

## Measure #182: Functional Outcome Assessment

### 2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES: CLAIMS, REGISTRY

#### DESCRIPTION:

Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies

#### INSTRUCTIONS:

This measure is to be reported **each visit** indicating the appropriate numerator code; however, the assessment is required to be current as defined for patients seen during the reporting period. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Documentation of a current functional outcomes assessment must include identification of the standardized tool used.

#### Clarification:

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 at each visit due to coding limitations. Therefore, for visits occurring within 30 days of a previously documented functional outcome assessment, the numerator quality-data code **G8942** should be used for reporting purposes.

#### Measure Reporting via Claims:

CPT codes and patient demographics are used to identify patients that are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT codes, and the appropriate numerator G-code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

#### Measure Reporting via Registry:

CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

#### DENOMINATOR:

All visits for patients aged 18 years and older

#### Denominator Criteria (Eligible Cases):

Patients aged  $\geq 18$  years on date of encounter

#### AND

Patient encounter during the reporting period (CPT): 97001, 97002, 98940, 98941, 98942

**NUMERATOR:**

Patients with a documented current functional outcome assessment using a standardized tool AND a documented care plan

**Definitions:**

**Standardized Tool** – 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), Neck Disability Index (NDI), and Patient-Reported Outcomes Measurement Information System (PROMIS). The use of a standardized tool assessing pain alone, such as the visual analog scale (VAS), does **not** meet the criteria of a functional outcome assessment standardized tool.

**Functional Outcome Assessment** – Patient completed questionnaires designed to measure a patient's limitations in performing the usual human tasks of living and to directly quantify functional and behavioral symptoms.

**Current** – A patient having a documented functional assessment within the previous 30 days.

**Functional Outcome Deficiencies** – Impairment or loss of physical function related to neuromusculoskeletal capacity, may include but are not limited to: restricted flexion, extension and rotation, back pain, neck pain, pain in the joints of the arms or legs, and headaches.

**Care Plan** – A care plan is an ordered assembly of expected/planned activities or actionable elements based on identified deficiencies. These may include 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 on one or more of the patient's health care problems. Care plans may also be known as a treatment plan.

**Not Eligible** – A patient is not eligible if the following reasons(s) exist:

- Patient refuses to participate
- Patient unable to complete questionnaire

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**

**Functional Outcome Assessment and Care Plan Documented**

*(One G-code [G8539 or G8542 or G8942] is required on the claim form to submit this numerator option)*

**G8539:** Documentation of a functional outcome assessment using a standardized tool **AND** documentation of a care plan based on identified deficiencies on the date of the functional outcome assessment

**OR**

**Functional Outcome Assessment Documented, No Functional Deficiencies Identified, Care Plan not Required**

**G8542:** Documentation of a functional outcome assessment using a standardized tool; no functional deficiencies identified, care plan not required

**OR**

**Functional Outcome Assessment and Care Plan Documented with in the previous 30 days**

**G8942:** Documented functional outcomes assessment and care plan within the previous 30 days

**OR**

**Functional Outcome Assessment not Documented, Patient not Eligible**

*(One G-code [G8540] is required on the claim form to submit this numerator option)*

**G8540:** Documentation that the patient is not eligible for a functional outcome assessment using a standardized tool

**OR**

**Functional Outcome Assessment not Documented, Reason not Given**

*(One G-code [G854x] is required on the claim form to submit this numerator option)*

**G8541:** Functional outcome assessment using a standardized tool not documented, reason not given

**OR**

**Functional Assessment Documented, Care Plan not Documented, Reason not Given**  
**G8543:** Documentation of a functional outcome assessment using a standardized tool; care plan not documented, reason not given

**RATIONALE:**

Standardized outcome assessments, questionnaires or tools are a vital part of evidence-based practice. Despite the recognition of the importance of outcomes assessments, questionnaires and tools, recent evidence suggests their use in clinical practice is limited. Selecting the most appropriate outcomes assessment, questionnaire or tool enhances clinical practice by (1) identifying and quantifying body function and structure limitations; (2) formulating the evaluation, diagnosis, and prognosis; (3) informing the plan of care; and (4) helping to evaluate the success of physical therapy interventions (Potter et al., 2011).

**CLINICAL RECOMMENDATION STATEMENTS:**

As a category, functional outcome assessments of everyday tasks are very suitable for evaluating treatment of dysfunctions of the neuromusculoskeletal system. Many questionnaires could be used; choice should depend upon the validity, reliability, responsiveness, and practicality demonstrated in the scientific literature. Functional questionnaires seek to directly quantify symptoms, function and behavior, rather than draw inferences from relevant physiological tests. Clinicians contemplating the use of functional instruments should be aware of differences between questionnaires and choose the most appropriate assessment tool for the specific purpose (Haldeman et al., 2005) (Evidence Class: I, II, III, Consensus Level: 1).

Outcome measures/standardized assessments are used by physical therapists to evaluate patient response to therapeutic interventions. In a 2006 Centers for Medicare & Medicaid Services report, *Uniform Patient Assessment for Post-Acute Care*, the Division of Health Care Policy and Research recommended there is a role for uniform outcome assessments to determine long term function for patients leaving the acute care hospital.

Farrel (2004) recommended the use of screening tools that allow therapists to identify patient's overall function, degree of frailty, risk of falls and endurance and can act as a communication tool for collaboration of physical therapists with other health care professionals potentially leading to improved outcomes.

The Council on Chiropractic Education (2012) recommended keeping appropriate records of the patient's evaluation and case management needs to aptly respond to changes in patient status, or failure of the patient to respond to care.

The Institute of Medicine's (2012) *Living Well with Chronic Illness: A Call for Public Health Action* stated the surveillance systems need to be improved to assess health-related quality of life and functional status of patients. Such systems need to inform the planning, development, implementation, and evaluation of public health policies, programs and interventions relevant to individuals with chronic illness.