Disease-Specific Care
ADVANCED CERTIFICATION PROGRAM

Acute Stroke Ready Inpatient
PERFORMANCE MEASUREMENT
IMPLEMENTATION GUIDE
January 2018
(With 2018 ICD-10 Code Update posted November 10, 2017)
# Acute Stroke Ready Inpatient (ASR-IP)

## Set Measures

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</tbody>
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## Measure Set Specific Data Elements

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</tr>
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<td>ASR-IP-1,</td>
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</tr>
<tr>
<td>Reason for Extending the Initiation of IV Thrombolytic</td>
<td>ASR-IP-1,</td>
</tr>
<tr>
<td>Reason for Not Administering Antithrombotic Therapy by End of Hospital Day</td>
<td>ASR-IP-2,</td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Reason for Not Initiating IV Thrombolytic</td>
<td>ASR-IP-1,</td>
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<td>ASR-IP-3,</td>
</tr>
<tr>
<td>Time Last Known Well</td>
<td>ASR-IP-1,</td>
</tr>
</tbody>
</table>

**ASR-IP Initial Patient Population**

The population of the ASR-IP measure set is identified using 4 data elements:

- ICD-10-CM Principal Diagnosis Code
- Admission Date
- Birthdate
- Discharge Date

Patients admitted to the hospital for inpatient acute care with an ICD-10-CM Principal Diagnosis Code for ischemic stroke as defined in Appendix A, Table 8.1, a Patient Age (Admission Date minus Birthdate) greater than or equal to 18 years and a Length of Stay (Discharge Date minus Admission Date) less than or equal to 120 days are included in the ASR-IP Initial Patient Population.
Acute Stroke Ready Hospital Inpatient Initial Patient Population Algorithm

Start ASR Inpatient Initial Patient Population Logic sub-routine

Process all cases that have successfully reached the point in the Transmission Data Processing Flow: Clinical which calls this Initial Patient Population Algorithm. Do not process cases that have been rejected before this point in the Transmission Data Processing Flow: Clinical.

ICD-10-AM Principal Diagnosis Code

On Table 8.1

Patient Age (in years) = Inpatient Admission Date minus Birthdate

Use the month and day portion of Inpatient Admission Date and birthdate to yield the most accurate age.

Patient Age on Inpatient Admission Date

< 18 years

Length of Stay (in days) = Discharge Date minus Admission Date

Length of Stay

> 120 days

Patient is in the ASR Inpatient Initial Patient Population

Set IP Initial Patient Population Reject Case Flag = "No"

<= 120 days

Patient is not in the ASR Inpatient Initial Patient Population

Set IP Initial Patient Population Reject Case Flag = "Yes"

Return to Transmission Data Processing Flow: Clinical (Data Transmission section)

Variable Key:

Patient Age

IP Initial Patient Population Reject Case Flag

Length of Stay
Measure Information Form

**Measure Set:** Acute Stroke Ready Inpatient (ASR-IP)

**Set Measure ID:** ASR-IP-1

**Performance Measure Name:** Thrombolytic Therapy: Inpatient Admission

**Description:** Acute ischemic stroke patients who arrive at this hospital within 2 hours of time last known well and for whom IV t-PA was initiated at this hospital within 3 hours of time last known well (i.e., patients admitted for inpatient care following initiation of IV t-PA in the emergency department).

**Rationale:** The administration of thrombolytic agents to carefully screened, eligible patients with acute ischemic stroke has been shown to be beneficial in several clinical trials. These included two positive randomized controlled trials in the United States: The National Institute of Neurological Disorders and Stroke (NINDS) Studies, Part I and Part II. Based on the results of these studies, the Food and Drug Administration (FDA) approved the use of intravenous recombinant tissue plasminogen activator (IV r-TPA or t-PA) for the treatment of acute ischemic stroke when given within 3 hours of stroke symptom onset. A large meta-analysis controlling for factors associated with stroke outcome confirmed the benefit of IV t-PA in patients treated within 3 hours of symptom onset. Physicians with experience and skill in stroke management and the interpretation of CT scans should supervise treatment.

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.

Although the benefit of t-PA has been well established, only a minority of patients with acute ischemic stroke actually receive this medication across the United States. Recent recommendations from the American Heart Association/American Stroke Association and FDA remove or make less specific many previous contraindications and warnings for therapy.

**Type of Measure:** Process

**Improvement Noted As:** Increase in the rate

**Numerator Statement:** Acute ischemic stroke patients for whom IV thrombolytic therapy was initiated at this hospital within 3 hours (less than or equal to 180 minutes) of time last known well.

**Included Populations:** Not applicable

**Excluded Populations:** None

**Data Elements:**

- Date Last Known Well
- IV Thrombolytic Initiation
- IV Thrombolytic Initiation Date
| IV Thrombolytic Initiation Time  
| Time Last Known Well  

**Denominator Statement:** Acute ischemic stroke patients whose time of arrival is within 2 hours (less than or equal to 120 minutes) of time last known well.

**Included Populations:** Discharges with an ICD-10-CM Principal Diagnosis Code for ischemic stroke as defined in Appendix A, Table 8.1

**Excluded Populations:**
- Patients less than 18 years of age
- Patients who have a Length of Stay greater than 120 days
- Time Last Known Well to arrival in the emergency department greater than 2 hours
- Patients with a documented Reason For Extending the Initiation of IV Thrombolytic
- Patients with a documented Reason For Not Initiating IV Thrombolytic

**Data Elements:**
- Admission Date
- Arrival Date
- Arrival Time
- Birthdate
- Date Last Known Well
- Discharge Date
- ED Patient
- ICD-10-CM Principal Diagnosis Code
- Last Known Well
- Reason for Extending the Initiation of IV Thrombolytic
- Reason for Not Initiating IV Thrombolytic
- Time Last Known Well

**Risk Adjustment:** No.

**Data Collection Approach:** Retrospective data sources for required data elements include administrative data and medical records. Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunities for improvement at the point of care/service. However, complete documentation includes the principal or other ICD-10 diagnosis and procedure codes, which require retrospective data entry.

**Data Accuracy:** Variation may exist in the assignment of ICD-10 codes; therefore, coding practices may require evaluation to ensure consistency.

**Measure Analysis Suggestions:** None

**Sampling:** No.

**Data Reported As:** Aggregate rate generated from count data reported as a proportion.

**Selected References:**

Acute Stroke Ready Performance Measurement Implementation Guide
Effective with Discharges on and after January 1, 2018


• "Diagnosis and Initial Treatment of Ischemic Stroke." [In eng]. MMWR Morb Mortal Wkly Rep 58, no. 16 (May 1 2009): 421-6.


• "Diagnosis and Initial Treatment of Ischemic Stroke." Institute for Clinical Systems Improvement (2001).


Measure Algorithm:
ASR-IP-1: Thrombolytic Therapy: Inpatient Admission

Numerator: Acute ischemic stroke patients for whom IV thrombolytic (t-PA) therapy was initiated at this hospital within 3 hours (< 180 minutes) of time last known well.

Denominator: Acute ischemic stroke patients whose time of arrival is within 2 hours (< 120 minutes) of time last known well.
Measure Information Form

Measure Set: Acute Stroke Ready Inpatient (ASR-IP)

Set Measure ID: ASR-IP-2

Performance Measure Name: Antithrombotic Therapy By End of Hospital Day 2

Description: Ischemic stroke patients administered antithrombotic therapy by the end of hospital day 2.

Rationale: The effectiveness of antithrombotic agents in reducing stroke mortality, stroke-related morbidity and recurrence rates has been studied in several large clinical trials. While the use of these agents for patients with acute ischemic stroke and transient ischemic attacks continues to be the subject of study, substantial evidence is available from completed studies. Data at this time suggest that antithrombotic therapy should be administered within 2 days of symptom onset in acute ischemic stroke patients to reduce stroke mortality and morbidity as long as no contraindications exist.

Anticoagulants at doses to prevent venous thromboembolism are insufficient antithrombotic therapy to prevent recurrent stroke or TIA.

Type of Measure: Process

Improvement Noted As: Increase in the rate

Numerator Statement: Ischemic stroke patients who had antithrombotic therapy administered by end of hospital day 2

Included Populations: Not applicable

Excluded Populations: None

Data Elements:

- Antithrombotic Therapy Administered by End of Hospital Day 2

Denominator Statement: Ischemic stroke patients.

Included Populations: Discharges with an ICD-10-CM Principal Diagnosis Code for ischemic stroke as defined in Appendix A, Table 8.1.

Excluded Populations:

- Patients less than 18 years of age
- Patients who have a Duration of Stay less than 2 days
- Patients who have a Length of Stay greater than 120 days
- Patients with Comfort Measures Only documented on day of or day after arrival
- Patients discharged prior to the end of hospital day 2
- Patients with IV OR IA Thrombolytic (t-PA) Therapy Administered at This Hospital or Within 24 Hours Prior to Arrival
- Patients with a documented Reason for Not Administering Antithrombotic Therapy by End of Hospital Day 2
Data Elements:

- Admission Date
- Arrival Date
- Birthdate
- Comfort Measures Only
- Discharge Date
- ICD-10-CM Principal Diagnosis Code
- IV OR IA Thrombolytic (t-PA) Therapy Administered at This Hospital or Within 24 Hours Prior to Arrival
- Reason for Not Administering Antithrombotic Therapy by End of Hospital Day 2

Risk Adjustment: No.

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records. Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunities for improvement at the point of care/service. However, complete documentation includes the principal or other ICD-10 diagnosis and procedure codes, which require retrospective data entry.

Data Accuracy: Variation may exist in the assignment of ICD-10 codes; therefore, coding practices may require evaluation to ensure consistency.

Measure Analysis Suggestions: None

Sampling: No.

Data Reported As: Aggregate rate generated from count data reported as a proportion.

Selected References:


Measure Algorithm:
ASR-IP-2: Antithrombotic Therapy by End of Hospital Day 2

Numerator: Ischemic stroke patients who had antithrombotic therapy administered by end of hospital day 2.

Denominator: Ischemic stroke patients.
Measure Information Form

Measure Set: Acute Stroke Ready Inpatient (ASR-IP)

Set Measure ID: ASR-IP-3

Performance Measure Name: Discharged on Antithrombotic Therapy

Description: Ischemic stroke patients prescribed antithrombotic therapy at hospital discharge

Rationale: The effectiveness of antithrombotic agents in reducing stroke mortality, stroke-related morbidity and recurrence rates has been studied in several large clinical trials. While the use of these agents for patients with acute ischemic stroke and transient ischemic attacks continues to be the subject of study, substantial evidence is available from completed studies. Data at this time suggest that antithrombotic therapy should be prescribed at discharge following acute ischemic stroke to reduce stroke mortality and morbidity as long as no contraindications exist.

For patients with a stroke due to a cardioembolic source (e.g., atrial fibrillation, mechanical heart valve), warfarin is recommended unless contraindicated. In recent years, novel oral anticoagulants (NOACs) have been developed and approved by the U.S. Food and Drug Administration (FDA) for stroke prevention, and may be considered as an alternative to warfarin for select patients. Anticoagulation therapy is not generally recommended for secondary stroke prevention in patients presumed to have a non-cardioembolic stroke.

