

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

2016 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** for patients seen during the 12 month reporting period. The functional outcome assessment is required to be current as defined in the definition section. 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.

Measure Reporting via Claims:

CPT codes and patient demographics are used to identify patients that are included in the measure's denominator. Quality-data 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 quality-data 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 listed numerator options 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 ≥ 18 years on date of encounter

AND

Patient encounter during the reporting period (CPT): 97001, 97002, 97003, 97004, 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 – 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 Quality-Data Coding Options for Reporting Satisfactorily:

Functional Outcome Assessment Documented as Positive AND Care Plan Documented

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

Performance Met: G8539:

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

OR

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

Performance Met: G8542:

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

OR

Functional Outcome Assessment Documented AND Care Plan Documented, if Indicated, Within the Previous 30 Days

Performance Met: G8942:

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

OR

Functional Outcome Assessment not Documented, Patient not Eligible

(One quality-data code [G8540 or G9227] is required on the claim form to submit this numerator option)

Other Performance Exclusion: G8540:

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

OR

Functional Outcome Assessment Documented, Care Plan not Documented, Patient not Eligible

Other Performance Exclusion: G9227:

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

OR

Functional Outcome Assessment not Documented, Reason not Given

(One quality-data code [G8541 or G8543] is required on the claim form to submit this numerator option)

Performance Not Met: G8541:

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

OR

Functional Outcome Assessment Documented as Positive, Care Plan not Documented, Reason not Given

Performance Not Met: G8543:

Documentation of a positive 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). "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. The Oswestry Disability Index and Numerical Pain Scale were the most commonly used outcome measures. The main barrier to their use was lack of time. Continuing education and reading the literature were identified as important tools to teach evidence-based practice to physical therapists in practice (Davies et al., 2014). Outcome use in occupational therapy indicated that some therapists used both biomechanical and self-assessment of function measures in their practice to measure outcomes, but the majority use biomechanical outcomes (Bohnen, 2011).

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). Of this large total, low back pain accounted for nearly half, neck pain a fifth, and osteoarthritis about 10% (Murray, 2012). In 2010 the top 15 diseases and risk factors contributing to Disability-adjusted life years (DALYs) are a complex mix of cardiovascular diseases (ischemic heart disease and stroke), musculoskeletal disorder (low back pain, other musculoskeletal disorders, and neck pain), etc. (US Burden of Disease Collaborators, 2013).

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).

One in two adults reports a musculoskeletal condition requiring medical attention. Annual direct and indirect costs for bone and joint health are 950 billion – 7.4% of the gross domestic product. Musculoskeletal disorders and diseases are the leading cause of disability in the United States. Between 1996-1998 and 2004-2006, the number of persons reporting a musculoskeletal disease increased nearly 14 million from 76 million reported in 1996. For the years 2004-2006 the sum of the direct expenditures in health care costs and indirect expenditures in lost wages has been estimated to be \$950 billion dollars annually, or 7.4% of the national gross domestic product (Bone and Joint Initiative USA, 2011). Musculoskeletal disorder (MSD) cases accounted for 33 percent of all injury and illness cases in 2013. Both the incidence rate and case count remained statistically unchanged from the previous year; however the median days away from work decreased by 1 day to a median of 11 days (Bureau of Labor and Statistics, 2014).

Neck Pain is ranked as the 4th greatest contributor to global disability (Hoy et al., 2014). “The annual prevalence of nonspecific neck pain is estimated to range between 30% and 50%. Persistent or recurrent neck pain continues to be reported by 50% to 85% of patients 1 to 5 years after initial onset. Its course is usually episodic, and complete recovery is uncommon for most patients. Twenty-seven percent of patients seeking chiropractic treatment report neck or cervical problems (Bryans et al., 2014)”. “Neck disorders can cause pain and impairments in: joint motion, sensory function, proprioception, motor function, coordination, posture and balance. These can be associated with functional disability, loss of physical activity, loss of work capacity, psychological distress, and impaired quality of life” (MacDermid et al., 2013).

Low back pain is the leading cause of disability globally and was estimated to be responsible for 83 million years lived with a disability in 2010 (Buchbinder et al., 2013). “The majority of individuals with an episode of acute low back pain improve and return to work within the first two weeks. The probability of recurrence within the first year ranges from 30 to 60%. Most of these recurrences will recover in much the same pattern as the initial event. In as many as one-third of the cases, the initial episode of low back pain persists for the next year. Most of these individuals continue to function with only limited impairment” (ICSI, 2012). “Low back pain symptoms peak between the ages of 40 and 69, are higher among females than males in all age groups, and are more common in affluent countries with high-income. Acute or chronic, LBP can lead to notable functional limitations and disability” (Learman et al., 2014).

