

Release Notes for the TJC2023A Manual

Measure Information Forms

Section	Rationale	Description
PC-02	<p>Updated rationale to reflect updated references. Added selected references to replace references with more current resources.</p>	<p>Rationale:</p> <p>Change from:</p> <p>The removal of any pressure to not perform a cesarean birth has led to a skyrocketing of hospital, state and national cesarean birth (CB) rates. Some hospitals now have CB rates over 50%. Hospitals with CB rates at 15-20% have infant outcomes that are just as good and better maternal outcomes (Gould et al., 2004). There are no data that higher rates improve any outcomes, yet the CB rates continue to rise. This measure seeks to focus attention on the most variable portion of the CB epidemic, the term labor CB in nulliparous women. This population segment accounts for the large majority of the variable portion of the CB rate, and is the area most affected by subjectivity.</p> <p>As compared to other CB measures, what is different about NTSV CB rate (Low-risk Primary CB in first births) is that there are clear cut quality improvement activities that can be done to address the differences. Main et al. (2006) found that over 60% of the variation among hospitals can be attributed to first birth labor induction rates and first birth early labor admission rates. The results showed if labor was forced when the cervix was not ready the outcomes were poorer. Alfirevic et al. (2004) also showed that labor and delivery guidelines can make a difference in labor outcomes. Many authors have shown that physician factors, rather than patient characteristics or obstetric diagnoses are the major driver for the difference in rates within a hospital (Berkowitz, et al., 1989; Goyert et al., 1989; Luthy et al., 2003). The dramatic variation in NTSV rates seen in all populations studied is striking according to Menacker</p>

(2006). Hospitals within a state (Coonrod et al., 2008; California Office of Statewide Hospital Planning and Development [OSHPD], 2007) and physicians within a hospital (Main, 1999) have rates with a 3-5 fold variation.

To:

The removal of any pressure to not perform a cesarean birth has led to a skyrocketing of hospital, state and national cesarean birth (CB) rates. Some hospitals' CB rates were over 50%. Hospitals with CB rates at 15-20% have infant outcomes that are just as good and better maternal outcomes (Symum et al., 2021). There is no data that higher rates improve any outcomes, yet the CB rates continue to rise. This measure seeks to focus attention on the most variable portion of the CB epidemic, the term labor CB in nulliparous women. This population segment accounts for the large majority of the variable portion of the CB rate and is the area most affected by subjectivity.

As compared to other CB measures, what is different about NTSV CB rate (Primary CB in first births with term singleton pregnancies in head down position) is that there are clear cut quality improvement activities that can be done to address the differences. Main et al. (2012) found that over 60% of the variation among hospitals can be attributed to first birth labor induction rates and first birth early labor admission rates. The results showed if labor was forced when the cervix was not ready the outcomes were poorer. Rosenstein et al. (2021) also showed that labor and delivery guidelines can make a difference in labor outcomes. Many authors have shown that physician factors, rather than patient characteristics or obstetric diagnoses are the major driver for the difference in rates within a hospital (Berkowitz, et al., 1989; Goyert et al., 1989; Luthy et al., 2003, Symum et al., 2021). The dramatic variation in cesarean rates seen in all populations studied is striking. (Cesarean rates varied ten-fold in US hospitals nationwide across hospitals, from 7.1 % to 69.9 % and there was a 15-fold variation among low-risk women, from 2.4% to 36.5% (Kozhimannil et al., 2013).

A reduction in the number of nulliparous patients with live term singleton newborns in vertex position (NTSV) delivering by cesarean birth will result in increased patient

safety, a substantial decrease in maternal and neonatal morbidity and substantial savings in health care costs. Successful quality improvement efforts incorporate audit and feedback strategies combined with provider and nurse education, guidelines and peer review.

The measure will assist health care organizations (HCOs) to track nulliparous patients with live term singleton newborns in vertex position delivering by cesarean birth to reduce the occurrence. Nulliparous women have 4-6 times the cesarean birth rate than multiparous women thus the NTSV population is the largest driver of primary cesarean birth rate (Sakala et al. 2020). NTSV has a large variation among facilities, thus identifying an important population on which to focus quality improvement efforts.

