Disease-Specific Care
ADVANCED CERTIFICATION PROGRAM

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

Set Measures

<table>
<thead>
<tr>
<th>Set Measure ID</th>
<th>Measure Short Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASR-OP-1</td>
<td>Thrombolytic Therapy: Drip and Ship</td>
</tr>
<tr>
<td>ASR-OP-2</td>
<td>Door to Transfer to Another Hospital</td>
</tr>
</tbody>
</table>

General Data Elements

<table>
<thead>
<tr>
<th>Element Name</th>
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<tbody>
<tr>
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<td>ICD-10-CM Principal Diagnosis Code</td>
<td>All Records, Optional for HBIPS-2, HBIPS-3</td>
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<tr>
<td>Payment Source</td>
<td>All Records, Optional for HBIPS-2 and HBIPS-3</td>
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<td>Race</td>
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Measure Set Specific Data Elements

<table>
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<tr>
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<tr>
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<td>ASR-OP-1, ASR-OP-2,</td>
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<tr>
<td>Comfort Measures Only</td>
<td>ASR-OP-2,</td>
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<tr>
<td>Date Last Known Well</td>
<td>ASR-OP-1,</td>
</tr>
<tr>
<td>Discharge Code</td>
<td>ASR-OP-2,</td>
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<tr>
<td>E/M Code</td>
<td>ASR-OP-1, ASR-OP-2,</td>
</tr>
<tr>
<td>ED Departure Date</td>
<td>ASR-OP-2,</td>
</tr>
<tr>
<td>ED Departure Time</td>
<td>ASR-OP-2,</td>
</tr>
</tbody>
</table>
### ASR-OP Initial Patient Population

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

- EM Code
- ICD-10-CM Principal Diagnosis Code
- Outpatient Encounter Date
- Birthdate

Patients admitted to the hospital for outpatient acute care with an EM Code and an ICD-10-CM Principal Diagnosis Code for ischemic or hemorrhagic stroke as defined in Appendix A, Table 8.1 or Table 8.2, a Patient Age (Outpatient Encounter Date minus Birthdate) greater than or equal to 18 years are included in the ASR-OP Initial Patient Population.
Acute Stroke Ready Hospital Outpatient Initial Patient Population Algorithm

Start ASR Outpatient Initial Patient Population Logic sub-routine

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

EDM Code

On Table 1.0

ICD-10-CM Principal Diagnosis Code

On Table 8.1 or 8.2

Patient Age on Outpatient Encounter Date (in years) =
Outpatient Encounter Date minus Birthdate

Use the month and day portion of outpatient encounter date and birthdate to yield the most accurate age.

Patient Age on Outpatient Encounter Date

< 18 years

Patient is in the ASR Outpatient Initial Patient Population

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

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

<= 18 years

Patient is not in the ASR Outpatient Initial Patient Population

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

End

Variable Key:

- Patient Age on Outpatient Encounter Date
- OP Initial Patient Population Reject Case Flag
Measure Information Form

Measure Set: Acute Stroke Ready Outpatient (ASR-OP)

Set Measure ID: ASR-OP-1

Performance Measure Name: Thrombolytic Therapy: Drip and Ship

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., drip and ship patients).

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 (t-PA) therapy was initiated at this hospital within 3 hours (< 180 min.) 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 (< 120 min.) of time last known well

Included Populations:

- Patients with an ICD-10-CM Principal Diagnosis Code for acute ischemic stroke as defined in Appendix A, Table 8.1, AND
- An E/M Code for emergency department encounter as defined in Appendix A, Table 1.0

Excluded Populations:

- Patients less than 18 years of age
- Time Last Known Well to arrival in ED > 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:

- Arrival Time
- Birthdate
- Date Last Known Well
- E/M Code
- ICD-10-CM Principal Diagnosis Code
- Last Known Well
- Outpatient Encounter Date
- 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:

