

Acknowledgement

The *Specifications Manual for Hospital Outpatient Department Quality Measures* was developed by the Centers for Medicare & Medicaid Services (CMS) to provide a uniform set of quality measures to be implemented in hospital outpatient settings. The primary purpose of these measures is to promote high quality care for patients receiving services in hospital outpatient settings.

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The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) is published by the United States Government. A CD-ROM, which may be purchased through the Government Printing Office, is the only official Federal government version of the ICD-9-CM. ICD-9-CM is an official Health Insurance Portability and Accountability Act standard.

IMPORTANT SUBMISSION ALERT!!

At this time, for submission of the Hospital Outpatient Measures to CMS under the Hospital Outpatient Quality Data Reporting Program, files must meet the specifications in this CMS manual only. Otherwise, the files will be rejected as not meeting CMS quality data submission requirements for receiving the full payment update.

Providers who are planning to also submit data for the Hospital Outpatient Measures to The Joint Commission must refer to the transmission section separately issued by The Joint Commission. This is important because at this time, CMS can only accept files which meet the CMS transmission manual specifications and such files cannot contain the additional Joint Commission transmission data elements (e.g., vendor tracking ID, measure category assignment, measurement value).

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Introduction

CMS Quality Initiatives

Background

In November 2001, Health & Human Services' (HHS') Secretary Tommy G. Thompson announced The Quality Initiative, his commitment to assure quality healthcare for all Americans through published consumer information coupled with healthcare quality improvement support through Medicare's Quality Improvement Organizations (QIOs). The Quality Initiative was launched nationally in 2002 as the Nursing Home Quality Initiative (NHQI) and expanded in 2003 with the Home Health Quality Initiative (HHQI) and the Hospital Quality Initiative (HQI). These initiatives are part of a comprehensive look at quality of care that includes hospitals, nursing homes, home health agencies, and physician offices. These efforts have continued to expand under Secretary Michael Leavitt through support and expansion of activities to support healthcare transparency and value-driven healthcare.

Most recently, the Medicare Improvements and Extension Act under Division B of Title I of the Tax Relief and Health Care Act (MIEA-TRHCA) of 2006 (Pub. L. 109-432), enacted on December 20, 2006, made changes in the Outpatient Prospective Payment System (OPPS). The Centers for Medicare & Medicaid Services (CMS) is now statutorily required to establish a program under which hospitals will report data on the quality of hospital outpatient care using standardized measures to receive the full annual update to the OPPS payment rate, effective for payments beginning in calendar year (CY) 2009. The program established under these amendments and supported by this manual is the Hospital Outpatient Quality Data Reporting Program (HOP QDRP). The measures described in this manual will expand as additional priority areas for quality improvement in hospital outpatient settings are identified and will be designed to evaluate the diversity of services and clinical topics provided to adult patients in hospital outpatient settings.

Objective

The HOP QDRP uses a variety of tools to stimulate and support a significant improvement in the quality of hospital outpatient care. This initiative aims to refine and standardize hospital outpatient data collection, data transmission, and performance measures in order to construct one robust, prioritized and standard quality outpatient measure set for hospitals. The goal is for all private and public purchasers, oversight and accrediting entities, and payers and providers of hospital outpatient care to use these same measures in their national public reporting activities. Quality improvement support, collaborations, standardization and assuring compliance with Medicare Conditions of Participation (CoPs) are important additional tools in achieving this objective.

Components of the Hospital Quality Initiative (HQI)

HQI creates an expanded, robust, and uniform measure sets for national hospital public reporting through the implementation of a structured public process to select quality measures that builds upon the existing quality measure set. The HQI consists of a number of developmental components.

- The Hospital Quality Alliance (HQA), a public-private collaboration, collects and reports hospital quality performance information and makes it available to consumers through CMS information channels. Participating hospitals voluntarily reported on a starter set of 10 hospital quality measures that were expanded, in addition to collecting information on patient perspectives of hospital care. The American Hospital Association (AHA), Federation of American Hospitals (FAH), and the Association of American Medical Colleges (AAMC) are working closely with CMS, The Joint Commission, the National Quality Forum (NQF), the Agency for Healthcare Research and Quality (AHRQ) and other stakeholders to implement this national public reporting initiative.
- Section 501(b) of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 stipulated that inpatient prospective payment system (IPPS) hospitals submit 10 quality “starter set” measures to CMS during fiscal years (FYs) 2005-2007 on the quality of inpatient care provided to their patients. For this purpose, the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) initiative was developed.
- Section 5001(a) of the Deficit Reduction Act of 2005, Pub. L. 109-171 (DRA) superseded the MMA of 2003 and set new requirements for the RHQDAPU program. The act requires IPPS hospitals to submit the additional quality measures for FY 2007 and each subsequent fiscal year. Hospitals that meet the requirements specified in the final regulation CMS-1488-F will receive their full annual payment update. Those hospitals that do not submit data for all required quality measures to the QIO Clinical Data Warehouse will receive a reduction of 2.0 percent in their Medicare Annual Payment Update for the applicable fiscal year.
- A hospital patient survey (HCAHPS), designed to develop a national standard for collecting information on patient perspectives of hospital care, was tested by hospitals in Arizona, Maryland and New York as part of a CMS hospital pilot. The survey is used by the hospitals participating in the national voluntary reporting effort, and in the special partnership with the Connecticut Department of Public Health.
- The Medicare Improvements and Extension Act under Division B of Title I of the Tax Relief and Health Care Act (MIEA-TRHCA) of 2006 (Pub. L. 109-432), enacted on December 20, 2006, required the establishment of a program under which hospitals will report data on the quality of hospital outpatient care using standardized measures to receive the full annual update to the OPSS payment rate, effective for payments beginning in CY 2009. The final rule (CMS-1392): *Changes to the Hospital Outpatient Prospective Payment System and CY 2008 Payment Rates* was published in the Federal Register on Nov 27, 2007.

Quality Strategy

HQI uses a multi-prong approach to support, provide incentives, and drive systems and facilities (including clinicians and professionals in those settings) toward superior care through:

- Ongoing regulation and enforcement conducted by State survey agencies and CMS,
- Professional and consumer hospital quality information on CMS websites (i.e., www.cms.hhs.gov and www.medicare.gov), and at 1-800-MEDICARE,
- The testing of rewards for superior performance on certain measures of quality,
- Continual, community-based quality improvement programs,
- Collaboration and partnership to leverage knowledge and resources.

Related National Activities

National Quality Forum

The NQF 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 a variety of healthcare settings across the nation using a standard set of measures.

The Hospital Quality Alliance

The AHA, FAH, and AAMC have launched a national voluntary initiative to collect and report hospital quality performance information. This effort is intended to make critical information about hospital performance accessible to the public and to inform and invigorate efforts to improve quality. The Joint Commission, NQF, CMS, AHRQ and others support this initiative to identify a robust set of standardized and easy-to-understand hospital quality measures that would be used by all stakeholders in the healthcare system in order to improve quality of care and the ability of consumers to make informed healthcare choices. The 21 measures currently reported on Hospital Compare include the 10 “starter set” measures, and additional measures on which hospitals also voluntarily report.

National Quality Measures Clearinghouse

The National Quality Measures Clearinghouse (NQMC™), sponsored by AHRQ, an agency of the U.S. Department of HHS, has included both CMS and Joint Commission measures in its public database for evidence-based quality measures and measure sets.

Measures Management System

The Measures Management System (MMS) is a set of processes and decision criteria used by CMS to oversee the development, implementation, and maintenance of healthcare quality measures. The Quality Measures Management Information System (QMIS) is a comprehensive, web-based, electronic tool to support the MMS. It is the repository of all of the quality measures used by CMS and the electronic tool to track the development and maintenance of those measures. Information includes the quality measures technical specifications, justification and history. Quality measures are currently used for managed care plans, dialysis centers, hospitals, nursing homes, home health agencies and physician offices.

Using the Manual

This portion of the manual provides a brief overview of the information contained within each section of the manual. It is intended as a quick reference to assist in the implementation of the hospital outpatient measures. The sections of this manual are interrelated and are most useful when considered together.

Section 1 – Measurement Information

This section contains a Measure Information Form (MIF) for each hospital outpatient measure.

MIFs describe the purpose, use, and clinical rationale for specific measures. They also identify populations assessed by the measure and how improvement in a measure would be demonstrated.

Detailed analytical algorithms are included with each MIF. The algorithms are used to calculate performance measurement rates for each of the measures. Each algorithm contains detailed steps regarding information used in the rate calculation. They specify when and how exclusion and inclusion criteria are applied for the specified measure.

Section 2 – Data Dictionary

This section describes the patient-level data elements required to capture and calculate individual measurements. It specifies those data elements that must be collected for each patient that falls into any of the selected populations and those data elements needed for a specific measure.

Section 3 – Missing and Invalid Data

This section addresses how to approach missing and invalid data. Missing data refers to data elements, required for calculating a hospital outpatient measure, that have no values present for one or more encounter. Invalid data refers to data element values, required for calculating a hospital outpatient measure, that fall outside of the range of allowable values defined for that data element.

Reducing missing and invalid data minimizes the bias to a measure rate, because records with missing or invalid data cannot be included in the calculation of the observed measure rate. This section describes preventing missing and invalid data in detail.

Section 4 – Population and Sampling Specifications

This section provides guidance on defining the hospital's outpatient population and information on the order of data flow. Defining the population is the first step to estimate a hospital's performance. A population is generally defined as a collection of patients sharing a common set of universally measured characteristics, such as an International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Principal Diagnosis or Current Procedural Terminology (CPT[®]) Code. The outpatient population and diagnosis/CPT[®] codes meet this description for the hospital outpatient measures. Additional information regarding population and sampling are found in this section.

Section 5- Hospital Outpatient Department Quality Measure Data Transmission

This section provides guidelines for transmitting hospital outpatient measure data. It highlights the unique data transmission specifications for hospital outpatient measure data for the CMS and the OPDS Clinical Warehouse. It is divided into three parts: Guidelines for Submission of Data, Transmission Data Element List, and Transmission Data Processing Flow. This section provides specific information regarding data transmission.

Appendix A – ICD-9-CM Diagnosis and CPT® Code Tables

For many of the measures, eligibility for inclusion or exclusion in the outpatient population of interest is defined by the presence of certain ICD-9-CM diagnosis codes and CPT® codes including Evaluation and Management (E/M) codes within the patient-level record. Appendix A contains the code tables that define the populations for all measures. There is a description of the codes as defined in the applicable coding manual and a shortened description that may be used in a data abstraction tool. The Measurement Information section also refers to the codes or tables provided in this section. The code tables in this Appendix are evaluated periodically and modified as indicated.

Appendix B – Glossary of Terms

Appendix C – Medication Tables

Several of the hospital outpatient measures address the use and timing of certain medications. This Appendix contains tables with the specific names that may be associated with medication categories (e.g., trade names). These tables are provided to facilitate appropriate data collection of applicable medications. These tables are not meant to be an inclusive list of all available therapeutic agents; rather they represent current information available at the time of publication.

Appendix P – Measure Preview Section

The measure preview section provides measure information forms and includes additional data collection information on the developmental measure(s). The measure(s) identified in this section are not currently collected. Placement in this appendix does not assume the measure(s) will be implemented into a future manual.

Delivery Settings

OP Measure Number	OP Measure Name	Surgery	Emergency Department
OP-1	Median Time to Fibrinolysis		x
OP-2	Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival		x
OP-3	Median Time to Transfer to Another Facility for Acute Coronary Intervention		x
OP-4	Aspirin at Arrival		x
OP-5	Median Time to ECG		x
OP-6	Timing of Antibiotic Prophylaxis (Prophylactic Antibiotic Initiated Within One Hour Prior to Surgical Incision)	x	
OP-7	Prophylactic Antibiotic Selection for Surgical Patients	x	

Measure Information Forms

Introduction

The measure information section is divided by measure (i.e., OP-1, OP-2, etc.). At the beginning of each measure are the measure identification number (alphanumeric number to identify a measure within a set) and the measure short name. This is followed by a data element list for the measure, including the general data elements, and the specific measure set data elements. Also included are subsections for each specific measure. These contain a Measure Information Form (MIF) and the Performance Measure Algorithm.

The algorithms and data elements needed to calculate each of the hospital outpatient department quality measures are identified in the MIF. Each algorithm provides the logical steps, data element evaluation, arithmetic calculations, and data manipulation steps that are required to calculate a given measure.

The following information is included in each MIF:

- Measure Set: Each measure has a unique name.
- Measure ID #: An alphanumeric number to identify each measure.
- Outpatient Setting: The setting of care is specified in each measure.
- Performance Measure Name: A concise name for each measure.
- Description: A general description of the measure.
- Rationale: Explains the clinical or process improvement importance of the measure.
- Type of Measures: Identifies each measure as process, outcome, or other type of measure.
- Improvement Noted As: States how improvement is demonstrated either by an increase or decrease in the measure rate.
- Numerator Statement: Includes the patients who meet the criteria for a specific measure and pass the measure. Specific inclusion and exclusion information for the population is listed.
- Denominator Statement: Includes the patients who meet the exclusion/inclusion criteria for a specific measure (i.e., patients who are eligible for the measure). Specific inclusion and exclusion information for the population is listed.
- Risk Adjustment: Indicates if risk adjustment methodology is applied to the measure.
- Data Collection Approach: Indicates the type of data used. For example, administrative and/or medical record.
- Data Accuracy: Suggestions on how data accuracy and consistency may be affected and can be improved.
- Measure Analysis Suggestions: Suggestions on interpreting and using the data.
- Sampling: Will refer to the sampling specifications in most instances to allow more detailed information to be provided in one reference.
- Data Reported As: Indicates the format in which data is reported.
- Selected References: Lists the most relevant clinical literature references.

Measure Category Assignments

Measure Category Assignments are calculated measure results for each record that is processed through a measure algorithm. They are used to summarize the outcome for a record that is processed through a specific measure algorithm.

The following are the possible Measure Category Assignments:

- B** Category B – Not in Measure Population
For rate-based and continuous variable measures: Record is not a member of the measure's population.
- D** Category D – In Measure Population (used for reporting)
For rate-based measures: Record is a member of the measure's population and there has not been an occurrence of the measure.

For continuous variable measures: Record is a member of the measure's population and has sufficient, accurate, and valid data to compute the measurement.
- D(#)** Category D(#) – In Measure Population (used to identify stratified populations of specific measures)
For rate-based measures: Record is a member of the measure's population and there has not been an occurrence of the measure.

For continuous variable measures: Record is a member of the measure's population and has sufficient, accurate, and valid data to compute the measurement.
- E** Category E – In Numerator Population
For rate-based measures: Record is a member of the measure's population and there has been an occurrence of the measure.

For continuous variable measures: Does not apply.
- X** Category X – Data Are Missing
For rate-based and continuous variable measures: Data are missing that is required to calculate the measure. The record will be rejected when transmitted.
- Y** Category Y – Unable to Determine (UTD) Allowable Value Does Not Allow Calculation of the Measure
For rate-based measures: Does not apply.
For continuous variable measures: Record contains a Date, Time or Numeric data element with a value of 'UTD.'

HOSPITAL OUTPATIENT DEPARTMENT QUALITY MEASURES
Acute Myocardial Infarction (AMI) and Chest Pain

Set Measure ID #	Measure Short Name
OP-1¹	Median Time to Fibrinolysis
OP-2¹	Fibrinolytic Therapy Received Within 30 Minutes
OP-3¹	Median Time to Transfer to Another Facility for Acute Coronary Intervention
OP-4²	Aspirin at Arrival
OP-5²	Median Time to ECG

¹ Measures only applicable to AMI Population

² Measures apply to both the AMI Population and Chest Pain Population

OP AMI AND CHEST PAIN GENERAL DATA ELEMENT LIST

General Data Element Name	Collected For:
<i>Arrival Time</i>	All Records
<i>Birthdate</i>	All Records
<i>CMS Certification Number^{3,4}</i>	All Records
<i>First Name</i>	All Records
<i>Hispanic Ethnicity</i>	All Records
<i>Last Name</i>	All Records
<i>National Provider Identifier^{3,4}</i>	All Records
<i>Outpatient Encounter Date</i>	All Records
<i>Patient HIC#</i>	All Records
<i>Patient Identifier</i>	All Records
<i>Payment Source</i>	All Records
<i>Physician 1</i>	Optional for All Records
<i>Physician 2</i>	Optional for All Records
<i>Postal Code</i>	All Records
<i>Race</i>	All Records
<i>Sex</i>	All Records

³ Transmission Data Element

⁴ Defined in the Transmission Data Element List within the Hospital Outpatient Measure Data Transmission section of this manual

OP AMI AND CHEST PAIN SPECIFIC DATA ELEMENT LIST

OP AMI and CP Data Element Name	Collected For:
<i>Aspirin Received</i>	OP-4
<i>Discharge Date and Time</i>	OP-3
<i>Discharge Status</i>	OP-1, OP-2, OP-3, OP-4, OP-5
<i>E/M Code</i>	OP-1, OP-2, OP-3, OP-4, OP-5
<i>ECG</i>	OP-5
<i>ECG Date and Time</i>	OP-5
<i>Fibrinolytic Administration</i>	OP-1, OP-2, OP-3

Specifications Manual for Hospital Outpatient Department Quality Measures
Encounter dates 01-01-10 (1Q10) through 06-30-10 (2Q10) v.3.0a

AMI-CP-1

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OP AMI and CP Data Element Name	Collected For:
<i>Fibrinolytic Administration Date and Time</i>	OP-1, OP-2
<i>ICD-9-CM Other Diagnosis Codes</i>	OP-4, OP-5
<i>ICD-9-CM Principal Diagnosis Code</i>	OP-1, OP-2, OP-3, OP-4, OP-5
<i>Initial ECG Interpretation</i>	OP-1, OP-2, OP-3
<i>Probable Cardiac Chest Pain</i>	OP-4, OP-5
<i>Reason for Delay in Fibrinolytic Therapy</i>	OP-1, OP-2
<i>Reason for No Aspirin on Arrival</i>	OP-4
<i>Reason for Not Administering Fibrinolytic Therapy</i>	OP-3
<i>Transfer for Acute Coronary Intervention</i>	OP-3

OP-1, OP-2, OP-3, OP-4, and OP-5 Hospital Outpatient Population

The Hospital Outpatient AMI/Chest Pain measures have two distinct populations.

Acute Myocardial Infarction

The population of the OP-1 through OP-5 AMI measures is identified using 5 data elements:

- *E/M Code*
- *Discharge Status*
- *Outpatient Encounter Date*
- *Birthdate*
- *ICD-9-CM Principal Diagnosis Code*

Patients seen in a Hospital Emergency Department (*E/M Code* on Appendix A OP Table 1.0) are included in the OP-1 through OP-5 AMI Hospital Outpatient Population and are eligible to be sampled if they have:

- Discharged / transferred to a short-term general hospital for inpatient care or to a Federal healthcare facility (*Discharge Status*), and
- A Patient Age on *Outpatient Encounter Date* (*Outpatient Encounter Date – Birthdate*) \geq 18 years, and
- An *ICD-9-CM Principal Diagnosis Code* for AMI defined in Appendix A, OP Table 1.1.

