Guidelines for Using Release Notes
Release Notes 4.4 provide modifications to the Specifications Manual for National Hospital Inpatient Quality Measures. The Release Notes are provided as a reference tool and are not intended to be used to program abstraction tools. Please refer to the Specifications Manual for National Hospital Inpatient Quality Measures for the complete and current technical specifications and abstraction information.

The notes are organized to follow the order of the Table of Contents. The implementation date is 01-01-2015, unless otherwise specified. The headings are described below:

- **Impacts** - used to identify the impacted measures and portion(s) of the Manual Section. (i.e., Alphabetical Data Dictionary, Measure Information Form (MIF) and Flowchart (Algorithm)).

- **Description of Changes** - used to identify the section within the document where the change occurs, e.g., Definition, Data Collection Question, Allowable Values, and Denominator Statement - Data Elements.

- **Rationale** - provided for the change being made.

Data elements that cross multiple measures and contain the same changes will be consolidated.
The notes in the tables below are organized to follow the Table of Contents in the specifications manual.

**Table of Contents**

| **Impacts:** | Section 2 Measurement Information |
| **Rationale:** | These measures are being removed based on the FY 2014 IPPS Final Rule and at the direction of CMS. |
| **Description of Changes:** | |
| **2.1 Acute Myocardial Infarction (AMI)** | Remove: AMI-2, AMI-10 |
| **2.2 Heart Failure (HF)** | Remove: HF-1, HF-3 |

| **Impacts:** | Section 2 Measurement Information |
| **Rationale:** | The PN-3a and PN-3b measures are being removed at the direction of CMS and based on the IPPS Fiscal Year 2014 Final Rule. |
| **Description of Changes:** | |
| **2.3 Pneumonia (PN)** | Measure Information Form (MIF) and Flowchart (Algorithm) Remove: PN-3a, PN-3b |

| **Impacts:** | Section 2 Measurement Information |
| **Rationale:** | The Hospital IQR Program Measure, Surgery Patients with Perioperative Temperature Management, was removed in the IPPS Fiscal Year 2014 Final Rule. |
| **Description of Changes:** | |
| **2.4 Surgical Care Improvement Project (SCIP)** | Measure Information Form (MIF) and Flowchart (Algorithm) Remove: SCIP-Inf-10 |
Impacts: Section 2 Measurement Information

Rationale: The measure specifications for AMI-2, AMI-10, HF-3, and PN-3a have been removed from the Specifications Manual for National Hospital Inpatient Quality Measures and placed in the Specifications Manual for Joint Commission National Quality Core Measures.

Description of Changes: Add at the bottom of last page of Table of Contents:

Additional comments
The measure specifications for AMI-2, AMI-10, HF-3, and PN-3a have been removed from the Specifications Manual for National Hospital Inpatient Quality Measures effective 01/01/2015, however, these will continue to be used by The Joint Commission and are available in the Specifications Manual for Joint Commission National Quality Core Measures which is located on The Joint Commission’s website at the following link: http://manual.jointcommission.org/bin/view/Manual.

Impacts: 10.5 CMS AMI Episode-of-Care Payment Measure

Rationale: The section name is being revised to reflect all payment measures. In addition, a new payment measure is being added.

Description of Changes:
Change section name from:
10.5 CMS AMI Episode-of-Care Payment Measure
To
10.5 CMS Payment Measures

Add new measure:
MSPB-1: Medicare Spending Per Beneficiary (MSPB)

Acknowledgement

No updates in this section.

Introduction

No updates in this section.
Using the Specifications Manual for National Hospital Inpatient Quality Measures

**Impacts:**
Not Applicable (N/A)

**Rationale:** The HF-1 measure is being removed based on the FY 2014 IPPS Final Rule and at the direction of CMS. Example needs changed in Measurement Information sub-section.

**Description of Changes:**
Section 2 - Measurement Information

Change third sentence in first paragraph to:
For example, in the Stroke (STK) measure set, the measure that addresses STK patients receiving VTE prophylaxis is listed as: STK-1 and measure short name: Venous Thromboembolism (VTE) Prophylaxis.

**Impacts:**
N/A

**Rationale:** This section is being updated to provide information on included measures.

**Description of Changes:**
Section 10 – CMS Outcome Measures (Claims Based)

Change first sentence in first paragraph to:
This section of the manual provides an overview and the Measure Information Forms for the CMS mortality, readmission and complication measures, as well as the AMI episode of care payment measure.

Change second sentence in first paragraph to:
In addition, this section provides a link to the development and technical specifications for the Agency for Healthcare Research and Quality (AHRQ) Claims-Based Quality Measures.

Add second paragraph:
The structural measures are listed in this section also, although they are not claim-based. Data entry for the structural measures is achieved through the secure side of QualityNet via an online tool available to authorized users.

**Impacts:**
N/A

**Rationale:** This change is to clarify for abstractors what measures in the specifications manual are considered chart-abstracted measures.

**Description of Changes:**
Section 2 - Measurement Information

Add paragraphs:
Measures listed in this section are known as Chart-Abstracted Measures. Chart abstraction is the review of medical record documentation from the current episode of care for purposes of data collection and submission.

In addition, measures in this section which are eligible for voluntary electronic submission as eMeasures for the Hospital Inpatient Quality Reporting (IQR) program are identified in the specific Measure Information Form(s).
Section 10 – CMS Outcome Measures (Claims Based)

Add paragraph:
The Inpatient Web-based Measure in this section is known as a Chart-Abstracted Measure as described in Section 2- Measurement Information. In addition, the measure is eligible for voluntary electronic submission as an eMeasure for the Hospital IQR program as identified in the specific Measure Information Form.

SECTION 1 – Data Dictionary

Introduction to Data Dictionary

Impacts:
General Abstraction Guidelines

Rationale: The verbiage used in the manual is being updated to reflect new guidance from the IPPS Final Rule.

Description of Changes:
Medical Record Documentation
Change seventh paragraph to:
Please note that hospitals that are selected for validation will need to provide a paper or electronic (i.e., CD, DVD, or thumb drive) copy of the current medical record in its entirety, including all previous testing or history documents used in abstraction. If a hospital uses electronic data for abstraction and is unable to provide a paper or electronic copy of these data, and the record is chosen for validation, there is the potential for a mismatch to occur.

Alphabetical Data Dictionary

Index Updates

Impacts:
Alphabetical Data Dictionary Index Rationale: The current measure specifications exclude patients with cognitive impairment from all of the TOB and SUB measures, if there is documentation of cognitive impairment for the entire hospitalization. Since the alcohol use screen and/or tobacco use screen must be completed within 3 days after admission, cognitive impairment will now be evaluated in the Alcohol Use Status and Tobacco Use Status data elements, and the data element Cognitive Impairment will be removed from all of the TOB and SUB measures.

Description of Changes:
Alcohol Use Status
Change under ‘Collected For’ column to:
All SUB Measures

Remove Cognitive Impairment row

Tobacco Use Status
Change under ‘Collected For’ column to:
All TOB Measures
Impacts:
Alphabetical Data Dictionary Index

Rationale: The Hospital IQR Program Measure, Surgery Patients with Perioperative Temperature Management, was removed in the IPPS Fiscal Year 2014 Final Rule.

Description of Changes:
Anesthesia End Date
Anesthesia End Time
Anesthesia Start Date
Anesthesia Start Time

Remove under ‘Collected For’ column:
SCIP-Inf-10

Impacts:
Alphabetical Data Dictionary Index

Rationale: The Hospital IQR Program Measure, Surgery Patients with Perioperative Temperature Management, was removed in the IPPS Fiscal Year 2014 Final Rule.

Description of Changes:
Remove rows in their entirety:
Anesthesia Type
Intentional Hypothermia
Temperature

Impacts:
Alphabetical Data Dictionary Index

Antibiotic Administration Date
Antibiotic Administration Route
Antibiotic Administration Time
Antibiotic Name
Antibiotic Received
Arrival Date
Arrival Time
Chest X-Ray
Clinical Trial
Comfort Measures Only
Discharge Disposition
ICU Admission or Transfer
Pneumonia Diagnosis: ED/Direct Admit
Transfer From Another Hospital or ASC

Rationale: The PN-3a and PN-3b measures are being removed at the direction of CMS and based on the IPPS Fiscal Year 2014 Final Rule.

Description of Changes:
Remove under ‘Collected For’ column:
PN-3a
PN-3b
Impacts:

Alphabetical Data Dictionary Index **Rationale**: These measures are being removed based on the FY 2014 IPPS Final Rule and at the direction of CMS.

**Description of Changes:**

**Remove** rows in their entirety:
- Aspirin Prescribed at Discharge
- Discharge Instructions Address Activity
- Discharge Instructions Address Diet
- Discharge Instructions Address Follow-up
- Discharge Instructions Address Medications
- Discharge Instructions Address Symptoms Worsening
- Discharge Instructions Address Weight Monitoring
- LDL-c Less Than 100 mg/dL
- Reason for No Aspirin at Discharge

**Remove** under ‘Collected For’ column:
- AMI-2
- AMI-10
- HF-1
- HF-3

**Comfort Measures Only**

**Remove** in the ‘Collected For’ column:
- All HF Measures

**Add** in the ‘Collected For’ column:
- HF-2

**Clinical Trial**

**Remove** in the ‘Collected For’ column:
- AMI-1
- AMI-3
- AMI-5
- AMI-7
- AMI-7a
- AMI-8
- AMI-8a

**Add** in the ‘Collected For’ column:
- All AMI Measures

Impacts:

Alphabetical Data Dictionary Index **Rationale**: The PN-3a and PN-3b measures are being removed at the direction of CMS and based on the IPPS Fiscal Year 2014 Final Rule.

**Description of Changes:**

**Remove** under ‘Collected For’ column:
PN-3a
PN-3b

Remove rows in their entirety:

- Blood Culture Collected
- Initial Blood Culture Collection Date
- Initial Blood Culture Collection Time

**Impacts:**
Alphabetical Data Dictionary Index

- Element Name
- Reason for Discontinuation of Parenteral Therapy

**Rationale:** Clinical scenarios presented to the Technical Advisory Panel (TAP) justified the need for defined time frames, and the need for examples and clarifications to capture acceptable documentation for these data elements.

**Description of Changes:**

- Change Element Name to:
  - Reason for Discontinuation of Parenteral Anticoagulation Therapy

**Impacts:**
Alphabetical Data Dictionary Index **Rationale:** This change is to adjust the measure flow logic and add a new data element that will exclude cases who received IV thrombolytic therapy in 3 to 4.5 hours because a reason delayed initiation within 3 hours.

**Description of Changes:**

- Add row under ‘Element Name’ and ‘Collected For’ column respectively:
  - Reason for Extending the Initiation of IV Thrombolytic
  - STK-4

**Impacts:**
Alphabetical Data Dictionary Index **Rationale:** The Technical Advisory Panel reviewed clinical scenarios presented and determined that a timeframe was needed for documentation to be acceptable for these data elements. An additional data element was added to further define reasons for not providing prophylaxis to records in VTE-6 Hospital Acquired VTE.

**Description of Changes:**

- Add row under ‘Element Name’ and ‘Collected For’ column respectively:
  - Reason for No Administration of VTE Prophylaxis
  - VTE-6

**Deleted Data Elements**

**Impacts:**
Data Elements

**Rationale:** The Hospital IQR Program Measure, Surgery Patients with Perioperative Temperature Management, was removed in the IPPS Fiscal Year 2014 Final Rule.
Description of Changes:
Remove in their entirety:
Anesthesia Type
Intentional Hypothermia
Temperature

Impacts:
Data Elements

Rationale: These measures are being removed based on the FY 2014 IPPS Final Rule and at the direction of CMS.

Description of Changes:
Remove data elements in their entirety:
Aspirin Prescribed at Discharge
Discharge Instructions Address Activity
Discharge Instructions Address Diet
Discharge Instructions Address Follow up
Discharge Instructions Address Medications
Discharge Instructions Address Symptoms Worsening
Discharge Instructions Address Weight Monitoring
LDL c Less Than 100 mg/dL
Reason for No Aspirin at Discharge

Data Element Updates

Impacts:
ACEI Prescribed at Discharge
ARB Prescribed at Discharge
LVSD
Reason for No ACEI and No ARB at Discharge

Rationale: These measures are being removed based on the FY 2014 IPPS Final Rule and at the direction of CMS.

Description of Changes:
Collected For
Change to:
The Joint Commission Only: AMI-3; CMS Voluntary Only: AMI-3

Impacts:
Admission Date

Rationale: The verbiage used in the manual for data elements collected for all records is being updated.

Description of Changes:
Notes for Abstraction
Remove in second bullet, first sub-bullet:
(Form Locator 12)

Remove in second bullet, second sub-bullet:
in Form Locator 6

ONLY ALLOWABLE SOURCES
Change the third listing to:
3. UB-04

Excluded Data Sources
Change to:
UB-04, “From” and “Through” dates

Impacts:
Alcohol Use Status

Rationale: The current measure specifications exclude patients with cognitive impairment from all of the TOB and SUB measures, if there is documentation of cognitive impairment for the entire hospitalization. Since the alcohol use screen and/or tobacco use screen must be completed within 3 days after admission, cognitive impairment will now be evaluated in the Alcohol Use Status and Tobacco Use Status data elements, and the data element Cognitive Impairment will be removed from all of the TOB and SUB measures.

Description of Changes:
Change:
Collected For
Change to:
The Joint Commission Only: All SUB Measures; CMS Informational Only: All SUB Measures

Allowable Values
Add new value:
7 The patient was not screened for alcohol use during the first three days of admission because of cognitive impairment.

Notes for Abstraction
Add new bullets and examples:
- Cognition refers to mental activities associated with thinking, learning, and memory. Cognitive impairment for the purposes of this measure set is related to documentation that the patient cannot be screened for alcohol use due to the impairment (e.g., comatose, obtunded, confused, memory loss) during the entire first three days of hospitalization.
- Cognitive impairment must be documented at all times during the first three days of the hospitalization in order to select value “7.” If there is documentation in the medical record that a patient is cognitively impaired, and there is no additional documentation that the patient’s mental status was normal at any other time during the first three days of the hospitalization, i.e., alert and oriented the abstractor can select value “7.”
- If there is documentation that the patient has temporary cognitive impairment due to acute substance use (e.g., overdose or acute intoxication) value “7” cannot be selected. Examples of cognitive impairment include:
- Altered Level of Consciousness (LOC)
- Altered Mental Status
- Cognitive impairment
- Cognitively impaired
- Confused
- Memory loss
- Mentally retarded
- Obtunded

**Impacts:**
- Anesthesia End Date
- Anesthesia End Time
- Anesthesia Start Date
- Anesthesia Start Time

**Rationale:** The Hospital IQR Program Measure, Surgery Patients with Perioperative Temperature Management, was removed in the IPPS Fiscal Year 2014 Final Rule.

**Description of Changes:**
- Anesthesia End Date
- Anesthesia End Time
- Anesthesia Start Time

**Remove** under ‘Collected For’:
- CMS Voluntary Only: SCIP-Inf-10

**Impacts:**
- Antibiotic Administration Date
- Antibiotic Administration Route
- Antibiotic Administration Time
- Antibiotic Name
- Antibiotic Received

**Rationale:** The PN-3a and PN-3b measures are being removed at the direction of CMS and based on the IPPS Fiscal Year 2014 Final Rule.

**Description of Changes:**
- Collected For
- Remove:
  - CMS Voluntary Only: PN-3b

**Impacts:**
- Arrival Date
- Arrival Time
- Clinical Trial
- Comfort Measures Only
**Rationale:** The PN-3a and PN-3b measures are being removed at the direction of CMS and based on the IPPS Fiscal Year 2014 Final Rule.

**Description of Changes:**

*Collected For*

**Remove** under ‘The Joint Commission Only’:
PN-3a

**Remove** under ‘CMS Voluntary Only’:
PN-3a, PN-3b

---

**Impacts:**

*Assessed for Rehabilitation Services*

**Rationale:** This change is to clarify which providers should be considered members of the rehabilitation team.

**Description of Changes:**

*Notes for Abstraction*

**Change** first bullet to:
- The assessment for rehabilitation services must be completed by a qualified provider. See the inclusion list.

**Suggested Data Sources**

**Change** to:

PHYSICIAN/APN/PA/KT/PT/OT/SLT OR NEUROPSYCHOLOGIST DOCUMENTATION ONLY FOR REHABILITATION ASSESSMENT:
- Consultation notes
- Discharge summary
- History and physical
- Progress notes
- Referral forms
- Rehabilitation records
- Therapy notes (e.g., KT/PT/OT/SLT)

**Excluded Data Sources**

**Add:**
Any documentation other than Physician/APN/PA/KT/PT/OT/SLT/Neuropsychologist

**Remove:**
- Nursing assessments for activities of daily living (ADLs).
- Nursing notes

**Inclusion Guidelines for Abstraction**

**Change** second bullet to:
- Patient received rehabilitation services from a member of the rehabilitation team.

**Change** third bullet with sub-bullets to:
- Members of the rehabilitation team:
  - Advanced Practice Nurse (APN)
Impacts:
* Atrial Fibrillation/Flutter*

**Rationale:** This change is to provide abstractor clarification for cases with questionable atrial fibrillation/flutter and/or conflicting documentation.

**Description of Changes:**

**Definition**

**Change to:**
Documentation by a physician/APN/PA that the patient has a history of ANY atrial fibrillation (e.g., remote, persistent, or paroxysmal) or atrial flutter OR a diagnosis or signed ECG tracing of ANY atrial fibrillation or flutter.

**Suggested Data Collection Question:**

**Change to:**
Was there physician/APN/PA documentation of a diagnosis, signed ECG tracing, or a history of ANY atrial fibrillation/flutter in the medical record?

**Allowable Values:**

**Change from:**

- **Y (Yes)** History of any atrial fibrillation/flutter or current finding of atrial fibrillation/flutter was documented.
- **N (No)** History of any atrial fibrillation/flutter or current finding of atrial fibrillation/flutter was not documented, OR unable to determine from medical record documentation.

**To:**

- **Y (Yes)** There is physician/APN/PA documentation of a diagnosis or a history of ANY atrial fibrillation/flutter.
- **N (No)** There is no physician/APN/PA documentation of a diagnosis or a history of ANY atrial fibrillation/flutter, OR unable to determine from medical record documentation.

**Notes for Abstraction**

**Change to:**
- If there is a documented history or diagnosis of ANY condition (e.g., remote, persistent, or paroxysmal) described in the definition statement, select “Yes”.
- If there is documentation of atrial fibrillation or flutter on a signed ECG, select “Yes.”
• If there is a diagnosis of atrial fibrillation or flutter anywhere in the medical record, or documentation of a past history of atrial fibrillation or flutter anywhere in the medical record, select “Yes.”

**EXCEPTION:**
If there is conflicting documentation of atrial fibrillation or flutter during the hospitalization, the most current cardiologist documentation should be used. If cardiology documentation is unavailable, the most current documentation by other physician/APN/PA should be used.

• If there is physician/APN/PA documentation of any of the following examples, disregard and continue to review the medical record for a confirmed diagnosis. If no other documentation exists, select “No.”
  o “suspected/suspicion of atrial fibrillation or flutter”
  o “rule out atrial fibrillation/flutter”
  o “questionable atrial fibrillation/flutter”
  o “possible atrial fibrillation/flutter”

• If there is documentation of a history of an ablation procedure for atrial fibrillation/flutter, select “Yes.”

• If there is documentation of a history of atrial fibrillation or flutter that terminated within 8 weeks following CABG, select “No.”

• If there is documentation of a history of transient and entirely reversible episode of atrial fibrillation or flutter due to thyrotoxicosis, select “No.”

**Suggested Data Sources**

**Change to:**

**Suggested Data Sources: PHYSICIAN/APN/PA DOCUMENTATION ONLY**

• Discharge instruction sheet
• Discharge summary
• History and physical
• ECG report
• Holter monitor report
• Problem list
• Progress Notes
• Transfer sheet

**Inclusion Guidelines for Abstraction**

**Change to:**

None

**Exclusion Guidelines for Abstraction**

**Change to:**

• PAC
• Paroxysmal atrial tachycardia
• Paroxysmal supraventricular tachycardia
• PAT
• Premature atrial contraction
• PST
Impacts:

**Birthdate**

**Rationale:** The verbiage used in the manual for data elements collected for all records is being updated.

**Description of Changes:**

**Suggested Data Sources**

**Change** last bullet to:

- UB-04

---

Impacts:

**Blood Culture Collected**

**Initial Blood Culture Collection Date**

**Initial Blood Culture Collection Time**

**Rationale:** The PN-3a and PN-3b measures are being removed at the direction of CMS and based on the IPPS Fiscal Year 2014 Final Rule.

**Description of Changes:**

**Remove** data elements in their entirety.

---

Impacts:

**Chest X-Ray**

**Pneumonia Diagnosis: ED/Direct Admit**

**Rationale:** The PN-3a and PN-3b measures are being removed at the direction of CMS and based on the IPPS Fiscal Year 2014 Final Rule.

**Description of Changes:**

**Remove** under ‘The Joint Commission Only’:

- PN-3a

**Remove:**

CMS Voluntary Only: PN-3a, PN-3b

---

Impacts:

**Clinical Trial**

**Comfort Measures Only**

**Discharge Disposition**

**Rationale:** These measures are being removed based on the FY 2014 IPPS Final Rule and at the direction of CMS.

**Description of Changes:**

**Collect**ed For

**Remove** under ‘The Joint Commission Only’:

- AMI-2, AMI-10, HF-3

**Remove** under ‘CMS Voluntary Only’:

---
Impacts:  
*Cognitive Impairment*

Rationale: The current measure specifications exclude patients with cognitive impairment from all of the TOB and SUB measures, if there is documentation of cognitive impairment for the entire hospitalization. Since the alcohol use screen and/or tobacco use screen must be completed within 3 days after admission, cognitive impairment will now be evaluated in the *Alcohol Use Status* and *Tobacco Use Status* data elements, and the data element *Cognitive Impairment* will be removed from all of the TOB and SUB measures.

Description of Changes:  
Remove *Cognitive Impairment* data element in its entirety

---

Impacts:  
*Comfort Measures Only*

Rationale: These changes will provide clarification to the abstractor and make the data element more consistent with the applicable measures.

Description of Changes:  
*Notes for Abstraction*

Change to:
- Only accept terms identified in the list of inclusions. No other terminology will be accepted.
- Physician/APN/PA documentation of comfort measures only (hospice, comfort care, etc.) mentioned in the following contexts suffices:
  - Comfort measures only recommendation
  - Order for consultation or evaluation by a hospice care service
  - Patient or family request for comfort measures only
  - Plan for comfort measures only
  - Referral to hospice care service
  - Discussion of comfort measures
- Determine the earliest day comfort measures only (CMO) was DOCUMENTED by the physician/APN/PA. If any of the inclusion terms are documented by the physician/APN/PA, select value “1,” “2,” or “3” accordingly.
  
