

Release Notes for the 2011A Manual

Section	Rationale	Description
Admission Type	Data element is now a measure specific data element. To clarify the use of the code for newborn.	<p>Under collected for change from: PC</p> <p>to:</p> <p>PC-04, PC-05</p> <p>Under the Notes for Abstraction add:</p> <ul style="list-style-type: none"> • If the patient is born outside of the hospital, e.g., in an ambulance, and the hospital issues the birth certificate, select "4".
Admission Date	To align with NHQM.	<p>In the Notes for Abstraction change from:</p> <ul style="list-style-type: none"> • The intent of this data element is to determine the date that the patient was actually admitted to 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. • A patient of a hospital is considered an inpatient upon issuance of written doctor's orders to that effect. (Refer to the Medicare Claims Processing Manual, Chapter 3, Section 40.2.2.) • 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. • For patients that are admitted for surgery and/or a procedure, if the admission order states the date the orders were written and they are effective for the surgery/procedure date, then the date of the surgery/procedure would be the admission date. If the medical record reflects that the admission order was written prior to the actual date the patient was admitted and there is no reference to the date of the surgery/procedure, then the date the order was written would be the admission date. • For HBIPS only, admission dates prior to 2001 are acceptable. <p>to:</p> <ul style="list-style-type: none"> • The intent of this data element is to determine the date that the patient was actually admitted to 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 from billing is incorrect, for purposes of abstraction, she/he should correct and override the downloaded value.

- 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. o 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.
- If there are multiple inpatient orders, use the order that most accurately reflects the date that the patient was admitted. The admission date should not be abstracted from the earliest admission order without regard 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. o 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 as 05-01-20xx.
- For HBIPS only, admission dates prior to 2001 are acceptable.
- For PC only, an initial set of physician orders addressing care or treatment of the newborn can be interpreted as newborn admission orders, and the date of these orders can be considered the admission date

Under suggested data sources change from:

PRIORITY ORDER FOR THESE SOURCES

- Physician orders
- Face sheet
- UB-04, Field Location: 12

to:

ONLY ALLOWABLE SOURCES

- 1. Physician orders
- 2. Face sheet

Excluded Data Sources

- UB-04, Field Location: 06

Antenatal Steroids	To clarify measure population to exclude fetal demise.	<p>Change denominator statement from:</p> <p>Patients delivering preterm newborns with 24-32 weeks gestation completed</p> <p>to:</p> <p>Patients delivering live preterm newborns with 24-32 weeks gestation completed</p> <p>Add to denominator excluded populations:</p> <ul style="list-style-type: none"> • <i>ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes</i> for fetal demise as defined in Appendix A, Table 11.09.1 <p>Add the following denominator data elements:</p> <ul style="list-style-type: none"> • <i>ICD-9-CM Other Diagnosis Codes</i> • <i>ICD-9-CM Principal Diagnosis Code</i> <p>Algorithm Change:</p> <p>Add a branch to check <i>ICD-9-CM Principal or Other Diagnosis Codes</i></p>
Antenatal Steroid Administered	To clarify documentation requirements.	<p>Add to the Notes for Abstraction:</p> <p>The names of the medications, dosage and timing must be documented in the medical record in order to select allowable value "yes".</p> <p>For bethamethasone, select allowable value "yes" if the repeat dose was given within 4 hours before or after the 24 hour repeat period.</p> <p>For dexamethasone, select allowable value "yes" if the repeat doses were given within 2 hours before or after the 12 hour repeat period.</p>
Birth Weight	To clarify documentation sources.	<p>Under the notes for abstraction add:</p> <ul style="list-style-type: none"> • In cases where there is conflicting data, use the document recording the birth weight closest to the time of delivery, e.g., the delivery record.
Birthdate	To correct age calculation for PC measures. To align with NHQM.	<p>Under Definition Note change from:</p> <p>For discharge measures, e.g., HBIPS-1, 4, 5, 6, 7, All PC measures, patient's age (in years) is calculated by Discharge Date minus Birthdate. For event measures, e.g., 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.</p> <p>to:</p> <ul style="list-style-type: none"> • Patient's age (in years) is calculated by Admission

