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PQRS Functional Outcome Assessment Reporting Specifics

General Rules:

In order to meet the quality reporting requirements as specified by CMS in their PQRS program, Chiropractors who send claims to Medicare for Chiropractic Manipulative Therapy (CMT) using the codes 98940, 98941 or 98942 must submit a functional outcome assessment quality code for each visit during which a CMT is performed. Only one of the functional outcome assessment (FOA) codes listed below can be included on the form. There are other measure that must be reported along with the FOA measure, most often just one. Please refer to "FS-PQRS Pain Reporting Specifics" for more information on that measure. In all, you must report a quality measure on pain and a quality measure on FOA's each visit for which you submit a claim for a CMT to Medicare. There is an additional Blood Pressure screening measure to be reported once per year per patient.

Definitions:

Not Eligible:

- 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 (life-threatening) Current: within the previous 30 days.

Care Plan: an ordered assembly of expected/planned activities or actionable elements based on identified deficiencies. May include observations, goals, services, appointments, procedures, etc. which have the objective of organizing and managing care activities for a patient, also known as a treatment plan.

Examples of Standardized Tools that May be Used for Pain Assessment: (including but not limited to)

- *Oswestry Disability Index (ODI)*
- *Roland Morris Disability Questionnaire (RMDQ)*
- *Neck Disability Index (NDI)*
- *Patient-Reported Outcomes Measurement Information System (PROMIS)*

Why Are There So Many Codes to Choose From?

While as a doctor you would say that function is either affected by a condition or not, CMS has developed three categories that they believe the doctor's performance will fall into. Each of the 300+ measures that all providers much choose from in the system shows a division of the required reporting codes. The Functional Outcomes Assessment measure is number 182 and the choices for reporting are divided into three sections. You will choose ONLY ONE code from this measure to report on each visit. The only reason for you to note these divisions is that CMS is moving to quality only outcomes and you must understand how PQRS reporting can reflect the reporting your sending to CMS.

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Under each measure the eligible codes are divided into three sections:
Functional Outcome Assessment #182:

- Quality Care Is Demonstrated and Meets Reporting Requirements:
  G8539 – FOA (functional outcome assessment) performed using standardized tool, is positive AND a care plan based on deficiencies is documented.
  G8542 – FOA using standardized tool is negative, no functional deficiencies, care plan not required.
  G8942 – FOA using a standardized tool (if indicated) is documented within the previous 30 days and care plan based on deficiencies identified in FOA is documented.

- Exempt from Quality Care Analysis but Meets Reporting Requirements
  G8540 – FOA not performed, patient not eligible (see definition for "not eligible for FOA as it differs from the Pain Assessment eligibility notice) for the assessment.
  G9227 – FOA using standardized tool documented, care plan not developed or documented, patient "not eligible" for care plan.

- Fails to Show Quality Care but Meets Reporting Requirements
  G8541 – FOA not performed or documented, reason not given.
  G8543 – FOA using standardized tool performed, care plan not documented, reason not given.

Examples of Narrative in documentation	Quality Code to Report
Oswestry score: 27/100. Goals: Improve sleeping from 50% disturbed to 25% ……. Treatment to include: (whatever you are doing) 2X per week for 4 weeks, re-evaluation to be done on completion of current care plan.	G8539
RMI score 0. Patient released to maintenance care.	G8542
Patient returns for visit today stating sleeping is improving now about 40% disturbed. Continue current care plan as outlined on Eval visit. (*the FOA must be performed 30 days or less prior to this visit to use this code)*	G8942 (must have an FOA on file less than 30 days old prior to this date of service and have a current care plan in place to use this code)

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Patient is unable to complete the questionnaire due to mental capacity but can demonstrate inability to rise from chair without assistance, states unable to sleep through the night…	G8540
FOA score is 34/100. Patient refuses to abide by	G9227
care plan and states will not fill out this form ever again.	
(no documentation of FOA in file or the FOA in the file is more than 30 days old	G8541
RMI 10. (no care plan documented)	G8543

Remember, only one FOA quality code should be reported for a visit on which a CMT (98940, 98941, 98942) is being billed to Medicare. To avoid any confusion, it is recommended that you bill each date of treatment on a separate form so your final Medicare claim for a CMT visit should look something like the example at the end of this document.

Documentation Requirements:

When you submit the quality code that states you performed a functional outcome assessment and have a Care plan documented, your note should have the following elements to support that G-code:

1. An FOA completed by or for the patient and reviewed by the doctor. It is acceptable to review the form for accuracy and make changes as you interview your patient.
2. Mention the deficiencies as noted on this standardized FOA. You are not limited to listing only deficiencies noted on the FOA and can add elements that the patient reports but are not obvious in a standardized form. For example, if your form doesn't have a listing for "I can no longer assist in my husband's care because I can't help him out of a chair", adding that to your documentation and creating a goal of returning the patient to that function is acceptable and encouraged.
3. Create goals of improving the functions found to be deficient on the FOA and any other regular activities that the patient has ceased or that are limited by his/her condition.

Submitting the Codes

You can see from the following example that a CMT was performed on a specific date of service. It appears from the dates that this could be the first treatment visit following an evaluation. A functional outcome assessment was performed on the exam visit and a Care plan was noted. This would indicate a G8539 should be reported. It is appropriate to report that code on the first CMT following an evaluation whether it is the same day as the evaluation or a subsequent visit.