  Example:  
  “Discussed comfort care with family on arrival” noted in day 2 progress note – Select “2.”

- **State Authorized Portable Orders (SAPOs):**
  - SAPOs are specialized forms or identifiers authorized by state law that translate a patient’s preferences about specific end-of-life treatment decisions into portable medical orders.
    
    Examples:
    - DNR-Comfort Care form
    - MOLST (Medical Orders for Life-Sustaining Treatment)
    - POLST (Physician Orders for Life-Sustaining Treatment)
    - Out-of-Hospital DNR (OOH DNR)
o If there is a SAPO in the record that is dated and signed prior to arrival with an option in which an inclusion term is found that is checked, select value “1.”

o If a SAPO lists different options for CMO and any CMO option is checked, select value “1,” “2,” or “3” as applicable.

o If one or more dated SAPOs are included in the record (and signed by the physician/APN/PA), use only the most recent one. Disregard undated SAPOs.

o For cases where there is a SAPO in the record with a CMO option selected: If the SAPO is dated prior to arrival and there is documentation on the day of arrival or the day after arrival that the patient does not want CMO, and there is no other documentation regarding CMO found in the record, disregard the SAPO.

Example:
Patient has a POLST dated prior to arrival in his chart and ED physician states in current record “Patient is refusing comfort measures, wants to receive full treatment and be a full code.”

• Documentation of an inclusion term in the following situations should be disregarded.
Continue to review the remaining physician/APN/PA documentation for acceptable inclusion terms. If the ONLY documentation found is an inclusion term in the following situations, select value "4."

  o Documentation (other than SAPOs) that is dated prior to arrival or documentation which refers to the pre-arrival time period.

  Examples:
  ▪ Comfort measures only order in previous hospitalization record.
  ▪ “Pt. on hospice at home” in MD ED note.

  o Inclusion term clearly described as negative or conditional.

  Examples:
  ▪ “No comfort care”
  ▪ "Not appropriate for hospice care"
  ▪ “Comfort care would also be reasonable - defer decision for now”
  ▪ “DNRCCA” (Do Not Resuscitate – Comfort Care Arrest)
  ▪ “Family requests comfort measures only should the patient arrest.”

  o Documentation of “CMO” should be disregarded if documentation makes clear it is not being used as an acronym for Comfort Measures Only (e.g., “hx dilated CMO” – Cardiomyopathy context).

• If there is physician/APN/PA documentation of an inclusion term in one source that indicates the patient is Comfort Measures Only, AND there is physician/APN/PA documentation of an inclusion term in another source that indicates the patient is NOT CMO, the source that indicates the patient is CMO would be used to select value “1,” “2,” or “3” for this data element.

Examples:
  o Physician documents in progress note on day 1 “The patient has refused Comfort Measures” AND then on day 2 the physician writes an order for a Hospice referral. Select value “2.”
  o ED physician documents in a note on day of arrival “Patient states they want to be enrolled in Hospice” AND then on day 2 there is a physician progress note with documentation of “Patient is not a Hospice candidate.” Select value “1.”

Suggested Data Sources:
Remove:
IN THE FOLLOWING ONLY ACCEPTABLE SOURCES:
Add new first bullet:
• Consultation notes

Add new fifth bullet:
• History and physical

Inclusion Guidelines for Abstraction
Add new bullet:
Terminal extubation

Impacts:
Date Last Known Well

Rationale: This change is to clarify the abstraction guidelines for data elements that generate the majority of stroke abstraction questions and ease the burden of abstraction.

Description of Changes:
Suggested Data Collection Question
Change to:
What was the date associated with the time at which the patient was last known to be well or at his or her baseline state of health?

Notes for Abstraction
Change to:
• Enter the date associated with the Time Last Known Well. If the date last known well is unable to be determined from medical record documentation, enter “UTD.”
• The medical record must be abstracted as documented (taken at “face value”). When the date documented is obviously in error (not a valid date/format) and no other documentation is found that provides this information, the abstractor should select “UTD.”
  Example: Documentation indicates the Date Last Known Well was 03-42-20xx. No other documentation in the medical record provides a valid date. Since the Date Last Known Well is outside of the range listed in the Allowable Values for “Day,” it is not a valid date and the abstractor should select “UTD.”

Note: Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission’s Data Warehouse. Use of “UTD” for Date Last Known Well allows the case to be accepted into the warehouse.

• If the date last known well is documented as a specific date and entered as Date Last Known Well on a “Code Stroke” form or stroke-specific electronic template, enter that date as the date last known well. Documentation of Date Last Known Well on a stroke-specific form or template should be selected regardless of other dates last known well documented elsewhere in the medical record.

• References in relation to Arrival Date are acceptable (e.g., today, tonight, this evening, and this morning). The Date Last Known Well and the Arrival Date may be the same date or a different date.
  Examples:
  o “Wife reports patient normal this evening until approximately 9 PM.” Hospital arrival is 0030 on 12-10-20xx.” Date Last Known Well is 12-09-20xx.
- “Patient states he felt perfectly fine earlier today. At noon, he began to have trouble seeing.” Hospital arrival is 3:59 PM on 12-10-20xx. *Date Last Known Well* is 12-10-20xx.

- If a reference to date last known well is documented without a specific date, enter that date for the *Date Last Known Well*. If multiple dates are documented, select the earliest date.
  - Examples:
    - “Patient last known well today (day of arrival).” Select *Arrival Date* for *Date Last Known Well*.
    - “Patient normal yesterday (day before arrival) documented in H&P and consult note documents that patient was last known to be well on Monday (two days prior to arrival).” Select Monday’s date for *Date Last Known Well*.

**Suggested Data Sources**

Add new bullet:

- Code Stroke form/template

**Inclusion Guidelines for Abstraction**

Change to:

**Signs and Symptoms of Stroke**

- Sudden numbness or weakness of the face, arm or leg, especially on one side of the body
- Sudden confusion, trouble speaking or understanding
- Sudden trouble seeing in one or both eyes
- Sudden trouble walking, dizziness, loss of balance or coordination
- Sudden severe headache

**Impacts:**

*Decision to Admit Date*

*Decision to Admit Time*

**Rationale:** These changes to the Notes for Abstraction and/or the Inclusion/Exclusion guidelines are being added for clarification in abstraction, based on questions received in the QualityNet Q&A tool.

**Description of Changes:**

Suggested Data Sources

Remove:

**PHYSICIAN/APN/PA DOCUMENTATION ONLY**

*Decision to Admit Date*

Inclusion Guidelines for Abstraction

Change second bullet to:

- Disposition Date

**Impacts:**

*Discharge Date*

**Rationale:** The verbiage used in the manual for data elements collected for all records is being updated.
Description of Changes:
Collected For
Change to:
CMS/The Joint Commission: All Records

Suggested Data Sources
Change last bullet to:
• UB-04

Impacts:
Discharge Disposition

Rationale: The PN-3a and PN-3b measures are being removed at the direction of CMS and based on the IPPS Fiscal Year 2014 Final Rule.

Description of Changes:
Collected For
Remove under ‘CMS Voluntary Only’:
PN-3b

Impacts:
ED Departure Date

Rationale: These changes to the Notes for Abstraction and/or the Inclusion/Exclusion guidelines are being added for clarification in abstraction, based on questions received in the QualityNet Q&A tool.

Description of Changes:
Notes for Abstraction
Remove fourth bullet:
• If there is documentation the patient left against medical advice and it cannot be determined what time the patient left against medical advice, select “UTD.”

Exclusion Guidelines for Abstraction
Change to:
Patient Admission Date

Impacts:
ED Departure Time

Rationale: These changes to the Notes for Abstraction and/or the Inclusion/Exclusion guidelines are being added for clarification in abstraction, based on questions received in the QualityNet Q&A tool.

Description of Changes:
Notes for Abstraction
Add new seventh bullet:
• Do not use documentation of vital signs or medications if they are later than the ED departure time.

Exclusion Guidelines for Abstraction
Add second bullet:
• Patient Admission Time

Impacts:
Follow-Up Contact

Rationale: The current follow-up contact does not exclude patients who expire after discharge from TOB-4 and SUB-4. Directions on the appropriate allowable value to select in order to exclude the case have been added.

Description of Changes:
Notes for Abstraction
Add new fourth bullet:
• If follow-up contact was made and contact was made with a family member or other person who reports the patient expired within 30 days following discharge from the hospital, select allowable value “3.”

Impacts:
ICD-9-CM Other Diagnosis Codes

Rationale: The verbiage used in the manual for data elements collected for all records is being updated.

Description of Changes:
Collected For
Change to:
CMS/The Joint Commission: All Records

Definition
Change to:
The other or secondary ICD-9-CM codes associated with the diagnosis for this hospitalization.

Allowable Values
Change from:
Any valid ICD-9-CM diagnosis code.
To
Any valid diagnosis code as per the CMS ICD-9-CM master code table (ICD-9-CM Full and Abbreviated Code Titles):

Suggested Data Sources
Change third bullet to:
• UB-04

Remove after third bullet:
Note: Medicare will only accept codes listed in fields A-H

Impacts:
ICD-9-CM Other Procedure Codes

Rationale: The verbiage used in the manual for data elements collected for all records is being updated.

Description of Changes:
Collected For
Change to:
CMS/The Joint Commission: All Records

Definition
Change to:
The other or secondary ICD-9-CM codes identifying all significant procedures other than the principal procedure.

Allowable Values
Change from:
Any valid ICD-9-CM procedure code.
To
Any valid procedure code as per the CMS ICD-9-CM master code table (ICD-9-CM Full and Abbreviated Code Titles):

Suggested Data Sources
Change third bullet to:
• UB-04

Inclusion Guidelines for Abstraction
Change to:
None

Impacts:
ICD-9-CM Other Procedure Dates

Rationale: The verbiage used in the manual for data elements collected for all records is being updated.

Description of Changes:
Suggested Data Sources
Change last bullet to:
• UB-04

Impacts:
ICD-9-CM Principal Diagnosis Code

Rationale: The verbiage used in the manual for data elements collected for all records is being updated.

Description of Changes:
Collected For
Change to:
CMS/The Joint Commission: All Records
Definition
Change to:
The ICD-9-CM diagnosis code that is primarily responsible for the admission of the patient to the hospital for care during this hospitalization.

Allowable Values
Change from:
Any valid ICD-9-CM diagnosis code
To
Any valid diagnosis code as per the CMS ICD-9-CM master code table (ICD-9-CM Full and Abbreviated Code Titles):

Suggested Data Sources
Change third bullet to:
• UB-04

Inclusion Guidelines for Abstraction
Change to:
None

Exclusion Guidelines for Abstraction
Change to:
None

Impacts:
ICD-9-CM Principal Procedure Code

Rationale: The verbiage used in the manual for data elements collected for all records is being updated.

Description of Changes:

Collected For
Change to:
CMS/The Joint Commission: All Records

Definition
Change to:
The principal procedure is the procedure performed to definitive treatment rather than diagnostic or exploratory purposes or which is necessary to take care of the complication.

Allowable Values
Change from:
Any valid ICD-9-CM procedure code.
To
Any valid procedure code as per the CMS ICD-9-CM master code table (ICD-9-CM Full and Abbreviated Code Titles):

Notes for Abstraction
Change to:
None

**Suggested Data Sources**

**Change** third bullet to:
- UB-04

**Inclusion Guidelines for Abstraction**

**Change** to:
None

---

**Impacts:**

*ICD-9-CM Principal Procedure Date*

**Rationale:** The verbiage used in the manual for data elements collected for all records is being updated.

**Description of Changes:**

**Suggested Data Sources**

**Change** last bullet to:
- UB-04

---

**Impacts:**

*ICU Admission or Transfer*

**Rationale:** The PN-3a and PN-3b measures are being removed at the direction of CMS and based on the IPPS Fiscal Year 2014 Final Rule.

**Description of Changes:**

- **Collected For**
- **Remove** under ‘The Joint Commission Only’:
  - PN-3a
- **Remove:**
  - CMS Voluntary Only: PN-3a

---

**Impacts:**

*ICU VTE Prophylaxis*

**Rationale:** The need for clarification of documentation that is acceptable for these data elements was identified through review of clinical scenarios by the Technical Advisory Panel.

**Description of Changes:**

- **Definition**
- **Remove** the word “initially”

**Suggested Data Collection Question**

**Remove** the word “initially”

**Notes for Abstraction**

**Change** to:
• No value should be selected more than once. If a value of “A” is selected, no other selection should be recorded.
Example:
   Lovenox is ordered and substituted with dalteparin. Only abstract value “2” once, as both are LMWH.
• Abstract ALL VTE prophylaxis(s) that was administered the day of or the day after ICU admission or the day of or the day after Surgery End Date for surgeries that start the day of or the day after ICU admission. If no ICU VTE prophylaxis was administered during this timeframe, select value “A.”
• Selection of allowable values 1-8 includes any prophylaxis that was administered in the allowable time frame.
Example:
   If a patient was admitted to ICU on 12/8/20xx and had bilateral GCS applied at 13:00 on 12/08/20xx and LMWH was administered at 22:00 on 12/9/20xx, select Values “2” and “4.”
• If one pharmacological medication is ordered and another medication is substituted (such as per pharmacy formulary substitution or protocol), abstract the medication administered. Note: No copy of the formulary or protocol is required in the medical record.
Example:
   Lovenox is ordered and not received and is substituted with fondaparinux sodium, which is received by the patient. Abstract fondaparinux sodium as Value “5” for ICU VTE Prophylaxis and abstract the date it was administered for ICU VTE Prophylaxis Date.
• If the patient received one of the pharmacologic anticoagulation medications for other reasons, select the allowable value that was administered during the specified timeframe.
Example:
   If the patient received warfarin for atrial fibrillation on the day of ICU admission, select Value “6.”
• Only select prophylaxis if there is documentation that it was administered. Documentation in the progress notes under assessment/Plan: “DVT prophylaxis – SCD/Teds” is not enough to select Values “3” and “4.”
• Application of mechanical prophylaxis may be documented by any personnel.
Example:
   Nursing assistant documentation of IPC application during the allowable timeframe is acceptable.

Impacts:
ICU VTE Prophylaxis Date

Rationale: The need for clarification of documentation that is acceptable for these data elements was identified through review of clinical scenarios by the Technical Advisory Panel.

Description of Changes:
Definition
Remove the word “initial”
Suggested Data Collection Question
Remove the word “initial”

Notes for Abstraction
Change first bullet to:
• The earliest date associated with a form of prophylaxis other than aspirin should be entered.
  Example:
    If the patient was admitted on 12/8/20xx and aspirin was administered at 13:00 on 12/8/20xx and LMWH was administered at 02:00 on 12/9/20xx, record the 12/9/20xx date.

Suggested Data Sources
Change to:
• Circulator’s notes
• Graphic/flow sheets
• Medication administration record
• Nursing notes
• Operative notes
• Physician notes
• Preoperative nursing notes
• Progress notes

Impacts:
Initial ECG Interpretation

Rationale: Cases with an initial ECG finding of "Not a STEMI" should be excluded from the reperfusion measures.

Description of Changes:
Notes for Abstraction
Change sixth bullet to:
• If documentation regarding an Inclusion term is contradictory within the same interpretation or between different interpretations, select “No.”
  Examples:
  o “ST-elevation” and “No ST-elevation”
  o "Acute anterior MI" and "no acute MI"
  Note: Documentation such as "STEMI" and "No ST elevation" should not be considered contradictory, for the purposes of this data element.

Exclusion Guidelines for Abstraction - ST-segment elevation
Add new first bullet:
• Documentation of the absence of STEMI (in reference to the ECG performed closest to arrival) - e.g., “No STEMI,” “not a STEMI,” “not consistent with STEMI,” “not diagnostic of STEMI”

Impacts:
Initial ECG Interpretation
**Rationale:** The latest ACCF/AHA STEMI clinical guidelines no longer support taking LBBB on the presenting ECG as a criterion for candidacy for acute reperfusion.

**Description of Changes:**

**Definition**

**Change to:**

ST-segment elevation based on the documentation of the electrocardiogram (ECG) performed closest to hospital arrival. The normal ECG is composed of a P wave (atrial depolarization), Q, R, and S waves (QRS complex, ventricular depolarization), and a T wave (ventricular repolarization). The ST-segment, the segment between the QRS complex and the T wave, may be elevated when myocardial injury (AMI) occurs.

**Suggested Data Collection Question**

**Change to:**

Is there documentation of ST-segment elevation on the electrocardiogram (ECG) performed closest to hospital arrival?

**Allowable Values**

**Change from:**

- **Y (Yes)**: ST-segment elevation or a LBBB on the interpretation of the 12-lead ECG performed closest to hospital arrival.
- **N (No)**: No ST-elevation or LBBB on the interpretation of the 12-lead ECG performed closest to hospital arrival, no interpretation or report available for the ECG performed closest to hospital arrival or unable to determine from medical record documentation.

**To:**

- **Y (Yes)**: ST-segment elevation on the interpretation of the 12-lead ECG performed closest to hospital arrival.
- **N (No)**: No ST-elevation on the interpretation of the 12-lead ECG performed closest to hospital arrival, no interpretation or report available for the ECG performed closest to hospital arrival or unable to determine from medical record documentation.

**Notes for Abstraction**

**Change second bullet to:**

- Do not measure ST-segments from the tracing itself.

**Remove** seventh bullet:

- If at least one interpretation describes an LBBB as old, chronic, or previously seen, or states LBBB and "no changes," "unchanged," "no acute changes," "no new changes," or "no significant changes" when compared to a prior ECG, all LBBB findings should be disregarded.

**Inclusion Guidelines for Abstraction**

**Remove:**

- Left bundle branch block (LBBB)
• Intraventricular conduction delay of LBBB type
• Variable LBBB

Exclusion Guidelines for Abstraction

Remove:
Left bundle branch block (LBBB)
• Incomplete left bundle branch block (LBBB)
• Left bundle branch block (LBBB), or any of the other left bundle branch block inclusion terms, described using one of the negative modifiers or qualifiers listed in Appendix H, Table 2.6, Qualifiers and Modifiers Table (except “possible”)
• Left bundle branch block (LBBB), or any of the other left bundle branch block inclusion terms, with any mention of pacemaker/pacing (unless atrial only or nonfunctioning pacemaker) in one interpretation

Impacts:

INR Value

Rationale: The time frame for documentation reflecting the intended reason for not ordering overlap therapy needed to be defined. The time frame for determining INR value was defined and examples provided.

Description of Changes:
Definition
Change to:
Documentation of an international normalized ratio (INR) value greater than or equal to 2.0 on the day of or the day after the last dose of the parenteral anticoagulation therapy. This value correlates to the ability of the blood to clot.

Suggested Data Collection Question
Change to:
Was there documentation of an INR value greater than or equal to 2.0 on the day of or the day after the last dose of the parenteral anticoagulation therapy?

Allowable Values
Change from:
Y (Yes) There is documentation of an INR result greater than or equal to 2 prior to discontinuation of the parenteral anticoagulation therapy.

N (No) There is no documentation of an INR result greater than or equal to 2 prior to discontinuation of the parenteral anticoagulation therapy or unable to determine from medical record documentation.

To:
Y (Yes) There is documentation of an INR result greater than or equal to 2.0 on the day of or the day after the last dose of the parenteral anticoagulation therapy.

N (No) There is no documentation of an INR result greater than or equal to 2.0 the day of or the day after the last dose of the parenteral anticoagulation therapy or unable to determine from medical record documentation.

Notes for Abstraction
Change to:

- To determine the value for this data element, review the INR values the day of or the day after the last dose of the parenteral anticoagulation therapy was administered. If any result is greater than or equal to 2.0, select “Yes.”

Examples:
  - On 1/1/20XX, after four days of overlap therapy, the INR is 1.8. On 1/2/20XX, the patient received enoxaparin, the INR is 2.0. Select “Yes” because the INR was equal to 2.0 on the day of or the day after the last dose of the parenteral anticoagulation therapy.
  - On 1/1/20XX, after four days of overlap therapy, the INR is 2.0. The last dose of dalteparin was on 1/2/20XX, on the same day, the INR was 1.8. The patient is discharged without parenteral anticoagulation therapy. Select “No” because the INR was not greater than or equal to 2.0 the day of or the day after the last dose of the parenteral anticoagulation therapy.
  - On 1/1/20XX, after five days of overlap therapy, the last dose of heparin is administered, the INR is 1.8. The patient is discharged without parenteral anticoagulation therapy. Select “No” because the INR was not greater than or equal to 2.0 on the day of or the day after the last dose of parenteral anticoagulation therapy.
  - On 1/1/20XX, after seven days of overlap therapy, the INR remains less than 2.0. On 1/2/20XX, the patient receives the last dose of enoxaparin and the INR equals 2.0. Select “Yes” because the INR is greater than or equal to 2.0 on the day of or the day after the last dose of parenteral anticoagulation therapy.

Impacts:

**IV Thrombolytic Initiation**

Rationale: This change is to remove Notes for Abstraction from the data element *IV Thrombolytic Initiation* which is counter-intuitive to the measure logic.

Description of Changes:
Notes for Abstraction

Remove fourth bullet:

- When IV thrombolytic therapy is initiated beyond 3 hours (180 min.) because a reason for not initiating IV thrombolytic therapy existed during the 3 hour timeframe, select “No”.

Examples:
  - Patient arrives in the emergency department within 2 hours of time last known well. Blood pressure 195/110 mmHg on arrival. Physician documents that patient is within the t-PA window, but blood pressure is an issue. Elevated blood pressure treated prior to t-PA administration. IV thrombolytic therapy administered at 3 hours and 30 minutes from time last known well.
  - Patient arrives in the emergency department within 2 hours of time last known well and refuses t-PA. Family arrives and after further discussion with them, patient consents to t-PA. IV thrombolytic therapy administered 4 hours later.

Suggested Data Sources

Add new bullet:

Specifications Manual for Hospital Inpatient Quality Measures Page 29
Discharges 01-1-15 (1Q15) through 09-30-15 (3Q15)
IV flow sheets

Exclusion Guidelines for Abstraction
Add new bullet:
- Thrombolytic administration to flush, open or maintain patency of a central line, e.g., PICC line.

Impacts:
Last Known Well

Rationale: This change is to clarify the abstraction guidelines for data elements that generate the majority of stroke abstraction questions and ease the burden of abstraction.

Description of Changes:
Notes for Abstraction
Change to:
- Select “Yes” if BOTH a Date Last Known Well and a Time Last Known Well are documented.
- Select “No” if there is ANY physician/APN/PA documentation that Last Known Well is “UNKNOWN.” Documentation must explicitly state that the Time Last Known Well is unknown/uncertain.
- If the time last known well is clearly greater than 2 hours prior to hospital arrival AND no specific time is documented, select “No.”
  Example: “Patient OK last night.” Select “No” because no other documentation of a specific time/time range/time reference was present in the medical record and the time is required for the Time Last Known Well.
- Documentation of Last Known Well or stroke symptoms that occurred at a date or time following hospital arrival (e.g., in-house stroke), select “No.”

