Quality ID #182: Functional Outcome Assessment

2026 COLLECTION TYPE:
MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) CLINICAL QUALITY MEASURE (CQM)

MEASURE TYPE:
Process – High Priority

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 performance deficits within two days of the date of the identified deficits.

INSTRUCTIONS:

Reporting Frequency:
This measure is to be submitted each denominator eligible visit for patients as defined in the denominator criteria.

Intent and Clinician Applicability:
This measure is intended to reflect the quality of services provided for patients who receive a functional outcome assessment. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions as defined by the numerator based on the services provided and the measure-specific denominator coding.

Measure Strata and Performance Rates:
This measure contains one strata defined by a single submission criteria.
This measure produces a single performance rate.

Implementation Considerations:
For the purposes of MIPS implementation, this visit measure is submitted each time a patient has a denominator eligible encounter during the performance period.

The functional outcome assessment is required to be current as defined in the definition section. A functional outcome assessment is multi-dimensional and quantifies pain, musculoskeletal/neuromusculoskeletal, or speech and language 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. Electronic use of the Oswestry Disability Index (ODI) tool is no longer available free of charge. A paper alternative is available at no cost.

Telehealth:
TELEHEALTH ELIGIBLE: This measure is appropriate for and applicable to the telehealth setting. Patient encounters conducted via telehealth using encounter code(s) found in the denominator encounter criteria are allowed for this measure. Therefore, if the patient meets all denominator criteria for a telehealth encounter, it would be appropriate to include them in the denominator eligible patient population. Telehealth eligibility is at the measure level for inclusion within the denominator eligible patient population and based on the measure specification definitions which are independent of changes to coding and/or billing practices.

Measure Submission:
The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this collection type for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. The coding provided to identify the measure criteria: Denominator or Numerator, may be an example of coding that could be used to identify patients that meet the intent of this clinical topic. When implementing this measure, please refer to the 'Reference Coding' section to determine if other codes or code languages

that meet the intent of the criteria may also be used within the medical record to identify and/or assess patients. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

DENOMINATOR:
All visits for patients aged 18 years and older.

DENOMINATOR NOTE:
**Signifies that this CPT Category I code is a non-covered service under the Medicare Part B Physician Fee Schedule (PFS). These non-covered services should be counted in the denominator population for MIPS CQMs.*

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the performance period (CPT): 92540, 92541, 92542, 92544, 92546, 92548, 92549, 92605, 92607, 92610, 92611, 92612, 92614, 92616, 96125, 92622, 92626, 97129, 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, 98016, 98940, 98941, 98942, 98943*, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:
Visits where patient has a documented current functional outcome assessment using a standardized tool AND a documented care plan based on the identified functional outcome deficiencies within two days of the assessment.

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), EAT-10: A Swallowing Screening Tool, Health Partners Hearing Assessment, Tinneti Performance Oriented Mobility Assessment (POMA), Western Ontario and McMaster University Osteoarthritis Index Physical Function subscale (WOMAC-PF), Berg Balance Test, Functional Independence Measure, Mini-Mental State Examination, and Motor-Free Visual Perception Test.

Table 1. Definitions for Magnitude of Effects, Based on Mean Between-Group Differences – Modified*

Slight/Small	Moderate	Large/Substantial
Function		
5-10 points on the ODI	>10-20 points on the ODI	>20 points on the ODI
1-2 points on the RDQ	>2-5 points on the RDQ	>5 points on the RDQ
SMD - Function		
0.2-0.5	>0.5-0.8	>0.8

ODI = Oswestry Disability Index; RDQ = Roland Morris Disability Questionnaire; SMD = standardized mean difference.
*The standardized tools listed in the above table are examples only and do not represent an exhaustive list.
Chou R, Devo R, Friedly J, Skelly A, Hashimoto R, Weimer M & Brodt ED. (2017). Nonpharmacologic Therapies for Low Back Pain: A Systematic Review for an American College of Physicians Clinical Practice Guideline. Ann Intern Med, 166:493-505.

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. If a patient is unable to complete a questionnaire, a standardized clinical assessment tool may be used to measure a patient's limitations.
Current (Functional Outcome Assessment) – A patient having a documented functional outcome assessment utilizing a standardized tool and a care plan if indicated at a qualifying encounter within the previous 30 days.
Functional Outcome Deficiencies – Impairment, loss of function, or difficulty with participation in daily activities related to physical (e.g., musculoskeletal, cardiovascular, pulmonary, integumentary), sensory, cognitive, behavioral, or visual/perceptual impairments
OR

Impairment or loss of function related to speech and language capacity, including but not limited to: swallowing or hearing and/or balance disorders.

