## Measure Information Forms

<table>
<thead>
<tr>
<th>Section</th>
<th>Rationale</th>
<th>Description</th>
</tr>
</thead>
</table>
| ACHFOP-03     | The update to mineralocorticoid receptor antagonist (MRA) will provide abstractor clarification and alignment with 2022 Clinical Practice Guidelines which recommend prescribing MRAs across the spectrum of HFrEF, inclusive of a wide range of etiologies and disease severities. | Performance Measure Name  
**Change from:**  
Hospital Outpatient Aldosterone Receptor Antagonists  
**To:**  
Hospital Outpatient Mineralocorticoid Receptor Antagonists (MRA)  
**Description**  
**Change from:**  
Patients with a diagnosis of heart failure, a New York Heart Association (NYHA) class III-IV, and heart failure with a left ventricular ejection fraction (LVSD) ≤35% or a narrative description of left ventricular systolic (LVS) function consistent with moderate or severe systolic dysfunction who are prescribed an aldosterone receptor antagonist.  
**To:**  
Patients with a diagnosis of heart failure, a New York Heart Association (NYHA) class II-IV, and heart failure with a left ventricular ejection fraction (LVSD) ≤40% or a narrative description of left ventricular systolic (LVS) function consistent with moderate or severe systolic dysfunction who are prescribed a mineralocorticoid receptor antagonist (MRA).  
**Rationale**  
**Change to:**  
The 2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure states a benefit of prescribing Mineralocorticoid Receptor Antagonists across the spectrum of HFrEF, inclusive of a wide range of etiologies and disease severities. An MRA (spironolactone or eplerenone) is recommended in patients with HFrEF and NYHA class II to IV symptoms to reduce morbidity and mortality, if eGFR is >30 mL/min/1.73 m² and serum potassium is <5.0 mEq/L. Hyperkalemia is a major risk of MRA therapy; therefore, careful monitoring of potassium, renal function, and diuretic dosing should be performed at initiation and closely monitored thereafter (Heidenreich et al., 2022).  
**Numerator Statement**  
**Change from:** |
Patients who are prescribed an aldosterone receptor antagonist (i.e. Aldactone, Aldactazide [Hydrochlorothiazide + Spironolactone], Eplerenone, Inspra, Spironolactone) when seen in the outpatient setting.

To:
Patients who are prescribed a mineralocorticoid receptor antagonist (MRA) (i.e. Aldactone, Aldactazide [Hydrochlorothiazide + Spironolactone], Eplerenone, Inspra, Spironolactone) when seen in the outpatient setting.

Numerator Data Elements
Change from:
- Aldosterone Receptor Antagonist Prescribed in the Outpatient Setting

To:
- Mineralocorticoid Receptor Antagonist (MRA) Prescribed in the Outpatient Setting

Denominator Statement
Change from:
Heart failure patients with a NYHA class III-IV and current or prior documentation of left ventricular ejection fraction (LVSD) ≤35%.

To:
Heart failure patients with a NYHA class II-IV and current or prior documentation of left ventricular ejection fraction (LVSD) ≤40%.

Denominator Included Populations
Change third and fourth bullet from:
- Documentation of LVSD ≤35%
- New York Heart Association (NYHA) Functional Classification III-IV

To:
- Documentation of LVSD ≤40%
- New York Heart Association (NYHA) Functional Classification II-IV

Denominator Excluded Populations
Change last bullet from:
- Patients with a documented Reason for No Aldosterone Receptor Antagonist Prescribed for LVSD in the Outpatient Setting

To:
- Patients with a documented Reason for No Mineralocorticoid Receptor Antagonist (MRA) Prescribed in the Outpatient Setting
Denominator Data Elements

Change from:
- *Reason for No Aldosterone Receptor Antagonist Prescribed in the Outpatient Setting*

To:
- *Reason for No Mineralocorticoid Receptor Antagonist (MRA) Prescribed in the Outpatient Setting*

Selected References

Add:

Algorithm

Denominator

Change from: Heart failure patients with a NYHA class III-IV and current or prior documentation of left ventricular ejection fraction (LVSD) ≤35%.

To: Heart failure patients with a NYHA class II-IV and current or prior documentation of left ventricular ejection fraction (LVSD) ≤40%.

Check Box LVSD

Change from:
- If LVSD quals 2, 3 or 5, the case will proceed to a Measure Category Assignment of B.
- If LVSD quals 1 or 4, continue processing and proceed to New York Heart Association (NYHA) Classification.

To:
- If LVSD quals 5, the case will proceed to a Measure Category Assignment of B.
- If LVSD quals 1, 2, 3 or 4, continue processing and proceed to New York Heart Association (NYHA) Classification.

Check Box New York Heart Association (NYHA) Classification

Change from:
- If New York Heart Association (NYHA) Classification quals 1, 2 or 5, the case will proceed to 2nd New York Heart Association (NYHA) Classification.
- If New York Heart Association (NYHA) Classification quals 3 or 4, continue processing and proceed to Mineralocorticoid Receptor Antagonist Prescribed for LVSD in the Outpatient Setting.
To:
If New York Heart Association (NYHA) Classificationquals 1 or 5, the case will proceed to 2nd New
York Heart Association (NYHA) Classification
If New York Heart Association (NYHA) Classificationquals 2, 3 or 4, continue processing and proceed
to Mineralocorticoid Receptor Antagonist Prescribed for LVSD in the Outpatient Setting.
2nd Check Box New York Heart Association (NYHA) Classification

Change from:
If New York Heart Association (NYHA) Classificationquals 1 or 2, the case will proceed to a Measure
Category Assignment of B.
If New York Heart Association (NYHA) Classificationquals 5, the case will proceed to a Measure
Category Assignment of D.

To:
If New York Heart Association (NYHA) Classificationquals 1, the case will proceed to a Measure
Category Assignment of B.
If New York Heart Association (NYHA) Classificationquals 5, the case will proceed to a Measure
Category Assignment of D.

**CCCIP**

The revisions to CCC initial patient population will provide abstracter clarification regarding mandatory and optional measures included in the program. Additionally, the update changing aldosterone to mineralocorticoid receptor antagonist (MRA) will provide abstracter clarification and alignment with 2022 clinical practice guidelines.

**Comprehensive Cardiac Center (CCC) Initial Patient Population**

Paragraphs two and three change from:

The measures chosen for implementation within the CCC certification program address major aspects of cardiac care, within the following 4 domains: cardiac rehabilitation, myocardial infarction (MI), heart failure (HF), and cardiac surgery (coronary artery bypass graft, cardiac valve repair/replacement and percutaneous coronary intervention [PCI]). The measures are separated into mandatory and optional measures and then again by inpatient and outpatient status. The certification program also includes 5 measures that are currently used in The Joint Commission’s Advanced Heart Failure Certification program (ACHF-01, ACHF-02, ACHF-06, ACHFOP-03, and ACHFOP-06). Organizations should follow the ACHF and ACHFOP initial patient population algorithm’s that are posted to The Joint Commission’s Measure Specifications Manual to determine the patient population for the heart failure measures.

There are 5 mandatory measures: high-intensity statin, aldosterone antagonist, beta-blockers, post-discharge appointment and post-discharge evaluation that all certified organizations must abstract.

The additional 13 inpatient and 5 outpatient measures are optional. It is highly recommended that the all organizations collect the optional measures to assist them with advancing quality of care for the cardiac patients they serve.
Change to:

The measures chosen for implementation within the CCC certification program address major aspects of cardiac care, within the following 4 domains: cardiac rehabilitation, myocardial infarction (MI), heart failure (HF), and cardiac surgery (coronary artery bypass graft, cardiac valve repair/replacement and percutaneous coronary intervention [PCI]). The measures are separated into mandatory and optional measures and then again by inpatient and outpatient status. It is highly recommended that all organizations collect the optional measures to assist them with advancing quality of care for the cardiac patients they serve. The certification program also includes 5 measures that are currently used in The Joint Commission’s Advanced Heart Failure Certification program (ACHF-01, ACHF-02, ACHF-06, ACHFOP-03, and ACHFOP-06). Organizations should follow the ACHF and ACHFOP initial patient population algorithm’s that are posted to The Joint Commission’s Measure Specifications Manual to determine the patient population for the heart failure measures.

There are 5 mandatory measures:
- CCCIP-01 High-intensity Statin Prescribed at Discharge
- CCCIP-02 Mineralocorticoid Receptor Antagonist (MRA) Prescribed at Discharge
- ACHF-01 Beta-blocker Therapy (i.e. Bisoprolol, Carvedilol, or Sustained-release Metoprolol Succinate Prescribed for LVSD at Discharge)
- ACHF-02 Post-discharge Appointment for Heart Failure Patients
- ACHF-06 Post-discharge Evaluation for Heart Failure Patients

There are 8 optional measures (3 inpatient and 5 outpatient):
- CCCIP-03 Cardiac Rehabilitation Referral from an Inpatient Setting
- CCCIP-04 Cardiac Rehabilitation Referral for Heart Failure Patients with Reduced Ejection Fraction from an Inpatient Setting
- CCCIP-05 Cardiac Rehabilitation Enrollment from an Inpatient Setting
- CCCOP-01 Cardiac Rehabilitation Referral from an Outpatient Setting
- CCCOP-02 Cardiac Rehabilitation Referral for Heart Failure Patients with Reduced Ejection Fraction from an Outpatient Setting
- CCCOP-03 Cardiac Rehabilitation Enrollment from an Outpatient Setting
- ACHFOP-03 Hospital Outpatient Mineralocorticoid Receptor Antagonists (MRA)
- ACHFOP-06 Hospital Outpatient Discussion of Advance Directives/Advance Care Planning

<table>
<thead>
<tr>
<th>CCCIP-02</th>
<th>The update to mineralocorticoid receptor antagonist (MRA) will provide abstracter clarification and alignment with 2022 Clinical Practice Guidelines</th>
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</thead>
<tbody>
<tr>
<td>Performance Measure Name Change from:</td>
<td>Aldosterone Antagonist Prescribed at Discharge</td>
</tr>
<tr>
<td>To:</td>
<td>Mineralocorticoid Receptor Antagonist (MRA) Prescribed at Discharge</td>
</tr>
</tbody>
</table>
which recommends prescribing MRAs across the spectrum of HFrEF, inclusive of a wide range of etiologies and disease severities.