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


**Measure Algorithm:**
ASR-OP-1: Thrombolytic Therapy: Drip and Ship

**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.

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**Variable Key:**
- Timing I
- Timing II

---

**Flowchart Description:**
- Start
- Run cases that are included in the ASR Outpatient Initial Patient Population and pass the rules defined in the Transmission Data Processing Flow: Clinical through this measure.
- ICD-10-CM Principal Diagnosis Code:
  - Not on Table 3.1
  - On Table 3.1
  - Arrival Time:
    - UTD
    - Non-UTD
  - Last Known Well:
    - Missing
    - ≠ Y
  - Date Last Known Well:
    - Missing
    - ≠ UTD
  - Non-UTD
  - Y

Acute Stroke Ready Performance Measurement Implementation Guide

Effective with Discharges on and after January 1, 2018
Measure Information Form

Measure Set: Acute Stroke Ready Outpatient (ASR-OP)

Set Measure ID: ASR-OP-2

<table>
<thead>
<tr>
<th>Set Measure ID</th>
<th>Performance Measure Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASR-OP-2a</td>
<td>Door to Transfer to Another Hospital - Overall Rate</td>
</tr>
<tr>
<td>ASR-OP-2b</td>
<td>Door to Transfer to Another Hospital - Hemorrhagic Stroke</td>
</tr>
<tr>
<td>ASR-OP-2c</td>
<td>Door to Transfer to Another Hospital - Ischemic Stroke; Drip and Ship</td>
</tr>
<tr>
<td>ASR-OP-2d</td>
<td>Door to Transfer to Another Hospital - Ischemic Stroke; No IV t-PA Prior to Transfer</td>
</tr>
</tbody>
</table>

Performance Measure Name: Door to Transfer to Another Hospital

Description: Median time from hospital arrival in the emergency department to transfer of a hemorrhagic stroke patient, an ischemic stroke patient (drip and ship), or an ischemic stroke patient (no IV t-PA given prior to transfer) to another hospital

Rationale: For the past ten years, the organization of acute stroke care in the United States has moved in the direction of stroke centers; however, many patients with an acute stroke live in areas without ready access to a Primary (PSC) or Comprehensive Stroke Center (CSC). A third designation of stroke center, the Acute Stroke Ready Hospital (ASRH), has emerged for hospitals that can provide timely, evidence-based care, i.e., initial diagnostic services, initial stroke diagnosis, stabilization, emergent care and therapies, to patients with an acute stroke who are seen in their emergency department.

Most patients with an acute stroke seen initially at an ASRH will require emergent transfer to a PSC or CSC. The Brain Attack Coalition recommends that such transfers occur within 2 hours of the patient presenting to the ASRH (Alberts, 2013). Additionally, written transfer agreements between the ASRH and at least one PSC or CSC and a transportation vendor with both ground and air ambulance transfer options are recommended. One in four patients are transferred while receiving intravenous (IV) thrombolytic therapy (t-PA) (Sheth, 2015); others transferred after initiation of coagulopathy reversal treatment. Reducing the time stroke patients remain in the emergency department (ED) can improve access to a higher-level of stroke care and advanced intra-arterial or endovascular treatments, and increase quality of care. For those stroke patients who are not transferred to a PSC or CSC, inpatient admission within 3 hours, preferably to a formal stroke unit, is recommended (Jauch, 2013).