In addition, a reduction in primary cesarean births will reduce the number of women having repeat cesarean births (almost 90% of mothers who have a primary cesarean birth will have subsequent cesarean birth (CDC, 2020)). Thus, improvement in the rates of cesarean birth for the first birth will reduce the morbidity of all future births and avoid all the controversies with trial of labor after cesarean/elective repeat cesareans.

Selected References:

REMOVE

- Alfirevic, Z., Edwards, G., & Platt, M.J. (2004). The impact of delivery suite guidelines on intrapartum care in “standard primigravida.” *Eur J Obstet Gynecol Reprod Biol.*115:28-31.
- California Office of Statewide Hospital Planning and Development. (2017). Hospital Volume and Utilization Indicators for California, Retrieved from the Internet on February 22, 2018 at: <https://www.oshpd.ca.gov/HID/AHRQ-Volume-Utilization.html>
- Coonrod, D.V., Drachman, D., Hobson, P., & Manriquez, M. (2008). Nulliparous term singleton vertex cesarean delivery rates: institutional and individual level

predictors. *Am J Obstet Gynecol.* 694-696.

- Gould, J., Danielson, B., Korst, L., Phibbs, R., Chance, K., & Main, E.K., et al. (2004). Cesarean delivery rate and neonatal morbidity in a low-risk population. *Am J Obstet Gynecol*, 104:11-19.
- Main, E.K. (1999). Reducing cesarean birth rates with data-driven quality improvement activities. *Peds.* 103: 374-383.
- Menacker, F. (2005). Trends in cesarean rates for first births and repeat cesarean rates for low-risk women: United States, 1990-2003. *Nat Vital Stat Rep.* 54(4): 1-5.
- U.S. Department of Health and Human Services. (2000). *Healthy People 2010: Understanding and Improving Health.* 2nd ed. Washington, DC: U.S. Government Printing Office. Measure 16-9.

ADD:

- Center for Disease Control (2020). Recent trends in vaginal birth after cesarean delivery: United States, 2016-2018. Retrieved from National Center for Health Statistics: <https://www.cdc.gov/nchs/products/databriefs/db359.htm>
- Kozhimannil, K. B., Law, M. R., & Virnig, B. A. (2013). Cesarean delivery rates vary tenfold among US hospitals; reducing variation may address quality and cost issues. *Health affairs (Project Hope)*, 32(3), 527-535. <https://doi.org/10.1377/hlthaff.2012.1030>
- Main, E. K., Chang, S. C., Cape, V., Sakowski, C., Smith, H., & Vasher, J. (2019). Safety Assessment of a Large-Scale Improvement Collaborative to Reduce Nulliparous Cesarean Delivery Rates. *Obstetrics and gynecology*, 133(4), 613-623. <https://doi.org/10.1097/AOG.0000000000003109>
- Main, E. K., Morton, C. H., Melsop, K., Hopkins, D., Giuliani, G., & Gould, J. B. (2012). Creating a public agenda for maternity safety and quality in cesarean delivery. *Obstetrics and gynecology*, 120(5), 1194-1198. <https://doi.org/10.1097/aog.0b013e31826fc13d>
- Rosenstein, M. G., Chang, S. C., Sakowski, C., Markow, C., Teleki, S., Lang, L., Logan, J., Cape, V., & Main, E. K. (2021). Hospital Quality Improvement Interventions, Statewide Policy Initiatives, and Rates of Cesarean Delivery for

		<p>Nulliparous, Term, Singleton, Vertex Births in California. JAMA, 325(16), 1631-1639. https://doi.org/10.1001/jama.2021.3816</p> <ul style="list-style-type: none"> • Sakala, C., Belanoff, C., & Declercq, E. R. (2020). Factors Associated with Unplanned Primary Cesarean Birth: Secondary Analysis of the Listening to Mothers in California Survey. BMC pregnancy and childbirth, 20(1), 462. https://doi.org/10.1186/s12884-020-03095-4 • Symum, H., & Zayas-Castro, J. L. (2021). A Multistate Decomposition Analysis of Cesarean Rate Variations, Associated Health Outcomes, and Financial Implications in the United States. American journal of perinatology, 10.1055/s-0041-1736538. Advance online publication. https://doi.org/10.1055/s-0041-1736538 • U.S. Department of Health and Human Services. (n.d.). Reduce cesarean births among low-risk women with no prior births-MICH-06. Retrieved from Healthy People 2030: https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/reduce-cesarean-births-among-low-risk-women-no-prior-births-mich-06
PC-05	Updated abbreviation of BF to breastfeeding for clarity.	<p>Rationale:</p> <p>Change From:</p> <p>Much evidence has now focused on the prenatal and intrapartum period as critical for the success of exclusive (or any) BF (Centers for Disease Control and Prevention [CDC], 2020; CDC, 2013; Petrova et al., 2007; Taveras et al., 2004).</p> <p>To:</p> <p>Much evidence has now focused on the prenatal and intrapartum period as critical for the success of exclusive (or any) breastfeeding (Centers for Disease Control and Prevention [CDC], 2020; CDC, 2013; Petrova et al., 2007; Taveras et al., 2004).</p>