“Most of the total cost for low back pain is dedicated to the small percentage of sufferers whose condition has progressed to the chronic disabling stage (pain for more than 12 weeks). The medical costs for low back pain in general were estimated at \$26.3 billion in 1998 and now are one-third to one-fourth of the total cost of care. Lost production and disability account for other costs. Disability alone claims 80% of the total expense of this condition. Expenditures for medical care and disability continue to increase. The human cost is equally significant; low back pain is currently the second most common cause of disability in the United States and is the most common cause of disability in those under age 45 (Centers for Disease Control and Prevention, 2009)” (ICSI, 2012).

“Visits to primary care clinicians for low back pain are equally split between chiropractors and allopathic clinicians, with low back pain the fifth most common reason for an office visit to all clinicians. The majority of these visits are not because of pain but rather due to the disability associated with the low back symptoms” (ICSI, 2012).

“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. According to recent results from the 2007 to 2009 National Health Interview Survey, just over 20% of adults have been physician diagnosed with arthritis, and this estimate is projected to reach 25% of adults, or 67 million by 2030. Affected most is the growing aging population that currently represents about 13% of the total US population, with this figure expected to increase over the next 2 decades to 19%, or 72 million persons. In rural (nonmetropolitan) areas, the elderly, approximately 15% of the rural population or 7.5 million persons, are especially affected, with evidence suggesting that these individuals experience higher rates of arthritis and comorbid conditions, poorer health status, greater poverty, and less access to medical care. Total attributable costs for arthritis in 2003 were US \$128 billion, with direct costs estimated at \$81 billion and indirect costs at \$47 billion. In addition, arthritis accounted for 3% of all hospitalizations and 5% of all ambulatory care visits in 2004 related to a primary diagnosis of arthritis. Costs related to pharmaceutical use for arthritis were estimated at more than \$75 billion in 2003 compared with \$33 billion in 1997” (Enyinnaya et al., 2012).

“Osteoarthritis (OA) is the most frequently diagnosed form of arthritis among the elderly and contributes substantially to their associated disability” (Enyinnaya et al., 2012). “Knee OA affects 28% of adults older than 45 years and 37% of adults older than 65 years in the United States. Osteoarthritis is a leading cause of disability among noninstitutionalized adults” (Wang et al., 2012).

Average expense per episode of ambulatory physical therapy was \$1184 with an average of 9.6 visits (Machlin et al., 2011). Physical activity limitations are associated with worse economic outcomes across multiple economic metrics (Dall et al., 2013). Inflation-adjusted biennial expenditures on ambulatory services for chronic back pain increased by 129% over the same period, from \$15.6 billion in 2000 to 2001 to \$35.7 billion in 2006-2007 (Smith et al., 2013).

“Back pain and arthritis make their impact by sheer numbers in the population. Even if affected individual miss just a few days of work on average, or have their productivity slightly impaired, the cumulative results across the affected population can amount to tens of billions of dollars in lost wages and reduced work capacity each year. Conversely, interventions that make small improvements in the onset and progression of these chronically disabling diseases may result in significant overall health care cost savings” (Ma et al., 2014).

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).

"The Oswestry Disability Questionnaire is used to assess the patient's subjective rating of perceived disability related to his or her functional limitations, e.g., work status, difficulty caring for oneself. The higher the score, the more perceived the disability. Using this test at the initial visit helps the examiner understand the patient's perception of how his or her back pain is affecting his or her life. There are two ways that this test aids in the treatment of back pain. A higher score is indicative of the need for more intensive treatment such as spinal manipulative therapy and education to help the patient understand the low likelihood of disability related to back pain. Understanding the low likelihood helps prevent the fear of disability from becoming a barrier to improvement. People with higher disability should be managed more aggressively, with a heightened sense of urgency to avoid the negative aspect of prolonged pain and disability. The use of anticipatory guidance and early return to work with appropriate restrictions are important aspects. By tracking these scores, improvement can be documented and monitored" (Goertz 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. Federal and state governments should expand surveillance systems which can be used to inform the planning, development, implementation, and evaluation of public health policies, programs and interventions relevant to individuals with chronic illness.

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).

