentation in the medical record of communication from the clinician treating the fracture to the clinician managing the patient's on-going care that the fracture occurred and that the patient was or should be tested or treated for osteoporosis. If multiple fractures occurring on the same date of service are submitted on the same claim form, only one instance of submission will be counted. Claims data will be analyzed to determine unique occurrences. Documentation must indicate that communication to the MIPS eligible clinician managing the on-going care of the patient occurred within three months of treatment for the fracture. The CPT Category II code should be submitted during the episode of care (e.g., treatment of the fracture). The submission of the code and documentation of communication do not need to occur simultaneously. Eligible cases are determined, and must be reported, if either of the following conditions (submission criteria) are met.

Telehealth:
TELEHEALTH ELIGIBLE: This measure is appropriate for and applicable to the telehealth setting. Patient encounters conducted via telehealth using encounter code(s) found in the denominator encounter criteria are allowed for this measure. Therefore, if the patient meets all denominator criteria for a telehealth encounter, it would be appropriate to include them in the denominator eligible patient population. Telehealth eligibility is at the measure level for inclusion within the denominator eligible patient population and based on the measure specification definitions which

are independent of changes to coding and/or billing practices.

Measure Submission:
The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this collection type for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. The coding provided to identify the measure criteria: Denominator or Numerator, may be an example of coding that could be used to identify patients that meet the intent of this clinical topic. When implementing this measure, please refer to the 'Reference Coding' section to determine if other codes or code languages that meet the intent of the criteria may also be used within the medical record to identify and/or assess patients. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

DENOMINATOR:
Adults aged 50 years and older who experienced a fracture, except fractures of the finger, toe, face or skull.
Eligible cases are determined, and must be submitted, if the patient had a fracture and an eligible encounter or eligible procedure.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 50 years on date of encounter or procedure
AND
Diagnosis for a fracture, except fractures of the finger, toe, face or skull (ICD-10-CM): M48.40XA, M48.41XA, M48.42XA, M48.43XA, M48.44XA, M48.45XA, M48.46XA, M48.47XA, M48.48XA, M80.00XA, M80.011A, M80.012A, M80.019A, M80.021A, M80.022A, M80.029A, M80.031A, M80.032A, M80.039A, M80.041A, M80.042A, M80.049A, M80.051A, M80.052A, M80.059A, M80.061A, M80.062A, M80.069A, M80.071A, M80.072A, M80.079A, M80.08XA, M80.0AXA, M80.0B1A, M80.0B1D, M80.0B1G, M80.0B1K, M80.0B1P, M80.0B1S, M80.0B2A, M80.0B2D, M80.0B2G, M80.0B2K, M80.0B2P, M80.0B2S, M80.0B9A, M80.0B9D, M80.0B9G, M80.0B9K, M80.0B9P, M80.0B9S, M80.80XA, M80.811A, M80.812A, M80.819A, M80.821A, M80.822A, M80.829A, M80.831A, M80.832A, M80.839A, M80.841A, M80.842A, M80.849A, M80.851A, M80.852A, M80.859A, M80.861A, M80.862A, M80.869A, M80.871A, M80.872A, M80.879A, M80.88XA, M80.8AXA, M80.8B1A, M80.8B1D, M80.8B1G, M80.8B1K, M80.8B1P, M80.8B1S, M80.8B2A, M80.8B2D, M80.8B2G, M80.8B2K, M80.8B2P, M80.8B2S, M80.8B9A, M80.8B9D, M80.8B9G, M80.8B9K, M80.8B9P, M80.8B9S, M84.311A, M84.312A, M84.319A, M84.321A, M84.322A, M84.329A, M84.331A, M84.332A, M84.333A, M84.334A, M84.339A, M84.341A, M84.342A, M84.343A, M84.350A, M84.351A, M84.352A, M84.353A, M84.359A, M84.361A, M84.362A, M84.363A, M84.364A, M84.369A, M84.371A, M84.372A, M84.373A, M84.374A, M84.375A, M84.376A, M84.38XA, M84.750A, M84.751A, M84.752A, M84.753A, M84.754A, M84.755A, M84.756A, M84.757A, M84.759A, M97.01XA, M97.02XA, M97.11XA, M97.12XA, M97.21XA, M97.22XA, M97.31XA, M97.32XA, M97.41XA, M97.42XA, S12.000A, S12.000B, S12.001A, S12.001B, S12.01XA, S12.01XB, S12.02XA, S12.02XB, S12.030A, S12.030B, S12.031A, S12.031B, S12.040A, S12.040B, S12.041A, S12.041B, S12.090A, S12.090B, S12.091A, S12.091B, S12.100A, S12.100B, S12.101A, S12.101B, S12.110A, S12.110B, S12.111A, S12.111B, S12.112A, S12.112B, S12.120A, S12.120B, S12.121A, S12.121B, S12.130A, S12.130B, S12.131A, S12.131B, S12.14XA, S12.14XB, S12.150A, S12.150B, S12.151A, S12.151B, S12.190A, S12.190B, S12.191A, S12.191B, S12.200A, S12.200B, S12.201A, S12.201B, S12.230A, S12.230B, S12.231A, S12.231B, S12.24XA, S12.24XB, S12.250A, S12.250B, S12.251A, S12.251B, S12.290A, S12.290B, S12.291A, S12.291B, S12.300A, S12.300B, S12.301A, S12.301B, S12.330A, S12.330B, S12.331A, S12.331B, S12.34XA, S12.34XB, S12.350A, S12.350B, S12.351A, S12.351B, S12.390A, S12.390B, S12.391A, S12.391B, S12.400A, S12.400B, S12.401A, S12.401B, S12.430A, S12.430B, S12.431A, S12.431B, S12.44XA, S12.44XB, S12.450A, S12.450B, S12.451A, S12.451B, S12.490A, S12.490B, S12.491A, S12.491B, S12.500A, S12.500B, S12.501A, S12.501B, S12.530A, S12.530B, S12.531A, S12.531B, S12.54XA, S12.54XB, S12.550A, S12.550B, S12.551A, S12.551B, S12.590A, S12.590B, S12.591A, S12.591B, S12.600A, S12.600B, S12.601A, S12.601B, S12.630A, S12.630B, S12.631A, S12.631B, S12.64XA, S12.64XB, S12.650A, S12.650B, S12.651A, S12.651B, S12.690A, S12.690B, S12.691A, S12.691B,