		<p>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.</p> <ul style="list-style-type: none"> For HBIPS discharge measures, i.e., HBIPS-1, 4, 5, 6, 7, patient's age (in years) is calculated by Discharge Date minus Birthdate. For HBIPS 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. <p>Under Allowable Values change from:</p> <p>MM = Month (01-12) DD = Day (01-31) YYYY = Year (1880-9999)</p> <p>to:</p> <p>MM = Month (01-12) DD = Day (01-31) YYYY = Year (1880-Current Year)</p>
Cesarean Section	To correct the logic for all of the stratum inclusions.	<p>Algorithm change:</p> <p>Change the patient age criteria at the end of the stratification logic.</p>
Clinical Trial	To align with NHQM.	<p>Under the Notes for Abstraction change the last paragraph under the last bullet point from:</p> <p>2. It is not clear whether the study described in the signed patient consent form is experimental or observational. It is not clear which study population the clinical trial is enrolling. Assumptions should not be made if it is not specified.</p> <p>to:</p> <p>2. It is not clear whether the study described in the signed patient consent form is experimental or observational.</p> <p>3. It is not clear which study population the clinical trial is enrolling. Assumptions should not be made if it is not specified.</p>
Discharge Status	Data element is now a measure specific data element.	<p>Under collected for change from:</p> <p>HBIPS, PC</p> <p>to:</p> <p>HBIPS-1, HBIPS-4, HBIPS-5, HBIPS-6, HBIPS-7, PC-04, PC-05</p>
Elective Delivery	To be consistent with other decision point check.	<p>Algorithm change:</p> <p>Move value "All Missing" of <i>ICD-9-CM Principal or Other Procedure Code</i> from the second decision point up to first decision point as an individual branch.</p>

Exclusive Breast Milk Feeding	To correct denominator statement. To remove the redundancy on missing data in the algorithm.	Algorithm change: Change denominator statement from: Newborns discharged from the hospital to: Single term newborns discharged from the hospital. Remove missing branch from <i>Admission Type</i> .
Exclusive Breast Milk Feeding	To clarify exclusive breast milk feeding.	Add to the Notes for Abstraction: If the newborn receives donor breast milk, select allowable value "Yes". If breast milk fortifier is added to the breast milk, select allowable value "Yes". In cases where there is conflicting documentation and both exclusive breast milk feeding and formula supplementation is documented, select allowable value "No".
Gestational Age	To clarify how to determine gestational age.	Add to the Notes for Abstraction: When the admission date is different from the delivery date, use documentation of the gestational age completed closest to the delivery date. If an ultrasound was performed prior to the first 20 weeks of pregnancy and there is a discrepancy of > 6 days based on the last menstrual period date, the ultrasound should be used to determine final gestational age.
Health Care-Associated Bloodstream Infections in Newborns	To clarify measure population and to remain consistent with other measure sets.	Algorithm Changes: Remove the branches of <i>Discharge Status, ICD-9-CM Principal or Other Procedure Codes, Admission Type</i> and <i>Point of Origin for Admission or Visit</i> . Change Connector "PC-04 Z" to "PC-04 J".
ICD-9-CM Other Diagnosis Codes	To align with NHQM.	Under Allowable Values change occurs from 17 to 24.
ICD-9-CM Other Procedure Codes	To align with NHQM.	Under Allowable Values change occurs from 5 to 24.
ICD-9-CM Other Procedure Dates	To align with NHQM.	Under Allowable Values change occurs from 5 to 24.
ICD-9-CM Principal Diagnosis Code	To update use of data element.	Under collected for under used in algorithm for add: PC-03
Minutes of Physical Restraint	To clarify definition and exclusions.	Under the guidelines for abstraction inclusion in the first paragraph change: A physical restraint is any manual or physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or