<table>
<thead>
<tr>
<th>Description</th>
<th>Change from:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with a diagnosis of heart failure with a left ventricular ejection fraction (LVSD) ≤35% who were prescribed an aldosterone antagonist at discharge.</td>
<td></td>
</tr>
</tbody>
</table>

| To: |
| Patients with a diagnosis of heart failure with a left ventricular ejection fraction (LVSD) ≤40% who were prescribed a mineralocorticoid receptor antagonist (MRA) at discharge. |

<table>
<thead>
<tr>
<th>Rationale</th>
<th>Change to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The 2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure states a benefit of prescribing Mineralocorticoid Receptor Antagonists across the spectrum of HFrEF, inclusive of a wide range of etiologies and disease severities. An MRA (spironolactone or eplerenone) is recommended in patients with HFrEF and NYHA class II to IV symptoms to reduce morbidity and mortality, if eGFR is &gt;30 mL/min/1.73 m2 and serum potassium is &lt;5.0 mEq/L. Hyperkalemia is a major risk of MRA therapy; therefore, careful monitoring of potassium, renal function, and diuretic dosing should be performed at initiation and closely monitored thereafter (Heidenreich et al., 2022).</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Numerator Statement</th>
<th>Change from:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients who are prescribed an aldosterone receptor antagonist (i.e. Aldactone, Aldactazide [Hydrochlorothiazide + Spironolactone], Eplerenone, Inspra, Spironolactone) at hospital discharge.</td>
<td></td>
</tr>
</tbody>
</table>

| To: |
| Patients who are prescribed a mineralocorticoid receptor antagonist (i.e. Aldactone, Aldactazide [Hydrochlorothiazide + Spironolactone], Eplerenone, Inspra, Spironolactone) at hospital discharge. |

<table>
<thead>
<tr>
<th>Numerator Data Elements</th>
<th>Change from:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aldosterone Receptor Antagonist Prescribed for LVSD at Discharge</td>
<td></td>
</tr>
</tbody>
</table>

| To: |
| Mineralocorticoid Receptor Antagonist (MRA) Prescribed for LVSD at Discharge |

<table>
<thead>
<tr>
<th>Denominator Statement</th>
<th>Change from:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart failure patients with current or prior documentation of left ventricular ejection fraction (LVSD) ≤35%.</td>
<td></td>
</tr>
</tbody>
</table>

| To: |
| Heart failure patients with current or prior documentation of left ventricular ejection fraction (LVSD) ≤40%. |
Denominator Included Populations

**Change** second bullet from:
- Documentation of LVSD ≤35%

**To:**
- Documentation of LVSD ≤40%

Denominator Excluded Populations

**Change** second bullet from:
- Patients with a documented *Reason for No Aldosterone Receptor Antagonist Prescribed at Discharge*

**To:**
- Patients with a documented *Reason for No Mineralocorticoid Receptor Antagonist Prescribed at Discharge*

Denominator Data Elements

**Change** from:
*Reason for No Aldosterone Receptor Antagonist Prescribed at Discharge*

**To:**
*Reason for No Mineralocorticoid Receptor Antagonist Prescribed at Discharge*

Selected References

**Add:**

Algorithm

**Numerator**

**Change** from: Patients who are prescribed an Aldosterone receptor antagonist (i.e. Aldactone, Aldactazide [Hydrochlorothiazide + Spironolactone], Eplerenone, Inspra, Spironolactone) at hospital discharge.

**To:** Patients who are prescribed a mineralocorticoid receptor antagonist (i.e. Aldactone, Aldactazide [Hydrochlorothiazide + Spironolactone], Eplerenone, Inspra, Spironolactone) at hospital discharge.
Denominator

Change from: Heart failure patients with current or prior documentation of left ventricular ejection fraction (LVSD) ≤55%
To: Heart failure patients with current or prior documentation of left ventricular ejection fraction (LVSD) ≤40%

Check Box Name

Change from: Aldosterone Receptor Antagonist Prescribed for LVSD at Discharge
To: Mineralocorticoid Receptor Antagonist Prescribed for LVSD at Discharge

Check Box LVSD Change from:
If LVSD quals 2, 3 or 5, the case will proceed to a Measure Category Assignment of B.
If LVSD quals 1 or 4, continue processing and proceed to Aldosterone Receptor Antagonist Prescribed for LVSD at Discharge.
To:
If LVSD quals 5, the case will proceed to a Measure Category Assignment of B.
If LVSD quals 1, 2, 3 or 4, continue processing and proceed to Mineralocorticoid Receptor Antagonist Prescribed for LVSD at Discharge.

CCCOP

The revisions to CCC initial patient population will provide abstracter clarification regarding mandatory and optional measures included in the program. Additionally, the update changing aldosterone to mineralocorticoid receptor antagonist (MRA) will provide abstracter clarification and alignment with 2022 clinical practice guidelines.

Comprehensive Cardiac Center (CCC) Initial Patient Population

Paragraphs two and three Change from:

The measures chosen for implementation within the CCC certification program address major aspects of cardiac care, within the following 4 domains: cardiac rehabilitation, myocardial infarction (MI), heart failure (HF), and cardiac surgery (coronary artery bypass graft, cardiac valve repair/replacement and percutaneous coronary intervention [PCI]). The measures are separated into mandatory and optional measures and then again by inpatient and outpatient status. The certification program also includes 5 measures that are currently used in The Joint Commission's Advanced Heart Failure Certification program (ACHF-01, ACHF-02, ACHF-06, ACHFOP-03, and ACHFOP-06). Organizations should follow the ACHF and ACHFOP initial patient population algorithm's that are posted to The Joint Commission's Measure Specifications Manual to determine the patient population for the heart failure measures.

There are 5 mandatory measures: high-intensity statin, aldosterone antagonist, beta-blockers, post-discharge appointment and post-discharge evaluation that all certified organizations must abstract. The additional 3 inpatient and 5 outpatient measures are optional. It is highly recommended that the all organizations collect the optional measures to assist them with advancing quality of care for the cardiac patients they serve.
Change to:

The measures chosen for implementation within the CCC certification program address major aspects of cardiac care, within the following 4 domains: cardiac rehabilitation, myocardial infarction (MI), heart failure (HF), and cardiac surgery (coronary artery bypass graft, cardiac valve repair/replacement and percutaneous coronary intervention [PCI]). The measures are separated into mandatory and optional measures and then again by inpatient and outpatient status. It is highly recommended that all organizations collect the optional measures to assist them with advancing quality of care for the cardiac patients they serve. The certification program also includes 5 measures that are currently used in The Joint Commission’s Advanced Heart Failure Certification program (ACHF-01, ACHF-02, ACHF-06, ACHFOP-03, and ACHFOP-06). Organizations should follow the ACHF and ACHFOP initial patient population algorithm's that are posted to The Joint Commission’s Measure Specifications Manual to determine the patient population for the heart failure measures.

There are 5 mandatory measures:
- CCCIP-01 High-intensity Statin Prescribed at Discharge
- CCCIP-02 Mineralocorticoid Receptor Antagonist (MRA) Prescribed at Discharge
- ACHF-01 Beta-blocker Therapy (i.e. Bisoprolol, Carvedilol, or Sustained-release Metoprolol Succinate Prescribed for LVSD at Discharge)
- ACHF-02 Post-discharge Appointment for Heart Failure Patients
- ACHF-06 Post-discharge Evaluation for Heart Failure Patients

There are 8 optional measures (3 inpatient and 5 outpatient):
- CCCIP-03 Cardiac Rehabilitation Referral from an Inpatient Setting
- CCCIP-04 Cardiac Rehabilitation Referral for Heart Failure Patients with Reduced Ejection Fraction from an Inpatient Setting
- CCCIP-05 Cardiac Rehabilitation Enrollment from an Inpatient Setting
- CCCOP-01 Cardiac Rehabilitation Referral from an Outpatient Setting
- CCCOP-02 Cardiac Rehabilitation Referral for Heart Failure Patients with Reduced Ejection Fraction from an Outpatient Setting
- CCCOP-03 Cardiac Rehabilitation Enrollment from an Outpatient Setting
- ACHFOP-03 Hospital Outpatient Mineralocorticoid Receptor Antagonists (MRA)
- ACHFOP-06 Hospital Outpatient Discussion of Advance Directives/Advance Care Planning

CSTK

The measure information was modified to increase capture of failed attempts at thrombectomy:

1) Updated CSTK IPP algorithm flow to add Table 8.1c to the sub-population 1 and sub-population 2 branch.
2) Change from:
Ischemic Stroke With IV t-PA, IA t-PA, or MER

The population of the CSTK 2-Ischemic Stroke With IV t-PA, IA t-PA, or MER measures (CSTK-01, CSTK-02, CSTK-05, CSTK-08, CSTK-09, CSTK-10, CSTK-11, CSTK-12) are identified using 5 data elements: • Admission Date • Birthdate • Discharge Date • ICD-10-CM Principal Diagnosis Code • ICD-10-PCS Principal or Other Procedure Codes Patients admitted to the hospital for inpatient acute care are included in the CSTK-2 Ischemic Stroke With IV t-PA, IA t-PA, or MER subpopulation sampling group if they have ICD-10-CM Principal Diagnosis Code as defined in Appendix A, Table 8.1 AND ICD-10-PCS Principal or Other Procedure Codes as defined in Appendix A, Table 8.1a OR Table 8.1b, a Patient Age (Admission Date – Birthdate) ≥ 18 years and a Length of Stay (Discharge Date – Admission Date) ≤ 120 days.

Change to:

Ischemic Stroke With IV t-PA, IA t-PA, or MER

The population of the CSTK 2-Ischemic Stroke With IV t-PA, IA t-PA, or MER measures (CSTK-01, CSTK-02, CSTK-05, CSTK-08, CSTK-09, CSTK-10, CSTK-11, CSTK-12) are identified using 5 data elements: • Admission Date • Birthdate • Discharge Date • ICD-10-CM Principal Diagnosis Code • ICD-10-PCS Principal or Other Procedure Codes Patients admitted to the hospital for inpatient acute care are included in the CSTK-2 Ischemic Stroke With IV t-PA, IA t-PA, or MER subpopulation sampling group if they have ICD-10-CM Principal Diagnosis Code as defined in Appendix A, Table 8.1 AND ICD-10-PCS Principal or Other Procedure Codes as defined in Appendix A, Table 8.1a OR Table 8.1b OR Table 8.1c, a Patient Age (Admission Date – Birthdate) ≥ 18 years and a Length of Stay (Discharge Date – Admission Date) ≤ 120 days.

CSTK-01

The measure algorithm was revised to add Table 8.1c.

Numerator Included Populations

Add:

• Patients with documented root procedures (ICD-10-PCS Principal or Other Procedure Codes as defined in Appendix A, Table 8.1c for ICD-10 codes)

Algorithm

Check Box ICD-10-PCS Principal or Other Procedure Codes

Change from:

If is all missing or None on Table 8.1a or 8.1b, continue processing and proceed to CSTK-01 NR.
If any on Table 8.1a or 8.1b, continue processing to and proceed to ICD-10-PCS Principal or Other Procedure Date and Time Note Box

To:

If is all missing or None on Table 8.1a and 8.1b and 8.1c, continue processing and proceed to CSTK-01
NR.
If any on Table 8.1a or 8.1b or 8.1c, continue processing to and proceed to ICD-10-PCS Principal or Other Procedure Date and Time Process Box.

Process Box: ICD-10-PCS Principal or Other Procedure Date and Time Change from:
Note: The earliest procedure code is the earliest procedure performed that is on Table 8.1a or/and 8.1b
- If there is only one procedure code on Table 8.1a or 8.1b, select that procedure's date and time even if UTD
- If there is more than one procedure code on Table 8.1a or/and 8.1b on the earliest date, select the procedure's date and the earliest non-UTD time.

To:
Note: The earliest procedure code is the earliest procedure performed that is on Table 8.1a or/and 8.1b or/and 8.1c
- If there is only one procedure code on Table 8.1a or 8.1b or 8.1c, select that procedure's date and time even if UTD
- If there is more than one procedure code on Table 8.1a or/and 8.1b or/and 8.1c on the earliest date, select the procedure's date and the earliest non-UTD time.

The Measure Information Form was updated to align references with current clinical practice guidelines for subarachnoid hemorrhage.