Suggested Data Sources
Change to:
- Ambulance record
- Code Stroke form/template
- Emergency department records
- History and physical
- IV flow sheets
- Medication administration record
- Nursing flow sheets
- Progress notes
- Transfer sheet

Remove:
Excluded Data Sources:
- Discharge summary

Impacts:
Measure Category Assignment
**Rationale:** Changes are being made to provide clarification regarding measures for which better quality is associated with a lower score or numerator. Additional clarification is being provided regarding how the records are included in the measure numerator and/or denominator for aggregate data for such inverse measures.

**Description of Changes:**

**Allowable Values**

Add after first paragraph for “Category D - In Measure Population”:

**Note:** For measures for which better quality is associated with a lower score or numerator, i.e., VTE-6 and PC-01, a Measure Category Assignment of “D” means that the appropriate care was provided and the intent of the measure was met. For aggregate data, the EOC record will be included in the measure denominator only.

Add after first paragraph for “Category E - In Numerator Population”:

**Note:** For measures for which better quality is associated with a lower score or numerator, i.e., VTE-6 and PC-01, a Measure Category Assignment of “E” means that the appropriate care was not provided and the intent of the measure was not met. For aggregate data, the EOC record will be included in both the measure numerator and denominator.

**Impacts:**

**Monitoring Documentation**

**Rationale:** Clinical scenarios were presented to the VTE Technical Advisory Panel, and it was determined that the measure did not allow for exceptions to the data element.

**Description of Changes:**

**Notes for Abstraction**

Add fifth bullet:

- If there is physician/APN/PA or pharmacist documentation of an explicit reason for not using documentation such as a nomogram or protocol, linked to the heparin order, select “Yes.”

  Example:

  Do not use heparin protocol, MD to manage heparin drip, select “Yes.”

**Suggested Data Sources**

Add:

- Protocol for heparin management
- Nomogram for heparin management
- Laboratory values

Change “Exception” to:

**Exception (Physician/APN/PA or pharmacist documentation not required)**

Nursing documentation on pathways

**Impacts:**

**Patient HIC#**

**Payment Source**

**Postal Code**
**Rationale:** The verbiage used in the manual for data elements collected for all records is being updated.

**Description of Changes:**

**Suggested Data Sources**

**Change** last bullet to:
- UB-04

**Impacts:**

*Pneumonia Diagnosis: ED/Direct Admit*

**Rationale:** This change is to provide clarification to the abstractor and to make the data element more consistent with the pneumonia measures.

**Description of Changes:**

**Definition**

**Change to:**
Documentation of the diagnosis of pneumonia either as the Emergency Department diagnosis/impression, or as an admission diagnosis/impression for the direct admit patient within 24 hours after arrival to the hospital.

**Notes for Abstractions**

**Add** new first bullet:
- Only consider diagnoses that have been documented by a Physician/APN/PA within 24 hours of patient’s arrival at the hospital. Do not accept any diagnosis that is documented greater than 24 hours after patient’s arrival to the hospital.

**Change** example in seventh bullet to:
ED diagnosis “Pneumonia vs. aspiration pneumonia."

**Add** new eighth bullet:
- If there is documentation of a diagnosis of pneumonia and a diagnosis of “aspiration pneumonia” on the same or different Only Acceptable Sources, select value “2”.
  
  Example:
  
  Admit H&P: Clinical Diagnosis/Impression: Pneumonia; Admitting Physician Orders: Diagnosis: Aspiration Pneumonia

**Patients seen in the Emergency Department**

**Change** third bullet to:
- For the purposes of this data element, the “ED form” is an area or section within the ED record for the physician/APN/PA to list diagnoses or impressions.

**Remove** fourth bullet:
- In the ED, the diagnosis of pneumonia should be taken from a section that is specifically designated for the physician/APN/PA to list diagnoses or impressions.

**Remove** eighth bullet:
• If pneumonia is listed as a diagnosis/impression on the ED form by any physician/APN/PA, select value “1.” No further review of additional suggested data sources is needed (e.g., the admit order or admit note).

Change eleventh bullet to:
• Those cases where the patient is seen in the emergency department but the medical record does not contain an ED form, which is different than just leaving the form blank (e.g., the physician treating the patient in the ED documented everything on an admit note) are limited to the following ONLY ACCEPTABLE SOURCES: Admitting notes, Admitting physician orders and Admit H&P.

Direct Admits
Change fourth bullet to:
• When the patient is a direct admit and is not seen in the ED, the diagnosis of pneumonia should be found on the following ONLY ACCEPTABLE SOURCES to select value 1: Admitting notes, Admitting physician orders, Admit History & Physical (H&P).

Remove eighth bullet:
• Any of the ONLY ACCEPTABLE SOURCES can be used without a date or time except for an Admit H&P for a direct admit patient. This must be written or dictated within 24 hours of hospital arrival.

Change ninth bullet to:
• An undated and/or untimed document is not an acceptable source.

Suggested Data Sources
Direct Admit
Change first bullet to:
  o Admit History & Physical (H&P)

Impacts:
Pre-Arrival Lipid-Lowering Agent
Rationale: The change is to correct a typographical error.
Description of Changes:
Collected For
Change to:
CMS/The Joint Commission: STK-6

Impacts:
Prescription for Alcohol or Drug Disorder Medication
Rationale: Patients without a residence in the USA are not a part of the measure population, so only allowable value “3” should be selected.
Description of Changes:
Allowable Values
Change value 3 from:
A prescription for an FDA-approved medication for alcohol or drug disorder was not offered at discharge because the patient’s residence is not in the USA.
To:
The patient’s residence is not in the USA.

Notes for Abstraction
Add new fourth bullet:
If the patient does not have a residence in the USA, value “3” must be selected.

Impacts:

Prescription for Tobacco Cessation Medication

Rationale:  Patients without a residence in the USA are not a part of the measure population, so only allowable value “3” should be selected.

Description of Changes:
Allowable Values:
Change value 3 from:
A prescription for an FDA-approved medication for alcohol or drug disorder was not offered at discharge because the patient’s residence is not in the USA.

To:
The patient’s residence is not in the USA.

Notes for Abstraction:
Add new 5th bullet:
If the patient does not have a residence in the USA, value “3” must be selected.

Impacts:

Reason for Discontinuation of Parenteral Therapy

Rationale:  Clinical scenarios presented to the Technical Advisory Panel (TAP) justified the need for defined time frames, and the need for examples and clarifications to capture acceptable documentation for these data elements.

Description of Changes:
Data Element Name
Change to:
Reason for Discontinuation of Parenteral Anticoagulation Therapy

Definition
Change to:
Documentation of a reason for discontinuation of the parenteral anticoagulation therapy by a physician/APN/PA or pharmacist on the same day or the day before the order for the discontinuation.

Suggested Data Collection Question
Change to:
Is there a reason for discontinuation of the parenteral anticoagulation therapy, documented by a physician/APN/PA or pharmacist on the same day or the day before the order for the discontinuation?

Allowable Values
Change from:
Y (Yes) There is a reason documented by a physician/APN/PA or pharmacist for discontinuation of the parenteral therapy.

N (No) There is no reason documented by a physician/APN/PA or pharmacist for discontinuation of the parenteral therapy or unable to determine from medical record documentation.

To:

Y (Yes) There is a reason documented for discontinuation of the parenteral anticoagulation therapy, by a physician/APN/PA or pharmacist on the same day or the day before the order for the discontinuation.

N (No) There is no reason for discontinuation of the parenteral anticoagulation therapy documented by a physician/APN/PA or pharmacist on the same day or the day before the order for the discontinuation or unable to determine from medical record documentation.

Notes for Abstraction

Change to:

- Reasons for discontinuation of parenteral anticoagulation therapy must be explicitly documented or clearly implied. The explicit reason for the discontinuation of the parenteral anticoagulation therapy must be documented by the physician/APN/PA/pharmacist on the same day or the day before the order for discontinuation.

- If reasons are not mentioned in the context of the discontinuation of the parenteral anticoagulation therapy, do not make inferences.
  Examples:
  - Actively Bleeding - Anticoagulation Contraindicated
  - Severe anemia, discontinue heparin
  - GI Bleed – Discontinue enoxaparin
  - D/C enoxaparin rectal bleed
  - Discontinue dalteparin, patient scheduled for surgery today

- Do not infer reasons based on laboratory values alone, ONLY physician/APN/PA or pharmacist documentation of the specified reason is acceptable.

- Documentation of reasons synonymous with a high or supratherapeutic INR or an INR >3.0 is acceptable for discontinuation of parenteral anticoagulation therapy when documented by a physician/APN/PA or pharmacist.
  Examples:
  - D/C enoxaparin, INR 6.0, select “Yes.”
  - D/C heparin, INR supratherapeutic, select “Yes.”

- For patient with less than five days of overlap therapy:
  - Additional documentation is needed to support the reason for discontinuation of parenteral anticoagulation therapy.
  Example:
  Dalteparin and warfarin are started on 01/01/20XX. On 01/03/20XX patient is discharged home on warfarin alone, select “No.” The patient has not received five days of parenteral anticoagulation therapy.
For documentation of therapeutic INR or an INR with a value equal to 2.0-3.0 (target range of 2.5), additional documentation is needed to support the reason to select “Yes.”

Examples:
- INR 2.5 Discharge home, select “No.” There is no additional documentation of a reason for the discontinuation of the parenteral anticoagulation therapy.
- INR 2.5 patient bleeding, D/C IV heparin, select “Yes.” There is additional documentation of a reason for the discontinuation of the parenteral anticoagulation therapy.
- Discontinue enoxaparin, patient INR is therapeutic, select “No.” There is no additional documentation of a reason for the discontinuation of the parenteral anticoagulation therapy.

• For patients with five or more days of overlap therapy and INR <2.0, explicit documentation of a reason for discontinuation of the parenteral anticoagulation therapy is needed to select “Yes.”

Examples:
- Discontinue enoxaparin therapy, INR 1.7, home on warfarin, select “No.” The INR value is < 2.0.
- Discontinue enoxaparin, INR 1.7, patient at risk for bleeding, select “Yes.” There is additional documentation of a reason for the discontinuation of the parenteral anticoagulation therapy.

• Overlap therapy days are calculated by taking the Parenteral Anticoagulant End Date minus the Overlap Therapy Start Date.

• Documentation that the patient is allergic or intolerant to ALL parenteral anticoagulation therapy is acceptable. An allergy or adverse reaction to ONE type of parenteral anticoagulant is NOT a reason for not administering all parenteral anticoagulants. Another medication can be ordered.

• Substitution of one parenteral anticoagulation drug for another parenteral drug is not considered discontinuation of parenteral anticoagulation therapy.

Example:
If a patient was on heparin subcutaneous and was changed to fondaparinux sodium subcutaneous on day 3, the patient is discharged on fondaparinux sodium, select “No.”

Add:
Exceptions to physician/APN/PA or pharmacist documentation only:

• Patient refusal of parenteral anticoagulation therapy during hospitalization or at discharge is a reason for discontinuation and may be documented by a nurse.

• Documentation that the patient is allergic or intolerant to ALL parenteral anticoagulation therapy is acceptable.

Suggested Data Sources
Change:
ONLY PHYSICIAN/APN/PA or PHARMACIST DOCUMENTATION OF A REASON FOR DISCONTINUING PARENTERAL THERAPY
To:
ONLY PHYSICIAN/APN/PA or PHARMACIST DOCUMENTATION OF A REASON FOR DISCONTINUING PARENTERAL ANTICOAGULATION THERAPY

Excluded Data Sources
Change to:
Any documentation dated/timed after discharge.

Inclusion Guidelines for Abstraction
Change to:
Documentation must be present on the same day or the day before the order for the discontinuation of the parenteral anticoagulation therapy.

• Documentation of active bleeding
• Documentation of a plan for surgery
• Documentation of a plan for blood transfusion
• Administration of Oral Factor Xa Inhibitors
  o Xarelto or rivaroxaban
  o Eliquis or apixaban
• Documentation that patient is not a candidate for anticoagulation therapy
• Documentation of thrombocytopenia

Exclusion Guidelines for Abstraction
Remove first bullet:
• A therapeutic INR value equal to 2.0-3.0 (target range of 2.5) without additional documentation that notes a decision was made to discontinue parenteral therapy.

Impacts: N/A
Rationale: This change is to adjust the measure flow logic and add a new data element that will exclude cases who received IV thrombolytic therapy in 3 to 4.5 hours because a reason delayed initiation within 3 hours.
Description of Changes:
Add new data element:
Reason for Extending the Initiation of IV Thrombolytic

Impacts: N/A
Rationale: The Technical Advisory Panel reviewed clinical scenarios presented and determined that a timeframe was needed for documentation to be acceptable for these data elements. An additional data element was added to further define reasons for not providing prophylaxis to records in VTE-6 Hospital Acquired VTE.
Description of Changes:
Add new data element:
Reason for No Administration of VTE Prophylaxis
Reason for No Overlap Therapy

Rationale: The time frame for documentation reflecting the intended reason for not ordering overlap therapy needed to be defined. The time frame for determining INR value was defined and examples provided.

Description of Changes:
Definition
Change to:
Physician/APN/PA/pharmacist documentation on the day of or the day after the VTE Diagnostic Test, of a reason why parenteral anticoagulation therapy and warfarin were not administered on the same day.

Suggested Data Collection Question
Change to:
Is there physician/APN/PA or pharmacist documentation on the day of or the day after the VTE Diagnostic Test, of a reason why parenteral anticoagulation therapy and warfarin were not administered on the same day?

Allowable Values
Change from:
Y (Yes) There is Physician/APN/PA/Pharmacist documentation of a reason why parenteral anticoagulation therapy and warfarin were not administered on the same day.
N (No) There is no Physician/APN/PA/Pharmacist documentation of a reason why parenteral anticoagulation therapy and warfarin were not administered on the same day or unable to determine from medical record documentation.

To:
Y (Yes) There is physician/APN/PA/pharmacist documentation on the day of or the day after the VTE Diagnostic Test of a reason why parenteral anticoagulation therapy and warfarin were not administered on the same day.
N (No) There is no physician/APN/PA/pharmacist documentation on the day of or the day after the VTE Diagnostic Test of a reason why parenteral anticoagulation therapy and warfarin were not administered on the same day or unable to determine from medical record documentation.

Notes for Abstraction
Change to:
- The explicit reason for no overlap therapy must be documented by the physician/APN/PA/pharmacist on the day of or the day after the VTE Diagnostic Test. Refer to the data element VTE Diagnostic Test for a list of acceptable tests.
- Reasons (other than those listed in the inclusion guidelines) not mentioned in the context of NO overlap therapy are not acceptable.
- Documentation by the physician/APN/PA or pharmacist must state the reason for no overlap therapy.
Examples:
  - No overlap therapy, patient bleeding.
  - No bridge therapy, GI bleed.
Intolerance to parenteral anticoagulation therapies

- If there is questionable documentation regarding the reason for no overlap therapy, select “No.”
  Example:
  The physician documents that the patient had a bleeding nose on arrival to the emergency department. Three days into the admission, a VTE Diagnostic Test was performed and VTE was confirmed. No overlap therapy was administered during the hospitalization. There is documentation of a bleeding nose on arrival, but NO documentation of a reason for no overlap therapy after the VTE was diagnosed. Select “No.”
- Documentation that the patient is allergic or intolerant to ALL parenteral anticoagulation therapy is acceptable. An allergy or adverse reaction to ONE type of anticoagulant is NOT a reason for not administering all anticoagulants. Another medication can be ordered.
- For VTE Diagnostic Tests performed prior to arrival, documentation must be present the day of or the day after arrival.

Add:
Exceptions to physician/APN/PA or pharmacist documentation only:
- Patient/family refusal of any or all forms of overlap therapy does not have to be documented by a physician/APN/PA or pharmacist. Refusal may be documented by a nurse, but should be documented within the same timeframe as overlap therapy.
  Example:
  There is documentation by the nurse that the patient refused heparin during the timeframe for overlap therapy. Select “Yes.”
- Documentation that the patient is allergic or intolerant to ALL parenteral anticoagulation therapy may be documented by a nurse.

Change “SUGGESTED DATA SOURCES FOR PATIENT REFUSAL (other than physician/APN/PA or pharmacist) documentation of a reason for not administering Overlap Therapy as above):”
To:
SUGGESTED DATA SOURCES FOR PATIENT REFUSAL, ALLERGY OR ADMINISTRATION OF ORAL FACTOR Xa INHIBITOR (other than physician/APN/PA or pharmacist documentation):

Add:
Excluded Data Sources:
Any documentation dated/timed after discharge.

Inclusion Guidelines for Abstraction
Change to:
Documentation must be present on the day of or the day after the VTE Diagnostic Test:
- Documentation of active bleeding
- Documentation of a plan for surgery
- Documentation of a plan for blood transfusion
- Administration of Oral Factor Xa Inhibitors
  o Xarelto or rivaroxaban
- Eliquis or apixaban
- Documentation that patient is not a candidate for anticoagulation therapy

**Impacts:**

*Reason for No VTE Prophylaxis – Hospital Admission*

**Rationale:** The need for clarification of documentation that is acceptable for these data elements was identified through review of clinical scenarios by the Technical Advisory Panel.

**Description of Changes:**

**Definition**

**Change to:**
Physician/APN/PA or pharmacist documentation why mechanical AND pharmacological VTE prophylaxis was not administered at hospital admission.

The two circumstances in which one can select “Yes” to this data element are:

- There is explicit documentation indicating that the patient is at low risk for VTE.
- There is explicit documentation of a contraindication to mechanical prophylaxis AND documentation of a contraindication to pharmacological prophylaxis.

**Suggested Data Collection Question**

**Change to:**
Is there physician/APN/PA or pharmacist documentation why VTE prophylaxis was not administered at hospital admission?

**Allowable Values**

**Change from:**

| Y (Yes) | There is documentation why VTE prophylaxis was not administered at hospital admission. |
| N (No)  | There is no documentation why VTE prophylaxis was not administered at hospital admission or unable to determine from medical record documentation. |

**To:**

| Y (Yes) | There is physician/APN/PA or pharmacist documentation why VTE prophylaxis was not administered at hospital admission. |
| N (No)  | There is no physician/APN/PA or pharmacist documentation why VTE prophylaxis was not administered at hospital admission or unable to determine from medical record documentation. |

**Notes for Abstraction**

**Change to:**

- If a patient received prophylaxis as per the data element *VTE Prophylaxis*, select “No.”
- If a risk assessment is used, and notes anything other than low risk (e.g. intermediate risk, moderate risk, or high risk), additional documentation must be present to answer “Yes.” **Explicit documentation** of a contraindication to mechanical AND contraindication to pharmacological prophylaxis must be addressed.
  - If there is physician documentation of “bleeding, no pharmacologic prophylaxis,” the chart must be reviewed for documentation about a reason for no mechanical prophylaxis in order to select “Yes.”
Examples:
- Bleeding, no pharmacologic prophylaxis, no mechanical prophylaxis.
- Active GI bleed – low molecular weight heparin contraindicated, no mechanical prophylaxis needed.

- To select “Yes” for this data element, documentation must be dated from arrival to the day after hospital admission or surgery end date. Documentation written after arrival but prior to admission is acceptable.
- **If reasons are not mentioned in the context of VTE prophylaxis, do not make inferences** (e.g., do not assume that VTE Prophylaxis was not administered because of a bleeding disorder unless documentation explicitly states so).
  Example:
  Physician/APN/PA documentation of bleeding risk, review the chart for documentation about reasons for no mechanical AND reasons for no pharmacological VTE Prophylaxis.

- Documentation that the patient is ambulating without mention of VTE prophylaxis is insufficient. Do not infer that VTE prophylaxis is not needed unless explicitly documented.
- For patients with a reason for no pharmacologic or no mechanical prophylaxis and an order for ANY prophylaxis that was NOT administered without a reason (e.g. patient refusal), select “No.”
- If two physicians/APN/PA or pharmacists document conflicting or questionable needs for prophylaxis, select “No.”
- **For ONLY those patients determined to be AT LOW RISK for VTE:**
  - If documentation of “No VTE Prophylaxis needed” is written, then it will be inferred that both mechanical and pharmacological options were not indicated for the patient, select “Yes.”
    Example:
    Low Risk, No VTE Prophylaxis, select “Yes.”
  - A completed risk assessment within this timeframe determining the patient is low risk is acceptable for this data element, select “Yes.” Risk Assessment forms may be initiated and completed by a nurse.
  - If there are multiple completed risk assessments with conflicting outcomes and prophylaxis was NOT administered within this timeframe, select “No.”
  - Any completed VTE risk assessment or physician/APN/PA or pharmacist documentation indicating “low risk” is acceptable.

**Change “Exceptions” to:**

**Exceptions** to physician/APN/PA or pharmacist documentation of a reason for no mechanical or pharmacological VTE prophylaxis:
- **If Comfort Measures Only (CMO) was documented after the day after arrival (Day 1) but by the day after hospital admission or surgery end date for surgeries that start the day of or the day after hospital admission, select “Yes.”**
  Examples:
  - Patient arrives in the ED on 06/01/20xx but is in observation until admission to the hospital on 06/03/20xx. If CMO is documented by 06/04/20xx, select “Yes.”
  - The patient was admitted on 5/31/20xx and the surgery end date was 06/01/20xx, select “Yes” if CMO was documented by 06/02/xx.
• Patient/family refusal may be documented by a nurse, but should be documented within the same timeframe as the reason for no VTE prophylaxis. Patient/family refusal of any form of prophylaxis is acceptable.
  Example:  
  Patient refused heparin, select “Yes.”

For patients on anticoagulants:
• For patients on continuous IV heparin therapy the day of or day after hospital admission, select “Yes.”
• If warfarin is listed as a home or current medication, select “Yes.”
• For patients receiving anticoagulant therapy for atrial fibrillation or for other conditions (e.g. angioplasty), with anticoagulation administered on the day of or the day after hospital admission, select “Yes.”
• Documentation that the patient is adequately anticoagulated or already anticoagulated, select “Yes.”
  Examples:
  o Patient is already anticoagulated, taking Coumadin at home prior to admission.
  o INR therapeutic and adequately anticoagulated at this time.
• Documentation synonymous with “abruptly reversed anticoagulation for major bleeding,” select “Yes.”
  Examples:
  o INR reversal for major bleeding.
  o Reverse anticoagulation for intracranial hemorrhage.

STK  
Stroke patients require a documented reason for not administering another form of prophylaxis when graduated compression stockings (GCS) or aspirin are the ONLY form of VTE prophylaxis administered.

VTE  
VTE patients require a documented reason for not administering another form of prophylaxis when aspirin is the ONLY form of VTE prophylaxis administered.

Inclusion Guidelines for Abstraction
Change first bullet to:
• Patient at low risk for VTE, no prophylaxis needed

Change third bullet to:
• Patient/family refusal of VTE Prophylaxis

Add:
Refer to Appendix H, Table 2.7 Anticoagulation Therapy for Atrial Fibrillation and Other Conditions.