		<p>head freely when it is used as a restriction to manage a patient's behavior or restrict the patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition.¹</p> <p>to:</p> <p>A physical restraint is any manual method or physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely when it is used as a restriction to manage a patient's behavior or restrict the patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition.¹</p> <p>Under the Guidelines for Abstraction under exclusion add:</p> <ul style="list-style-type: none"> • Restraint uses that are forensic or correctional restrictions applied and used by designated hospital security personnel for the purpose of transporting the patient to court off the locked unit.
Parity	To clarify parity terminology.	<p>Add to the Notes for Abstraction:</p> <p>If parity is not documented and GTPAL terminology is documented where G= Gravida, T= Term, P= Preterm, A= Abortions and L= Living, all previous term and preterm deliveries prior to this hospitalization should be added together to determine parity.</p> <p>If parity is not documented and gravidity is documented as one, parity should be considered zero.</p> <p>Add to Exclusion:</p> <p>When GTPAL terminology is documented, G= Gravida, T= Term, P= Preterm, A= Abortions, L= Living, P does not equal parity.</p>
Patient Referral to Next Level of Care Provider	To clarify AMA and elopement.	<p>Add to the Notes for Abstraction:</p> <p>When a patient checks himself out of a hospital against the advice of his doctor (AMA) this is not the same as an elopement. The patient should still be offered a referral to a next level of care provider. If the patient refuses the referral, select allowable value 2.</p>
Perinatal Care	The Initial patient population and narrative has been updated to be consistent with the data dictionary for allowable values and definitions. Reformatted the paragraph to make definitions more clear and distinct between different	<p>1. Initial Patient Population Algorithm: a. Newborns with BSI: Remove allowable value '6' from the arrow flowing down from <i>Admission Type</i> in the Initial Patient Population algorithm for Newborns with BSI. Add allowable value '9' to the arrow flowing down from <i>Admission Type</i> in the Initial Patient Population algorithm for Newborns with BSI. Add allowable values '2', '6' to the arrow flowing from the left of <i>Point of Origin for Admission or Visit</i>. Remove allowable values '2', '6' from the arrow flowing to the right of <i>Point of Origin for Admission or Visit</i>.</p> <p>b. Delete offpage connector 'J' that flows into the process box "Set Initial Patient Population Reject Case Flag = Yes",</p>

	<p>sets of criteria for this population.</p>	<p>on the last page of the Initial Patient Population algorithm. Add offpage connector 'J' to flow into the termination point "Return to Data Processing Flow" on the last page of the Initial Patient Population algorithm.</p> <p>2. Initial Patient Population-Newborns with BSI: Change the last bullet from " <i>Admission Type</i> of Elective, Emergency, Urgent, Trauma Center or Information not available; and <i>Point of Origin for Admission or Visit</i> from Non-Health Care Facility Point of Origin, Clinic, Transfer From a Hospital (Different Facility), Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), another Health Care Facility Court/Law Enforcement Information not Available Transfer from One Distinct Unit of the Hospital to another Distinct Unit of the Same Hospital Resulting in a Separate Claim to the Payer, Ambulatory Surgery Center, or Hospice"</p> <p>To:</p> <p>" <i>Admission Type</i> of Elective, Emergency, Urgent, Trauma Center or Information not available; AND <i>Point of Origin for Admission or Visit</i> from Clinic, Transfer From a Hospital (Different Facility) or another Health Care Facility."</p> <p>Add bullet "Birthweight Missing or Unable To Determine (UTD)" below the existing last bullet.</p>
<p>Point of Origin for Admission or Visit</p>	<p>Data element is now a measure specific data element. To align with NUBC changes.</p>	<p>Under collected for change: PC</p> <p>to: PC-04, PC-05</p> <p>Change Allowable Values:</p> <p>1 Non-Health Care Facility Point of Origin The patient was admitted to this facility upon order of a physician. <u>Usage Note</u>: Includes patients coming from home, a physician's office, or workplace</p> <p>to:</p> <p>1 Non-Health Care Facility Point of Origin Inpatient: The patient was admitted to this facility. Outpatient: The patient presented to this facility for outpatient services. <u>Usage Note</u>: Includes patients coming from home or workplace</p> <p>Change:</p> <p>2 Clinic The patient was admitted to this facility as a transfer from a freestanding or non-freestanding clinic.</p> <p>to:</p> <p>2 Clinic or Physician Inpatient: The patient was admitted to this facility.</p>

Outpatient: The patient presented to this facility for outpatient services.

Under the Notes for Abstraction change:

- The intent of this data element is to focus on patients' place or point of origin rather than the source of a physician order or referral.
- The point of origin is the direct source for the particular facility.

