# Functional Status Assessments for Heart Failure eCQM CMS90v12

07/24/2024 2:50 pm EDT

# Description

Percentage of patients 18 years of age and older with heart failure who completed initial and follow-up patient-reported functional status assessments.

## Guidance

Initial functional status assessment (FSA) and encounter: The initial FSA is an FSA that occurs within two weeks before or during an encounter, in the 180 days or more before the end of the measurement period.

Follow-up FSA: The follow-up FSA must be completed at least 30 days but no more than 180 days after the initial FSA.

The same FSA instrument must be used for the initial and follow-up assessment.

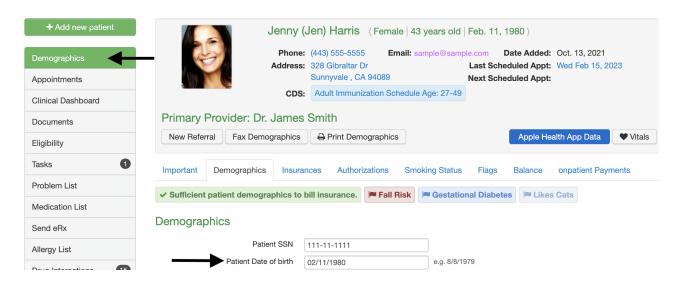
This eCQM is a patient-based measure.

This version of the eCQM uses QDM version 5.6. Please refer to the eCQI resource center (https://ecqi.healthit.gov/qdm) for more information on the QDM.

# **Initial Population**

Patients 18 years of age and older who had two outpatient encounters during the measurement period and a diagnosis of heart failure that starts any time before and continues into the measurement period.

Date of birth information can be entered in DrChrono in the patient chart under the **Demographics** tab with the **Patient's Date of Birth**.

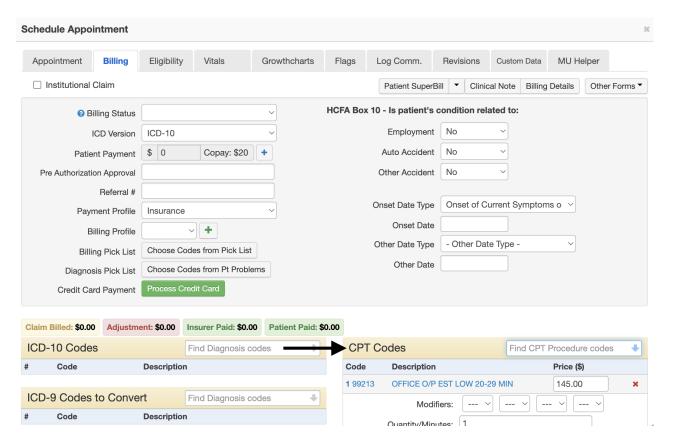


# **AND**

2 Qualifying Encounter During the Measurement Period

Relevant **CPT** or **HCPCS** codes for encounters: 98966, 98967, 98968, 98969, 98970, 98971, 98972, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99421, 99423, 99441, 99442, 99443, 99458, G2061, G2062, G2063, G0071, G2010, G2012

CPT and HCPCS codes can be entered in the billing section of the encounter. Below is an example from the appointment window.



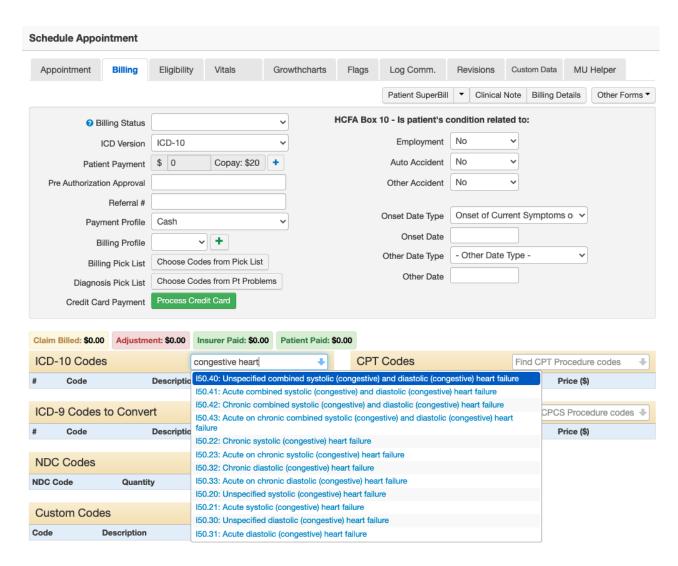
## **AND**

A diagnosis of heart failure.