Selected References

Add:


Remove:
Connolly ES, Rabinstein AA, Carhuapoma JR, Derdeyn CP, Dion J, Higashida RT, Hoh BL, Kirkness CJ, Naidech AM, Ogilvy CS, Patel AB, Thompson BG, Vespa P. Guidelines for the management of aneurys-
CPT® only copyright 2023 American Medical Association

| CSTK-04 | The reference list was revised to add an updated 2022 guideline from the American Heart Association/American Stroke Association. |
| CSTK-06 | The Measure Information Form was updated to align references with current clinical practice guidelines for subarachnoid hemorrhage. |

### Selected References

**Add:**


Remove:


### Selected References

**Add:**


Remove:

<table>
<thead>
<tr>
<th>Specification</th>
<th>Description</th>
<th>Denominator Included Populations</th>
</tr>
</thead>
</table>
| CSTK-08       | The measure information was modified to increase capture of failed attempts at thrombectomy. | **Change from:**  
  - Discharges with *ICD-10-CM Principal Diagnosis Code* for ischemic stroke as defined in Appendix A, Table 8.1 for ICD-10 codes,  
  AND  
  - Patients with documented *Mechanical Endovascular Reperfusion Therapy (ICD-10-PCS Principal or Other Procedure Codes)* as defined in Appendix A, Table 8.1b for ICD-10 codes,  
  AND  
  - Patients with documented *Failed Attempt at Thrombectomy (ICD-10-PCS Principal or Other Procedure Codes)* as defined in Appendix A, Table 8.1c for ICD-10 codes |
|               |            | **To:**  
  - Discharges with *ICD-10-CM Principal Diagnosis Code* for ischemic stroke as defined in Appendix A, Table 8.1 for ICD-10 codes,  
  AND  
  - Patients with documented *Mechanical Endovascular Reperfusion Therapy (ICD-10-PCS Principal or Other Procedure Codes)* as defined in Appendix A, Table 8.1b for ICD-10 codes,  
  OR  
  - Patients with documented *Failed Attempt at Thrombectomy (ICD-10-PCS Principal or Other Procedure Codes)* as defined in Appendix A, Table 8.1c for ICD-10 codes |
| CSTK-11       | The measure information was modified to increase capture of failed attempts at thrombectomy. | **Change from:**  
  - Discharges with *ICD-10-CM Principal Diagnosis Code* for ischemic stroke as defined in Appendix A, Table 8.1 for ICD-10 codes,  
  AND  
  - Patients with documented *Mechanical Endovascular Reperfusion Therapy (ICD-10-PCS Principal or Other Procedure Codes)* as defined in Appendix A, Table 8.1b for ICD-10 codes,  
  AND  
  - Patients with documented *Failed Attempt at Thrombectomy (ICD-10-PCS Principal or Other Procedure Codes)* as defined in Appendix A, Table 8.1c for ICD-10 codes |
|               |            | **To:**  
  - Discharges with *ICD-10-CM Principal Diagnosis Code* for ischemic stroke as defined in Appendix A, Table 8.1 for ICD-10 codes,  
  AND  
  - Patients with documented *Mechanical Endovascular Reperfusion Therapy (ICD-10-PCS Principal or Other Procedure Codes)* as defined in Appendix A, Table 8.1b for ICD-10 codes,  
  OR  
  - Patients with documented *Failed Attempt at Thrombectomy (ICD-10-PCS Principal or Other Procedure Codes)* as defined in Appendix A, Table 8.1c for ICD-10 codes |
<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Description</th>
<th>Denominator Included Populations</th>
</tr>
</thead>
</table>
| CSTK-12   | The measure information was modified to increase capture of failed attempts at thrombectomy. | Change from:  
- Discharges with ICD-10-CM Principal Diagnosis Code for ischemic stroke as defined in Appendix A, Table 8.1 for ICD-10 codes, and  
- Patients with documented Mechanical Endovascular Reperfusion Therapy (ICD-10-PCS Principal or Other Procedure Codes as defined in Appendix A, Table 8.1b for ICD-10 codes), and  
- Patients with documented Failed Attempt at Thrombectomy (ICD-10-PCS Principal or Other Procedure Codes as defined in Appendix A, Table 8.1c for ICD-10 codes)  
To:  
- Discharges with ICD-10-CM Principal Diagnosis Code for ischemic stroke as defined in Appendix A, Table 8.1 for ICD-10 codes, and  
- Patients with documented Mechanical Endovascular Reperfusion Therapy (ICD-10-PCS Principal or Other Procedure Codes as defined in Appendix A, Table 8.1b for ICD-10 codes), or  
- Patients with documented Failed Attempt at Thrombectomy (ICD-10-PCS Principal or Other Procedure Codes as defined in Appendix A, Table 8.1c for ICD-10 codes) |
| ED-1      | A narrative of the algorithm has been added for accessibility. | ED-1: Median Time from ED Arrival to ED Departure for Admitted ED Patients Narrative Algorithm was added after the measure flow algorithm. |
| ED-2      | A narrative of the algorithm has been added for accessibility. | ED-2: Admit Decision Time to ED Departure Time for Admitted Patients Narrative Algorithm was added after the measure flow algorithm. |
| HBIPS     | A narrative of the algorithm has been added for accessibility. | Hospital Based Inpatient Psychiatric Services (HBIPS) Initial Patient Population Algorithm Narrative has been added after the measure flow algorithm. |
| HBIPS-2   | A narrative of the algorithm has been added for accessibility. |  
Updates to the rationale and reference list to reflect current evidence.  
Rationale Change from: Mental health providers that value and respect an individual's autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of  
HBIPS-2: Hours of Physical Restriction Use Narrative Algorithm was added after the measure flow algorithm. |
seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint and seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).

To:
Mental health providers that value and respect an individual’s autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint and seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).

Seclusion or restraint should be initiated only when less restrictive measures have proven ineffective, and the behavioral emergency poses serious and imminent danger to the person, staff, or others. Such interventions should be discontinued as soon as the behavioral criteria for release has been met, and never used as punishment (APNA, 2022).

Providers should first attempt verbal de-escalation, and establish clear protocols to guide decision-making for the initiation and removal of restraint and seclusion (APA, 2022).

Selected References
Add:

Algorithm
Numerator Statement
Change from: The total number of hours that all psychiatric inpatients spent in physical restraint
To: The total number of hours that all psychiatric inpatients were maintained in physical restraint

| HBIPS-3 | A narrative of the algorithm has been added for accessibility. Updates to the rationale and references to reflect current evidence. | HBIPS-3: Hours of Seclusion Use Narrative Algorithm was added after the measure flow algorithm. Rationale
| HBIPS-3: | |
| Change from: | Mental health providers that value and respect an individual’s autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of |
seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint and seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).

To:
Mental health providers that value and respect an individual’s autonomy, independence and safety seek to avoid the use of dangerous or restrictive interventions at all times (Donat, 2003). The use of seclusion and restraint is limited to situations deemed to meet the threshold of imminent danger and when restraint and seclusion are used; such use is rigorously monitored and analyzed to prevent future use. Providers also seek to prevent violence or aggression from occurring in their treatment environments by focusing their attention on prevention activities that have a growing evidence base (Donat, 2003).

Seclusion or restraint should be initiated only when less restrictive measures have proven ineffective, and the behavioral emergency poses serious and imminent danger to the person, staff, or others. Such interventions should be discontinued as soon as the behavioral criteria for release has been met, and never used as punishment (APNA, 2022).

Providers should first attempt verbal de-escalation, and establish clear protocols to guide decision-making for the initiation and removal of restraint and seclusion (APA, 2022).

Selected References
Add:

Algorithm
Numerator Statement
Change from: The total number of hours that all psychiatric inpatients spent in seclusion
To: The total number of hours that all psychiatric inpatients were held in seclusion

<table>
<thead>
<tr>
<th>HBIPS-5</th>
<th>A narrative of the algorithm has been added for accessibility.</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBIPS-5</td>
<td>Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification Narrative Algorithm was added after the measure flow algorithm.</td>
</tr>
<tr>
<td>IMM-2</td>
<td>A narrative of the algorithm has been added after the measure flow</td>
</tr>
<tr>
<td>IMM-2</td>
<td>Influenza Immunization Narrative Algorithm has been added after the measure flow</td>
</tr>
</tbody>
</table>
Removing less than or equal to 120 day Length of Stay inclusion criteria to align with eCQM maternal initial patient population. Change verbiage within the PC-Newborn population, algorithm, and narrative to Human Milk Feeding to align with the verbiage in PC-05.

Perinatal Care (PC) Initial Patient Population-Mothers
Change from:
Patients admitted to the hospital for inpatient acute care are included in the PC Mother Initial sampling group if they have: ICD-10-PCS Principal or Other Procedure Codes as defined in Appendix A, Table 11.0.1 Delivery, a Patient Age (Admission Date — Birthdate) >= 8 years and < 65 and a Length of Stay (Discharge Date - Admission Date) <= 120 days.
To:
Patients admitted to the hospital for inpatient acute care are included in the PC Mother Initial sampling group if they have: ICD-10-PCS Principal or Other Procedure Codes as defined in Appendix A, Table 11.0.1 Delivery, a Patient Age (Admission Date — Birthdate) >= 8 years and < 65.

Perinatal Care (PC) Initial Patient Population-Newborns
Change from:
Within the PC-Newborn population, there are two baby measures, Exclusive Breast Milk Feeding and Unexpected Complications in Term Newborns. The patients in each measure are processed independently. Patients in the newborn population always run against the Unexpected Complication in Term Newborns measure and they may run against Exclusive Breast Milk Feeding measure if sampled.
To:
Within the PC-Newborn population, there are two baby measures, Exclusive Human Milk Feeding and Unexpected Complications in Term Newborns. The patients in each measure are processed independently. Patients in the newborn population always run against the Unexpected Complication in Term Newborns measure and they may run against Exclusive Human Milk Feeding measure if sampled.

Change: all references to Exclusive Breast Milk Feeding within the document
To:
Exclusive Human Milk Feeding

PC Initial Patient Population Algorithm
Remove:
any references to length of stay

Change from:
Exclusive Breast Milk Feeding
To:
Exclusive Human Milk Feeding

PC Initial Patient Population Algorithm Narrative
Change from:
<table>
<thead>
<tr>
<th>PC-01</th>
<th>Removed length of stay greater than 120 days exclusion to align with maternal initial patient population.</th>
<th>Excluded Populations&lt;br&gt;Remove:&lt;br&gt;• Length of stay &gt; 120 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>PC-02</td>
<td>Removed length of stay greater than 120 days exclusion to align with maternal initial patient population.</td>
<td>Excluded Populations&lt;br&gt;Remove:&lt;br&gt;• Length of stay &gt; 120 days</td>
</tr>
<tr>
<td>PC-05</td>
<td>Changes to the measure information for verbiage are being made in order to be more inclusive.</td>
<td>Performance Measure Name&lt;br&gt;&lt;b&gt;Change from:&lt;/b&gt; &lt;br&gt;Exclusive Breast Milk Feeding&lt;br&gt;To:&lt;br&gt;Exclusive Human Milk Feeding</td>
</tr>
</tbody>
</table>
Health for the last several years using newborn genetic disease testing data. Healthy People 2020 and the CDC have also been active in promoting this goal.

To:

Exclusive human milk feeding for the first 6 months of neonatal life has long been the expressed goal of World Health Organization (WHO), Department of Health and Human Services (DHHS), American Academy of Pediatrics (AAP) and American College of Obstetricians and Gynecologists (ACOG). ACOG has recently reiterated its position (ACOG, 2018). A Cochrane review substantiates the benefits (Kramer et al., 2012). Much evidence has now focused on the prenatal and intrapartum period as critical for the success of exclusive (or any) human milk feeding (Centers for Disease Control and Prevention [CDC], 2020; CDC, 2013; Petrova et al., 2007; Tavers et al., 2004). Exclusive human milk feeding rate during birth hospital stay has been calculated by the California Department of Public Health for the last several years using newborn genetic disease testing data. Healthy People 2020 and the CDC have also been active in promoting this goal.

Numerator Statement

Change from:

Newborns that were fed breast milk only since birth

To:

Newborns that were fed human milk only since birth

Data Elements

Change from:

Exclusive Breast Milk Feeding

To:

Exclusive Human Milk Feeding

Denominator Exclusions

Remove:

Length of Stay > 120 Days

Add:

Patients whose term status or gestational age is missing and birthweight < 3000 gm

Measure Analysis Suggestions

Change from:

In order to identify areas for improvement in breast milk feeding rates, hospitals may wish to review documentation for reasons. Education efforts can be targeted based on the specific reasons identified.

To:

In order to identify areas for improvement in human milk feeding rates, hospitals may wish to review
documentation for reasons. Education efforts can be targeted based on the specific reasons identified.