Data Elements

Section	Rationale	Description
Comfort Measures Only	The data element was updated to provide clarification for abstractors.	Inclusion Guidelines for Abstraction Add: <ul style="list-style-type: none"> Comfort focused treatment
CPT® Codes with Modifier	Appendix B no longer exists.	Appendix B changed to Appendix A.
Discharge Code	The data element definition was updated to align with CMS OQR Manual Version 16.0.	Notes for Abstraction (bullet 1) Change from: If documentation is contradictory, use the latest documentation. If there is documentation that further clarifies the level of care, that documentation should be used to determine the correct value to abstract. To: Use the latest documentation. However, if there is documentation that further clarifies the level of care, that documentation should be used to determine the correct value to abstract, even if it is not the latest.
Influenza Vaccination Status	Updated link under Inclusion.	Guidelines for Abstraction: Inclusion Change From: Acceptable terms for influenza vaccines include those listed below or refer to CDC list of Influenza vaccines at http://www.cdc.gov/flu/protect/vaccine/vaccines.htm . To:

		Acceptable terms for influenza vaccines include those listed below or refer to the CDC Table: Influenza Vaccines- United States link for a list of Influenza vaccines at https://www.cdc.gov/flu/professionals/vaccination/index.htm .
Labor	Updated verbiage to clarify meaning.	<p>Notes for Abstraction:</p> <p>Change from:</p> <ul style="list-style-type: none"> Spontaneous Rupture Of Membranes (SROM) is not the same as labor. There are diagnosis codes on Table 11.07 Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation which should be used for pre-labor (preterm) rupture of membranes and for prolonged rupture. <p>To:</p> <ul style="list-style-type: none"> Spontaneous Rupture Of Membranes (SROM) is not the same as labor. There are diagnosis codes on Table 11.07 Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation which should be used for pre-labor (pre-mature) rupture of membranes and for prolonged rupture.
MER Eligibility	The data element definition was updated to provide clarification for abstractors.	<p>Inclusion Guidelines for Abstraction</p> <p>Add:</p> <ul style="list-style-type: none"> Neuro-endovascular
Reason for No ACEI and No ARB Prescribed for LVSD in Outpatient Setting	The addition of a nurse being able to document patient refusal will provide abstractor clarification.	<p>Notes for Abstraction</p> <p>Add:</p> <ul style="list-style-type: none"> Reasons for not prescribing an ACEI and ARB must be documented by a physician/APN/PA or pharmacist with one exception: Patient/family refusal of ACEI and ARB (e.g., "Patient refusing ACEI/ARB") may be documented by a nurse.
Reason for No Aldosterone Receptor	The addition of a nurse being able to document patient refusal will pro-	<p>Notes for Abstraction</p> <p>Change from:</p>

