Quick Guide

Functional Status Assessment for THR (CMS56)

The following is for educational purposed only and is not intended to be clinical or legal advice. The information provided in the Measure Details section is based on specification published by CMS at https://ecqi.healthit.gov/ecqm/ec/2023/cms056v11

Measure Details

Description *

Percentage of patients 18 19 years of age and older who received an elective primary total hip arthroplasty (THA) and completed a functional status assessment (FSA) within 90 days prior to the surgery and in the 270-365 365 days after the surgery

Initial Population

Patients 19 years of age and older who had a primary total hip arthroplasty (THA) in the year prior to the measurement period and who had an outpatient encounter during the measurement period

Denominator

Equals Initial Population

Numerator

Patients with patient-reported functional status assessment results (i.e., Veterans RAND 12-item health survey [VR-12], <u>Patient-Reported Outcomes</u> Measurement Information System [PROMIS]-10-Global Health, Hip Disability and Osteoarthritis Outcome Score [HOOS], HOOS Jr.) in the 90 days prior to or on the day of the primary THA procedure, and in the 270 - 365 days after the THA procedure

Denominator Exclusion

- Exclude patients with two or more fractures indicating trauma in the 24 hours before or at the time start of the total hip arthroplasty
- Patients with severe cognitive impairment that starts before or in any part of the measurement period
- Exclude patients who are in hospice care for any part of the measurement period

Numerator Exclusion

NA

Overview

What is Documented	When is it Documented	Where in QMER
Qualifying Encounter	During Measurement Period (2023)	Coded SOAP Note
Total Hip Arthroplasty in 2022	At the Time of THA	DxCPT or History Module
Pre-Op FSA	On or 90 Days Prior to THA	Screening Tools
Outpatient Visit	During Measurement Period (2023)	Past Exams
Post Op FSA	270 - 365 days after the THA procedure	Screening Tools

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Exclusions/Exceptions	Where in QEMR
Two or more fractures indicating trauma in the 24 hours before or at the start of the THA	DxCPT Module
Patients who are in hospice care for any part of the measurement period	History Module
Patients with severe cognitive impairment that starts before or during the measurement period	History Module

2022 to 2023 Changes

NA

Set Up

All codification shown is an example for incrementation, for a full list of accepted codes please visit <u>Value Set Authority</u> <u>Center.</u>

Qualifying Encounter

No set up required

Pre/Post Op FSA

No set up required

Building Hospice Care History Item

Build the history items below:

- 1. Log into **QEMR** > Navigate to **Edit** > **History**
- 2. Highlight desired History Category list on left side bar
- 3. Click New hot button
- 4. Complete the Update History Screen as seen below
- 5. Click Save & Close hot button

10	Update History
8	
Save&Cls Close	
 History Category : 	Health Maintenance Screening 🗸
Item Description :	Hospice Care
Comments :	
History Type :	Procedure v
SNOMED :	305336008-Admission to hospice
ICD9/10:	
CPT :	<u>G</u> ×
LOINC Code :	
Refusal\Reason Code :	Q, ×

Workflow

Qualifying Encounter

Following standard office workflow, document patient visit(s) via SOAP notes and code with CPT and diagnosis codes using either DxCPT, SmartDx or Smart CPT modules.

Pre/Post Op FSA

HOOS Hip Survey must be completed 90 days prior to THA and 270-365 days after THA via **Go > Screening Tools > HOOS Hip Survey**

HOOS HIP SURVEY
INSTRUCTIONS
This survey ails for year investigation by this information will help as long toxic of how you feel about your hip and how wall you are able to do your usual activities. Hence every quanties by taking the appropriate box, only one loss for each quanties. If you are uncertain about him to answer a question, given give the best enswer you can
Symptoms
These questions should be answered thinking of your hip symptoms and difficulties during the last week.
S1. Do you look grinding, hear chicking or any other type of noise how your high
Terrer O Tanky O Sometimer O Office O Allonys
S2. Difficultien remaining legs wilde spart.
★ Naie O Mill O Modeste O Seere O Externe
SI. Diffulier to shife out when subling
Nate O Mild O Multiste O Serer O Lettere

Documenting Hospice Exclusion

To document, follow steps below:

- 1. Navigate to **History** Module > **Health Maintenance** category
 - a. Double-click applicable history item
 - b. Enter Occur Date

Category	Item	Comments	Smoking Status	Active	Occur Date	Date Entered	Source
Health Maintenance Screening							
	Hospice Care				01/13/2022 🗸	1/18/2022 9:51 AM	gloEMR

Incrementing Details

Occur Dates

To increment ANY measure using the History Module the Occur Dater MUST be documented using appropriate date based upon Measure Description.

Exam Coding

If exam notes (Past Exams) are not coded with Diagnosis Code and CPT code measures will not increment.

Measure Specific Codes

The codification shown in this document are examples of qualifying documentation. To see a full list please visit <u>Value</u> <u>Set Authority Center</u>.

CMS Guidance *

The same functional status assessment (FSA) instrument must be used for the initial and follow-up assessment