Exclusion Guidelines for Abstraction
Change to:
Aspirin alone is not an acceptable form of VTE prophylaxis in the VTE and STK population.
Rationale: The need for clarification of documentation that is acceptable for these data elements was identified through review of clinical scenarios by the Technical Advisory Panel.

Description of Changes:

Definition

Change to:
Physician/APN/PA or pharmacist documentation why mechanical AND pharmacologic VTE prophylaxis was not administered at ICU admission/transfer.

The two circumstances in which one can select “Yes” to this data element are:

- There is explicit documentation indicating that the patient is at “low risk” for VTE.
- There is explicit documentation of a contraindication to mechanical prophylaxis AND documentation of a contraindication to pharmacological prophylaxis.

Suggested Data Collection Question

Change to:
Is there physician/APN/PA or pharmacist documentation why VTE prophylaxis was not administered at ICU admission or transfer?

Allowable Values

Change from:

Y (Yes) There is documentation why VTE prophylaxis was not administered at ICU admission/transfer.

N (No) There is no documentation why VTE prophylaxis was not administered at ICU admission/transfer or unable to determine from medical record documentation.

To:

Y (Yes) There is physician/APN/PA or pharmacist documentation why VTE prophylaxis was not administered at ICU admission/transfer.

N (No) There is no physician/APN/PA or pharmacist documentation why VTE prophylaxis was not administered at ICU admission/transfer or unable to determine from medical record documentation.

Notes for Abstraction

Change to:

- If a patient received prophylaxis as per the data element *ICU VTE Prophylaxis*, select “No.”
- If a risk assessment is used, and notes anything other than low risk (e.g. intermediate risk, moderate risk, or high risk), additional documentation must be present to answer “Yes.” Explicit documentation of a contraindication to mechanical AND contraindication to pharmacological prophylaxis must be addressed.
  - If there is physician documentation of “bleeding, no pharmacologic prophylaxis,” the chart must be reviewed for documentation about a reason for no mechanical prophylaxis in order to select “Yes.”

Examples:

- Bleeding, no pharmacologic prophylaxis, no mechanical prophylaxis.
- Active GI bleed – low molecular weight heparin contraindicated, no mechanical prophylaxis needed.

- To select “Yes” for this data element, documentation must be dated from arrival to the day after ICU admission/transfer or surgery end date for those surgeries that start the day of or the day after ICU admission/transfer.

- Documentation written after arrival to the ICU, but prior to the decision to admit is acceptable.

- If a patient did not receive VTE prophylaxis on the medical unit due to physician documentation and is transferred to the ICU, another reason (even if it is the same reason) must be documented if no VTE prophylaxis was administered upon admission/transfer to ICU.

- **If reasons are not mentioned in the context of VTE prophylaxis, do not make inferences** (e.g., do not assume that VTE Prophylaxis was not administered because of a bleeding disorder unless documentation explicitly states so).

  *Example:* There is physician/APN/PA documentation of bleeding risk. Review the chart for documentation of reasons for no mechanical AND reasons for no pharmacological VTE Prophylaxis.

- Documentation that the patient is ambulating without mention of VTE prophylaxis is insufficient. Do not infer that VTE prophylaxis is not needed unless explicitly documented.

- For patients with a reason for no pharmacological or no mechanical prophylaxis and an order for ANY prophylaxis that was NOT administered without a reason (e.g. patient refusal), select “No.”

- If two physicians/APN/PA or pharmacist document conflicting or questionable needs for prophylaxis, select “No.”

- For **ONLY** those patients determined to be **AT LOW RISK** for VTE:
  - If documentation of “No VTE Prophylaxis needed” is written, then it will be inferred that both mechanical and pharmacological options were not indicated for the patient, select “Yes.”

    *Example:* Low Risk, No VTE Prophylaxis, select “Yes.”

  - A completed risk assessment within this timeframe determining the patient is low risk is acceptable for this data element, select “Yes.” Risk Assessment forms may be initiated and completed by a nurse.

  - If there are multiple completed risk assessments with conflicting outcomes and prophylaxis was NOT administered within this timeframe, select “No.”

  - Any completed VTE risk assessment or physician/APN/PA or pharmacist documentation indicating “low risk” is acceptable.

**Change “Exceptions” to:**

**EXCEPTIONS** to physician/APN/PA or pharmacist documentation of a reason for no mechanical or pharmacological VTE prophylaxis:

- If **Comfort Measures Only** (CMO) was documented after the day after arrival (Day 1) but by the day after ICU admission or surgery end date for surgeries that start the day of or the day after ICU admission, select “Yes.”

  *Examples:*

  - Patient arrives in the ED on 06/01/20xx but is in observation until admission to the ICU on 06/03/20xx. If CMO is documented by 06/04/20xx, select “Yes.”
The patient was admitted on 05/31/20xx and the surgery end date was 06/01/20xx, select “Yes” if CMO was documented by 06/02/20xx.

- Patient/family refusal may be documented by a nurse, but should be documented within the same timeframe as the reason for no VTE prophylaxis. Patient/family refusal of any form of prophylaxis is acceptable.
  Example:
  Patient refused heparin, select “Yes.”

For patients on anticoagulants:
- For patients on continuous IV heparin therapy the day of or day after ICU admission, select “Yes.”
- If warfarin is listed as a home med, previous medication prior to admission/transfer to ICU, or current medication, select “Yes.”
- For patients receiving anticoagulant therapy for atrial fibrillation or for other conditions (e.g. angioplasty) with anticoagulation administered on the day of or the day after ICU admission/transfer, select “Yes.”
- Documentation that the patient is adequately anticoagulated or already anticoagulated, select “Yes.”
  Examples:
  o Patient is already anticoagulated, taking Coumadin at home prior to admission.
  o INR therapeutic and adequately anticoagulated at this time.
- Documentation synonymous with “abruptly reversed anticoagulation for major bleeding,” select “Yes.”
  Examples:
  o INR reversal for major bleeding.
  o Reverse anticoagulation for intracranial hemorrhage.

Inclusion Guidelines for Abstraction
Change second bullet to:
- Patient at low risk for VTE, no prophylaxis needed.

Change third bullet to:
- Patient/family refusal of VTE Prophylaxis

Add:
Refer to Appendix H, Table 2.7 Anticoagulation Therapy for Atrial Fibrillation and Other Conditions.

Exclusion Guidelines for Abstraction
Change to:
Aspirin alone is not an acceptable form of VTE Prophylaxis in the VTE and STK population.

Impacts:
Reason for Not Initiating IV Thrombolytic
Rationale: This change is to clarify the abstraction guidelines for data elements that generate the majority of stroke abstraction questions and ease the burden of abstraction.

Description of Changes:
Definition
Change to:
Definition: Reasons for not initiating IV thrombolytic.
- Documentation that intravenous (IV) or intra-arterial (IA) thrombolytic was initiated by a transferring hospital or emergency medical staff (EMS) prior to hospital arrival
- Documentation of patient/family refusal of IV thrombolytic
- Documentation of a National Institutes for Health Stroke Scale (NIHSS) score of zero in the emergency department
- Documentation of cardiac arrest, respiratory arrest, cardiopulmonary resuscitation, defibrillation, or intubation in the emergency department
- Comfort Measures Only documented by a physician/APN/PA
- Other reasons for not initiating IV thrombolytics documented by physician/APN/PA or pharmacist

Suggested Data Collection Question
Change to:
Is there documentation on the day of or day after hospital arrival of a reason for not initiating IV thrombolytic?

Allowable Values
Change from:
Y (Yes) There is physician/APN/PA or pharmacist documentation of a reason for not initiating IV thrombolytic.
N (No) There is no physician/APN/PA or pharmacist documentation of a reason for not initiating IV thrombolytic, OR unable to determine from the medical record documentation.
To:
Y (Yes) There is documentation on the day of or the day after hospital arrival of a reason for not initiating IV thrombolytic.
N (No) There is no documentation on the day of or day after hospital arrival of a reason for not initiating IV thrombolytic, OR unable to determine from the medical record documentation.

Notes for Abstraction
Change to:
- **Documentation of a reason for not initiating IV thrombolytic must be done on the day of or the day after hospital arrival. It is not necessary to review documentation outside of this timeframe to answer this data element.**
- “Other” reasons for not initiating IV thrombolytic therapy must be documented by a physician/APN/PA or pharmacist.
  **EXCEPTION:**
  Nursing documentation of a telemedicine/teleneurology reason for not initiating IV thrombolytic therapy is acceptable.
• The following are acceptable as *stand-alone reasons* for not initiating IV thrombolytics
  – IV thrombolytic therapy linkage is not needed:
    o Documentation that intravenous (IV) or intra-arterial (IA) thrombolytic was
      initiated by a transferring hospital or EMS prior to hospital arrival
    o Documentation of patient/family refusal of IV thrombolytic
    o Documentation of NIHSS score of zero in the emergency department
    o Documentation of cardiac arrest, respiratory arrest, cardiopulmonary
      resuscitation, defibrillation, or intubation in the emergency department
    o *Comfort Measures Only* documented by a physician/APN/PA

• If “other” reasons are not mentioned in the context of IV thrombolytics, do not
  make inferences (e.g., do not assume that IV thrombolytic was not initiated because of
  a bleeding disorder unless explicitly stated in the documentation).
  Acceptable examples (select “Yes”):
    o “Frail 95 year old – will not give thrombolytics due to age”
    o “Patient with Stage IV cancer – No t-PA”
    o “Increased risk of bleeding – hold t-PA for further evaluation”

• Documentation by a physician/APN/PA or pharmacist that the patient is not a t-PA
  candidate, not eligible for IV thrombolytic therapy, thrombolytics are not indicated, or t-
  PA is contraindicated, without mention of the underlying reason, is acceptable as an
  “other” reason if it is documented on the day of or day after hospital arrival.

• Documentation by a physician/APN/PA that the patient has no neurological deficits,
  e.g., “normal neuro exam,” “neurological exam has returned to baseline” at the time of
  presentation to the emergency department, is acceptable as an “other” reason if it is
  documented on the day of or day after hospital arrival.

• Reason documentation which refers to intravenous medications only (e.g., “Hold IV
  medications,” “No IVs”), is not acceptable.

• **System reasons are not acceptable as “other” reasons, regardless of any linkage to
  IV thrombolytics:**
  o Equipment-related (e.g., CT not available, IV pump malfunction)
  o Pharmacy-related (e.g., thrombolytic agent not available from pharmacy)
  o Staff-related (e.g., unable to contact consulting MD)

**Suggested Data Sources**

**Remove:**

*ONLY PHYSICIAN/APN/PA OR PHARMACIST DOCUMENTATION OF A REASON FOR NOT
INITIATING IV THROMBOLYTIC:*

**Add:**

• Medical transport records
• Nursing notes
• Physician orders
• Transfer forms

**Remove:**

**Excluded Data Sources:**

Discharge summary

**Remove:**
ADDITIONAL SUGGESTED DATA SOURCES FOR PATIENT/FAMILY REFUSAL, NIHSS SCORE OF ZERO, AND INITIATION OF IV or IA THROMBOLYTIC AT A TRANSFERRING HOSPITAL ONLY:

- Medical transport records
- Nurses notes
- Transfer forms

Inclusion Guidelines for Abstraction

Change to:
None

Exclusion Guidelines for Abstraction

Change to:
- Delay in stroke diagnosis
- Hold IV thrombolytic without a documented reason
- No IV access

Impacts:

Reason for Not Prescribing Statin Medication at Discharge
Statin Medication Prescribed at Discharge

Rationale: These measures are being removed based on the FY 2014 IPPS Final Rule and at the direction of CMS.

Description of Changes:
Remove:
The Joint Commission Only: AMI-10; CMS Voluntary Only: AMI-10

Impacts:

Referral for Addictions Treatment

Rationale: Patients without a residence in the USA are not a part of the measure population, so only allowable value “4” should be selected. The referral can also be made by health care organization staff and can be completed at any time during the hospitalization prior to discharge.
Description of Changes:
Allowable Values

Change value 1 from:
The referral to addictions treatment was made by the healthcare provider prior to discharge.
To:
The referral to addictions treatment was made by the healthcare provider or health care organization at any time prior to discharge.

Change value 2 from:
Referral information was given to the patient at discharge but the appointment was not made by the provider prior to discharge.
To:
Referral information was given to the patient at discharge but the appointment was not made by the provider or health care organization prior to discharge.

Change value 4 from:
The referral for addictions treatment was not offered because the patient’s residence is not in the USA.
To:
The patient’s residence is not in the USA.

Notes for Abstraction
Add new second bullet:
• If the patient does not have a residence in the USA, value “4” must be selected.

Impacts:
Referral for Outpatient Tobacco Cessation Counseling

Rationale: Patients without a residence in the USA are not a part of the measure population, so only allowable value “4” should be selected. The referral can also be made by health care organization staff and can be completed at any time during the hospitalization prior to discharge.

Description of Changes:
Allowable Values

Change value 1 from:
The referral to outpatient tobacco cessation counseling treatment was made by the healthcare provider or prior to discharge.
To:
The referral to outpatient tobacco cessation counseling treatment was made by the healthcare provider or health care organization at any time prior to discharge.

Change value 2 from:
Referral information was given to the patient at discharge but the appointment was not made by the provider prior to discharge.
To:
Referral information was given to the patient at discharge but the appointment was not made by the provider or health care organization prior to discharge.
Change value 4 from:
The referral for outpatient tobacco cessation counseling treatment was not offered because the patient’s residence is not in the USA.
To:
The patient’s residence is not in the USA.

Notes for Abstraction
Add new fifth bullet:
• If the patient does not have a residence in the USA, value “4” must be selected.

Impacts:
Sex

Rationale:  The verbiage used in the manual for data elements collected for all records is being updated.

Description of Changes:
Collected For
Change to:
CMS/The Joint Commission:  All Records

Suggested Data Sources
Change last bullet to:
• UB-04

Impacts:
Time Last Known Well

Rationale:  This change is to clarify the abstraction guidelines for data elements that generate the majority of stroke abstraction questions and ease the burden of abstraction.

Description of Changes:
Notes for Abstraction
Change to:
• For times that include “seconds,” remove the seconds and record the time as is. Example:
  15:00:35 would be recorded as 15:00
• If the time last known well is unable to be determined from medical record documentation, select “UTD.”

EXCEPTION:
If the only time last known well is documented as a time immediately before hospital arrival without a specific time range in minutes, e.g., “symptoms started just prior to ED arrival,” and no other documentation mentioning time last known well is available in the medical record, use the Arrival Time for Time Last Known Well.
• The medical record must be abstracted as documented (taken at “face value”). When the time documented is obviously in error (not a valid time) and no other documentation is found that provides this information, the abstractor should select “UTD.”
  Example:
Documentation indicates the time last known well was 3300. No other documentation in the medical record provides a valid time. Since the time last known well is outside of the range listed in the Allowable Values for “Hour,” it is not a valid time and the abstractor should select “UTD.”

**Note:** Transmission of a case with an invalid time as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission’s Data Warehouse. Use of “UTD” for *Time Last Known Well* allows the case to be accepted into the warehouse.

- If the time last known well is documented as a specific time and entered as *Time Last Known Well* on a “Code Stroke” form or stroke-specific electronic template, enter that time as the time last known well. Documentation of *Time Last Known Well* on a stroke-specific form or template should be selected regardless of other times last known well documented elsewhere in the medical record.
- If the time last known well is documented as being a specific number of hours prior to arrival (e.g., felt left side go numb 2 hours ago) rather than a specific time, subtract that number from the time of ED arrival and enter that time as the time last known well.
- If the time last known well is noted to be a range of time prior to ED arrival (e.g., felt left side go numb 2-3 hours ago), assume the maximum time from the range (e.g., 3 hours), and subtract that number of hours from the time of arrival to compute the time last known well.
- If both the time last known well and the time of symptom onset are documented, select the *Time Last Known Well*.

**Examples:**

- H&P states, “Patient watching TV with family and complained of blurred vision in both eyes at 8:30 PM.” ED MD notes, “Patient normal at 8:30 PM.” *Time Last Known Well* is 2030.
- “Patient was doing well at 4:30 PM – noticed difficulty speaking around 6 PM.” *Time Last Known Well* is 1630.
- Patient normal at 2200 before going to bed. Awoke at 0200 with headache and took two aspirin before returning to sleep. OK at 0700 and went to work. Felt confused, unable to speak without slurring at 0800. *Time Last Known Well* is 0700.

- If the only time documented is time of symptom onset without mention of when the patient was last known well, use the time of symptom onset for time last known well. Example:

- If there are multiple times of last known well documented in the absence of the *Time Last Known Well* explicitly documented on a “Code Stroke” form, use physician documentation first before other sources, e.g., nursing, EMS. Example:
  “Patient last seen normal this morning at 1000” per H&P. ED nurse documented 09:50 as time last well. *Time Last Known Well* is 1000.

- If multiple times last known well are documented by different physicians or by the same provider, use the earliest time documented.
- If there is documentation of one or more episodes of stroke symptoms AND documentation of symptom resolution between episodes, use the time of the most recent (last) episode prior to arrival, regardless if all symptoms resolved prior to arrival.
Examples:
  o  “Patient reported right hand paresthesia two days ago that resolved spontaneously after a few minutes. New onset of symptoms today around 0700 involving right arm and right leg.” *Time Last Known Well* is 0700.
  o  “Wife states that he was having trouble with slurred speech and confusion yesterday. Symptom free this morning. Return of symptoms with facial droop noted around noon.” *Time Last Known Well* is 1200.
  o  “Wife noticed slurred speech at 8:30 last night. Without symptoms early this morning. Wife noticed slurred speech again at 0900 during breakfast conversation.” *Time Last Known Well* is 0900.
  o  “Wife noticed slurred speech at 8:30 last night. Symptom-free this morning. Came to ED to get checked out.” *Time Last Known Well* is 2030.

Suggested Data Sources
Add new bullet:
•  Code Stroke form/template

Inclusion Guidelines for Abstraction
Change to:
Signs and Symptoms of Stroke
•  Sudden numbness or weakness of the face, arm or leg, especially on one side of the body
•  Sudden confusion, trouble speaking or understanding
•  Sudden trouble seeing in one or both eyes
•  Sudden trouble walking, dizziness, loss of balance or coordination
•  Sudden severe headache

Impacts:
*Tobacco Use Status*

Rationale:  This change is to make the language consistent throughout the measure set.

Description of Changes:
Notes for Abstraction
Change the 1st bullet to:
•  If there is definitive documentation that the patient either currently uses tobacco products or is an ex-user that quit less than 30 days prior to admission, select the appropriate allowable value for the type of product used, *regardless of whether or not there is conflicting documentation.*

Impacts:
*Tobacco Use Status*

Rationale:  The current measure specifications exclude patients with cognitive impairment from all of the TOB and SUB measures, if there is documentation of cognitive impairment for the entire hospitalization. Since the alcohol use screen and/or tobacco use screen must be completed within 3 days after admission, cognitive impairment will now be evaluated in the *Alcohol Use Status* and *Tobacco Use Status* data elements, and the data element Cognitive Impairment will be removed from all of the TOB and SUB measures.
Description of Changes:

Format
Change ‘Length’ from 2 to:
1

Allowable Values
Add new value:
6 The patient was not screened for tobacco use during the first three days of admission because of cognitive impairment.

Notes for Abstraction
Change first bullet to:
- If there is definitive documentation that the patient either currently uses tobacco products or is an ex-user that quit less than 30 days prior to admission, select the appropriate allowable value for the type of product used, regardless of whether or not there is conflicting documentation.

Add new bullets and examples:
- Cognition refers to mental activities associated with thinking, learning, and memory. Cognitive impairment for the purposes of this measure set is related to documentation that the patient cannot be screened for tobacco use due to the impairment (e.g., comatose, obtunded, confused, memory loss) during the entire first three days of hospitalization.
- Cognitive impairment must be documented at all times during the first three days of the hospitalization in order to select value “6.” If there is documentation in the medical record that a patient’s mental status was normal at any other time during the first three days of the hospitalization, i.e., alert and oriented, the abstractor can select value “6.”
- If there is documentation that the patient has temporary cognitive impairment due to acute substance use (e.g., overdose or acute intoxication) value “6” cannot be selected. Examples of cognitive impairment include:
  o Altered Level of Consciousness (LOC)
  o Altered Mental Status
  o Cognitive impairment
  o Cognitively impaired
  o Confused
  o Memory loss
  o Mentally retarded
  o Obtunded

Impacts:
Tobacco Use Treatment FDA - Approved Cessation Medication

Rationale: This change is to make the language consistent throughout the measure set.

Description of Changes:
Exclusion Guidelines for Abstraction:
Change 2nd bullet to:
• Light smokers (4 or less cigarettes per day)
Impacts:
Transfer From Another Hospital or ASC

Rationale: The PN-3a and PN-3b measures are being removed at the direction of CMS and based on the IPPS Fiscal Year 2014 Final Rule.

Description of Changes:
Collected For
Remove under ‘The Joint Commission Only’: PN-3a

Remove under ‘CMS Voluntary Only’: PN-3a

Impacts:
Urinary Catheter

Rationale: This change is to provide additional abstraction instructions.

Description of Changes:
Notes for Abstraction
Add seventh bullet:
• If a urinary catheter is used to monitor intra-abdominal pressure on POD 0, 1, or 2, select value “No.”

Impacts:
Vancomycin

Rationale: Documentation is being added to define the preoperative period for the data element.

Description of Changes:
Notes for Abstraction
Change second bullet:
• Physician/APN/PA, pharmacist or infection control practitioner documentation of the reason for the use of vancomycin as prophylaxis must have been entered into the medical record prior to the incision time to select values “5,” “6,” “8,” and “10.” If the documentation was not entered prior to the incision time, select value “9”- No documented reason/Unable to Determine.

Impacts:
VTE Confirmed

Rationale: The Technical Advisory Panel reviewed clinical scenarios presented and determined that a timeframe was needed for documentation to be acceptable for these data elements. An additional data element was added to further define reasons for not providing prophylaxis to records in VTE-6 Hospital Acquired VTE.

Description of Changes:
Definition
Change to:
Documentation by a physician/APN/PA that a diagnosis of VTE [deep vein thrombosis (DVT) and/or pulmonary embolism (PE)] was confirmed in a defined location within four days prior to arrival, or anytime during the hospitalization.

**Suggested Data Collection Question**

**Change to:**
Is there physician/APN/PA documentation that the patient had a *VTE Diagnostic Test* and a VTE was confirmed in one of the defined locations within four days prior to arrival, or anytime during the hospitalization?