**PC-05 Algorithm Changes**

**On page 1**

**Change from:**
Exclusive Breast Milk Feeding
**To:**
Exclusive Human Milk Feeding.

**On page 2**

**Change from:**
Check box Exclusive Breast Milk Feeding
**To:**
Exclusive Human Milk Feeding.

Check box -Term Newborn

**Change from:**
If Term Newborn is missing, the case will proceed to a Measure Category Assignment of X.
If Term Newborn equals 2 or 3, the case will proceed to a Measure Category Assignment of B
**To:**
If Term Newborn is missing or equals 3, continue processing and proceed to check BirthWeight.

**Add new:**
Check box - BirthWeight
If BirthWeight is missing, the case will proceed to a Measure Category Assignment of X.
If BirthWeight is less than 3000g, the case will proceed to a Measure Category Assignment of B.
If BirthWeight is greater than or equals 3000g, continue processing and proceed to check Admission to NICU.

<table>
<thead>
<tr>
<th>PC-06</th>
<th>Abstraction guidance was added to assist facilities in abstraction of cases where there is a co-located neonatal intensive care unit operating under a separate license. Narrative ver-</th>
</tr>
</thead>
</table>
|       | Data Collection Approach:
|       | **Add:**
<p>|       | Please see Appendix G for information on Guidance for Chart Abstraction when there is a Co-located NICU Appendix G |</p>
<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Selected References</th>
<th>Measure Name</th>
</tr>
</thead>
</table>
| STK-1   | The reference list was revised to add an updated 2022 guideline from the American Heart Association/American Stroke Association. | Add:  

STK-10  | The reference list was revised to add an updated 2022 guideline from the American Heart Association/American Stroke Association. | | |

STK-8   | The reference list was revised to add an updated 2022 guideline from the American Heart Association/American Stroke Association. | Add:  

STK-VOL-1| The Measure Information Form was updated to remove the word “eligible” from the specifications. | | |
Description

Change from:
Percentage of eligible patients with ischemic stroke who receive mechanical endovascular reperfusion therapy.

To:
Percentage of patients with ischemic stroke who receive mechanical endovascular reperfusion therapy.

SUB-2

A narrative of the algorithm has been added for accessibility.

Update to rationale and references to reflect current evidence.

SUB-2: Alcohol Use Brief Intervention Provided or Offered Narrative Algorithm has been added after the measure flow algorithm.

Rationale

Change To:
Excessive use of alcohol and drugs has a substantial harmful impact on health and society in the United States. It is a drain on the economy and a source of enormous personal tragedy (The National Quality Forum, A Consensus Report, 2007).

More than 140,000 people in America die each year due to alcohol-related causes, which is the fourth-leading cause of death in the United States (CDC, 2022, NIAAA, 2023). Substance abuse costs the US economy approximately $400 billion dollars each year in lost productivity, crime, and healthcare spending (HHS, 2016). Substance use disorder treatment in US emergency departments and inpatient settings reached more than $13 billion dollars in 2017 (Peterson, 2021).

According to the 2020 National Survey on Drug Use and Health (NSDUH), 40.3 million Americans, aged 12 or older, had a substance use disorder (SUD) in the past year (CDC, 2022). As of 2021, 10.6% of the US population age 12 and older (29.5 million people) had an alcohol use disorder in the past year (SAMHSA, 2021).

Clinical trials have demonstrated that brief interventions, especially prior to the onset of addiction, significantly improve health and reduce costs, and that similar benefits occur in those with addictive disorders who are referred to treatment (Fleming, 2002, Di Clemente, 2017).

Individuals with psychiatric disorders are more likely to have co-occurring substance use disorders. In 2019, 3.6 million people were diagnosed with both a serious mental illness and substance use disorder—which is increasing year over year. While there are substantial evidence-based interventions for substance use, few patients receive substance use care: of the 21.6 million people in 2019 who needed substance use treatment in 2019, 12.2% (or 2.6 million people) received care in a specialty facility (SAMHSA, 2020).
Selected References

Change To:

- SAMHSA. Center for Behavioral Health Statistics and Quality. 2021 National Survey on Drug Use and Health. Table 5.6A—Alcohol use disorder in past year: among people aged 12 or older; by age group and demographic characteristics, numbers in thousands, 2021.
<table>
<thead>
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<th>Specification</th>
<th>Description</th>
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<tr>
<td>SUB-3</td>
<td>A narrative of the algorithm has been added for accessibility.</td>
</tr>
<tr>
<td></td>
<td>Update to rationale and references to reflect current evidence.</td>
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</table>

**Rationale**

**Change To:**

Excessive use of alcohol and drugs has a substantial harmful impact on health and society in the United States. It is a drain on the economy and a source of enormous personal tragedy (The National Quality Forum, A Consensus Report, 2007).

More than 140,000 people in America die each year due to alcohol-related causes, which is the fourth-leading cause of death in the United States (CDC, 2022. NIAAA, 2023). Substance abuse costs the US economy approximately $400 billion dollars each year in lost productivity, crime, and healthcare spending (HHS, 2016). Substance use disorder treatment in US emergency departments and in-patient settings reached more than $13 billion dollars in 2017 (Peterson, 2021).

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Clinical trials have demonstrated that brief interventions, especially prior to the onset of addiction, significantly improve health and reduce costs, and that similar benefits occur in those with addictive disorders who are referred to treatment (Fleming, 2002, Di Clemente, 2017).

Individuals with psychiatric disorders are more likely to have co-occurring substance use disorders. In 2019, 3.6 million people were diagnosed with both a serious mental illness and substance use disorder—which is increasing year over year. While there are substantial evidence-based interventions for substance use, few patients receive substance use care: of the 21.6 million people in 2019 who needed substance use treatment in 2019, 12.2% (or 2.6 million people) received care in a specialty facility (SAMHSA, 2020).
Selected References
Change To:
- SAMHSA. Center for Behavioral Health Statistics and Quality. 2021 National Survey on Drug Use and Health. Table 5.6A—Alcohol use disorder in past year: among people aged 12 or older; by age group and demographic characteristics, numbers in thousands, 2021.
<table>
<thead>
<tr>
<th>THKR-IP-5</th>
<th>Update the time period to submit post-operative assessments of general and joint specific functional status assessments to align with a more realistic timeline for optimal healing and regain of function.</th>
</tr>
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<tbody>
<tr>
<td><strong>Description</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Change from:</strong></td>
<td></td>
</tr>
<tr>
<td>Patients who completed the general health and joint specific functional status assessments, within 90 days after surgery, as specified below:</td>
<td></td>
</tr>
<tr>
<td>Hips: [VR-12 or PROMIS-Global] AND [HOOS Jr. (6 questions) or HOOS Pain, Function Daily Living Subscales (27 questions)]</td>
<td></td>
</tr>
<tr>
<td>Knees: [VR-12 or PROMIS-Global] and [KOOS Jr. (7 questions) or KOOS Stiffness, Pain, Function Daily Living Subscales (28 questions)]</td>
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</tr>
<tr>
<td><strong>To:</strong></td>
<td></td>
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<tr>
<td>Patients who completed the general health and joint specific functional status assessments, within 365 days after surgery, as specified below:</td>
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</tr>
<tr>
<td>Hips: [VR-12 or PROMIS-Global] AND [HOOS Jr. (6 questions) or HOOS Pain, Function Daily Living Subscales (27 questions)]</td>
<td></td>
</tr>
<tr>
<td>Knees: [VR-12 or PROMIS-Global] and [KOOS Jr. (7 questions) or KOOS Stiffness, Pain, Function Daily Living Subscales (28 questions)]</td>
<td></td>
</tr>
<tr>
<td><strong>Numerator Statement</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Change from:</strong></td>
<td></td>
</tr>
<tr>
<td>Number of patients who completed the general health (VR-12 or PROMIS-Global) AND joint specific functional status assessments (HOOS Jr./subscales or KOOS Jr./subscales) within 90 days after surgery.</td>
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</tr>
<tr>
<td><strong>To:</strong></td>
<td></td>
</tr>
<tr>
<td>Specification</td>
<td>Description</td>
</tr>
<tr>
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<tr>
<td>Number of patients who completed the general health (VR-12 or PROMIS-Global) AND joint specific functional status assessments (HOOS Jr./subscores or KOOS Jr./subscores) within 365 days after surgery.</td>
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<tr>
<td><strong>Algorithm Change</strong></td>
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</tr>
<tr>
<td><strong>Numerator statement:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Change from:</strong></td>
<td></td>
</tr>
<tr>
<td>Number of patients who completed the general health (VR-12 or PROMIS-Global) AND joint specific functional status assessments (HOOS Jr./subscores or KOOS Jr./subscores) within 90 days after surgery.</td>
<td></td>
</tr>
<tr>
<td><strong>To:</strong></td>
<td></td>
</tr>
<tr>
<td>Number of patients who completed the general health (VR-12 or PROMIS-Global) AND joint specific functional status assessments (HOOS Jr./subscores or KOOS Jr./subscores) within 365 days after surgery.</td>
<td></td>
</tr>
<tr>
<td><strong>Decision box “Post Assessment day”:</strong></td>
<td></td>
</tr>
<tr>
<td>The exit condition for “D” change from “&lt;30 day(s) or &gt;150 days” to “&lt;300 day(s) or &gt;425 days”.</td>
<td></td>
</tr>
<tr>
<td>The exit condition for “E” change from “&gt;=30 day(s) or &lt;=150 days” to “&gt; =300 and &lt;=425 days”.</td>
<td></td>
</tr>
</tbody>
</table>

**THKR-OP-5**  
Update the time period to submit post-operative assessments of general and joint specific functional status assessments to align with a more realistic timeline for optimal healing and regain of function.

**Description**

**Change from:**

Patients who completed the general health and joint specific functional status assessments, within 90 days after surgery, as specified below:

- Hips: [VR-12 or PROMIS-Global] AND [HOOS Jr. (6 questions) or HOOS Pain, Function Daily Living Subscales (27 questions)]
- Knees: [VR-12 or PROMIS-Global] and [KOOS Jr. (7 questions) or KOOS Stiffness, Pain, Function Daily Living Subscales (28 questions)]

**To:**
Patients who completed the general health and joint specific functional status assessments, within 365 days after surgery, as specified below:

Hips: [VR-12 or PROMIS-Global] AND [HOOS Jr. (6 questions) or HOOS Pain, Function Daily Living Subscales (27 questions)]

Knees: [VR-12 or PROMIS-Global] and [KOOS Jr. (7 questions) or KOOS Stiffness, Pain, Function Daily Living Subscales (28 questions)]

**Numerator Statement**

**Change from:**

Number of patients who completed the general health (VR-12 or PROMIS-Global) AND joint specific functional status assessments (HOOS Jr./subscales or KOOS Jr./subscales) within 90 days after surgery.

**To:**

Number of patients who completed the general health (VR-12 or PROMIS-Global) AND joint specific functional status assessments (HOOS Jr./subscales or KOOS Jr./subscales) within 365 days after surgery.

**Algorithm Change**

**Numerator statement:**

**Change from:**

Number of patients who completed the general health (VR-12 or PROMIS-Global) AND joint specific functional status assessments (HOOS Jr./subscales or KOOS Jr./subscales) within 90 days after surgery.

**To:**

Number of patients who completed the general health (VR-12 or PROMIS-Global) AND joint specific functional status assessments (HOOS Jr./subscales or KOOS Jr./subscales) within 365 days after surgery.
**Decision box "Post Assessment day":**

The exit condition for "D" change from "<30 day(s) or >150 days" to "<300 day(s) or >425 days".

The exit condition for "E" change from "≥30 day(s) or ≤150 days" to "≥300 and ≤425 days".