Anticoagulants at doses to prevent venous thromboembolism are insufficient antithrombotic therapy to prevent recurrent ischemic stroke or TIA.

Type of Measure: Process

Improvement Noted As: Increase in the rate

Numerator Statement: Ischemic stroke patients prescribed antithrombotic therapy at hospital discharge.

Included Populations: Not applicable

Excluded Populations: None

Data Elements:

- Antithrombotic Therapy Prescribed at Discharge

Denominator Statement: Ischemic stroke patients.

Included Populations: Discharges with an ICD-10-CM Principal Diagnosis Code for ischemic stroke as defined in Appendix A, Table 8.1.

Excluded Populations:

- Patients less than 18 years of age
Patients who have a Length of Stay greater than 120 days
Patients with Comfort Measures Only documented
Patients discharged to another hospital
Patients who left against medical advice
Patients who expired
Patients discharged to home for hospice care
Patients discharged to a health care facility for hospice care
Patients with a documented Reason For Not Prescribing Antithrombotic Therapy at Discharge

Data Elements:

- Admission Date
- Birthdate
- Comfort Measures Only
- Discharge Date
- Discharge Disposition
- ICD-10-CM Principal Diagnosis Code
- Reason for Not Prescribing Antithrombotic Therapy at Discharge

Risk Adjustment: No.

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records. Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunities for improvement at the point of care/service. However, complete documentation includes the principal or other ICD-10 diagnosis and procedure codes, which require retrospective data entry.

Data Accuracy: Variation may exist in the assignment of ICD-10 codes; therefore, coding practices may require evaluation to ensure consistency.

Measure Analysis Suggestions: None

Sampling: No.

Data Reported As: Aggregate rate generated from count data reported as a proportion.

Selected References:

• "A Comparison of Two Doses of Aspirin (30 Mg Vs. 283 Mg a Day) in Patients after a Transient Ischemic Attack or Minor Ischemic Stroke. The Dutch Tia Trial Study Group." [In eng]. N Engl J Med 325, no. 18 (Oct 31 1991): 1261-6.


Measure Algorithm:
**ASR-IP-3: Discharged on Antithrombotic Therapy**

**Numerator:** Ischemic stroke patients prescribed antithrombotic therapy at hospital discharge

**Denominator:** Ischemic stroke patients.

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Flowchart Description:

- **START**
- **Discharge Diagnosis:** Includes codes 2, 3, 4, 6, 7
- **Clinical Measures Only:** Includes codes 1, 2, 3
- **Antithrombotic Therapy Prescribed at Discharge:** If yes, go to **ASR-IP-3 B**; if no, go to **D**
- **Reason for Not Prescribing Antithrombotic Therapy at Discharge:** If yes, go to **ASR-IP-3 B**; if no, go to **D**
- **In Numerator Population:** If yes, go to **Stop**; if no, go to **B**

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*Acute Stroke Ready Performance Measurement Implementation Guide*

*Effective with Discharges on and after January 1, 2018*
Data Elements
Data Element Name: Admission Date

Collected For: All Records

Definition: The month, day, and year of admission to acute inpatient care.

Suggested Data Collection Question: What is the date the patient was admitted to acute inpatient care?

Format: Length: 10 — MM-DD-YYYY (includes dashes)
Type: Date
Occurs: 1

Allowable Values:

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)

Notes for Abstraction:

• The intent of this data element is to determine the date that the patient was actually admitted to acute inpatient care. Because this data element is critical in determining the population for all measures, the abstractor should NOT assume that the claim information for the admission date is correct. If the abstractor determines through chart review that the date is incorrect, for purposes of abstraction, she/he should correct and override the downloaded value.

• If using claim information, the “Statement Covers Period” is not synonymous with the “Admission Date” and should not be used to abstract this data element. These are two distinctly different identifiers:
  ◦ The Admission Date is purely the date the patient was admitted as an inpatient to the facility.
  ◦ The Statement Covers Period (“From” and “Through” dates) identifies the span of service dates included in a particular claim. The “From” Date is the earliest date of service on the claim.

• For patients who are admitted to Observation status and subsequently admitted to acute inpatient care, abstract the date that the determination was made to admit to acute inpatient care and the order was written. Do not abstract the date that the patient was admitted to Observation.

Example: Medical record documentation reflects that the patient was admitted to observation on 04-05-20xx. On 04-06-20xx the physician writes an order to admit to acute inpatient effective 04-05-20xx. The Admission Date would be abstracted as 04-06-20xx; the date the determination was made to admit to acute inpatient care and the order was written.

• The admission date should not be abstracted from the earliest admission order without regards to substantiating documentation. If documentation suggests that the earliest admission order does not reflect the date the patient was admitted to inpatient care, this date should not be used.

Example: Preoperative Orders are dated as 04-06-20xx with an order to admit to Inpatient. Postoperative Orders, dated 05-01-20xx, state to admit to acute inpatient. All other documentation supports that the patient presented to the hospital for surgery on 05-01-20xx. The Admission Date would be abstracted 05-01-20xx.

• If there are multiple inpatient orders, use the order that most accurately reflects the date that the patient was admitted.

• For newborns that are born within this hospital, the Admission Date is the date the baby was born.
Suggested Data Sources: ONLY ALLOWABLE SOURCES

- Physician orders
- Face sheet
- UB-04

Note: The physician order is the priority data source for this data element. If there is not a physician order in the medical record, use the other only allowable sources to determine the Admission Date.

Excluded Data Sources

- UB-04, “From” and “Through” dates

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Admit to observation</td>
</tr>
<tr>
<td></td>
<td>Arrival date</td>
</tr>
</tbody>
</table>
**Data Element Name:** Antithrombotic Therapy Administered by End of Hospital Day 2

**Collected For:** ASR-IP-2, STK-5,

**Definition:** Documentation that antithrombotic therapy was administered by the end of hospital day 2. Antithrombotics include both anticoagulant and antiplatelet drugs.

**Suggested Data Collection Question:** Was antithrombotic therapy administered by the end of hospital day 2?

**Format:**
- **Length:** 1
- **Type:** Alphanumeric
- **Occurs:** 1

**Allowable Values:**
- Y (Yes) Antithrombotic therapy was administered by the end of hospital day 2.
- N (No) Antithrombotic therapy was not administered by the end of hospital day 2, OR unable to determine from medical record documentation.

**Notes for Abstraction:**
- To compute end of hospital day 2, count the arrival date as hospital day 1. If antithrombotic therapy was administered by 11:59 p.m. of hospital day two, select “Yes” for this data element. Documentation of antithrombotic administration must be found within the timeframe of arrival to the end of hospital day 2. **It is not necessary to review documentation outside of this timeframe to answer this data element.**
- For antithrombotic therapy administered in the Emergency Department/observation area prior to the end of hospital day 2, select “Yes.”
- Antithrombotic therapy administration information must demonstrate actual administration of the medication. Example: Do not use physician orders as they do not demonstrate administration of the antithrombotic therapy (in the ED this may be used if signed/initialed by a nurse).
- When antithrombotic is noted as a “home” or “current” medication or documentation indicates that it was received prior to hospital arrival only, select “No.”
- Lovenox SQ for VTE prophylaxis (i.e. enoxaparin SQ 40 mg once daily; enoxaparin SQ 30 mg Q12 hours) is not sufficient. If no other antithrombotic therapy is administered by the end of hospital day 2, select “No.”

**Suggested Data Sources:**
- Emergency department record
- Nursing notes
- Nursing flow sheet
- Progress notes
- Physician orders
- Medication administration record (MAR)

**Excluded Data Sources**
- Emergency medical system (EMS) or ambulance documentation.
- Any documentation dated/timed prior to hospital arrival or after hospital day 2.

**Additional Notes:**

**Guidelines for Abstraction:**
Refer to Appendix C, Table 8.2 for a list of medications used for antithrombotic therapy.

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refer to Appendix C, Table 8.2 for a list of medications used for antithrombotic therapy.</td>
<td>• Heparin Flush</td>
</tr>
<tr>
<td></td>
<td>• Heparin SQ</td>
</tr>
<tr>
<td></td>
<td>• Hep-Lock</td>
</tr>
</tbody>
</table>
Data Element Name: Antithrombotic Therapy Prescribed at Discharge

Collected For: ASR-IP-3, STK-2,

Definition: Documentation that antithrombotic therapy was prescribed or continued at hospital discharge. Antithrombotics include both anticoagulant and antiplatelet drugs.

Suggested Data Collection Question: Was antithrombotic therapy prescribed at hospital discharge?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:
(Y) Antithrombotic therapy was prescribed at hospital discharge.
(N) Antithrombotic therapy was not prescribed at hospital discharge, OR unable to determine from medical record documentation.

Notes for Abstraction:
- If there is documentation in the medical record that an antithrombotic medication was prescribed at discharge, then select "Yes". Documentation that the patient should continue to take an antithrombotic medication that was administered during the hospital stay or taken prior to hospital admission (e.g., home medication) is also acceptable. At minimum, the name of the antithrombotic medication must be documented.
- In determining whether antithrombotic therapy was prescribed at discharge, it is not uncommon to see conflicting documentation amongst different medical record sources. For example, the discharge summary may list an antithrombotic that is not included in any of the other discharge medication sources (e.g., discharge orders). All discharge medication documentation available in the chart should be reviewed and taken into account by the abstractor.
  - In cases where there is an antithrombotic in one source that is not mentioned in other sources, it should be interpreted as a discharge medication (select "Yes") unless documentation elsewhere in the medical record suggests that it was NOT prescribed at discharge - Consider it a discharge medication in the absence of contradictory documentation.
  - If documentation is contradictory (e.g., physician noted “d/c Plavix” in the discharge orders, but Plavix is listed in the discharge summary’s discharge medication list), or after careful examination of circumstances, context, timing, etc., documentation raises enough questions, the case should be deemed "unable to determine" (select "No").
  - Consider documentation of a hold on an antithrombotic after discharge in one location and a listing of that antithrombotic as a discharge medication in another location as contradictory ONLY if the timeframe on the hold is not defined (e.g., “Hold Plavix”). Examples of a hold with a defined timeframe include “Hold Plavix x2 days” and “Hold ASA until after stress test.”
  - If an antithrombotic is NOT listed as a discharge medication, and there is only documentation of a hold or plan to delay initiation/restarting of antithrombotic therapy after discharge (e.g., “Hold Plavix x2 days,” “Start Plavix as outpatient,” “Hold Plavix”), select “No.”
  - If two discharge summaries are included in the medical record, use the one with the latest date/time. If one or both are not dated or timed, and you cannot determine which was done last, use both. This also applies to discharge medication reconciliation forms. Use the dictated date/time over transcribed date/time, file date/time, etc.

Examples:
Two discharge summaries, one dictated 5/22 (day of discharge) and one dictated 5/27 - Use the 5/27 discharge summary.