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S99.142A, S99.142B, S99.149A, S99.149B, S99.191A, S99.191B, S99.192A, S99.192B, S99.199A, S99.199B

AND

Patient encounter during the performance period (CPT or HCPCS): 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0402

OR

Patient procedure during the performance period (CPT Codes): 22310, 22315, 22318, 22319, 22325, 22326, 22327, 22510, 22511, 22513, 22514, 25600, 25605, 25606, 25607, 25608, 25609, 27230, 27232, 27235, 27236, 27238, 27240, 27244, 27245, 27246, 27248,

AND NOT

DENOMINATOR EXCLUSION:

Patients using hospice services any time during the measurement period: G9688

NUMERATOR:

Patients with documentation of communication with the physician or other clinician managing the patient's on-going care that a fracture occurred and that the patient was or should be considered for osteoporosis testing or treatment.

Definition:

Communication – May include documentation in the medical record indicating that the clinician treating the fracture communicated (e.g., verbally, by letter, through shared electronic health record, a bone mineral density test report was sent) with the clinician managing the patient's on-going care OR a copy of a letter in the medical record outlining whether the patient was or should be treated for osteoporosis.

Numerator Options:

Performance Met:	Documentation of communication that a fracture occurred and that the patient was or should be tested or treated for osteoporosis (5015F)

OR

Performance Not Met:	No documentation of communication that a fracture occurred and that the patient was or should be tested or treated for osteoporosis, reason not otherwise specified (5015F *with* 8P)

RATIONALE:

This measure aims to improve the communication and coordination from the physician treating the fracture in the acute care setting to the physician or clinician who is responsible for follow-up care for osteoporosis. Patients who experience a fragility fracture should either be treated or screened for the presence of osteoporosis. Although the fracture may be treated by the orthopedic surgeon, the testing and/or treatment is likely to be under the responsibility of the physician providing on-going care. It is important the physician or other clinician providing on-going care for the patient be made aware the patient has sustained a fracture so that the proper care and treatment plan can be put in place to prevent a secondary fracture from occurring. This measure holds the physician who treated the fracture accountable for this communication to the on-going care provider.

CLINICAL RECOMMENDATION STATEMENTS:

The most important risk factors for osteoporosis-related fractures are a prior low-trauma fracture as an adult and a low BMD in patients with or without fractures. (Watts, et al., 2010) BMD measurement should be performed in all women 40 years old or older who have sustained a fracture. (AACE)

The decision to measure bone density should follow an individualized approach. It should be considered when it will help the patient decide whether to institute treatment to prevent osteoporotic fracture. It should also be considered in

patients receiving glucocorticoid therapy for 2 months or more and patients with other conditions that place them at high risk for osteoporotic fracture. (NIH)