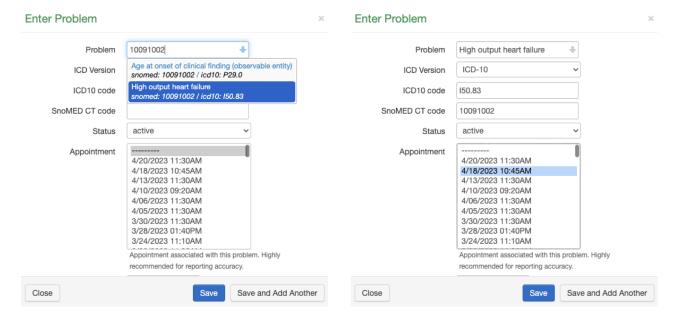
# **ICD-10 Codes**

111.0, 113.0, 113.2, 150.1, 150.20, 150.21, 150.22, 150.23, 150.30, 150.31, 150.32, 150.33, 150.40, 150.41, 150.42, 150.43, 150.814, 150.82, 150.83, 150.84, 150.89, 150.9

ICD-10 Codes can be entered in any of the billing or assessment sections for the patient's visit. Below is an example from the appointment window.



A diagnosis can also be entered in the patient's chart in the problem list using the ICD-10 or SNOMED CT code. You can search or enter the code. Select an appointment and Save.



# **SNOMED Codes**

10091002 High output heart failure (disorder)101281000119107 Congestive heart failure due to cardiomyopathy (disorder)

10633002	Acute congestive heart failure (disorder)
111283005	Chronic left-sided heart failure (disorder)
120851000119104	Systolic heart failure stage D (disorder)
120861000119102	Systolic heart failure stage C (disorder)
120871000117102	Systolic heart failure stage B (disorder)
120881000119106	Diastolic heart failure stage D (disorder)
120891000119109	Diastolic heart failure stage C (disorder)
120901000119108	Diastolic heart failure stage B (disorder)
153931000119109	Acute combined systolic and diastolic heart failure (disorder)
153941000119100	Chronic combined systolic and diastolic heart failure (disorder)
153951000119103	Acute on chronic combined systolic and diastolic heart failure (disorder)
	Congestive heart failure stage C due to ischemic cardiomyopathy (disorder)
	Congestive heart failure stage B due to ischemic cardiomyopathy (disorder)
	Systolic heart failure stage B due to ischemic cardiomyopathy (disorder)
	Systolic heart failure stage C due to ischemic cardiomyopathy (disorder)
130277 +1000117102	Hypertensive heart AND chronic kidney disease with congestive heart failure
15781000119107	(disorder)
15964701000119109	Acute cor pulmonale co-occurrent and due to saddle embolus of pulmonary artery (disorder)
194767001	Benign hypertensive heart disease with congestive cardiac failure (disorder)
404770004	Hypertensive heart and renal disease with (congestive) heart failure
194779001	(disorder)
194781004	Hypertensive heart and renal disease with both (congestive) heart failure and
	renal failure (disorder)
195111005	Decompensated cardiac failure (disorder)
195112003	Compensated cardiac failure (disorder)
195114002	Acute left ventricular failure (disorder)
206586007	Congenital cardiac failure (disorder)
23341000119109	Congestive heart failure with right heart failure (disorder)
233924009	Heart failure as a complication of care (disorder)
25544003	Low output heart failure (disorder)
314206003	Refractory heart failure (disorder)
364006	Acute left-sided heart failure (disorder)
410431009	Cardiorespiratory failure (disorder)
417996009	Systolic heart failure (disorder)
418304008	Diastolic heart failure (disorder)
42343007	Congestive heart failure (disorder)
424404003	Decompensated chronic heart failure (disorder)
426263006	Congestive heart failure due to left ventricular systolic dysfunction (disorder)
426611007	Congestive heart failure due to valvular disease (disorder)
43736008	Rheumatic left ventricular failure (disorder)
44088000	Low cardiac output syndrome (disorder)
441481004	Chronic systolic heart failure (disorder)
441530006	Chronic diastolic heart failure (disorder)
44313006	Right heart failure secondary to left heart failure (disorder)
443253003	Acute on chronic systolic heart failure (disorder)
443254009	Acute systolic heart failure (disorder)
443343001	Acute diastolic heart failure (disorder)
443344007	Acute on chronic diastolic heart failure (disorder)

46113002 Hypertensive heart failure (disorder)

471880001 Heart failure due to end stage congenital heart disease (disorder)

48447003 Chronic heart failure (disorder)

5148006 Hypertensive heart disease with congestive heart failure (disorder)

5375005 Chronic left-sided congestive heart failure (disorder)

56675007 Acute heart failure (disorder)

67431000119105 Congestive heart failure stage D (disorder)
67441000119101 Congestive heart failure stage C (disorder)
698594003 Symptomatic congestive heart failure (disorder)
703272007 Heart failure with reduced ejection fraction (disorder)

Heart failure with reduced ejection fraction due to coronary artery disease

(disorder)

703274008 Heart failure with reduced ejection fraction due to myocarditis (disorder)
703275009 Heart failure with reduced ejection fraction due to cardiomyopathy (disorder)

Heart failure with reduced ejection fraction due to heart valve disease

(disorder)

717840005 Congestive heart failure stage B (disorder)

72481000119103 Congestive heart failure as early postoperative complication (disorder)

74960003 Acute left-sided congestive heart failure (disorder) 82523003 Congestive rheumatic heart failure (disorder)

83105008 Malignant hypertensive heart disease with congestive heart failure (disorder)

84114007 Heart failure (disorder) 85232009 Left heart failure (disorder)

871617000 Low output heart failure due to and following Fontan operation (disorder)

88805009 Chronic congestive heart failure (disorder)

90727007 Pleural effusion due to congestive heart failure (disorder)

92506005 Biventricular congestive heart failure (disorder)

### Denominator

703273002

703276005

Equals Initial Population.

