Release Notes for the 2013B Manual

Section	Rationale	Description
Admission Date	To align with NHQM.	**Delete** under the notes for abstraction: • A patient of a hospital is considered an inpatient upon issuance of written doctor's orders to that effect. (Refer to the Medicare Claims Processing Manual, Chapter 3, Section 40.2.2.) **Add** the following after the third sub-bullet: Example: • ○ Medical record documentation reflects that the patient was admitted to observation on 04-05-20xx. On 04-06-20xx the physician writes an order to admit to acute inpatient effective 04-05-20xx. The *Admission Date* would be abstracted as 04-06-20xx; the date the determination was made to admit to acute inpatient care and the order was written. • If there are multiple inpatient orders, use the order that most accurately reflects the date that the patient was admitted. The admission date should not be abstracted from the earliest admission order without 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.

		Delete the following bullets: • For patients that are admitted for surgery and/or a procedure, if the admission order states the date the orders were written and they are effective for the surgery/procedure date, then the date of the surgery/procedure would be the admission date. If the medical record reflects that the admission order was written prior to the actual date the patient was admitted and there is no reference to the date of the surgery/procedure, then the date the order was written would be the admission date. • For patients for whom there is no admission to inpatient status, enter 00-00-0000.
Antenatal Steroids	To correct name of data element. To clarify gestational age range for the denominator population.	**Change** the third bullet under Denominator Excluded Populations from: • Documented *Reason for Not Administering Antenatal Steroid* TO: • Documented *Reason for Not Initiating Antenatal Steroid Therapy* **Add** under denominator excluded populations: • *Gestational Age* < 24 or >= 32 weeks
Antenatal Steroid Therapy Initiated	To correct typo.	**Change** the second paragraph of the Definition from: Initial antenatal steroid therapy is 12mg bethamethasone IM or 6mg dexamethasone IM. TO: Initial antenatal steroid therapy is 12mg betamethasone IM or 6mg dexamethasone IM.

Birth Weight	To provide an additional acceptable data source.	**Add** the following paragraph in the Notes for Abstraction: It is acceptable to use data derived from vital records reports received from state or local departments of public health if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the suggested data sources listed below.
Bloodstream Infection Present on Admission	Data element created to identify newborns with bloodstream infections present on admission.	**Add** as a new data element
Cesarean Section	The overall rate is the only rate which is used for reporting. To clarify gestational age range for the denominator population.	**Remove** the following Measure Set IDs and Performance Measure Names: • PC-02a Cesarean Section - Overall Rate • PC-02b Cesarean Section - 8 through 14 years • PC-02c Cesarean Section - 15 through 19 years • PC-02d Cesarean Section - 20 through 24 years • PC-02e Cesarean Section - 25 through 29 years • PC-02f Cesarean Section - 30 through 34 years • PC-02g Cesarean Section - 35 through 39 years • PC-02h Cesarean Section - 40 through 44 years • PC-02i Cesarean Section - 45 through 64 years **Add** under denominator excluded populations: • *Gestational Age* < 37 weeks
Elective Delivery	To clarify gestational age range for the denominator population and to provide an update on the use of data by	**Add** under Denominator Excluded Populations: • *Gestational Age* < 37 or >=39 weeks **Add** the following language:

	other programs.	Adopted for CMS Hospital Inpatient Quality Reporting Program FY 2015 and Stage 2 Medicare and Medicaid EHR Incentive Program
Event Type	To provide definitions of event types.	**Add** under the notes for abstraction: A physical restraint is any manual method or physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely when it is used as a restriction to manage a patient's behavior or restrict the patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition.[1] Refer to the data element *Minutes of Physical Restraint* for a list of inclusions and exclusions. Seclusion is the involuntary confinement of a patient alone in a room or an area where the patient is physically prevented from leaving.[1] Refer to the data element *Minutes of Seclusion* for a list of inclusions and exclusions. [1] 42 CFR Part 482, Medicare and Medicaid Programs; Hospital Conditions of Participation: Patient's Rights
Gestational Age	To provide an additional acceptable data source.	**Add** the following paragraph in the Notes for Abstraction: It is acceptable to use data derived from vital records reports received from state or local departments of public health if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the acceptable data sources listed below.
Health Care-Associated Bloodstream Infections in Newborns	To exclude the newborns who were born in the hospital with Bloodstream Infection or transferred-in with a bloodstream infection	**Change** under Numerator Included Populations from: • *ICD-9-CM Other Diagnosis Codes* for septicemias or bacteremias as defined in Appendix A, Table 11.10.2 TO:

	present at hospital admission. To idntify only newborns with a health care-associated septicemia or bacteremia.	• *ICD-9-CM Other Diagnosis Codes* for newborn septicemia or bacteremia as defined in Appendix A, Table 11.10 OR • *ICD-9-CM Other Diagnosis Codes* for sepsis as defined in Appendix A, Table 11.10.1 **Change** the second bullet under Denominator Excluded Populations from: • *ICD-9-CM Principal Diagnosis Code* for liveborn newborn as defined in Appendix A, Table 11.10.3 AND *ICD-9-CM Other Diagnosis Codes* for newborn septicemia or bacteremia as defined in Appendix A, Table 11.10 TO: • *ICD-9-CM Other Diagnosis Codes* for septicemias or bacteremias as defined in Appendix A, Table 11.10.2 or *ICD-9-CM Principal or Other Diagnosis Codes* for newborn septicemia or bacteremia as defined in Appendix A, Table 11.10 with a *Bloodstream Infection Present on Admission* **Add** the following Denominator Data Element: • *Bloodstream Infection Present on Admission* Algorithm Changes: **Add** the following branches into the algorithm after the branch of *Clinical Trial*: 1. *ICD-9-CM Principal or Other Diagnosis Codes* on Table 11.10 2. *ICD-9-CM Other Diagnosis Codes* on Table 11.10.2 3. *Bloodstream Infection Present on Admission* if at least one

		ICD-9-CM Principal or Other Diagnosis Codes on Table 11.10 or at least one *ICD-9-CM Other Diagnosis Codes* on Table 11.10.2 **Add** the following branches into the algorithm after the branch of *Discharge Disposition*: 1. *ICD-9-CM Other Diagnosis Codes* on Table 11.10 2. *ICD-9-CM Other Diagnosis Codes* on Table 11.10.1
Hours of physical restraint use	To provide an update on the use of data by other programs.	**Add** the following language: Adopted for CMS Inpatient Psychiatric Facility Quality Reporting Program FY 2014
Hours of seclusion use	To provde an update on the use of data by other programs.	**Add** the following language: Adopted for CMS Inpatient Psychiatric Facility Quality Reporting Program FY 2014
Labor	To add different descriptors for labor	**Add** to the Guidelines for Abstraction Inclusion: • Early Labor **Add** to the Guidelines for Abstraction Exclusion: • Latent Labor
Parity	To provide an additional acceptable data source.	**Add** the following paragraph in the Notes for Abstraction: It is acceptable to use data derived from vital records reports received from state or local departments of public health if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the acceptable data sources listed below.
Patient Strengths	To clarify the acceptable admission	**Change** under the notes for abstraction in the last paragraph from: The admission screening timeframe must have occurred within the

