

Measure #182 (NQF 2624): Functional Outcome Assessment – National Quality Strategy Domain: Communication and Care Coordination

2017 OPTIONS FOR INDIVIDUAL MEASURES:

REGISTRY ONLY

MEASURE TYPE:

Process

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 denominator eligible visit for patients seen during the 12 month performance period. The functional outcome assessment is required to be current as defined in the definition section. This measure may be reported by eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting:

The listed denominator criteria is used to identify the intended patient population. The numerator options included in this specification are used to submit the quality actions allowed by 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 ≥ 18 years on date of encounter

AND

Patient encounter during the **performance period** (CPT): 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, 98940, 98941, 98942

NUMERATOR:

Patients with a documented current functional outcome assessment using a standardized tool AND a documented care plan based on the identified functional outcome deficiencies

Numerator Instructions: Documentation of a current functional outcome assessment must include identification of the standardized tool used.

Definitions:

Standardized Tool – A tool that has been normed and validated. 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), Patient-Reported Outcomes Measurement Information System (PROMIS), Disabilities of the Arm, Shoulder and Hand (DASH), and Knee Outcome Survey Activities of Daily Living Scale (KOS-ADL).

Note: A functional outcome assessment is multi-dimensional and quantifies pain and musculoskeletal/neuromusculoskeletal capacity; therefore 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 physical limitations in performing the usual human tasks of living and to directly quantify functional and behavioral symptoms.

Current (Functional Outcome Assessment) – A patient having a documented functional outcome assessment utilizing a standardized tool and a care plan if indicated within the previous 30 days.

Functional Outcome Deficiencies – Impairment or loss of physical function related to musculoskeletal/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 (Denominator Exception) – A patient is not eligible if one or more of the following reasons(s) is documented:

- Patient refuses to participate
- Patient unable to complete questionnaire
- Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status

NUMERATOR NOTE: *The intent of this measure is for a 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.*

Numerator Options:

Performance Met:

Functional outcome assessment documented as positive using a standardized tool AND a care plan based, on identified deficiencies on the date of the functional outcome assessment, is documented (G8539)

OR

Performance Met:

Functional outcome assessment using a standardized tool is documented; no functional deficiencies identified, care plan not required (G8542)

OR

Performance Met:

Functional outcome assessment using a standardized tool is documented within the previous 30 days and care plan, based on identified deficiencies on the date of the functional outcome assessment, is documented (G8942)

OR

Denominator Exception:

Functional Outcome Assessment NOT documented as being performed, documentation the patient is not eligible for a functional outcome assessment using a standardized tool (G8540)

OR

Denominator Exception:

Functional outcome assessment documented, care plan not documented, documentation the patient is not eligible for a care plan (G9227)

OR

Performance Not Met:

Functional outcome assessment using a standardized tool not documented, reason not given (G8541)

OR

Performance Not Met:

Documentation of a positive functional outcome assessment using a standardized tool; care plan not documented, reason not given (G8543)

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). "The use of standardized tests and measures early in an episode of care establishes the baseline status of the patient/client, providing a means to quantify change in the patient's/client's functioning. Outcome measures, along with other standardized tests and measures used throughout the episode of care, as part of periodic reexamination, provide information about whether predicted outcomes are being realized" (American Physical Therapy Association (APTA), 2011).

Early in the intervention process, occupational therapists should select outcomes that are valid, reliable, sensitive to change; congruent with client goals and based on their actual or purported ability to predict future outcomes.

Outcomes are applied to measure progress and adjust goals and interventions. Results are used to make decisions about future direction of intervention (American Occupational Therapy Association (AOTA), 2014).

"Few outcome measures are routinely used to assess patients with neck pain other than a numeric pain rating scale. A comparison of practice patterns to current evidence suggests overutilization of some measures that have questionable reliability and underutilization of some with better supporting evidence. This practice analysis suggests that there is substantial need to implement more consistent outcome measurement" (MacDermid et al., 2013).

Barriers to use of classification systems and outcome measures were lack of knowledge, too limiting, and time. Classification systems are being used for decision-making in physical therapy practice for patients with lower back pain (LBP). Lack of knowledge and training seems to be the main barrier to the use of classification systems in practice (Davies et al., 2014).

Musculoskeletal disorders accounted for 6.8% of total Disability-adjusted life years (DALYs) as reported in the Global Burden of Disease Study 2010 (Hoy et al., 2014). Chronic low back pain, joint pain and disability from arthritis are three of the top four most commonly reported medical conditions. In the 2012 National Health Interview Survey musculoskeletal medical conditions were reported by 126.6 million adults in the United States, representing more than one in two people 18 and over. Fifty six out of every 100 adult females and 51 out of every 100 adult males report musculoskeletal conditions and 61% of persons 65 years and older report musculoskeletal conditions (US Bone and Joint Initiative, 2014).