**Allowable Values**

**Change from:**

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y (Yes)</td>
<td>There is documentation that the patient had a diagnosis of VTE confirmed in one of the defined locations.</td>
</tr>
<tr>
<td>N (No)</td>
<td>There is no documentation that the patient had a diagnosis of VTE confirmed in one of the defined locations or unable to determine from medical record documentation.</td>
</tr>
</tbody>
</table>

**To:**

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y (Yes)</td>
<td>There is physician/APN/PA documentation that the patient had a <em>VTE Diagnostic Test</em> and VTE was confirmed in one of the defined locations within four days prior to arrival or anytime during the hospitalization.</td>
</tr>
<tr>
<td>N (No)</td>
<td>There is no physician/APN/PA documentation that the patient had a <em>VTE Diagnostic Test</em> and VTE was confirmed in one of the defined locations within four days of arrival or anytime during the hospitalization, or unable to determine from medical record documentation.</td>
</tr>
</tbody>
</table>

**Notes for Abstraction**

**Change to:**

- This data element includes patients who had an acceptable *VTE Diagnostic Test* and are confirmed to have an acute VTE by a physician/APN/PA within four days prior to arrival or anytime during the hospitalization. Refer to the data element *VTE Diagnostic Test* for a list of acceptable tests.

Examples:

- Physician/APN/PA documentation states that PE was confirmed with a VQ scan on arrival in the emergency department, select “Yes.”

- Physician/APN/PA documentation states that the patient may have arrived without prior DVT confirmation, but after arrival, there is documentation based on a venous Doppler that the patient developed an acute DVT.

- Physician/APN/PA documentation states that the patient had an acceptable *VTE Diagnostic Test* which confirmed the development of the VTE anytime during the hospital stay.

- If a patient had a new or acute VTE confirmed in one of the defined locations by an acceptable *VTE Diagnostic Test* within four days prior to arrival or anytime during the hospitalization, select “Yes.”

Examples:
Patient arrives as a direct admission on 01/03/20XX with documentation of a pulmonary emboli confirmed in the right upper lobe by VQ scan, dated 01/01/20XX from an outside facility, select “Yes.”

Patient arrives to the emergency department on 01/03/20XX with outside documentation of a DVT in the right femoral vein and no date is noted, select “No.”

Patient arrives to the emergency department on 05/01/20XX and past medical history reveals a DVT confirmed in the right superficial distal vein from 1/01/20XX, greater than four calendar days prior to arrival, select “No.”

- If the patient was transferred from another acute care hospital with a VTE, and there is no documentation indicating the VTE location, select “No.”

- Recurrent, chronic, sub-acute, or history of VTE is acceptable ONLY if there is documentation of an acute or new VTE.

  Example:
  If a patient had a history of lower extremity DVT, but vascular ultrasound found a new DVT in the proximal vein of the right lower extremity, select “Yes.”

- If more than one acceptable VTE Diagnostic Test was performed, review the chart for the earliest acceptable VTE Diagnostic Test that confirmed the VTE in one of the defined locations.

  Example:
  Patient had CT of chest with contrast in the emergency department on arrival on 02/01/20XX for shortness of breath, no PE confirmed. The patient was admitted, then on 02/03/20XX patient had venous ultrasound with confirmed proximal left lower extremity DVT. Select “Yes.”

- For patients with “low probability” or “inconclusive test results” on any of the acceptable VTE Diagnostic Tests, select “No.”

- For patients with a nuclear medicine VQ scan to rule-out PE; if the result was documented as “high probability,” select “Yes.” For all other impressions (e.g., “low probability,” “intermediate,” “intermediate to high probability” or “inconclusive test results”), select “No.”

- If there is questionable physician/APN/PA documentation regarding whether the patient had VTE, select “Yes.”

  Example:
  If the radiologist interpretation of the exam did not confirm DVT, but there is documentation of a DVT in physician’s progress notes, select “Yes.”

- If the record indicates ONLY a radiology report, and that report is questionable regarding whether the patient had a VTE, select “No.”

  Examples:
  - If the radiology report of a CTA indicates, “possible” or “suggestive of” common femoral clot, select “No”.
  - If the radiology report of an angiogram indicates, distal vein clot that may extend into the greater saphenous vein, select “No.”

**Documentation in sources other than radiology reports:**

- The physician/APN/PA documentation must reflect the time frame within four calendar days prior to arrival or anytime during hospitalization.

- The physician/APN/PA documentation must indicate the clinician’s confirmation of an acute VTE.
Example:

Physician Notes: Venous Doppler on day of admission positive for DVT left popliteal vein clot, select “Yes.”

**Inclusion Guidelines for Abstraction**

**VTE Location**

**Change to:**

*VTE Confirmed* is defined as:

- DVT located in the proximal leg veins, including superficial femoral vein
- DVT located in the inferior vena cava (IVC)
- DVT located in the iliac, femoral or popliteal veins
- Pulmonary Emboli (PE)

**Exclusion Guidelines for Abstraction**

**Change first and second bullet:**

- Confirmed sites of venous thrombosis without a proximal leg DVT or PE also involved.
- History of VTE greater than four days prior to arrival, without documentation of a new/acute event.

**Impacts:**

**VTE Diagnostic Test**

**Rationale:** The Technical Advisory Panel reviewed clinical scenarios presented and determined that a timeframe was needed for documentation to be acceptable for these data elements. An additional data element was added to further define reasons for not providing prophylaxis to records in VTE-6 Hospital Acquired VTE.

**Description of Changes:**

**Definition**

**Change to:**

Documentation that a diagnostic test was performed within four days prior to arrival or anytime during the hospitalization.

**Suggested Data Collection Question**

**Change to:**

Is there documentation that a diagnostic test was performed within four days prior to arrival or anytime during the hospitalization?

**Allowable Values**

**Change from:**

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y (Yes)</td>
<td>There is documentation that a diagnostic test for VTE was performed.</td>
</tr>
<tr>
<td>N (No)</td>
<td>There is no documentation that a diagnostic test for VTE was performed or unable to determine from medical record documentation.</td>
</tr>
</tbody>
</table>

**To:**

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y (Yes)</td>
<td>There is documentation that a diagnostic test was performed within four days prior to arrival or anytime during the hospitalization.</td>
</tr>
</tbody>
</table>
N (No) There is no documentation that a diagnostic test was performed **within four days prior to arrival**, or anytime during the hospitalization, or unable to determine from medical record documentation.

**Notes for Abstraction**

**Change to:**

- This data element includes patients who had one of the acceptable diagnostic tests performed **within four days prior to arrival** or anytime during hospitalization.

**Examples:**

- Patient arrives on 01/01/20XX and documentation indicates a CT of chest with contrast was performed on arrival, earlier that same day.
- Patient arrived on 01/01/20XX and documentation indicates that the patient was admitted on 01/02/20XX. A VQ scan was performed on 01/02/20XX.
- Patient transferred on 01/05/20XX with documentation from a transferring hospital indicating vascular ultrasound was performed on 01/02/20XX."

- If a diagnostic test was performed that is not on the inclusion list, select “No.”

**Example:**

Physician notes indicate a 2D Echo was done that confirmed a PE, select “No.”

**Documentation in sources other than radiology reports:**

- Documentation other than radiology reports must confirm one of the acceptable tests was performed.

**Examples:**

- Physician Notes: Venous doppler positive for DVT left popliteal, select “Yes.”
- Emergency Notes: Patient to CT without contrast, select “No.”

- The physician/APN//PA documentation must reflect the time frame within four calendar days prior to arrival or anytime during hospitalization.

**Suggested Data Sources**

**Remove:**

- Nursing Notes

**Inclusion Guidelines for Abstraction**

**Change to:**

- Compression Ultrasound of lower extremities
- Vascular Ultrasound of lower extremities
- Duplex Ultrasound (DUS) of lower extremities
- Venous Doppler of lower extremities
- Computed tomography (CT) of thorax (chest) with contrast
- Computed tomography (CT) of the abdomen with contrast
- Computed tomography (CT) of the pelvis with contrast
- Computed tomography (CT) of the lower extremity leg veins with contrast
- Magnetic resonance imaging (MRI or MRV) of the thorax (chest)
- Magnetic resonance imaging (MRI or MRV) of the abdomen
- Magnetic resonance imaging (MRI or MRV) of the pelvis
- Magnetic resonance imaging (MRI or MRV) of the lower extremity leg veins
- Nuclear Medicine Pulmonary Scan/ventilation/perfusion (V/Q) lung scan
• Pulmonary arteriography/angiography/angiogram
• Venography/Venogram of pelvis using contrast material
• Venography/Venogram of femoral using contrast material
• Venography/Venogram of other lower extremity veins using contrast material

Exclusion Guidelines for Abstraction
Add bullet:
• Patients with a diagnostic test performed greater than four days prior to arrival.

Impacts:
VTE Present at Admission

Rationale: The Technical Advisory Panel reviewed clinical scenarios presented and determined that a timeframe was needed for documentation to be acceptable for these data elements. An additional data element was added to further define reasons for not providing prophylaxis to records in VTE-6 Hospital Acquired VTE.

Description of Changes:
Definition Change to:
Documentation by a physician/APN/PA that VTE was diagnosed or suspected on arrival to the day after admission.

Suggested Data Collection Question Change to:
Was there any documentation by the physician/APN/PA that VTE was diagnosed or suspected on arrival to the day after admission?

Allowable Values Change from:
Y (Yes) There is documentation by the physician/APN/PA that VTE was diagnosed or suspected on admission.
N (No) There is no documentation by the physician/APN/PA that VTE was diagnosed or suspected on admission or unable to determine from medical record documentation.

To:
Y (Yes) There is documentation by the physician/APN/PA that VTE was diagnosed or suspected on arrival to the day after admission.
N (No) There is no documentation by the physician/APN/PA that VTE was diagnosed or suspected on arrival or the day after admission, or unable to determine from medical record documentation.
Notes for Abstraction

Change to:

- The time frame for this data element includes any documentation of VTE confirmed or suspected from arrival to the day after admission. Documentation of a VTE Diagnostic Test, diagnosis or suspicion of VTE is acceptable.
  
  Example:
  
  A patient arrived on 10/1/20xx with shortness of breath. On 10/2/20XX, there is documentation that a pulmonary emboli (PE) was suspected, select “Yes.”

- If documentation is questionable regarding whether VTE was present or suspected at admission, select “Yes.”

- For patients with only a history of VTE documented, select “No.”

- If the patient was admitted and had surgery on day of or day after hospital admission or ICU admission and there was no documentation of diagnosed/suspected VTE prior to surgery, the VTE is not considered present on admission. Select “No.”

Inclusion Guidelines for Abstraction

Change to:

None

Impacts:

VTE Prophylaxis

Rationale: The need for clarification of documentation that is acceptable for these data elements was identified through review of clinical scenarios by the Technical Advisory Panel.

Description of Changes:

Notes for Abstraction

ALL

Change example to:

Lovenox is ordered and substituted with dalteparin. Only abstract value "2" once, as both are LMWH.

VTE

Change to:

Abstract ALL VTE prophylaxis(s) that was administered the day of or the day after hospital admission or the day of or the day after Surgery End Date for surgeries that start the day of or the day after hospital admission. If no VTE prophylaxis was administered during this timeframe, select “A.”

STK

Change to:

Abstract ALL VTE prophylaxis(s) that was administered the day of or the day after hospital admission. If no VTE prophylaxis was administered during this timeframe, select “A.”

VTE or STK

Change first bullet to:

- Selection of allowable values 1-9 includes any prophylaxis that was administered in the allowable time frame.
  Example:
If a patient was admitted on 12/8/20xx and had bilateral GCS applied at 13:00 on 12/09/20xx and LMWH was administered at 22:00 on 12/8/20xx, select values “2” and “4.”

**Change** example in third bullet to:
Lovenox is ordered, but not received and is substituted with fondaparinux sodium, which is received by the patient. Abstract fondaparinux sodium as value “5” for VTE Prophylaxis and abstract the date it was administered for VTE Prophylaxis Date.

**Remove** fourth bullet:
- Aspirin is not an approved medication for prophylaxis in the VTE and STK population. If aspirin is the only source of prophylaxis found in the record, select “A,” and check for a Reason for No VTE Prophylaxis.

**Impacts:**

**VTE Prophylaxis Date**

**Rationale:** The need for clarification of documentation that is acceptable for these data elements was identified through review of clinical scenarios by the Technical Advisory Panel.

**Description of Changes:**

**Definition**

**Remove** the words “the initial”

**Suggested Data Collection Question**

**Remove** the word “initial”

**Notes for Abstraction**

**Add:**

**STK**

The earliest date associated with a form of prophylaxis other than GCS or aspirin should be entered.

**Example:**

If the patient was admitted on 12/8/20xx and bilateral GCS was applied at 13:00 on 12/8/20xx and LMWH was administered at 02:00 on 12/9/20xx, record the 12/9/20xx date.

**VTE**

The earliest date associated with a form of prophylaxis other than aspirin should be used entered.

**Example:**

If the patient was admitted on 12/8/20xx and aspirin was administered at 13:00 on 12/8/20xx and LMWH was administered at 02:00 on 12/9/20xx, record the 12/9/20xx date.

**Suggested Data Sources**

**Change** to:

- Circulator’s notes
- Graphic/flow sheets
- Medication administration record
Impacts:
VTE Prophylaxis Status

Rationale: The Technical Advisory Panel reviewed clinical scenarios presented and determined that a timeframe was needed for documentation to be acceptable for these data elements. An additional data element was added to further define reasons for not providing prophylaxis to records in VTE 6 Hospital Acquired VTE.

Description of Changes:
Definition Change to:
Documentation of VTE prophylaxis (mechanical or pharmacologic) administration between the hospital admission date and VTE Diagnostic Test order date.

Suggested Data Collection Question Change to:
Was VTE prophylaxis administered between the admission date and the VTE Diagnostic Test order date?

Allowable Values Change from:
1. There is documentation that VTE prophylaxis was administered between the day of admission and the day before the VTE diagnostic test order date.
2. There is no documentation that VTE prophylaxis was administered between the day of admission and the day before the VTE diagnostic test order date or unable to determine from medical record documentation.
3. There is physician/advanced practice nurse/physician assistant (physician/APN/PA) or pharmacist documentation of a reason for not administering mechanical and pharmacological VTE prophylaxis during hospitalization.

To:
Y (Yes) There is documentation that VTE prophylaxis was administered between the day of admission and the VTE Diagnostic Test order date.
N (No) There is no documentation that VTE prophylaxis was administered between the day of admission and the VTE Diagnostic Test order date or unable to determine from medical record documentation.

Notes for Abstraction Change to:
• To determine the value for this data element, the abstractor must determine the admission date and review the chart to ascertain if VTE prophylaxis was administered
before the *VTE Diagnostic Test* order date. Refer to the data element *VTE Diagnostic Test* for a list of acceptable tests. If any VTE prophylaxis was administered within the specified timeframe above, select “Yes.”

- If more than one acceptable *VTE Diagnostic Test* was ordered to rule out VTE and both confirmed VTE, select the earliest diagnostic test ordered that confirmed VTE to determine if the patient received VTE prophylaxis.
  
  **Example:**
  
  Patient was admitted on 11/1/20XX. A venous doppler of lower extremities was ordered 11/4/20xx and confirmed a DVT of the right lower extremity. In addition, a CT scan with contrast was ordered on 11/5/20xx and confirmed a PE. Determine if any prophylaxis was administered any time between the hospital admission date of 11/1/20XX and 11/4/20xx. If no prophylaxis was given, select “No.”

- If the *VTE Diagnostic Test* was ordered the day of or the day after the admission date, select “Yes.”

- If the record contains questionable information regarding the administration of VTE prophylaxis prior to the *VTE Diagnostic Test* was ordered, select “No.”

- Application of mechanical prophylaxis may be documented by any personnel.
  
  **Example:**
  
  Nursing assistant documentation of IPC application during the allowable timeframe is acceptable.

- Evaluate prophylaxis with documentation of administration only.
  
  **Example:**
  
  The only documentation of prophylaxis is in the physician progress notes under assessment/Plan: “DVT prophylaxis – IPC,” select “No” because there is no documentation of administration.

- If one pharmacological medication is ordered and another medication is substituted (such as per pharmacy formulary substitution or protocol), select “Yes” if the substitution medication was administered.
  
  **Note:** No copy of the formulary or protocol is required in the medical record.
  
  **Example:**
  
  Lovenox is ordered but not administered, and is substituted with Arixtra, which is administered. Select “Yes.”

- Aspirin is not an approved medication for prophylaxis in the VTE population. If aspirin is the only form of prophylaxis documented in the record, select “No.”

**Suggested Data Sources**

**Change to:**

- Circulator notes
- Emergency department record
- Graphic/flow sheets
- Medication administration record
- Nursing notes
- Operative notes
- Physician notes
- Preoperative nursing notes
- Progress notes
- Radiology reports
Remove:
Allowable Values 1 or 2:
• Consultation notes
• Discharge summary
• Emergency department record
• Medication administration record
• Nursing notes
• Progress notes

Allowable Value 3:
ONLY PHYSICIAN/APN/PA OR PHARMACIST DOCUMENTATION OF A REASON FOR NOT ADMINISTERING BOTH MECHANICAL AND PHARMACOLOGIC VTE PROPHYLAXIS
• Anesthesia record
• Consultation notes
• Discharge summary
• History and physical
• Physician orders
• Physician progress notes

SUGGESTED DATA SOURCES FOR PATIENT REFUSAL (other than physician/APN/PA or pharmacist documentation of a reason for not administering any type of VTE prophylaxis as above):
• Medication administration record
• Nurses notes

Inclusion Guidelines for Abstraction
Change to:
A list of the ONLY acceptable diagnostic tests is found in the data element VTE Diagnostic Test.

Exclusion Guidelines for Abstraction
Change to:
None

Impacts:
Warfarin Administration

Rationale: Clinical scenarios presented to the Technical Advisory Panel (TAP) justified the need for defined time frames, and the need for examples and clarifications to capture acceptable documentation for these data elements.

Description of Changes:
Definition
Change to:
Documentation that warfarin was administered any time after the VTE Diagnostic Test.
Suggested Data Collection Question

Change to:
Was warfarin administered any time after the VTE Diagnostic Test?

Allowable Values

Change from:
Y (Yes) There is documentation that warfarin was administered during hospitalization.
N (No) There is no documentation that warfarin was administered during hospitalization or unable to determine from the medical record documentation.

To:
Y (Yes) There is documentation that warfarin was administered any time after the VTE Diagnostic Test.
N (No) There is no documentation that warfarin was administered any time after the VTE Diagnostic Test, or unable to determine from the medical record documentation.

Notes for Abstraction

Change to:
• To determine the value for this data element, the abstractor must locate the acceptable VTE Diagnostic Test completed, and then review the chart to ascertain if warfarin was administered any time after the test. If warfarin was administered, select “Yes.” Refer to the data element VTE Diagnostic Test for a list of acceptable tests.
• If warfarin was ordered, but not administered, select “No.”
• If VTE was diagnosed prior to admission and warfarin was administered on arrival, select “Yes.”
• If the VTE Diagnostic Test and warfarin administration are on the same day, or any time thereafter select “Yes.”

Exclusion Guidelines for Abstraction

Change to:
Warfarin administered prior to day of arrival.

SECTION 2 – Measurement Information

Impacts:
Algorithms
Measure(s)
CAC-1
CAC-2
ED-1
ED-2
IMM-1
SCIP-Inf-1
SCIP-Inf-2
SCIP-Inf-3
SUB-2
SUB-3
TOB-2
TOB-3

Rationale: This change will provide consistency in algorithm stratification across measure sets.

Description of Changes:
SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3, ED-1, ED-2, CAC-1, CAC-2, SUB-2, SUB-3, TOB-2, TOB-3

Change: Corresponding stratum to X when the overall measure category assignment is X.

IMM-1
Change: Overall measure category assignment X goes directly to Stop and does not go through stratification.

ED-1, ED-2
Remove: UTD Counter and all associated logic.
Remove: Variable Key box.
Remove: Both Note Boxes near the “B” measure category assignment boxes.
Remove: The “B” measure category assignment box after the “X” measure category assignment box.
Add: Overall Rate Category Assignment decision box on Strata page before the ICD-9-CM Principal Diagnosis Code decision box.

Subsection 2.1 – Acute Myocardial Infarction (AMI)

Impacts:
Measure(s)
AMI-2
AMI-10

Rationale: These measures are being removed based on the FY 2014 IPPS Final Rule and at the direction of CMS.

Description of Changes:
ACUTE MYOCARDIAL INFARCTION NATIONAL HOSPITAL INPATIENT QUALITY MEASURES Table
Remove under ‘Set Measure ID #’ column:
AMI-2
AMI-10

Remove under ‘Measure Short Name’ column:
Aspirin Prescribed at Discharge
Statin Prescribed at Discharge

AMI DATA ELEMENT LIST
Remove rows:
Aspirin Prescribed at Discharge
LDL-c Less Than 100 mg/dL
Reason for No Aspirin at Discharge
Reason for Not Prescribing Statin Medication at Discharge
Statin Medication Prescribed at Discharge

Change in the ‘Collected For’ column for Clinical Trial to:
All AMI Measures

Remove in the ‘Collected For’ column for Comfort Measures Only:
AMI-2
AMI-10

Remove in the ‘Collected For’ column for Discharge Disposition:
AMI-2
AMI-10

Remove the following Measure Information Forms in their entirety:
AMI-2: Aspirin Prescribed at Discharge
AMI-10: Statin Prescribed at Discharge

Impacts:
AMI Data Element List

Rationale: This change is to remove the reference to algorithms in general data elements to correct inconsistencies in data elements collected for all records. Measure algorithm information is identified in the XML file layout document.

Description of Changes:
Discharge Date
Remove under ‘Collected For’ column:
(Used in Algorithm for AMI-1)

ICD-9-CM Other Procedure Codes
ICD-9-CM Principal Procedure Code
Remove under ‘Collected For’ column:
(Used in Algorithm for AMI-8, AMI-8a)

Impacts:
Measure(s)
AMI-7

Rationale: The latest ACCF/AHA STEMI clinical guidelines no longer support taking LBBB on the presenting ECG as a criterion for candidacy for acute reperfusion.

Description of Changes:
Description
Change to:
Median time from arrival to administration of fibrinolytic therapy in acute myocardial infarction (AMI) patients with ST-segment elevation on the electrocardiogram (ECG) performed closest to hospital arrival time.

**Continuous Variable Statement**

**Change** to:  
Time (in minutes) from hospital arrival to administration of fibrinolytic therapy in patients with ST-segment elevation on the ECG performed closest to hospital arrival.

**Included Populations**  
**Change** second bullet to:  
- ST-segment elevation on the ECG performed closest to hospital arrival

**Impacts:**  
**Measure(s)**  
AMI-7  
AMI-7a  
AMI-8  
AMI-8a

**Rationale:** The latest ACCF/AHA STEMI clinical guidelines no longer support taking LBBB on the presenting ECG as a criterion for candidacy for acute reperfusion.

**Description of Changes:**  
AMI-7  
AMI-8

**Remove:** “Or LBBB” from the **Continuous Variable Statement**.

AMI-7a  
AMI-8a

**Remove:** “Or LBBB” from the **Denominator statement**.

---

**Impacts:**  
**Measure(s)**  
AMI-7a

**Rationale:** The latest ACCF/AHA STEMI clinical guidelines no longer support taking LBBB on the presenting ECG as a criterion for candidacy for acute reperfusion.