<p>Antagonist Prescribed in the Outpatient Setting</p>	<p>vide abstractor clarification.</p>	<ul style="list-style-type: none"> Reasons for not prescribing an aldosterone antagonist must be documented by a physician/APN/PA or pharmacist. <p>Change to:</p> <ul style="list-style-type: none"> 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.
<p>Reason for No Aldosterone Receptor Antagonist Prescribed at Discharge</p>	<p>The addition of a nurse being able to document patient refusal will provide abstractor clarification.</p>	<p>Notes for Abstraction</p> <p>Change from:</p> <ul style="list-style-type: none"> Reasons for not prescribing an aldosterone antagonist at discharge must be documented by a physician/APN/PA or pharmacist. <p>Change to:</p> <ul style="list-style-type: none"> 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.
<p>Reason for No Bisoprolol, Carvedilol, or Sustained-Release Metoprolol Succinate Prescribed for LVSD at Discharge</p>	<p>The addition of a nurse being able to document patient refusal will provide abstractor clarification.</p>	<p>Notes for Abstraction</p> <p>Add:</p> <ul style="list-style-type: none"> Reasons for not prescribing a Beta-blocker must be documented by a physician/APN/PA or pharmacist with one exception: Patient/family refusal of Beta-blocker (e.g., “Bisoprolol refused,” “Patient refusing Beta-blocker”) may be documented by a nurse.
<p>Reason for No Bisoprolol, Carvedilol, or Sustained-Release Metoprolol Prescribed for LVSD in the Outpatient Setting</p>	<p>The addition of a nurse being able to document patient refusal will provide abstractor clarification.</p>	<p>Notes for Abstraction</p> <p>Add:</p> <ul style="list-style-type: none"> Reasons for not prescribing a Beta-blocker must be documented by a physician/APN/PA or pharmacist with one exception: Patient/family refusal of

		Beta-blocker (e.g., “Bisoprolol refused,” “Patient refusing Beta-blocker”) may be documented by a nurse.
Reason for No Cardiac Rehabilitation Enrollment	The addition of PT/OT/case manager being allowed to document reasons for patient not attending cardiac rehabilitation will provide abstractor clarification.	<p>Notes for Abstraction</p> <p>Change from:</p> <ul style="list-style-type: none"> Reasons for not attending one cardiac rehabilitation session must be documented by the physician/APN/PA/RN (e.g. patient refused to attend cardiac rehabilitation). <p>Change to:</p> <ul style="list-style-type: none"> Reasons for not attending one cardiac rehabilitation session must be documented by the physician/APN/PA/RN/physical therapist/occupational therapist/care manager (e.g. patient refused to attend cardiac rehabilitation).
Reason for Not Prescribing a High-Intensity Statin	The addition of a nurse being able to document patient refusal will provide abstractor clarification.	<p>Notes for Abstraction</p> <p>Change from:</p> <ul style="list-style-type: none"> Reasons that precludes prescribing a high-intensity statin must be documented by a physician/APN/PA/or pharmacist. <p>Change to:</p> <ul style="list-style-type: none"> Reasons for not prescribing a High-Intensity Statin must be documented by a physician/APN/PA or pharmacist with one exception: Patient/family refusal of a High-Intensity Statin (e.g., “Patient refusing high-intensity statin”) may be documented by a nurse.
Reason for Oral Factor Xa Inhibitor	The data element was updated to provide clarification for abstractors.	<p>Notes for Abstraction</p> <p>Change from:</p> <ul style="list-style-type: none"> The only acceptable reasons are identified in the list of inclusions. No other reasons will be accepted. History of atrial fibrillation/flutter or current finding of atrial fibrillation/flutter, select “Yes.”

		<ul style="list-style-type: none"> • If the patient has a history of previous strokes and/or taking an Oral Factor Xa Inhibitor prior to hospital arrival, select "Yes". • History of hip or knee replacement surgery, select "Yes." • When conflicting information is documented in the medical record, select "Yes." • History of treatment for venous thromboembolism or current treatment for venous thromboembolism, select "Yes." <p>To:</p> <ul style="list-style-type: none"> • History of atrial fibrillation/flutter or current finding of atrial fibrillation/flutter, select "Yes." • If the patient has a history of previous strokes, select "Yes". • History of hip or knee replacement surgery, select "Yes." • History of treatment for venous thromboembolism or current treatment for venous thromboembolism, select "Yes." • If the patient was taking an Oral Factor Xa Inhibitor prior to hospital arrival, select "Yes." • When conflicting information is documented in the medical record, select "Yes."
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Supplemental Materials

Section	Rationale	Description
Acknowledgement - Acknowledgment and Conditions of Use	Updated CPT® copyright date.	<p>Change from:</p> <p>The five character CPT® codes included in the <i>Specifications Manual for Joint Commission National Quality Measures</i> are obtained from Current Procedural Terminology (CPT®), copyright 2019 by the American Medical Association (AMA).</p> <p>To:</p>