Chest Pain

The population of the OP-4 and OP-5 Chest Pain measures is identified using 6 data elements:

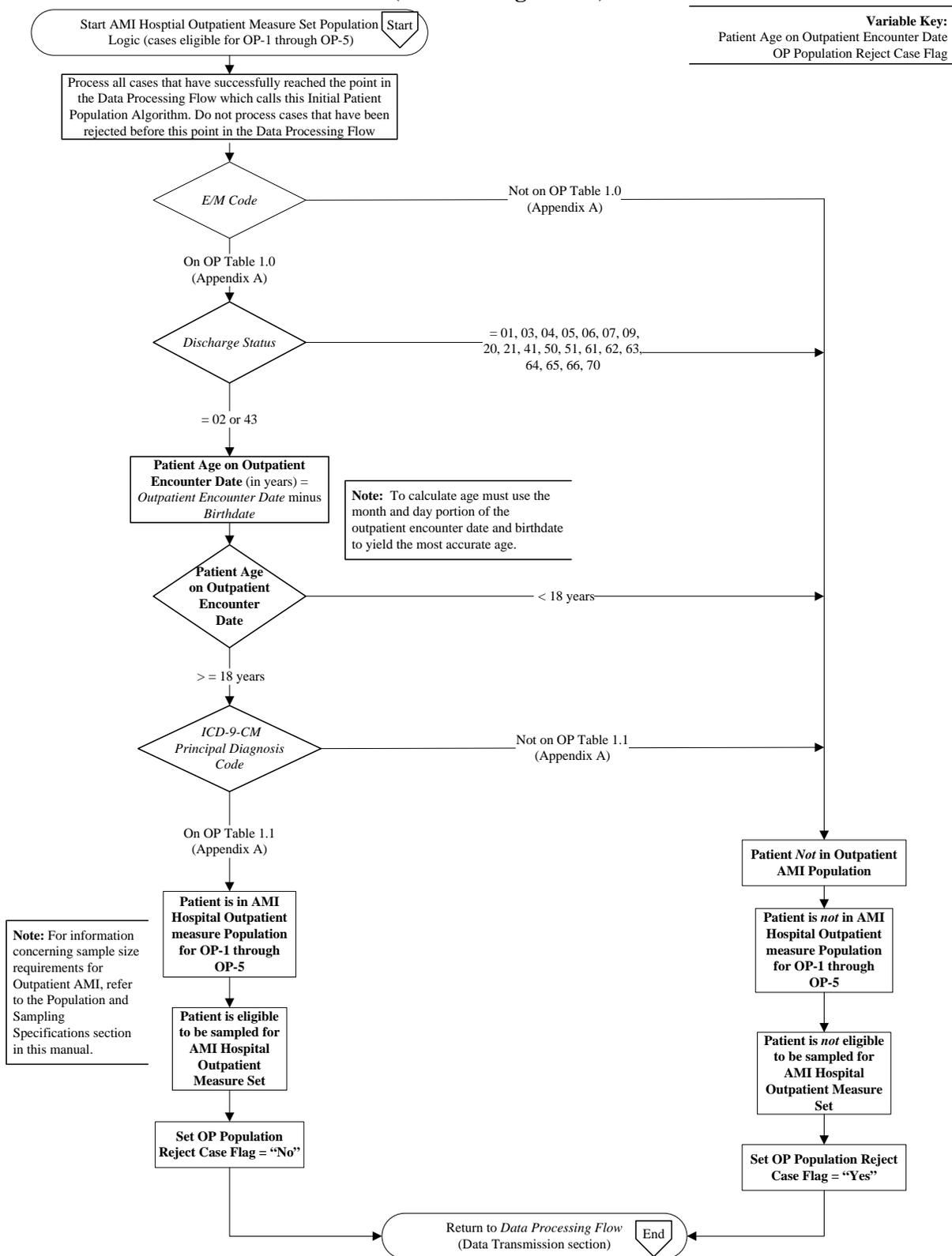
- *E/M Code*
- *Discharge Status*
- *Outpatient Encounter Date*
- *Birthdate*
- *ICD-9-CM Principal Diagnosis Code*
- *ICD-9-CM Other Diagnosis Codes*

Patients seen in a Hospital Emergency Department (*E/M Code* on Appendix A OP Table 1.0) are included in the OP-4 and OP-5 Chest Pain Hospital Outpatient Population and are eligible to be sampled if they have:

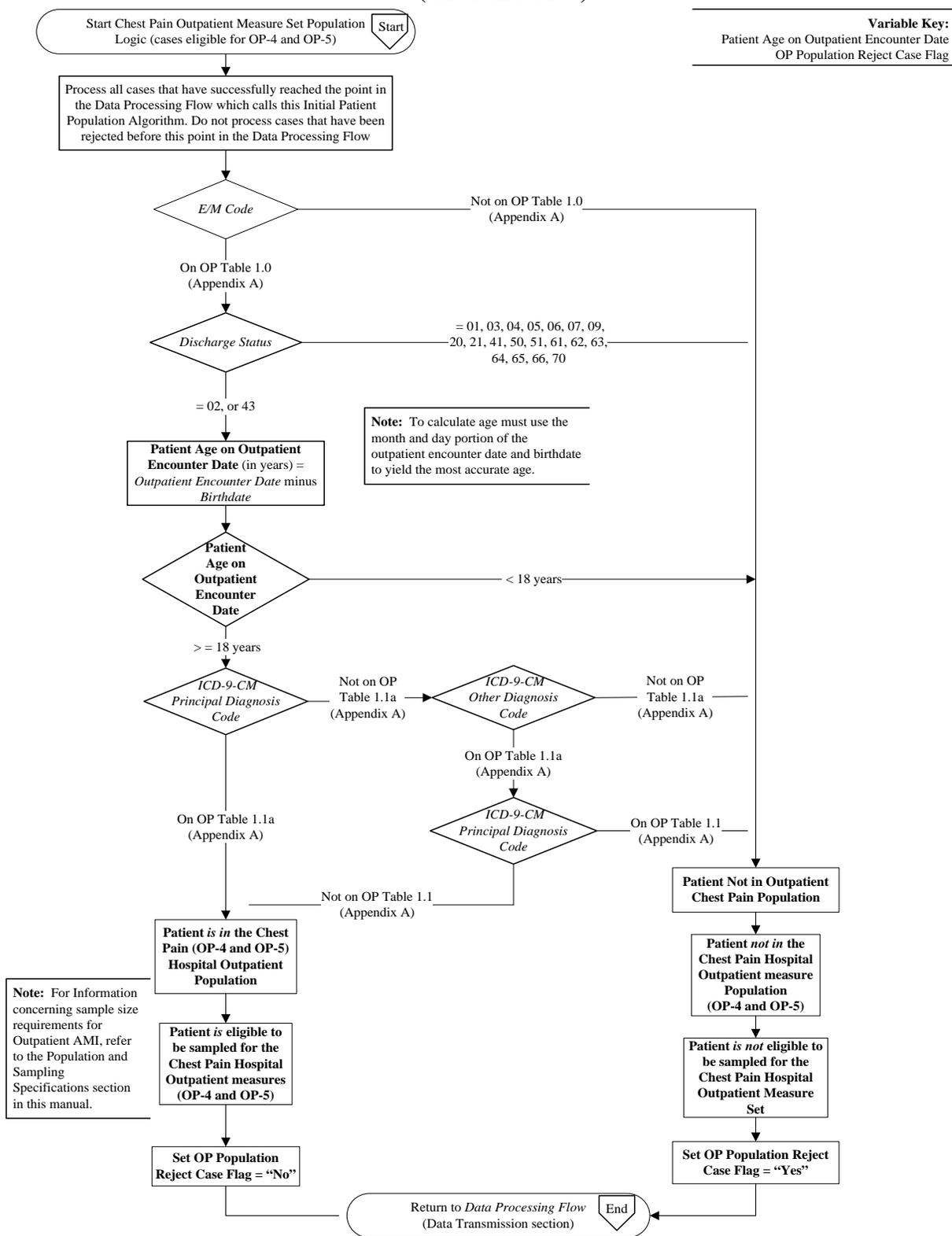
- Discharged / transferred to a short-term general hospital for inpatient care, or to a Federal healthcare facility (*Discharge Status*), and
- A Patient Age on *Outpatient Encounter Date* (*Outpatient Encounter Date – Birthdate*) \geq 18 years, and
- An *ICD-9-CM Principal or Other Diagnosis Codes* for Chest Pain as defined in Appendix A, OP Table 1.1a.

Patients with an *ICD-9-CM Principal Diagnosis Code* for AMI are not eligible for the Chest Pain Hospital Outpatient Population

AMI Hospital Outpatient Population Algorithm (OP-1 through OP-5)



Chest Pain Hospital Outpatient Population Algorithm (OP-4 and OP-5)



Measure Information Form

Measure Set: Hospital Outpatient Acute Myocardial Infarction

Measure ID#: OP-1

Outpatient Setting: Emergency Department

Performance Measure Name: Median Time to Fibrinolysis

Description: Median time from emergency department arrival to administration of fibrinolytic therapy in ED patients with ST-segment elevation or left bundle branch block (LBBB) on the electrocardiogram (ECG) performed closest to ED arrival and prior to transfer.

Rationale: Time to fibrinolytic therapy is a strong predictor of outcome in patients with an acute myocardial infarction. Nearly 2 lives per 1,000 patients are lost per hour of delay (Fibrinolytic Therapy Trialists' Collaborative Group, 1994). National guidelines recommend that fibrinolytic therapy be given within 30 minutes of hospital arrival in patients with ST-segment elevation myocardial infarction (Antman, 2004). Despite these recommendations, few eligible older patients hospitalized with AMI receive timely fibrinolytic therapy (Jencks, 2000).

Type of Measure: Process

Improvement Noted As: A decrease in the median value

Continuous Variable Statement: Time (in minutes) from emergency department arrival to administration of fibrinolytic therapy in AMI patients with ST-segment elevation or LBBB on the ECG performed closest to ED arrival and prior to transfer.

Included Populations:

- An *E/M Code* for emergency department encounter as defined in Appendix A, OP Table 1.0, and
- Patients discharged/transferred to a short-term general hospital for inpatient care, or to a Federal healthcare facility, and
- An *ICD-9-CM Principal Diagnosis Code* for AMI as defined in Appendix A, OP Table 1.1, and
- ST-segment elevation or LBBB on the ECG performed closest to ED arrival, and
- *Fibrinolytic Administration* as defined in the Data Dictionary

Excluded Populations:

- Patients less than 18 years of age

- Patients who did not receive *Fibrinolytic Administration* within 30 minutes and had a *Reason for Delay in Fibrinolytic Therapy* as defined in the Data Dictionary

Data Elements:

- *Arrival Time*
- *Birthdate*
- *Discharge Status*
- *E/M Code*
- *Fibrinolytic Administration*
- *Fibrinolytic Administration Date and Time*
- *ICD-9-CM Principal Diagnosis Code*
- *Initial ECG Interpretation*
- *Outpatient Encounter Date*
- *Reason for Delay in Fibrinolytic Therapy*

Risk Adjustment: No

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records. Some facilities may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunity for improvement at the point of care/service. However, complete documentation includes the ICD-9-CM diagnosis, which requires retrospective data entry.

Data Accuracy: Variation may exist in the assignment of ICD-9-CM codes; therefore, coding practices may require evaluation to ensure consistency.

Measure Analysis Suggestions: The median time to fibrinolysis should be analyzed in conjunction with the measure rate for fibrinolysis received within 30 minutes of emergency department arrival (OP-2). These measures, used together, will assist in understanding the median time to fibrinolysis and will identify the number of AMI patients that are receiving fibrinolysis within 30 minutes of emergency department arrival and potential opportunities for improvement to decrease the median time to fibrinolysis.

Sampling: Yes, for additional information see the Population and Sampling Specifications section.

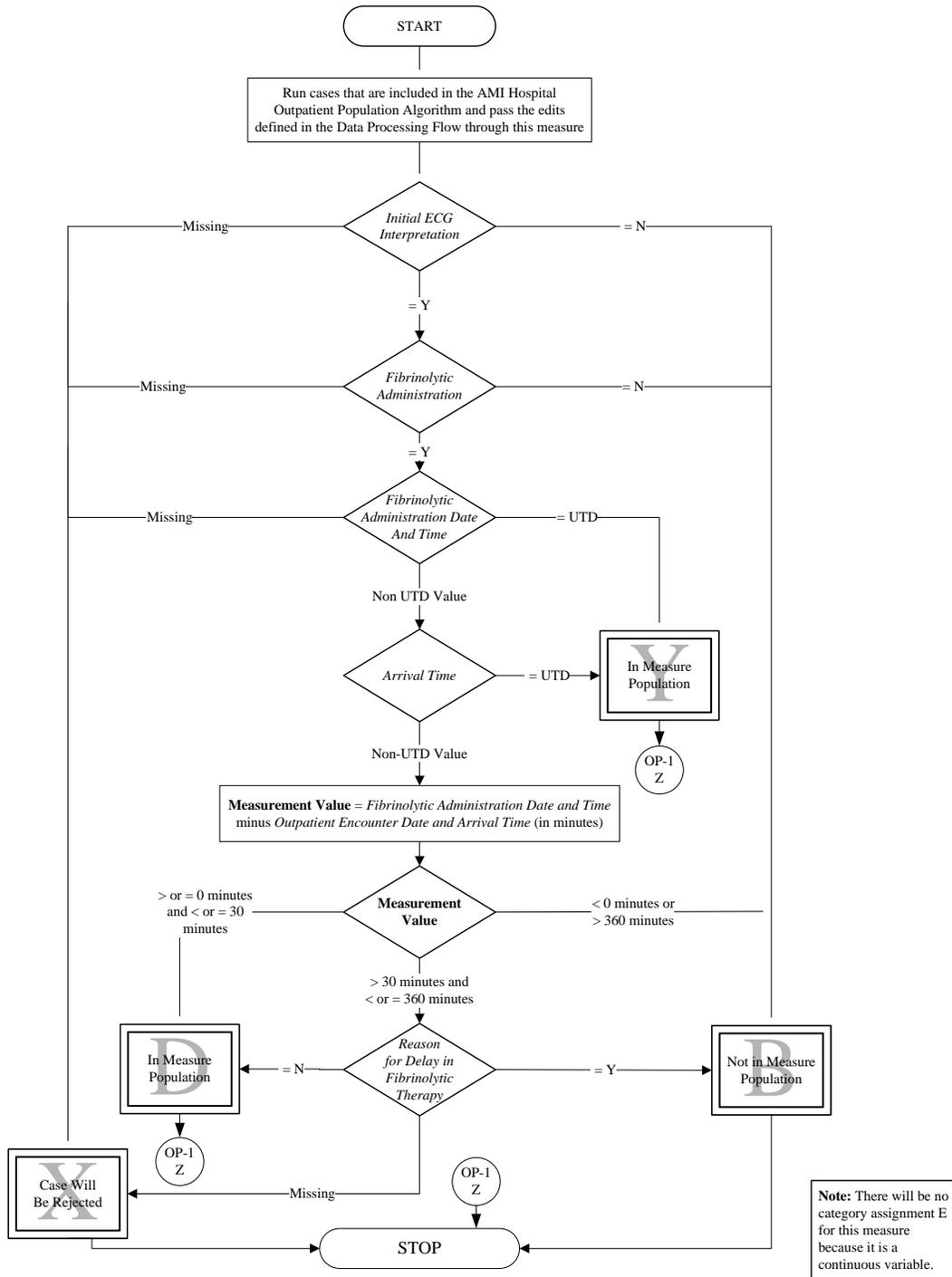
Data Reported As: Aggregate measure of central tendency

Selected References:

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- Krumholz HM, Anderson JL, Brooks NH, Fesmire FM, Lambrew CT, Landrum MB, Weaver WD, Whyte J. ACC/AHA Clinical Performance Measures for Adults With ST-Elevation and Non-ST-Elevation Myocardial Infarction: a report of the ACC/AHA Task Force on Performance Measures (ST-Elevation and Non-ST-Elevation Myocardial Infarction Performance Measures Writing Committee). *J Am Coll Cardiol* 2006; 47:236–65. Available at: <http://www.acc.org/qualityandscience/clinical/measures/stemi/pdfs/STEMIfinal.pdf>

OP-1: Median Time to Fibrinolysis

Continuous Variable Statement: Time (in minutes) from emergency department arrival to administration of fibrinolytic therapy in AMI patients with ST-segment elevation or LBBB on the ECG performed closest to ED arrival and prior to transfer.



Measure Information Form

Measure Set: Hospital Outpatient Acute Myocardial Infarction

Measure ID#: OP-2

Outpatient Setting: Emergency Department

Performance Measure Name: Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival

Description: Emergency Department acute myocardial infarction (AMI) patients receiving fibrinolytic therapy during the ED stay and having a time from ED arrival to fibrinolysis of 30 minutes or less.

Rationale: Time to fibrinolytic therapy is a strong predictor of outcome in patients with an acute myocardial infarction. Nearly 2 lives per 1,000 patients are lost per hour of delay (Fibrinolytic Therapy Trialists' Collaborative Group, 1994). National guidelines recommend that fibrinolytic therapy be given within 30 minutes of hospital arrival in patients with ST-segment elevation myocardial infarction (Antman, 2004). Despite these recommendations, few eligible older patients hospitalized with AMI receive timely fibrinolytic therapy (Jencks, 2000).

Type of Measure: Process

Improvement Noted as: An increase in the rate

Numerator Statement: Emergency Department AMI patients whose time from ED arrival to fibrinolysis is 30 minutes or less.

Included Populations: Not Applicable

Excluded Populations: None

Data Elements:

- *Arrival Time*
- *Fibrinolytic Administration*
- *Fibrinolytic Administration Date and Time*
- *Outpatient Encounter Date*

Denominator Statement: Emergency Department AMI patients with ST-segment elevation or LBBB on ECG who received fibrinolytic therapy.

Included Populations:

- An *E/M Code* for emergency department encounter as defined in Appendix A, OP Table 1.0, and
- Patients discharged/transferred to a short-term general hospital for inpatient care, or to a Federal healthcare facility, and
- An *ICD-9-CM Principal Diagnosis Code* for AMI as defined in Appendix A, OP Table 1.1, and
- ST-segment elevation or LBBB on the ECG performed closest to ED arrival, and
- *Fibrinolytic Administration* as defined in the Data Dictionary

Excluded Populations:

- Patients less than 18 years of age
- Patients who did not receive *Fibrinolytic Administration* within 30 minutes AND had a *Reason for Delay in Fibrinolytic Therapy* as defined in the Data Dictionary

Data Elements:

- *Birthdate*
- *Discharge Status*
- *E/M Code*
- *ICD-9-CM Principal Diagnosis Code*
- *Initial ECG Interpretation*
- *Reason for Delay in Fibrinolytic Therapy*

Risk Adjustment: No

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records. Some facilities may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunity for improvement at the point of care/service. However, complete documentation includes the ICD-9-CM diagnosis, which requires retrospective data entry.

Data Accuracy: Variation may exist in the assignment of ICD-9-CM codes; therefore, coding practices may require evaluation to ensure consistency.