Two discharge medication reconciliation forms, one not dated and one dated 4/24 (day of discharge) - Use both.

- Disregard an antithrombotic medication documented only as a recommended medication for discharge (e.g., “Recommend sending patient home on aspirin”). Documentation must be clearer that an antithrombotic was actually prescribed at discharge.
- Disregard documentation of antithrombotic prescribed at discharge when noted only by medication class (e.g., “Antithrombotic Prescribed at Discharge: Yes” on a core measures form). The antithrombotic must be listed by name.

**Suggested Data Sources:**
- Consultation notes
- Progress notes
- Physician orders
- Discharge summary
- Medication reconciliation form
- After Visit Summary (AVS)

**Additional Notes:**

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
</table>
| Refer to Appendix C, Table 8.2 for a list of medications used for antithrombotic therapy. | • Heparin Flush  
• Heparin SQ  
• Hep-Lock |
Data Element Name:  *Arrival Date*

Collected For:  ASR-IP-1, ASR-IP-2, CAH-01, CAH-02, CAH-04, CAH-07, CAH-08, CAH-09, CAH-10, CSTK-01, CSTK-03, CSTK-05, CSTK-06, CSTK-07, CSTK-09, CSTK-11, PN-3a, STK-4, STK-5,

Definition:  The earliest documented month, day, and year the patient arrived at the hospital.

Suggested Data Collection Question:  What was the *earliest* documented date the patient arrived at the hospital?

Format:  
Length:  10 — MM-DD-YYYY (includes dashes) or UTD  
Type:  Date  
Occurs:  1

Allowable Values:

Enter the earliest documented date

MM = Month (01-12)  
DD = Day (01-31)  
YYYY = Year (20xx)  
UTD = Unable to Determine

Notes for Abstraction:

- If the date of arrival is unable to be determined from medical record documentation, select "UTD".
- The medical record must be abstracted as documented (taken at "face value"). When the date documented is obviously in error (not a valid format/range or outside of the parameters of care [after the *Discharge Date*] and no other documentation is found that provides this information, the abstractor should select "UTD".

Examples:
- Documentation indicates the *Arrival Date* was 03-42-20xx. No other documentation in the list of Only Acceptable Sources provides a valid date. Since the *Arrival Date* is outside of the range listed in the Allowable Values for "Day", it is not a valid date and the abstractor should select "UTD".
- Patient expires on 02-12-20xx and all documentation within the Only Acceptable Sources indicates the *Arrival Date* was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the *Arrival Date* is after the *Discharge Date* (death), it is outside of the parameter of care and the abstractor should select "UTD".

Note:  Transmission of a case with an invalid date as described above will be rejected from the CMS Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" for *Arrival Date* allows the case to be accepted into the warehouse.

- Review the Only Acceptable Sources to determine the earliest date the patient arrived at the ED, nursing floor, or observation, or as a direct admit to the cath lab. The intent is to utilize any documentation which reflects processes that occurred after arrival at the ED or after arrival to the nursing floor/observation/cath lab for a direct admit.
- Documentation outside of the Only Acceptable Sources list should NOT be referenced (e.g., ambulance record, physician office record, H&P). Examples:
  - ED Triage Date/Time 03-22-20xx 2355. ED rhythm strip dated/timed 03-23-20xx 0030. EMS report indicates patient was receiving EMS care from 0005 through 0025 on 03-23-20xx. The EMS report is disregarded. Enter 03-22-20xx for *Arrival Date*.
  - ED noted arrival time of 0100 on 04-14-20xx. Lab report shows blood culture collected at 2345 on 04-13-20xx. It is not clear that the blood culture was collected in the ED because the
lab report does not specify it was collected in the ED (unable to confirm lab report as an Only Acceptable Source). Enter 04-14-20xx for Arrival Date.

- ED Triage Date/Time 06-18-20xx 0025. EMS report indicates patient arrived by ambulance on 06-17-20xx 2355. Patient routed directly to CT. The EMS report is disregarded. Enter 06-18-20xx for Arrival Date.

- Arrival date should NOT be abstracted simply as the earliest date in one of the Only Acceptable Sources, without regard to other substantiating documentation. When looking at the Only Acceptable Sources, if the earliest date documented appears to be an obvious error, this date should not be abstracted. Examples:
  - ED arrival time noted as 0030 on 10-29-20xx. ED MAR shows an antibiotic administration time of 0100 on 10-28-20xx. Surrounding documentation on the ED MAR makes clear that the 10-28-20xx date is an obvious error - Date was not changed to 10-29-20xx. The antibiotic administration date/time would be converted to 0100 on 10-29-20xx. Enter 10-29-20xx for Arrival Date.
  - ED MAR shows an antibiotic administration time of 1430 on 11-03-20xx. All other dates in the ED record note 12-03-20xx. The antibiotic administration date of 11-03-20xx would not be used for Arrival Date because it is an obvious error.
  - ED ECG dated/timed as 05-07-20xx 2142. ED Greet Date/Time 05-08-20xx 0125. ED Triage Date/Time 05-08-20xx 0130. There is no documentation in the Only Acceptable Sources which suggests the 05-07-20xx is an obvious error. Enter 05-07-20xx for Arrival Date.
  - ED RN documents on a nursing triage note dated 04-24-20xx, “Blood culture collected at 2230.” ED arrival time is documented as 0130 on 04-25-20xx. There is no documentation in the Only Acceptable Sources which suggests the 04-24-20xx is an obvious error. Enter 04-24-20xx for Arrival Date.

- The source "Emergency Department record" includes any documentation from the time period that the patient was an ED patient — (e.g., ED face sheet, ED consent/Authorization for treatment forms, ED/Outpatient Registration/sign-in forms, ED vital sign record, ED triage record, ED physician orders, ED ECG reports, ED telemetry/rhythm strips, ED laboratory reports, ED x-ray reports, ED head CT scan, CTA, MRI, MRA reports).
- The source "Procedure notes" refers to procedures such as cardiac caths, endoscopies, and surgical procedures. Procedure notes do not include ECG and x-ray reports.

- The arrival date may differ from the admission date.

- If the patient is in either an outpatient setting of the hospital other than observation status (e.g., dialysis, chemotherapy, cardiac cath) or a SNF unit of the hospital, and is subsequently admitted to acute inpatient, use the date the patient arrived at the ED or on the floor for acute inpatient care as the arrival date.

- **Observation status:**
  - If the patient was admitted to observation from an outpatient setting of the hospital, use the date the patient arrived at the ED or on the floor for observation care as the arrival date.
  - If the patient was admitted to observation from the ED of the hospital, use the date the patient arrived at the ED as the arrival date.

- **Direct Admits:**
  - If the patient is a "Direct Admit" to the cath lab, use the earliest date the patient arrived at the cath lab (or cath lab staging/holding area) as the arrival date.
  - For "Direct Admits" to acute inpatient or observation, use the earliest date the patient arrived at the nursing floor or in observation (as documented in the Only Acceptable Sources) as the arrival date.
  - If the patient was transferred from your hospital's satellite/free-standing ED or from another hospital within your hospital's system (as an inpatient or ED patient), and there is one medical
record for the care provided at both facilities, use the arrival date at the first facility.

**CSTK, STK, AND ASR MEASURES ONLY**

**EXCEPTION:** Use the arrival date at the comprehensive stroke center/primary stroke center.

**Suggested Data**

**Sources:**

**ONLY ACCEPTABLE SOURCES:**

- Emergency department record
- Nursing admission assessment/admitting note
- Observation record
- Procedure notes
- Vital signs graphic record

**Additional Notes:**

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Addressographs/Stamps</td>
</tr>
</tbody>
</table>
Data Element Name: Arrival Time

Collected For: ASR-IP-1, ASR-OP-1, ASR-OP-2, CAH-02, CAH-04, CAH-07, CAH-08, CAH-09, CAH-10, CSTK-01, CSTK-03, CSTK-05, CSTK-06, CSTK-07, CSTK-09, CSTK-11, PN-3a, STK-4

Definition: The earliest documented time (military time) the patient arrived at the hospital.

Suggested Data Collection Question: What was the earliest documented time the patient arrived at the hospital?

Format:

Length: 5 - HH:MM (with or without colon) or UTD
Type: Time
Occurs: 1

Allowable Values:
Enter the earliest documented time of arrival
HH = Hour (00-23)
MM = Minutes (00-59)
UTD = Unable to Determine

Time must be recorded in military time format. With the exception of Midnight and Noon:
- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:
Midnight - 00:00  Noon - 12:00
5:31 am - 05:31  5:31 pm - 17:31
11:59 am - 11:59  11:59 pm - 23:59

Note: 00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the Arrival Date should remain 11-24-20xx or if it should be converted to 11-25-20xx.

When converting 24:00 to 00:00 do not forget to change the Arrival Date.
Example: Midnight or 24:00 on 11-24-20xx = 00:00 on 11-25-20xx

Notes for Abstraction:
- 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 of arrival is unable to be determined from medical record documentation, select “UTD.”
- The medical record must be abstracted as documented (taken at “face value”). When the time documented is obviously in error (not a valid format/range) and no other documentation is found that provides this information, the abstractor should select “UTD.”
  Example: Documentation indicates the Arrival Time was 3300. No other documentation in the list of Only Acceptable Sources provides a valid time. Since the Arrival Time is outside of the range 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
CMS Clinical Warehouse and the Joint Commission’s Data Warehouse. Use of “UTD” for Arrival Time allows the case to be accepted into the warehouse.

• Review the Only Acceptable Sources to determine the earliest time the patient arrived at the ED, nursing floor, or observation, or as a direct admit to the cath lab. The intent is to utilize any documentation which reflects processes that occurred after arrival at the ED or after arrival to the nursing floor/observation/cath lab for a direct admit.

• Documentation outside of the Only Acceptable Sources list should NOT be referenced (e.g., ambulance record, physician office record, H&P).

Examples:
- ED Triage Time 0800. ED rhythm strip 0830. EMS report indicates patient was receiving EMS care from 0805 through 0825. The EMS report is disregarded. Enter 0800 for Arrival Time.
- ED noted arrival time of 0945. Lab report shows blood culture collected at 0830. It is not clear that the blood culture was collected in the ED because the lab report does not specify it was collected in the ED (unable to confirm lab report as an Only Acceptable Source). Enter 0945 for Arrival Time.
- ED Triage Time 1525. EMS report indicates patient was receiving care 1435 through 1455. ED report documents time of head CT 1505. The EMS report is disregarded. Enter 1505 for Arrival Time.

• Arrival time should NOT be abstracted simply as the earliest time in one of the Only Acceptable Sources, without regard to other substantiating documentation. When looking at the Only Acceptable Sources, if the earliest time documented appears to be an obvious error, this time should not be abstracted.