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 at the time of the encounter:

- Patient refuses to participate
- Patient unable to participate in administration of the functional outcome assessment(s)
- 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 Instructions:

Documentation of a current functional outcome assessment must include identification of the standardized tool used. The follow-up plan must still be provided for and discussed with the patient during the qualifying encounter used to evaluate the numerator. However, documentation of the follow-up plan can occur up to two calendar days after the qualifying encounter, in accordance with the policies of an eligible clinician's practice or health system. All services should be documented during, or as soon as practicable, after the qualifying encounter in order to maintain an accurate medical record.

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 submission is only required at each qualifying encounter 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 is documented within two days of the functional outcome assessment (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 a care plan, based on identified deficiencies is documented within two days of the functional outcome assessment (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 at the time of the encounter (G8540)

OR

Denominator Exception: Functional outcome assessment documented, care plan not documented, documentation the patient is not eligible for a care plan at the time of the encounter (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 within two days of assessment, 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. Utilization of the appropriate outcomes assessment, questionnaires, and tools enhances clinical practice by (1) identifying and quantifying body function and structure limitations, (2) formulating evaluation, diagnosis, and prognosis, (3) forming the plan of care, (4) assisting in evaluating the patient progress towards the goals and validating the benefits of treatment, (5) improving communication between client, clinician, and third party payer, (6) assisting to improve the documentation of care provided (Lesher et al., 2016; Potter et al., 2011; Schenk et al. 2016).

"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, 2016). "Consistent assessment of functional status and capacity, as well as health domains that may contribute to impaired function, can help patients and providers make treatment decisions that align with the patient's values, enhance preprocedure or posthospitalization planning, and prevent use of interventions whose risks could well outweigh their benefits" (High et al., 2019).

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), 2020).

"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). Lesher et al. (2016) noted that Occupational Therapists who use assessment tools may not have understood the tools design or intent leading to over interpretation, under interpretation, or misuse of the tool.

Treatment for musculoskeletal disorders and associated lost wages is on the increase in the U.S. One in every 2 Americans have a musculoskeletal disorder leading to an estimated cost of $213 billion for treatment, care, and lost wages (Bone and Joint Initiative, USA, 2016). Hoy et al. (2014) noted in the Global Burden of Disease Study, musculoskeletal disorders accounted for 6.8% of the total disability –adjusted life years (DALYs).

Of the musculoskeletal disorders, arthritis was noted to be the most common cause of disability with an estimated 51.8 million people experiencing some level of disability from arthritis (Bone and Joint Initiative, USA, 2016). Osteoarthritis of the upper limbs produces higher disability scores and earlier episodes of disability; while osteoarthritis of the knees, hips, and spine worsens with age and causes progressive disability (Montero et al., 2016). The total cost of treating osteoarthritis is $580.9 billion, an increase of 13 percent since 2000, with an estimated 25 million people losing an average of 11.4 days of work for a total of 290.8 million lost work days (Bone and Joint Initiative, USA, 2016).

While arthritis is considered the most common cause of disability, there are several other musculoskeletal disorders that are prevalent. The U.S. Bureau of Labor Statistics (2015) reported that musculoskeletal disorders had the highest incidence of injury, 31% of cases, which accounted for more than four thousand lost work days, with sprains, strains, and tears being the most commonly reported. Of those injuries, the most commonly affected was the upper extremities, with hands and shoulder injuries accounting for the majority of missed days (U.S. Bureau of Labor Statistics, 2015).

Also, Marik et al. (2016) noted that half of the population will experience shoulder pain leading to decreased strength and restricted range of motion (ROM) impacting quality of life and limiting involvement in meaningful occupational activities. In addition, Blanchette et al. (2016) reported that low back pain is one of the leading causes of disability worldwide, one of the most common reasons patients seek medical care, most common occupational disorder, and major cause of lost work days.