Measure Analysis Suggestions: The measure rate for fibrinolytic agent received within 30 minutes of emergency department arrival should be analyzed in conjunction with the ED median time to fibrinolysis measure (OP-1). These measures, used together, will assist in understanding the number of AMI patients that are receiving fibrinolysis within 30 minutes of emergency department arrival and will identify the emergency department's median time to fibrinolysis and potential opportunities for improvement to increase the rate of patients receiving fibrinolysis in 30 minutes or less.

Sampling: Yes, for additional information see the Population and Sampling Specifications section.

Data Reported as: Aggregate rate generated from count data reported as a proportion

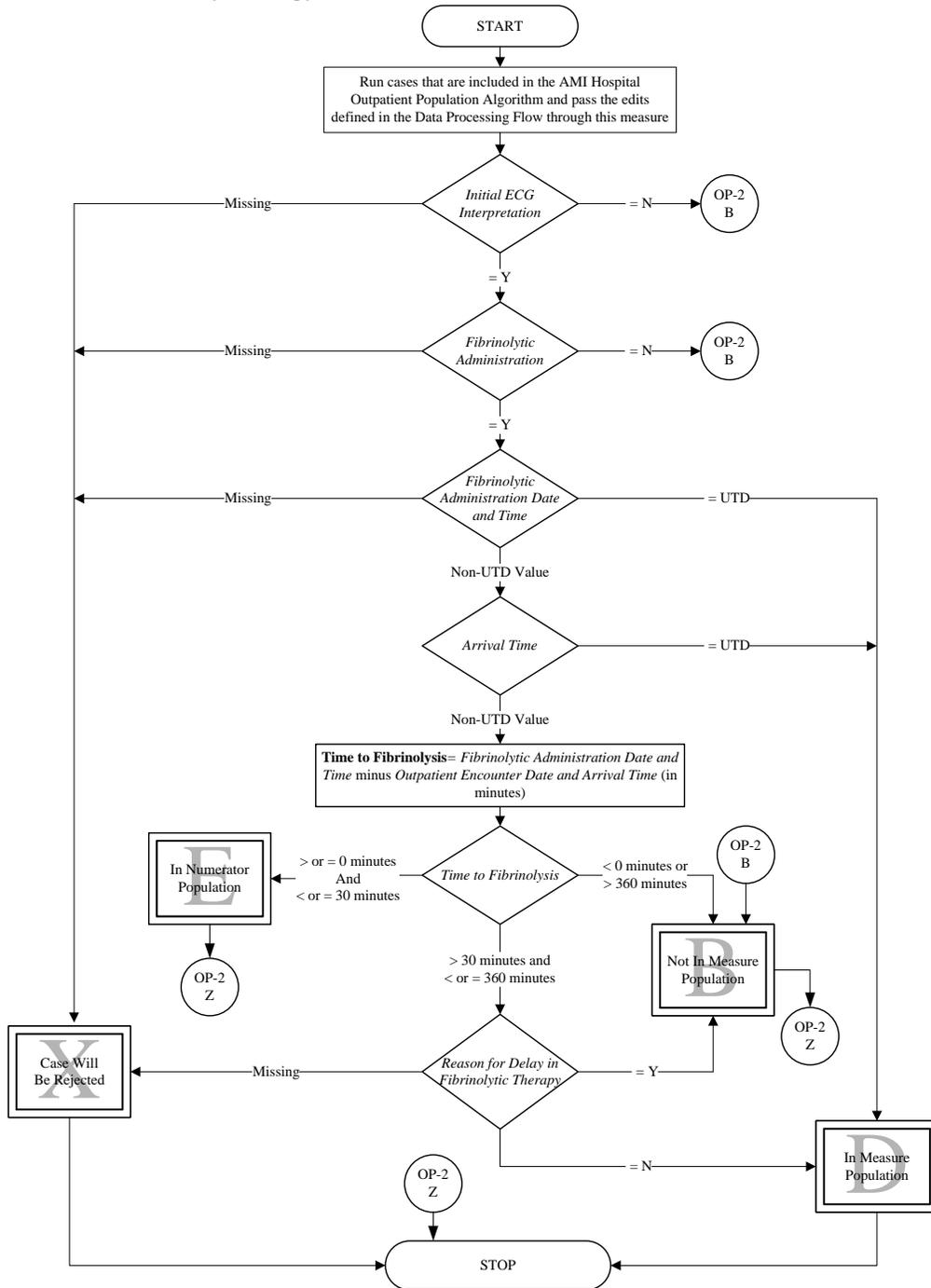
Selected References:

- Antman EM, Anbe DT, Armstrong PW, Bates ER, Green LA, Hand M, Hochman JS, Krumholz HM, Kushner FG, Lamas GA, Mullany CJ, Ornato JP, Pearle DL, Sloan MA, Smith SC Jr. ACC/AHA guidelines for the management of patients with ST-elevation myocardial infarction: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee to Revise the 1999 Guidelines for the Management of Patients With Acute Myocardial Infarction). 2004. Available at: <http://www.acc.org/qualityandscience/clinical/guidelines/stemi/Guideline1/index.htm>
- Fibrinolytic Therapy Trialists' (FTT) Collaborative Group. Indications for fibrinolytic therapy in suspected acute myocardial infarction: collaborative overview of early mortality and major morbidity results from all randomized trials of more than 1000 patients. *Lancet*. 1994; 343:311-22.
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- Krumholz HM, Anderson JL, Brooks NH, Fesmire FM, Lambrew CT, Landrum MB, Weaver WD, Whyte J. ACC/AHA Clinical Performance Measures for Adults With ST-Elevation and Non-ST-Elevation Myocardial Infarction: a report of the ACC/AHA Task Force on Performance Measures (ST-Elevation and Non-ST-Elevation Myocardial Infarction Performance Measures Writing Committee). *J Am Coll Cardiol* 2006;47:236-65. Available at: <http://www.acc.org/qualityandscience/clinical/measures/stemi/pdfs/STEMIfinal.pdf>

OP-2: ED Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival

Numerator: Emergency Department AMI patients whose time from ED arrival to fibrinolysis is 30 minutes or less

Denominator: Emergency Department AMI patients with ST-segment elevation or LBBB on ECG who received fibrinolytic therapy.



Measure Information Form

Measure Set: Hospital Outpatient Acute Myocardial Infarction

Measure ID #: OP-3

Outpatient Setting: Emergency Department

Set Measure ID #	Performance Measure Name
OP-3a	Median Time to Transfer to Another Facility for Acute Coronary Intervention – Overall Rate
OP-3b	Median Time to Transfer to Another Facility for Acute Coronary Intervention –Reporting Measure
OP-3c*	Median Time to Transfer to Another Facility for Acute Coronary Intervention –Quality Improvement Measure

**(previously noted as D prime)*

Performance Measure Name: Median Time to Transfer to Another Facility for Acute Coronary Intervention

Description: Median time from emergency department arrival to time of transfer to another facility for acute coronary intervention

Rationale: The early use of primary angioplasty in patients with acute myocardial infarction (AMI) who present with ST-segment elevation or LBBB results in a significant reduction in mortality and morbidity. The earlier primary coronary intervention is provided, the more effective it is (Brodie, 1998 and DeLuca, 2004). National guidelines recommend the prompt initiation of percutaneous coronary intervention (PCI) in patients presenting with ST-segment elevation myocardial infarction (Antman, 2004). Despite these recommendations, few eligible older patients hospitalized with AMI receive primary angioplasty within a timely manner (Jencks, 2000). Patients transferred for primary PCI rarely meet recommended guidelines for door-to-balloon time (Nallamothu, 2005). Times to treatment in transfer patients undergoing primary PCI may influence the use of PCI as an intervention (Nallamothu, 2005). Current recommendations support a door-to-balloon time of 90 minutes or less (Krumholz, 2006).

Type of Measure: Process

Improvement Noted As: A decrease in the median value

Continuous Variable Statement: Time (in minutes) from emergency department arrival to transfer to another facility for acute coronary intervention.

Included Populations:

- An *E/M Code* for emergency department encounter as defined in Appendix A, OP Table 1.0, and
- Patients discharged/transferred to a short-term general hospital for inpatient care, or to a Federal healthcare facility, and
- An *ICD-9-CM Principal Diagnosis Code* for AMI as defined in Appendix A, OP Table 1.1, and
- ST-segment elevation or LBBB on the ECG performed closest to ED arrival, and
- Patients with *Transfer for Acute Coronary Intervention* as defined in the Data Dictionary

Excluded Populations:

- Patients less than 18 years of age
- Patients receiving *Fibrinolytic Administration* as defined in the Data Dictionary

Data Elements:

- *Arrival Time*
- *Birthdate*
- *Discharge Date and Time*
- *Discharge Status*
- *E/M Code*
- *Fibrinolytic Administration*
- *ICD-9-CM Principal Diagnosis Code*
- *Initial ECG Interpretation*
- *Outpatient Encounter Date*
- *Reason for Not Administering Fibrinolytic Therapy*
- *Transfer for Acute Coronary Intervention*

Risk Adjustment: No

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records. Some facilities may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunity for improvement at the point of care/service. However, complete documentation includes the ICD-9-CM diagnosis, which requires retrospective data entry.

Data Accuracy: Variation may exist in the assignment of ICD-9-CM codes; therefore, coding practices may require evaluation to ensure consistency.

Measure Analysis Suggestions: None

Sampling: Yes, for additional information see the Population and Sampling Specifications section.

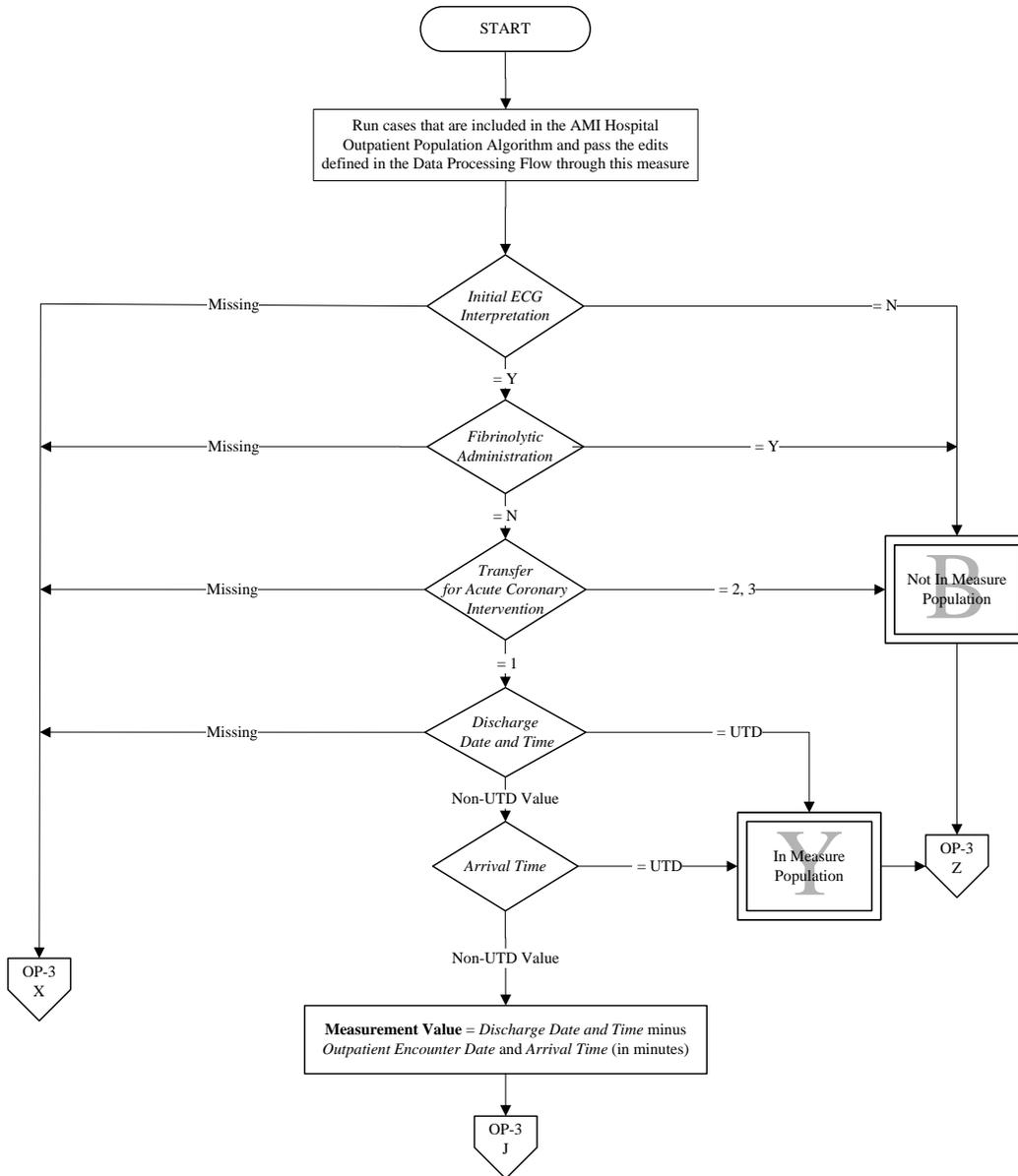
Data Reported As: Aggregate measure of central tendency

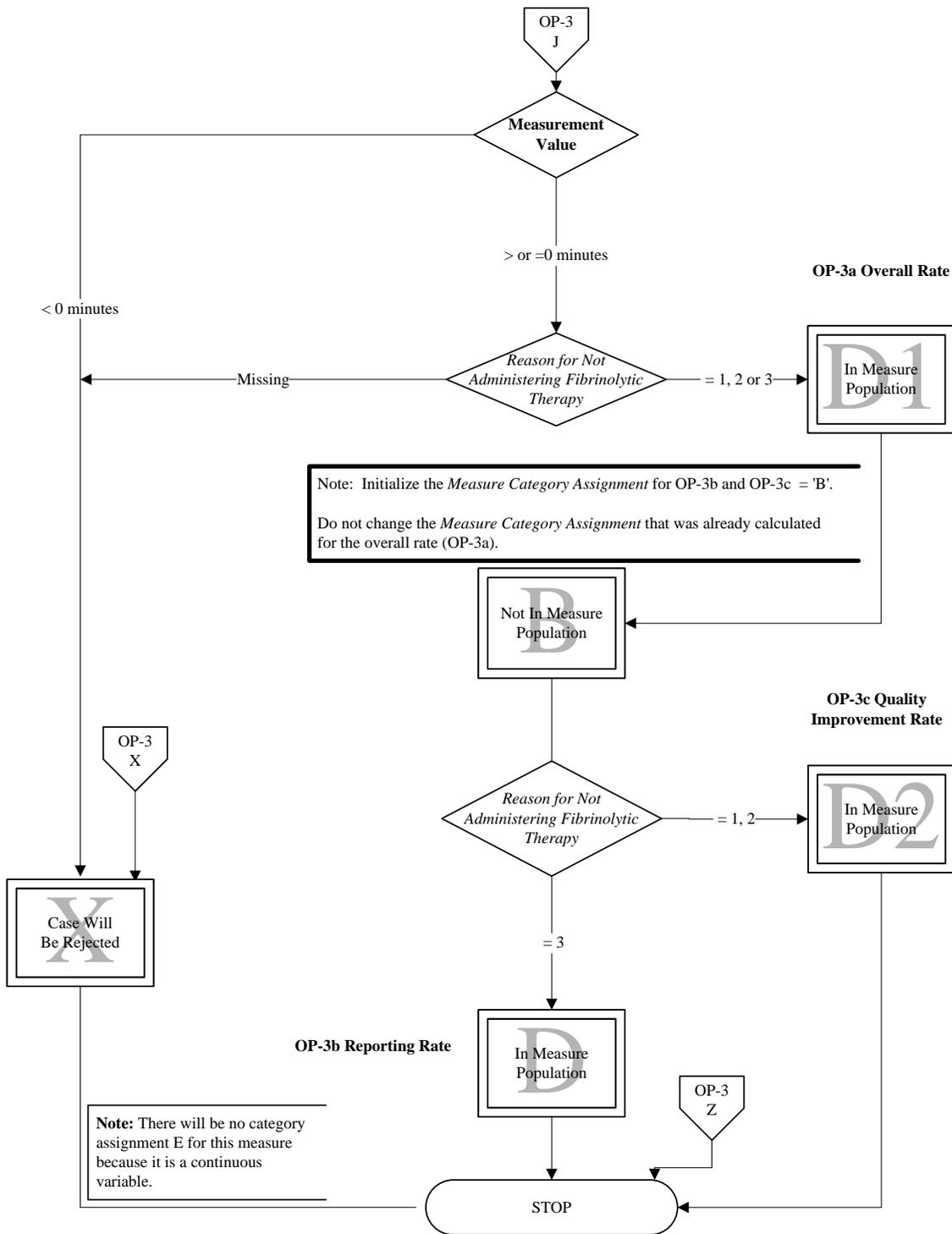
Selected References:

- Antman EM, Anbe DT, Armstrong PW, Bates ER, Green LA, Hand M, Hochman JS, Krumholz HM, Kushner FG, Lamas GA, Mullany CJ, Ornato JP, Pearle DL, Sloan MA, Smith SC Jr. ACC/AHA guidelines for the management of patients with ST-elevation myocardial infarction: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee to Revise the 1999 Guidelines for the Management of Patients With Acute Myocardial Infarction). 2004. Available at: <http://www.acc.org/qualityandscience/clinical/guidelines/stemi/Guideline1/index.htm>
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- Jencks SJ, Cuedon T, Burwen DR, Fleming B, Houck PM, Kussmaul AE, Nilasena DS, Ordin DL, Arday DR. Quality of medical care delivered to Medicare beneficiaries: a profile at state and national levels. *JAMA*. 2000;284:1670-1676.
- Krumholz HM, Anderson JL, Brooks NH, Fesmire FM, Lambrew CT, Landrum MB, Weaver WD, Whyte J. ACC/AHA Clinical Performance Measures for Adults With ST-Elevation and Non-ST-Elevation Myocardial Infarction: a report of the ACC/AHA Task Force on Performance Measures (ST-Elevation and Non-ST-Elevation Myocardial Infarction Performance Measures Writing Committee). *J Am Coll Cardiol* 2006;47:236–65. Available at: <http://www.acc.org/qualityandscience/clinical/measures/stemi/pdfs/STEMIfinal.pdf>
- Nallamothu BK, Bates ER, Herrin J, Wang Y, Bradley EH, Krumholz HM; NRMI Investigators. Times to treatment in transfer patients undergoing primary percutaneous coronary intervention in the United States: National Registry of Myocardial Infarction (NRMI)-3/4 analysis. *Circulation*. 2005;111:761-7.

OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention

Continuous Variable Statement: Time (in minutes) from emergency department arrival to transfer to another facility for acute coronary intervention





Measure Information Form

Measure Set: Hospital Outpatient Acute Myocardial Infarction and Hospital Outpatient Chest Pain

Measure ID#: OP-4

Outpatient Setting: Emergency Department

Performance Measure Name: Aspirin at Arrival

Description: Emergency Department acute myocardial infarction (AMI) patients or chest pain patients (with *Probable Cardiac Chest Pain*) who received aspirin within 24 hours before ED arrival or prior to transfer.