Examples:
- ED arrival time noted as 2300 on 10-28-20xx. ED MAR shows an antibiotic administration time of 0100 on 10-28-20xx. Surrounding documentation on the ED MAR makes clear that the 10-28-20xx date is an obvious error - Date was not changed to 10-29-20xx. The antibiotic administration date/time would be converted to 0100 on 10-29-20xx. Enter 2300 for Arrival Time.
- ED face sheet lists arrival time of 13:20. ED Registration Time 13:25. ED Triage Time 13:30. ED consent to treat form has 1:17 time but “AM” is circled. ED record documentation suggests the 1:17 AM is an obvious error. Enter 13:20 for Arrival Time.
- ED ECG timed as 1742. ED Greet Time 2125. ED Triage Time 2130. There is no documentation in the Only Acceptable Sources which suggests the 1742 is an obvious error. Enter 1742 for Arrival Time.
- ED RN documents on the nursing triage note, “Blood culture collected at 0730.” ED arrival time is documented as 1030. There is no documentation in the Only Acceptable Sources which suggests the 0730 is an obvious error. Enter 0730 for Arrival Time.

• The source “Emergency Department record” includes any documentation from the time period that the patient was an ED patient (e.g., ED face sheet, ED consent/Authorization for treatment forms, ED/Outpatient Registration/sign-in forms, ED vital sign record, ED triage record, ED physician orders, ED ECG reports, ED telemetry/rhythm strips, ED laboratory reports, ED x-ray reports, ED head CT scan, CTA, MRI, MRA reports).

• The source “Procedure notes” refers to procedures such as cardiac caths, endoscopies, and surgical procedures. Procedure notes do not include ECG and x-ray reports.

• The arrival time may differ from the admission time.

• If the patient is in either an outpatient setting of the hospital other than observation status (e.g., dialysis, chemotherapy, cardiac cath) or a SNF unit of the hospital, and is subsequently admitted to acute inpatient, use the time the patient arrived at the ED or on the floor for acute inpatient care as the arrival time.
• **Observation status:**
  - If the patient was admitted to observation from an outpatient setting of the hospital, use the time the patient arrived at the ED or on the floor for observation care as the arrival time.
  - If the patient was admitted to observation from the ED of the hospital, use the time the patient arrived at the ED as the arrival time.

• **Direct Admits:**
  - If the patient is a “Direct Admit” to the cath lab, use the earliest time the patient arrived at the cath lab (or cath lab staging/holding area) as the arrival time.
  - For “Direct Admits” to acute inpatient or observation, use the earliest time the patient arrived at the nursing floor or in observation (as documented in the Only Acceptable Sources) as the arrival time.
  - If the patient was transferred from your hospital’s satellite/free-standing ED or from another hospital within your hospital’s system (as an inpatient or ED patient), and there is one medical record for the care provided at both facilities, use the arrival time at the first facility.

**CSTK, STK, AND ASR MEASURES ONLY**
EXCEPTION: Use the arrival time at the comprehensive stroke center/primary stroke center.

**Suggested Data Sources:**

**ONLY ACCEPTABLE SOURCES**
- Emergency department record
- Nursing admission assessment/admitting note
- Observation record
- Procedure notes
- Vital signs graphic record

**Additional Notes:**

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Addressographs/Stamps</td>
</tr>
</tbody>
</table>
Data Element Name: Birthdate

Collected For: All Records

Definition: The month, day, and year the patient was born.

Note:

- Patient's age (in years) is calculated by Admission Date minus Birthdate. The algorithm to calculate age must use the month and day portion of admission date and birthdate to yield the most accurate age.
- For HBIPS discharge measures, i.e., HBIPS-1, 5, patient's age (in years) is calculated by Discharge Date minus Birthdate. For event measures, i.e., HBIPS-2, 3, patient's age at time of event (in years) is calculated by Event Date minus Birthdate. The algorithm to calculate age must use the month and day portion of birthdate, and discharge date or event, as appropriate to yield the most accurate age.

Suggested Data Collection Question: What is the patient's date of birth?

Format: Length: 10 MM-DD-YYYY (includes dashes)
Type: Date
Occurs: 1

Allowable Values:

- MM = Month (01-12)
- DD = Day (01-31)
- YYYY = Year (1880-Current Year)

Notes for Abstraction: Because this data element is critical in determining the population for all measures, the abstractor should NOT assume that the claim information for the birthdate is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct birthdate through chart review, she/he should default to the date of birth on the claim information.

Suggested Data Sources:

- Emergency department record
- Face sheet
- Registration form
- UB-04

Additional Notes:

Guidelines for Abstraction:

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<tr>
<th>Inclusion</th>
<th>Exclusion</th>
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<tbody>
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</table>
Data Element Name: Comfort Measures Only

Collected For: ACHF, AMI-10, AMI-2, ASR-IP-2, ASR-IP-3, ASR-OP-2, , , CAH-01.1, CAH-03, CAH-04, CSTK-01, CSTK-03, CSTK-04, CSTK-06, HF-3, PICU-03, PN-3a, STK-1, STK-10, STK-2, STK-3, STK-5, STK-6, STK-8,

Definition: Comfort Measures Only refers to medical treatment of a dying person where the natural dying process is permitted to occur while assuring maximum comfort. It includes attention to the psychological and spiritual needs of the patient and support for both the dying patient and the patient’s family. Comfort Measures Only is commonly referred to as “comfort care” by the general public. It is not equivalent to a physician order to withhold emergency resuscitative measures such as Do Not Resuscitate (DNR).

Suggested Data Collection Question: When is the earliest physician/APN/PA documentation of comfort measures only?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 Day 0 or 1: The earliest day the physician/APN/PA documented comfort measures only was the day of arrival (Day 0) or day after arrival (Day 1).

2 Day 2 or after: The earliest day the physician/APN/PA documented comfort measures only was two or more days after arrival day (Day 2+).

3 Timing unclear: There is physician/APN/PA documentation of comfort measures only during this hospital stay, but whether the earliest documentation of comfort measures only was on day 0 or 1 OR after day 1 is unclear.

4 Not Documented/UTD: There is no physician/APN/PA documentation of comfort measures only, or unable to determine from medical record documentation.

Notes for Abstraction:

• 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.
Examples:
"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)
  - 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.”
  - If a SAPO lists different options for CMO and any CMO option is checked, select value “1,” “2,” or “3” as applicable.
  - 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.
  - 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.”
  - 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.
  - 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.”
  - 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:
◦ 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.”
◦ 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: PHYSICIAN/APN/PA DOCUMENTATION ONLY IN THE FOLLOWING ONLY ACCEPTABLE SOURCES:
• Consultation notes
• Discharge summary
• DNR/MOLST/POLST forms
• Emergency department record
• History and physical
• Physician orders
• Progress notes

Additional Notes: Excluded Data Sources:
• Restraint order sheet

Guidelines for Abstraction:

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</thead>
<tbody>
<tr>
<td>Brain dead</td>
<td>None</td>
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<tr>
<td>Brain death</td>
<td></td>
</tr>
<tr>
<td>Comfort care</td>
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</tr>
<tr>
<td>Comfort measures</td>
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<tr>
<td>Comfort measures only (CMO)</td>
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<tr>
<td>Comfort only</td>
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<tr>
<td>DNR-CC</td>
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<tr>
<td>End of life care</td>
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<td>Hospice</td>
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<td>Hospice care</td>
<td></td>
</tr>
<tr>
<td>Organ harvest</td>
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<tr>
<td>Terminal care</td>
<td></td>
</tr>
<tr>
<td>Terminal extubation</td>
<td></td>
</tr>
</tbody>
</table>
Data Element Name: Date Last Known Well

Collected For: ASR-IP-1, ASR-OP-1, STK-4,

Definition: The date prior to hospital arrival at which the patient was last known to be without the signs and symptoms of the current stroke or at his or her baseline state of health.

Suggested Data Collection Question: 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?

Format: Length: 10 - MM-DD-YYYY (includes dashes) or UTD
Type: Date
Occurs: 1

Allowable Values: MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)
UTD = Unable to Determine

Notes for Abstraction: • 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 CMS 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.
  o “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:
  o “Patient last known well today (day of arrival).” Select Arrival Date for Date Last Known Well.
  o “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:
- Emergency department record
- History and physical
- Nursing flow sheet
- Progress notes
- Medication administration record (MAR)
- Transfer sheet
- Ambulance record
- Code Stroke form/template
- IV flow sheets

Additional Notes:

Guidelines for Abstraction:

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<tbody>
<tr>
<td><strong>Signs and Symptoms of Stroke</strong></td>
<td>Code Stroke Form</td>
</tr>
<tr>
<td>• Sudden numbness or weakness of the face, arm or leg, especially on one side of the body</td>
<td>• Stroke Education Form</td>
</tr>
<tr>
<td>• Sudden confusion, trouble speaking or understanding</td>
<td>• Core Measure Form</td>
</tr>
<tr>
<td>• Sudden trouble seeing in one or both eyes</td>
<td></td>
</tr>
<tr>
<td>• Sudden trouble walking, dizziness, loss of balance or coordination</td>
<td></td>
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<tr>
<td>• Sudden severe headache</td>
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<tr>
<td><strong>Code Stroke Form</strong></td>
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<tr>
<td>• Stroke Activation Form</td>
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<td>• Stroke Alert Form</td>
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<td>• Stroke Assessment Form</td>
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<td>• Stroke Intervention Form</td>
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<td>• Stroke Rapid Response Form</td>
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<tr>
<td>• Thrombolysis Checklist</td>
<td></td>
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<tr>
<td>• tPA Eligibility Form</td>
<td></td>
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</tbody>
</table>
Data Element Name: Discharge Date

Collected For: All Records, Not collected for HBIPS-2 and HBIPS-3

Definition: The month, day, and year the patient was discharged from acute care, left against medical advice, or expired during this stay.

Suggested Data Collection Question: What is the date the patient was discharged from acute care, left against medical advice (AMA), or expired?

Format: Length: 10 MM-DD-YYYY (includes dashes)
Type: Date
Occurs: 1

Allowable Values:
- MM = Month (01-12)
- DD = Day (01-31)
- YYYY = Year (20xx)

Notes for Abstraction: Because this data element is critical in determining the population for many measures, the abstractor should NOT assume that the claim information for the discharge date is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct discharge date through chart review, she/he should default to the discharge date on the claim information.

For HBIPS only, if the patient was in an acute-care hospital and had multiple admissions to the psychiatric unit during his or her hospitalization, this information should be abstracted only once at the time of discharge from the hospital.

Suggested Data Sources:
- Face sheet
- Progress notes
- Physician orders
- Discharge summary
- Nursing discharge notes
- Transfer note
- UB-04

Additional Notes:

Guidelines for Abstraction:

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<tbody>
<tr>
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</tbody>
</table>
**Data Element Name:** Discharge Disposition

**Collected For:** ACHF, ASR-IP-3, CSTK-02, HBIPS-5, PAL-05, PC-04, PC-05, STK-10, STK-2, STK-3, STK-6, STK-8, THKR-IP-2, THKR-IP-3.