**Description of Changes:**

**Description**  
**Change** to:  
Acute myocardial infarction (AMI) patients with ST-segment elevation on the ECG closest to arrival time receiving fibrinolytic therapy during the hospital stay and having a time from hospital arrival to fibrinolysis of 30 minutes or less.

**Denominator Statement**  
**Change** to:
AMI patients with ST-elevation on ECG who received fibrinolytic therapy.

Included Populations
Change second bullet to:
• ST-segment elevation on the ECG performed closest to hospital arrival

Impacts:
Measure(s)
AMI-7a

Rationale: The Measure analysis section needed to be updated to reflect that this is suggested analysis and not mandatory.

Description of Changes:
Measure Analysis Suggestions
Change to:
The measure rate for fibrinolytic agent received within 30 minutes of hospital arrival may be analyzed in conjunction with the median time to fibrinolysis measure (AMI-7). These measures, used together, can assist in understanding the number of AMI patients that are receiving fibrinolysis within 30 minutes of hospital arrival and can identify the hospital's median time to fibrinolysis and potential opportunities for improvement to increase the rate of patients receiving fibrinolysis in 30 minutes or less.

Impacts:
Measure(s)
AMI-8

Rationale: The latest ACCF/AHA STEMI clinical guidelines no longer support taking LBBB on the presenting ECG as a criterion for candidacy for acute reperfusion.

Description of Changes:
Description
Change to:
Median time from hospital arrival to primary percutaneous coronary intervention (PCI) in acute myocardial infarction (AMI) patients with ST-segment elevation on the electrocardiogram (ECG) performed closest to hospital arrival time.

Continuous Variable Statement
Change to:
Time (in minutes) from hospital arrival to primary PCI in patients with ST-segment elevation on the ECG performed closest to hospital arrival.

Included Populations
Change third bullet to:
• ST-segment elevation on the ECG performed closest to hospital arrival

Impacts:
Measure(s)
AMI-8
AMI-8a
**Rationale:** This change updates the Selected References and Rationale with the latest ACCF/AHA heart failure clinical guidelines.

**Description of Changes:**

Rationale

**Change** reference in third sentence to:
(O’Gara, 2013 and Levine, 2011)

Selected References

**Change** fourth bullet to:

**Impacts:**

**Measure(s)**
AMI-8a

**Rationale:** The Measure analysis section needed to be updated to reflect that this is suggested analysis and not mandatory.

**Description of Changes:**

Measure Analysis Suggestions

**Change** to:
The measure rate for primary PCI received within 90 minutes of hospital arrival may be analyzed in conjunction with the median time to primary PCI measure (AMI-8). These measures, used together, can assist in understanding the number of AMI patients that are receiving primary PCI within 90 minutes of hospital arrival, and can identify the hospital’s median time to primary PCI and potential opportunities for improvement to increase the rate of patients receiving primary PCI in 90 minutes or less.

**Impacts:**

**Measure(s)**
AMI-8a

**Rationale:** The latest ACCF/AHA STEMI clinical guidelines no longer support taking LBBB on the presenting ECG as a criterion for candidacy for acute reperfusion.

**Description of Changes:**

**Description**

**Change** to:
Acute myocardial infarction (AMI) patients with ST-segment elevation on the ECG closest to arrival time receiving primary PCI during the hospital stay with a time from hospital arrival to PCI of 90 minutes or less.

**Denominator Statement**

**Change** to:
AMI patients with ST-elevation on ECG who received primary PCI.
Included Populations
Change third bullet to:
• ST-segment elevation on the ECG performed closest to hospital arrival

Subsection 2.2 – Heart Failure (HF)

Impacts:
HF Data Element List

Rationale: This change is to remove the reference to algorithms in general data elements to correct inconsistencies in data elements collected for all records. Measure algorithm information is identified in the XML file layout document.

Description of Changes:
ICD-9-CM Other Procedure Codes
ICD-9-CM Principal Procedure Code
Remove under ‘Collected For’ column:
(Used in Algorithm for All HF Measures)

Impacts:
Measure(s)
HF-1
HF-3

Rationale: These measures are being removed based on the FY 2014 IPPS Final Rule and at the direction of CMS.

Description of Changes:
HEART FAILURE NATIONAL HOSPITAL INPATIENT QUALITY MEASURES Table
Remove under ‘Set Measure ID #’ column:
HF-1
HF-3

Remove under ‘Measure Short Name’ column:
Discharge Instructions
ACEI or ARB for LVSD

AMI DATA ELEMENT LIST
Remove rows:
ACEI Prescribed at Discharge
ARB Prescribed at Discharge
Discharge Instructions Address Activity
Discharge Instructions Address Diet
Discharge Instructions Address Follow-up
Discharge Instructions Address Medications
Discharge Instructions Address Symptoms Worsening
Discharge Instructions Address Weight Monitoring
LVSD
Reason for No ACEI and No ARB at Discharge

**Change** in the ‘Collected For’ column for Clinical Trial to:
HF-2

**Change** in the ‘Collected For’ column for Comfort Measures Only to:
HF-2

**Change** in the ‘Collected For’ column for Discharge Disposition to:
HF-2

**Remove** the following Measure Information Forms in their entirety:
HF-1: Discharge Instructions
HF-3: ACEI or ARB for LVSD

---

**Impacts:**
Measure(s)
HF-2

**Rationale:** This change updates the Selected References and Rationale with the latest ACCF/AHA heart failure clinical guidelines.

**Description of Changes:**
Rationale
**Change** reference in second sentence to:
(Yancy, 2013 and HFSA, 2010).

**Selected References**
**Remove** second bullet:

**Add** new bullet:

---

**Subsection 2.3 – Pneumonia (PN)**

**Impacts:**
PN Data Element List

**Another Source of Infection**
Antibiotic Administration Date
Antibiotic Administration Route
Antibiotic Administration Time
Antibiotic Allergy
Antibiotic Name
Antibiotic Received
Blood Culture Collected
Discharge Disposition
ICU Admission or Transfer
Initial Blood Culture Collection Date
Initial Blood Culture Collection Time
Reason for alternative Empiric antibiotic Therapy
Transfer from Another Hospital or ASC

**Rationale:** The PN-3a and PN-3b measures are being removed at the direction of CMS and based on the IPPS Fiscal Year 2014 Final Rule.

**Description of Changes:**

*Collect For*

**Change to:**

All PN Measures

**Remove:**

Blood Culture Collected
Discharge Disposition
Initial Blood Culture Collection Date
Initial Blood Culture Collection Time

---

**Impacts:**

PN Data Element List

**Rationale:** This change is to remove the reference to algorithms in general data elements to correct inconsistencies in data elements collected for all records. Measure algorithm information is identified in the XML file layout document.

**Description of Changes:**

Discharge Date
ICD-9-CM Other Diagnosis Codes

**Remove** under ‘Collect For’ column:

(Used in Algorithm for All PN Measures)

---

**Impacts:**

Measure(s)
PN-3a
PN-3b

**Rationale:** The PN-3a and PN-3b measures are being removed at the direction of CMS and based on the IPPS Fiscal Year 2014 Final Rule.

**Description of Changes:**

**Remove** rows in Set Measure ID table:

PN-3a
PN-3b

**Impacts:**
**Measure(s)**
PN-3a
PN-3b

**Rationale:** The PN-3a and PN-3b measures are being removed at the direction of CMS and based on the IPPS Fiscal Year 2014 Final Rule.

**Description of Changes:**
Remove measure information forms in their entirety.

---

**Impacts:**
**Measure(s)**
PN-6
PN-6a
PN-6b

**Rationale:** The Pneumonia Antibiotic Consensus Recommendations tables have been revised to make them more organized and easier to follow.

**Description of Changes:**
Change Pneumonia Antibiotic Consensus Recommendations Table
Review table in the manual document as it has significantly changed.

---

**Subsection 2.4 – Surgical Care Improvement Project (SCIP)**

**Impacts:**
Set Measure ID#

**Rationale:** The Hospital IQR Program Measure, Surgery Patients with Perioperative Temperature Management, was removed in the IPPS Fiscal Year 2014 Final Rule.

**Description of Changes:**
Remove SCIP-Inf-10 row

---

**Impacts:**
SCIP Data Element List
Anesthesia End Date
Anesthesia End Time
Anesthesia Start Date
Anesthesia Start Time

**Rationale:** The Hospital IQR Program Measure, Surgery Patients with Perioperative Temperature Management, was removed in the IPPS Fiscal Year 2014 Final Rule.

**Description of Changes:**
Remove under ‘Collected For’ column:
SCIP-Inf-10
Impacts:
SCIP Data Element List

Rationale: The Hospital IQR Program Measure, Surgery Patients with Perioperative Temperature Management, was removed in the IPPS Fiscal Year 2014 Final Rule.

Description of Changes:
Remove rows:
Anesthesia Type
Intentional Hypothermia
Temperature

Impacts:
SCIP Data Element List

Rationale: This change is to remove the reference to algorithms in general data elements to correct inconsistencies in data elements collected for all records. Measure algorithm information is identified in the XML file layout document.

Description of Changes:
Discharge Date
Remove under ‘Collected For’ column:
(Used in Algorithm for SCIP-Inf-4)

ICD-9-CM Principal Procedure Code
Change to:
All Records

Impacts:
SCIP Initial Patient Population – Stratum Table

Rationale: The Hospital IQR Program Measure, Surgery Patients with Perioperative Temperature Management, was removed in the IPPS Fiscal Year 2014 Final Rule.

Description of Changes:
Change under ‘Measures’ column from:
SCIP-Inf-4, 6, 9, and 10
To:
SCIP-Inf-4, 6, and 9

Impacts:
SCIP Initial Patient Population Algorithm

Rationale: The algorithm is being updated due to the removal of SCIP-Inf-10 from the manual.

Description of Changes:
Add:
Age calculation and all associated logic.

Add a branch to the left of the condition box checking for Principal Procedure code on table 5.08. The new branch would check for any code not on tables 5.01-5.08 and not on 5.25, and if...
true for The Joint Commission only, exits from the Initial Patient Population flow without assigning the case to any stratum, and therefore taking it out of sampling.

**Impacts:**
Algorithms

**Measure(s)**
SCIP-Inf-1
SCIP-Inf-2
SCIP-Inf-3

**Rationale:** This change will provide consistency in algorithm stratification across measure sets.

**Description of Changes:**
**Change:**
Corresponding stratum to X when the overall measure category assignment is X.

**Impacts:**
Algorithms

**Measure(s)**
SCIP-Inf-1
SCIP-Inf-2
SCIP-Inf-3
SCIP-Inf-4
SCIP-Inf-6
SCIP-Inf-9
SCIP-CARD-2
SCIP-VTE-2

**Rationale:** Update the measures due to the removal of SCIPInf-10 from the Manual.

**Description of Changes:**
**Remove:**
Age calculation and all associated logic.

**Impacts:**
SCIP Sample Size Requirements

**Rationale:** Change made to reflect the appropriate measure name for SCIP-Inf-4.

**Description of Changes:**
Sample Size Examples
**Remove** in first sentence:
6 A.M.

**Impacts:**
Measure Information Form and Algorithm
Rationale: The Hospital IQR Program Measure, Surgery Patients with Perioperative Temperature Management, was removed in the IPPS Fiscal Year 2014 Final Rule.

Description of Changes:
Remove:
SCIP-Inf-10 measure information form in its entirety
Subsection 2.6 – Children’s Asthma Care (CAC)

**Impacts:**
CAC Data Element List

**Rationale:** This change is to remove the reference to algorithms in general data elements to correct inconsistencies in data elements collected for all records. Measure algorithm information is identified in the XML file layout document.

**Description of Changes:**
- *Admission Date*
- *Birthdate*
- *ICD-9-CM Principal Diagnosis Code*

**Remove** under ‘Collected For’ column:
(Used in Algorithm for All CAC Measures)

---

**Impacts:**
Measure(s)
- CAC-1
- CAC-2
- CAC-3

**Rationale:** Updating CAC reference to provide current link to source.

**Description of Changes:**
- **Selected References**

**Remove:**

**Add:**

---

**Impacts:**
Algorithms

**Measure(s)**
- CAC-1
- CAC-2

**Rationale:** This change will provide consistency in algorithm stratification across measure sets.

**Description of Changes:**
**Change:**
Corresponding stratum to X when the overall measure category assignment is X.
Subsection 2.7 – Venous Thromboembolism (VTE)

Impacts:
VTE Data Element List

Rationale: This change is to remove the reference to algorithms in general data elements to correct inconsistencies in data elements collected for all records. Measure algorithm information is identified in the XML file layout document.

Description of Changes:

*ICD-9-CM Other Diagnosis Codes*
*ICD-9-CM Principal Diagnosis Code*

**Remove** under ‘Collected For’ column:
(Used in Algorithm for All VTE Measures)

*ICD-9-CM Principal Procedure Code*

**Remove** under ‘Collected For’ column:
(Used in Algorithm for VTE-1, VTE-2)

Impacts:
N/A

Rationale: This change is to provide information on the specified measures that are eligible for voluntary electronic submission for the Hospital IQR Program.

Description of Changes:

**Add** after Set Measure ID # table:
For voluntary electronic submission of the Hospital Inpatient Quality (IQR) Reporting Program specified measures for the Medicare EHR Incentive Program Stage 2, this measure may be electronically submitted using a Quality Reporting Document Architecture (QRDA) Category-I Release 2 formatted file.

For information about the requirements and technical specifications of the QRDA specifications and data submission, see the resources located on QualityNet, [Hospitals-Inpatient], Electronically Specified Clinical Quality Measures (eCQM) Reporting. If you have questions regarding the EHR Incentive Program measures collected for the Hospital IQR Program, please refer to the CMS website. For resource links see Appendix G.

Impacts:
VTE Data Element List

Rationale: The Technical Advisory Panel reviewed clinical scenarios presented and determined that an acceptable documentation needed to be defined for this new data element.

Description of Changes:

**Change** under “VTE Data Element Name” column:
*Reason for Discontinuation of Parenteral Therapy*
To
*Reason for Discontinuation of Parenteral Anticoagulation Therapy*
Add under “VTE Data Element Name” column and “Collected For” column respectively:
Reason for No Administration of VTE Prophylaxis
VTE-6

Impacts:
Measure(s)
VTE-3

Rationale: Clinical scenarios presented to the Technical Advisory Panel (TAP) justified the need for defined time frames, and the need for examples and clarifications to capture acceptable documentation for these data elements.

Description of Changes:
Description
Change Reason for Discontinuation of Parenteral Therapy to:
Reason for Discontinuation of Parenteral Anticoagulation Therapy

Numerator Statement – Data Elements
Change sixth bullet to:
• Reason for Discontinuation of Parenteral Anticoagulation Therapy

Impacts:
Algorithm
Measure(s)
VTE-3

Rationale: A data element name is being changed based on Technical Advisory Panel (TAP) feedback.

Description of Changes:
Change data element name of Reason for Discontinuation of Parenteral Therapy to:
Reason for Discontinuation of Parenteral Anticoagulation Therapy.

Impacts:
Measure(s)
VTE-6

Rationale: The Technical Advisory Panel reviewed clinical scenarios presented and determined that an acceptable documentation needed to be defined for this new data element.

Description of Changes:
Denominator Statement - Data Element
Add bullet:
Reason for No Administration of VTE Prophylaxis
**Rationale:** The Technical Advisory Panel reviewed clinical scenarios presented and determined that an acceptable documentation needed to be defined for this new data element.

**Description of Changes:**

**Change** allowable values of *VTE Prophylaxis Status* to ‘Yes’ and ‘No’.
- If VTE Prophylaxis Status is missing, the case will proceed to a Measure Category Assignment of X.
- If VTE Prophylaxis Status equals Yes, the case will proceed to a Measure Category Assignment of D.
- If VTE Prophylaxis Status equals No, continue processing and proceed to *Reason for No Administration of VTE Prophylaxis*.

**Add** a new branch of *Reason for No Administration of VTE Prophylaxis* when *VTE Prophylaxis Status* equals ‘No’.
- If *Reason for No Administration of VTE Prophylaxis* is missing, the case will proceed to a Measure Category Assignment of X.
- If *Reason for No Administration of VTE Prophylaxis* equals ‘Yes’, the case will proceed to a Measure Category Assignment of B.
- If *Reason for No Administration of VTE Prophylaxis* equals No, the case will proceed to a Measure Category Assignment of E.

**Subsection 2.8 – Stroke (STK)**

**Impacts:**
STK Data Element List

**Rationale:** This change is to remove the reference to algorithms in general data elements to correct inconsistencies in data elements collected for all records. Measure algorithm information is identified in the XML file layout document.

**Description of Changes:**

- **ICD-9-CM Principal Diagnosis Code**
- **Remove** under ‘Collected For’ column:
  (Used in Algorithm for STK-2, STK-3, STK-4, STK-5, STK-6)

**Impacts:**
N/A

**Rationale:** This change is to provide information on the specified measures that are eligible for voluntary electronic submission for the Hospital IQR Program.

**Description of Changes:**

**Add** after Set Measure ID # table:
For voluntary electronic submission of the Hospital Inpatient Quality Reporting (IQR) Program specified measures for the Medicare EHR Incentive Program Stage 2, this measure may be electronically submitted using a Quality Reporting Document Architecture (QRDA) Category-I Release 2 formatted file.
For information about the requirements and technical specifications of the QRDA specifications and data submission, see the resources located on QualityNet, [Hospitals-Inpatient], Electronically Specified Clinical Quality Measures (eCQM) Reporting. If you have questions regarding the EHR Incentive Program measures collected for the Hospital IQR Program, please refer to the CMS website. For resource links see Appendix G.

**Impacts:**
Stroke Data Element List

**Rationale:** This change is to adjust the measure flow logic and add a new data element that will exclude cases who received IV thrombolytic therapy in 3 to 4.5 hours because a reason delayed initiation within 3 hours.

**Description of Changes:**
Add row under ‘Element Name’ and ‘Collected For’ column respectively:
*Reason for Extending the Initiation of IV Thrombolytic*
STK-4

---

**Impacts:**
Measure(s)
STK-4

**Rationale:** This change is to remove the reference table of contraindications and warnings from the measure information to avoid confusion with the inclusion guidelines for abstraction for the data element *Reason for Not Initiating IV Thrombolytic*.

**Description of Changes:**
Rationale
Add in third sentence after Food and Drug Administration:
(FDA)
Add second paragraph:
The European Cooperative Acute Stroke Study (ECASS) III trial indicated that intravenous rtPA can be given safely to, and can improve outcomes for, carefully selected patients treated 3 to 4.5 hours after stroke; however, as the NINDS investigators concluded, the earlier that IV thrombolytic therapy is initiated, the better the patient outcome. Therefore, the target for IV t-PA initiation remains within 3 hours of time last known well. The administration of IV thrombolytic therapy beyond 3 hours of stroke symptom onset has not been FDA approved.

**Denominator Statement**

**Excluded Populations**
Add new bullet:
- Patients with a documented *Reason for Extending the Initiation of IV Thrombolytic*

**Data Elements**
Add new bullet:
- *Reason for Extending the Initiation of IV Thrombolytic*

**Selected References**
Add new reference:

Remove:
Conditions Making the Administration of IV Thrombolytic Therapy Inadvisable

Contraindications:
• CT findings of intracranial hemorrhage, subarachnoid hemorrhage, or major infarct signs
• History of intracranial hemorrhage, brain aneurysm, vascular malformation, or brain tumor
• Internal bleeding (less than 22 days)
• IV or IA t-PA given at a transferring hospital
• No IV access
• Patient/family refusal
• Platelets less than 100,000, PTT greater than 40 sec after heparin use
• PT greater than 15 or INR greater than 1.7, or unknown bleeding diathesis
• Recent intracranial or spinal surgery, head trauma, or stroke (less than 3 months)
• Recent surgery/trauma (less than 15 days)
• Seizure at onset
• Suspicion of subarachnoid hemorrhage
• Systolic blood pressure greater than 185 or diastolic blood pressure greater than 110 mm hg
• Unable to determine eligibility

Remove:
Warnings/Conditions that might lead to increased risk of bleeding or unfavorable outcomes:
• Acute pericarditis
• Advanced age
• Diabetic hemorrhagic retinopathy or other ophthalmic bleeding
• Glucose less than 50 or greater than 400 mg/dl
• Hemostatic defects including those secondary to severe renal or hepatic disease
• Left heart thrombus
• Life expectancy less than 1 year or severe co-morbid illness
• Myocardial infarction (MI) within the past 3 months
• Patient currently receiving oral anticoagulants (e.g. Warfarin sodium, Coumadin)
• Pregnancy
• Rapid improvement
• Septic thrombophlebitis or occluded AV cannula at seriously infected site
• Stroke severity – Too mild
• Stroke severity – Too severe (e.g., NIHSS greater than 22)
• Subacute bacterial endocarditis

Impacts:
Algorithm
Measure(s)
STK-4
**Rationale:** This change is to adjust the measure flow logic and add a new data element that will exclude cases who received IV thrombolytic therapy in 3 to 4.5 hours because a reason delayed initiation within 3 hours.

**Description of Changes:**

**Add** one decision branch of “Timing I”
- When allowable value is "< 0 minute(s)", case proceeds to a Category Assignment 'X'.

**Add** another "Timing II" decision box
- When allowable value is "< 0 minute(s)", case proceeds to a Category Assignment 'X'.
- When allowable value is "≥ 0 and ≤ 270 minute(s)", case will flow down to another "Timing II"
- When allowable value is "> 270 minute(s)", case proceeds to a Category Assignment 'D'.

**Change**
- 2
° Timing II allowable value from:
  - ≥ 0 and ≤ 180
  - To: ≥ 0 and ≤ 180 minute(s)
- 2
° Timing II allowable value from:
  - > 180
  - To: > 180 and ≤ 270 minute(s)

**Add** "Reason for Extending the Initiation of IV Thrombolytic" decision box
- When allowable value is "=N", case proceed to a Category Assignment "D"
- When allowable value is "=Y", case proceed to a Category Assignment "B"
- When allowable value is missing, case proceed to a Category Assignment "X"

**Impacts:**

**Measure(s)**
STK-6

**Rationale:** The wording of "Included Populations" needed to be revised to clearly state which patients are included in the measure population.

**Description of Changes:**

**Included Populations**

**Add** the word "AND" between the first and second bullet

**Change** second bullet to:
- Patients who were on a lipid-lowering medication prior to hospital arrival as defined in Appendix C, Table 1.6, OR

**Change** third bullet to:
- Patients with LDL-c not measured, OR
**Impacts:**

Measure(s)
STK-8

**Rationale:** The change is to revise wording of “Included Populations” to clearly state which patients are included in the measure population.

**Description of Changes:**

Included Populations

Add the word “AND” between the first and second bullet

---

**Subsection 2.9 – Global Initial Patient Population (ED, IMM, TOB, SUB)**

**Impacts:**

Global – Inpatient Population
Initial Patient Population Algorithm

**Rationale:** Changes are being made to remove redundant verbiage and to provide clarification regarding the Global Initial Patient Population flow.