<table>
<thead>
<tr>
<th>TOB-2</th>
<th>A narrative of the algorithm has been added for accessibility. Update to rationale and references to reflect current evidence.</th>
<th>TOB-2: Tobacco Use Treatment Provided or Offered Narrative Algorithm has been added after the measure flow algorithm.</th>
</tr>
</thead>
</table>

**Rationale**

**Change To:**

Tobacco use is the single greatest cause of disease in the United States today and accounts for more than 480,000 deaths each year (CDC MMWR 2014). Smoking is a known cause of multiple cancers, heart disease, stroke, complications of pregnancy, chronic obstructive pulmonary disease, other respiratory problems, poorer wound healing, and many other diseases (CDC, 2020). Tobacco use creates a heavy cost to society as well as to individuals. Smoking-attributable health care expenditures are estimated to be at least $240 billion per year in direct medical expenses for adults, and over $185 billion in lost productivity (CDC, 2022).

There is strong and consistent evidence that tobacco dependence interventions, if delivered in a timely and effective manner, significantly reduce the user’s risk of suffering from tobacco-related disease and improve outcomes for those already suffering from a tobacco-related disease (CDC, 2021, DHHS, 2020, Choi et al, 2021, DHHS, 2000; Baumeister, 2007; Lightwood, 2003 and 1997; Rigotti, 2012). Effective, evidence-based tobacco dependence interventions have been clearly identified and include brief clinician advice, individual, group, or telephone counseling, and use of FDA-approved medications. These treatments are clinically effective and extremely cost-effective relative to other commonly used disease prevention interventions and medical treatments. Hospitalization (both because hospitals are a tobacco-free environment and because patients may be more motivated to quit as a result of their illness) offers an ideal opportunity to provide cessation assistance that may promote the patient’s medical recovery.

**Selected References**

**Change To:**

TOB-3

A narrative of the algorithm has been added for accessibility.

Update to rationale and references to reflect current evidence.

TOB-3: Tobacco Use Treatment Provided or Offered at Discharge Narrative Algorithm has been added after the measure flow algorithm.

Rationale

Change To:

Tobacco use is the single greatest cause of disease in the United States today and accounts for more than 480,000 deaths each year (CDC MMWR 2014). Smoking is a known cause of multiple cancers, heart disease, stroke, complications of pregnancy, chronic obstructive pulmonary disease, other respiratory problems, poorer wound healing, and many other diseases (CDC, 2020). Tobacco use creates a heavy cost to society as well as to individuals. Smoking-attributable health care expenditures are estimated to be at least $240 billion per year in direct medical expenses for adults, and over $185 billion in lost productivity (CDC, 2022).
There is strong and consistent evidence that tobacco dependence interventions, if delivered in a timely and effective manner, significantly reduce the user’s risk of suffering from tobacco-related disease and improve outcomes for those already suffering from a tobacco-related disease (CDC, 2021, DHHS, 2020, Choi et al, 2021, DHHS, 2000; Baumeister, 2007; Lightwood, 2003 and 1997; Rigotti, 2012). Effective, evidence-based tobacco dependence interventions have been clearly identified and include brief clinician advice, individual, group, or telephone counseling, and use of FDA-approved medications. These treatments are clinically effective and extremely cost-effective relative to other commonly used disease prevention interventions and medical treatments. Hospitalization (both because hospitals are a tobacco-free environment and because patients may be more motivated to quit as a result of their illness) offers an ideal opportunity to provide cessation assistance that may promote the patient’s medical recovery.

Selected References

- **Centers for Disease Control and Prevention. (2020).** Smoking & Tobacco Use: Health Effects. [https://www.cdc.gov/tobacco/basic_information/health_effects/index.htm](https://www.cdc.gov/tobacco/basic_information/health_effects/index.htm).
Data Elements

<table>
<thead>
<tr>
<th>Section</th>
<th>Rationale</th>
<th>Description</th>
</tr>
</thead>
</table>
| Discharge Time   | The data element definition was updated to align with the CMS inpatient manual, Version 5.15 for discharges on and after January 1, 2024. | Notes for Abstraction:  
Remove sixth and seventh bullets:  
- If the patient was discharged from acute inpatient care, left AMA, transferred out to another facility, or discharged to home, use the time the patient actually left, not the time the order was written.  
- If there are multiple times documented when the patient was discharged from acute inpatient care or left AMA, use the earliest time.  
Add:  
- Use the time the that is directly associated with the documentation indicating the patient actually left (e.g., time patient was discharged from acute inpatient care, left AMA, or transferred out to another facility).  
  - If the patient was discharged from acute inpatient care, was no longer receiving acute inpatient care, but remained in the same hospital, use the time directly associated with the documentation that the patient was discharged from acute inpatient care (e.g., acute inpatient care discharge and admit to inpatient hospice services).  
- Use the earliest time that is directly associated with the documentation indicating the patient actually left if there are multiple times documented when the patient was discharged from acute inpatient care or left AMA.  
- Use the earliest time that is directly associated with the documentation indicating the patient actually left if there is subsequent documentation of care after this time. |
| Exclusive Human Milk Feeding | Name of data element and verbiage within the data element changed to be more inclusive and align with the PC-05 measure. | Data Element Name

**Change** from:

*Exclusive Breast Milk Feeding*

**To:**

*Exclusive Human Milk Feeding*

Anywhere the verbiage says breast milk feeding:

**Change** from:

Breast milk

**To:**

Human milk |
| Initial Hunt and Hess Scale Time | The data element definition was updated to provide clarification for abstractors. | Notes for Abstraction

**Add** to first bullet:

**Note:**

- **Arrival Time** at the hospital will be the earliest documented time. The **Arrival Time** should not be selected for *Initial Hunt and Hess Scale Time* when a timed score is documented.
  
  **Example:**
  

**Change** fourth bullet, second sub-bullet to:

- Documentation indicates that the Hunt and Hess done on arrival was III. Patient arrived at your hospital 2100. Time stamp on the note is 2136. This is the only documented initial Hunt and Hess. The abstracter should select "2100" for *Initial Hunt and Hess Scale Time.* |
| Initial ICH Score Time | The data element definition was updated to provide clarification for abstractors. | Notes for Abstraction

**Add** to first bullet:

**Note:**

- **Arrival Time** at the hospital will be the earliest documented time. The **Arrival Time** should not be selected for *Initial ICH Score Time* when a timed score is documented.
  
  **Example:**
  
  - 0800-**Arrival Time. 0810-APN documents ICH 3. 0830-ICH assessment-Total ICH 4. 0815-Physician documents ICH 4 on arrival. The abstracter should select "0810" for
**Initial ICH Score Time.**

**Change** fourth bullet, second sub-bullet to:
- Documentation indicates that the ICH score done on arrival was 5. Patient arrived at your hospital 2100. Time stamp on the note is 2136. This is the only documented initial ICH score. The abstractor should select “2100” for *Initial ICH Score Time.*

<table>
<thead>
<tr>
<th>Initial NIHSS Score Time</th>
<th>The data element definition was updated to provide clarification for abstractors.</th>
<th>Notes for Abstraction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Add</strong> to first bullet:</td>
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<tr>
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<td></td>
<td><strong>Note:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The <em>Arrival Time</em> at the hospital will be the earliest documented time. The <em>Arrival Time</em> should not be selected for <em>Initial NIHSS Score Time</em> when a timed score is documented. Example:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 0800-<em>Arrival Time.</em> 0810-APN documents NIHSS 3. 0830-NIHSS assessment-Total NIH 4. 0815-Physician documents NIHSS 4 on arrival. The abstractor should select “0810” for Initial NIHSS Score Time.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Change</strong> fifth bullet, second sub-bullet to:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Documentation indicates that the NIHSS score done on arrival was 12. Patient arrived at your hospital 2100. Time stamp on the note is 2136. This is the only documented initial NIHSS score. The abstractor should select “2100” for <em>Initial NIHSS Score Time.</em></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>MER Eligibility</th>
<th>Inclusion terms were updated to provide clarification for abstractors.</th>
<th>Inclusion Guidelines for Abstraction</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Add:</strong></td>
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<tr>
<td></td>
<td></td>
<td><strong>Neurovascular</strong></td>
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</table>

<table>
<thead>
<tr>
<th>Mineralocorticoid Receptor Antagonist (MRA) Prescribed in the Outpatient Setting</th>
<th>The update to mineralocorticoid receptor antagonist (MRA) will provide abstractor clarification and alignment with 2022 Clinical Practice Guidelines.</th>
<th>Name <strong>Change</strong> from: Aldosterone Receptor Antagonist Prescribed in the Outpatient Setting <strong>To:</strong> Mineralocorticoid Receptor Antagonist (MRA) Prescribed in the Outpatient Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Definition <strong>Change</strong> from: Documentation that an aldosterone receptor antagonist was prescribed for New York Heart Association (NYHA) class III-IV and LVSD ≤ 35% in the outpatient setting. <strong>To:</strong></td>
</tr>
</tbody>
</table>
Documentation that a mineralocorticoid receptor antagonist (MRA) was prescribed for New York Heart Association (NYHA) class II-IV and LVSD ≤40% in the outpatient setting.

Question
*Change from:*
Was an aldosterone receptor antagonist prescribed for a NYHA class III-IV and LVSD ≤35% in the outpatient setting?

*To:*
Was a mineralocorticoid receptor antagonist (MRA) prescribed for a NYHA class II-IV and LVSD ≤40% in the outpatient setting?

Allowable Values
*Change from:*
Y (Yes) An aldosterone receptor antagonist was prescribed for a NYHA class III-IV and an LVSD ≤35%.
N (No) An aldosterone receptor antagonist was not prescribed for a NYHA class III-IV and an LVSD ≤35% or unable to determine from medical record documentation.

*To:*
Y (Yes) A mineralocorticoid receptor antagonist (MRA) was prescribed for a NYHA class II-IV and an LVSD ≤40%.
N (No) A mineralocorticoid receptor antagonist (MRA) was not prescribed for a NYHA class II-IV and an LVSD ≤40% or unable to determine from medical record documentation.

Notes for Abstraction
*Change second bullet from:*
- If the patient is currently on an aldosterone receptor antagonist, select 1.

*To:*
- If the patient is currently on a mineralocorticoid receptor antagonist (MRA), select 1.

Guidelines for Abstraction, Exclusion
*Change from:*
All other aldosterone receptor antagonist medications other than those listed as inclusions.

*To:*
All other mineralocorticoid receptor antagonist (MRA) medications other than those listed as inclusions.

<table>
<thead>
<tr>
<th>Mineralocorticoid Receptor Antagonist (MRA) Prescribed for LVSD at Discharge</th>
<th>The update to mineralocorticoid receptor antagonist (MRA) will provide abstractor clarification and alignment with 2022 Clinical Practice Guidelines</th>
<th>Name</th>
</tr>
</thead>
</table>
| | | *Change from:*
Aldosterone Receptor Antagonist Prescribed for LVSD at Discharge

*To:*
Mineralocorticoid Receptor Antagonist (MRA) Prescribed for LVSD at Discharge
which recommends prescribing MRAs across the spectrum of HFrEF, inclusive of a wide range of etiologies and disease severities.

Definition

Change from:
Documentation that aldosterone receptor antagonist was prescribed for LVSD at discharge.
To:
Documentation that mineralocorticoid receptor antagonist (MRA) was prescribed for LVSD at discharge.

Question

Change from:
Was an aldosterone receptor antagonist for an LVSD ≤35% prescribed at discharge?
To:
Was a mineralocorticoid receptor antagonist (MRA) for an LVSD ≤40% prescribed at discharge?

Allowable Values

Change from:
Y (Yes) An aldosterone receptor antagonist for an LVSD ≤35% was prescribed at discharge.
N (No) An aldosterone receptor antagonist for an LVSD ≤35% was not prescribed at discharge or unable to determine from medical record documentation.
To:
Y (Yes) A mineralocorticoid receptor antagonist (MRA) for an LVSD ≤40% was prescribed at discharge.
N (No) A mineralocorticoid receptor antagonist (MRA) for an LVSD ≤40% was not prescribed at discharge or unable to determine from medical record documentation.