**Definition:** The final place or setting to which the patient was discharged on the day of discharge.

**Suggested Data Collection Question:** What was the patient's discharge disposition on the day of discharge?

**Format:**
- **Length:** 1
- **Type:** Alphanumeric
- **Occurs:** 1

**Allowable Values:**
1. Home
2. Hospice - Home
3. Hospice - Health Care Facility
4. Acute Care Facility
5. Other Health Care Facility
6. Expired
7. Left Against Medical Advice/AMA
8. Not Documented or Unable to Determine (UTD)

**Notes for Abstraction:**
- Only use documentation written on the day prior to discharge through 30 days after discharge when abstracting this data element.
  - Example:
    Documentation in the Discharge Planning notes on 04-01-20xx state that the patient will be discharged back home. On 04-06-20xx the physician orders and nursing discharge notes on the day of discharge reflect that the patient was being transferred to skilled care. The documentation from 04-06-20xx would be used to select value "5" (Other Health Care Facility).
  - The medical record must be abstracted as documented (taken at "face value"). Inferences should not be made based on internal knowledge.
  - If there is documentation that further clarifies the level of care that documentation should be used to determine the correct value to abstract. If documentation is contradictory, use the latest documentation.
    - Examples:
      - Discharge summary dictated 2 days after discharge states patient went home. Physician note on day of discharge further clarifies that the patient will be going home with hospice. Select value "2" (Hospice - Home).
      - Discharge planner note from day before discharge states XYZ Nursing Home. Discharge order from day of discharge states Discharge home. Contradictory documentation, use latest. Select value "1" (Home).
      - Physician order on discharge states Discharge to ALF. Discharge instruction sheet completed after the physician order states patient discharged to SNF. Contradictory documentation, use latest. Select value "5" (Other Health Care Facility).
  - If documentation is contradictory, and you are unable to determine the latest documentation, select the disposition ranked highest (top to bottom) in the following list. See Inclusion lists for examples.
    - Acute Care Facility
    - Hospice - Health Care Facility
    - Hospice - Home
    - Other Health Care Facility
- Home
- Hospice (values "2" and "3") includes discharges with hospice referrals and evaluations.
- If the medical record states only that the patient is being discharged to another hospital and does not reflect the level of care that the patient will be receiving, select value "4" (Acute Care Facility).
- If the medical record identifies the facility the patient is being discharged to by name only (e.g., Park Meadows), and does not reflect the type of facility or level of care, select value "5" (Other Health Care Facility).
- If the medical record states only that the patient is being discharged and does not address the place or setting to which the patient was discharged, select value "1" (Home).
- When determining whether to select value "7" (Left Against Medical Advice/AMA):
  - Explicit "left against medical advice" documentation is not required. E.g., Patient is refusing to stay for continued care - Select value "7".
  - Documentation suggesting that the patient left before discharge instructions could be given does not count.
  - A signed AMA form is not required, for the purposes of this data element.
  - Do not consider AMA documentation and other disposition documentation as contradictory. If any source states the patient left against medical advice, select value "7", regardless of whether the AMA documentation was written last. E.g., AMA form signed and discharge instruction sheet states Discharged home with belongings - Select "7".

**Suggested Data Sources:**

- Progress notes
- Physician orders
- Discharge summary
- Discharge instruction sheet
- Discharge planning notes
- Nursing discharge notes
- Social service notes
- Transfer record

**Excluded Data Sources**

- Any documentation prior to the last two days of hospitalization
- Coding documents
- UB-04

**Additional Notes:**

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home (Value 1):</strong></td>
<td>None</td>
</tr>
<tr>
<td>- Assisted Living Facilities (ALFs) - Includes ALFs and assisted living care at nursing home, intermediate care, and skilled nursing facilities</td>
<td></td>
</tr>
<tr>
<td>- Court/Law Enforcement - includes detention facilities, jails, and prison</td>
<td></td>
</tr>
<tr>
<td>- Home - includes board and care, foster or residential care, group or personal care homes, retirement communities, and homeless shelters</td>
<td></td>
</tr>
<tr>
<td>- Home with Home Health Services</td>
<td></td>
</tr>
<tr>
<td>- Outpatient Services including outpatient procedures at another hospital, Outpatient Chemical Dependency Programs and Partial Hospitalization</td>
<td></td>
</tr>
<tr>
<td><strong>Hospice - Home (Value 2):</strong></td>
<td></td>
</tr>
</tbody>
</table>
- Hospice in the home (or other Home setting as above in Value 1)

**Hospice Health Care Facility (Value 3):**
- Hospice - General Inpatient and Respite
- Hospice - Residential and Skilled Facilities
- Hospice - Other Health Care Facilities

**Acute Care Facility (Value 4):**
- Acute Short Term General and Critical Access Hospitals
- Cancer and Children's Hospitals
- Department of Defense and Veterans Administration Hospitals

**Other Health Care Facility (Value 5):**
- Extended or Intermediate Care Facility (ECF/ICF)
- Long Term Acute Care Hospital (LTACH)
- Nursing Home or Facility including Veterans Administration Nursing Facility
- Psychiatric Hospital or Psychiatric Unit of a Hospital
- Rehabilitation Facility including Inpatient Rehabilitation Facility/Hospital or Rehabilitation Unit of a Hospital
- Skilled Nursing Facility (SNF), Sub-Acute Care or Swing Bed
- Transitional Care Unit (TCU)
- Veterans Home
Data Element Name:  

ED Patient

Collected For:  

ASR-IP-1, CAH-01.1, CAH-02.1, CAH-03, CAH-04, CAH-05, CAH-06, CAH-08.1, CAH-09.1, CAH-10.1, CSTK-01, CSTK-03, STK-4,

Definition:  

Patient received care in a dedicated emergency department of the facility.

Suggested Data Collection Question:  

Was the patient an ED patient at the facility?

Format:  

Length: 1  
Type: Alphanumeric  
Occurs: 1

Allowable Values:  

Y (Yes) There is documentation the patient was an ED patient.  
N (No) There is no documentation the patient was an ED patient, OR unable to determine from medical record documentation.

Notes for Abstraction:

- For the purposes of this data element an ED patient is defined as any patient receiving care or services in the Emergency Department.  
- Patients seen in an Urgent Care, ER Fast Track, etc. are not considered an ED patient unless they received services in the emergency department at the facility (e.g., patient treated at an urgent care and transferred to the main campus ED is considered an ED patient, but a patient seen at the urgent care and transferred to the hospital as a direct admit would not be considered an ED patient).  
- Patients presenting to the ED who do not receive care or services in the ED abstract as a "No" (e.g., patient is sent to hospital from physician office and presents to ED triage and is instructed to proceed straight to floor).  
- Patients presenting to the ED for outpatient services such as lab work etc. will abstract as a "Yes."

ED: (Abstraction Guidelines for ED Measures Only)  

- If a patient is transferred in from any emergency department (ED) or observation unit OUTSIDE of your hospital, select "No." This applies even if the emergency department or observation unit is part of your hospitals system (e.g., your hospitals free-standing or satellite emergency department), has a shared medical record or provider number, or is in close proximity. Select "No", even if the transferred patient is seen in this facility's ED.  
- If the patient is transferred to your hospital from an outside hospital where he was an inpatient or outpatient, select "No." This applies even if the two hospitals are close in proximity, part of the same hospital system, have the same provider number, and/or there is one medical record. Select "No", even if the transferred patient is seen in this facility's ED.

Suggested Data Sources:  

- Emergency department record  
- Face sheet  
- Registration form

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
</table>
| None      | • Urgent Care  
|           | • Fast Track ED  
|           | • Terms synonymous with Urgent Care |
Data Element Name: Hispanic Ethnicity

Collected For: All Records

Definition: Documentation that the patient is of Hispanic ethnicity or Latino.

Suggested Data Collection Question: Is the patient of Hispanic ethnicity or Latino?

Format: Length: 1
Type: Character
Occurs: 1

Allowable Values:
Y (Yes) Patient is of Hispanic ethnicity or Latino.
N (No) Patient is not of Hispanic ethnicity or Latino or unable to determine from medical record documentation.

Notes for Abstraction: The data element, Race, is required in addition to this data element.

Suggested Data Sources:
- Emergency department record
- History and physical
- Face sheet
- Nursing admission assessment
- Progress notes

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term Spanish origin can be used in addition to Hispanic or Latino. Examples: Black-Hispanic Chicano H Hispanic Latin American Latino/Latina Mexican-American Spanish White-Hispanic</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: ICD-10-CM Principal Diagnosis Code

Collected For: All Records, Optional for HBIPS-2, HBIPS-3

Definition: The ICD-10-CM diagnosis code that is primarily responsible for the admission of the patient to the hospital for care during this hospitalization.

Suggested Data Collection Question: What was the ICD-10-CM code selected as the principal diagnosis for this record?

Format: Length: 3-7 (without decimal point or dot; upper or lower case)
Type: Character
Occurs: 1


Notes for Abstraction: None

Suggested Data Sources:
• Discharge summary
• Face sheet
• UB-04

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: IV OR IA Thrombolytic (t-PA) Therapy Administered at This Hospital or Within 24 Hours Prior to Arrival

Collected For: ASR-IP-2, STK-5,

Definition: There is documentation in the record that the patient received intravenous (IV) or intra-arterial (IA) thrombolytic therapy (t-PA) at this hospital or within 24 hours prior to arrival. Antithrombotic administration within 24 hours of thrombolytic therapy (t-PA) is contraindicated.

Suggested Data Collection Question: Did the patient receive IV or IA thrombolytic (t-PA) therapy at this hospital or within 24 hours prior to arrival?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:
Y (Yes) Patient received IV or IA thrombolytic (t-PA) therapy at this hospital or within 24 hours prior to arrival.

N (No) Patient did not receive IV or IA (t-PA) thrombolytic therapy at this hospital or within 24 hours prior to arrival, OR unable to determine from medical record documentation.

Notes for Abstraction:
• Documentation in the medical record must reflect that the patient received IV or IA thrombolytic (t-PA) therapy at this hospital or within 24 hours prior to arrival (i.e., drip and ship).
• If there is documentation that the patient received IV or IA thrombolytic (t-PA) therapy and mechanical thrombectomy at this hospital or within 24 hours prior to arrival, select “Yes”.
• If there is documentation that the patient received mechanical thrombectomy only with no IV or IA thrombolytic (t-PA) given, select “No”.

Suggested Data Sources:
• Emergency department record
• Progress notes
• Transfer sheet
• Medication records
• Medical transport records

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only Acceptable Thrombolytic Therapy for Stroke:</td>
<td>• Heparin Flush</td>
</tr>
<tr>
<td>• Activase</td>
<td>• Heparin Lock</td>
</tr>
<tr>
<td>• Alteplase</td>
<td>• Thrombolytic administration to flush, open, or maintain patency of a central line, e.g., PICC line.</td>
</tr>
<tr>
<td>• Intra-arterial (IA) t-PA</td>
<td></td>
</tr>
<tr>
<td>• IV t-PA</td>
<td></td>
</tr>
<tr>
<td>• Recombinant t-PA Tissue plasminogen activator</td>
<td></td>
</tr>
</tbody>
</table>
Data Element Name: **IV Thrombolytic Initiation**

Collected For: ASR-IP-1, ASR-OP-1, ASR-OP-2, CSTK-05, STK-4,

**Definition:** Intravenous (IV) thrombolytic therapy was initiated at this hospital. IV thrombolytics convert plasminogen to plasmin, which in turn breaks down fibrin and fibrinogen, thereby dissolving thrombus. IV t-PA is the only FDA-approved IV thrombolytic for stroke.