Rationale: The early use of aspirin in patients with AMI results in a significant reduction in adverse events and subsequent mortality. Aspirin therapy provides a percent reduction in mortality that is comparable to thrombolytic therapy and the combination provides additive benefit for patients with ST-segment elevation myocardial infarction (ISIS-2, 1988) and is also effective in patients with non-ST-segment elevation myocardial infarction (Theroux, 1988 and RISC Group, 1990). National guidelines strongly recommend early aspirin for patients hospitalized with AMI (Braunwald, 2002 and Antman, 2004).

Type of Measure: Process

Improvement Noted As: An increase in the rate

Numerator Statement: Emergency Department AMI or Chest Pain patients (with *Probable Cardiac Chest Pain*) who received aspirin within 24 hours before ED arrival or prior to transfer.

Included Populations: Not Applicable

Excluded Populations: None

Data Elements:

Aspirin Received

Denominator Statement: Emergency Department AMI or Chest Pain patients (with *Probable Cardiac Chest Pain*)

Included Populations:

- An E/M Code for emergency department encounter as defined in Appendix A, Table 1.0, and

- Patients discharged/transferred to a short term general hospital for inpatient care, or to a Federal healthcare facility, and
- An *ICD-9-CM Principal Diagnosis Code* for AMI as defined in Appendix A, OP Table 1.1 or an *ICD-9-CM Principal or Other Diagnosis Codes* for Angina, Acute Coronary Syndrome, or Chest Pain as defined in Appendix A, OP Table 1.1a with *Probable Cardiac Chest Pain*

Excluded Populations:

- Patients less than 18 years of age
- Patients with a documented *Reason for No Aspirin on Arrival*

Data Elements:

- *Birthdate*
- *Discharge Status*
- *E/M Code*
- *ICD-9-CM Other Diagnosis Codes*
- *ICD-9-CM Principal Diagnosis Code*
- *Outpatient Encounter Date*
- *Probable Cardiac Chest Pain*
- *Reason for No Aspirin on Arrival*

Risk Adjustment: No

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records. Some facilities may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunity for improvement at the point of care/service. However, complete documentation includes the ICD-9-CM diagnosis, which requires retrospective data entry.

Data Accuracy: Variation may exist in the assignment of ICD-9-CM codes; therefore, coding practices may require evaluation to ensure consistency.

Measure Analysis Suggestions: None

Sampling: Yes, for additional information see the Population and Sampling Specifications section. Sampling requirements apply to each distinct hospital outpatient measure set (AMI and Chest Pain).

Data Reported As: Aggregate rate generated from count data reported as a proportion

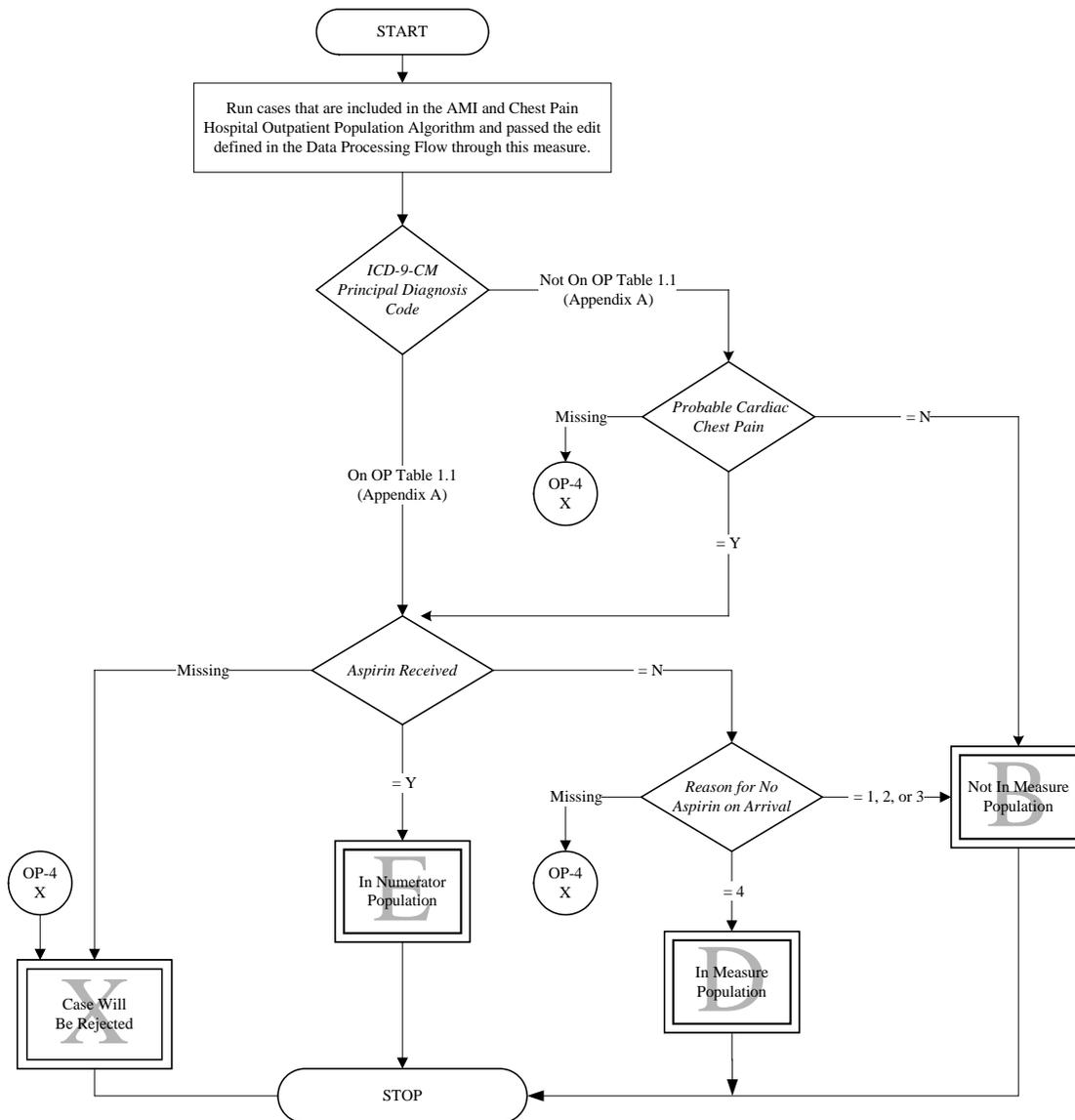
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- Antman EM, Anbe DT, Armstrong PW, Bates ER, Green LA, Hand M, Hochman JS, Krumholz HM, Kushner FG, Lamas GA, Mullany CJ, Ornato JP, Pearle DL, Sloan MA, Smith SC Jr. ACC/AHA guidelines for the management of patients with ST-elevation myocardial infarction: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee to Revise the 1999 Guidelines for the Management of Patients With Acute Myocardial Infarction). 2004. Available at <http://www.acc.org/qualityandscience/clinical/guidelines/stemi/Guideline1/index.htm>
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- Risk of myocardial infarction and death during treatment with low dose aspirin and intravenous heparin in men with unstable coronary artery disease. The RISC Group. *Lancet* 1990; 336(8719):827-30.
- Theroux P, Ouimet H, McCans J et al. Aspirin, heparin, or both to treat acute unstable angina. *N Engl J Med* 1988; 319:1105-11.

OP-4: Aspirin at Arrival

Numerator: Emergency Department AMI or Chest Pain patients (with Probable Cardiac Chest Pain) who received aspirin within 24 hours before ED arrival or prior to transfer.

Denominator: Emergency Department AMI or Chest Pain patients (with Probable Cardiac Chest Pain).



Measure Information Form

Measure Set: Hospital Outpatient Acute Myocardial Infarction and Hospital Outpatient Chest Pain

Measure ID#: OP-5

Outpatient Setting: Emergency Department

Performance Measure Name: Median Time to ECG

Description: Median time from emergency department arrival to ECG (performed in the ED prior to transfer) for acute myocardial infarction (AMI) or Chest Pain patients (with Probable Cardiac Chest Pain).

Rationale: Guidelines recommend patients presenting with chest discomfort or symptoms suggestive of ST-segment elevation myocardial infarction (STEMI) have a 12-lead electrocardiogram (ECG) performed within a target of 10 minutes of emergency department arrival (Krumholz, 2006). Evidence supports reperfusion benefits patients with identified STEMI (Antman 2004). The diagnosis and management of STEMI patients is dependent upon practices within the emergency department. Timely ECGs assist in identifying STEMI patients and impact the choice of reperfusion strategy (Peacock, 2007). This measure will identify the median time to ECG for chest pain or AMI patients and potential opportunities for improvement to decrease the median time to ECG.

Type of Measure: Process

Improvement Noted As: A decrease in the median value

Continuous Variable Statement: Time (in minutes) from emergency department arrival to ECG (performed in the ED prior to transfer) for AMI or Chest Pain patients (with *Probable Cardiac Chest Pain*).

Included Populations:

- An *E/M Code* for emergency department encounter as defined in Appendix A, OP Table 1.0, and
- Patients discharged/transferred to a short term general hospital for inpatient care, or to a Federal healthcare facility, and
- An *ICD-9-CM Principal Diagnosis Code* for AMI as defined in Appendix A, OP Table 1.1 or an *ICD-9-CM Principal or Other Diagnosis Codes* for Angina, Acute Coronary Syndrome, or Chest Pain as defined in Appendix A, OP Table 1.1a, and
- Patients receiving an *ECG* as defined in the Data Dictionary

Excluded Populations:

- Patients less than 18 years of age

Data Elements:

- *Arrival Time*
- *Birthdate*
- *Discharge Status*
- *E/M Code*
- *ECG*
- *ECG Date and Time*
- *ICD-9-CM Other Diagnosis Codes*
- *ICD-9-CM Principal Diagnosis Code*
- *Outpatient Encounter Date*
- *Probable Cardiac Chest Pain*

Risk Adjustment: No

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records. Some facilities may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunity for improvement at the point of care/service. However, complete documentation includes the ICD-9-CM diagnosis, which requires retrospective data entry.

Data Accuracy: Variation may exist in the assignment of ICD-9-CM codes; therefore, coding practices may require evaluation to ensure consistency.

Measure Analysis Suggestions: None

Sampling: Yes, for additional information see the Population and Sampling Specifications section. Sampling requirements apply to each distinct hospital outpatient measure set (AMI and Chest Pain).

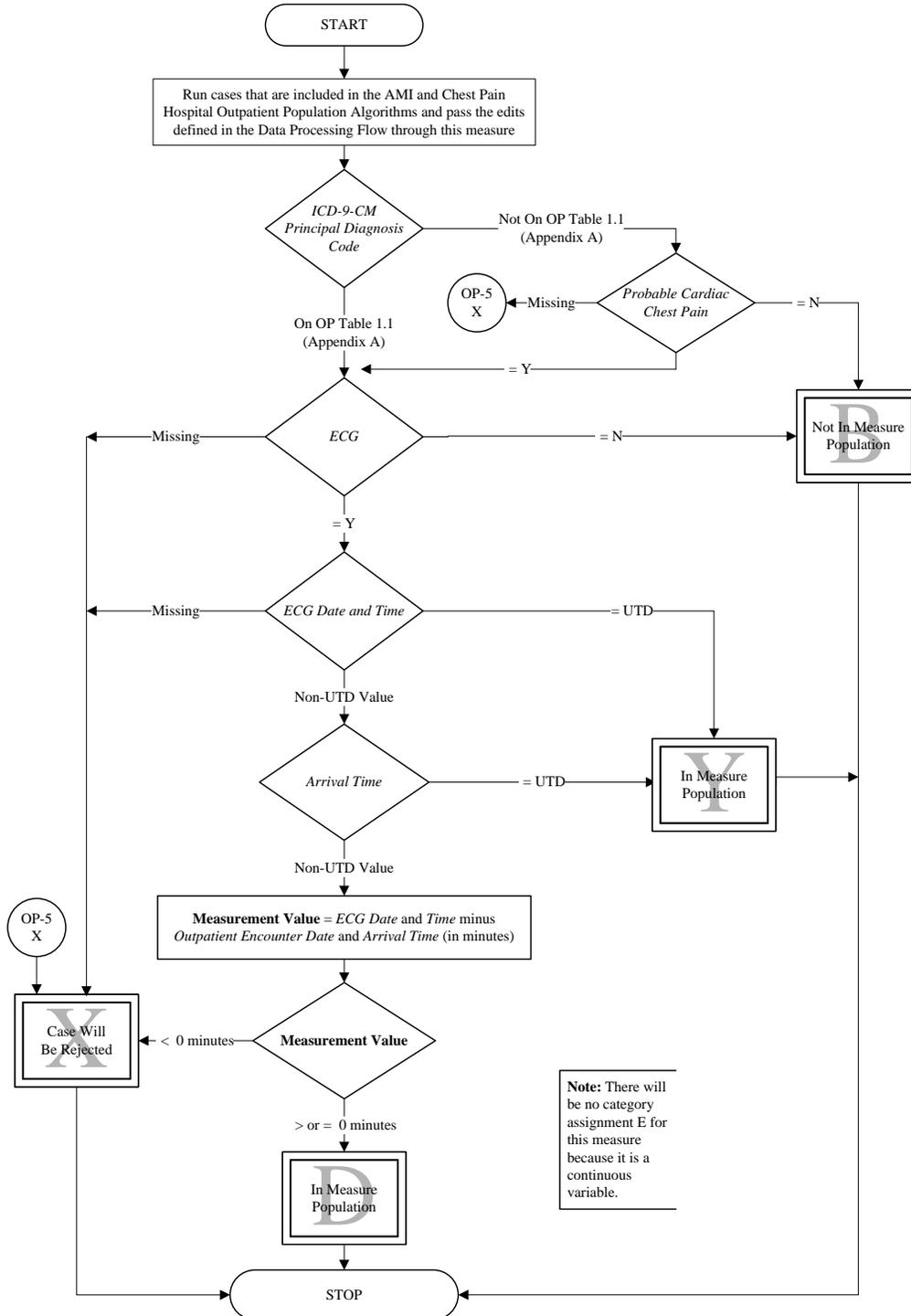
Data Reported As: Aggregate measure of central tendency

Selected References:

- Antman EM, Anbe DT, Armstrong PW, Bates ER, Green LA, Hand M, Hochman JS, Krumholz HM, Kushner FG, Lamas GA, Mullany CJ, Ornato JP, Pearle DL, Sloan MA, Smith SC Jr. ACC/AHA guidelines for the management of patients with ST-elevation myocardial infarction: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee to Revise the 1999 Guidelines for the Management of Patients With Acute Myocardial Infarction). 2004. Available at <http://www.acc.org/qualityandscience/clinical/guidelines/stemi/Guideline1/index.htm>
- Krumholz HM, Anderson JL, Brooks NH, Fesmire FM, Lambrew CT, Landrum MB, Weaver WD, Whyte J. ACC/AHA Clinical Performance Measures for Adults With ST-Elevation and Non-ST-Elevation Myocardial Infarction: a report of the ACC/AHA Task Force on Performance Measures (ST-Elevation and Non-ST-Elevation Myocardial Infarction Performance Measures Writing Committee). *J Am Coll Cardiol* 2006; 47:236–65. Available at <http://www.acc.org/qualityandscience/clinical/measures/stemi/pdfs/STEMIfinal.pdf>
- Peacock WF, Hollander JE, Smalling RW, and Bresler MJ. Reperfusion Strategies in the emergency treatment of ST-segment elevation myocardial infarction. *Am J Emerg Med* 2007; 25: 353-66.

OP-5: ED Median Time to ECG

Continuous Variable Statement: Time (in minutes) from emergency department arrival to ECG (performed in the ED prior to transfer) for acute myocardial infarction (AMI) or Chest Pain patients (with probable cardiac chest pain).



HOSPITAL OUTPATIENT DEPARTMENT QUALITY MEASURES
Surgical

Set Measure ID #	Measure Short Name
OP-6	Antibiotic Timing
OP-7	Antibiotic Selection

OP SURGICAL GENERAL DATA ELEMENT LIST

General Data Element Name	Collected For:
<i>Arrival Time</i>	All Records
<i>Birthdate</i>	All Records
<i>CMS Certification Number^{1,2}</i>	All Records
<i>First Name</i>	All Records
<i>Hispanic Ethnicity</i>	All Records
<i>Last Name</i>	All Records
<i>National Provider Identifier^{1,2}</i>	All Records
<i>Outpatient Encounter Date</i>	All Records
<i>Patient HIC#</i>	All Records
<i>Patient Identifier</i>	All Records
<i>Payment Source</i>	All Records
<i>Physician 1</i>	Optional for All Records
<i>Physician 2</i>	Optional for All Records
<i>Postal Code</i>	All Records
<i>Race</i>	All Records
<i>Sex</i>	All Records

OP SURGICAL SPECIFIC DATA ELEMENT LIST

OP Surgical Data Element Name	Collected For:
<i>Antibiotic</i>	OP-6, OP-7
<i>Antibiotic Allergy</i>	OP-7
<i>Antibiotic Name</i>	OP-6, OP-7
<i>Antibiotic Route</i>	OP-6, OP-7
<i>Antibiotic Timing</i>	OP-6
<i>Case Canceled</i>	OP-6, OP-7
<i>Clinical Trial</i>	OP-6, OP-7
<i>CPT[®] Code</i>	OP-6, OP-7
<i>CPT[®] Code Date</i>	OP-6, OP-7
<i>Infection Prior to Anesthesia</i>	OP-6, OP-7

¹ Transmission Data Element

² Defined in the Transmission Data Element List within the Hospital Outpatient Measure Data Transmission section of this manual

OP Surgical Data Element Name	Collected For:
<i>Replacement</i>	OP-6, OP-7
<i>Vancomycin</i>	OP-7