The most commonly used measurement to diagnose osteoporosis and predict fracture risk is based on assessment of BMD by dual-energy X-ray absorptiometry (DXA). (NIH) Measurements of BMD made at the hip predict hip fracture better than measurements made at other sites while BMD measurement at the spine predicts spine fracture better than measures at other sites. (NIH)

The single most powerful predictor of a future osteoporotic fracture is the presence of previous such fractures. (AGA)

REFERENCES:

Watts, N. B., Bilezikian, J. P., Camacho, P. M., Greenspan, S. L., Harris, S. T., Hodgson, S. F., ... & Petak, S. M. (2010). American Association of Clinical Endocrinologists Medical Guidelines for Clinical Practice for the diagnosis and treatment of postmenopausal osteoporosis: executive summary of recommendations. *Endocrine practice: official journal of the American College of Endocrinology and the American Association of Clinical Endocrinologists*, *16*(6), 1016.

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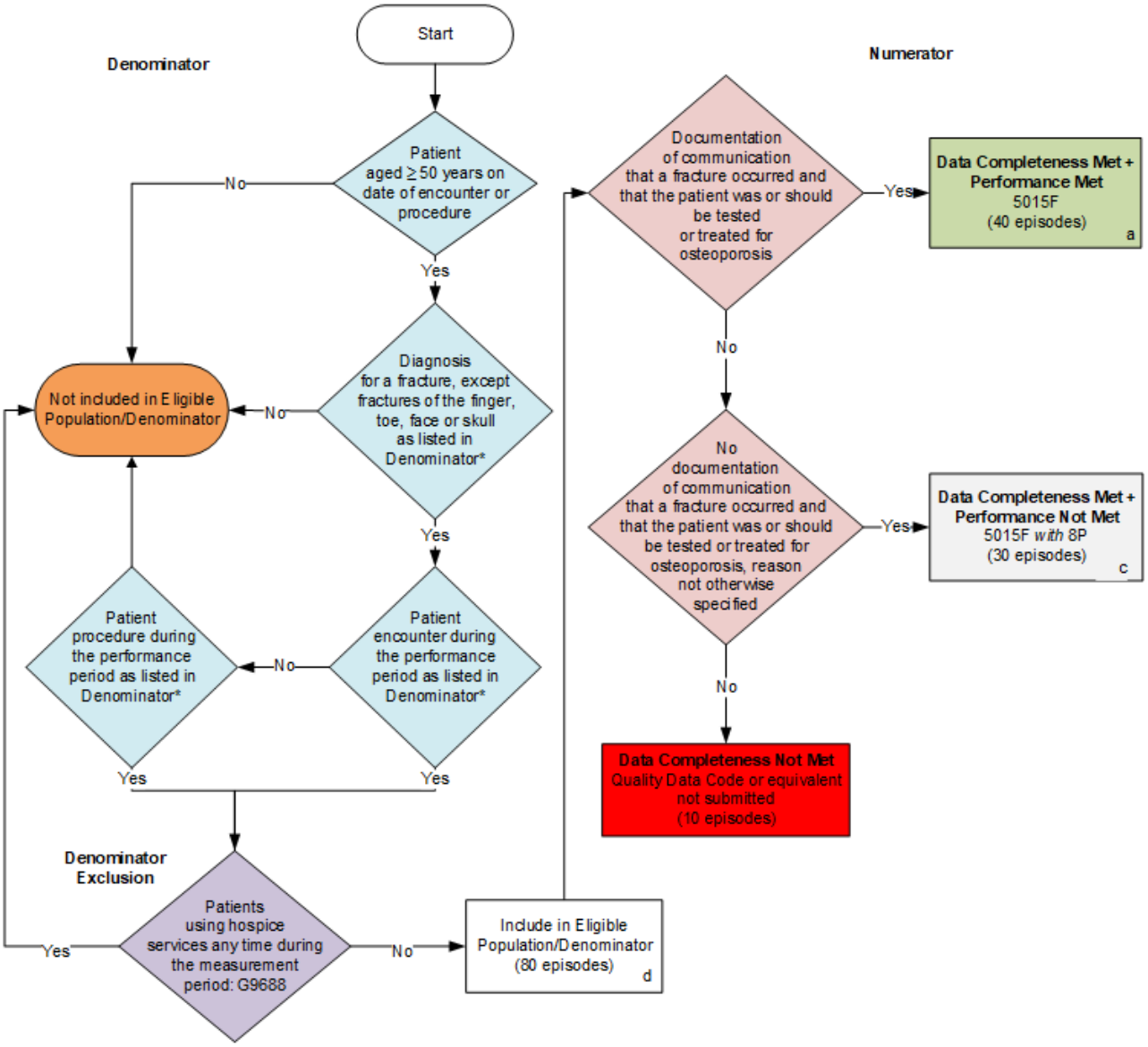
2026 Clinical Quality Measure Flow for Quality ID #024: Communication with the Physician or Other Clinician Managing On-Going Care Post-Fracture for Men and Women Aged 50 Years and Older