**Suggested Data Collection Question:** Is there documentation that IV thrombolytic therapy was initiated at this hospital?

**Format:**
- **Length:** 1
- **Type:** Alphanumeric
- **Occurs:** 1

**Allowable Values:**
- Y (Yes) IV thrombolytic was initiated at this hospital.
- N (No) IV thrombolytic was not initiated at this hospital, OR unable to determine from medical record documentation.

**Notes for Abstraction:**
- When a “hang time” or “infusion time” for IV thrombolytic is documented in the medical record, select “Yes.”
- If IV thrombolytic therapy was administered at another hospital and patient was subsequently transferred to this hospital, select “No.”
- If the patient was transferred to this hospital with IV thrombolytic infusing, select “No.”

**Suggested Data Sources:**
- Emergency department record
- Progress notes
- IV flow sheets
- Medication records

**Additional Notes:**

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Only Acceptable Thrombolytic Therapy for Stroke:</strong></td>
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</tr>
<tr>
<td>• Activase</td>
<td>• Thrombolytic administration to flush, open, or maintain patency of a central line, e.g., PICC line</td>
</tr>
<tr>
<td>• Alteplase</td>
<td></td>
</tr>
<tr>
<td>• IV t-PA</td>
<td></td>
</tr>
<tr>
<td>• Recombinant t-PA Tissue plasminogen activator</td>
<td></td>
</tr>
</tbody>
</table>
Data Element Name: IV Thrombolytic Initiation Date

Collected For: ASR-IP-1, ASR-OP-1, CSTK-05, STK-4,

Definition: The month, date, and year that IV thrombolytic therapy was initiated to a patient with ischemic stroke at this hospital. IV thrombolytics convert plasminogen to plasmin, which in turn breaks down fibrin and fibrinogen, thereby dissolving thrombus.

Suggested Data Collection Question: What is the date that IV thrombolytic therapy was initiated for this patient at this hospital?

Format: Length: 10 - MM-DD-YYYY (includes dashes) or UTD
Type: Date
Occurs: 1

Allowable Values:

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)
UTD = Unable to Determine

Notes for Abstraction:
- Use the date at which initiation of the IV thrombolytic was first documented. If a discrepancy exists in date documentation from different sources, choose nursing documentation first before other sources. If multiple dates are documented by the same individual, use the earliest date recorded by that person.
- If the date IV thrombolytic therapy was initiated is unable to be determined from medical record documentation, select “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 IV thrombolytic initiation date was 03-42-20xx. No other documentation in the medical record provides a valid date. Since the IV thrombolytic initiation date 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 CMS Clinical Warehouse and the Joint Commission’s Data Warehouse. Use of “UTD” for IV Thrombolytic Initiation Date allows the case to be accepted into the warehouse.

Suggested Data Sources:
- Emergency department record
- Nursing flow sheet
- Progress notes
- IV flow sheets
- Medication administration record

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
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</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name:  *IV Thrombolytic Initiation Time*

**Collected For:**  ASR-IP-1, ASR-OP-1, CSTK-05, STK-4,

**Definition:**  The time for which IV thrombolytic therapy was initiated at this hospital.

**Suggested Data Collection Question:**  What was the time of initiation for IV thrombolytic therapy?

**Format:**
- **Length:**  5 - HH-MM (with or without colon) or UTD
- **Type:**  Time
- **Occurs:**  1

**Allowable Values:**

- HH = Hour (00-23)
- MM = Minutes (00-59)
- UTD = Unable to Determine

Time must be recorded in military time format. With the exception of Midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

**Examples:**

- Midnight = 00:00
- Noon = 12:00
- 5:31 am = 05:31
- 5:31 pm = 17:31
- 11:59 am = 11:59
- 11:59 pm = 23:59

**Note:**

00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the *IV Thrombolytic Initiation Date* should remain 11-24-20xx or if it should be converted to 11-25-20xx.

When converting Midnight or 24:00 to 00:00, do not forget to change the *IV Thrombolytic Initiation Date*.

**Example:**

Midnight or 24:00 on 11-24-20xx = 00:00 on 11-25-20xx

**Notes for Abstraction:**

- Use the time at which initiation of the IV thrombolytic was first documented. If a discrepancy exists in time documentation from different sources, choose nursing documentation first before other sources. If multiple times are documented by the same individual, use the earliest time recorded by that person.
- For times that include “seconds”, remove the seconds and record the time as is. Example: 15:00:35 would be recorded as 15:00
- The use of “hang time” or “infusion time” is acceptable as IV thrombolytic initiation time when other documentation cannot be found.
- IV thrombolytic initiation time refers to the time the thrombolytic bolus/infusion was started.
• Do not use physician orders unless there is documentation with the order that it was administered.
• If the time of IV thrombolytic initiation is unable to be determined from medical record documentation, select “UTD”.
• 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 IV thrombolytic initiation time was 3300. No other documentation in the medical record provides a valid time. Since the IV thrombolytic initiation time 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 CMS Clinical Warehouse and the Joint Commission’s Data Warehouse. Use of “UTD” for IV Thrombolytic Initiation Time allows the case to be accepted into the warehouse.

Suggested Data Sources:
• Emergency department record
• Nursing flow sheet
• Progress notes
• IV flow sheets
• Medication administration record

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: Last Known Well

Collected For: ASR-IP-1, ASR-OP-1, STK-4,

Definition: The date and time prior to hospital arrival at which it was witnessed or reported that the patient was last known to be without the signs and symptoms of the current stroke or at his or her baseline state of health.

Suggested Data Collection Question: Is there documentation that the date and time of last known well was witnessed or reported?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:
- Y (Yes) There is documentation that the date and time of last known well was witnessed or reported.
- N (No) There is no documentation that the date and time of last known well was witnessed or reported, OR unable to determine from medical record documentation.

Notes for Abstraction:
- Select “Yes” if BOTH a date and 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 Last Known Well is unknown/uncertain/unclear. Documentation that time of symptom onset is unknown/uncertain/unclear is also acceptable when Time Last Known Well is not documented. If Last Known Well is not explicitly documented as unknown, do not make inferences (e.g. do not assume that patient woke with stroke so Last Known Well unknown unless explicitly documented).
  - If one physician documents a Time Last Known Well and another documents time of symptom onset unknown, select “Yes.”
  - If physician documents a Time Last Known Well and nurse/EMS documents Last Known Well unknown, select “Yes.”
  - If one physician documents Last Known Well unknown and another documents a Time Last Known Well, select “No.”

EXCEPTION:
- If the physician documents Last Known Well as unknown and the same physician crosses out unknown or mentions in a later note that Last Known Well is now known with a time documented, select “Yes.”
- If the Time Last Known Well is clearly greater than 2 hours prior to hospital arrival AND no 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.
- If the only Time Last Known Well is documented as a time immediately before hospital arrival without a specific time range, select “Yes.”
- If there is no documentation that Last Known Well or stroke signs/symptoms occurred prior to hospital arrival but there is documentation that Last Known Well first occurred after Arrival Time (e.g., in-house stroke), select “No.”

Suggested Data Sources:
- Emergency department record
- History and physical
- Nursing notes
- Nursing flow sheet
- Progress notes
Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Signs and Symptoms of Stroke</strong></td>
<td>Delay in stroke diagnosis</td>
</tr>
<tr>
<td>• Sudden numbness or weakness of the face, arm or leg, especially on one side of the body</td>
<td></td>
</tr>
<tr>
<td>• Sudden confusion, trouble speaking or understanding</td>
<td></td>
</tr>
<tr>
<td>• Sudden trouble seeing in one or both eyes</td>
<td></td>
</tr>
<tr>
<td>• Sudden trouble walking, dizziness, loss of balance or coordination</td>
<td></td>
</tr>
<tr>
<td>• Sudden severe headache</td>
<td></td>
</tr>
</tbody>
</table>
Data Element Name: *Payment Source*

Collected For: All Records, Optional for HBIPS-2 and HBIPS-3

Definition: The source of payment for this episode of care.

Suggested Data Collection Question: What is the patient's source of payment for this episode of care?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values: 1 Source of payment is Medicare.
2 Source of payment is NonMedicare.

Notes for Abstraction:
- If Medicare is listed as the primary, secondary, tertiary, or even lower down on the list or payers, select "1".
- If the patient has Medicaid only or Medicaid and another insurance type, other than Medicare, select "2". If the patient has Medicaid and Medicare, select "1".
- If the patient is an Undocumented Alien or Illegal immigrant select "1". Undocumented Alien: Section 1011 of the Medicare Modernization Act of 2003 allows for reimbursement for services rendered to patients who are: Undocumented or illegal aliens (immigrants), Aliens who have been paroled into a United States port of entry and Mexican citizens permitted to enter the United States on a laser visa.

Suggested Data Sources:
- Face sheet
- UB-04

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare includes, but is not limited to:</td>
<td></td>
</tr>
<tr>
<td>• Medicare Fee for Service (includes DRG or PPS)</td>
<td>• None</td>
</tr>
<tr>
<td>• Black Lung</td>
<td></td>
</tr>
<tr>
<td>• End Stage Renal Disease (ESRD)</td>
<td></td>
</tr>
<tr>
<td>• Railroad Retirement Board (RRB)</td>
<td></td>
</tr>
<tr>
<td>• Medicare Secondary Payer</td>
<td></td>
</tr>
<tr>
<td>• Medicare HMO/Medicare Advantage</td>
<td></td>
</tr>
</tbody>
</table>
Data Element Name: Race
Collected For: All Records
Definition: Documentation of the patient's race.
Suggested Data Collection Question: What is the patient's race?
Format: Length: 1
Type: Character
Occurs: 1
Allowable Values: Select one:
1. **White**: Patients race is White or the patient has origins in Europe, the Middle East, or North Africa.
2. **Black or African American**: Patients race is Black or African American.
3. **American Indian or Alaska Native**: Patients race is American Indian/Alaska Native.
4. **Asian**: Patients race is Asian.
5. **Native Hawaiian or Pacific Islander**: Patients race is Native Hawaiian/Pacific Islander.
6. **RETIRED VALUE** (effective 07-01-05 discharges)
7. **UTD**: Unable to determine the patient's race or not stated (e.g., not documented, conflicting documentation or patient unwilling to provide).

