

Functional Outcome Assessment in Chiropractic Care

*This measure is to be reported at **each visit** during the reporting period for all patients aged 18 years and older.*

Measure description

Percentage of patients age 18 years and older with documentation of a current functional outcome assessment¹ using a standardized tool 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 current² functional outcome using a standardized tool³ and documented a care plan⁴, 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.

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).

¹Questionnaires 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.

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

³An 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).

⁴A 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.