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*



SAMPLE CALCULATIONS

Data Completeness=

Performance Met (a=40 episodes) + Performance Not Met (c=30 episodes) / Eligible Population / Denominator (d=80 episodes) = 70 episodes / 80 episodes = **87.50%**

Performance Rate=

Performance Met (a=40 episodes) / Data Completeness Numerator (70 episodes) = 40 episodes / 70 episodes = **57.14%**

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

NOTE: Submission Frequency: Episode

2026 Clinical Quality Measure Flow Narrative for Quality ID #024:
Communication with the Physician or Other Clinician Managing On-Going Care Post-Fracture for Men and Women Aged 50 Years and Older

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

1. Start with Denominator
2. Check *Patient aged greater than or equal to 50 years on date of encounter or procedure*:
    a. If *Patient aged greater than or equal to 50 years on date of encounter or procedure* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient aged greater than or equal to 50 years on date of encounter or procedure* equals Yes, proceed to *Diagnosis for a fracture, except fractures of the finger, toe, face or skull as listed in the Denominator**.
3. Check *Diagnosis for a fracture, except fractures of the finger, toe, face or skull as listed in the Denominator**:
    a. If *Diagnosis for a fracture, except fractures of the finger, toe, face or skull as listed in the Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Diagnosis for a fracture, except fractures of the finger, toe, face or skull as listed in the Denominator** equals Yes, proceed to *Patient encounter during the performance period as listed in Denominator** .
4. Check *Patient encounter during the performance period as listed in Denominator** :
    a. If Patient encounter during the performance period as listed in Denominator* equals No, proceed to Patient procedure during the performance period as listed in Denominator*.
    b. If Patient encounter during the performance period as listed in Denominator* equals Yes, proceed to Patient using hospice services any time during the measurement period.
5. Check *Patient procedure during the performance period as listed in Denominator*.*
    a. If *Patient procedure during the performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient procedure during the performance period as listed in Denominator** equals Yes, proceed to *Patient using hospice services any time during the measurement period.*
6. Check *Patient using hospice services any time during the measurement period:*
    a. If Patient using hospice services any time during the measurement period equals Yes, do not include in Eligible Population/Denominator. Stop processing.
    b. If *Patient using hospice services any time during the measurement period* equals No, include in the *Eligible Population/Denominator.*
7. Denominator Population:
    a. Denominator Population is all Eligible Episodes in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 episodes in the Sample Calculation.
8. Start Numerator

9. Check *Documentation of communication that a fracture occurred and that the patient was or should be tested or treated for osteoporosis*:

    a. If *Documentation of communication that a fracture occurred and that the patient was or should be tested or treated for osteoporosis* equals Yes, include in *Data Completeness Met and Performance Met*.

        - *Data Completeness Met and Performance Met* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a equals 40 episodes in the Sample Calculation.

    b. If *Documentation of communication that a fracture occurred and that the patient was or should be tested or treated for osteoporosis* equals No, proceed to *No documentation of communication that a fracture occurred and that the patient was or should be tested or treated for osteoporosis, reason not otherwise specified*.

10. Check *No documentation of communication that a fracture occurred and that the patient was or should be tested or treated for osteoporosis, reason not otherwise specified*:

    a. If *No documentation of communication that a fracture occurred and that the patient was or should be tested or treated for osteoporosis, reason not otherwise specified* equals Yes, include in *Data Completeness Met and Performance Not Met*.

        - *Data Completeness Met and Performance Not Met* letter is represented as Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 30 episodes the Sample Calculation.

    b. If *No documentation of communication that a fracture occurred and that the patient was or should be tested or treated for osteoporosis, reason not otherwise specified* equals No, proceed to *Data Completeness Not Met*.

11. Check *Data Completeness Not Met*:

a. If *Data Completeness Not Met*, the Quality Data Code was not submitted. 10 episodes have been subtracted from the Data Completeness Numerator in the Sample Calculation.

Sample Calculations:
Data Completeness equals Performance Met (a equals 40 episodes) plus Performance Not Met (c equals 30 episodes) divided by Eligible Population/Denominator (d equals 80 episodes). All equals 70 episodes divided by 80 episodes. All equals 87.50 percent.

Performance Rate equals Performance Met (a equals 40 episodes) divided by Data Completeness Numerator (70 episodes). All equals 40 episodes divided by 70 episodes. All equals 57.14 percent.

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

NOTE: Submission Frequency: Episode

The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.