OP-6 and OP-7 Hospital Outpatient Population

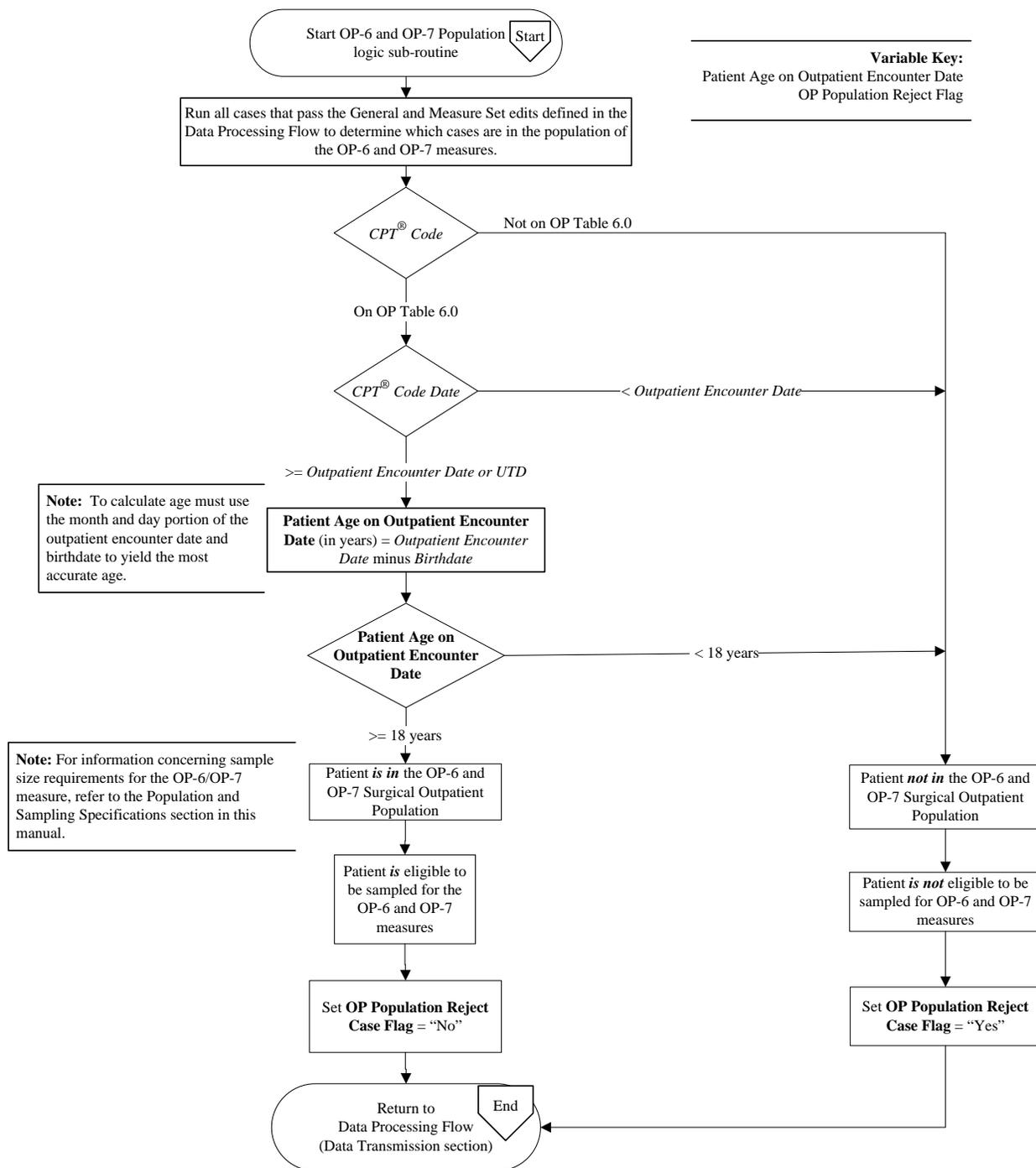
The population of the OP-6 and OP-7 Surgical measures is identified using four data elements in this order:

- *CPT[®] Code*
- *CPT[®] Code Date*
- *Outpatient Encounter Date*
- *Birthdate*

Patients seen in a hospital-based outpatient surgery center are included in the OP-6 and OP-7 Hospital Outpatient Population and are eligible to be sampled if they have:

- A Current Procedural Terminology (*CPT[®]*) Code for surgery as defined in Appendix A, OP Table 6.0, and
- A Patient Age on *Outpatient Encounter Date* (*Outpatient Encounter Date – Birthdate*) \geq 18 years

Surgical Hospital Outpatient Population Algorithm OP-6 and OP-7



Measure Information Form

Measure Set: Hospital Outpatient Surgery

Measure ID#: OP- 6

Outpatient Setting: Hospital Outpatient Department Surgery

Performance Measure Name: Timing of Antibiotic Prophylaxis (Prophylactic Antibiotic Initiated Within One Hour Prior to Surgical Incision*)

Description: Surgical patients with prophylactic antibiotics initiated within one hour* prior to surgical incision.

*Patients who received vancomycin or a fluoroquinolone for prophylaxis should have the antibiotic initiated within two hours prior to surgical incision. Due to the longer infusion time required for vancomycin or a fluoroquinolone, it is acceptable to start these antibiotics within two hours prior to incision time.

Rationale: Multiple studies have demonstrated that timing is critical to the effectiveness of surgical antimicrobial prophylaxis and current guidelines recommend dosing within 1 hour before incision. It has been demonstrated that antibiotics to prevent experimental infections were effective only if administered during the 3 to 4 hour period after inoculation of bacteria into the wound (Miles, 1957). Furthermore, it has been reported that a variety of antimicrobials could prevent the development of experimental infections, but only if given within about 3 hours following wound contamination (Burke, 1961). In randomized clinical trials reported in 1964 and 1969, antimicrobials given before, during, and shortly after abdominal surgery were effective in preventing surgical site infection (SSI). The lowest rates of SSI in abdominal operations were associated with prophylaxis started within one hour prior to the incision (Stone, 1976). Similar findings have also been reported for cardiac operations (Classen, 1992). In a recent review of data from a European total joint arthroplasty registry, antibiotic delivery just before surgical incision was the most important factor in reducing surgical site infection rates.

Type of Measure: Process

Improvement Noted As: An increase in the rate

Numerator Statement: Surgical patients with prophylactic antibiotics initiated within one hour prior to surgical incision (two hours if initiating vancomycin, in Appendix C, OP Table 6.12, or a fluoroquinolone, in Appendix C, OP Table 6.11).

Included Populations: Not Applicable

Excluded Populations: None

Data Elements:

- *Antibiotic Timing*

Denominator Statement: Surgical patients with no evidence of prior infection.

Included Populations:

- Patients with a *CPT*[®] Code of selected surgeries as defined in Appendix A, OP Table 6.0

Excluded Populations:

- Patients who are less than 18 years of age
- Patients whose procedure is canceled prior to incision as defined in the Data Dictionary
- Patients with a *CPT*[®] Code of gastrostomy placement that represents a *Replacement* only, as defined in the Data Dictionary
- Patients enrolled in a *Clinical Trial* as defined in the Data Dictionary
- Patients with an *Infection Prior to Anesthesia* as defined in the Data Dictionary
- Patients who receive oral antibiotics only

Data Elements:

- *Antibiotic*
- *Antibiotic Name*
- *Antibiotic Route*
- *Birthdate*
- *Case Canceled*
- *Clinical Trial*
- *CPT*[®] Code
- *Infection Prior to Anesthesia*
- *Outpatient Encounter Date*
- *Replacement*

Risk Adjustment: No

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.

Data Accuracy: Abstracted antibiotics are those administered from the time of arrival until patient leaves from the outpatient setting. Refer to Appendix C, OP Table 6.0 which contains a complete listing of antibiotics.

Measure Analysis Suggestions: Consideration may be given to relating this measure to OP-7 in order to evaluate which aspects of antibiotic prophylaxis (i.e., timing, selection) would most benefit from an improvement effort. The process-owners for timing of administration of antibiotics, as assessed in this measure, may include clinicians and support staff on the nursing

unit as well as in the presurgical holding area, as well as in the operating room itself. Opportunities may exist in any of these arenas which, when addressed jointly, can generate true process improvement.

Sampling: Yes, for additional information see the Population and Sampling Specifications Section.

Data Reported As: Aggregate rate generated from count data reported as a proportion

Selected References:

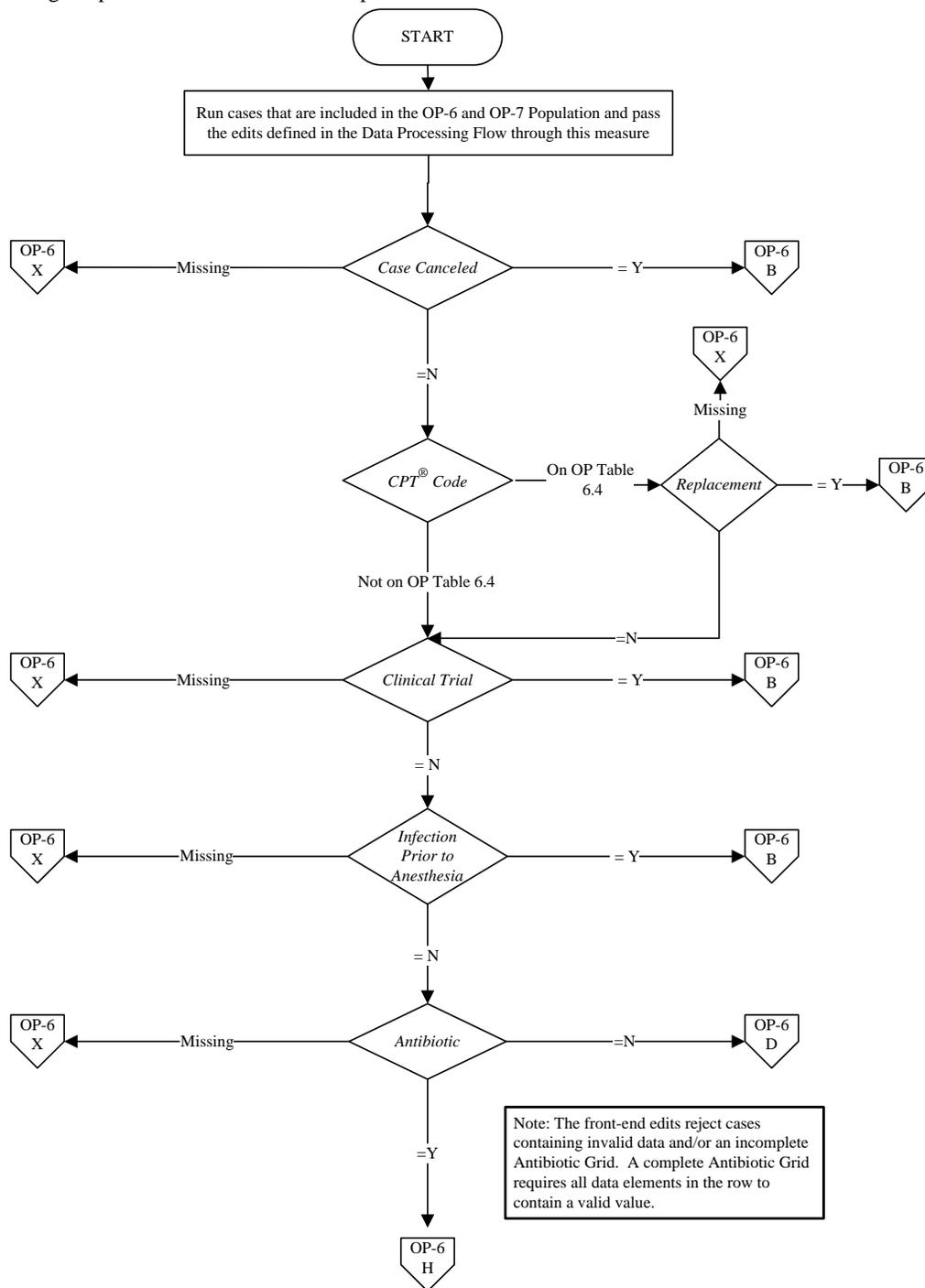
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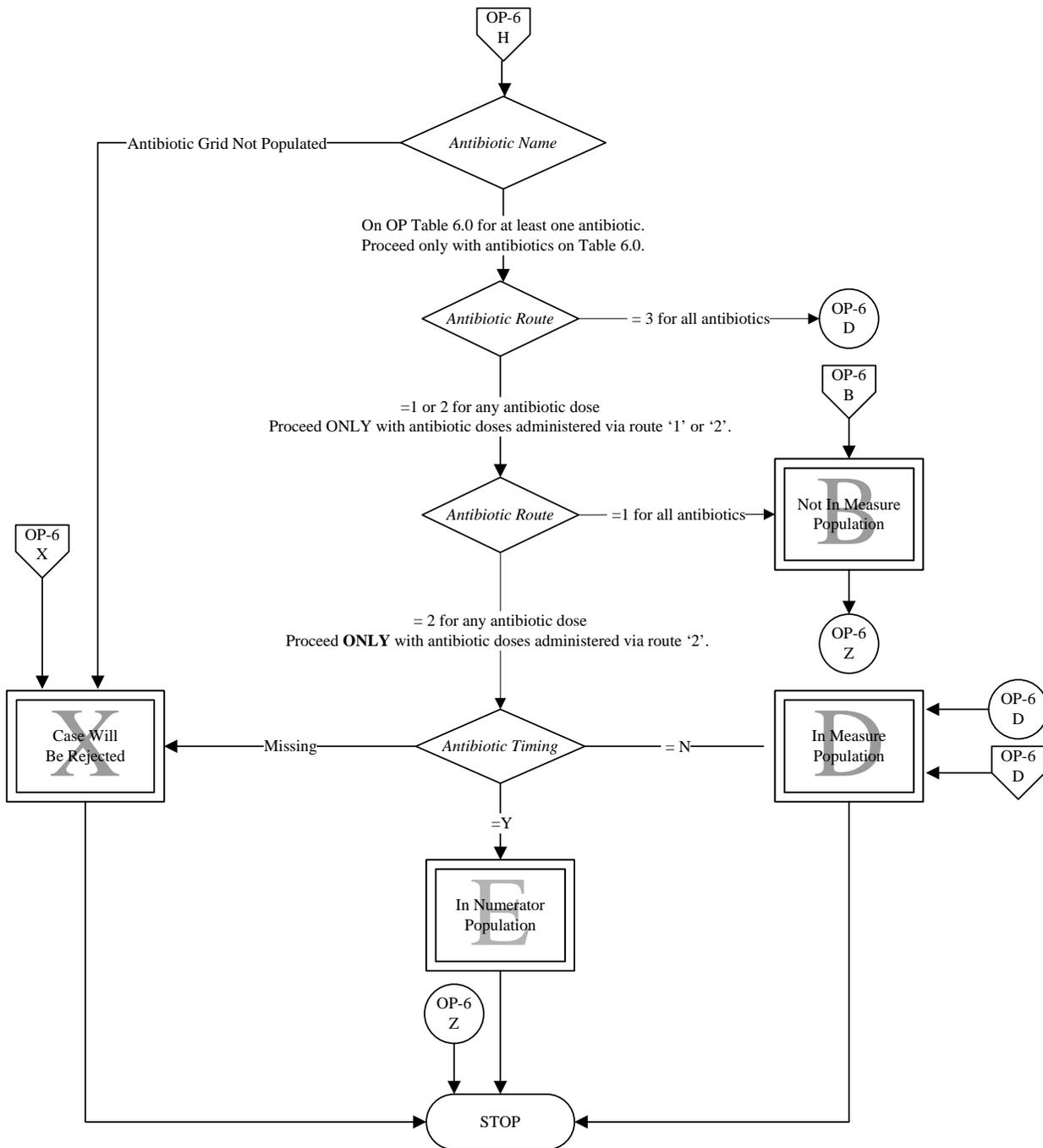
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OP-6: Timing of Antibiotic Prophylaxis (Prophylactic Antibiotic Initiated Within One Hour Prior to Surgical Incision)

Numerator: Surgical patients with prophylactic antibiotics initiated within one hour prior to surgical incision (two hours if initiating vancomycin, in Appendix C, OP Table 6.12, or a fluoroquinolone, in Appendix C, OP Table 6.11).

Denominator: Surgical patients with no evidence of prior infection.





Measure Information Form

Measure Set: Hospital Outpatient Surgery

Measure ID #: OP-7

Outpatient Setting: Hospital Outpatient Department Surgery

Performance Measure Name: Prophylactic Antibiotic Selection for Surgical Patients

Description: Surgical patients who received prophylactic antibiotics consistent with current guidelines (specific to each type of surgical procedure).

Rationale: A goal of prophylaxis with antibiotics is to use an agent that is safe, cost-effective, and has a spectrum of action that covers most of the probable intraoperative contaminants for the operation. First- or second-generation cephalosporins satisfy these criteria for most operations, although quinolones are recommended for some urologic operations. Vancomycin is not recommended for routine use because of the potential for development of antibiotic resistance, but is acceptable if a patient is allergic to beta-lactams, as are fluoroquinolones and clindamycin in selected situations.

Type of Measure: Process

Improvement Noted As: An increase in the rate.

Numerator Statement: Surgical patients who received prophylactic antibiotics recommended for their specific operation.

Included populations: Not Applicable

Excluded Populations: None

Data Elements:

- *Antibiotic Allergy*
- *Antibiotic Name*
- *Vancomycin*

Denominator Statement: Surgical patients with no evidence of prior infection.

Included Populations:

- Patients with a *CPT® Code* of selected surgeries as defined in Appendix A, OP Table 6.0.

Excluded Populations:

- Patients less than 18 years of age
- Patients whose procedure is canceled prior to incision as defined in the Data Dictionary
- Patients with a CPT® Code of gastrostomy placement that represents a *Replacement* only, as defined in the Data Dictionary
- Patients enrolled in a *Clinical Trial* as defined in the Data Dictionary
- Patients with an *Infection Prior to Anesthesia* as defined in the Data Dictionary
- Patients who do not receive any antibiotics during the encounter

Data Elements:

- *Antibiotic*
- *Antibiotic Route*
- *Birthdate*
- *Case Canceled*
- *Clinical Trial*
- *CPT® Code*
- *Infection Prior to Anesthesia*
- *Outpatient Encounter Date*
- *Replacement*

Risk Adjustment: No

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records.

Data Accuracy: Abstracted antibiotics are those administered from the time of arrival until the patient leaves the outpatient setting. Refer to Appendix C, OP Table 6.0, which contains a complete listing of antibiotics.

Measure Analysis Suggestions: Consideration may be given by relating this measure to OP-6 in order to evaluate which aspects of antibiotic prophylaxis would most benefit from an improvement effort. The process owners for selection of appropriate antibiotics could include physicians/APNs/PAs and committees (e.g., QA, Infection Control, Pharmacy and Therapeutics, Surgical Section Subcommittees, etc.), any of which may choose to address this physician/APN/PA practice issue as part of a larger surgical infection prevention initiative.

Sampling: Yes, for additional information see the Population and Sampling Specifications Section.

Data Reported As: Aggregate rate generated from count data reported as a proportion

Selected References:

- Bratzler DW, Houck PM, for the Surgical Infection Prevention Guidelines Writers Group. Antimicrobial prophylaxis for surgery: An advisory statement from the National Surgical Infection Prevention Project. *Clin Infect Dis*. 2004;38: 1706-1715.
- Mangram AJ, Horan TC, Pearson ML, et al. Guidelines for prevention of surgical site infection, 1999. *Infect Control Hosp Epidemiol*. 1999; 20:247-280.
- American Society of Health-System Pharmacists. ASHP therapeutic guidelines on antimicrobial prophylaxis in surgery. *Am J Health Syst Pharm*. 1999; 56:1839-1888.
- American Urological Association. Best practice policy statement on urologic surgery antimicrobial prophylaxis. Updated September 2008. Available at <http://www.auanet.org/content/guidelines-and-quality-care/clinical-guidelines/main-reports/antimicroprop08.pdf> (last accessed October 21, 2008)
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- Dellinger EP, Gross PA, Barrett TL, et al. Quality standard for antimicrobial prophylaxis in surgical procedures. *Clin Infect Dis*. 1994; 18:422-427.
- Gilbert DN, Moellering RC Jr., Eliopoulos, GM, Sande MA, eds. *The Sanford Guide to Antimicrobial Therapy*. 37th ed. Hyde Park, VT: Antimicrobial Therapy, Inc; 2007. pp.160-161.
- Page CP, Bohnen JM, Fletcher JR, et al. Antimicrobial prophylaxis for surgical wounds. *Arch Surg*. 1993; 128:79-88.
- ASGE Standards of Practice Committee, Banerjee S, Shen B, Baron TH, Nelson DB, Anderson MA, Cash BD, Dominitz JA, Gan SI, Harrison ME, Ikenberry SO, Jagannath SB, Lichtenstein D, Fanelli RD, Lee K, van Guilder T, Stewart LE. Antibiotic prophylaxis for GI endoscopy. *Gastrointest Endosc* 2008 May;67(6):791-798.
- Johns Hopkins Antibiotic Guide: Surgical Prophylaxis. Available at http://prod.hopkins-abxguide.org/diagnosis/surgical_infections/surgical_prophylaxis.html?contentInstanceId=255354 (last accessed April 6, 2009).

