Functional Outcome Assessment in Chiropractic Care

*This measure is to be reported **each visit** during the reporting period for all patients 18 years and older. The assessment is required to be current as defined for patients seen during the reporting period. This measure may be reported by non-MD/DO clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.*

Measure description

Percentage of patients age 18 years and older with documentation of a current[2] functional outcome assessment[1] using a standardized tool[3] AND documentation of a care plan based on identified functional outcome deficiencies

What will you need to report for each patient for this measure?

If you select this measure for reporting, you will report:

- Whether or not you assessed the patient's current[2] functional outcome using a standardized tool[3] and documented a care plan[4], if deficiencies have been identified. Functional outcome deficiencies are defined as impairment or loss of physical function related to neuromusculoskeletal capacity, including but not limited to, restricted flexion, extension and rotation, back pain, neck pain, pain in the joints of the arms or legs, and headaches.
- The intent of the measure is for the functional outcome assessment tool to be utilized at a minimum of every 30 days but reporting is required each visit due to coding limitations. Therefore, for visits between each 30 day functional outcome assessment, the denominator exclusion code not documented/ not eligible would be used for reporting purposes.

What if this process or outcome of care is not appropriate for your patient?

There may be times when it is not appropriate to assess the patient's current functional outcome, due to:

- Documented reasons (eg, patient refuses to participate, patient unable to complete questionnaire)

In these cases, you will need to indicate that a documented reason applies, and specify the reason on the worksheet and in the medical chart. The office/billing staff will then report the G-code that represents these valid reasons (also called exclusions).

[1]Questionnaires designed to measure a patient's limitations in performing the usual human tasks of living. Functional questionnaires seek to quantify symptoms, functional and behavior directly, rather than to infer them from less relevant physiological tests. (Mercy Guideline, pg. 143)

[2]Patient having a documented functional assessment within the previous 30 days.

[3]An assessment tool that has been appropriately normalized and validated for the population in which it is used. Examples of tools for functional outcome assessment include, but are not limited to, Oswestry Disability Index (ODI), Roland Morris Disability/Activity Questionnaire (RM), and Neck Disability Index (NDI).

[4]A care plan is an ordered assembly of expected or planned activities, including observations goals, services, appointments and procedures, usually organized in phases or sessions, which have the objective of organizing and managing health care activity for the patient, often focused upon one or more of the patient's health care problems. Care plans may include order sets as actionable elements, usually supporting a single session or phase. Also known as a treatment plan.