Example 1: A SNF patient has chest pain is taken to the emergency department of Hospital A where it is determined that she is suffering an acute myocardial infarction. The patient is then transferred to Hospital B for admission as an inpatient. The Point of Origin for Hospital A would be 5 – Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF); the point of origin code for Hospital B would be 4 – Transfer from a Hospital.

Usage Notes/Cases:

I. Transfers – From an Another Facility Overall Scenario
While at another acute care hospital/facility, the patient is seen by the emergency room physicians. The patient is then transferred to our facility through the emergency room.

- The Point of Origin code would be Code 4 – Transfer from a Hospital (Different Facility) due to the patient being seen at the other acute care facility's emergency room.
- If the decision to admit was not made by the other facility's emergency room personnel and instead was made by our facilities emergency doctor, the Point of Origin code would still be 4. Even though the decision to admit was not made by the other facility, the patient was still seen by the other facility's emergency room personnel and a decision to transfer was made by them.
- The patient is seen by the other facility's emergency room physician; the patient arrives at our emergency room, but receives no additional emergency room care at our facility. Instead, the patient is transferred immediately to the Heart Catheterization Department of our facility the Point of Origin code would still be 4. Since the patient is seen by a different hospital's emergency room personnel, the decision to transfer the patient is first made by the other facility. The arrival of the patient at the receiving hospital's emergency room and subsequent transfer to the Heart Catheterization Department is secondary to the transfer from the previous facility transfer.

II. Transfers – Skilled Nursing Facility Overall Scenario
A resident from a skilled nursing facility is taken to an acute care hospital for medical care.

- The Point of Origin code would be Code 5 – Transfer from a Skilled Nursing Facility.

- The patient's family stopped by to pick-up the patient for a routine doctor's office visit (regularly scheduled); but while at the doctor's office the doctor sends the patient to the emergency room from the acute care hospital. The Point of Origin code would be a 5 as the original Point of Origin is the skilled nursing facility. The subsequent visit to the doctor's office (or even the emergency room of the hospital) is secondary to the events that took place earlier that day.

III. Transfer by Law Enforcement or Court Overall Scenario
A patient arrives at the health care facility accompanied by police.

- The Point of Origin code would be Code 8 – Court/Law Enforcement as the patient is under the supervision of law enforcement.

to:

- The intent of this data element is to focus on patients' place or point of origin rather than the source of a physician order or referral.
- The point of origin is the direct source for the particular facility.
- Code of Structure for Newborn should be selected when the hospital issues the birth certificate and Admission Type is 4.

Example 1: A newborn is born in an ambulance on the way to the hospital. The patient is then transported to the hospital's nursery for admission as an inpatient. The hospital issues the birth certificate. The Point of Origin for the patient would be assigned under the Code Structure for Newborn as 6 – Born Outside this Hospital.

Usage Notes/Cases:

I. Transfers – From an Another Facility Overall Scenario
While at another acute care hospital/facility, the patient is seen by the emergency room physicians. The patient is then transferred to our facility through the emergency room.

- The Point of Origin code would be Code 4 – Transfer from a Hospital (Different Facility) due to the patient being seen at the other acute care facility's emergency room.
- If the decision to admit was not made by the other facility's emergency room personnel and instead was made by our facilities emergency doctor, the Point of Origin code would still be 4. Even though the decision to admit was not made by the other facility, the patient was still seen by the other facility's emergency room personnel and a decision to transfer was made by them.
- The patient is seen by the other facility's emergency room physician; the patient arrives at our emergency room, but receives no additional emergency room care at our facility. Instead, the patient is transferred immediately to the Neonatal Intensive Care Unit of our