"Balance is a complex phenomenon that entails the interaction of multiple body systems to accomplish the basic task of remaining upright. There is a strong correlation between sitting balance and level of selfcare functioning" (Franc, 2020). For hearing, "…data suggest that people wait on average 7–10 yr after noticing hearing problems before seeking help (Davis et al., 2007). One potential reason for the delay in uptake of hearing health care is that the onset of age-related hearing loss is very gradual, and thus individuals may be unaware of the extent of their impairment. As a result, they do not perceive a need for help (Fischer et al., 2011; Smith et al., 2011; Contrera et al., 2016). As noted by Smith et al. (2011), population screening can give individuals who are unaware of a health problem an earlier awareness of that problem" (Saunders et al., 2019). "Swallowing impairment, or dysphagia, is a known complication of cardiovascular surgical procedures that is reported in up to 70% of patients (Daly et al., 2016). Postoperative dysphagia is associated with delayed resumption of oral intake (Barker et al., 2009), increased likelihood of reintubation (Skoretz et al., 2014), pneumonia (Miles et al., 2018), prolonged hospital stay (Barker et al., 2009), increased cost of care (Kozlow et al., 2003) and mortality (Bicer et al., 2005; Ferraris et al., 2001)…Early and accurate detection of dysphagia is therefore critical to allow timely interventions that optimise patient care (O'Horo et al., 2015)" (York et al, 2020).

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). Lesher et al. (2017) and Wales et al. (2017) found that functional assessments can be descriptive, evaluative, discriminative and/or predictive, and should be tested and validated in the population being tested. The tool should be selected based on purpose of the assessment and type of injury sustained (Lesher et al., 2017; and Wales et al., 2016). Utilization of validated pain and function scales help to differentiate treatment approaches in order to improve the patient's ability to function (ICSI, 2012).

Clinicians should use validated functional outcome assessment tools, 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). Clinicians should use validated self-report questionnaires for patients with neck pain, to identify a patient's baseline status and to monitor changes relative to pain, function, disability, and psychosocial functioning (Blanpied et al., 2017) (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. The American Physical Therapy Association recommends that clinicians should utilize easily reproducible activity limitation and participation restriction measures associated with the patient's neck pain to assess the changes in the patient's level of function over the episode of care (Blanpied et al, 2017) (Guideline).

The American College of Physicians 2017 guidelines for noninvasive treatment of acute, subacute, and chronic low back pain noted that the clinician should utilize non-pharmacologic interventions, such as exercise, spinal manipulation, heat, psychological therapies, etc., prior to pharmacologic interventions. Patients who received non-pharmacologic interventions demonstrated improvement in pain and overall function with fewer harms experience than those patients who received pharmacologic therapies (Chou et al., 2017; & Qaseem et al., 2017).

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).

REFERENCES:

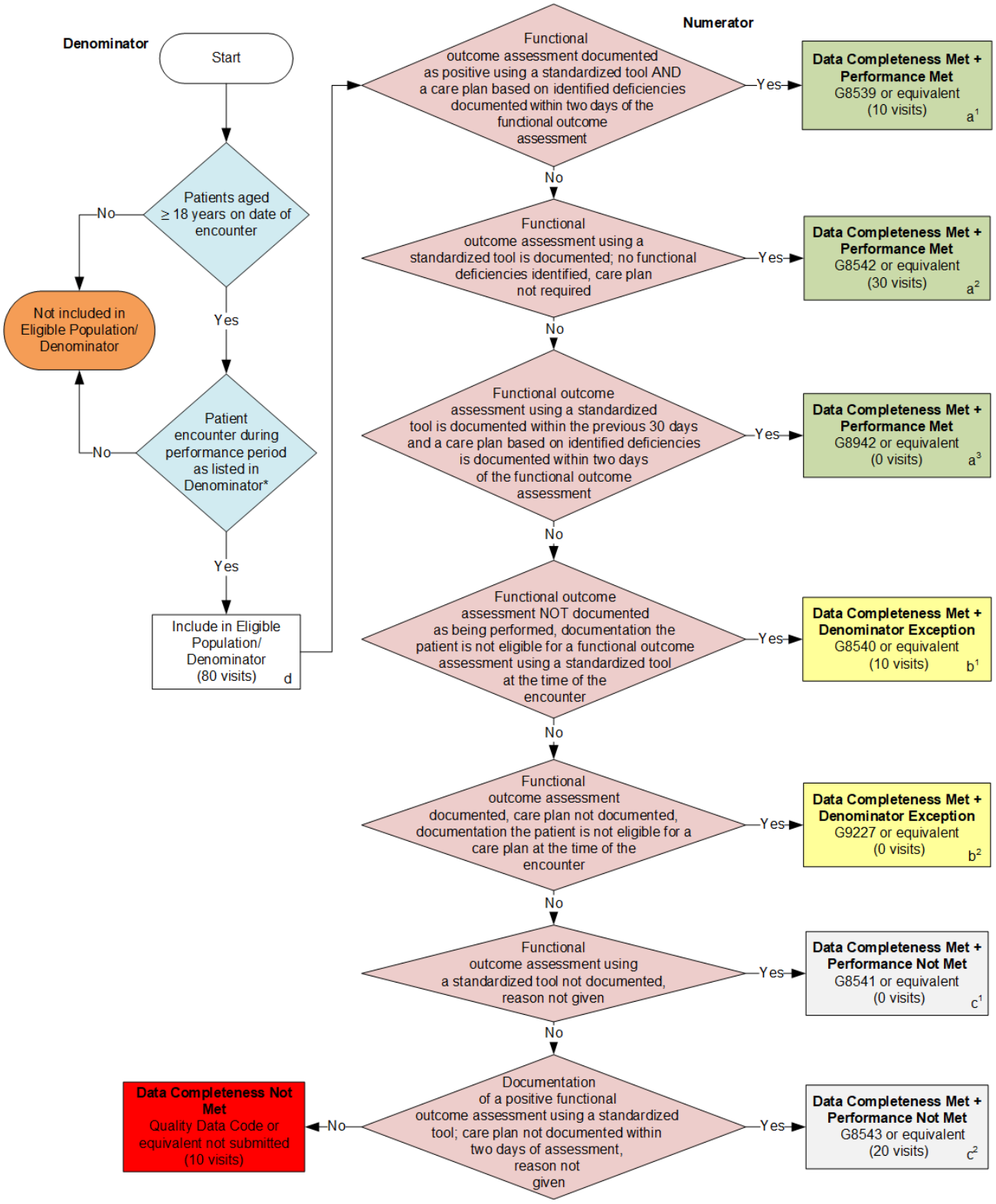
There are no sources in the document.