Notes for Abstraction:
- The data element *Hispanic Ethnicity* is required in addition to this data element.
- If documentation indicates the patient has more than one race (e.g., Black-White, Indian-White), select the first listed race.
- Although the terms Hispanic and Latino are actually descriptions of the patient's ethnicity, it is not uncommon to find them referenced as race. If the patient's race is documented only as Hispanic/Latino, select White. If the race is documented as mixed Hispanic/Latino with another race, use whatever race is given (e.g., Black-Hispanic select Black). Other terms for Hispanic/Latino include Chicano, Cuban, H (for Hispanic), Latin American, Latina, Mexican, Mexican-American, Puerto Rican, South or Central American, and Spanish.

Suggested Data Sources:
- Emergency department record
- History and physical
- Face sheet
- Nursing admission assessment
- Progress notes

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Black or African American</strong></td>
<td>• None</td>
</tr>
<tr>
<td>A person having origins in any of the black racial groups of Africa. Terms such as Haitian or Negro can be used in addition to Black or African American.</td>
<td></td>
</tr>
<tr>
<td><strong>American Indian or Alaska Native</strong></td>
<td></td>
</tr>
<tr>
<td>A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment</td>
<td></td>
</tr>
</tbody>
</table>
(e.g., any recognized tribal entity in North and South America [including Central America, Native American.])

**Asian**
A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

**White**
A person having origins in any of the original peoples of Europe, the Middle East, or North Africa (e.g., Caucasian, Iranian, White).

**Native Hawaiian or Pacific Islander**
A person having origins in any of the other original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
Data Element Name: Reason for Extending the Initiation of IV Thrombolytic

Collected For: ASR-IP-1, ASR-OP-1, STK-4,

Definition: Reasons for extending the initiation of IV thrombolytic to 3 to 4.5 hours.
- Documentation of treatment to lower blood pressure prior to IV thrombolytic initiation
- Documentation of patient/family refusal of IV thrombolytic which was recanted/reversed prior to IV thrombolytic initiation
- Documentation of cardiac arrest, respiratory arrest, cardiopulmonary resuscitation, defibrillation, or intubation in the emergency department prior to IV thrombolytic initiation
- Other reasons for extending the initiation of IV thrombolytics to 3 to 4.5 hours documented by physician/APN/PA or pharmacist

Suggested Data Collection Question: Is there documentation on the day of or day after hospital arrival of a reason for extending the initiation of IV thrombolytic to 3 to 4.5 hours of Time Last Known Well?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes)  There is documentation on the day of or the day after hospital arrival of a reason for extending the initiation of IV thrombolytic to 3 to 4.5 hours of Time Last Known Well.
N (No)  There is no documentation on the day of or day after hospital arrival of a reason for extending the initiation of IV thrombolytic to 3 to 4.5 hours of Time Last Known Well, OR unable to determine from the medical record documentation.

Notes for Abstraction: • Documentation of a reason for extending the initiation of IV thrombolytic to 3 to 4.5 hours must be done on the day of or the day after hospital arrival and must refer to the time period prior to IV thrombolytic initiation. It is not necessary to review documentation outside of this timeframe to answer this data element.
• “Other” reasons for extending the initiation of IV thrombolytic therapy to 3 to 4.5 hours must be documented by a physician/APN/PA or pharmacist.

EXCEPTION: Nursing documentation of a telemedicine/teleneurology reason for extending the initiation of IV thrombolytic therapy to 3 to 4.5 hours is acceptable.

• The following are acceptable as stand-alone reasons for extending the initiation of IV thrombolytics – IV thrombolytic therapy linkage is not needed:
  ○ Documentation of treatment to lower blood pressure, (e.g. nicardipine, hydralazine), prior to IV thrombolytic initiation
  ○ Documentation of patient/family refusal of IV thrombolytic which was recanted/reversed prior to IV thrombolytic initiation
  ○ Documentation of cardiac arrest, respiratory arrest, cardiopulmonary resuscitation, defibrillation, or intubation in the emergency department prior to IV thrombolytic initiation

• 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 initiated in 3 to 4.5 hours because patient consent could not be obtained from family in 3 hours unless explicitly documented).
Examples:
  ○ Documentation to initiate IV thrombolytic for worsening symptoms following documentation to not give tPA because symptoms resolved after hospital arrival, select “Yes.”
  ○ NIHSS score of 1 on arrival. IV thrombolytic ordered 4 hours after hospital arrival, select “No.”

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

**Suggested Data**

**Sources:**
- Consultation notes
- Emergency department record
- History and physical
- Nursing notes
- Progress notes
- Physician orders
- Medical transport records
- Medication reconciliation form
- Transfer Form

**Additional Notes:**

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
</table>
| None      | - Delay in hospital arrival greater than 2 hours  
           | - Delay in stroke diagnosis  
           | - Hold IV thrombolytic without a documented reason  
           | - No IV access |
Data Element Name: Reason for Not Administering Antithrombotic Therapy by End of Hospital Day 2

Collected For: ASR-IP-2, ASR-OP-2, STK-5,

Definition: Reason for not administering antithrombotic therapy by end of hospital day 2.
- Other reasons documented by physician/APN/PA or pharmacist.

Suggested Data Collection Question: Is there documentation by a physician/advanced practice nurse/physician assistant (physician/APN/PA) or pharmacist in the medical record of a reason for not administering antithrombotic therapy by end of hospital day 2?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:
Y (Yes) There is physician/APN/PA or pharmacist documentation of a reason for not administering antithrombotic therapy by end of hospital day 2.
N (No) There is no physician/APN/PA or pharmacist documentation of a reason for not administering antithrombotic therapy by end of hospital day 2 or unable to determine from the medical record documentation.

Notes for Abstraction:
- Documentation for allowable value “Yes” must be found within the timeframe of arrival to the end of hospital day 2. It is not necessary to review documentation outside of this timeframe to answer this data element.
- To compute end of hospital day 2, count the arrival date as hospital day 1. If a reason for not administering antithrombotic therapy was documented by 11:59 P.M. of hospital day 2, select “Yes” for this data element.
- Reasons for not administering antithrombotic therapy must be documented by a physician/APN/PA or pharmacist with one exception: Patient/family refusal of any form of antithrombotic therapy (e.g., “ASA refused,” “Patient refusing antithrombotic therapy”) may be documented by a nurse. However, it must be documented in the timeframe of arrival to the end of hospital day 2.
  Example:
  Patient arrived on 03/01/20XX. Nursing notes on 03/02/20XX indicates that patient refused antithrombotic therapy, select “Yes.”
- If reasons are not mentioned in the context of antithrombotics, do not make inferences (e.g., do not assume that antithrombotic therapy was not administered because of a bleeding disorder unless documentation explicitly states so).
  - Reasons must be explicitly documented (e.g., “Hemorrhagic transformation – do not give aspirin,” “Active GI bleed – antithrombotic therapy contraindicated,” “H/O bleeding disorder – anticoagulation therapy contraindicated,” “Low platelet count - do not give antiplatelet medications,” “No ASA” [no reason given]).
  - Physician/APN/PA or pharmacist documentation of a hold on an antithrombotic medication or discontinuation of an antithrombotic medication that occurs the day of or day after hospital arrival constitutes a “clearly implied” reason for not administering antithrombotic therapy by end of hospital day 2. A hold/discontinuation of all P.O. medications counts if an antithrombotic was on order at the time of the notation.
  - NPO is NOT a reason for not administering antithrombotic therapy without explicit documentation that no antithrombotic medication should be given. Another route of administration can be used.
  - An allergy or adverse reaction to one type of antithrombotic would NOT be a reason for not administering all antithrombotics. Another medication can be ordered.
  - For patients on warfarin therapy prior to hospital arrival, but placed on hold the day of or after arrival due to “high INR,” select “Yes.”
Suggested Data Sources:

**ONLY PHYSICIAN/APN/PA OR PHARMACIST DOCUMENTATION OF A REASON FOR NOT ADMINISTERING ANTITHROMBOTIC THERAPY:**
- Consultation notes
- Emergency room records
- History and physical
- Medication reconciliation form
- Progress Notes

**SUGGESTED DATA SOURCES FOR PATIENT/FAMILY REFUSAL (other than physician/APN/PA or pharmacist documentation of a reason for not administering antithrombotic therapy as noted above):**
- Medication Administration Record
- Nurses notes

**Excluded Data Sources:**
Any documentation dated/timed prior to hospital arrival or after hospital day 2.

Additional Notes:

**Guidelines for Abstraction:**

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<thead>
<tr>
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<tbody>
<tr>
<td>- None</td>
<td>- Delay in stroke diagnosis</td>
</tr>
<tr>
<td>- Refer to Appendix C, Table 8.2 for a comprehensive list of Antithrombotic Medications</td>
<td>- Antithrombotic medication allergy described using one of the negative modifiers or qualifiers listed in Appendix H, Table 2.6, Qualifiers and Modifiers Table.</td>
</tr>
</tbody>
</table>
Data Element Name: **Reason for Not Initiating IV Thrombolytic**

Collected For: ASR-IP-1, ASR-OP-1, STK-4,

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 by a physician/APN/PA that the patient has “no neurological deficit” or “normal neurological exam” 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: Is there documentation on the day of or day after hospital arrival of a reason for not initiating IV thrombolytic?

Format:
- **Length:** 1
- **Type:** Alphanumeric
- **Occurs:** 1

Allowable Values:
- **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:
- *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:
  - Documentation that intravenous (IV) or intra-arterial (IA) thrombolytic was initiated by a transferring hospital or EMS prior to hospital arrival
  - Documentation of patient/family refusal of IV thrombolytic
  - Documentation of NIHSS score of zero in the emergency department
  - Documentation by a physician/APN/PA that the patient has “no neurological deficit” or “normal neuro exam” 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

- 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”):
- “Patient with Stage IV cancer – No t-PA”
“Increased risk of bleeding – hold t-PA for further evaluation”

Unacceptable examples (select “No”):

- “Age”
- “Stroke too mild”
- “Stroke too severe”
- “Symptoms resolving”
- “No gait deficit”
- “Metastatic brain tumor”

- 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.
- 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:
  - Equipment-related (e.g., CT not available, IV pump malfunction)
  - Pharmacy-related (e.g., thrombolytic agent not available from pharmacy)
  - Staff-related (e.g., unable to contact consulting MD)

Suggested Data Sources:

- Consultation notes
- History and physical
- Nursing notes
- Progress notes
- Physician orders
- Medical transport records
- Medication reconciliation form
- Transfer Form
- Emergency room record

Additional Notes:

Guidelines for Abstraction:

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<td>• Hold IV thrombolytic without a documented reason</td>
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<td></td>
<td>• No IV access</td>
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</tbody>
</table>
Reason for Not Prescribing Antithrombotic Therapy at Discharge

Collected For: ASR-IP-3, STK-2,

Definition:
- Reason for not prescribing antithrombotic therapy at hospital discharge.
- Other reason documented by physician/APN/PA or pharmacist

Antithrombotic therapy is administered to reduce morbidity, mortality, and recurrence rate in stroke.

Suggested Data Collection Question:
- Is there documentation by a physician/advanced practice nurse/physician assistant (physician/APN/PA) or pharmacist in the medical record of a reason for not prescribing antithrombotic therapy at hospital discharge?