Type of Measure: Process
Improvement Noted As: Decrease in the median value

Continuous Variable Statement:

ASR-2b Time (in minutes) from ED arrival to transfer of a hemorrhagic stroke patient to another hospital

ASR-2c Time (in minutes) from ED arrival to transfer of an ischemic stroke patient (drip and ship) to another hospital

ASR-2d Time (in minutes) from ED arrival to transfer of an ischemic stroke patient (no IV t-PA prior to transfer) to another hospital

Included Populations:

- Patients with an ICD-10-CM Principal Diagnosis Code for ischemic or hemorrhagic stroke as defined in Appendix A, Table 8.1 or Table 8.2

  AND

- Patients who are transferred to another hospital

  AND

- An E/M Code for emergency department encounter as defined in Appendix A, Table 1.0

Excluded Populations:

- Patients less than 18 years of age
- Patients with Comfort Measures Only documented on day of or day after arrival
- Patients who expired in the emergency department
- Discharges to dispositions other than an acute care facility

Data Elements:

- Arrival Time
- Birthdate
- Comfort Measures Only
- Discharge Code
- E/M Code
- ED Departure Date
- ED Departure Time
- ICD-10-CM Principal Diagnosis Code
- IV Thrombolytic Initiation
Outpatient Encounter Date

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 measure of central tendency.

Selected References:


Measure Algorithm:
Measure Algorithm:

ASR-OP-2: Door to Transfer to Another Hospital

Continuous Variable Statement: Time (in minutes) from ED arrival to transfer of an ischemic or hemorrhagic stroke patient to another hospital.

[Diagram of the Measure Algorithm]

Note: There will be no category assignment E for this measure because it is a continuous variable.
Data Elements
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)
- YYYYY = 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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<thead>
<tr>
<th>Inclusion</th>
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<tbody>
<tr>
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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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<th>Inclusion</th>
<th>Exclusion</th>
</tr>
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<tbody>
<tr>
<td>Brain dead</td>
<td>None</td>
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<tr>
<td>Brain death</td>
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<tr>
<td>Comfort care</td>
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<tr>
<td>DNR-CC</td>
<td></td>
</tr>
<tr>
<td>End of life care</td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td></td>
</tr>
<tr>
<td>Hospice care</td>
<td></td>
</tr>
<tr>
<td>Organ harvest</td>
<td></td>
</tr>
<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 abistrator 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 abistrator 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:

- “Wife reports patient normal this evening until approximately 9 PM.” Hospital arrival is 0030 on 12-10-20xx. Date Last Known Well is 12-09-20xx.
- “Patient states he felt perfectly fine earlier today. At noon, he began to have trouble seeing.” Hospital arrival is 3:59 PM on 12-10-20xx. Date Last Known Well is 12-10-20xx.
• If a reference to date last known well is documented without a specific date, enter that date for the Date Last Known Well. If multiple dates are documented, select the earliest date.

Examples:
  ▪ “Patient last known well today (day of arrival).” Select Arrival Date for Date Last Known Well.
  ▪ “Patient normal yesterday (day before arrival) documented in H&P and consult note documents that patient was last known to be well on Monday (two days prior to arrival).” Select Monday’s date for Date Last Known Well.

Suggested Data Sources:
- 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:

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

**Collected For:** ACHFOP, ASR-OP-2, THKR-OP-2, THKR-OP-3,

**Definition:** The final place or setting to which the patient was discharged from the outpatient setting.

**Suggested Data Collection Question:** What was the patient’s discharge code from the outpatient setting?

**Format:**
- **Length:** 2
- **Type:** Alphanumeric
- **Occurs:** 1

**Allowable Values:**

1. Home
2. Hospice - Home
3. Hospice — Health Care Facility
4a. Acute Care Facility- General Inpatient Care
4b. Acute Care Facility- Critical Access Hospital
4c. Acute Care Facility- Cancer Hospital or Children's Hospital
4d. Acute Care Facility — Department of Defense or Veteran's Administration
5. Other Health Care Facility
6. Expired
7. Left Against Medical Advice/AMA
8. Not Documented or Unable to Determine (UTD)