		<p>facility the Point of Origin code would still be 4. Since the patient is seen by a different hospital's emergency room personnel, the decision to transfer the patient is first made by the other facility. The arrival of the patient at the receiving hospital's emergency room and subsequent transfer to the Neonatal Intensive Care Unit is secondary to the transfer from the previous facility transfer.</p> <p>Overall Scenario While at another acute care hospital/facility, the patient is born. The patient is then transferred to our facility as a direct admit to the Neonatal Intensive Care Unit.</p> <ul style="list-style-type: none"> • The Point of Origin code would be Code 4 – Transfer from a Hospital (Different Facility) due to the patient being seen at the other acute care facility's nursery.
<p>Predicted Value</p>	<p>To align with NHQM.</p>	<p>Change the second sentence in the JOINT COMMISSION NOTE TO PROGRAMMERS from:</p> <ul style="list-style-type: none"> • Use only the seventeen ICD-9-CM Diagnosis Codes that are transmitted as part of the patient record when evaluating the patient against the risk model. <p>to:</p> <ul style="list-style-type: none"> • Use only the twenty four ICD-9-CM Diagnosis Codes that are transmitted as part of the patient record when evaluating the patient against the risk model.
<p>Reason for Not Exclusively Feeding Breast Milk</p>	<p>To update professionals who can document reason for not exclusively feeding breast milk in the medical record.</p>	<p>Under the allowable values change:</p> <p>Y (Yes) There is documentation by physician/APN/PA/CNM of a reason for not exclusively feeding breast milk during the entire hospitalization due to a maternal medical condition where breast milk feeding should be avoided.</p> <p>N (No) There is no documentation by physician/APN /PA/CNM of a reason for not exclusively feeding breast milk during the entire hospitalization due to a maternal medical condition for which breast milk feeding should be avoided OR unable to determine from medical record documentation.</p> <p>to:</p> <p>Y (Yes) There is documentation by physician/APN/PA/CNM /lactation consultant of a reason for not exclusively feeding breast milk during the entire hospitalization due to a maternal medical condition where breast milk feeding should be avoided.</p> <p>N (No) There is no documentation by physician/APN /PA/CNM/lactation consultant of a reason for not exclusively feeding breast milk during the entire hospitalization due to a maternal medical condition for which breast milk feeding should be avoided OR unable to determine from medical record documentation.</p>

		<p>Under the notes for abstraction in the second paragraph change:</p> <p>When determining whether there is a reason documented by a physician/APN/PA or CNM for not exclusively feeding breast milk, reasons must be explicitly documented (e.g., "mother is HIV positive - infant will not be breast fed") or clearly implied (e.g., "mother is currently abusing alcohol - infant will be fed formula"). If reasons are not mentioned in the context of infant feeding, do not make references (e.g., Do not assume that the infant is not receiving breast milk because of the medications the mother is currently taking).</p> <p>to:</p> <p>When determining whether there is a reason documented by a physician/APN/PA/CNM or lactation consultant for not exclusively feeding breast milk, reasons must be explicitly documented (e.g., "mother is HIV positive - infant will not be breast fed") or clearly implied (e.g., "mother is currently abusing alcohol - infant will be fed formula"). If reasons are not mentioned in the context of infant feeding, do not make inferences (e.g., Do not assume that the infant is not receiving breast milk because of the medications the mother is currently taking).</p>
a. Cover page for the Joint Commission Manual	New version of manual	Updated version number.
b. Introduction to the Data Dictionary	The three data elements <i>Discharge Status</i> , <i>Admission Type</i> and <i>Point of Origin for Admission or Visit</i> are applicable to only certain measures and therefore not considered as "general" to the whole set.	Added new header "Data elements that are general for every patient that falls into specific measures that are reported at the time of discharge include: <i>Discharge Status</i> (PC-04, PC-05, HBIPS Discharge Measures only) <i>Admission Type</i> (PC-04, PC-05 only) <i>Point Of Origin for Admission or Visit</i> (PC-04, PC-05 only)"
d. Missing and Invalid Data	<p>1- To provide the exact location of the Edit document on PET.</p> <p>2- These Data elements are now measure specific data elements.</p>	<p>1- Add the following to the 1st sentence of the 1st paragraph:</p> <p>"The Joint Commission's Data Warehouse evaluates patient data using the missing, invalid and data integrity edits. Refer to the Edit Message documents located on the Upload/Download page in the HCD section on PET for Joint Commission, for a complete listing of all critical and informational edits. "</p> <p>2- Add the following to the bullet points of the 'Missing and Invalid Episode of Care (EOC) Data' section:</p> <p>"The following Measure-specific elements that are missing</p>