COPYRIGHT:

This performance measure is not a clinical guideline, does not establish a standard of medical care, and has not been tested for all potential applications.

2026 Clinical Quality Measure Flow for Quality ID #182: Functional Outcome Assessment

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*



SAMPLE CALCULATIONS

Data Completeness=

Performance Met ($a^1+a^2+a^3$=40 visits) + Denominator Exception (b^1+b^2=10 visits) + Performance Not Met (c^1+c^2=20 visits) = 70 visits = **87.50%**

Eligible Population / Denominator (d=80 visits) = 80 visits

Performance Rate=

Performance Met ($a^1+a^2+a^3$=40 visits) = 40 visits = **66.67%**

Data Completeness Numerator (70 visits) – Denominator Exception (b^1+b^2=10 visits) = 60 visits

*See the posted measure specification for specific coding and instructions to submit this measure.
NOTE: Submission Frequency: Visit

2026 Clinical Quality Measure Flow Narrative for Quality ID #182: Functional Outcome Assessment

Disclaimer: *Refer to the measure specification for specific coding and instructions to submit this measure.*

1. Start with Denominator
2. Check *Patients aged greater than or equal to 18 years on date of encounter*:
    a. If *Patients aged greater than or equal to 18 years on date of encounter* equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patients aged greater than or equal to 18 years on date of encounter* equals Yes, proceed to *Patient encounter during performance period as listed in Denominator**.
3. Check *Patient encounter during performance period as listed in Denominator**:
    a. If *Patient encounter during performance period as listed in Denominator** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
    b. If *Patient encounter during performance period as listed in Denominator** equals Yes, include in *Eligible Population/Denominator.*
4. Denominator Population:
    - Denominator Population is all Eligible Visits in the Denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 visits in the Sample Calculation.
5. Start Numerator
6. Check *Functional outcome assessment documented as positive using a standardized tool AND a care plan based on identified deficiencies documented within two days of the functional outcome assessment*:
    a. If *Functional outcome assessment documented as positive using a standardized tool AND a care plan based on identified deficiencies documented within two days of the functional outcome assessment* equals Yes, include in *Data Completeness Met and Performance Met*.
        - *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 a^1 equals 10 visits in the Sample Calculation.
    b. If *Functional outcome assessment documented as positive using a standardized tool AND a care plan based on identified deficiencies documented within two days of the functional outcome assessment* equals No, proceed to *Functional outcome assessment using a standardized tool is documented; no functional deficiencies identified, care plan not required*.
7. Check *Functional outcome assessment using a standardized tool is documented; no functional deficiencies identified, care plan not required*:
    a. If *Functional outcome assessment using a standardized tool is documented; no functional deficiencies identified, care plan not required* equals Yes, include in *Data Completeness Met and Performance Met.*
        - *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 a^2 equals 30 visits in the Sample Calculation.

b. If *Functional outcome assessment using a standardized tool is documented; no functional deficiencies identified, care plan not required* equals No, proceed to *Functional outcome assessment using a standardized tool is documented within the previous 30 days and a care plan based on identified deficiencies documented within two days of the functional outcome assessment*.