**Notes for Abstraction:**
- If documentation is contradictory, use the latest documentation. If there is documentation that further clarifies the level of care that documentation should be used to determine the correct value to abstract.
  - Example:
    - Nursing discharge note documentation reflects that the patient is being discharged to "XYZ" Hospital. The Social Service notes from the day before discharge further clarify that the patient will be transferred to the rehab unit of "XYZ" Hospital, select value “5”.
- 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 “4a”.
- When determining whether to select value 7 (“Left Against Medical Advise”):
  - A signed AMA form is not required for this data element, but in the absence of a signed form, the medical record must contain physician or nurse documentation that the patient left against medical advice or AMA.
  - For this data element, a signed AMA form is not required.
  - 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 value 7).
  - Physician order written to discharge to home. Nursing notes reflect that the patient left before discharge instructions could be given; select value 1.
Suggested Data

Sources:
- Discharge instruction sheet
- Emergency Department Record
- Nursing discharge notes
- Physician orders
- Progress notes
- Transfer record

Additional Notes: Excluded Data Sources:
- UB-04

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>For Value 1:</td>
<td>None</td>
</tr>
<tr>
<td>- Assisted Living 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, 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>
</tbody>
</table>
Data Element Name:     *E/M Code*

Collected For:        ACHFOP, ASR-OP-1, ASR-OP-2, CAH-01.2, CAH-02.2, CAH-07, CAH-08.2, CAH-09.2, CAH-10.2,

Definition:           The code used to report evaluation and management services provided in the outpatient department clinic or emergency department.

Suggested Data Collection Question:  What was the E/M code documented for this outpatient encounter?

Format:               Length:  5
                      Type:   Alphanumeric
                      Occurs: 1

Allowable Values:     Select the E/M code from Appendix A, Table 1.0.

Notes for Abstraction: None

Suggested Data Sources:  • Outpatient medical record

Additional Notes:      

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refer to Appendix A, Table 1.0, E/M Codes</td>
<td>None</td>
</tr>
</tbody>
</table>
Data Element Name:  
*ED Departure Date*

Collected For: 
ASR-OP-2, CAH-07,

Definition: 
The month, day, and year at which the patient departed from the emergency
department.

Suggested Data Collection Question: 
What is the date the patient departed from the emergency department?

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

Allowable Values:
Enter the documented date of the ED Departure
MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)
UTD = Unable to Determine

Notes for Abstraction:

- 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 *ED Departure Date* was 03-42-20xx. No other
documentation in the list of ONLY ACCEPTABLE SOURCES provides a valid date.
  Since the *ED Departure 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 *ED Departure Date* was 03-12-20xx. Other
  documentation in the medical record supports the date of death as being
  accurate. Since the *ED Departure 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 QIO Clinical Warehouse and the Joint Commission's Data
Warehouse. Use of “UTD” for *ED Departure Date* allows the case to be accepted
into the warehouse.

- If the date the patient departed is unable to be determined from medical record
documentation, select “UTD”.
- If the date of departure is not documented, but you are able to determine the date
  from other documentation this is acceptable (e.g., you are able to identify from
documentation the patient arrived and was transferred on the same day).
- If there is documentation the patient left against medical advice and it cannot be
determined what time the patient left against medical advice, select “UTD”.
For patients who are placed into observation services, use the date of the physician/APN/PA order for observation services as the *ED Departure Date*.

The intent of this guidance is to abstract the date that the patient is no longer under the care of the ED. When a patient is placed into observation, their clinical workflow may vary from patients who are not placed into observation prior to departure from the ED, so the observation order may be used instead of the actual *ED Departure Date*.

If there is a discharge date listed on a disposition sheet this may be abstracted as *ED Departure Date*.

The inclusion and exclusion lists are not to be considered comprehensive lists of inclusions and exclusions.

**Suggested Data Sources:**

**ONLY ACCEPTABLE SOURCES:**

- Emergency department record

**Additional Notes:**

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>ED Departure Date</em></td>
<td><em>Disposition Date</em></td>
</tr>
<tr>
<td><em>ED Discharge Date</em></td>
<td></td>
</tr>
<tr>
<td><em>ED Leave Date</em></td>
<td></td>
</tr>
</tbody>
</table>
Data Element Name: ED Departure Time

Collected For: ASR-OP-2, CAH-07,

Definition: The time (military time) represented in hours and minutes at which the patient departed from the emergency department.