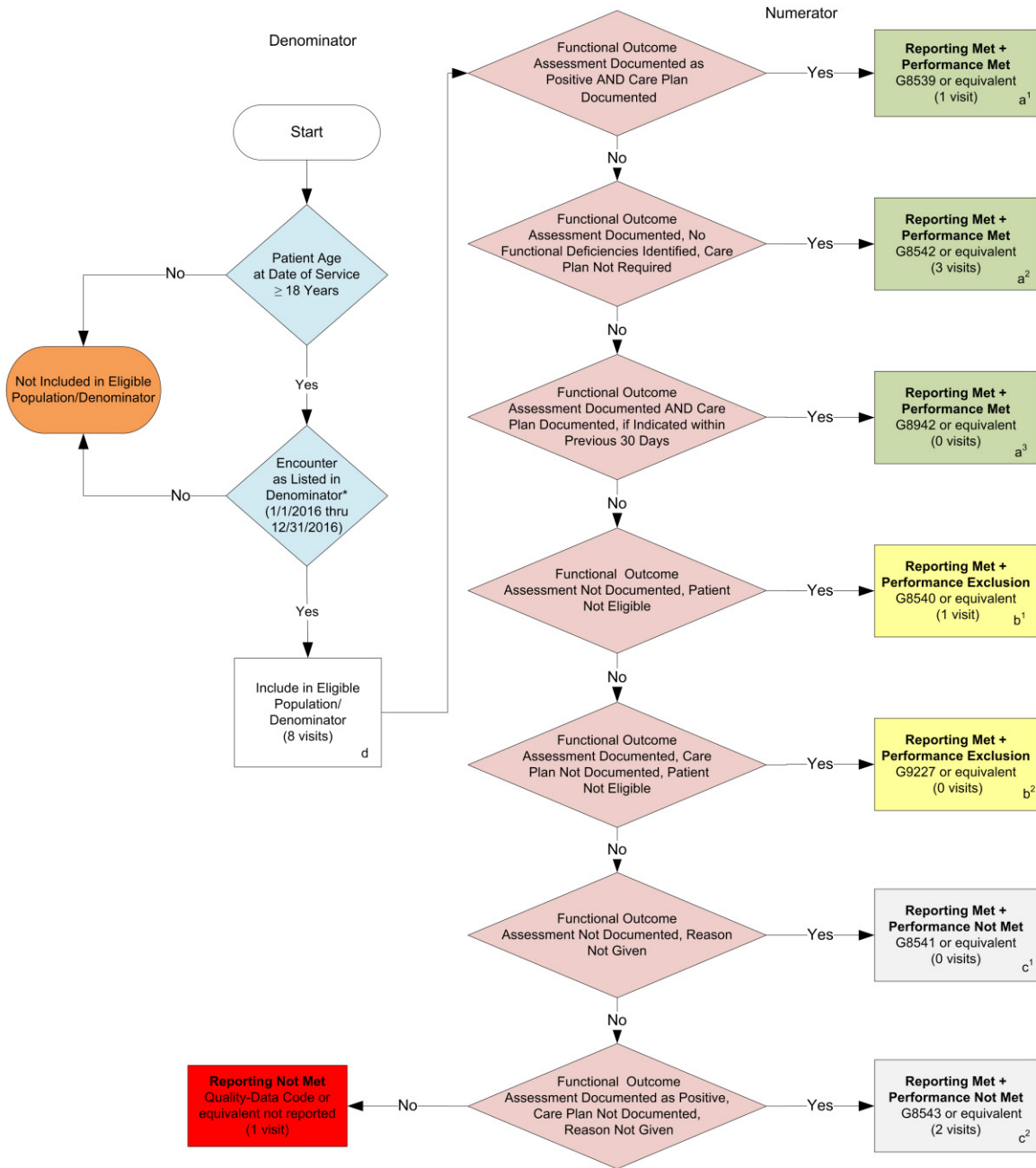
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2016 Claims/Registry Individual Measure Flow PQRS #182 NQF #2624: Functional Outcome Assessment



SAMPLE CALCULATIONS:

Reporting Rate=

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

Performance Rate=

$$\frac{\text{Performance Met (a}^1\text{+a}^2\text{+a}^3\text{= 4 visits)}}{\text{Reporting Numerator (7 visits) - Performance Exclusion (b}^1\text{+ b}^2\text{= 1 visit)}} = \frac{4 \text{ visits}}{6 \text{ visits}} = \mathbf{66.66\%}$$

*See the posted Measure Specification for specific coding and instructions to report this measure.

NOTE: Report Frequency- Visit

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The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

v2

2016 Claims/Registry Individual Measure Flow
PQRS #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 Reporting Met and Performance Met.
 - b. Reporting Met and Performance Met letter is represented in the Reporting Rate 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 Reporting Met and Performance Met.
 - b. Reporting Met and Performance Met letter is represented in the Reporting Rate 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 Reporting Met and Performance Met.
 - b. Reporting Met and Performance Met letter is represented in the Reporting Rate 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 Reporting Met and Performance Exclusion.
 - b. Reporting Met and Performance Exclusion letter is represented in the Reporting Rate 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 Reporting Met and Performance Exclusion.
 - b. Reporting Met and Performance Exclusion letter is represented in the Reporting Rate 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 Reporting Met and Performance Not Met.
 - b. Reporting Met and Performance Not Met letter is represented in the Reporting Rate and Performance Rate 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 Reporting Met and Performance Not Met.
 - b. Reporting Met and Performance Not Met letter is represented in the Reporting Rate and Performance Rate 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 Reporting Not Met.

13. Check Reporting Not Met:
 - a. If Reporting Not Met equals No, Quality Data Code or equivalent not reported. 1 visit has been subtracted from the reporting numerator in the sample calculation.

SAMPLE CALCULATIONS:

Reporting Rate=

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

Performance Rate=

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