Release Notes for the 2014A Manual

Section	Rationale	Description
Admission Date	To align with NHQM.	**Change** under the Notes for Abstraction from: • If there are multiple inpatient orders, use the order that most accurately reflects the date that the patient was admitted. The admission date should not be abstracted from the earliest admission order without regards to substantiating documentation. If documentation suggests that the earliest admission order does not reflect the date the patient was admitted to inpatient care, the date should not be used. Example: Preoperative Orders are dated as 04-05-20xx with an order to admit to Inpatient. Postoperative Orders, dated 05-01-20xx, state to admit to acute inpatient. All other documentation supports that the patient presented to the hospital for surgery on 05-01-20xx. The admission date would be abstracted as 05-01-20xx. TO: • If there are multiple inpatient orders, use the order that most accurately reflects the date that the patient was admitted. **Add** the following bullet: • The admission date should not be abstracted from the earliest admission order without regards to substantiating documentation. If documentation suggests that the earliest admission order does not reflect the date the patient was admitted to inpatient care, this date should not be used. Example: Preoperative Orders are dated as 04-06-20xx with an order to admit to Inpatient. Postoperative Orders, dated 05-01-20xx, state to admit to acute inpatient. All other documentation supports that the patient presented to the hospital for surgery on 05-01-20xx. The admission date would be abstracted 05-01-20xx.

		Add under Suggested Data Sources: **Note**: The physician order is the priority data source for this data element. If there is not a physician order in the medical record, use the other only allowable sources to determine the Admission Date.
Antenatal Steroids	To clarify denominator included populations.	**Add** under denominator included populations: • *ICD-9-CM Principal or Other Diagnosis Codes* for pregnancy as defined in Appendix A, Tables 11.01, 11.02, 11.03 or 11.04
Appropriate Justification for Multiple Antipsychotic Medications	To clarify intent of allowable value 4.	**Change** the Notes for Abstraction from: The recommended plan to taper to monotherapy must appear in the continuing care plan transmitted to the next level of care provider. All other justifications may be documented anywhere in the medical record. TO: The recommended plan to taper to monotherapy must appear in the continuing care plan transmitted to the next level of care provider. If an addendum about the recommended plan to taper to monotherapy is added to the continuing care plan within the medical record, it must occur within 5 days after discharge or prior to transmission of the continuing care plan. All other justifications may be documented anywhere in the medical record.
Bloodstream Infection Present on Admission		**Change** the Definition from: Documentation in the medical record that the patient had a bloodstream infection present on admission. This includes both patients with positive blood cultures or negative or inconclusive blood cultures when the patient is suspected of having a bloodstream infection or septicemia and is being treated for the condition. A blood culture can be defined as a culture of microorganisms from specimens of blood to determine the presence and nature of bacteremia.

TO:

Documentation in the medical record within the first 48 hours after admission that the patient had a bloodstream infection present on admission. This includes both patients with positive blood cultures or negative or inconclusive blood cultures when the patient is suspected of having a bloodstream infection or septicemia and is being treated for the condition. A blood culture can be defined as a culture of microorganisms from specimens of blood to determine the presence and nature of bacteremia.

Change the question from:
Is there documentation that the patient had a bloodstream infection present on admission or is receiving treatment for a suspected bloodstream infection or septicemia on admission?

TO:

Is there documentation within the first 48 hours after admission that the patient had a bloodstream infection present on admission or is receiving treatment for a suspected bloodstream infection or septicemia on admission?

Change the Allowable Values from:
Y (Yes) There is documentation that the patient had a bloodstream infection present on admission or is receiving treatment for a suspected bloodstream infection or septicemia on admission.

N (No) There is no documentation that the patient had a bloodstream infection present on admission or is receiving treatment for a suspected bloodstream infection or septicemia present on admission or unable to determine from medical record documentation.

TO:

Y (Yes) There is documentation within the first 48 hours after admission that the patient had a bloodstream infection present on admission or is receiving treatment for a suspected bloodstream infection or septicemia on admission.