Suggested Data Collection Question: What is the time the patient departed from the emergency department?

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

Allowable Values:

MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)
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 ED Departure 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 ED Departure 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 military time. Example: 15:00:35 would be recorded as 15:00.
• The intention is to capture the latest time at which the patient was receiving care in the emergency department, under the care of emergency department services, or awaiting transport to services/care.
• 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 \textit{ED Departure Time} was 3300. No other documentation in the list of ONLY ACCEPTABLE SOURCES provides a valid time. Since the \textit{ED Departure Time} is outside of the range in the Allowable Values for “Hour,” it is not a valid time and the abstractor should select “UTD”.

\textbf{Note:} Transmission of a case with an invalid time as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission’s Data Warehouse. Use of “UTD” for ED Departure Time allows the case to be accepted into the warehouse.

• \textit{ED Departure Time} is the documented time the patient physically left the emergency department.

Examples:
\begin{itemize}
  \item ED nursing notes documented the “ED Departure Time” as 1030, however, vital signs are documented at 1040. There is no documentation to support that the patient was in the ED at 1040. Enter 1030 for ED Departure Time.
  \item ED nursing notes document patient departed from the ED at 0730. ED nursing notes document medication administration at 0735. Enter 0730 for ED Departure Time.
\end{itemize}

• If the time the patient departed is unable to be determined from medical record documentation, select, “UTD.”

Example:
\begin{itemize}
  \item ED nursing notes document patient departed from the ED at 1225. Nursing notes document medication administration at 1245. Physician progress notes document assessment at 1310. There is substantial documentation to support that the patient was in the ED after documented departure and no additional documented time of ED departure. Enter UTD for \textit{ED Departure Time}.
\end{itemize}

• When more than one emergency department departure/discharge time is documented abstract the latest time.

Examples:
\begin{itemize}
  \item ED nursing notes contain documentation that the patient was transferred to floor at 1800 and transport documentation states that patient left the ED via stretcher at 1815. There are multiple times documented for departure. Use the later time of 1815 as ED Departure Time.
  \item ED nursing notes contain documentation that the patient departed the ED at 0500. ED record contains documentation of medication administration at 0510 and that the patient departed the ED at 0620. Physician notes contain documentation of an assessment at 0540. As there are multiple departure times documented, enter 0620 for ED Departure Time as it is the latest time documented.
\end{itemize}

• If patient expired in the ED, use the time of death as the departure time.
• Do not use the time the discharge order was written because it may not represent the actual time of departure.
• If ED Departure Time is documented prior to arrival abstract UTD.
• For patients who are placed into observation services, use the time of the physician/APN/PA order for observation for ED Departure Time.
• The intent of this guidance is to abstract the time that the patient is no longer under the care of the ED. When a patient is placed into observation, their clinical workflow may vary from patients who are not placed into observation prior to departure from the ED, so the observation order may be used instead of the actual ED Departure Time.
• If there is a discharge time listed on a disposition sheet, this may be used for ED Departure Time.
• The inclusion and exclusion lists are not to be considered comprehensive lists of inclusions and exclusions.

Suggested Data
Sources: ONLY ACCEPTABLE SOURCES:
• Emergency Department record

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Leave Time</td>
<td>Report Called Time</td>
</tr>
<tr>
<td>ED Discharge Time</td>
<td>Disposition Time</td>
</tr>
<tr>
<td>ED Departure Time</td>
<td></td>
</tr>
<tr>
<td>ED Check Out Time</td>
<td></td>
</tr>
</tbody>
</table>
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

Allowable Values: Any valid diagnosis code as per the CMS ICD-10-CM master code table (Code Descriptions in Tabular Order):