Prophylactic Antibiotic Regimen Selection for Surgery

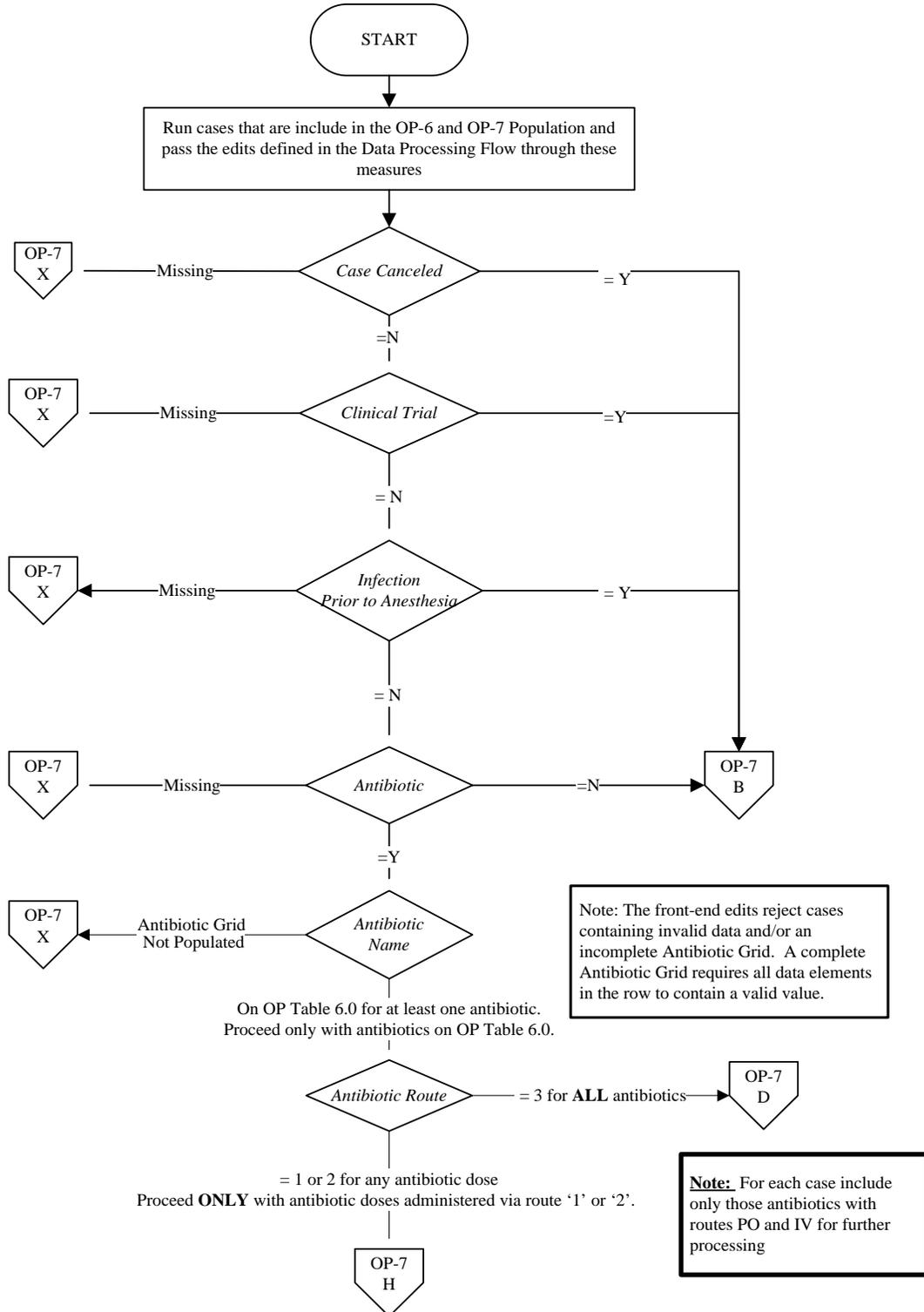
Surgical Procedure (Appendix A)	Approved Antibiotics (Appendix C)
Cardiac (Pacemakers or AICDs) or Vascular	
OP Table 6.1	Cefazolin or Cefuroxime, OP Table 6.6 or Vancomycin* OP Table 6.12 If β -lactam allergy: Vancomycin OP Table 6.12 or Clindamycin OP Table 6.7
Orthopedic/Podiatry	
OP Table 6.2	Cefazolin or Cefuroxime OP Table 6.6 or Vancomycin* OP Table 6.12 If β -lactam allergy: Vancomycin OP Table 6.12 or Clindamycin OP Table 6.7
Genitourinary	
Transrectal prostate biopsy OP Table 6.3	Quinolone [†] OP Table 6.11 OR 2 nd Generation cephalosporin OP Table 6.6b OR 3 rd Generation cephalosporin OP Table 6.6c OR Aminoglycoside OP Table 6.2 + Metronidazole OP Table 6.9 OR Aminoglycoside OP Table 6.2 + Clindamycin OP Table 6.7 OR Aztreonam OP Table 6.5 + Metronidazole OP Table 6.9 OR Aztreonam OP Table 6.5 + Clindamycin OP Table 6.7
Penile prosthesis insertion, removal, revision OP Table 6.3a	Ampicillin/Sulbactam or Ticarcillin/Clavulanate or Piperacillin/Tazobactam OP Table 6.3 OR Aminoglycoside OP Table 6.2 + 1 st Generation cephalosporin OP Table 6.6a OR Aminoglycoside OP Table 6.2 + 2 nd Generation cephalosporin OP Table 6.6b OR Aminoglycoside OP Table 6.2 + Vancomycin OP Table 6.12 OR Aminoglycoside OP Table 6.2 + Clindamycin OP Table 6.7 OR Aztreonam OP Table 6.5 + 1 st Generation cephalosporin OP Table 6.6a OR Aztreonam OP Table 6.5 + 2 nd Generation cephalosporin OP Table 6.6b OR Aztreonam OP Table 6.5 + Vancomycin OP Table 6.12 OR Aztreonam OP Table 6.5 + Clindamycin OP Table 6.7
Gastric/Biliary	
PEG placement, PEG revision OP Table 6.4	Cefazolin or Cefuroxime OP Table 6.6, Cefoxitin or Cefotetan OP Table 6.4 OR Ampicillin/Sulbactam OP Table 6.3a or Cefazolin or Cefuroxime OP Table 6.6 + Metronidazole OP Table 6.9 If β -lactam allergy: Clindamycin OP Table 6.7 + Aminoglycoside OP Table 6.2 OR Clindamycin OP Table 6.7 + Quinolone OP Table 6.11 OR Vancomycin OP Table 6.12 + Aminoglycoside OP Table 6.2 OR Vancomycin OP Table 6.12 + Quinolone OP Table 6.11

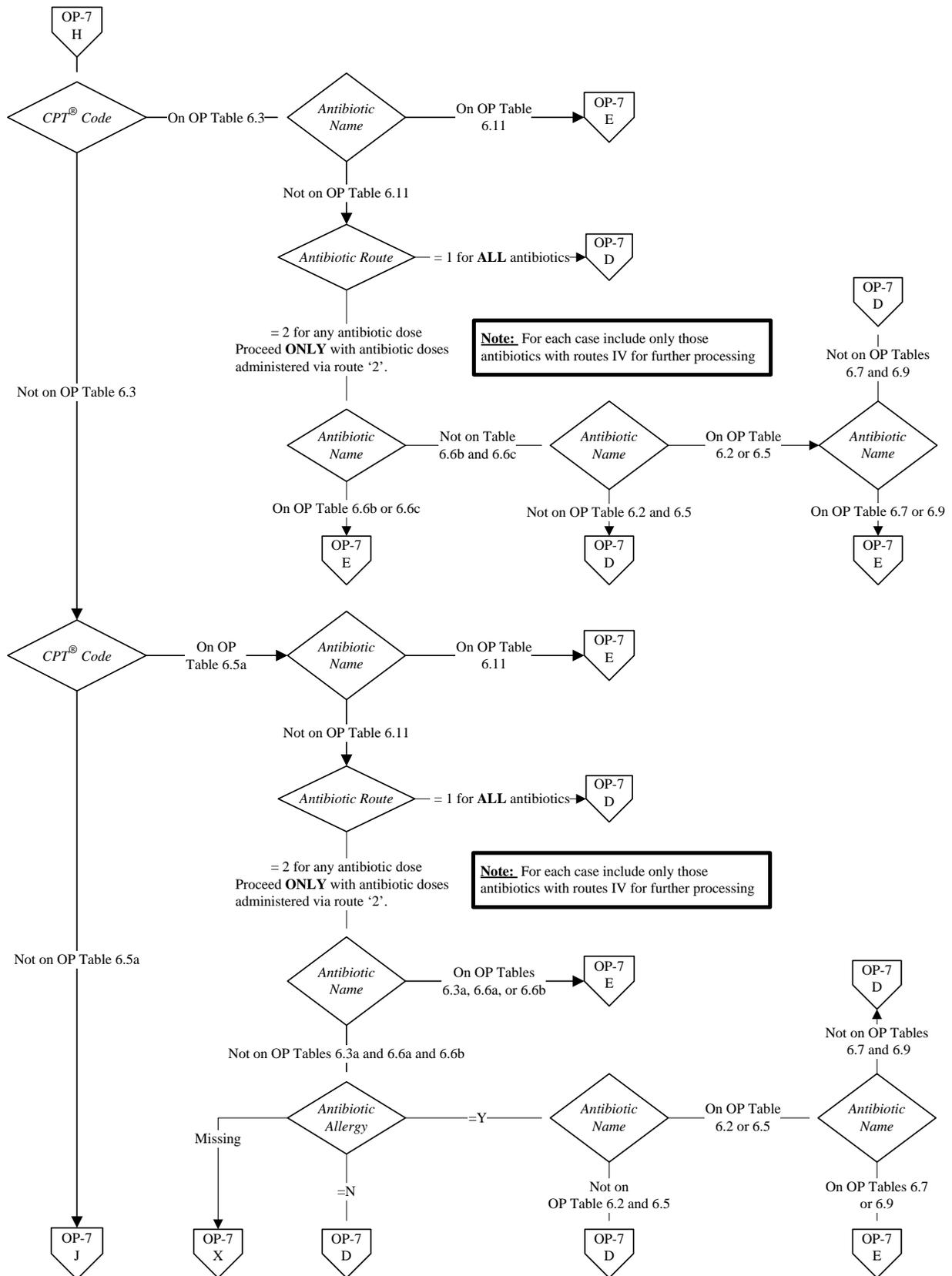
Gynecological	
Laparoscopically-assisted hysterectomy, Vaginal hysterectomy OP Table 6.5	Cefazolin or Cefuroxime OP Table 6.6, Cefoxitin or Cefotetan OP Table 6.4 OR Ampicillin/Sulbactam OP Table 6.3a If β -lactam allergy: Metronidazole OP Table 6.9 + Aminoglycoside OP Table 6.2 OR Metronidazole OP Table 6.9 + Quinolone OP Table 6.11 OR Clindamycin OP Table 6.7 + Aminoglycoside OP Table 6.2 OR Clindamycin OP Table 6.7 + Aztreonam OP Table 6.5 OR Clindamycin OP Table 6.7 + Quinolone OP Table 6.11
Pubovaginal sling OP Table 6.5a	1 st Generation cephalosporin OP Table 6.6a OR 2 nd Generation cephalosporin OP Table 6.6b OR Ampicillin/Sulbactam OP Table 6.3a OR Quinolone [†] OP Table 6.11 If β -lactam allergy: Aminoglycoside OP Table 6.2 + Clindamycin OP Table 6.7 OR Aminoglycoside OP Table 6.2 + Metronidazole OP Table 6.9 OR Aztreonam OP Table 6.5 + Clindamycin OP Table 6.7 OR Aztreonam OP Table 6.5 + Metronidazole OP Table 6.9
Head and Neck	
OP Table 6.6	Cefazolin or Cefuroxime OP Table 6.6 OR Clindamycin OP Table 6.7 \pm Aminoglycoside OP Table 6.2
Neurological	
OP Table 6.7	Nafcillin or Oxacillin OP Table 6.8, Cefazolin or Cefuroxime OP Table 6.6, or Vancomycin* OP Table 6.12 or Clindamycin OP Table 6.7
Special Considerations	
<p>*Vancomycin is acceptable with a physician/APN/PA/pharmacist documented justification for its use (see data element <i>Vancomycin</i>).</p> <p>[†]The only operations for which oral antibiotics alone are acceptable are the Transrectal prostate biopsy and Pubovaginal sling procedures.</p>	

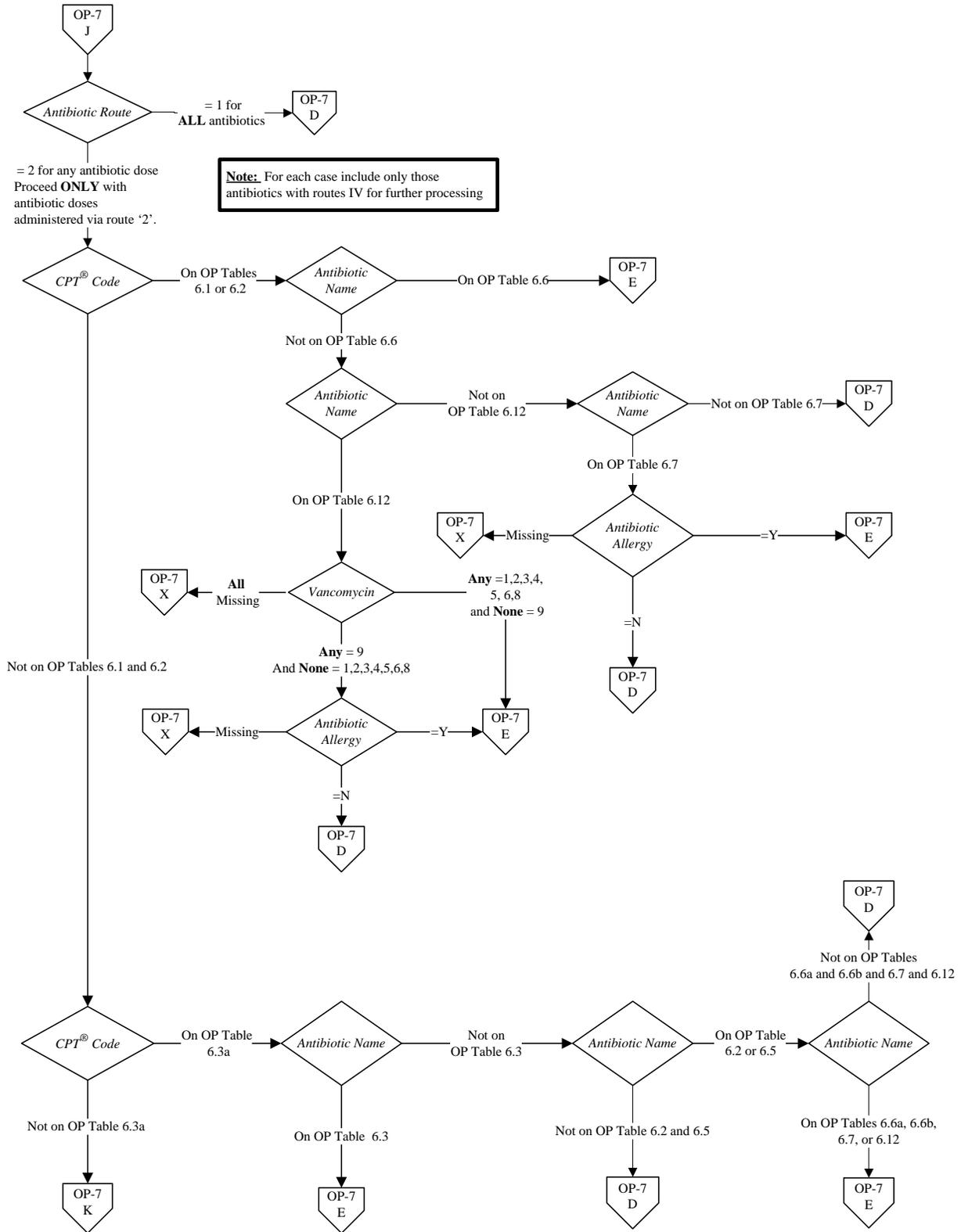
OP-7: Prophylactic Antibiotic Selection for Surgical Patients

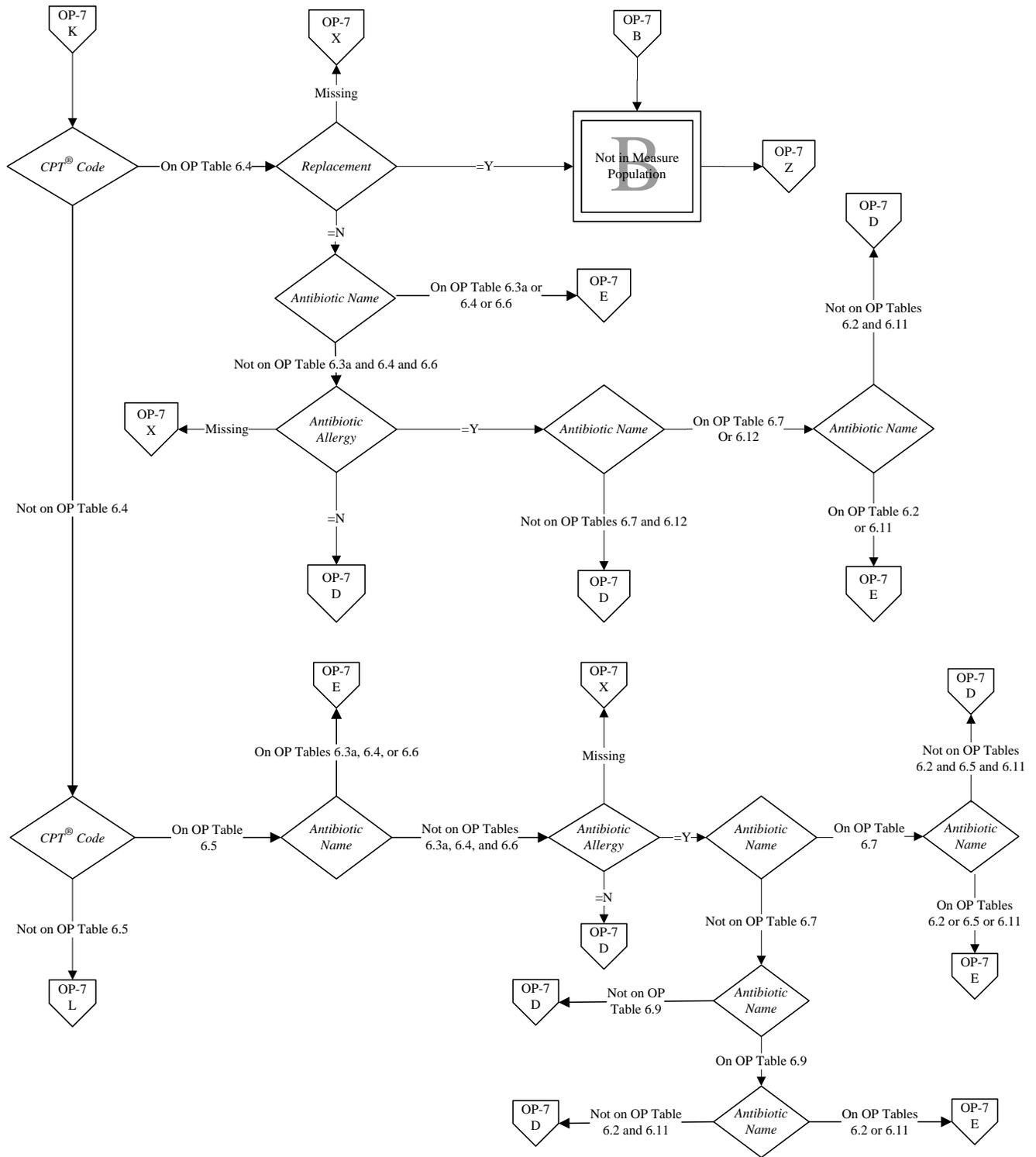
Numerator: Surgical patients who received prophylactic antibiotics recommended for their specific operation.