Format:
- Length: 1
- Type: Alphanumeric
- Occurs: 1

Allowable Values:
- Y (Yes) There is documentation of a reason for not prescribing antithrombotic therapy at hospital discharge.
- N (No) There is no documentation of a reason for not prescribing antithrombotic therapy at hospital discharge, OR unable to determine from the medical record documentation.

Notes for Abstraction:
- Reasons for not prescribing antithrombotic therapy at hospital discharge must be documented by a physician/APN/PA or pharmacist with one exception: Patient/family refusal of any form of antithrombotic therapy (e.g., “ASA refused,” “Patient refusing antithrombotic therapy”) may be documented by a nurse.
- If reasons are not mentioned in the context of antithrombectics, do not make inferences (e.g., do not assume that antithrombotic therapy was not prescribed because of a bleeding disorder unless documentation explicitly states so).
  - Reasons must be explicitly documented (e.g., “Active GI bleed – antithrombotic therapy contraindicated,” “H/O bleeding disorder – anticoagulation therapy contraindicated,” “Low platelet count – do not give antiplatelet medications,” “No ASA” [no reason given]).
  - Physician/APN/PA or pharmacist documentation of a hold on an antithrombotic medication or discontinuation of an antithrombotic medication that occurs during the hospital stay constitutes a “clearly implied” reason for not prescribing antithrombotic therapy at discharge. A hold/discontinuation of all p.o. medications counts if an oral antithrombotic medication (e.g., Plavix) was on order at the time of the notation.

EXCEPTIONS:
- Documentation of a conditional hold or discontinuation of an antithrombotic medication does not count as a reason for not prescribing an antithrombotic medication at discharge (e.g., “Hold ASA if guaiac positive,” “Stop Plavix if rash persists,” “No ASA for 24 hours following thrombolytic therapy”).
- Discontinuation of a particular antithrombotic medication documented in combination with the start of a different antithrombotic medication (i.e., switch type of antithrombotic medication) does not count as a reason for not prescribing an antithrombotic medication at discharge.
  - Examples:
    - “Stop Plavix” and “Start Plavix 75 mg po daily” in same physician order
    - “Change Plavix to aspirin” in progress note
    - “Do not continue after discharge” checked for Plavix and “Continue after discharge” checked for clopidogrel on a physician-signed discharge medication reconciliation form
- Discontinuation of an antithrombotic medication at a particular dose documented in combination with the start of a different dose of that antithrombotic (i.e., change in dosage) does not count as a reason for not prescribing an antithrombotic medication at discharge.
Examples:
“Stop Ecotrin 300 mg po daily” and “Start Ecotrin 325 mg po daily” in same physician order
“Increase Ecotrin 81 mg to 325 mg daily” in progress note
“Do not continue after discharge” checked for Ecotrin 300 mg and “Continue after discharge” checked for Ecotrin 325 mg on a physician-signed discharge medication reconciliation form

○ Deferral of antithrombotic therapy from one physician/APN/PA or pharmacist to another does NOT count as a reason for not prescribing antithrombotic therapy at discharge unless the problem underlying the deferral is also noted.
Examples:
- “Consulting neurologist to evaluate pt. for warfarin therapy.” - select “No.”
- “Rule out GI bleed. Start ASA if OK with gastroenterology.” - select “Yes.”

○ If there is documentation of a plan to initiate/restart antithrombotic therapy, and the reason/problem underlying the delay in starting/restarting antithrombotic therapy is also noted, this constitutes a “clearly implied” reason for not prescribing antithrombotic therapy at discharge.
Acceptable examples (select “Yes”):
- “Stool Occult Blood positive.
- May start Coumadin as outpatient.”
- “Start ASA if hematuria subsides.”
Unacceptable examples (select “No”):
- “Consider starting Coumadin in a.m.”
- “May add Plavix when pt. can tolerate”

○ Reasons do NOT need to be documented at discharge or otherwise linked to the discharge timeframe: Documentation of reasons anytime during the hospital stay are acceptable (e.g., mid-hospitalization note stating “no ASA due to rectal bleeding” - select “Yes,” even if documentation indicates that the rectal bleeding has resolved by the time of discharge and ASA was restarted).

○ Crossing out of an antithrombotic medication counts as a “clearly implied reason” for not prescribing antithrombotic therapy at discharge only if on a pre-printed form.

- An allergy or adverse reaction to one type of antithrombotic would NOT be a reason for not administering all antithrombotics. Another medication can be ordered.
- When conflicting information is documented in a medical record, select “Yes.”
- When the current record includes documentation of a pre-arrival reason for no antithrombotic therapy, the following counts regardless of whether this documentation is included in a pre-arrival record made part of the current record or whether it is noted by hospital staff during the current hospital stay:
  ○ Pre-arrival hold/discontinuation or notation such as “No Coumadin” IF the underlying reason/problem is also noted (e.g., “Coumadin held in transferring hospital due to possible GI bleed”).
  ○ Pre-arrival “other reason” (other than hold/discontinuation or notation of “No ASA”) (e.g., “Hx GI bleeding with ASA” in transferring ED record).

ONLY PHYSICIAN/APN/PA OR PHARMACIST DOCUMENTATION OF A REASON FOR NOT PRESCRIBING ANTITHROMBOTIC THERAPY AT HOSPITAL DISCHARGE:

- Consultation notes
- Discharge summary
- Emergency Department record
- History and physical
- Medication administration record
- Medication reconciliation form
- Physician orders

Suggested Data Sources:
- Progress Notes

**Excluded Data Sources:**
Any documentation dated/timed after discharge, except discharge summary.

### Additional Notes:

**Guidelines for Abstraction:**

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<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Antithrombotic medication allergy described using one of the negative modifiers or qualifiers listed in Appendix H, Table 2.6, Qualifiers and Modifiers Table.</td>
</tr>
<tr>
<td>Refer to Appendix C, Table 8.2 for a comprehensive list of Antithrombotic Medications.</td>
<td></td>
</tr>
</tbody>
</table>
Data Element Name: Sex

Collected For: All Records

Definition: The patient's documented sex on arrival at the hospital.

Suggested Data Collection Question: What is the patient's sex on arrival?

Format: Length: 1
Type: Character
Occurs: 1

Allowable Values:
M = Male
F = Female
U = Unknown

Notes for Abstraction:
- Collect the documented patient's sex at admission or the first documentation after arrival.
- Consider the sex to be unable to be determined and select Unknown if:
  - The patient refuses to provide their sex.
  - Documentation is contradictory.
  - Documentation indicates the patient is a Transexual.
  - Documentation indicates the patient is a Hermaphrodite.

Suggested Data Sources:
- Consultation notes
- Emergency department record
- History and physical
- Face sheet
- Progress notes
- Nursing admission notes
- UB-04

Additional Notes:

Guidelines for Abstraction:

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name: Time Last Known Well

Collected For: ASR-IP-1, ASR-OP-1, STK-4,

Definition: The time prior to hospital arrival at which the patient was last known to be without the signs and symptoms of the current stroke or at his or her baseline state of health.

Suggested Data Collection Question: At what time was the patient last known to be well or at his or her prior baseline state of health?

Format: Length: 5 - HH-MM (with or without colon) or UTD
Type: Time
Occurs: 1

Allowable Values:

HH = Hour (00-23)
MM = Minutes (00-59)
UTD = Unable to Determine

Time must be recorded in military time format. With the exception of Midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:

Midnight = 00:00
Noon = 12:00
5:31 am = 05:31
5:31 pm = 17:31
11:59 am = 11:59
11:59 pm = 23:59

Note:

00:00 = midnight. If the time is documented as 00:00 11-24-20xx, review supporting documentation to determine if the Date Last Known Well should remain 11-24-20xx or if it should be converted to 11-25-20xx.

When converting Midnight or 24:00 to 00:00, do not forget to change the Date Last Known Well.

Example:
Midnight or 24:00 on 11-24-20xx = 00:00 on 11-25-20xx

Notes for Abstraction:

- The Time Last Known Well must be a time prior to the patient’s Arrival Time. Do not use times after hospital arrival for Time Last Known Well.
- 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 CMS 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 one **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.

**EXCEPTIONS:**
- ANY physician/APN/PA documentation that **Last Known Well/onset of signs/symptoms is unknown/uncertain/unclear** takes precedence over specific time on “Code Stroke” form.
- Crossing out of a specific time on a Code Stroke Form and a specific time documented on the same or different Code Stroke Form, use the specific time that is not crossed out.
- A specific time on a Code Stroke Form and another time reference documented, e.g. <8 hours, on the same or different Code Stroke Forms, use the specific time.
- Multiple specific times on the same or different Code Stroke Forms, use abstraction guidelines for multiple Times Last Known Well.
- Unable to determine if a form is a Code Stroke Form, continue to review the medical record for **Time Last Known Well** documentation in other sources.

- A Code Stroke Form is used by the stroke team or ED staff to document the acute stroke process.
- See the inclusion list for acceptable terms used for a Code Stroke Form. The list is not all-inclusive.
- **Time Last Known Well** on a Code Stroke Form may be documented by a nurse.
- 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 the time is noted to be “less than” a period of time prior to ED arrival, assume the maximum range.
  Example:
  **Time Last Known Well** less than one hour ago. Subtract one hour from the time of arrival to compute 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:
  “Sudden onset headache one hour before ED arrival,” documented by ED MD. Arrival time
19:24. No other documentation referencing time last known well available in medical record. 
*Time Last Known Well* is 18:24.
- 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:
  
  ◦ “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.
  ◦ “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.
  ◦ “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.
  ◦ “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:**
- Emergency department record
- History and physical
- Nursing flow sheet
- Progress notes
- Medication administration record (MAR)
- Transfer sheet
- Ambulance record
- Code Stroke form/template
- IV flow sheets

**Additional Notes:**

**Guidelines for Abstraction:**

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<td><strong>Signs and Symptoms of Stroke</strong></td>
<td><strong>Code Stroke Form</strong></td>
</tr>
<tr>
<td>- Sudden numbness or weakness of the face, arm or leg, especially on one side of the body</td>
<td>- Stroke Education Form</td>
</tr>
<tr>
<td>- Sudden confusion, trouble speaking or understanding</td>
<td>- Core Measure Form</td>
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<tr>
<td>- Sudden trouble seeing in one or both eyes</td>
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<tr>
<td>- Sudden trouble walking, dizziness, loss of balance or coordination</td>
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<td>- Sudden severe headache</td>
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- Stroke Intervention Form
- Stroke Rapid Response Form
- Thrombolysis Checklist
- tPA Eligibility Form
Tables
Appendix A

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- Table Number 1.0: E/M Codes for Emergency Department Encounters
- Table Number 8.1: Ischemic Stroke
- Table Number 8.2: Hemorrhagic Stroke

Table Number 1.0: E/M Codes for Emergency Department Encounters

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Table Number 8.1: Ischemic Stroke

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Acute Stroke Ready Performance Measurement Implementation Guide
Effective with Discharges on and after January 1, 2018
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