

Functional Status Assessments for Heart Failure eCQM CMS90v13

Last modified on 10/08/2024 2:43 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.

Schedule Appointment

- Appointment
- Billing
- Eligibility
- Vitals
- Growthcharts
- Flags
- Log Comm.
- Revisions
- Custom Data
- MU Helper

Institutional Claim

- Patient SuperBill
- Clinical Note
- Billing Details
- Other Forms

<p>Billing Status <input type="text"/></p> <p>ICD Version <input type="text" value="ICD-10"/></p> <p>Patient Payment \$ <input type="text" value="0"/> Copay: \$20 <input type="button" value="+"/></p> <p>Pre Authorization Approval <input type="text"/></p> <p>Referral # <input type="text"/></p> <p>Payment Profile <input type="text" value="Insurance"/></p> <p>Billing Profile <input type="text"/> <input type="button" value="+"/></p> <p>Billing Pick List <input type="text" value="Choose Codes from Pick List"/></p> <p>Diagnosis Pick List <input type="text" value="Choose Codes from Pt Problems"/></p> <p>Credit Card Payment <input type="button" value="Process Credit Card"/></p>	<p>HCFA Box 10 - Is patient's condition related to:</p> <p>Employment <input type="text" value="No"/></p> <p>Auto Accident <input type="text" value="No"/></p> <p>Other Accident <input type="text" value="No"/></p> <p>Onset Date Type <input type="text" value="Onset of Current Symptoms o"/></p> <p>Onset Date <input type="text"/></p> <p>Other Date Type <input type="text" value="- Other Date Type -"/></p> <p>Other Date <input type="text"/></p>
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Claim Billed: \$0.00 Adjustment: \$0.00 Insurer Paid: \$0.00 Patient Paid: \$0.00

<p>ICD-10 Codes <input type="text" value="Find Diagnosis codes"/></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>#</th> <th>Code</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	#	Code	Description				<p>CPT Codes <input type="text" value="Find CPT Procedure codes"/></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Code</th> <th>Description</th> <th>Price (\$)</th> </tr> </thead> <tbody> <tr> <td>1 99213</td> <td>OFFICE O/P EST LOW 20-29 MIN</td> <td>145.00</td> </tr> </tbody> </table> <p>Modifiers: <input type="text" value="---"/> <input type="text" value="---"/> <input type="text" value="---"/> <input type="text" value="---"/></p> <p>Quantity/Minutes: <input type="text" value="1"/></p>	Code	Description	Price (\$)	1 99213	OFFICE O/P EST LOW 20-29 MIN	145.00
#	Code	Description											
Code	Description	Price (\$)											
1 99213	OFFICE O/P EST LOW 20-29 MIN	145.00											

AND

A diagnosis of heart failure.

ICD-10 Codes

I11.0, I13.0, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.814, I50.82, I50.83, I50.84, I50.89, I50.9

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.

Schedule Appointment

Appointment **Billing** Eligibility Vitals Growthcharts Flags Log Comm. Revisions Custom Data MU Helper

Patient SuperBill Clinical Note Billing Details Other Forms

Billing Status ICD Version ICD-10 Patient Payment \$ 0 Copay: \$20 Pre Authorization Approval Referral # Payment Profile Cash Billing Profile Billing Pick List Choose Codes from Pick List Diagnosis Pick List Choose Codes from Pt Problems Credit Card Payment **Process Credit Card**

HCFA Box 10 - Is patient's condition related to:

Employment No Auto Accident No Other Accident No Onset Date Type Onset of Current Symptoms Onset Date Other Date Type - Other Date Type - Other Date

Claim Billed: \$0.00 Adjustment: \$0.00 Insurer Paid: \$0.00 Patient Paid: \$0.00

ICD-10 Codes CPT Codes

#	Code	Description	Price (\$)
	I50.40	Unspecified combined systolic (congestive) and diastolic (congestive) heart failure	
	I50.41	Acute combined systolic (congestive) and diastolic (congestive) heart failure	
	I50.42	Chronic combined systolic (congestive) and diastolic (congestive) heart failure	
	I50.43	Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure	
	I50.22	Chronic systolic (congestive) heart failure	
	I50.23	Acute on chronic systolic (congestive) heart failure	
	I50.32	Chronic diastolic (congestive) heart failure	
	I50.33	Acute on chronic diastolic (congestive) heart failure	
	I50.20	Unspecified systolic (congestive) heart failure	
	I50.21	Acute systolic (congestive) heart failure	
	I50.30	Unspecified diastolic (congestive) heart failure	
	I50.31	Acute diastolic (congestive) heart failure	

ICD-9 Codes to Convert NDC Codes Custom Codes

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.

Enter Problem

Problem ICD Version ICD10 code SnoMED CT code Status Appointment Appointment associated with this problem. Highly recommended for reporting accuracy.

Enter Problem

Problem ICD Version ICD10 code SnoMED CT code Status Appointment Appointment associated with this problem. Highly recommended for reporting accuracy.

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)
120871000119108	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)
15629541000119106	Congestive heart failure stage C due to ischemic cardiomyopathy (disorder)
15629591000119103	Congestive heart failure stage B due to ischemic cardiomyopathy (disorder)
15629641000119107	Systolic heart failure stage B due to ischemic cardiomyopathy (disorder)
15629741000119102	Systolic heart failure stage C due to ischemic cardiomyopathy (disorder)
15781000119107	Hypertensive heart AND chronic kidney disease with congestive heart failure (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)
194779001	Hypertensive heart and renal disease with (congestive) heart failure (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)
703273002	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)
703276005	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

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.**

- Allergy List 0
- Drug Interactions 13
- CQMs
- Intake Data

Risk Category/Assessment

➔ + New

Datetime	Code	Description	Value	
Jan 27, 2023	LOINC: 44261-6	Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]		✎ ✖
May 25, 2022	LOINC: 73830-2	Fall risk assessment	Abuse of herbal medicine or folk remedy (disorder)	✎ ✖

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

Create Risk Category/Assessment

Risk Categ/Asst Required

Appointment

Kansas City Cardiomyopathy Questionnaire - 12 item [KC
LOINC: 86923-0

- Adolescent depression screening assessment
LOINC: 73831-0
- Adult depression screening assessment
LOINC: 73832-8
- Alcoholic drinks per drinking day - Reported
LOINC: 11287-0
- Attending Emergency department Note
LOINC: 83818-5
- Birth weight - Reported
LOINC: 56056-5
- Birth weight GNWCH
LOINC: 56092-0
- Birth weight Measured
LOINC: 8339-4
- Birth weight NVSS
LOINC: 56093-8
- Emergency department Admission history and physical r
LOINC: 78249-0
- Emergency department Consult note
LOINC: 51016-4

Datetime

Value

Create

Create Risk Category/Assessment

Risk Categ/Asst

Appointment

- 4/20/2023 11:30AM
- 4/18/2023 10:45AM
- 4/13/2023 11:30AM
- 4/10/2023 09:20AM
- 4/06/2023 11:30AM
- 4/05/2023 11:30AM
- 3/30/2023 11:30AM
- 3/28/2023 01:40PM
- 3/24/2023 11:10AM

Highly recommended

Datetime

LOINC

Value (optional)

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.

[Measurement Information](#)