		N (No) There is no documentation within the first 48 hours after admission that the patient had a bloodstream infection present on admission or is receiving treatment for a suspected bloodstream infection or septicemia present on admission or unable to determine from medical record documentation.
Cesarean Section	To clarify denominator included populations.	**Add** to Denominator Included Populations: • *ICD-9-CM Principal or Other Diagnosis Codes* for pregnancy as defined in Appendix A, Tables 11.01, 11.02, 11.03 or 11.04
Continuing Care Plan -Discharge Medications	To keep the definition and suggested data collection question consistent with the allowable values. To clarify time frame for an addendum to the continuing care plan.	**Change** the Definition from: Documentation in the medical record of a continuing care plan which includes the discharge medications, dosage and indication for use or that no medications were prescribed at discharge. Such documentation should be transmitted to the next level of care provider by the **fifth post-discharge day.** TO: Documentation in the medical record of a continuing care plan which includes the discharge medications, dosage and indication for use or that no medications were ordered at discharge. Such documentation should be transmitted to the next level of care provider by the **fifth post-discharge day.** **Change** the Suggested Data Collection Question from: Is there documentation in the medical record of a continuing care plan which includes the discharge medications, dosage and indication for use or states no medications were prescribed at discharge AND was the continuing care plan including discharge medications transmitted to the next level of care provider no later than the **fifth post-discharge day?** TO: Is there documentation in the medical record of a continuing care plan which includes the discharge medications, dosage and

		indication for use or states no medications were ordered at discharge AND was the continuing care plan including discharge medications transmitted to the next level of care provider no later than the **fifth post-discharge day**? **Add** to the Notes for Abstraction: If an addendum about the discharge medications is added to continuing care plan within the medical record, it must occur within 5 days after discharge or prior to transmission of the continuing care plan.
Continuing Care Plan -Next Level of Care	To clarify the time frame for an addendum to the continuing care plan.	**Add** to the Notes for Abstraction: If an addendum about the next level of are recommendations is added to continuing care plan within the medical record, it must occur within 5 days after discharge or prior to transmission of the continuing care plan.
Continuing Care Plan -Principal Discharge Diagnosis	To clarify the time frame for an addendum to the continuing care plan.	**Add** to the Notes for Abstraction: If an addendum about the principal discharge diagnosis is added to continuing care plan within the medical record, it must occur within 5 days after discharge or prior to transmission of the continuing care plan.
Continuing Care Plan -Reason for Hospitalization	To clarify the time frame for an addendum to the continuing care plan.	**Add** to the Notes for Abstraction: If an addendum about the reason for hospitalization is added to continuing care plan within the medical record, it must occur within 5 days after discharge or prior to transmission of the continuing care plan.
Discharge Disposition	To align with NHQM.	**Change** the first bullet under the Notes for Abstraction from: • **Only use documentation from the day of or the day before discharge** when abstracting this data element. Example: Documentation in the Discharge Planning notes on 04-01-20xx state that the patient will be discharged back home. On 04-06-20xx the physician orders and nursing discharge notes on the day of discharge reflect that the patient was being transferred to

		skilled care. The documentation from 04-06-20xx would be used to select value “5” (Other Health Care Facility). TO: • **Only use documentation written on the day prior to discharge through 30 days after discharge** when abstracting this data element. **Remove** the following bullet under the Notes for Abstraction: • Consider discharge disposition documentation in the discharge summary, a post-discharge addendum, or a late entry as day of discharge documentation, regardless of when it was dictated/written. **Add** under Guidelines for Abstraction Inclusion: • Veterans Home
Elective Delivery	To clarify the denominator included populations, and to reduce the burden of data abstraction by moving *Prior Uterine Surgery* to the numerator population.	**Change** the second bullet under Numerator Included Populations from: • Cesarean section as defined in Appendix A, Table 11.06 while not in *Labor* or experiencing *Spontaneous Rupture of Membranes* TO: • Cesarean section as defined in Appendix A, Table 11.06 and all of the following: ◦ not in *Labor* ◦ not experiencing *Spontaneous Rupture of Membranes* ◦ no history of a *Prior Uterine Surgery* **Add** under Numerator Data Elements: • *Prior Uterine Surgery* **Add** under Denominator Included Populations:

		• *ICD-9-CM Principal or Other Diagnosis Codes* for pregnancy as defined in Appendix A, Tables 11.01, 11.02, 11.03 or 11.04 **Remove** under Denominator Excluded Populations: • *Prior Uterine Surgery* **Remove** under Denominator Data Elements: • *Prior Uterine Surgery* Algorithm **change**: **Move** the branch of *Prior Uterine Surgery* to be after *Spontaneous Rupture of Membranes* = N as following: 1. If *Prior Uterine Surgery* is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Stop processing. 2. If *Prior Uterine Surgery* equals Yes, the case will proceed to a Measure Category Assignment of D and will be in the Measure Population. Stop processing. 3. If *Prior Uterine Surgery* equals No, the case will proceed to a Measure Category Assignment of E and will be in the Numerator Population. Stop processing.
Exclusive Breast Milk Feeding	To clarify the intent of PC-05a.	**Change** the denominator statement from: • PC-05 Single term newborns discharged alive from the hospital • PC-05a Single term newborns discharged alive from the hospital excluding those whose mothers chose not to breast feed TO: • PC-05 Single term newborns discharged alive from the hospital • PC-05a Single term newborns discharged alive from the hospital excluding those whose mothers chose not to exclusively feed breast milk

		Algorithm **change**: **Change** the PC-05a denominator statement to: • Single term newborns discharged alive from the hospital excluding those whose mothers chose not to exclusively feed breast milk
Gestational Age	To provide clarification of determining gestational age	**Change** under the Notes for Abstraction from: If the patient has not received prenatal care, and the gestational age is unknown, select allowable value UTD. TO: If the patient has not received prenatal care, estimated gestational age (EGA) may be used to answer gestational age. **Change** from: Gestational age should be documented by the clinician as a numeric value between 1-50. The clinician, not the abstractor, should perform the calculation to determine gestational age based on the first day of the last normal menstrual period (not presumed time of conception) and the date of delivery. TO: Gestational age should be documented by the clinician as a numeric value between 1-50. The clinician, not the abstractor, should perform the calculation to determine gestational age based on the first day of the last normal menstrual period (not presumed time of conception) and the date of delivery. Ultrasound-based dating is also an acceptable method of determining gestational age.
Labor	To clarify documentation requirements for labor.	**Add** under the Notes for Abstraction:

		• Documentation of labor by the clinician should be abstracted at face value. No additional documentation of regular contractions or cervical change is required in order to answer yes to labor. **Change** the Guidelines for Abstraction Inclusion from: • Active Labor • Early Labor • Spontaneous Labor TO: The following are acceptable descriptors for labor: • Active • Early • Spontaneous **Change** the Guidelines for Abstraction Exclusion from: • Latent Labor • Prodromal Labor TO: The following are not acceptable descriptors for labor: • Latent • Prodromal
Parity	To define previous deliveries to coincide with vital records data.	**Change** the Definition from: The number of deliveries, whether resulting in live or stillborn infants, the patient experienced prior to current hospitalization. TO: The number of live deliveries the patient experienced prior to current hospitalization.