In 2010, there were 777 million Years lived with disability (YLDs) from all causes, up from 583 million in 1990. The main contributors to global YLDs were mental and behavioral disorders, musculoskeletal disorders and diabetes or endocrine disorders (Vos et al., 2012). In 2010 the top 8 conditions were the same in 1990 and 2010 for Years lived with disability (YLDs) in the United States: low back pain, major depressive disorder, other musculoskeletal disorders, neck pain, anxiety disorders and diabetes (US Burden of Disease Collaborators, 2013).

Direct and indirect costs for treatment of musculoskeletal disorders were \$874 billion in 2015 (5.7% of gross domestic product) (US Bone and Joint Initiative, 2014). Musculoskeletal disorder (MSD) cases accounted for 32 percent of all injury and illness cases in 2014. The incidence rate decreased to 33.8 cases per 10,000 full time workers in 2014, down from 35.8 in (Bureau of Labor and Statistics, 2015). In 2012, there were 216 million work days lost to a musculoskeletal condition (US Bone and Joint Initiative, 2014).

In 2012 nearly 66 million US adults reported low back pain, the most frequently reported musculoskeletal condition. The estimated cost for all back related conditions were \$253 billion (US Bone and Joint Initiative, 2014). "Acute or chronic,

LBP can lead to notable functional limitations and disability” (Learman et al., 2014). Neck Pain is ranked as the 4th greatest contributor to global disability (Hoy et al., 2014).

“In 2014, upper extremities affected by an injury or illness accounted for 346,170 cases, or 32 cases per 10,000 full-time workers. Hands accounted for 40 percent of those cases, the most among upper extremities. Shoulder injuries and illnesses caused workers to miss a median of 26 days of work, more than any other body part (Bureau of Labor Statistics, 2015)”.

Fifty percent of United States adults have some form of arthritis (US Bone and Joint Initiative, 2014). Arthritis is considered the leading cause of disability among adults in the United States today and contributes substantially to the rising cost of health care (Enyinnaya et al., 2012).

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). Utilization of validated pain and function scales help to differentiate treatment approaches in order to improve the patient's ability to function (ICSI, 2012).

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.

Clinicians should use validated functional outcome measures, such as the Disabilities of the Arm, Shoulder and Hand (DASH), the American Shoulder and Elbow Surgeons shoulder scale (ASES), or the Shoulder Pain and Disability Index (SPPADI). These should be utilized before and after interventions intended to alleviate the impairments of body function and structure, activity limitations, and participation restrictions associated with adhesive capsulitis (Kelley et al., 2013) (Guideline). Clinicians should use validated self-report questionnaires, such as the Oswestry Disability Index and the Roland- Morris Disability Questionnaire. These tools are useful for identifying a patient's baseline status relative to pain, function, and disability and for monitoring a change in a patient's status throughout the course of treatment (Delitto et al., 2012) (Guideline).

Tracking the outcomes of an implementation program is critical to evaluating its benefit to patients (Kramer et al., 2013). Understanding the clinical course of a condition can help assessment of individual patient outcomes by providing a meaningful point of reference with which to compare an individual patient's progress (Leaver et al., 2013). 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.

Outcome assessment scales provide a concise, valid way to track function and improvement in function. Anchored numerical scales are recommended for tracking routine progress, particularly pain interference with important activities. Regional or condition functional outcome scales should be routinely used at baseline and periodic follow-ups. More frequent follow-up is recommended with higher frequency care (Washington State Department of Labor and Industries, 2014).

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2017 Registry Individual Measure Flow #182 NQF #2624: Functional Outcome Assessment



SAMPLE CALCULATIONS:

Data Completeness=

$$\frac{\text{Performance Met } (a^1+a^2+a^3=4 \text{ visits}) + \text{Denominator Exception } (b^1+b^2=1 \text{ visit}) + \text{Performance Not Met } (c^1+c^2=2 \text{ visits})}{\text{Eligible Population / Denominator } (d=8 \text{ visits})} = \frac{7 \text{ visits}}{8 \text{ visits}} = 87.50\%$$

Performance Rate=

$$\frac{\text{Performance Met } (a^1+a^2+a^3=4 \text{ visits})}{\text{Data Completeness Numerator } (7 \text{ visits}) - \text{Denominator Exception } (b^1+b^2=1 \text{ visit})} = \frac{4 \text{ visits}}{6 \text{ visits}} = 66.66\%$$

*See the posted Measure Specification for specific coding and instructions to report this measure.
 NOTE: Report Frequency- Visit

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v1

2017 Registry Individual Measure Flow
#182 NQF# 2624: Functional Outcome Assessment

Please refer to the specific section of the Measure Specification to identify the denominator and numerator information for use in reporting this Individual Measure.