	screening timeframe.	first three days of admission for psychiatric care. The day after admission is defined as the first day. TO: The admission screening timeframe must have occurred within the first three days of admission for psychiatric care. The day after admission is defined as the first day. An admission screen performed in an ambulatory setting, i.e. emergency department, crisis center which results in an admission to an inpatient psychiatric care setting can be used if the screen becomes a permanent part of the medical record.
Patients discharged on multiple antipsychotic medications	To provide an update on the use of data by other programs.	**Add** the following language: Adopted for CMS Inpatient Psychiatric Facility Quality Reporting Program FY 2014
Patients discharged on multiple antipsychotic medications with appropriate justification	To provide an update on the use of data by other programs.	**Add** the following language: Adopted for CMS Inpatient Psychiatric Facility Quality Reporting Program FY 2014
Perinatal Care	Allowing hospitals to use vital records reports received from state or local departments of public health to identify the PC-Mother Population. Move identification of newborns transferred in and born with bloodstream infections to the	1- **Add** to the PC-Mother Population section **Note**: Hospitals are NOT required to sample their data. If sampling offers minimal benefit (i.e., a hospital has 80 cases for the quarter and must select a sample of 76 cases), or if the hospital has access to a data source which makes medical record review unnecessary (e.g., using vital records as a data source for some of the maternal measures in the perinatal measure set), the hospital may choose to use all cases. 2- **Add** following paragraph to the 'Sample Size Requirement'

	measure level algorithm.	section: "A hospital may choose to use vital records to identify the PC-Mother Initial Patient Population as given in the Population section earlier. If a hospital uses this method to identify the initial patient population, then the hospital is encouraged to submit all the records of the initial population rather than using sampling to identify the cases for submission. Submitting all the initial patient population provides a more precise estimate of the performance rate for the measures." **Remove** from Newborns with BSI population flow: The decision point evaluating *ICD-9-CM Principal Diagnosis Code* on Table 11.10.3 and the decision point evaluating *ICD-9-CM Other Diagnosis Codes* on Table 11.10 **Remove** from Newborns with BSI population narrative bullet Number 2: 2. NO *ICD-9-CM Principal Diagnosis Code* as defined in Appendix A, Table 11.10.3 AND NO *ICD-9-CM Other Diagnosis Codes* as defined in Appendix A, Table 11.10
Post discharge continuing care plan created	To provide an update on the use of data by other programs.	**Add** the following language: Adopted for CMS Inpatient Psychiatric Facility Quality Reporting Program FY 2014
Post discharge continuing care plan transmitted to next level of care provider upon discharge	To provide an update on the use of data by other programs.	**Add** the following language: Adopted for CMS Inpatient Psychiatric Facility Quality Reporting Program FY 2014
Prior Uterine Surgery	To clarify the definition of a classical cesarean section	**Change** the Guidelines for Abstraction Inclusion from: The **only** prior uterine surgeries considered for the purposes of the measure are:

		• Prior classical cesarean section • Prior myomectomy • Prior uterine surgery resulting in a perforation of the uterus • History of a uterine window noted during prior uterine surgery • History of uterine rupture requiring surgical repair TO: The **only** prior uterine surgeries considered for the purposes of the measure are: • Prior classical cesarean section resulting in a vertical incision into the upper uterine segment • Prior myomectomy • Prior uterine surgery resulting in a perforation of the uterus • History of a uterine window noted during prior uterine surgery • History of uterine rupture requiring surgical repair
Psychiatric Care Setting	To correct typo.	**Change** under the notes for abstraction: Example 2 - Psychiatric Units that treat dual diagnosis patient (patients with **both** substance use disorders and psychiatric diagnoses) are included in the BHIPS measures. TO: Example 2 - Psychiatric Units that treat dual diagnosis patient (patients with **both** substance use disorders and psychiatric diagnoses) are included in the HBIPS measures.
Psychological Trauma History	To clarify the acceptable admission screening timeframe.	**Change** under the notes for abstraction in the last paragraph from: The admission screening timeframe must have occurred within the first three days of admission for psychiatric care. The day after admission is defined as the first day. TO:

		The admission screening timeframe must have occurred within the first three days of admission for psychiatric care. The day after admission is defined as the first day. An admission screen performed in an ambulatory setting, i.e. emergency department, crisis center which results in an admission to an inpatient psychiatric care setting can be used if the screen becomes a permanent part of the medical record.
Reason for Not Exclusively Feeding Breast Milk	To clarify only the maternal choice upon admission to not breast feed is only considered for maternal choice.	**Change** first paragraph of Defintion 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. 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 breast feed upon admission. **Change** Allowable Value 2 from: 2.) There is documentation that the newborn's mother chose not to breast feed. TO: 2.) There is documentation that the newborn's mother chose not to breast feed upon admission. **Change** the Notes for Abstraction the second paragraph from: A mother's choice to not breast feed 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 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.
Reason for Not Initiating Antenatal Steroid Therapy	To correct typo.	**Change** the second paragraph of the Definition from: Initial antenatal steroid therapy is 12mg bethamethasone IM or 6mg dexamethasone IM. TO: Initial antenatal steroid therapy is 12mg betamethasone IM or 6mg dexamethasone IM.
Substance Use	To clarify the acceptable admission screening timeframe.	**Change** under the notes for abstraction in the third paragraph from: The admission screening timeframe must have occurred within the first three days of admission for psychiatric care. The day after admission is defined as the first day. TO: The admission screening timeframe must have occurred within the first three days of admission for psychiatric care. The day after admission is defined as the first day. An admission screen performed in an ambulatory setting, i.e. emergency department, crisis center which results in an admission to an inpatient psychiatric care setting can be used if the screen becomes a permanent part of the medical record.

Total Leave Days-Non-Medicare Only	To add another acceptable description for leave day.	**Add** under guidelines for abstraction inclusion: Therapeutic pass
Total Leave Days - Medicare Only	To add another acceptable description for leave day.	**Add** under guidelines for abstraction inclusion: Therapeutic pass
Violence Risk to Others	To clarify the acceptable admission screening timeframe.	**Change** under the notes for abstraction in the third paragraph from: The admission screening timeframe must have occurred within the first three days of admission for psychiatric care. The day after admission is defined as the first day. TO: The admission screening timeframe must have occurred within the first three days of admission for psychiatric care. The day after admission is defined as the first day. An admission screen performed in an ambulatory setting, i.e. emergency department, crisis center which results in an admission to an inpatient psychiatric care setting can be used if the screen becomes a permanent part of the medical record.
Violence Risk to Self	To clarify the acceptable admission screening timeframe.	**Change** under the notes for abstraction in the third paragraph from: The admission screening timeframe must have occurred within the first three days of admission for psychiatric care. The day after admission is defined as the first day. TO: The admission screening timeframe must have occurred within the first three days of admission for psychiatric care. The day after admission is defined as the first day. An admission screen performed in an ambulatory setting, i.e. emergency department, crisis center which results in an admission to an inpatient psychiatric care setting can be used if the screen becomes a permanent part of the medical

		record.
e. Sampling	HBIPS measure set no longer is required to utilize Global sampling methodology, even if Global measure set are submitted.	**Update** Section 'Order of Data Flow': Extensive change applied to this section to remove HBIPS from Global Sampling Methodology. Please read the entire section.
g1. Transmission of Data	A new data element was added to the layout.	**Update** Hospital Clinical Data XML File Layout - new data element, *Bloodstream Infection Present on Admission*, added to the Detail tab,the coverge period updated in footer and header **and** Initial Patient Population XML File Layout - only coverge period updated in footer and header
z. Appendix E - Miscellaneous Tables	Since each VTE sub-population has different population criterion, the combination is broken to sub-populations. CMS adopted STK and VTE.	**Change** Appendix E, Table 2.7 Allowable Measure Set Combinations: **1-** VTE measure set is broken to 3 sub-populations: No-VTE sub-population, Principal-VTE Sub-population, and Other-VTE-Only sub-population. **2- Remove** the footnote from STK and VTE.
z. Appendix A - ICD-9-CM Code Tables	To update code tables to reflect changes to PC-04.	**Add** Table 11.10.1 Sepsis