**Description of Changes:**

Global – Inpatient Population

Change first sentence in fifth paragraph to:

For The Joint Commission, hospitals must submit the same case for all applicable measure sets elected by the hospital (i.e., ED, IMM, SUB and TOB) under the Global Initial Patient Population.

Change seventh paragraph to:

For Emergency Department (ED), Immunization (IMM), Substance Use (SUB) and Tobacco Treatment (TOB) Initial Patient Population definitions and algorithms, please refer to the Global Initial Patient Population.

Remove eighth paragraph:

For Emergency Department, Immunization, Substance Use and Tobacco Treatment Initial Patient Population Algorithms please refer to the Global Initial Patient Population Algorithm.

Initial Patient Population Algorithm

Add returning arrows after each measure set's 'Reject Case Flag=No' to come back to the main flow and go to the next global measure set to ensure all the reject flags for applicable measure sets are set to No for any case that satisfies the global IPP condition.

---

**Subsection 2.10 - Emergency Department (ED)**

**Impacts:**

ED Data Element List

**Rationale:** This change is to remove the reference to algorithms in general data elements to correct inconsistencies in data elements collected for all records. Measure algorithm information is identified in the XML file layout document.
Description of Changes:

ICD-9-CM Principal Diagnosis Code

Remove under ‘Collected For’ column:
(Used in Algorithm for ED-1, ED-2)

Impacts:
N/A

Rationale: This change is to provide information on the specified measures that are eligible for voluntary electronic submission for the Hospital IQR Program.

Description of Changes:
Add after Set Measure ID # table:
For voluntary electronic submission of the Hospital Inpatient Quality (IQR) Reporting Program specified measures for the Medicare EHR Incentive Program Stage 2, this measure may be electronically submitted using a Quality Reporting Document Architecture (QRDA) Category-I Release 2 formatted file.

For information about the requirements and technical specifications of the QRDA specifications and data submission, see the resources located on QualityNet, [Hospitals-Inpatient], Electronically Specified Clinical Quality Meaures (eCQM) Reporting. If you have questions regarding the EHR Incentive Program measures collected for the Hospital IQR Program, please refer to the CMS website. For resource links see Appendix G.

Impacts:
Algorithms

Measure(s)
ED-1
ED-2

Rationale: This change will provide consistency in algorithm stratification across measure sets.

Description of Changes:
Change:
Corresponding stratum to X when the overall measure category assignment is X.

Remove: UTD Counter and all associated logic.
Remove: Variable Key box.
Remove: Both Note Boxes near the “B” measure category assignment boxes.
Remove: The “B” measure category assignment box after the “X” measure category assignment box.
Add: Overall Rate Category Assignment decision box on Strata page before the ICD-9-CM Principal Diagnosis Code decision box.
Subsection 2.11.1 - Immunization (IMM)

**Impacts:**
IMM Data Element List

**Rationale:** This change is to remove the reference to algorithms in general data elements to correct inconsistencies in data elements collected for all records. Measure algorithm information is identified in the XML file layout document.

**Description of Changes:**

**ICD-9-CM Other Diagnosis Codes**
**ICD-9-CM Principal Diagnosis Code**
**Remove** under ‘Collected For’ column:
(Used in Algorithm for IMM-1)

**ICD-9-CM Other Procedure Codes**
**ICD-9-CM Principal Procedure Code**
**Remove** under ‘Collected For’ column:
(Used in Algorithm for All IMM Measures)

---

**Impacts:**
Algorithms

**Measure(s)**
IMM-1

**Rationale:** This change will provide consistency in algorithm stratification across measure sets.

**Description of Changes:**

**Change:** Overall measure category assignment X goes directly to Stop and does not go through stratification.

---

Subsection 2.11.2 - Tobacco Treatment (TOB)

**Impacts:**
TOB Data Element Lists

**Rationale:** This change is to remove the reference to algorithms in general data elements to correct inconsistencies in data elements collected for all records. Measure algorithm information is identified in the XML file layout document.

**Description of Changes:**

**ICD-9-CM Other Diagnosis Codes**
**ICD-9-CM Principal Diagnosis Code**
**Remove** under ‘Collected For’ column:
(Used in Algorithm for TOB-2, TOB-3)
Impacts:
Tobacco Use Data Element List

Rationale: The current measure specifications exclude patients with cognitive impairment from all of the TOB and SUB measures, if there is documentation of cognitive impairment for the entire hospitalization. Since the alcohol use screen and/or tobacco use screen must be completed within 3 days after admission, cognitive impairment will now be evaluated in the Alcohol Use Status and Tobacco Use Status data elements, and the data element Cognitive Impairment will be removed from all of the TOB and SUB measures.

Description of Changes:
Remove Cognitive Impairment row

Impacts:
Measure(s)
TOB-1

Rationale: The current measure specifications exclude patients with cognitive impairment from all of the TOB and SUB measures, if there is documentation of cognitive impairment for the entire hospitalization. Since the alcohol use screen and/or tobacco use screen must be completed within 3 days after admission, cognitive impairment will now be evaluated in the Alcohol Use Status and Tobacco Use Status data elements, and the data element Cognitive Impairment will be removed from all of the TOB and SUB measures.

Description of Changes:
Denominator Statement
Data Elements
Remove Cognitive Impairment
Add Tobacco Use Status

Impacts:
Measure(s)
TOB-1
TOB-2
TOB-2a
TOB-3
TOB-3a

Rationale: National Quality Forum (NQF) endorsement was obtained for SUB-1, SUB-2, SUB-2a, SUB-3, SUB-3a, TOB-1, TOB-2, TOB-2a, TOB-3 and TOB-3a.

Description of Changes:
Add at the top of page header:
NQF ENDORSED VOLUNTARY CONSENSUS STANDARDS FOR HOSPITAL CARE

Impacts:
Algorithms

Measure(s)
TOB-1
TOB-2
TOB-3
TOB-4

**Rationale:** This change is to provide clarification for programmers and abstractors.

**Description of Changes:**
- **Remove** *Cognitive Impairment* decision point and logic branches below *Comfort Measures Only* decision point
- **Add** *Tobacco Use Status Allowable Value* (AV) 6
  - Flow to category ‘B’ when AV equals to 6
  - Remain unchanged when AV equals to 1,2,3,4,5

**Impacts:**
- **Algorithms**
- **Measure(s)**
  - TOB-2
  - TOB-3

**Rationale:** This change will provide consistency in algorithm stratification across measure sets.

**Description of Changes:**
**Change:**
Corresponding stratum to X when the overall measure category assignment is X.

**Impacts:**
- **Measure(s)**
  - TOB-2
  - TOB-3
  - TOB-4

**Rationale:** The current measure specifications exclude patients with cognitive impairment from all of the TOB and SUB measures, if there is documentation of cognitive impairment for the entire hospitalization. Since the alcohol use screen and/or tobacco use screen must be completed within 3 days after admission, cognitive impairment will now be evaluated in the *Alcohol Use Status* and *Tobacco Use Status* data elements, and the data element *Cognitive Impairment* will be removed from all of the TOB and SUB measures.

**Description of Changes:**
**Denominator Statement - Data Elements**
- **Remove** *Cognitive Impairment*

**Impacts:**
- **Algorithm**
- **Measure(s)**
  - TOB-3

**Rationale:** This change is to move the first *Prescription for Tobacco Cessation Medication* decision point before category assigned to ‘E’ in the TOB-3 to avoid program dead end in TOB-3a.
**Description of Changes:**

**Add** *Prescription for Tobacco Cessation Medication* point and logic branches below *Referral for Outpatient Tobacco Cessation Counseling* decision point

- If *Prescription for Tobacco Cessation Medication* value is missing, the case flows to category ‘X’ for Overall Rate Category Assignment
- If *Prescription for Tobacco Cessation Medication* equals to 3, the case flows to category ‘B’ for Overall Rate Category Assignment
- If *Prescription for Tobacco Cessation Medication* equals to 1, 2, or 4, the case flows to connector ‘K’

**Remove** *Prescription for Tobacco Cessation Medication* decision point and logic branches below recheck Tobacco Use Status decision point

**Impacts:**
- Algorithms

**Measure(s)**
- TOB-3
- TOB-4

**Rationale:** Change the order of Tobacco Use Status decision point and Discharge Disposition decision point in TOB-3 and TOB-4 to be consistent in the measure set.

**Description of Changes:**

**Change** *Tobacco Use Status* decision point and logic branches below *Comfort Measures Only* decision point.

**Change** *Discharge Disposition* decision point and logic branches below *Tobacco Use Status* decision point.

---

**Subsection 2.11.3 - Substance Use (SUB)**

**Impacts:**
- Substance Use Data Element List

**Rationale:** The current measure specifications exclude patients with cognitive impairment from all of the TOB and SUB measures, if there is documentation of cognitive impairment for the entire hospitalization. Since the alcohol use screen and/or tobacco use screen must be completed within 3 days after admission, cognitive impairment will now be evaluated in the *Alcohol Use Status* and *Tobacco Use Status* data elements, and the data element *Cognitive Impairment* will be removed from all of the TOB and SUB measures.

**Description of Changes:**

*Alcohol Use Status*

**Add** in ‘Collected For’ column:
- SUB-3, SUB-4

**Remove:**
- *Cognitive Impairment* row
Impacts: 
SUB Data Element List

Rationale: This change is to remove the reference to algorithms in general data elements to correct inconsistencies in data elements collected for all records. Measure algorithm information is identified in the XML file layout document.

Description of Changes:
- ICD-9-CM Other Diagnosis Codes
- ICD-9-CM Other Procedure Codes
- ICD-9-CM Principal Diagnosis Code
- ICD-9-CM Principal Procedure Code

Remove under ‘Collected For’ column: (Used in Algorithm for SUB-3, SUB4)

Impacts: 
Denominator Statement

Measure(s)
SUB-1
SUB-2

Rationale: The current measure specifications exclude patients with cognitive impairment from all of the TOB and SUB measures, if there is documentation of cognitive impairment for the entire hospitalization. Since the alcohol use screen and/or tobacco use screen must be completed within 3 days after admission, cognitive impairment will now be evaluated in the *Alcohol Use Status* and *Tobacco Use Status* data elements, and the data element Cognitive Impairment will be removed from all of the TOB and SUB measures.

Description of Changes:
Data Elements
Remove: *Cognitive Impairment*

Impacts: 
Algorithm

Measure(s)
SUB-1
SUB-2

Rationale: This change is to provide clarification for programmers and abstractors.

Description of Changes:
Remove Cognitive Impairment decision point and logic branches below Comfort Measures
Only decision point

Add Alcohol Use Status *Allowable Value* (AV) 7
- Flow to category ‘B’ when AV equals to 7
- Remain unchanged when AV equals to 1,2,3,4,5,6
Impacts: Measure(s)
SUB-1
SUB-2
SUB-2a
SUB-3
SUB-3a

Rationale: National Quality Forum (NQF) endorsement was obtained for SUB-1, SUB-2, SUB-2a, SUB-3, SUB-3a, TOB-1, TOB-2, TOB-2a, TOB-3 and TOB-3a.

Description of Changes:
Add at the top of page header:
NQF ENDORSED VOLUNTARY CONSENSUS STANDARDS FOR HOSPITAL CARE

Impacts: Measure(s)
SUB-1
SUB-3
SUB-4

Rationale: The current measure specifications exclude patients with cognitive impairment from all of the TOB and SUB measures, if there is documentation of cognitive impairment for the entire hospitalization. Since the alcohol use screen and/or tobacco use screen must be completed within 3 days after admission, cognitive impairment will now be evaluated in the Alcohol Use Status and Tobacco Use Status data elements, and the data element Cognitive Impairment will be removed from all of the TOB and SUB measures.

Description of Changes:
Denominator Statement - Data Elements
Add:
Alcohol Use Status

Remove:
Cognitive Impairment

Impacts: Algorithms Measure(s)
SUB-2
SUB-3

Rationale: This change will provide consistency in algorithm stratification across measure sets.

Description of Changes:
Change:
Corresponding stratum to X when the overall measure category assignment is X.
Measure(s)
SUB-3

Rationale: This change is to move the first Prescription for Alcohol or Drug Disorder Medication decision point before category assigned to ‘E’ in SUB-3 to avoid program dead end in SUB-3a.

Description of Changes:
Add Prescription for Alcohol or Drug Disorder Medication decision point and logic branches below Referral for Addictions Treatment decision point
- If Prescription for Alcohol or Drug Disorder Medication value is missing, the case flows to category ‘X’ for Overall Rate Category Assignment
- If Prescription for Alcohol or Drug Disorder Medication equals to 3, the case flows to category ‘B’ for Overall Rate Category Assignment
- If Prescription for Alcohol or Drug Disorder Medication equals to 1, 2, or 4, the case flows to connector ‘K’

Remove Prescription for Alcohol or Drug Disorder Medication decision point and logic branches below recheck Referral for Addictions Treatment decision point

Impacts:
Algorithm

Measure(s)
SUB-3
SUB-4

Rationale: This change is to provide clarification for programmers and abstractors.

Description of Changes:
Remove Cognitive Impairment decision point and logic branches below Comfort Measures Only decision point

Add Alcohol Use Status decision point and logic branches below Comfort Measures Only decision point
- Flow to category ‘B’ when AV equals to 7
- Flow down when AV equals to 1,2,3,4,5,6

SECTION 3 – Missing and Invalid Data
No updates in this section.

SECTION 4 – Population and Sampling Specifications
No updates in this section.
SECTION 9 – Data Transmission

Impacts:
N/A

Rationale: Guidance added related to the transmission and processing of ICD codes for both the QIO Clinical and the Joint Commission’s Data Warehouses.

Description of Changes:
CMS and Joint Commission Guidelines for Submission of Hospital Clinical Data

Change sub-header from:
Principal and Other Diagnosis Codes
To
Principal and Other Diagnosis and Procedure Codes

Add:
• Only valid ICD diagnosis and ICD procedure codes, as per the CMS master code tables, will be accepted into the QIO Clinical Warehouse and Joint Commission's Data Warehouse. Submission of other codes not included on the CMS master code tables will result in cases being rejected from both warehouses.

Impacts:
N/A

Rationale: Changes made to the allowable measure set combinations related to the change in the SCIP Initial Patient Population.

Description of Changes:
CMS and Joint Commission Guidelines for Submission of Hospital Clinical Data

Allowable Measure Set Combination per Episode of Care

Change 1e to:
e. ED, IMM and SCIP for patients age 18 and older

Change 2 to:
2. Joint Commission’s Data Warehouse only
   a. ED, IMM, TOB, SUB and SCIP for patients age 18 and older
   b. HF, ED, IMM, TOB, SUB and SCIP for patients age 18 and older
   c. AMI, ED, IMM, TOB, SUB and SCIP for patients age 18 and older
   d. PN, ED, IMM, TOB, SUB and SCIP for patients age 18 and older
   e. STK, IMM, TOB, SUB and SCIP for patients age 18 and older
   f. ED, IMM, TOB, SUB and CAC for patients age 2 to under the age of 18
   g. ED, IMM, TOB and SUB

Add new bullet under 4:
f. CAC and SCIP

Impacts:
N/A

Rationale: To provide clarification and consistency on how the patient age is calculated.
**Description of Changes:**

**Patient-Level Clinical Data XML File Layout**

**Patient**

*Add* new paragraph:

For algorithms that calculate the patient age, *Admission Date* minus the *Birthdate*, use the month and day portion of admission date and birthdate to yield the most accurate age. The traditional approach of counting months or years by the birthday date or the first day of the next month, when the exact date does not exist in the calendar for the end point, must be used when calculating the patient age. For example, if calculating the age by year, a patient born on March 31st turns one year older on March 31st. A patient born on February 29th in a leap year, has a birthday on February 29th on all leap years, and March 1st in all non-leap years. Or if calculating age by month, if a patient is born on March 31st the patient turns 6 months on October 1st and not on September 30th. Since the 31 date does not exist in September, you would move to the first day of the next month, which would be October 1st, to add one month to the patient age.

---

**Transmission Alphabetical Data Dictionary**

**Impacts:**

*National Provider Identifier (NPI)*

**Rationale:** The verbiage used in data elements collected for all records is being updated.

**Description of Changes:**

*Suggested Data Sources*

*Change* to:

UB-04

---

**Hospital Clinical Data XML File Layout**

**Impacts:** **Hospital Clinical Data – Detail Elements Information**

**Rationale:** The changes are being made to align with the specifications manual alphabetical data dictionary.

**Description of Changes:**

*Remove* the following elements:

- Anesthesia Type
- Aspirin Prescribed at Discharge
- Blood Culture Collected
- Cognitive Impairment
- Discharge Instructions Address Activity
- Discharge Instructions Address Diet
- Discharge Instructions Address Follow-up
- Discharge Instructions Address Medications
- Discharge Instructions Address Symptoms Worsening
- Discharge Instructions Address Weight Monitoring
- Initial Blood Culture Collection Date
Initial Blood Culture Collection Time
Intentional Hypothermia
LDL-c Less Than 100 mg/dL
Reason for No Aspirin at Discharge
Temperature

**Impacts:**
Hospital Clinical Data – Detail Elements Information
ACEI Prescribed at Discharge
ARB Prescribed at Discharge
Reason for No ACEI and No ARB at Discharge
LSVD

**Rationale:** The changes are being made to align with the specifications manual alphabetical data dictionary.

**Description of Changes:**
Remove:
HF-3 from Applicable Measure(s) and Programming Notes columns

**Impacts:**
Hospital Clinical Data – Detail Elements Information
Alcohol Use Status

**Rationale:** The changes are being made to align with the specifications manual alphabetical data dictionary.

**Description of Changes:**
Add new Answer Code and Answer Value:
7 The patient was not screened for alcohol use during the first three days of admission because of cognitive impairment.

**Change** Applicable Measures(s)
From
SUB-1, SUB-2
To
All SUB Measures

**Impacts:**
Hospital Clinical Data – Detail Elements Information
Anesthesia End Date
Anesthesia End Time
Anesthesia Start Time

**Rationale:** The changes are being made to align with the specifications manual alphabetical data dictionary.

**Description of Changes:**
Remove from the Applicable Measure(s) column:
SCIP-Inf-10

Remove from the Programming Notes:
Impacts:
Hospital Clinical Data – Detail Elements Information
Anesthesia Start Date

Rationale: The changes are being made to align with the specifications manual alphabetical data dictionary.

Description of Changes:
Remove from the Programming Notes:
Collected by CMS as Voluntary Only: SCIP-Inf-10
Not Accepted by The Joint Commission: SCIP-Inf-10

Impacts:
Hospital Clinical Data – Detail Elements Information
Antibiotic Administration Date

Rationale: The changes are being made to align with the specifications manual alphabetical data dictionary.

Description of Changes:
Remove from the Applicable Measure(s) column
PN-3b
Remove from the Programming Notes
Collected by CMS as Voluntary Only: PN-3b
Not Accepted by The Joint Commission: PN-3b
CMS Only: Required for transmission of PN-3b

Impacts:
Hospital Clinical Data – Detail Elements Information
Antibiotic Administration Route

Rationale: The changes are being made to align with the specifications manual alphabetical data dictionary.

Description of Changes:
Remove from Programming Notes:
CMS Only: Required for transmission of PN-3b

Impacts:
Hospital Clinical Data – Detail Elements Information
Antibiotic Name

Rationale: The changes are being made to align with the specifications manual alphabetical data dictionary.

Description of Changes:
Remove from the Applicable Measure(s) column
PN-3b
Remove from the Programming Notes
Collected by CMS as Voluntary Only: PN-3a, PN-3b
PN-3a from the Collected by The Joint Commission Only
Not Accepted by The Joint Commission: PN-3b

**Impacts:**
Hospital Clinical Data – Detail Elements Information
Antibiotic Received
Antibiotic Administration Time

**Rationale:** The changes are being made to align with the specifications manual alphabetical data dictionary.

**Description of Changes:**
Remove from the Applicable Measure(s) column:
PN-3b

Remove from the Programming Notes:
Collected by CMS as Voluntary Only: PN-3b
Not Accepted by The Joint Commission: PN-3b

---

Impacts:
Hospital Clinical Data – Detail Elements Information
Arrival Date
Arrival Time
Pneumonia Diagnosis: ED/Direct Admit

**Rationale:** The changes are being made to align with the specifications manual alphabetical data dictionary.

**Description of Changes:**
Remove from the Applicable Measure(s) column:
PN-3a and PN-3b

Remove from the Programming Notes:
PN-3a and PN-3b from the Collected by CMS as Voluntary Only
PN-3a from the Collected by The Joint Commission Only
Not Accepted by The Joint Commission: PN-3b

---

Impacts:
Hospital Clinical Data – Detail Elements Information
Atrial Fibrillation/Flutter

**Rationale:** The changes are being made to align with the specifications manual alphabetical data dictionary.

**Description of Changes:**
Change Suggested Data Collection Question to:
Was there physician/APN/PA documentation of a diagnosis, signed ECG tracing, or a history of **ANY** atrial fibrillation/flutter in the medical record?
Impacts:
Hospital Clinical Data – Detail Elements Information
Chest X-Ray

Rationale: The changes are being made to align with the specifications manual alphabetical data dictionary.

Description of Changes:
Change under the Applicable Measure(s) column:
All PN Measures to PN-6, PN-6a, PN-6b

Remove from the Programming Notes:
Collected by CMS as Voluntary Only: PN-3a, PN-3b
Not Accepted by The Joint Commission: PN-3b

Impacts:
Hospital Clinical Data – Detail Elements Information
Clinical Trial

Rationale: The changes are being made to align with the specifications manual alphabetical data dictionary.

Description of Changes:
Remove from the Programming Notes:
AMI-2, AMI-10, HF-3, and PN-3a from the Collected by The Joint Commission Only
Not Accepted by The Joint Commission: HF-1, PN-3b
AMI-2, AMI-10, HF-1, HF-3, PN-3a and PN-3b from the Collected by CMS as Voluntary Only

Impacts:
Hospital Clinical Data – Detail Elements Information
Comfort Measures Only

Rationale: The changes are being made to align with the specifications manual alphabetical data dictionary.

Description of Changes:
Remove from the Applicable Measure(s) column:
AMI-2 and AMI-10

Change under the Applicable Measures(s) column:
All HF Measures to HF-2

Remove from the Programming Notes:
AMI-2, AMI-10, HF-3, PN-3a from the Collected by The Joint Commission Only
Not Accepted by The Joint Commission: HF-1, PN-3b
AMI-2, AMI-10, HF-1, HF-3, PN-3a and PN-3b from the Collected by CMS as Voluntary Only

Impacts:
Hospital Clinical Data – Detail Elements Information
Date Last Known Well
**Rationale:** The changes are being made to align with the specifications manual alphabetical data dictionary.

**Description of Changes:**
**Change** Suggested Data Collection Question to:
What was the date associated with the time at which the patient was last known to be well or at his or her baseline state of health?