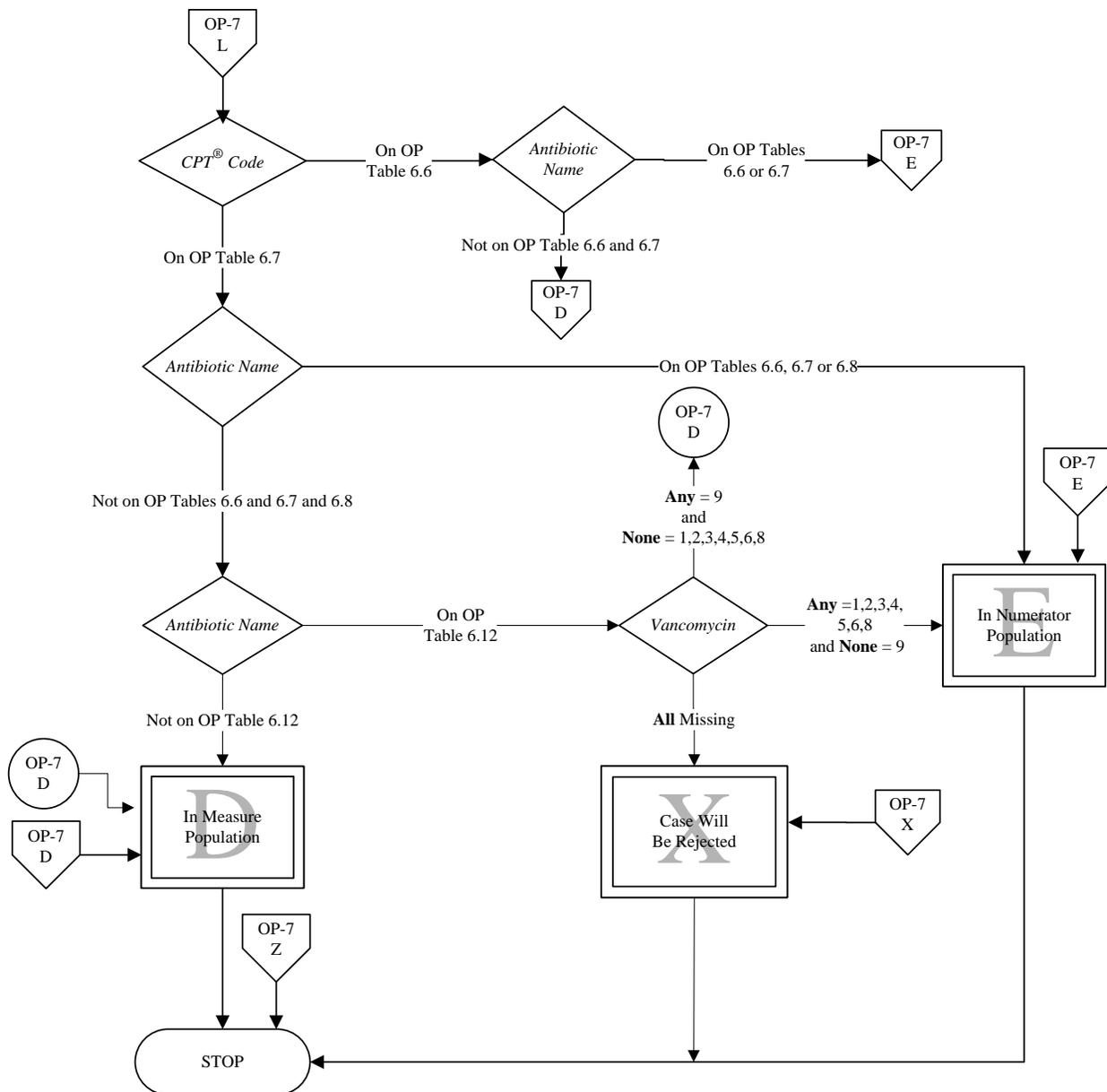
Denominator: Surgical patients with no evidence of prior infection.











Measure Information Form

Measure Set: Imaging Efficiency Measures

Set Measure ID #: OP-8

Performance Measure Name: MRI Lumbar Spine for Low Back Pain

Description: This measure estimates the percentage of people who had an MRI of the Lumbar Spine with a diagnosis of low back pain without claims based on evidence of antecedent conservative therapy. Studies are limited to the outpatient place of service.

Detailed specifications for the measures, including measure implementation information, can be found via the following link:

<http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228695266120>

Measure Information Form

Measure Set: Imaging Efficiency Measures

Set Measure ID #: OP-9

Performance Measure Name: Mammography Follow-up Rates

Description: This measure calculates the percentage of patients with mammography screening studies that are followed by a diagnostic mammography or ultrasound of the breast study in an outpatient or office setting. An abnormally high rate of “call-backs” from indeterminate screening studies may be an indication of the inability of the reader to adequately determine when additional imaging is necessary (high false positive rate). This points to the experience and confidence of the interpreting physician and indicates both quality and efficiency, although a recent survey of 1,570 women concluded that “a substantial fraction of women in this study would have preferred the inconvenience of and anxiety associated with a higher recall rate if it resulted in the possibility of detecting breast cancer earlier.” Recall rates with follow-up “diagnostic” mammography studies greater than 10 to 14 percent are generally felt to be unusual unless explained by the morbidity of the underlying population.

Detailed specifications for the measures, including measure implementation information, can be found via the following link:

<http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228695266120>

Measure Information Form

Measure Set: Imaging Efficiency Measures

Set Measure ID #: OP-10

Performance Measure Name: Abdomen CT - Use of Contrast Material

Description: This measure calculates the percentage of abdomen studies that are performed with and without contrast out of all abdomen studies performed (those with contrast, those without contrast, and those with both). Current literature clearly defines indications for the use of combined studies, that is, examinations performed without contrast followed by contrast enhancement. The intent of this measure is to assess questionable utilization of contrast agents that carry an element of risk and significantly increase examination cost. While there may be a direct financial benefit to the service provider for the use of contrast agents due to increased reimbursements for “combined” studies, this proposed measure is directed at the identification of those providers who typically employ interdepartmental/facility protocols that call for its use in nearly all cases. The mistaken concept is that more information is always better than not enough.

Detailed specifications for the measure, including measure implementation information, can be found via the following link:

<http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=OnetPublic%2FPage%2FOnetTier2&cid=1228695266120>

Measure Information Form

Measure Set: Imaging Efficiency Measures

Set Measure ID #: OP-11

Performance Measure Name: Thorax CT - Use of Contrast Material

Description: This measure calculates the percentage of thorax studies that are performed with and without contrast out of all thorax studies performed (those with contrast, those without contrast, and those with both). Current literature clearly defines indications for the use of combined studies, that is, examinations performed without contrast followed by contrast enhancement. The intent of this measure is to assess questionable utilization of contrast agents that carry an element of risk and significantly increase examination cost. While there may be a direct financial benefit to the service provider for the use of contrast agents due to increased reimbursements for “combined” studies, this proposed measure is directed at the identification of those providers who typically employ interdepartmental/facility protocols that call for its use in nearly all cases. The mistaken concept is that more information is always better than not enough. The focus of this measure is one of the specific body parts where the indications for contrast material are more specifically defined.

Detailed specifications for the measures, including measure implementation information, can be found via the following link:

<http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=OnetPublic%2FPage%2FQnetTier2&cid=1228695266120>

Data Dictionary

Introduction

This section of the manual describes the data elements required to calculate category assignments and measurements for the hospital outpatient measures. It includes information necessary for defining and formatting the data elements, as well as the allowable values for each data element. This information is intended to assist in processing patient level data elements for hospital outpatient measures.

It is of primary importance that all hospitals using hospital outpatient measures gather and utilize the data elements as defined in this section. This will ensure that the data are standardized and comparable across hospitals.

Regardless of which measures are selected by a hospital, certain general data elements must be collected and submitted for **every** patient that falls into **any** of the selected outpatient populations. These data elements are considered “general” to each outpatient encounter.

These data elements include:

- *Arrival Time*
- *Birthdate*
- *CMS Certification Number*^{1,2}
- *Hispanic Ethnicity*
- *National Provider Identifier*^{1,2}
- *Outpatient Encounter Date*
- *Patient HIC#*³
- *Patient Identifier*
- *Payment Source*
- *Postal Code*
- *Race*
- *Sex*

¹Transmission Data Element

²Defined in the Transmission Data Element List within the Hospital Outpatient Quality Measure Data Transmission section of this manual.

³Collected by CMS for patients with a *Payment Source* of Medicare who have a standard HIC number

Interpretation of Data Dictionary Terms

Data elements fall into two broad categories in order to support specific measures. They include:

- *General Data Elements* – data elements that must be collected by hospitals for each patient record
 - o data elements required for each hospital outpatient encounter record submitted
 - o data elements used to identify the hospital on each patient record required for each patient-level record submitted
 - o patient demographic data required for each hospital outpatient encounter record submitted

- *Measure-Specific Data Elements* – data elements used by one specific measure or outpatient measure set, such as the surgery outpatient measure set

Data Dictionary Terms

Data Element Name:	A short phrase identifying the data element.
Collected For:	Identifies the measure(s) that utilize this data element or specifies that the data element is used for data transmission or verification.
Definition:	A detailed explanation of the data element.
Suggested Data Collection Question:	A suggested wording for a data element question in a data abstraction tool.
Format:	<p>Length = number of characters or digits allowed for the data element</p> <p>Type = type of information the data element contains (i.e., numeric, alphanumeric, date, decimal, or time)</p> <p>Occurs = the number of times the data element occurs in a single encounter record</p>
Allowable Values:	A list of acceptable responses for this data element.
Notes for Abstraction:	Provided to assist abstractors in the selection of an appropriate value for a data element.
Suggested Data Sources:	Source document from which data can be identified such as administrative or medical record. Some data elements also list excluded data sources that are unacceptable sources for collecting information.
Guidelines for Abstraction:	Designed to assist abstractors in determining how a data element should be answered.

General Abstraction Guidelines

The General Abstraction Guidelines are a resource designed to assist abstractors in determining how an abstraction question should be answered. The abstractor should first refer to the specific notes and guidelines under each data element as these instructions should take precedence over the following General Abstraction Guidelines. All of the allowable values for a given data element are outlined, and notes and guidelines are often included in each data element's notes and guidelines which provide the necessary direction for abstracting a data element. Thus, it is important to utilize the information found in the notes and guidelines when entering or selecting the most appropriate answer.

Medical Record Documentation

Documentation which is dated/timed after the end date of service should not be used unless it was added during the hospital's normal course of completing a medical record (e.g., diagnosis coding) per organization policy or within 30 days after ending date of service, whichever is sooner. (Refer to the Medicare Conditions of Participation for Medical Records, 42CFR482.24(c)(2)(viii).)

Important Note: Data element specific notes and guidelines always take precedence over the General Abstraction Guidelines.

All documentation in the medical record should be legible, **timed, dated, authenticated,** and complete. **Authentication may include written signatures, initials, computer key, and other codes. (Refer to the Medicare Conditions of Participation: Medical record services 42CFR482.24(c)(1).)** When abstracting a medical record, if a handwritten document is determined to be not legible, other documentation should be reviewed in an attempt to obtain the answer. If no other source document is available to verify the handwritten documentation, only then is the abstractor to answer "Unable to Determine" (UTD) from the medical record documentation, unless otherwise specified.

Data element information should be retrieved from the current medical record, covering the encounter date being abstracted. Information ascertainable from previous testing or previous history AND determined to be part of the current medical record may be used in abstraction. Previous testing or history information used in abstraction should be information that was part of the medical record during the encounter, when care was being delivered.

The medical record must be abstracted as documented (i.e., taken at "face value"). When the value documented is obviously in error (not a valid format/range or outside of the parameters for the data element) **and** no other documentation is found that provides this information, the abstractor should select "UTD."

Suggested Data Sources

- Suggested Data Sources are listed in alphabetical order, NOT priority order, unless otherwise specified. Suggested Data Sources are designed to provide guidance to the abstractor as to the locations/sources where the information needed to abstract a data element will likely be found. However, the abstractor is not limited to these sources for abstracting the information and is encouraged to review the entire medical record.

- In some instances, a data element may restrict the sources that may be used to gain the information. If so, these sources will be identified and labeled as “Excluded Data Sources.”
- In the course of abstraction, if conflicting information is found in a source other than the suggested data sources, and use of this source is not restricted, consider using this information if it more accurately answers the question, unless otherwise specified.
- If, after due diligence, the abstractor determines that a value is not documented or is not able to determine the answer value, the abstractor must select “UTD” as the answer.
- Hospitals often label forms and reports with unique names or titles. Suggested Data Sources are listed by commonly used titles; however, information may be abstracted from any source that is equivalent to those listed.

Inclusions/Exclusions

- Inclusions are “acceptable terms” that should be abstracted as *positive findings* (e.g., “Yes”).
- Inclusion lists are limited to those terms that are believed to be most commonly used in medical record documentation. **The list of inclusions should not be considered all-inclusive, unless otherwise specified in the data element.**
- Exclusions are “unacceptable terms” that should be abstracted as *negative findings* (e.g., “No”).
- Exclusion lists are limited to those terms an abstractor may most frequently question whether or not to abstract as a positive finding for a particular element. **The list of exclusions should not be considered all-inclusive, unless otherwise specified in the data element.**
- When both an inclusion and exclusion are documented in a medical record, the inclusion takes precedence over the exclusion and would be abstracted as a positive finding (e.g., answer “Yes”), unless otherwise specified.

Physician/Advanced Practice Nurse/ Physician Assistant Documentation

- Advanced Practice Nurse (APN, APRN) titles may vary between state and clinical specialties. Some common titles that represent the advanced practice nurse role are:
 - o Nurse Practitioner (NP)
 - o Certified Registered Nurse Anesthetist (CRNA)
 - o Clinical Nurse Specialist (CNS)
 - o Certified Nurse Midwife (CNM)
- When a physician/advanced practice nurse/ physician assistant (physician/APN/PA) signs a form or report (e.g., ED sheet with triage and nursing information and a physician/APN/PA has signed somewhere on the form), information on that form/report should be considered physician/APN/PA documentation. **“Rubber” stamped physician/APN/PA signatures are not acceptable on any document within the medical record. Handwritten, electronic signatures or facsimiles of original written or electronic signatures are acceptable.**
- Resident and intern notes should be considered physician documentation. Medical student notes must be co-signed by a physician.

Pharmacist Documentation

Pharmacist titles may vary. Some common titles that represent the pharmacist role are:

- Doctor of Pharmacy (Pharm.D. or D.Ph.)
- Registered Pharmacist (R.Ph.)

Medications

- The approved medication tables contained in Appendix C may not be inclusive lists of all available therapeutic agents acceptable for a particular data element. Discrepancies must be reported.
- Whether or not a medication has been administered to a patient is often clear when using medical record sources such as medication administration records, but documentation can be more ambiguous in other sources, namely, physician orders, ED records, and ambulance records. To make a determination using these sources, use the following criteria:
 - For electronic health records (EHRs) only accept documentation that reflects the actual administration of the medication in the context of the chart.
 - If a medication in the physician orders has been initialed and signed off with a time, do NOT presume that the medication was administered. The documentation MUST indicate that the medication was actually given.
 - For an ED or ambulance record, there is no need for documentation indicating that the medication was actually given.
Example: If the ED or ambulance record reflects “ASA 325mg po 13:00” and no other documentation exists indicating that the medication was actually given (e.g., “given” or “administered”), this is acceptable documentation to abstract.

Diagnostic/Laboratory Tests

Whether or not a diagnostic or laboratory test has been done is usually clear when using medical record sources such as diagnostic test reports, laboratory reports, or progress notes (where a physician might note test findings), but documentation can be more ambiguous in other sources, namely, physician orders and ED records. To make a determination using these sources, use the following criteria:

- If a test in the physician orders has been initialed and signed off with a time, do NOT presume that the test was done. The documentation MUST indicate that the test was actually done (e.g., accompanied by a word such as “done”).
- For an ED record, there is no need for explicit documentation indicating that the test was actually done. For example, if an ED record notes “Lipid profile,” and this is followed by a signature and/or a time, the abstractor should presume the test was performed.

Grids

Instructions for reading values recorded on grids: Measure from the midpoint of the symbol, number, or letter. If the value falls between two lines on the grid, abstract the first occurring value.

Abstraction Recommendations for Multiple Same-Day Encounters

- If two ED visits on the same day are rolled into one claim, abstract the **first** chronological encounter that meets the inclusion criteria for the population.
- If two ED visits on the same encounter date meet the inclusion criteria and are billed as two separate claims, **both** cases may be eligible for abstraction according to sampling requirements. Because the data element *Arrival Time* is used to differentiate between two cases that occur on the same encounter date, if both cases are submitted with “UTD” for *Arrival Time*, the case submitted last will override the previous case.

- If two surgical procedures meeting the inclusion criteria (CPT[®] code on Table 6.0) are performed during the same encounter but during separate OR times, abstract the surgery performed **first** chronologically.
- If two surgical procedures meeting the inclusion criteria are performed on the same encounter date but two separate claims are submitted, **both** cases may be eligible for abstraction according to sampling requirements. Because the data element *Arrival Time* is used to differentiate between two cases that occur on the same encounter date, if both cases are submitted with “UTD” for *Arrival Time*, the case submitted last will override the previous case.
- If a single case meets the inclusion criteria for both a surgical measure and an ED measure, the case may be abstracted for **both** measure sets.