8. Check *Functional outcome assessment using a standardized tool is documented within the previous 30 days and a care plan documented based on identified deficiencies within two days of the functional outcome assessment.*

   a. If *Functional outcome assessment using a standardized tool is documented within the previous 30 days and a care plan documented based on identified deficiencies within two days of the functional outcome assessment* equals Yes, include in the *Data Completeness Met and Performance Met.*

      - *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 a^3 equals 0 visits in the Sample Calculation.

   b. If *Functional outcome assessment using a standardized tool is documented within the previous 30 days and a care plan documented based on identified deficiencies within two days of the functional outcome assessment* equals No, proceed to *Functional outcome assessment NOT documented as being performed, documentation the patient is not eligible for a functional outcome assessment using a standardized tool at the time of the encounter*.

9. Check *Functional outcome assessment NOT documented as being performed, documentation the patient is not eligible for a functional outcome assessment using a standardized tool at the time of the encounter*:

   a. If *Functional outcome assessment NOT documented as being performed, documentation the patient is not eligible for a functional outcome assessment using a standardized tool at the time of the encounter* equals Yes, include in *Data Completeness Met and Denominator Exception.*

      - *Data Completeness Met and Denominator Exception* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^1 equals 10 visits in the Sample Calculation.

   b. If *Functional outcome assessment NOT documented as being performed, documentation the patient is not eligible for a functional outcome assessment using a standardized tool at the time of the encounter* equals No, proceed to *Functional outcome assessment documented, care plan not documented, documentation the patient is not eligible for a care plan at the time of the encounter*.

10. Check *Functional outcome assessment documented, care plan not documented, documentation the patient is not eligible for a care plan at the time of the encounter*:

    a. If *Functional outcome assessment documented, care plan not documented, documentation the patient is not eligible for a care plan at the time of the encounter* equals Yes, include in *Data Completeness Met and Denominator Exception*.

       - *Data Completeness Met and Denominator Exception* letter is represented as Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b^2 equals 0 visits in the Sample Calculation.

    b. If *Functional outcome assessment documented, care plan not documented, documentation the patient is not eligible for a care plan at the time of the encounter* equals No, proceed to *Functional outcome assessment using a standardized tool not documented, reason not given*.

11. Check *Functional outcome assessment using a standardized tool not documented, reason not given*:

    a. If *Functional outcome assessment using a standardized tool not documented, reason not given* equals Yes, include in *Data Completeness Met and Performance Not Met.*

        - *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 c^1 equals 0 visits in the Sample Calculation.

    b. If *Functional outcome assessment using a standardized tool not documented, reason not given* equals No, proceed to *Documentation of positive functional outcome assessment using a standardized tool; care plan not documented within two days of assessment, reason not given*.

12. Check *Documentation of positive functional outcome assessment using a standardized tool; care plan not documented within two days of assessment, reason not given*:

    a. If *Documentation of positive functional outcome assessment using a standardized tool; care plan not documented within two days of assessment, reason not given* equals Yes, include in *Data Completeness Met and Performance Not Met.*

        - *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 c^2 equals 20 visits in the Sample Calculation.

    b. If *Documentation of positive functional outcome assessment using a standardized tool; care plan not documented within two days of assessment, reason not given* equals No, proceed to check *Data Completeness Not Met.*

13. Check *Data Completeness Not Met*:

    - If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 visits have been subtracted from the Data Completeness Numerator in the Sample Calculation.

<u>Sample Calculations:</u>

Data Completeness equals Performance Met (a^1 plus a^2 plus a^3 equals 40 visits) plus Denominator Exception (b^1 plus b^2 equals 10 visits) plus Performance Not Met (c^1 plus c^2 equals 20 visits) divided by Eligible Population/Denominator (d equals 80 visits). All equals 70 visits divided by 80 visits. All equals 87.50 percent.

Performance Rate equals Performance Met (a^1 plus a^2 plus a^3 equals 40 visits) divided by Data Completeness Numerator (70 visits) minus Denominator Exception (b^1 plus b^2 equals 10 visits). All equals 40 visits divided by 60 visits. All equals 66.67 percent.

*See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Visit

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.