Notes for Abstraction

Change second and third bullet from:
- If the patient is currently on an aldosterone receptor antagonist, answer “Yes”.
- If the patient does not have LVSD or an ejection fraction ≤35, select “No”.
To:
- If the patient is currently on a mineralocorticoid receptor antagonist (MRA), answer “Yes”.
- If the patient does not have LVSD or an ejection fraction ≤40%, select “No”.

Guidelines for Abstraction, Exclusion

Change from:
- All other aldosterone receptor antagonist medications other than those listed as inclusions.
To:
- All other mineralocorticoid receptor antagonist (MRA) medications other than those listed as inclusions.
<table>
<thead>
<tr>
<th>Postoperative Assessments Completion Date</th>
<th>The update will reflect the updated time period to submit postoperative functional/health status assessments.</th>
<th>Notes for Abstraction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Change to: Patients who have completed the general health and joint specific functional status assessments within 365 days after surgery (300-425 days).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Example: Patient had surgery on 2/17/2021. Postoperative general health and joint specific functional status assessments were completed on 2/18/2022. The case would pass the measure.</td>
</tr>
<tr>
<td>Reason for No Mineralocorticoid Receptor Antagonist (MRA) Prescribed in the Outpatient Setting</td>
<td>The update to mineralocorticoid receptor antagonist (MRA) will provide abstractor clarification and alignment with 2022 Clinical Practice Guidelines.</td>
<td>Name</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Change from: Reason for No Aldosterone Receptor Antagonist Prescribed in the Outpatient Setting</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Change to: Reason for No Mineralocorticoid Receptor Antagonist (MRA) Prescribed in the Outpatient Setting</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Definition</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Change from: Documentation of a reason for not prescribing an aldosterone antagonist in the outpatient setting by a physician/APN/PA or pharmacist.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Change to: Documentation of a reason for not prescribing a mineralocorticoid receptor antagonist (MRA) in the outpatient setting by a physician/APN/PA or pharmacist.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Question</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Change from: Did a physician/APN/PA or pharmacist document a contraindication to or a reason against an aldosterone antagonist prescription in the outpatient setting?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Change to:</td>
</tr>
</tbody>
</table>
Did a physician/APN/PA or pharmacist document a contraindication to or a reason against a mineralocorticoid receptor antagonist (MRA) prescription in the outpatient setting?

**Allowable Values**

**Change from:**

Y (Yes) There is documentation by a physician/APN/PA or pharmacist of a contraindication to or a reason for not prescribing an aldosterone receptor antagonist in the outpatient setting.

N (No) There is no documentation by a physician/APN/PA or pharmacist of a contraindication to or a reason for not prescribing an aldosterone receptor antagonist in the outpatient setting or unable to determine from medical record documentation.

**Change to:**

Y (Yes) There is documentation by a physician/APN/PA or pharmacist of a contraindication to or a reason for not prescribing a mineralocorticoid receptor antagonist (MRA) in the outpatient setting.

N (No) There is no documentation by a physician/APN/PA or pharmacist of a contraindication to or a reason for not prescribing a mineralocorticoid receptor antagonist (MRA) in the outpatient setting or unable to determine from medical record documentation.

**Notes for Abstraction**

**Change from:**

- All medication documentation available in the chart should be reviewed and taken into account by the abstractor.
- Reasons for not prescribing an aldosterone antagonist must be documented by a physician/APN/PA or pharmacist with one exception: Patient/family refusal of an Aldosterone Receptor Antagonist (e.g., "Patient refusing Aldosterone Receptor Antagonist") may be documented by a nurse.
- Reasons for no aldosterone antagonist must be explicitly documented or clearly implied.
  - If reasons are not mentioned in the context of aldosterone antagonist, do not make inferences (e.g., do not assume that an aldosterone antagonist is not prescribed because of the patient's chronic renal disease alone).

**Examples**
- "Cr 2.6 mg/dL – No aldosterone antagonist" **Severe hyperkalemia with aldosterone antagonist in past**
- "No aldosterone – patient non-compliant with labs"
- "Aldosterone antagonist contraindicated"
- "Supportive care only – no medications"
- "Aldosterone antagonist therapy not indicated"
- "No aldosterone antagonist" (reason not given).

- Physician/APN/PA or pharmacist documentation of a hold on an aldosterone antagonist or discontinuation of an aldosterone antagonist constitutes a "clearly implied" reason for not prescribing an aldosterone antagonist.
  - A hold/discontinuation of all p.o. medications counts if an aldosterone antagonist p.o. was on order at the time of the notation.
  - If there is documentation of a plan to initiate/restart an aldosterone antagonist, and the reason/problem underlying the delay in starting/restarting the aldosterone antagonist is also noted, this constitutes a "clearly implied" reason for not prescribing an aldosterone antagonist at discharge.
  - Documentation of a conditional hold/discontinuation of an aldosterone antagonist does not count as a reason for not prescribing an aldosterone antagonist.
  - Deferral of an aldosterone antagonist from one physician/APN/PA or pharmacist to another does NOT count as a reason for not prescribing an aldosterone antagonist, unless the problem underlying the deferral is also noted.

- An aldosterone antagonist "allergy" or "sensitivity" documented in the medical record counts as an allergy regardless of what type of reaction might be noted (e.g., "Allergies: aldosterone antagonist – select "Yes").
  - Documentation of an allergy/sensitivity to one particular aldosterone antagonist is acceptable to take as an allergy to the entire class of aldosterone antagonist (e.g., "Allergic to Spironolactone").

- Aldosterone antagonist (along with ACEI and ARBs) are sometimes described as RAS (renin-angiotensin system) or RAAS (renin-angiotensin-aldosterone system) blockers/inhibitors. Documentation of a reason for not prescribing "RAS" or "RAAS" blockers or inhibitors should be considered implicit documentation of a reason for no aldosterone antagonist (e.g., "Hold all RAS blockers").

- Documentation that refers to a more general medication class, such as "avoid all nephotoxic medications" or "Hold BP Meds" is not acceptable as a reason for not prescribing aldosterone antagonist. Reason documentation must mention aldosterone antagonist as a class or a specific aldosterone antagonist medication.

**Change to:**
- All medication documentation available in the chart should be reviewed and taken into account by the abstractor.
- Reasons for not prescribing a mineralocorticoid receptor antagonist (MRA) must be documented by a physician/APN/PA or pharmacist with one exception: Patient/family refusal of a mineralocorticoid receptor antagonist (MRA) (e.g., “Patient refusing MRA”) may be documented by a nurse.
- Reasons for no mineralocorticoid receptor antagonist (MRA) must be explicitly documented or clearly implied.
  - If reasons are not mentioned in the context of mineralocorticoid receptor antagonist (MRA), do not make inferences (e.g., do not assume that an MRA is not prescribed because of the patient’s chronic renal disease alone).

**Examples**

- "Cr 2.6 mg/dL – No mineralocorticoid receptor antagonist" **"Severe hyperkalemia with MRA in past”
- "No MRA – patient non-compliant with labs”
- "MRA contraindicated”
- "Supportive care only – no medications”
- "MRA therapy not indicated”
- "No mineralocorticoid receptor antagonist (MRA)” (reason not given).

- Physician/APN/PA or pharmacist documentation of a hold on a mineralocorticoid receptor antagonist or discontinuation of an MRA constitutes a “clearly implied” reason for not prescribing an MRA.
  - A hold/discontinuation of all p.o. medications counts if an MRA p.o. was on order at the time of the notation.
  - If there is documentation of a plan to initiate/restart an MRA, and the reason/problem underlying the delay in starting/restarting the MRA is also noted, this constitutes a “clearly implied” reason for not prescribing an MRA at discharge.
  - Documentation of a conditional hold/discontinuation of an MRA does not count as a reason for not prescribing an MRA.
  - Deferral of an MRA from one physician/APN/PA or pharmacist to another does NOT count as a reason for not prescribing an MRA, unless the problem underlying the deferral is also noted.

- A mineralocorticoid receptor antagonist (MRA) “allergy” or “sensitivity” documented in the medical record counts as an allergy regardless of what type of reaction might be noted (e.g., "Allergies: mineralocorticoid receptor antagonist – select “Yes”).
  - Documentation of an allergy/sensitivity to one particular mineralocorticoid receptor antagonist (MRA) is acceptable to take as an allergy to the entire class of MRAs (e.g.,
“Allergic to Spironolactone”).

- Mineralocorticoid receptor antagonist (MRA) (along with ACEI and ARBs) are sometimes described as RAS (renin-angiotensin system) or RAAS (renin-angiotensin-aldosterone system) blockers/inhibitors. Documentation of a reason for not prescribing “RAS” or “RAAS” blockers or inhibitors should be considered implicit documentation of a reason for no mineralocorticoid receptor antagonist (MRA) (e.g., “Hold all RAS blockers”).
- Documentation that refers to a more general medication class, such as “avoid all nephrotoxic medications” or “Hold BP Meds” is not acceptable as a reason for not prescribing mineralocorticoid receptor antagonist. Reason documentation must mention mineralocorticoid receptor antagonist (MRA) as a class or a specific MRA medication.

### Guidelines for Abstraction

**Exclusion Change from:**

None

**Change to:**

All other mineralocorticoid receptor antagonist (MRA) medications other than those listed as inclusions.

<table>
<thead>
<tr>
<th>Reason for No Mineralocorticoid Receptor Antagonist (MRA) Prescribed at Discharge</th>
<th>The update to mineralocorticoid receptor antagonist (MRA) will provide abstractor clarification and alignment with 2022 Clinical Practice Guidelines.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Change from:</td>
</tr>
<tr>
<td></td>
<td>Reason for No Aldosterone Receptor Antagonist Prescribed at Discharge</td>
</tr>
<tr>
<td>Change to:</td>
<td>Reason for No Mineralocorticoid Receptor Antagonist (MRA) Prescribed at Discharge</td>
</tr>
<tr>
<td>Definition</td>
<td>Change from:</td>
</tr>
<tr>
<td></td>
<td>Documentation of reasons for not prescribing an aldosterone antagonist at discharge by a physician/APN/PA or pharmacist.</td>
</tr>
<tr>
<td>Change to:</td>
<td></td>
</tr>
</tbody>
</table>
Documentation of reasons for not prescribing a mineralocorticoid receptor antagonist (MRA) at discharge by a physician/APN/PA or pharmacist

Question

Change from:

Did a physician/APN/PA or pharmacist document a contraindication to or reason against an aldosterone antagonist prescription at discharge?

Change to:

Did a physician/APN/PA or pharmacist document a contraindication to or reason against a mineralocorticoid receptor antagonist (MRA) prescription at discharge?

Allowable Values

Change from:

Y  (Yes)  There is documentation by a physician/APN/PA or pharmacist of a contraindication to or reason against an aldosterone antagonist prescription at discharge.

N  (No)  There is no documentation by a physician/APN/PA or pharmacist of a contraindication to or reason against an aldosterone antagonist prescription at discharge, or unable to determine from medical record documentation.

Change to:

Y  (Yes)  There is documentation by a physician/APN/PA or pharmacist of a contraindication to or reason against a mineralocorticoid receptor antagonist prescription at discharge.

N  (No)  There is no documentation by a physician/APN/PA or pharmacist of a contraindication to or reason against a mineralocorticoid receptor antagonist prescription at discharge, or unable to determine from medical record documentation.

Notes for Abstraction

Change from:
- All medication documentation available in the chart should be reviewed and taken into account by the abstractor.
- Reasons for not prescribing an Aldosterone Receptor Antagonist at discharge must be documented by a physician/APN/PA or pharmacist with one exception: Patient/family refusal of an Aldosterone Receptor Antagonist (e.g., "Patient refusing Aldosterone Receptor Antagonist") may be documented by a nurse.
- If the patient refuses a prescription for an aldosterone receptor antagonist, answer "Yes".
- Reasons for no aldosterone antagonist must be explicitly documented or clearly implied.
  - If reasons are not mentioned in the context of aldosterone antagonist, do not make inferences (e.g., do not assume that an aldosterone antagonist is not prescribed because of the patient's chronic renal disease alone).

