Chiropractic Care

Functional Outcome Assessment in Chiropractic Care

Physician Quality Reporting System Data Collection Sheet

		/ /	☐ Male ☐ Female
Patient's Name	Practice Medical Record Number (MRN)	Birth Date (mm/dd/yyyy)	Gender
National Provider Identifier (NPI)		Date of Service	

Clinical Information

Step 1 Is patient eligible for this measure?

	Yes	No
Patient is aged 18 years and older on date of encounter.	☐	☐
There is a CPT Code for chiropractic manipulative treatment for this visit.	☐	☐
If **No** is checked for any of the above, STOP. Do not report a G-code.		

Billing Information

Code Required on Claim Form

Verify date of birth on claim form.

Refer to coding specifications document for list of applicable codes. Codes determining a patient's eligibility must be reported on the same claim as the quality code(s) identified below.

Step 2 Does patient meet or have an acceptable reason for not meeting the measure?

Current[1] Functional Outcome[2]	Yes	No	Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)
Assessed using a standardized tool[3] AND care plan[4] documented	☐	☐	G8539
Not assessed for the following reason: • Documented reasons (ie, patient refuses to participate, patient unable to complete questionnaire)	☐	☐	G8540
Assessed, but no care plan documented for the following reason: • Documented reasons (ie, no functional outcome deficiencies[5] identified, patient not eligible for care plan)	☐	☐	G8542
Document reason here and in medical chart. _____ _____ _____ _____			If **No** is checked for **all** of the above, report G8541 (No documentation of a current functional outcome assessment using a standardized tool, reason not specified.) **OR** G8543 (Documentation of a current functional outcome assessment using a standardized tool; no documentation of a care plan, reason not specified.)

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

[2]Function outcome assessment includes 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)

[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.

[5]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.

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