1. Start with Denominator
2. Check Patient Age:
 - a. If the Age is greater than or equal to 18 years of age at Date of Service and equals No during the measurement period, do not include in Eligible Patient Population. Stop Processing.
 - b. If the Age is greater than or equal to 18 years of age at Date of Service and equals Yes during the measurement period, proceed to check Encounter Performed.
3. Check Encounter Performed:
 - a. If Encounter as Listed in the Denominator equals No, do not include in Eligible Patient Population. Stop Processing.
 - b. If Encounter as Listed in the Denominator equals Yes, include in the Eligible Population.
4. Denominator Population:
 - a. Denominator population is all Eligible Patients in the denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 8 visits in the sample calculation.
5. Start Numerator
6. Check Functional Outcome Assessment Documented as Positive AND Care Plan Documented:
 - a. If Functional Outcome Assessment Documented as Positive AND Care Plan Documented equals Yes, include in Data Completeness Met and Performance Met.
 - b. 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 a¹ equals 1 visit in Sample Calculation.
 - c. If Functional Outcome Assessment Documented as Positive AND Care Plan Documented equals No, proceed to Functional Outcome Assessment Documented, No Functional Deficiencies Identified, Care Plan Not Required.
7. Check Functional Outcome Assessment Documented, No Functional Deficiencies Identified, Care Plan Not Required:
 - a. If Functional Outcome Assessment Documented, No Functional Deficiencies Identified, Care Plan Not Required equals Yes, include in Data Completeness Met and Performance Met.
 - b. 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 a² equals 3 visits in the Sample Calculation.

- c. If Functional Outcome Assessment Documented, No Functional Deficiencies Identified, Care Plan Not Required equals No, proceed to Functional Outcome Assessment Documented AND Care Plan Documented, if Indicated within Previous 30 Days.
- 8. Check Functional Outcome Assessment Documented AND Care Plan Documented, if Indicated within Previous 30 Days:
 - a. If Functional Outcome Assessment Documented AND Care Plan Documented, if Indicated within Previous 30 Days equals Yes, include in the Data Completeness Met and Performance Met.
 - b. 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 a³ equals 0 visits in the Sample Calculation.
 - c. If Functional Outcome Assessment Documented AND Care Plan Documented, if Indicated within Previous 30 Days equals No, proceed to Functional Outcome Assessment Not Documented, Patient Not Eligible.
- 9. Check Functional Outcome Assessment Not Documented, Patient Not Eligible:
 - a. If Functional Outcome Assessment Not Documented, Patient Not Eligible equals Yes, include in Data Completeness Met and Denominator Exception.
 - b. Data Completeness Met and Denominator Exception letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b¹ equals 1 visit in the Sample Calculation.
 - c. If Functional Outcome Assessment Not Documented, Patient Not Eligible equals No, proceed to Functional Outcome Assessment Documented, Care Plan Not Documented, Patient Not Eligible.
- 10. Check Functional Outcome Assessment Documented, Care Plan Not Documented, Patient Not Eligible:
 - a. If Functional Outcome Assessment Documented, Care Plan Not Documented, Patient Not Eligible equals Yes, include in Data Completeness Met and Denominator Exception.
 - b. Data Completeness Met and Denominator Exception letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b² equals 0 visits in the Sample Calculation.
 - c. If Functional Outcome Assessment Documented, Care Plan Not Documented, Patient Not Eligible equals No, proceed to Functional Outcome Assessment Not Documented, Reason Not Given.
- 11. Check Functional Outcome Assessment Not Documented, Reason Not Given:
 - a. If Functional Outcome Assessment Not Documented, Reason Not Given equals Yes, include in Data Completeness Met and Performance Not Met.
 - b. 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 c¹ equals 0 visits in the Sample Calculation.
 - c. If Functional Outcome Assessment Not Documented, Reason Not Given equals No, proceed to Functional Outcome Assessment Documented as Positive, Care Plan Not Documented, Reason Not Given.

12. Check Functional Outcome Assessment Documented as Positive, Care Plan Not Documented, Reason Not Given:

- a. If Functional Outcome Assessment Documented as Positive, Care Plan Not Documented, Reason Not Given equals Yes, include in Data Completeness Met and Performance Not Met.
- b. 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 c² equals 2 visits in the Sample Calculation.
- c. If Functional Outcome Assessment Documented as Positive, Care Plan Not Documented, Reason Not Given equals No, proceed to Data Completeness Not Met.

13. Check Data Completeness Not Met:

If Data Completeness Not Met equals No, Quality Data Code or equivalent not reported. 1 visit has been subtracted from the data completeness numerator in the sample calculation.

SAMPLE CALCULATIONS:

Data Completeness=

$$\frac{\text{Performance Met (a}^1+\text{a}^2+\text{a}^3= 4 \text{ visits) + Denominator Exception (b}^1+\text{b}^2=1 \text{ visit) + Performance Not Met (c}^1+\text{c}^2=2 \text{ visits) = 7 visits}}{\text{Eligible Population / Denominator (d=8 visits) = 8 visits}} = \mathbf{87.50\%}$$

Performance Rate=

$$\frac{\text{Performance Met (a}^1+\text{a}^2+\text{a}^3= 4 \text{ visits) = 4 visits}}{\text{Data Completeness Numerator (7 visits) – Denominator Exception (b}^1+ \text{b}^2= 1 \text{ visit) = 6 visits}} = \mathbf{66.66\%}$$