		<p>data cause the EOC record to be rejected if elements is used in the Measure set Initial Population or an algorithm flow: <i>Discharge Status, Point of Origin for Admission or Visit and Admission Type.</i> "</p>
<p>g1. Transmission of Data</p>	<p>1- To provide the exact location of the Edit document on PET.</p> <p>2- To clarify when the Delete Action-code is required.</p> <p>3- Mirroring the changes done in the Data Dictionary and correcting previous typing errors in the Hospital Clinical Data XML Layout.xml. To align with NHQM.</p>	<p>1- Add the following to the end of the Introduction section:</p> <p>"In addition, it highlights the decision points as to when cases are rejected from the warehouse. Refer to the Edit Message documents located on the Upload/Download page in the HCD section of PET for The Joint Commission, for a complete listing of all critical and informational edits."</p> <p>2- The 'Transaction Processing' section change</p> <p>From:</p> <p>"Data can be added, replaced, and deleted during the current reporting quarter using the Action-Code in the XML file. In order to replace or delete an existing file at The Joint Commission, the files must match on the unique key data elements as defined above."</p> <p>To:</p> <p>"Data can be added, replaced, and deleted during the current reporting quarter using the Action-Code in the XML file. In order to replace or delete an existing file at The Joint Commission, the files must match on the unique key data elements as defined above. In order to update a key element in an existing file, the file must be deleted and a new file must be submitted. If the element to update is not a key element, then the file can be resubmitted using the 'Add' Action-Code; there is no need to delete the file first as long as the file matches on the unique key data elements."</p> <p>3- Following changes were applied to Hospital Clinical Data XML Layout.xml:</p> <p>a- Discharge Status: value 21 , Though existed in the data dictionary and is a valid value, was missing from the old version of xml layout file. The new value was added. Also the description for the Discharge Status, value 04 was also not updated to the new description originally given in V2010A2.</p> <p>b- <i>Admission Type</i> and <i>Point of Origin for Admission or Visit</i> which were removed in 2010B and were added again in 2010B2 but they were not added to the XML layout mistakenly. They were added to 2011A.</p> <p>c- <i>Point of Origin for Admission or Visit</i> value 7 was discontinued in 2010B.</p> <p>d- Number of Occurs change to 24 for the following elements: <i>ICD-9-CM Other Diagnosis Codes (OTHRDX#)</i>, <i>ICD-9-CM Other Procedure Codes (OTHRPX#)</i>, <i>ICD-9-CM Other Procedure Dates (OTHRPX#DT)</i></p> <p>e- <i>Point of Origin for Admission or Visit</i> value 2 description</p>

		<p>was changed from '2 Clinic' to '2 Clinic or Physician's Office'</p> <p>f- Add the column 'Programming Notes' to the 'Elements' tab of the XML layout file and brought the existing note from Data Dictionary for data element <i>Predicted Value</i> as "Round to 8 decimal places. Use only the twenty four ICD-9-CM Diagnosis Codes that are transmitted as part of the patient record "</p> <p>g- Added the existing 'Code of Structure' notes from data Dictionary, element <i>Point of Origin for Admission or Visit</i> to the 'Programming Notes' column in the 'Detail Element Info' tab.</p>
<p>g3. Transmission Data Processing Flow: Clinical</p>	<p>1- These data elements used to belong to General data elements and have been moved to Measure set data elements.</p> <p>2- The location of Measure Set Combination table, table 2.7, was added for clarification.</p>	<p>1- Add the following line to step 8:</p> <p>"However, 3 data elements listed in the <i>Measure Set</i> specific data elements, <i>Discharge Status</i>, <i>Point of Origin for Admission or Visit</i> and <i>Admission Type</i> are evaluated for missing and would be rejected if missing."</p> <p>2- Add Appendix E to step 11 for location of the table 2.7, Measure Set Combination table.</p>
<p>g4. Transmission Data Processing Flow: Population and Sampling</p>	<p>'Delete' has been removed from allowable values for Action-code element. The documents and the flow have changed.</p>	<p>1- Fixed a typing error in step 3:</p> <ul style="list-style-type: none"> • The <i>Measure Set</i> /Stratum is evaluated to ensure a valid value is submitted. • If the data are not expected, reject the XML file and stop processing. <p>2- Transmission Data Processing Flow changes:</p> <p>a- Change bullet 7 to:</p> <p>7. Check the action-code</p> <ul style="list-style-type: none"> • If action-code equals Add, continue with processing. • If the action-code is missing or invalid, reject the XML file and stop processing. <p>b- Remove the following line:</p> <p>"The following steps are performed if the record's action code equals DELETE:"</p> <p>c- Remove step 11. " 11. The database is checked to see if a record with the same Unique Record Key, as defined in the Data Transmission section, exists: • If the case does not exist in the database, then the transmitted DELETE record is rejected. • If the record does exist in the database, the existing record is deleted."</p> <p>d- Uploaded the new Transmission Data Processing Flow:</p>