Examples

- "Cr 2.6 mg/dL - No aldosterone antagonist" **"Severe hyperkalemia with aldosterone antagonist in past"**
- "No aldosterone - patient non-compliant with labs"
- "Aldosterone antagonist contraindicated"
- "Supportive care only - no medications"
- "Aldosterone antagonist therapy not indicated"
- Aldosterone antagonist on pre-printed order form is crossed out
- "No aldosterone antagonist" (reason not given).
- Physician/APN/PA or pharmacist documentation of a hold on an aldosterone antagonist or discontinuation of an aldosterone antagonist that occurs during the hospital stay constitutes a "clearly implied" reason for not prescribeing an aldosterone antagonist at discharge.
  - A hold/discontinuation of all p.o. medications counts if an aldosterone antagonist p.o. was on order at the time of the notation.
  - If there is documentation of a plan to initiate/restart an aldosterone antagonist, and the reason/problem underlying the delay in starting/restarting the aldosterone antagonist is also noted, this constitutes a "clearly implied" reason for not prescribing an aldosterone antagonist at discharge.
  - Documentation of a conditional hold/discontinuation of an aldosterone antagonist does not count as a reason for not prescribing an aldosterone antagonist at discharge.
  - Deferral of an aldosterone antagonist from one physician/APN/PA or pharmacist to another does NOT count as a reason for not prescribing an aldosterone antagonist at discharge unless the problem underlying the deferral is also noted.
- Reasons do NOT need to be documented at discharge or otherwise linked to the discharge timeframe: documentation of reasons anytime during the hospital stay is acceptable.
• An aldosterone antagonist "allergy" or "sensitivity" documented at any time during the hospital stay counts as an allergy regardless of what type of reaction might be noted (e.g., "Allergies: aldosterone antagonist – select "Yes").
• Documentation of an allergy/sensitivity to one particular aldosterone antagonist is acceptable to take as an allergy to the entire class of aldosterone antagonist (e.g., "Allergic to Spironolactone").
• Aldosterone antagonist (along with ACEI and ARBs) are sometimes described as RAS (renin-angiotensin system) or RAAS (renin-angiotensin-aldosterone system) blockers/inhibitors. Documentation of a reason for not prescribing “RAS” or “RAAS” blockers or inhibitors should be considered implicit documentation of a reason for no aldosterone antagonist at discharge (e.g., “Hold all RAS blockers”).
• Documentation that refers to a more general medication class, such as “avoid all nephrotoxic medications” or “Hold BP Meds” is not acceptable as a reason for not prescribing aldosterone antagonist at discharge. Reason documentation must mention aldosterone antagonist as a class or a specific aldosterone antagonist medication.

Change to:

• All medication documentation available in the chart should be reviewed and taken into account by the abstractor.
• Reasons for not prescribing a mineralocorticoid receptor antagonist (MRA) at discharge must be documented by a physician/APN/PA or pharmacist with one exception: Patient/family refusal of a mineralocorticoid receptor antagonist (e.g., “Patient refusing mineralocorticoid receptor antagonist”) may be documented by a nurse.
• If the patient refuses a prescription for a mineralocorticoid receptor antagonist, answer “Yes”
• Reasons for no mineralocorticoid receptor antagonist must be explicitly documented or clearly implied.
  ◦ If reasons are not mentioned in the context of mineralocorticoid receptor antagonist, do not make inferences (e.g., do not assume that an MRA is not prescribed because of the patient’s chronic renal disease alone).

Examples

- "Cr 2.6 mg/dL – No mineralocorticoid receptor antagonist" * "Severe hyperkalemia with MRA in past"
- "No MRA – patient non-compliant with labs"
- "MRA contraindicated"
- "Supportive care only – no medications"
- "MRA therapy not indicated"
- Mineralocorticoid receptor antagonist on pre-printed order form is crossed out
- "No mineralocorticoid receptor antagonist" (reason not given).
- Physician/APN/PA or pharmacist documentation of a hold on a mineralocorticoid receptor antagonist or discontinuation of an MRA that occurs during the hospital stay constitutes a "clearly implied" reason for not prescribing an MRA at discharge.
  - A hold/discontinuation of all p.o. medications counts if an MRA p.o. was on order at the time of the notation.
  - If there is documentation of a plan to initiate/restart an MRA, and the reason/problem underlying the delay in starting/restarting the MRA is also noted, this constitutes a "clearly implied" reason for not prescribing an MRA at discharge.
  - Documentation of a conditional hold/discontinuation of an MRA does not count as a reason for not prescribing an MRA at discharge.
  - Deferral of an MRA from one physician/APN/PA or pharmacist to another does NOT count as a reason for not prescribing an MRA at discharge unless the problem underlying the deferral is also noted.
- Reasons do NOT need to be documented at discharge or otherwise linked to the discharge timeframe: documentation of reasons anytime during the hospital stay is acceptable.
- A mineralocorticoid receptor antagonist "allergy" or "sensitivity" documented at any time during the hospital stay counts as an allergy regardless of what type of reaction might be noted (e.g., "Allergies: mineralocorticoid receptor antagonist - select "Yes").
- Documentation of an allergy/sensitivity to one particular mineralocorticoid receptor antagonist is acceptable to take as an allergy to the entire class of MRAs (e.g., "Allergic to Spironolactone").
- Mineralocorticoid receptor antagonist (MRA) (along with ACEI and ARBs) are sometimes described as RAS (renin-angiotensin system) or RAAS (renin-angiotensin-aldosterone system) blockers/inhibitors. Documentation of a reason for not prescribing "RAS" or "RAAS" blockers or inhibitors should be considered implicit documentation of a reason for no mineralocorticoid receptor antagonist at discharge (e.g., "Hold all RAS blockers").
- Documentation that refers to a more general medication class, such as "avoid all nephrotoxic medications" or "Hold BP Meds" is not acceptable as a reason for not prescribing MRA at discharge. Reason documentation must mention mineralocorticoid receptor antagonist as a class or a specific MRA medication.

Guidelines for Abstraction, Exclusion

Change from:

- All other aldosterone receptor antagonist medications other than those listed as inclusions.

Change to:
| Reason for No VTE Prophylaxis - Hospital Admission | The data element definition was updated to recognize recently available treatment to reverse Factor Xa Inhibitor medications. | Notes for Abstraction  
Change tenth bullet from:  
- Documentation synonymous with "abruptly reversed anticoagulation for major bleeding" select "Yes."  
  Examples:  
  - INR reversal for major bleeding.  
  - Reverse anticoagulation for intracranial hemorrhage.  
To:  
- Documentation synonymous with "abruptly reversed anticoagulation for major bleeding" select "Yes."  
  Examples:  
  - INR reversal for major bleeding.  
  - Factor Xa inhibitor reversal for major bleeding.  
  - Reverse anticoagulation for intracranial hemorrhage. |

---

**Supplemental Materials**

<table>
<thead>
<tr>
<th>Section</th>
<th>Rationale</th>
<th>Description</th>
</tr>
</thead>
</table>
| Appendix A - Code Tables  | Global changes to Appendix A to include ICD-10 CM and PCS 2024 updates additions, deletions and revisions.  
                         | Several ICD-10 Tables updated based on clinical, expert panel, and public feedback.  
                         | ICD-10 Tables added to Appendix A for the PC Measures.                      | Appendix A Tables updated to include 2024 ICD-10 updates:  
                         | Table 10.01  
                         | Table 10.02  
                         | Table 11.07  
                         | Table 11.30  
                         | Table 11.31  
                         | Table 14.10  
                         | Table 2.2  
                         | Table 2.3  
                         | Updates based on clinical, expert panel, and public feedback.  
                         | Table 8.1c |
ICD-10 Table 11.09 renamed to reflect intent of the code set.

Removed Codes:
03JY3ZZ Inspection of Upper Artery, Percutaneous Approach
03JY4ZZ Inspection of Upper Artery, Percutaneous Endoscopic Approach

Added Codes:
03HH3DZ Insertion of Intraluminal Device into Right Common Carotid Artery, Percutaneous Approach
03HH4DZ Insertion of Intraluminal Device into Right Common Carotid Artery, Percutaneous Endoscopic Approach
03HJ3DZ Insertion of Intraluminal Device into Left Common Carotid Artery, Percutaneous Approach
03HJ4DZ Insertion of Intraluminal Device into Left Common Carotid Artery, Percutaneous Endoscopic Approach
03HK3DZ Insertion of Intraluminal Device into Right Internal Carotid Artery, Percutaneous Approach
03HK4DZ Insertion of Intraluminal Device into Right Internal Carotid Artery, Percutaneous Endoscopic Approach
03HL3DZ Insertion of Intraluminal Device into Left Internal Carotid Artery, Percutaneous Approach
03HL4DZ Insertion of Intraluminal Device into Left Internal Carotid Artery, Percutaneous Endoscopic Approach
03HM3DZ Insertion of Intraluminal Device into Right External Carotid Artery, Percutaneous Approach
03HM4DZ Insertion of Intraluminal Device into Right External Carotid Artery, Percutaneous Endoscopic Approach
03HN3DZ Insertion of Intraluminal Device into Left External Carotid Artery, Percutaneous Approach
03HN4DZ Insertion of Intraluminal Device into Left External Carotid Artery, Percutaneous Endoscopic Approach
047K3ZZ Dilation of Right Femoral Artery, Percutaneous Approach
047K4ZZ Dilation of Right Femoral Artery, Percutaneous Endoscopic Approach
047L3ZZ Dilation of Left Femoral Artery, Percutaneous Approach
047L4ZZ Dilation of Left Femoral Artery, Percutaneous Endoscopic Approach
04HK3DZ Insertion of Intraluminal Device into Right Femoral Artery, Percutaneous Approach
04HK4DZ Insertion of Intraluminal Device into Right Femoral Artery, Percutaneous Endoscopic Approach
04HL3DZ Insertion of Intraluminal Device into Left Femoral Artery, Percutaneous Approach
04HL4DZ Insertion of Intraluminal Device into Left Femoral Artery, Percutaneous Endoscopic Approach
Z538 Procedure and treatment not carried out for other reasons
Z539 Procedure and treatment not carried out, unspecified reason

Table 10.01 Removed Codes:
F1090 Alcohol use, unspecified, uncomplicated
F1091 Alcohol use, unspecified, in remission

Table 10.02 added Codes:
F1090 Alcohol use, unspecified, uncomplicated
F1091 Alcohol use, unspecified, in remission

Table 11.09 O43213 Placenta accreta, third trimester
O43219 Placenta accreta, unspecified trimester
O43223 Placenta increta, third trimester
O43229 Placenta increta, unspecified trimester
O43233 Placenta percreta, third trimester
O43239 Placenta percreta, unspecified trimester O648XX0 Obstructed labor due to other malposition and malpresentation, not applicable or unspecified
O648XX1 Obstructed labor due to other malposition and malpresentation, fetus 1
O648XX2 Obstructed labor due to other malposition and malpresentation, fetus 2
O648XX3 Obstructed labor due to other malposition and malpresentation, fetus 3
O648XX4 Obstructed labor due to other malposition and malpresentation, fetus 4
O648XX5 Obstructed labor due to other malposition and malpresentation, fetus 5
O648XX9 Obstructed labor due to other malposition and malpresentation, other fetus
O694XX0 Labor and delivery complicated by vasa previa, not applicable or unspecified
O694XX1 Labor and delivery complicated by vasa previa, fetus 1
O694XX2 Labor and delivery complicated by vasa previa, fetus 2
O694XX3 Labor and delivery complicated by vasa previa, fetus 3
O694XX4 Labor and delivery complicated by vasa previa, fetus 4
O694XX5 Labor and delivery complicated by vasa previa, fetus 5
O694XX9 Labor and delivery complicated by vasa previa, other fetus

Table 13.1:
F1090 Alcohol use, unspecified, uncomplicated

Tables added to Appendix A for PC Measures to indicate coded weeks gestation:
Table 11.07.1 Table 11.10

Table 11.09 renamed to:
Multiple Gestations, Abnormal Presentations, and Conditions Justifying Cesarean Delivery

Appendix D - Glossary of Terms
Appendix D was updated to align with glossary terms and acronyms in the CMS manual, Version 5.15 effective for dis-
measure set A unique grouping of performance measures carefully selected to provide, when viewed together, a robust picture of the care provided in a given area (e.g., cardiovascular care, pregnancy).