---

**Impacts:**
Hospital Clinical Data – Detail Elements Information
Discharge Disposition

**Rationale:** The changes are being made to align with the specifications manual alphabetical data dictionary.

**Description of Changes:**
**Change** under the Applicable Measure(s) column:
All HF Measures to HF-2

**Remove** from the Programming Notes:
AMI-2, AMI-10 and HF-3 from the Collected by The Joint Commission Only
HF-1 and PN-3b from the Not Accepted by The Joint Commission
AMI-2, AMI-10, HF-1, HF-3, and PN-3b from the Collected by CMS as Voluntary Only

---

**Impacts:**
Hospital Clinical Data – Detail Elements Information
ICD-9-CM Other Diagnosis Codes

**Rationale:** The changes are being made to align with the specifications manual alphabetical data dictionary.

**Description of Changes:**
**Change** Answer Value from ICD-9-CM Diagnosis Code, with or without decimal
To:
Any valid diagnosis code as per the CMS ICD-9-CM master code table ICD-9-CM Full and Abbreviated Code Titles):

**Change** under Applicable Measure(s) Used for IMM-1, All PN Measures, All VTE Measures, Sub-3, SUB-4, TOB-2, TOB-3, TOB-4
To:
Used in the algorithm for IMM-1, All VTE Measures, SUB-2, SUB-3, SUB-4, TOB-2, TOB-3, TOB-4

**Remove** under Programming Notes:
PN-3a from Collected by CMS as Voluntary Only
PN-3a, PN-6a, PN-6b from Collected by The Joint Commission Only
PN-3b from the Not Accepted by the Joint Commission Only

**Add** under Programming Notes:
SUB-2 to the Collected by The Joint Commission Only
Impacts:
Hospital Clinical Data – Detail Elements Information
ICD-9-CM Other Procedure Codes

Rationale: The changes are being made to align with the specifications manual alphabetical data dictionary.

Description of Changes:
Change Answer Value from ICD-9-CM Procedure Code, with or without decimal
To: Any valid procedure code as per the CMS ICD-9-CM master code table ICD-9-CM Full and Abbreviated Code Titles):

Change under Applicable Measure(s) Used for AMI-8, AMI-8a, All HF Measures, All IMM Measures, SUB-3, SUB-4
To: Used in the algorithm for AMI-8, AMI-8a, All IMM Measures, SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-9, SUB-3, SUB-4

Remove under Programming Notes:
HF-3 from Collected by The Joint Commission Only
HF-1 from Not Accepted by The Joint Commission
HF-1 and HF-3 from Collected by CMS as Voluntary Only

Impacts:
Hospital Clinical Data – Detail Elements Information
ICD-9-CM Principal Diagnosis Code

Rationale: The changes are being made to align with the specifications manual alphabetical data dictionary.

Description of Changes:
Change Answer Value from ICD-9-CM Diagnosis Code, with or without decimal
To: Any valid diagnosis code as per the CMS ICD-9-CM master code table ICD-9-CM Full and Abbreviated Code Titles):

Change under Applicable Measure(s) Used for IMM-1, STK-2, STK-3, STK-4, STK-5, STK-6, SUB-3, SUB-4, TOB-2, TOB-3, TOB-4, All VTE Measures, ED-1, ED-2
To: Used in the algorithm for IMM-1 STK-2, STK-3, STK-4, STK-5, STK-6, SUB-2, SUB-3, SUB-4, TOB-2, TOB-3, TOB-4, All VTE Measures, ED-1, ED-2, SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-9, SCIP-Inf-4, SCIP-VTE-2

Remove under Programming Notes:
PN-3a from Collected by CMS as Voluntary Only
PN-3a, PN-6a, PN-6b from Collected by The Joint Commission Only
PN-3b from the Not Accepted by the Joint Commission Only

Add under Programming Notes:
SUB-2 to the Collected by The Joint Commission Only
Impacts:
Hospital Clinical Data – Detail Elements Information
ICD-9-CM Principal Procedure Code

Rationale: The changes are being made to align with the specifications manual alphabetical data dictionary.

Description of Changes:
Change Answer Value from ICD-9-CM Procedure Code, with or without decimal
To:
Any valid procedure code as per the CMS ICD-9-CM master code table ICD-9-CM Full and Abbreviated Code Titles):

Change under Applicable Measure(s) Used in AMI-8, AMI-8a, All HF Measures, All IMM Measures, All SCIP Measures, VTE-1, VTE-2, SUB-3, SUB-4
To:
Used in the algorithm for AMI-8, AMI-8a, All IMM Measures, SCIP-Inf-1, SCIP-Inf-2, SCIP-Inf-3, SCIP-Inf-4, SCIP-Inf-9, SCIP-Card-2, SCIP-VTE-2, VTE-1, VTE-2, SUB-3, SUB-4

Remove under Programming Notes:
HF-3 and SCIP-Inf-6 from Collected by The Joint Commission Only
HF-1 and SCIP-Inf-10 from Not Accepted by The Joint Commission
HF-1, HF-3, SCIP-Inf-6 and SCIP-Inf-10 from Collected by CMS as Voluntary Only

Impacts:
Hospital Clinical Data – Detail Elements Information
ICU Admission or Transfer
Transfer from Another Hospital or ASC

Rationale: The changes are being made to align with the specifications manual alphabetical data dictionary.

Description of Changes:
Remove from the Applicable Measure(s) column
PN-3a

Remove from the Programming Notes
Collected by CMS as Voluntary Only: PN-3a
PN-3a from the Collected by The Joint Commission Only

Impacts:
Hospital Clinical Data – Detail Elements Information
ICU VTE Prophylaxis

Rationale: The changes are being made to align with the specifications manual alphabetical data dictionary.

Description of Changes:
Change the Suggested Data Collection Question to
What type of VTE prophylaxis was administered in the ICU?

Impacts:
Hospital Clinical Data – Detail Elements Information

ICU VTE Prophylaxis Date

**Rationale:** The changes are being made to align with the specifications manual alphabetical data dictionary.

**Description of Changes:**
**Change** Suggested Data Collection Question to:
What date was the VTE prophylaxis administered in the ICU?

**Impacts:**
Hospital Clinical Data – Detail Elements Information
Initial ECG Interpretation

**Rationale:** The changes are being made to align with the specifications manual alphabetical data dictionary.

**Description of Changes:**
**Change** Suggested Data Collection Question to:
Is there documentation of ST-segment elevation on the electrocardiogram (ECG) performed closest to hospital arrival?

**Impacts:**
Hospital Clinical Data – Detail Elements Information
INR Value

**Rationale:** The changes are being made to align with the specifications manual alphabetical data dictionary.

**Description of Changes:**
**Change** Suggested Data Collection Question to:
Was there documentation of an INR value greater than or equal to 2.0 on the day of or the day after the last dose of the parenteral anticoagulation therapy?

**Impacts:**
Hospital Clinical Data – Detail Elements Information
Prescription for Alcohol or Drug Disorder Medication
Prescription for Tobacco Cessation Medication

**Rationale:** The changes are being made to align with the specifications manual alphabetical data dictionary.

**Description of Changes:**
**Change** the following Answer Value to:
3          The patient’s residence is not in the USA.

**Impacts:**
Hospital Clinical Data – Detail Elements Information
Reason for Discontinuation of Parenteral Therapy

**Rationale:** The changes are being made to align with the specifications manual alphabetical data dictionary.
Description of Changes:

**Change** Question from:
Reason for Discontinuation of Parenteral Therapy
To
Reason for Discontinuation of Parenteral Anticoagulation Therapy

**Change** Suggested Data Collection Question to:
Is there a reason for discontinuation of the parenteral anticoagulation therapy, documented by a physician/APN/PA or pharmacist on the same day or the day before the order for the discontinuation?

**Impacts:**
Hospital Clinical Data – Detail Elements Information
Reason for Extending the Initiation of IV Thrombolytic
Reason for No Administration of VTE Prophylaxis

**Rationale:** The changes are being made to align with the specifications manual alphabetical data dictionary.

**Description of Changes:**

Add the following new elements:
Reason for Extending the Initiation of IV Thrombolytic
Reason for No Administration of VTE Prophylaxis

**Impacts:**
Hospital Clinical Data – Detail Elements Information
Reason for No Overlap Therapy

**Rationale:** The changes are being made to align with the specifications manual alphabetical data dictionary.

**Description of Changes:**

**Change** Suggested Data Collection Question to:
Is there physician/APN/PA or pharmacist documentation on the day of or the day after the VTE Diagnostic Test, of a reason why parenteral anticoagulation therapy and warfarin were not administered on the same day?

**Impacts:**
Hospital Clinical Data – Detail Elements Information
Reason for No VTE Prophylaxis – Hospital Admission

**Rationale:** The changes are being made to align with the specifications manual alphabetical data dictionary.

**Description of Changes:**

**Change** Suggested Data Collection Question to:
Is there physician/APN/PA or pharmacist documentation why VTE prophylaxis was not administered at hospital admission?
Impacts:  
Hospital Clinical Data – Detail Elements Information  
Reason for No VTE Prophylaxis – ICU Admission

Rationale:  The changes are being made to align with the specifications manual alphabetical data dictionary.

Description of Changes:  
Change  Suggested Data Collection Question to:  
Is there physician/APN/PA documentation why VTE prophylaxis was not administered at ICU admission or transfer?

Impacts:  
Hospital Clinical Data – Detail Elements Information  
Reason for Not Initiating IV Thrombolytic

Rationale:  The changes are being made to align with the specifications manual alphabetical data dictionary.

Description of Changes:  
Change  Suggested Data Collection Question to:  
Is there documentation on the day of or day after hospital arrival of a reason for not initiating IV thrombolytic?

Impacts:  
Hospital Clinical Data – Detail Elements Information  
Reason for Not Prescribing Statin Medication at Discharge  
Statin Medication Prescribed at Discharge

Rationale:  The changes are being made to align with the specifications manual alphabetical data dictionary.

Description of Changes:  
Remove  AMI-10 from the Applicable Measures(s) column

Remove  from Programming Notes:  
Collected by the Joint Commission Only: AMI-10  
Collected by CMS as Voluntary Only: AMI-10

Impacts:  
Hospital Clinical Data – Detail Elements Information  
Referral for Addictions Treatment

Rationale:  The changes are being made to align with the specifications manual alphabetical data dictionary.

Description of Changes:  
Change  the following Answer Values to:  
1  The referral to addictions treatment was made by the healthcare provider or health care organization at any time prior to discharge.
2 Referral information was given to the patient at discharge but the appointment was not made by the provider or health care organization prior to discharge.
4 The patient’s residence is not in the USA.

Impacts:
Hospital Clinical Data – Detail Elements Information
Referral for Outpatient Tobacco Cessation Counseling

Rationale: The changes are being made to align with the specifications manual alphabetical data dictionary.

Description of Changes:
Change the following Answer Values to:
1 The referral to outpatient tobacco cessation counseling treatment was made by the healthcare provider or the health care organization at any time prior to discharge.
2 Referral information was given to the patient at discharge but the appointment was not made by the provider or health care organization prior to discharge.
4 The patient’s residence is not in the USA.

Impacts:
Hospital Clinical Data – Detail Elements Information
Tobacco Use Status

Rationale: The changes are being made to align with the specifications manual alphabetical data dictionary.

Description of Changes:
Change Field Size from 2 to 1.

Add new Answer Code and Answer Value:
6 The patient was not screened for tobacco use during the first three days of admission because of cognitive impairment.

Impacts:
Hospital Clinical Data – Detail Elements Information
VTE Confirmed

Rationale: The changes are being made to align with the specifications manual alphabetical data dictionary.

Description of Changes:
Change Suggested Data Collection Question to:
Is there physician/APN/PA documentation that the patient had a VTE Diagnostic Test and a VTE was confirmed in one of the defined locations within four days prior to arrival, or anytime during the hospitalization?
VTE Diagnostic Test

**Rationale:** The changes are being made to align with the specifications manual alphabetical data dictionary.

**Description of Changes:**

**Change** Suggested Data Collection Question to:
Is there documentation that a diagnostic test was performed within four days prior to arrival or anytime during the hospitalization?

**Impacts:**

Hospital Clinical Data – Detail Elements Information
VTE Present at Admission

**Rationale:** The changes are being made to align with the specifications manual alphabetical data dictionary.

**Description of Changes:**

**Change** Suggested Data Collection Question to:
Was there any documentation by the physician/APN/PA that VTE was diagnosed or suspected on arrival to the day after admission?

**Impacts:**

Hospital Clinical Data – Detail Elements Information
VTE Prophylaxis Date

**Rationale:** The changes are being made to align with the specifications manual alphabetical data dictionary.

**Description of Changes:**

**Change** Suggested Data Collection Question to:
What date was the VTE prophylaxis administered after hospital admission?

**Impacts:**

Hospital Clinical Data – Detail Elements Information
VTE Prophylaxis Status

**Rationale:** The changes are being made to align with the specifications manual alphabetical data dictionary.

**Description of Changes:**

**Change** Suggested Data Collection Question to:
Was VTE prophylaxis administered between the admission date and the VTE Diagnostic Test order date?

**Change** Answer Code and Answer Values to:
N  No
Y  Yes

**Impacts:**

Hospital Clinical Data – Detail Elements Information
Warfarin Administration
**Rationale:** The changes are being made to align with the specifications manual alphabetical data dictionary.

**Description of Changes:**

**Change** Suggested Data Collection Question to:
Was warfarin administered any time after the VTE Diagnostic Test?

<table>
<thead>
<tr>
<th>Hospital Initial Patient Population Data XML File Layout</th>
</tr>
</thead>
<tbody>
<tr>
<td>No updates in this section.</td>
</tr>
</tbody>
</table>

### SECTION 10 – CMS Outcome Measures (Claims Based)

#### Subsection 10.1 – Introduction Risk Standardized Mortality Measures

**Impacts:**
Introduction

**Rationale:** This change is to provide clarification to the abstractor.

**Description of Changes:**

**Change** third sentence in fourth paragraph to:
Questions and comments about the mortality measures should be directed to cmsmortalitymeasures@yale.edu.

**Remove** fourth sentence in fourth paragraph:
Questions and comments about the COPD measure can be sent to copdmortality@yale.edu, and for the stroke measure, questions and comments can be directed to strokemortality@yale.edu.

#### Subsection 10.2 – Introduction Risk Standardized Readmission and Complication Measures

**Impacts:**
Introduction

**Rationale:** This change is to provide clarification to the abstractor.

**Description of Changes:**

**Change** third sentence in fourth paragraph to:
Questions and comments about the readmission measures should be directed to cmsreadmissionmeasures@yale.edu.

**Remove** fifth sentence in fourth paragraph:
For the COPD measure, questions and comments can be sent to copdreadmission@yale.edu, and for the stroke measure, questions and comments can be sent to strokereadmission@yale.edu.
Subsection 10.3 – Agency for Healthcare Research and Quality (AHRQ) Measures

Impacts:
Agency for Healthcare Research and Quality (AHRQ) Claims-Based Quality Measures (No Hospital Data Submission Required)

Rationale: This change is to correct the link for questions regarding the Agency for Healthcare Research and Quality’s (AHRQ) Patient Safety Indicators (PSIs) contact information.

Description of Changes:
Change third paragraph to:
For questions regarding the technical specifications for the Agency for Healthcare Research and Quality’s (AHRQ) Patient Safety Indicators (PSIs) contact: support@qualityindicators.ahrq.gov or: (888) 512–6090.

Subsection 10.4 – Healthcare Associated Infections (HAI) Measures

No updates in this section.

Subsection 10.5 – CMS Payment Measures

Impacts:
N/A

Rationale: This measure is being included to provide a comprehensive set of specifications for the claims-based measures in the aligned manual.

Description of Changes:
Add new measure:
Medicare Spending Per Beneficiary (MSPB)
Subsection 10.6 – Structural Measures

Impacts:
Inpatient Web-Based Measure

Rationale: This change is to provide information on the specified measures that are eligible for voluntary electronic submission for the Hospital IQR Program.

Description of Changes:
Add after last paragraph:

For voluntary electronic submission of the Hospital Inpatient Quality Reporting (IQR) Program specified measures for the Medicare EHR Incentive Program Stage 2, this measure may be electronically submitted using a Quality Reporting Document Architecture (QRDA) Category-I Release 2 formatted file.

For information about the requirements and technical specifications of the QRDA specifications and data submission, see the resources located on QualityNet, [Hospitals-Inpatient], Electronically Specified Clinical Quality Measures (eCQM) Reporting. If you have questions regarding the EHR Incentive Program measures collected for the Hospital IQR Program, please refer to the CMS website. For resource links see Appendix G.

APPENDICES

Appendix A – ICD-9-CM Code Tables

Impacts:
Table 7.02 Obstetrics

Rationale: Obstetrical tables were reviewed by the Technical Advisory Panel and edits were suggested.

Description of Changes:
Add row:

648.33   DRUG DEPENDENCE-ANTEPART
648.34   DRUG DEPENDENCE-POSTPART

Remove entire row for codes listed below:
675.02
675.12
675.22
675.80
675.81
675.82
675.90
675.91
675.92
676.02
676.04
676.12
Impacts:
Table 12.5 Chronic Obstructive Pulmonary Disease (COPD)

Rationale: The Advisory Committee on Immunization Practices does not specify that individuals diagnosed with emphysematous bleb need to receive the pneumococcal vaccine.

Description of Changes:
Remove row:
492.0  EMPHYSEMATOUS BLEB

Impacts:
Table 13.1 Alcohol Dependence

Rationale: A code is being removed, since it does not identify patients with an alcohol dependence problem. In addition, codes are being added to identify patients with alcohol dependence.

Description of Changes:
Remove row:
570  ACUTE NECROSIS OF LIVER

Add:
303.03  AC ALCOHOL INTOX-REMISS
Impacts:
Table 13.2 Drug Dependence

Rationale: A code is being removed, since it does not identify patients with an alcohol dependence problem.

Description of Changes:
Remove row:
357.6 NEUROPATHY DUE TO DRUGS

Appendix C – Medication Tables

Impacts:
Table 1.2 ACEIs

Rationale: This change is to add a new FDA-approved Angiotensin Converting Enzyme Inhibitor (ACEI) medication.

Description of Changes:
Add:
Epaned

Impacts:
Table 1.6 Lipid-Lowering Medications

Rationale: This change is to add new FDA-approved lipid-lowering medications.

Description of Changes:
Add:
Atorvastatin/ezetimibe
Icosapent-Ethyl
Juxtapid
Kynamro
Liptruzet
Lomitapide
Mipomersen Sodium
Vascepa

Impacts:
Table 6.2 Reliever Medications – CAC
**Release Notes Version 4.4**

**Rationale:** This change is to add new FDA-approved medications for consistency with guidelines.

**Description of Changes:**

**Add** row:
Left column: Auvi-Q
Right column: Epinephrine

**Add** row:
Left column: Combivent Respimat
Right column: Albuterol/Ipratropium

---

**Impacts:**
Table 6.3 Systemic Corticosteroid Medications – CAC

**Rationale:** This change is to add new FDA-approved medications for consistency with guidelines.

**Description of Changes:**

**Add** row:
Left column: AsmalPred
Right column: Prednisolone

**Add** row:
Left column: Baycadron
Right column: Dexamethasone

**Add** row:
Left column: Rayos
Right column: Prednisone

---

**Impacts:**
Table 8.1 Statin Medications

**Rationale:** This change is to add a new FDA-approved statin combination medication.

**Description of Changes:**

**Add:**
Atorvastatin/ezetimibe
Liptruzet

---

**Impacts:**
Table 8.2 Antithrombotic Medications – Stroke
Table 8.3 Anticoagulant Medications - Stroke

**Rationale:** This change is to align Stroke medications with the new Anticoagulation Therapy table in Appendix H.

**Description of Changes:**

**Add:**
Acova
Hirudin
Appendix D – Glossary of Terms

Appendix E – Overview of Measure Information Form and Flowchart Formats

Impacts:
N/A

Rationale: Changes are being made to provide clarification regarding measures for which better quality is associated with a lower score or numerator. Additional clarification is being provided regarding how the measure outcomes are included in the measure numerator and/or denominator for aggregate data.

Description of Changes:
Measure Outcomes (CMS Only)

Change first paragraph for “D” to:
D In Measure Population (Used for Reporting):
For rate-based measures: EOC record is a member of the measure’s population and the intent of the measure was not met. Note: For measures for which better quality is associated with a lower score or numerator, i.e., VTE-6 and PC-01, a measure outcome of “D” means that the appropriate care was provided and the intent of the measure was met. For aggregate data, the EOC record will be included in the measure denominator only.

Change first paragraph for “E” to:
E In Numerator Population:
For rate-based measures: EOC record is a member of the measure’s population and the intent of the measure was met. Note: For measures for which better quality is associated with a lower score or numerator, i.e., VTE-6 and PC-01, a measure outcome of “E” means that the appropriate care was not provided and the intent of the measure was not met. For aggregate data, the EOC record will be included in both the measure numerator and denominator.

Appendix F – Measure Name Crosswalk

No updates in this section.

Appendix G – Resources

Impacts:
N/A

Rationale: This change identifies the resources available on the voluntary electronic submission of the eMeasures for the Hospital Inpatient Quality Reporting Program.

Description of Changes:
CMS Hospital Inpatient Quality Reporting Program

Add second paragraph:
For information on voluntary electronic submission of the Hospital IQR Program specified measures requirements and technical specifications, resources are available at http://www.qualitynet.org/. From the QualityNet web site select “Electronically Specified Clinical Quality Measures (eCQM) Reporting” located under Hospitals-Inpatient. If you have questions regarding the EHR Incentive Program measures collected for the Hospital IQR Program, please refer to the CMS website, http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Stage_2.html or the QualityNet helpdesk.

Appendix H – Miscellaneous Tables

**Impacts:**
Index

**Rationale:** An additional table is being added to assist abstractors with data collection.

**Description of Changes:**

**Change** in row for Table 2.7 under ‘Name column’ from ‘Reserved for Future Use’ to:
Anticoagulation Therapy Table

**Change** under Page column to:
Appendix H-6

**Add** new table:
Table 2.7 Anticoagulation Therapy Table

---

**Impacts:**
Table 2.3 VTE Parenteral Therapy Table

**Rationale:** This change is being made to assist abstractors with data collection.

**Description of Changes:**

**Change** first column header title to:
VTE Parenteral Therapy

**Remove** under “Direct Thrombin Inhibitors”:
- argatroban
- bivalirudin
- lepirudin

**Add** in “Inclusion/Synonyms” column for “Direct Thrombin Inhibitors” row:
- Acova
- Angiomax
- Angiox
- Recombinant Hirudin

Appendix P – Preview Section

**Impacts:**
N/A
**Rationale:** The ICD-9 tables are being replaced with ICD-10 tables in the manual.

**Description of Changes:**

*ICD-10 Code Tables*

**Change to:**
The ICD-9 to ICD-10 crosswalks corresponding to the ICD-10 code tables in this appendix can be found on QualityNet.org via the following link:

https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228773919011