		Change the Suggested Data Collection Question from: How many deliveries did the patient experience prior to current hospitalization? TO: How many live deliveries did the patient experience prior to current hospitalization?
Patient Referral to Next Level of Care Provider	A specific patient referral to a next level of care provider must occur first before a continuing care plan can be created and transmitted.	**Add** under the Notes for Abstraction: When allowable value 2 or 3 is selected, creation and transmission of a continuing care plan is not required.
Perinatal Care	To correct a typo.	**Change** the following text of Perinatal Care (PC) Initial Patient Population section: from: Newborns with BSI - Patients with a Newborn Patient Age at admission (Admission Date – Birthdate) <= 2 days AND satisfy conditions #1 through #4 to Newborns with BSI - Patients with a Newborn Patient Age at admission (Admission Date – Birthdate) <= 2 days AND satisfy conditions #1 through #3
Prior Uterine Surgery	To clarify inclusions and exclusions.	**Change** the Guidelines for Abstraction Inclusion from: • Prior classical cesarean section resulting in a vertical incision into the upper uterine segment TO:

		• Prior classical cesarean section which is defined as a vertical incision into the upper uterine segment **Change** from: • Prior uterine surgery resulting in a perforation of the uterus TO: • Prior uterine surgery resulting in a perforation of the uterus due to an accidental injury **Change** from: • History of a uterine window noted during prior uterine surgery TO: • History of a uterine window or thinning of the uterine wall noted during prior uterine surgery or during ultrasound **Add** to the Guidelines for Abstraction Exclusion: • Prior low transverse cesarean section • Prior cesarean section without specifying prior classical cesarean section
Reason for Not Exclusively Feeding Breast Milk	To clarify the intent of maternal choice upon admission and the documentation requirements. To add additional maternal medical conditions as reasons for not exclusively feeding breast milk.	**Change** first paragraph of Definition from: Reasons for not exclusively feeding breast milk during the entire hospitalization are clearly documented in the medical record. These reasons are due to a maternal medical condition for which feeding breast milk should be avoided or due to mother's choice to not breast feed upon admission. TO: Reasons for not exclusively feeding breast milk during the entire hospitalization are clearly documented in the medical record. These reasons are due to a maternal medical condition for which feeding

breast milk should be avoided or due to mother's choice to not exclusively feed breast milk upon admission.

Change Allowable Value 2 from:

2.) There is documentation that the newborn's mother chose not to breast feed upon admission.

TO:

2.) There is documentation by physician/APN/PA/CNM/lactation consultant/RN that the newborn's mother chose to not exclusively feed breast milk upon admission.

Change Allowable Value 3 from:

3.) There is no documentation by physician/APN/PA/CNM/lactation consultant of a reason for not exclusively feeding breast milk during the entire hospitalization due to a maternal medical condition with which breast milk feeding should be avoided OR newborn's mother's choice to not breast feed OR unable to determine from medical record documentation.

TO:

3.) There is no documentation by physician/APN/PA/CNM/lactation consultant/RN of a reason for not exclusively feeding breast milk during the entire hospitalization due to a maternal medical condition with which breast milk feeding should be avoided OR newborn's mother's choice to not exclusively feed breast milk OR unable to determine from medical record documentation.

Change under the Notes for Abstraction from:

A mother's choice to not breast feed upon admission must be clearly documented in the newborn's medical record in the context of the newborn feeding method in order to select allowable value "2". Do not assume that the newborn was not exclusively fed breast milk due to maternal choice in the absence of such documentation.

TO:

A mother’s choice to not exclusively feed breast milk upon admission must be clearly documented in the newborn’s medical record in the context of the newborn feeding method in order to select allowable value “2”. Do not assume that the newborn was not exclusively fed breast milk due to maternal choice in the absence of such documentation.

Add under the Notes for Abstraction:

If the mother's choice is to feed both formula and breast milk upon admission select allowable value "2".

RN documentation of the mother's choice to not exclusively feed breast milk upon admission may be used only if there is additional documentation during the hospitalization from the physician/APN/PA/CNM/lactation consultant that they are aware of the mother's decision to not exclusively breast milk feed the newborn.