Change the following terms to:
clinical performance measure to:
clinical quality measure (CQM) CQMs can be measures of processes, experiences and/or outcomes of patient care, observations or treatment that relate to one or more quality aims for health care such as effective, safe, efficient, patient-centered, equitable, and timely care.

CMS certification number This is Hospital’s six digit acute care CMS Certification Number (CCN). CCN is collected for CMS by hospitals for each patient record. Currently, CCN number is used for eCQM data reporting in the Direct Data Submission platform, but it’s not reported in the Direct Data Submission platform, chart-abstracted module. The first two digits in CCN are the numeric state code. The third digit of zero represents an acute facility. The third digit of “1” and fourth digit of “3” represents a Critical Access Hospital (CAH).

critical access hospital (CAH) A Medicare participating hospital can become, and remain, a certified CAH by meeting these regulatory requirements (this isn’t an all-inclusive list but includes basic criteria):
- Located in a state that established a rural health plan for Medicare Rural Hospital Flexibility Programs [MRHFPs] (currently only Connecticut, Delaware, Maryland, New Jersey, and Rhode Island haven’t established MRHFP State Rural Plans)
- Located in a rural area or treated as rural under a special provision treating qualified hospital providers in urban areas as rural (42 CFR 412.103)
- CAHs have a 2-year transition period to reclassify as rural if the Office of Management and Budget changes their location designation to urban
- Provide 24-hour emergency services, 7 days a week, using on-site or on-call staff, with specific on-site, on-call staff response times
- Does not exceed 25 inpatient beds used for inpatient or swing bed services
- It may operate a distinct part rehabilitation and/or psychiatric unit, each with up to 10 beds
- CAHs with Distinct Part Units (DPUs) must follow all hospital and CAH CoPs in the DPU
- Report an annual average acute care inpatient Length of Stay (LOS) of 96 hours or less (excluding swing bed services and DPU beds)

measurement value This data element is used to store the calculated results of the measurements that are outputs from continuous variable measure algorithms. This is used in conjunction with Measure Category Assignment when its allowable value = "D" (In Measure Population). One Measurement Value is expected per episode of care (EOC) for every continuous variable measure that
a hospital is participating in. This number is reported or calculated per measure per month for the Joint Commission’s aggregate data.

**Remove** the following terms:

**national hospital inpatient quality measure** Quality measures are tools that help us measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care. These goals include effective, safe, efficient, patient-centered, equitable, and timely care.

**national hospital inpatient quality measure set** A unique grouping of performance measures carefully selected to provide, when viewed together, a robust picture of the care provided in a given area (e.g., cardiovascular care, pregnancy).

### Appendix G - Resources

Appendix G was updated to align with definitions in the CMS manual, Version 5.15 effective for discharges on and after January 1, 2024.

Resource added for PC-06 Unexpected Complications in Term Newborns for guidance on chart abstraction when there is a co-located NICU.

**Resources**

**Add:**

**CMS Abstraction, Measure, or Electronic Clinical Quality Measures (eCQMs) Questions**

For questions you may go to [https://qualitynet.cms.gov](https://qualitynet.cms.gov) then select "Hospitals-Inpatient" under "Questions & Answers" to submit your questions. Questions & Answers is an online questions and answers database that allows for the submission and retrieval of questions and answers based on the measure set and keyword criterion.

For questions regarding eCQM specifications, value sets, and appropriateness of mapping, please submit questions to the Office of the National Coordinator for Health Information Technology (ONC) eCQM Issue Tracker at [https://onprojecttracking.healthit.gov/support/projects/CQM/summary](https://onprojecttracking.healthit.gov/support/projects/CQM/summary). The eCQM Issue Tracker is an online database that allows for the submission and retrieval of questions and answers based on the measure and keyword criterion.

**Change to:**

**CMS Hospital Inpatient Quality Reporting (IQR) Program**

For information on measures that are required for the CMS Hospital IQR Program and/or used for Public Reporting, refer to the Hospital IQR Program Measures and/or the Acute Care Hospital Quality Reporting Program Measures documents for the appropriate fiscal year, at [https://qualitynet.cms.gov](https://qualitynet.cms.gov). Please go to the QualityNet web site and select Hospitals-Inpatient on the QualityNet home page, Measures on the Hospitals-Inpatient page, and Learn More under Hospital Inpatient Quality Reporting (IQR) Inpatient Measures on the Hospital Inpatient Measures page. You may also refer to the IPPS final rule at [http://www.cms.gov/AcuteInpatientIPPS](http://www.cms.gov/AcuteInpatientIPPS).
Information regarding the Hospital IQR Program electronic clinical quality measures (eCQM) reporting is available on QualityNet at [https://qualitynet.cms.gov/](https://qualitynet.cms.gov/). From the QualityNet web site, select Electronic Clinical Quality Measures (eCQMs) Reporting under Hospital Inpatient Quality Reporting Program under Hospitals-Inpatient.

**Add:**

PC-06 Unexpected Complications in Term Newborns: Guidance for Chart Abstraction when there is a Co-located NICU

<table>
<thead>
<tr>
<th>Data Dictionary - Introduction to the Data Dictionary</th>
<th>The Introduction to the Data Dictionary was updated to align with the CMS manual, version 5.15 effective for discharges on and after January 1, 2024.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Record</strong></td>
<td><strong>Add</strong> second paragraph: All medical records must be promptly completed. Every medical record must be complete with all documentation of orders, diagnosis, evaluations, treatments, test results, care plans, discharge plans, consents, interventions, discharge summary, and care provided along with the patient’s response to those treatments, interventions, and care. The record must be completed promptly after discharge in accordance with State law and hospital policy but no later than 30 days after discharge [42CFR482.24(b)].</td>
</tr>
</tbody>
</table>
| **Physician/Advance Practice Nurse/Physician Assistant Documentation** | **Add** the following terms:  
  - Advance Practice Nurse (APP)  
  - Advanced Practitioners (AP)  
  - Non-Physician Providers (NPP) |
| **Pharmacist Documentation**                        | **Change** the first bullet from:  
  - Doctor of Pharmacy (Pharm.D. or D.Ph.)  
  To:  
  - Doctor of Pharmacy (Pharm.D., PD, or D.Ph.) |
| **Nursing Care Plans, Standing Orders and Protocols** | **Change** first bullet to:  
  - Per Medicare Conditions of Participation [42CFR482.23(b)(4)], the hospital must ensure that the nursing staff develops and keeps current a nursing care plan for each patient that reflects the patient’s goals and the nursing care to be provided to meet the patient’s needs. The nursing care plan may be part of an interdisciplinary care plan. Hospitals have the option of having a stand-alone nursing care plan or a single interdisciplinary care plan that addresses nursing and other disciplines. |
<table>
<thead>
<tr>
<th>Global Initial Patient Population</th>
<th>A narrative of the algorithm has been added for accessibility.</th>
<th>Global Initial Patient Population Narrative Algorithm was added after the measure flow algorithm.</th>
</tr>
</thead>
</table>
| Introduction to the Manual       | The Introduction to the Manual was updated to align with the CMS manual, version 5.15 effective for discharges on and after January 1, 2024. | Related National Activities
Remove: National Quality Forum The NOF has approved a set of national voluntary consensus standards for measuring the quality of hospital care. These measures will permit consumers, providers, purchasers, and quality improvement professionals to evaluate and compare the quality of care in general acute care hospitals across the nation using a standard set of measures.

Change to:
Electronic Clinical Quality Measures (eCQMs) Overview Beginning in calendar year (CY) 2013, CMS provided hospitals with the opportunity to voluntarily submit eCQM data. These quality measures were developed specifically to allow an electronic health record (EHR) system certified to the Office of the National Coordinator for Health Information Technology (ONC) standards to capture, export, calculate, and report measure data. Since CY 2016, hospitals have been required to report eCQM data for the Hospital IQR Program and the Medicare Promoting Interoperability Program (previously known as the Medicare EHR Incentive Program). Hospitals that successfully submit eCQM data to meet Hospital IQR Program requirements will also fulfill the Medicare Promoting Interoperability Program requirement for eCQM reporting with one submission.

Refer to the Technical Specifications and Resources for the CMS Quality Reporting Document Architecture (QRDA) Category I Implementation Guide for the applicable reporting period, measure specification information, and program resources to support successful eCQM reporting on the eCQI Resource Center.

Note: Critical access hospitals (CAHs) are required to participate in the Medicare Promoting Interoperability Program and are encouraged but not required to participate in the Hospital IQR Program. Review the Medicare Promoting Interoperability Programs information on the CMS.gov website for more information.

Change to:
Hospital Value-Based Purchasing (VBP) Program The Hospital VBP Program is part of the CMS' long-standing effort to link Medicare's payment system to healthcare quality in the inpatient setting. The program implements value-based purchasing within the payment system that accounts for the largest share of Medicare spending, affecting payment for inpatient stays in approximately 3,000 hospitals across the county. Hospitals are paid for inpatient acute care services based on the quality of care (as evaluated using a select set of quality and cost measures), not just quantity of the services they pro-
provide. Section 1886 (a) of the Social Security Act set forth the statutory requirements for the Hospital VBP Program.

The Hospital VBP Program is designed to promote better clinical outcomes for hospital patients, as well as improve their experience of care during hospital stays, while reducing costs to make care affordable. Specifically, the Hospital VBP Program seeks to incentivize hospitals to improve the quality and safety of care that Medicare beneficiaries and all patients receive during acute-care inpatient stays by:

- Eliminating or reducing the occurrence of adverse events (healthcare errors resulting in patient harm).
- Adopting evidence-based care standards and protocols that result in the best outcomes for the most patients.
- Re-engineering hospital processes that improve patients’ experience of care.
- Increasing the transparency of care for consumers.
- Recognizing hospitals that are involved in the provision of high-quality care at a lower cost to Medicare.

Add:
Measures Management System (MMS) The Measures Management System (MMS) is a standardized system for developing and maintaining the quality measures used in various CMS initiatives and programs. MMS also supports quality-related activities across the agency. Quality measures are tools that help improve the quality of healthcare through an approach that is consistent and accountable.

The primary goals of the MMS are to:

- Provide support and guidance to measure developers to help them produce high-caliber healthcare quality measures, and
- Educate and inform stakeholders to promote involvement in and awareness of the Measure Lifecycle.

<table>
<thead>
<tr>
<th>Sampling</th>
<th>1. Updated verbiage in Population and Sampling Specifications section at 3 places to align with the PC-05 Measure Name change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Guidance offering process steps for record re-abstraction to check inter-rater reliability</td>
</tr>
<tr>
<td></td>
<td>Population and Sampling Specifications</td>
</tr>
<tr>
<td></td>
<td><strong>Change from:</strong> Exclusive Breast Milk Feeding</td>
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<tr>
<td></td>
<td><strong>To:</strong> Exclusive Human Milk Feeding</td>
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<tr>
<td></td>
<td><strong>Add</strong> new section: Inter-rater Reliability</td>
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## General Release Notes

<table>
<thead>
<tr>
<th>Rationale</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSTK-07 has been suspended since 2016 and now is retired.</td>
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