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 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>Only Acceptable Thrombolytic Therapy for Stroke:</td>
<td>• Intra-arterial (IA) t-PA</td>
</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>
</tr>
</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 in minutes, e.g., “symptoms started just prior to ED arrival,” 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
- Medication administration record (MAR)
- Transfer sheet
- Ambulance record
- Code Stroke form/template
- IV flow sheets

**Additional Notes:**

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signs and Symptoms of Stroke</td>
<td></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>
<tr>
<td>Delay in stroke diagnosis</td>
<td></td>
</tr>
</tbody>
</table>
Data Element Name: **Outpatient Encounter Date**

Collected For: ACHFOP, ASR-OP-1, ASR-OP-2, THKR-OP,

Definition: The documented month, day, and year the patient arrived in the outpatient setting.

Suggested Data Collection Question: What was the date the patient arrived in the outpatient setting?

Format: Length: 10-MM-DD-YYYY
Type: Date
Occurs: 1

Allowable Values:

- MM = Month (01-12)
- DD = Day (01-31)
- YYYY = Year (2008-Current Year)

Notes for Abstraction:
- The intent of this data element is to determine the date the patient arrived in the outpatient setting.
- UTD is NOT an allowable value.
- Consider the outpatient encounter date as the earliest documented date the patient arrived in the applicable hospital outpatient setting. If the patient had preoperative laboratory or other screening tests performed prior to the date of surgery, use the date the patient arrived for surgery.

Suggested Data Sources:
- Emergency department record
- Outpatient medical record

Additional Notes:

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>* Preoperative tests or screening</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 of 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>None</td>
</tr>
<tr>
<td>• Medicare Fee for Service (includes DRG or PPS)</td>
<td></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: Patient's race is White or the patient has origins in Europe, the Middle East, or North Africa.

2 Black or African American: Patient's race is Black or African American.

3 American Indian or Alaska Native: Patient's race is American Indian/Alaska Native.

4 Asian: Patient's race is Asian.

5 Native Hawaiian or Pacific Islander: Patient's 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
### 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>&lt;br&gt;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>• None</td>
</tr>
<tr>
<td><strong>American Indian or Alaska Native</strong>&lt;br&gt;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 (e.g., any recognized tribal entity in North and South America [including Central America], Native American.)</td>
<td></td>
</tr>
<tr>
<td><strong>Asian</strong>&lt;br&gt;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.</td>
<td></td>
</tr>
<tr>
<td><strong>White</strong>&lt;br&gt;A person having origins in any of the original peoples of Europe, the Middle East, or North Africa (e.g., Caucasian, Iranian, White).</td>
<td></td>
</tr>
<tr>
<td><strong>Native Hawaiian or Pacific Islander</strong>&lt;br&gt;A person having origins in any of the other original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.</td>
<td></td>
</tr>
</tbody>
</table>
**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 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:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>• Delay in hospital arrival greater than 2 hours</td>
</tr>
<tr>
<td></td>
<td>• Delay in stroke diagnosis</td>
</tr>
<tr>
<td></td>
<td>• Hold IV thrombolytic without a documented reason</td>
</tr>
<tr>
<td></td>
<td>• No IV access</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:  
  o The patient refuses to provide their sex.  
  o Documentation is contradictory.  
  o Documentation indicates the patient is a Transexual.  
  o 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:

<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:  
*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:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<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>
</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>

**Code Stroke Form**
- Stroke Activation Form
- Stroke Alert Form
- Stroke Assessment Form
- Stroke Intervention Form
- Stroke Rapid Response Form
- Thrombolysis Checklist
- tPA Eligibility Form
Tables
Appendix A

Index of Appendix A

↓ 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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<thead>
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Table Number 8.1: Ischemic Stroke

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<tr>
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<td>Cerebral infarction due to thrombosis of bilateral carotid arteries</td>
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### Table Number 8.2: Hemorrhagic Stroke

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