		<p>Population and Sampling , which displays the following change:</p> <p>Remove the DELETE branch from the “action-code” diamond Add a Missing/Invalid branch and associated logic to the “action-code”diamond</p> <p>Remove the off-page connector “Z” after the process box “Accept data into the warehouse (action-code = ADD)”</p> <p>Add Stop box and off-page connector Z to the left of the stop box after the process box “Accept data into the warehouse (action-code = ADD)”</p> <p>Remove off-page connector “K” and associated logic and “Key Data Elements” text.</p>
z. Appendix A - ICD-9-CM Code Tables	To update code tables.	<p>Table 10.01 change long description for code 300.13 from: Dissociative fufue, Hysterical fugue</p> <p>to:</p> <p>Dissociative fugue, Hysterical fugue</p> <p>Add code 315.35</p> <p>Table 11.07</p> <p>Add: Code 658.41 Delete: 663.53</p> <p>Table 11.09</p> <p>Delete: Codes 651.03, 651.13, 651.23, 651.33, 651.43, 651.53, 651.63, 651.83, 651.93, 652.23, 652.33, 652.43, 652.63, 654.23, 656.43, 660.53, 662.33</p> <p>Add Table 11.09.1, Fetal Demise</p>
z. Appendix B - Medication Tables	To update medication table.	<p>Delete Moban and Molindone from Table 10.0.</p> <p>Add Latuda and Lurasidone to Table 10.0</p>
z. Appendix C - Glossary of Terms	To update terms.	<p>Add the following new terms:</p> <p>AMA (Against Medical Advice) When a patient checks himself out of a hospital against the advice of his doctor.</p> <p>calculation model A description of the steps or statistical calculations (computations) used to derive the numerator and denominator or continuous variable values required for a measure. Measure Information Forms in this manual will include either an algorithm or calculation model.</p> <p>Hospital Inpatient Quality Reporting Program The Hospital Inpatient Quality Reporting Program, formerly known as Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program, initiative is intended to empower consumers with quality of care information to make more informed decisions about their health care, while encouraging hospitals and clinicians to improve the quality of inpatient care provided to all patients. The hospital quality</p>

		<p>of care information gathered through the Hospital Inpatient Quality Reporting Program initiative is available to consumers on the Hospital Compare website.</p> <p>inpatient psychiatric services Inpatient psychiatric services include care provided to a patient for a mental disorder while hospitalized in a psychiatric unit of an acute care hospital or a free-standing psychiatric hospital. Services</p> <p>multiple antipsychotic medications Antipsychotic medications are drugs prescribed to treat certain mental disorders; if two or more of these medications are routinely administered or prescribed this is considered multiple antipsychotic medications.</p> <p>physical restraint A physical restraint is any manual method or physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely when it is used as a restriction to manage a patient's behavior or restrict the patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition.</p> <p>post discharge continuing care plan Communication from the hospital to the next level of care provider after a patient is discharged from the hospital. The plan must contain the reason for hospitalization, main diagnosis at discharge, a list of medications at discharge, and recommendations for the next level of care.</p> <p>seclusion Seclusion is the involuntary confinement of a patient alone in a room or an area where the patient is physically prevented from leaving.</p> <p>Delete: Reporting Hospital Data for Annual Payment Update The Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) initiative is intended to empower consumers with quality of care information to make more informed decisions about their health care, while encouraging hospitals and clinicians to improve the quality of inpatient care provided to all patients. The hospital quality of care information gathered through the RHQDAPU initiative is available to consumers on the Hospital Compare website.</p>
<p>z. Appendix D - Overview of Measure Information Form and Flowchart Formats</p>	<p>To align with NHQM</p>	<p>Add:</p> <p>Calculation Model</p> <p>A description of the steps or statistical calculations (computations) used to derive the numerator and denominator or continuous variable values required for a measure. Measure Information Forms in this manual will include either an algorithm or calculation model.</p>