		<p>The five character CPT® codes included in the <i>Specifications Manual for Joint Commission National Quality Measures</i> are obtained from Current Procedural Terminology (CPT®), copyright 2022 by the American Medical Association (AMA).</p>
<p>Appendix A - Code Tables</p>	<p>Appendix A Code Tables were revised to reflect the ICD-10 code updates for Fiscal Year (FY) 2023, effective for discharges October 1,2022.</p> <p>Table 2.0 E/M Codes for Hospital Outpatient Encounters CPT® codes updated to reflect CPT® Terminology updates.</p> <p>PC-06: P55.8 Other hemolytic diseases of newborn and P55.9 Hemolytic disease of newborn, unspecified have been removed from Table 11.31: Fetal Conditions and added to Table 11.33: Neonatal Jaundice. Patients with Length of Stay greater than 5 days and codes on Table: 11.33 Neonatal Jaundice will be removed from the numerator if they have no Moderate or Severe Complication Codes.</p>	<p>Multiple Codes added, removed, or revised per 2023 updates on the following tables:</p> <p>Table 2.0 E/M Codes for Hospital Outpatient Encounters CPT® codes updated to reflect CPT® Terminology updates</p> <p>Table 10.01 Mental Disorders-HBIPS/ED</p> <p>Table 10.02 Mental Disorders-ED</p> <p>Table 11.07 Conditions Possibly Justifying Elective Delivery</p> <p>Table 11.30 Congenital Malformations</p> <p>Table 11.31 Fetal Conditions</p> <p>Table 11.35 Social Indications</p> <p>Table 11.50 Moderate Respiratory Complications with LOS</p> <p>Table 12.10 Organ Transplant During Current Hospitalization</p> <p>Table 13.1 Alcohol Dependence</p> <p>Table 8.2e Surgical Intervention Procedures</p> <p>Table 8.2f Traumatic Brain Injury</p> <p>PC-06: Table 11.31 Fetal Conditions-Codes Removed:</p> <p>P558 Other hemolytic diseases of newborn</p> <p>P559 Hemolytic disease of newborn, unspecified</p> <p>Table 11.33 Neonatal Jaundice-Codes Added:</p> <p>P558 Other hemolytic diseases of newborn</p> <p>P559 Hemolytic disease of newborn, unspecified</p>

Appendix C - Medication Tables	Update Appendix C table 10.0 Antipsychotic Medications to include two new FDA approved medications.	<p>Add to table 10.0</p> <p>Caplyta Lumateperone Lybalvi Olanzapine+Samidorphan</p>
Appendix D - Glossary of Terms	<p>Health Care Organization Identifier was not in the correct alphabetical order.</p> <p>Glossary terms were updated to align with CMS IQR Manual Version 5.13.</p>	<p>Moved Health Care Organization Identifier to the correct place.</p> <p>Appendix D, Glossary of Terms and Acronyms Change the following terms to:</p> <p>clinical performance measure The National Quality Forum (NQF) describes performance measures as a way to calculate whether and how often a healthcare system does what it should. Measures are based on scientific evidence about processes, outcomes, perceptions, or systems that relate to high quality care. The Centers for Medicare & Medicaid Services (CMS) considers high quality care to include effective, safe, efficient, patient-centered, equitable, and timely care. Performance measures are also used by health payers, such as CMS, to incentivize providers to improve quality of care.</p> <p>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.</p>
Appendix G - Resources	<p>Link gnetsupport@hcqis.org updated to current address gnetsupport@cms.hhs.gov.</p>	<p>Change From:</p> <p>CMS Abstraction & Reporting Tool (CART) For technical assistance with CART, please contact the Applications/LocalApps.QualityNet help desk at gnetsupport@hcqis.org, or call 1-866-288-8912.</p>

Update link for NUBC website.

To:

CMS Abstraction & Reporting Tool (CART) For technical assistance with CART, please contact the Applications/LocalApps.QualityNet help desk at qnetssupport@cms.hhs.gov, or call 1-866-288-8912.

Change From:

National Uniform Billing Committee (NUBC) For further information regarding the UB-04 and NUBC related data elements, please refer to the NUBC manual, “Official UB-04 Data Specifications Manual© Copyright American Hospital Association” or website at <http://www.nubc.org/index.html>.

To:

National Uniform Billing Committee (NUBC) For further information regarding the UB-04 and NUBC related data elements, please refer to the NUBC manual, “Official UB-04 Data Specifications Manual© Copyright American Hospital Association” or website at <https://www.nubc.org/>.