# **Denominator Exclusions:**

Exclude patients with severe cognitive impairment in any part of the measurement period.

Exclude patients who are in hospice care for any part of the measurement period.

## **Denominator Exceptions:**

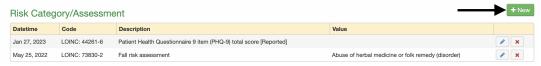
None

## **Numerator**

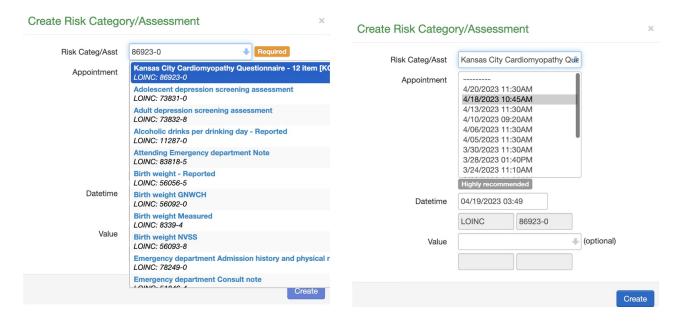
Patients with patient-reported functional status assessment results (i.e., Veterans RAND 12-item health survey [VR-12]; VR-36; Kansas City Cardiomyopathy Questionnaire [KCCQ]; KCCQ-12; Minnesota Living with Heart Failure Questionnaire [MLHFQ]; Patient-Reported Outcomes Measurement Information System [PROMIS]-10 Global Health, PROMIS-29) present in the EHR within two weeks before or during the **initial** FSA encounter **and** results for the **follow-up** FSA at least 30 days but no more than 180 days after the initial FSA.

Assessments can be entered in the patient's chart in the Assessment section of the CQMs tab. Click+New.





You can enter the code or search by keyword. Select an appointment and then click Create.



#### **Assessment LOINC Codes**

- Kansas City Cardiomyopathy Questionnaire 12 item [KCCQ-12] LOINC Code (86923-0)
- Overall summary score [KCCQ-12] LOINC Code (86924-8)
- Overall summary score [KCCQ] LOINC Code (71940-1)
- Physical limitation score [KCCQ] LOINC Code (72195-1)
- Quality of life score [KCCQ] LOINC Code (72189-4)
- Self-efficacy score [KCCQ] LOINC Code (72190-2)
- Social limitation score [KCCQ] LOINC Code (72196-9)
- Symptom stability score [KCCQ] LOINC Code (72194-4)
- Total symptom score [KCCQ] LOINC Code (72191-0)
- Physical score [MLHFQ] LOINC Code (85618-7)
- Emotional score [MLHFQ] LOINC Code (85609-6)
- PROMIS-10 Global Mental Health (GMH) score T-score LOINC Code (71969-0)
- PROMIS-10 Global Physical Health (GPH) score T-score LOINC Code (71971-6)
- PROMIS-29 Anxiety score T-score LOINC Code (71967-4)
- PROMIS-29 Depression score T-score LOINC Code (71965-8)
- PROMIS-29 Fatigue score T-score LOINC Code (71963-3)
- PROMIS-29 Pain interference score T-score LOINC Code (71961-7)
- PROMIS-29 Physical function score T-score LOINC Code (71959-1)
- PROMIS-29 Satisfaction with participation in social roles score T-score LOINC Code (71957-5)
- PROMIS-29 Sleep disturbance score T-score LOINC Code (71955-9)
- VR-12 Mental component summary (MCS) score oblique method T-score LOINC Code (72026-8)
- VR-12 Mental component summary (MCS) score orthogonal method T-score LOINC Code (72028-4)
- VR-12 Physical component summary (PCS) score oblique method T-score LOINC Code (72025-0)
- VR-12 Physical component summary (PCS) score orthogonal method T-score LOINC Code (72027-6)
- VR-36 Mental component summary (MCS) score oblique method T-score LOINC Code (71990-6)
- VR-36 Mental component summary (MCS) score orthogonal method T-score LOINC Code (72008-6)
- VR-36 Physical component summary (PCS) score oblique method T-score LOINC Code (71989-8)

• VR-36 Physical component summary (PCS) score - orthogonal method T-score LOINC Code (72007-8)		
Numerator Exclusions:		
None.		
Measure Information		