Document Plus Technologies

The Transformation of Information

Outcome Assessments…….Measuring Quality of Life!

What are Outcome Assessment Questionnaires?

These questionnaires are available for your patients to fill out and provide you and your staff with assessment tools that can help establish validity, responsiveness, and reliability of treatment.

The healthcare and legal systems of today are moving into an era of assessment and accountability. The emerging tools for measuring the effectiveness of patient treatment procedures are the Outcome Assessment questionnaires, which offer a statement of both subjective and objective data.

Document Plus has four Outcome Assessment questionnaires that should be administered based on patient histories and your examination/re-examination findings to provide a detailed assessment of the patient's progress over time. ***Estimated time for the patient to complete each questionnaire: 5-10 minutes***

How it Works

Utilizing Outcome Assessments in your office is a simple process. First, have the patient complete the Outcome Assessment Questionnaire. Next, your staff will scan the questionnaire into the system and the data is incorporated into reports for the patient, insurance companies and/or attorneys. In a matter of minutes you will have established validity, responsiveness, and reliability of treatment.

Billing for Outcome Assessments

Follow the 3 Easy Steps outlined on page 2 when you use Outcome Assessment questionnaires!

To properly incorporate assessment questionnaires into your normal office protocol you must be in compliance with the following: Administer the questionnaire to the patient, produce the outcome assessment report independently or as part of the report of findings, schedule a time for an outcome assessment consultation and review the report with your patient. The billable code for an initial visit is 96150 and on a subsequent outcome assessment (i.e. re-exam) the code is 96151. These are classified as Health and Behavior Assessment Codes and the description of the procedure is as follows: "An assessment of patient's condition was performed through the administration of various health and behavior assessment instruments."

Most insurance companies will have these codes in their current database. Assuming that both the provider and the payer are following CPT guidelines and protocols, and the codes are covered services in an insurance contract and clinically needed, payment would be expected.

NOTE: These service codes are for time units of 15 minutes or less. Any forms and/or questionnaires used are considered assessment tools and are not intended as substitutes for actual professional services rendered by the doctor. Remember that you are billing for a service and not for an assessment tool.

Steps to Follow……Easy as 1, 2, and 3

Implementing and billing for Outcome Assessments is as easy as 1, 2, and 3. The process of implementing the use of Outcome Assessments should consist of the following three steps:

1. Administer the questionnaire – Have the patient fill out the appropriate questionnaire.

2. Scan the questionnaire and create the report – After the patient has completed the questionnaire, scan it and generate the related outcome assessment report.

NOTE: Information from questionnaires administered on the **Initial** visit will appear in the **"Initial Report of Findings"** document. Information from questionnaires administered on a **subsequent visit** can be generated by selecting **"Outcome Measures"** in the **"Generate Documents"** screen or by generating **"re-eval"** or **"final"** narratives.

3. Review the outcome assessment with the patient – After generating the report, schedule a time when you will review the findings with the patient. This is typically done on the visit **following** an initial examination or re-evaluation.

What to remember…

- Establish a time when "Health and Behavior Assessment" consultations will be held in your office. These are typically done on the visit following an initial examination or re-evaluation..
- Only use "Health and Behavior Assessment" codes when a patient presents a problem.
- You are billing for a service and not the assessment tool.

You can find additional information regarding Health and Behavior Assessment codes in the ChiroCode "Hot Topics" Newsletter. http://www.docplus.net/training/chirocode.pdf

Getting Started

*One of the most common questions doctors have is **"How do I implement these questionnaires in my office?"** The answer is simple. If your patients are already filling out a Health Questionnaire, all YOU need to do is have your STAFF administer the questionnaires based on the patient's complaints. Each questionnaire and associated patient complaints are outlined below.*

Neck Pain Disability Index Questionnaire	This assessment is designed to measure the activities of daily living in persons with neck pain. ***Use when patient complains of: Headaches, Neck pain, Upper shoulder pain, Upper back pain***
Roland Morris Acute Low Back Pain Disability Questionnaire	This form is designed to be a simple and accurate measure of assessing back pain and disability. ***Use when patient complains of: Acute low back pain (4 weeks or less)***
Revised Oswestry Chronic Low Back Pain Disability Questionnaire	This is a subjective questionnaire that quantifies the degree of functional impairment of individuals with chronic low back pain. The Oswestry is a well known outcome measure used in evaluating the effectiveness of treatment protocols. ***Use when patient complains of: Chronic low back pain (more than 30 days)***
Health Status Questionnaire	This questionnaire measures eight specific health attributes grouped under three major health dimensions; functional status, well-being, and overall health and is used to show overall functional status. It is commonly used in personal injury cases and in wellness cases. ***To establish a baseline of overall health, the Health Status Questionnaire should be incorporated as part of the routine exam on each new patient, and then administered again at each re-evaluation.***