Change Guidelines for Abstraction Inclusion from:

These are the only acceptable maternal medical conditions for which breast milk feeding should be avoided which includes one or more of the following medical conditions:

- HIV infection
- Human t-lymphotrophic virus type I or II
- Substance abuse and/or alcohol abuse
- Active, untreated tuberculosis
- Taking certain medications, i.e., prescribed cancer chemotherapy, radioactive isotopes, antimetabolites, antiretroviral medications and other medications where the risk of morbidity outweighs the benefits of breast milk feeding
- Undergoing radiation therapy
- Active, untreated varicella
- Active herpes simplex virus with breast lesions
- Admission to Intensive Care Unit (ICU) post-partum
- Adoption or foster home placement of newborn

		• Previous breast surgery, i.e., bilateral mastectomy, bilateral breast reduction or augmentation where the mother is unable to produce breast milk TO: These are the only acceptable maternal medical conditions for which breast milk feeding should be avoided which includes one or more of the following medical conditions: • HIV infection • Human t-lymphotrophic virus type I or II • Substance abuse and/or alcohol abuse • Active, untreated tuberculosis • Taking certain medications, i.e., prescribed cancer chemotherapy, radioactive isotopes, antimetabolites, antiretroviral medications and other medications where the risk of morbidity outweighs the benefits of breast milk feeding • Undergoing radiation therapy • Active, untreated varicella • Active herpes simplex virus with breast lesions • Admission to Intensive Care Unit (ICU) post-partum • Adoption or foster home placement of newborn • Previous breast surgery, i.e., bilateral mastectomy, bilateral breast reduction or augmentation where the mother is unable to produce breast milk • Breast abnormality, i.e., hypoplasia, tumor where the mother is unable to produce breast milk • Surrogate delivery resulting in placement of the newborn with another person who will assume care of the newborn after discharge
Substance Use	To clarify the minimum time frame for screening the past history of substance use.	**Add** to the Notes for Abstraction: Documentation of a past history of substance use must at a minimum state over the past 12 months or over a longer period of time, i.e., life time history. Documentation of "no history" cannot be used, unless the minimum time frame of 12 months or a longer is specified.

Violence Risk to Others	To clarify the minimum time frame for screening the past history of violence risk to others.	**Add** to the Notes for Abstraction: Documentation of a past history of violence risk to others must at a minimum state over the past 6 months or over a longer period of time, i.e., life time history. Documentation of "no history" cannot be used, unless the minimum time frame of 6 months or a longer is specified.
Violence Risk to Self	To clarify the minimum time frame for screening the past history of violence risk to others.	**Add** to the Notes for Abstraction: Documentation of a past history of violence risk to self must at a minimum state over the past 6 months or over a longer period of time, i.e., life time history. Documentation of "no history" cannot be used, unless the minimum time frame of 6 months or a longer is specified.
a2. Introduction to the Manual	To align with NHQM.	The entire section contains extensive revisions.
a3. Using the The Joint Commission's National Measure Specifications Manual	To align with the NHQM.	**Add** a new section of "Appendix P – Preview Section": The preview section is intended to provide an overview of future updates. The information provided in this section **is not** to be programmed or submitted. Placement in this appendix does not assume that the information listed will be implemented in a future manual.
b. Introduction to the Data Dictionary	To align with the NHQM.	Under the "Episode of Care" section, **Add** the following sentence to the first paragraph: In the event that there are multiple ED visits within the inpatient medical record, for the same episode of care, it is recommended that the ED visit resulting in the admission to observation or inpatient status be utilized for the purposes of abstraction. Under the "General Abstraction Guidelines" section, **Change** the whole paragraph to: The intent of abstraction is to use only documentation that was part of the medical record during the hospitalization (is present upon discharge) and that is present at the time of abstraction. There are

instances where an addendum or late entry is added after discharge. This late entry or addendum can be used, for abstraction purposes, as long as it has been added within 30 days of discharge, [Refer to the Medicare Conditions of Participation for Medical Records, 42CFR482.24(c)(2)(viii)], unless otherwise specified in the data element. Documents containing amendments, corrections, or delayed entries must employ the following widely accepted recordkeeping principles (CMS “Medicare Program Integrity Manual” Chapter 3, Section 3.3.2.4):

- Clearly and permanently identify any amendments, corrections or addenda;
- Clearly indicate the date and author of any amendments, corrections, or addenda; and
- Clearly identify all original content.