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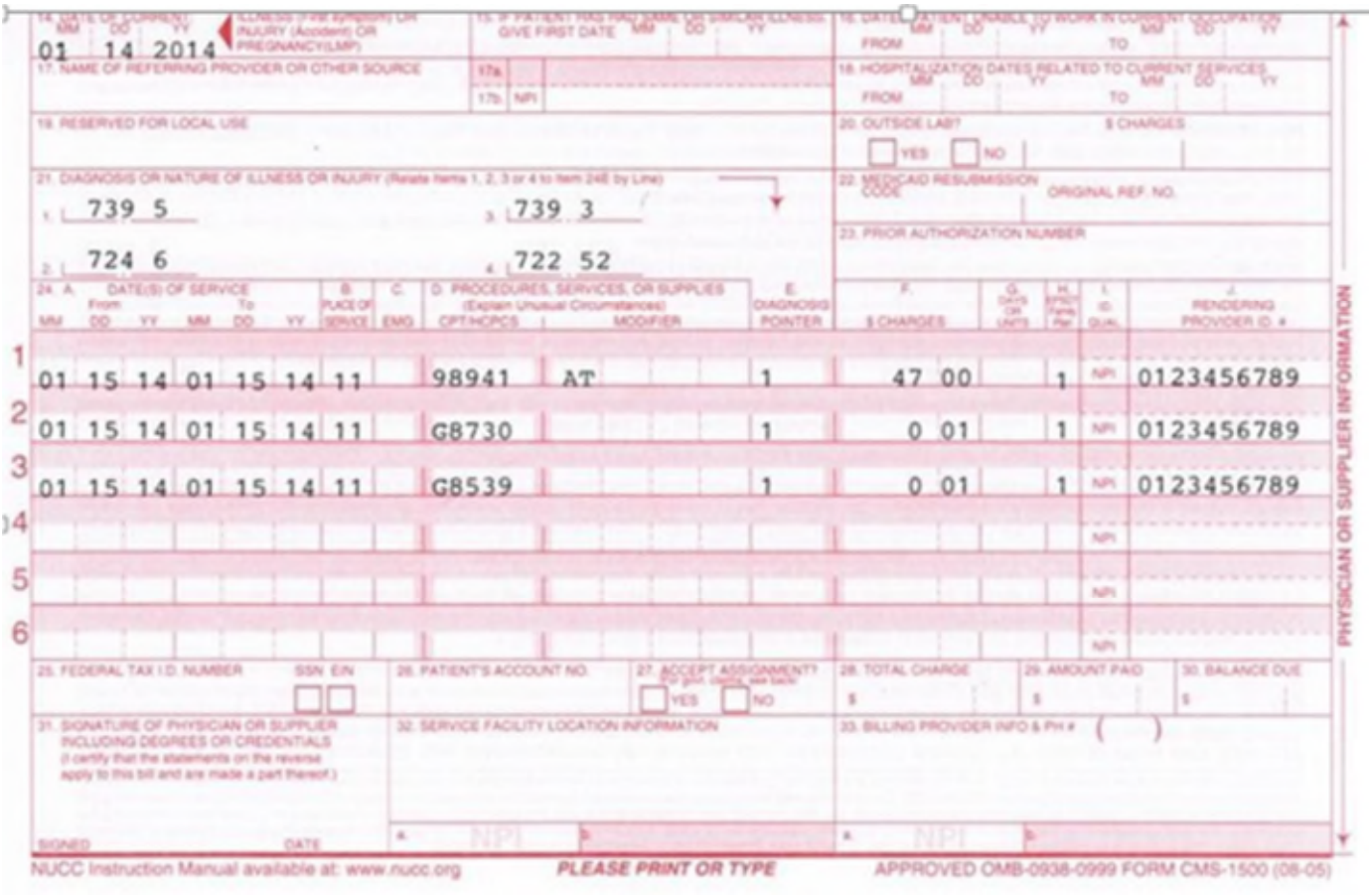
You will also note that an additional G-code is present on this form. Please refer to "PQRS Pain Reporting Specifics" and for information on choosing quality codes for your Medicare claims. This claim form does not contain any doctor specific or practice specific information. For information on how to fully complete a claim form, please refer to the KMC University website for comprehensive training on claims, documentation, Medicare and other practice specific helpful resources.



14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP): 01 14 2014
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE — 17a. — 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES NO — $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 739 5 — 3. 739 3
2. 724 6 — 4. 722 52
22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 15 14	01 15 14	11		98941	AT	1	47 00	1		NPI	0123456789
2 01 15 14	01 15 14	11		G8730		1	0 01	1		NPI	0123456789
3 01 15 14	01 15 14	11		G8539		1	0 01	1		NPI	0123456789
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO
28. TOTAL CHARGE $
29. AMOUNT PAID $
30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE
32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.
33. BILLING PROVIDER INFO & PH # ( ) a. NPI b.
PHYSICIAN OR SUPPLIER INFORMATION
NUCC Instruction Manual available at: www.nucc.org — PLEASE PRINT OR TYPE — APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)