It is not the intent to have documentation added at the time of abstraction to ensure the passing of a measure.

Under the "Medications" section, **Add** a new bullet:

- Hospitals may allow a patient (or his or her caregiver/support person where appropriate) to self-administer both hospital-issued medications and the patient’s own medications brought into the hospital. Hospitals must document the administration of each medication, as reported by the patient (or the patient’s caregiver/support person where appropriate), in the patient’s medical record [42CFR482.23(c)(6)].

After the "Medications" section, **Add** a new section of "Nursing Care Plans, Standing Orders and Protocols" with 2 new bullets:

Nursing Care Plans, Standing Orders and Protocols

- Per Medicare Conditions of Participation [42CFR482.23(b)(4)] hospitals have the option of having a stand-alone nursing care plan or a single interdisciplinary care plan that addresses nursing and other disciplines.
- Hospitals may use pre-printed and electronic standing orders, order sets, and protocols for patient orders if such orders and

		protocols are dated, timed, and authenticated promptly in the patient's medical record by the ordering practitioner responsible for the care of the patient [42CFR482.24(c)(3)].
g1. Transmission of Data	To reflect the new version information for the Initial Population XML layout. To reflect Data Dictionary changes, the new version information and fix typos for the Clinical XML layout.	**Update** to Hospital Clinical Data XML File Layout: 1- Elements were updated to match the Data Dictionary elements: a. 'Admission to NICU' Suggested Data Collection Question was updated. b. 'Bloodstream Infection Present on Admission' Suggested Data Collection question and value descriptions were updated. c. 'Continuing Care Plan-Discharge Medications' Suggested Data Collection question and Programming Note were updated. d. 'Continuing Care Plan-Next Level of Care' Programming Note was updated. e. 'Continuing Care Plan-Principal Discharge Diagnosis' Programming Note was updated. f. 'Continuing Care Plan-Reason for Hospitalization' Programming Note was updated. g. 'Discharge Disposition' Suggested Data Collection Question was updated. h. 'ICD-9-CM Principal Procedure Code' Suggested Data Collection Question was updated. i. 'Parity' Suggested Data Collection Question was updated. j. 'Patient Strengths' X value description was updated. k. 'Psychiatric Care Setting' Programming Note was updated. l. 'Psychological Trauma History' X value description was updated. m. 'Reason for Not Exclusively Feeding Breast Milk' value 2 and 3 descriptions were updated. n. 'Substance Use ' X value description was updated. o. 'Violence Risk to Others' X value description was updated. p. 'Violence Risk to Self' X value description was updated. 2- The coverage period has been updated in the footer and header. **Update** to Initial Patient Population XML File Layout: The coverage period has been updated in the footer and header.

z. Appendix A - ICD-9 -CM Code Tables	To update code tables to reflect additional exclusions for PC-01.	**Add** the following ICD-9-CM diagnosis codes to Table 11.07: 576.8, 663.01, 665.01.
z. Appendix C - Glossary of Terms	To correct a typo.	**Change** the following term from: **sub-population** A population that is part of a larger population. For example, the measure set Perinatal Care evaluates the obstetrical population in the hospital. This measure set is broken into two distinct sub-populations, mothers (PC-01, PC-02 and PC-33) and newborns (PC-04 and PC-05). TO: **sub-population** A population that is part of a larger population. For example, the measure set Perinatal Care evaluates the obstetrical population in the hospital. This measure set is broken into two distinct sub-populations, mothers (PC-01, PC-02 and PC-03) and newborns (PC-04 and PC-05).
z. Appendix P - preview section of ICD-10 Code Tables	Adding preview section to display future manual updates. This section is for preview only and is not to be used for programming.	**Add** new Appendix: Appendix P-Preview section.