Alphabetical Data Element List

Element Name	Page #	Collected For:
<i>Antibiotic</i>	5	OP-6, OP-7
<i>Antibiotic Allergy</i>	7	OP-7
<i>Antibiotic Name</i>	9	OP-6, OP-7
<i>Antibiotic Route</i>	11	OP-6, OP-7
<i>Antibiotic Timing</i>	13	OP-6
<i>Arrival Time</i>	15	All Records
<i>Aspirin Received</i>	17	OP-4
<i>Birthdate</i>	19	All Records
<i>Case Canceled</i>	20	OP-6, OP-7
<i>Clinical Trial</i>	21	OP-6, OP-7
<i>CPT® Code</i>	23	OP-6, OP-7
<i>CPT® Code Date</i>	24	OP-6, OP-7
<i>Discharge Date and Time</i>	25	OP-3
<i>Discharge Status</i>	27	OP-1, OP-2, OP-3, OP-4, OP-5
<i>E/M Code</i>	30	OP-1, OP-2, OP-3, OP-4, OP-5
<i>ECG</i>	31	OP-5
<i>ECG Date and Time</i>	32	OP-5
<i>Fibrinolytic Administration</i>	34	OP-1, OP-2, OP-3
<i>Fibrinolytic Administration Date and Time</i>	35	OP-1, OP-2
<i>First Name</i>	37	All Records
<i>Hispanic Ethnicity</i>	38	All Records
<i>ICD-9-CM Other Diagnosis Codes</i>	39	OP-4, OP-5
<i>ICD-9-CM Principal Diagnosis Code</i>	40	OP-1, OP-2, OP-3, OP-4, OP-5
<i>Infection Prior to Anesthesia</i>	41	OP-6 OP-7
<i>Initial ECG Interpretation</i>	43	OP-1, OP-2, OP-3
<i>Last Name</i>	47	All Records
<i>Outpatient Encounter Date</i>	48	All Records
<i>Patient HIC#</i>	49	Collected by CMS for patients with a <i>Payment Source</i> of Medicare who have a standard HIC number
<i>Patient Identifier</i>	51	All Records
<i>Payment Source</i>	52	All Records
<i>Physician 1</i>	53	Optional for All Records
<i>Physician 2</i>	54	Optional for All Records
<i>Postal Code</i>	55	All Records
<i>Probable Cardiac Chest Pain</i>	56	OP-4, OP-5
<i>Race</i>	58	All Records
<i>Reason for Delay in Fibrinolytic Therapy</i>	60	OP-1, OP-2
<i>Reason for No Aspirin on Arrival</i>	63	OP-4

Element Name	Page #	Collected For:
<i>Reason for Not Administering Fibrinolytic Therapy</i>	65	OP-3
Replacement	67	OP-6, OP-7
<i>Sex</i>	68	All Records
<i>Transfer for Acute Coronary Intervention</i>	69	OP-3
<i>Vancomycin</i>	71	OP-7

Data Element Name:	<i>Antibiotic</i>
Collected For:	OP-6, OP-7
Definition:	Documentation that the patient received antibiotics during this outpatient encounter. An antibiotic may be defined as any drug, such as penicillin or streptomycin, containing any quantity of any chemical substance produced by a microorganism or made synthetically (e.g., quinolones) which has the capacity to inhibit the growth of or destroy bacteria and other microorganisms. Antibiotics are used in the prevention and treatment of infectious diseases.
Suggested Data Collection Question:	Did the patient receive an antibiotic during this outpatient encounter?
Format:	Length: 1 Type: Alphanumeric Occurs: 1
Allowable Values:	Y (Yes) Antibiotic received during this outpatient encounter. N (No) No antibiotics received during this outpatient encounter or unable to determine from medical record documentation.
Notes for Abstraction:	<ul style="list-style-type: none"> • Only consider antibiotics listed in Appendix C, OP Table 6.0. Do not consider any medications other than antibiotics (i.e., antivirals, antifungals, antituberculin, antiprotozoans, etc.). • Consider antibiotics initiated via an appropriate route (PO, IV or UTD) to answer this data element. • Either a signature or initials signifying administration of the antibiotic is required to abstract that antibiotics were given. • Antibiotic initiation information should be abstracted from a single source that demonstrates actual administration of the specific antibiotic. If the antibiotic name and route are not contained in a single source for that specific antibiotic, utilize “UTD” for the missing information. • <u>For urologic and pubovaginal sling procedures only:</u> <ul style="list-style-type: none"> • If there is documentation that an oral antibiotic was taken prior to arrival for surgical prophylaxis, enter this antibiotic name and route as an antibiotic that was taken during the outpatient encounter. • If there is documentation of instructions for “oral antibiotics” to be taken at home OR documentation of instructions or prescriptions given to the patient in

regard to oral antibiotics, assume the antibiotics were taken and collect them as given during the outpatient encounter.

- If the oral antibiotic is listed on the medication reconciliation list or the patient’s list of home medications, but there is documentation that the antibiotic is NOT a routine medication, collect this antibiotic as given during the outpatient encounter.

Suggested Data Sources:

- Outpatient record

Guidelines for Abstraction:

Inclusion	Exclusion
<p>Include any antibiotics given:</p> <p>Intravenous:</p> <ul style="list-style-type: none"> • Bolus • Infusion • IV • I.V. • IVPB • IV piggyback • Parenteral <p>PO/NG/PEG tube:</p> <ul style="list-style-type: none"> • Any kind of feeding tube (e.g., percutaneous endoscopic gastrostomy, percutaneous endoscopic jejunostomy, gastrostomy tube) • By mouth • Gastric tube • G-tube • Jejunostomy • J-tube • Nasogastric tube (NG tube) • PO • P.O. <p>Refer to Appendix C, OP Table 6.0, Antimicrobial Medications.</p>	<ul style="list-style-type: none"> • Abdominal irrigation • Chest irrigation • Eardrops • Enema/rectally • Eyedrops • I.M. • IM • Inhalation • Injected • Intramuscular • Joint irrigation • Mouthwash • Nasal sprays • PB • Peritoneal dialysate (antibiotic added) • Peritoneal irrigation • Piggyback (without “IV”) • Swish and spit • Swish and swallow (S/S) • Topical antibiotics • Troches • Vaginal administration • Wound irrigation

Data Element Name:	<i>Antibiotic Allergy</i>						
Collected For:	OP-7						
Definition:	Documentation that the patient has an allergy, sensitivity, or intolerance to penicillin, beta-lactams, or cephalosporins. An allergy can be defined as an acquired, abnormal immune response to a substance (allergen) that does not normally cause a reaction.						
Suggested Data Collection Question:	Did the patient have any allergies, sensitivities or intolerance to beta-lactam/penicillin antibiotic or cephalosporin medications?						
Format:	<table border="0"> <tr> <td>Length:</td> <td>1</td> </tr> <tr> <td>Type:</td> <td>Alphanumeric</td> </tr> <tr> <td>Occurs:</td> <td>1</td> </tr> </table>	Length:	1	Type:	Alphanumeric	Occurs:	1
Length:	1						
Type:	Alphanumeric						
Occurs:	1						
Allowable Values:	<p>Y (Yes) Documentation that the patient has an antibiotic allergy to beta-lactam, penicillin, or cephalosporins (e.g., either history or current finding).</p> <p>N (No) No documentation that the patient had an allergy to beta-lactam, penicillin, or cephalosporins or unable to determine from medical record documentation.</p>						
Notes for Abstraction:	<ul style="list-style-type: none"> • If the patient was noted to be allergic to “cillins,” “penicillin,” or “all cillins,” select “Yes.” • If one source in the record documents “Allergies: penicillin” and another source in the record documents “penicillin causes upset stomach,” select “Yes.” • If a physician/advanced practice nurse/physician assistant (physician/APN/PA) or pharmacist documents a specific reason not to give penicillin, beta-lactams, or cephalosporins, select “Yes.” 						
Suggested Data Sources:	<ul style="list-style-type: none"> • Outpatient record 						

Guidelines for Abstraction:

Inclusion	Exclusion
Symptoms include: <ul style="list-style-type: none">• Adverse drug event• Adverse effect• Adverse reaction• Anaphylaxis• Anaphylactic reaction• Hives• Rash Refer to Appendix C, OP Table 6.1, Antibiotic Allergy.	None

Data Element Name:	<i>Antibiotic Name</i>
Collected For:	OP-6, OP-7
Definition:	The name of the antibiotic(s). An antibiotic may be defined as any drug, such as penicillin or streptomycin, containing any quantity of any chemical substance produced by a microorganism or made synthetically (i.e., quinolones) which has the capacity to inhibit the growth of or destroy bacteria and other microorganisms. Antibiotics are used in the prevention and treatment of infectious diseases.
Suggested Data Collection Question:	What is the name of the antibiotic(s)?
Format:	Length: 244 Type: Alphanumeric Occurs: 20
Allowable Values:	Name of any antibiotic - see Appendix C, OP Table 6.0
Notes for Abstraction:	<ul style="list-style-type: none"> • For EACH <i>Antibiotic Name</i>, enter an <i>Antibiotic Route</i>. • Collect only antibiotics initiated via an appropriate route (PO and IV or UTD) to answer this question. • Antibiotic initiation information should be abstracted from a single source that demonstrates actual administration of the specific antibiotic. If the antibiotic name and route are not contained in a single source for that specific antibiotic, utilize “UTD” for the missing information. • Collect the name of the antibiotics initiated (started) during this outpatient encounter. • <u>For urologic and pubovaginal sling procedures only:</u> <ul style="list-style-type: none"> • If there is documentation that an oral antibiotic was taken prior to arrival for surgical prophylaxis, enter this antibiotic name and route as an antibiotic that was taken during the outpatient encounter. • If there is documentation of instructions for “oral antibiotics” to be taken at home OR documentation of instructions or prescriptions given to the patient in regard to oral antibiotics, assume the antibiotics were taken and collect them as given during the outpatient encounter. • If the oral antibiotic is listed on the medication reconciliation list or the patient’s list of home medications, but there is documentation that the antibiotic is NOT a routine medication, collect this antibiotic as given during the outpatient encounter. • Only use “Antibiotic NOS” in the following situations:

- For new antibiotics that are not yet listed in Appendix C, OP Table 6.0.
- When there is documentation an antibiotic was initiated (started) but unable to identify the name. It must be apparent that the medication is an antibiotic.

Example:

- On 2-12-07, the medical record contains the documentation “Antibiotic started *name illegible*, 2gm, IV, 0200-WJ.” In the antibiotic grid, “Antibiotic NOS” would be entered for the name and IV for the route (If “Antibiotic started” had not been documented in this example, the medication could not be abstracted as an antibiotic initiated).
- If an antibiotic name is misspelled or abbreviated in the medical record and it can be determined from supporting documentation which medication was administered, that medication may be abstracted for *Antibiotic Name*.
- A specific antibiotic is defined as having a single generic name and being administered via a single appropriate route (if trade names are used, a crosswalk is provided in Appendix C, OP Table 6.0). If the route of administration of an antibiotic changes during the encounter, record the antibiotic name once for each route by which it was administered.
- Either a signature or initials signifying administration of the medication is required to abstract a specific antibiotic name.

Suggested Data Sources:

- Outpatient record

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendix C, OP Table 6.0, Antimicrobial Medications.	None

Data Element Name: *Antibiotic Route*

Collected For: OP-6, OP-7

Definition: Method of administration of a dose of medication. Medications may be administered in a variety of ways depending upon how they are supplied and prescribed. Methods of administration are listed below as allowable values.

Suggested Data Collection Question: What was the route of administration for the antibiotic dose?

Format:

Length	1
Type:	Alphanumeric
Occurs:	20

Allowable Values:

- 1 PO/NG/PEG tube (Oral)
- 2 IV (Intravenous)
- 3 UTD

Notes for Abstraction:

- Collect only antibiotics administered via an appropriate route (**PO and IV or UTD**) to answer this question.
- For EACH *Antibiotic Name*, enter an *Antibiotic Route*.
- Either a signature or initials signifying administration of the medication is required to abstract a specific antibiotic name and route.
- A specific antibiotic is defined as having a single generic name and being administered via a single appropriate route (if trade names are used, a crosswalk is provided in Appendix C, OP Table 6.0). If the route of administration of an antibiotic changes during the encounter, record the antibiotic name once for each route by which it was administered.
- Antibiotic initiation information should be abstracted from a single source that demonstrates actual administration of the specific antibiotic. If the antibiotic name and route are not contained in a single data source for that specific antibiotic, utilize “UTD” for the missing information.

Suggested Data Source: • Outpatient record

Guidelines for Abstraction:

Inclusion	Exclusion
<p>Include any antibiotics given:</p> <p>Intravenous:</p> <ul style="list-style-type: none"> • Bolus • Infusion • IV • I.V. • IVPB • IV piggyback • Parenteral • Perfusion <p>PO/NG/PEG tube:</p> <ul style="list-style-type: none"> • Any kind of feeding tube (e.g., percutaneous endoscopic gastrostomy, percutaneous endoscopic jejunostomy, gastrostomy tube) • By mouth Gastric tube • G-tube • Jejunostomy • J-tube • Nasogastric tube (NG tube) • PO • P.O. <p>Refer to Appendix C, OP Table 6.0, Antimicrobial Medications.</p>	<ul style="list-style-type: none"> • Abdominal irrigation • Chest irrigation • Eardrops • Enema/rectally • Eyedrops • IM • I.M. • Inhalation • Injected • Intracoronary • Intramuscular • Joint irrigation • Mixed in cement • Mouthwash • Nasal sprays • PB • Peritoneal dialysate (antibiotic added to) • Peritoneal irrigation • Piggyback (without “IV”) • Swish and spit • Swish and swallow (S/S) • Topical antibiotics • Troches • Vaginal administration • Wound irrigation

Data Element Name:	<i>Antibiotic Timing</i>	
Collected For:	OP-6	
Definition:	Documentation that an antibiotic was initiated (started) within 60 minutes (120 minutes for Vancomycin or Quinolones) prior to surgical incision.	
Suggested Data Collection Question:	Was an antibiotic initiated (started) within 60 minutes (120 minutes for Vancomycin or Quinolones) prior to surgical incision?	
Format:	Length:	1
	Type:	Alphanumeric
	Occurs:	1
Allowable Values:	Y (Yes)	An antibiotic was initiated (started) within 60 minutes (120 minutes for Vancomycin or Quinolones) prior to surgical incision.
	N (No)	An antibiotic was not initiated (started) within 60 minutes (120 minutes for Vancomycin or Quinolones) prior to surgical incision or unable to be determined from medical record documentation.

- Notes for Abstraction:**
- This data element applies to the antibiotics administered via the **intravenous** route only. Do NOT consider antibiotics that are given orally for this data element. For a list of acceptable intravenous inclusions, refer to the data element *Antibiotic Route*.
 - Antibiotic initiation information should be abstracted from a single source that demonstrates actual administration of the specific antibiotic.
 - If the route for the antibiotic(s) given within the 60 minutes (120 minutes for vancomycin and quinolones) prior to incision is unable to be determined, answer “No.”
 - If more than one procedure from OP Table 6.0 was performed during the same surgical episode, the incision time will be the incision that occurs first. If no incision time is documented, use the priority list of synonyms.
 - If an incision time is not documented in the hospital outpatient record, follow the priority order list of synonyms. If multiple times are found, use the earliest time among the highest priority of synonyms.
- First priority:** Incision Time
Second priority: Surgery start/begin time or tourniquet time
Third priority: Anesthesia time

- If two procedures were performed during the same surgical episode but the first procedure performed is not on OP Table 6.0, the incision time OR surgery start time of the first procedure should be used to determine whether the IV antibiotic was started within 60 minutes (120 minutes for Vancomycin or Quinolones) of incision.
- The use of “hang time” or “infusion time” is acceptable as antibiotic administration time when other documentation cannot be found.

Suggested Data Sources: • Outpatient record

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendix C, OP Table 6.0, Antimicrobial Medications.	None
Refer to Appendix C, OP Table 6.11, Quinolones.	
Refer to Appendix C, OP Table 6.12, Vancomycin.	

Data Element Name: *Arrival Time*

Collected For: All Records (used in algorithm for OP-1, OP-2, OP-3, OP-5)

Definition: The earliest documented time (military time) the patient arrived at the outpatient or emergency department.

Suggested Data Collection Question: What was the **earliest** documented time the patient arrived at the outpatient or emergency department?

Format: **Length:** 5 - HH:MM (with or without colon) or UTD
Type: Time
Occurs: 1

Allowable Values: Enter the earliest documented time of arrival
 HH = Hour (00-23)
 MM = Minutes (00-59)

UTD = Unable to Determine

Time must be recorded in military time format.
 With the exception of Midnight and Noon:

- If the time is in the a.m., conversion is not required.
- If the time is in the p.m., add 12 to the clock time hour.

Examples:

Midnight - 00:00	Noon - 12:00
5:31 am - 05:31	5:31 pm - 17:31
11:59 am - 11:59	11:59 pm - 23:59

For times that include “seconds,” remove the seconds and record the military time.

Example: 15:00:35 would be recorded as 15:00

Note:

Transmission of a case with an invalid time will be rejected from the OPDS Clinical Warehouse. Use of “UTD” for *Arrival Time* allows the case to be accepted into the warehouse, but should only be used when all efforts to locate or determine an *Arrival Time* have been exhausted.

Notes for Abstraction:

- If the time of the outpatient or emergency department arrival is unable to be determined from medical record documentation, enter UTD.
- The medical record must be abstracted as documented (taken at “face value”). When the time documented is obviously in error (not a valid time) **and** no other documentation is found

that provides this information, the abstractor should select “UTD.”

Example:

- o Documentation indicates that the arrival time was 3300. No other documentation in the medical record provides a valid time. Since the arrival time is outside of the range listed in the Allowable Values for “Hour,” it is not a valid time and the abstractor should select “UTD.”
- When reviewing records for arrival time do NOT include any documentation from external sources (e.g., ambulance records, physician/advanced practice nurse/physician assistant [physician/APN/PA] office record, laboratory reports, or ECGs) obtained prior to arrival. The intent is to utilize any documentation which reflects processes that occurred after arrival.

NOTE: Medical record documentation should be carefully examined in determining the most correct time of the outpatient or emergency department arrival. The arrival time should NOT be abstracted simply as the earliest time in the acceptable sources, without regard to other (i.e., ancillary services) substantiating documentation. If documentation suggests that the earliest time in the acceptable sources does not reflect the time the patient arrived at the outpatient or emergency department, this time should not be used.

Suggested Data Sources:

- Emergency Department record
- Outpatient record

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	<i>Aspirin Received</i>
Collected For:	OP-4
Definition:	Aspirin received within 24 hours before emergency department arrival or administered prior to transfer. Aspirin reduces the tendency of blood to clot by blocking the action of a type of blood cell involved in clotting. Aspirin improves the chances of surviving a heart attack and reduces the risk of recurrence in patients who have experienced a heart attack.
Suggested Data Collection Question:	Was aspirin received within 24 hours before emergency department arrival or administered prior to transfer?
Format:	Length: 1 Type: Alphanumeric Occurs: 1
Allowable Values:	Y (Yes) Aspirin was received within 24 hours before emergency department arrival or administered prior to transfer. N (No) Aspirin was not received within 24 hours before emergency department arrival or administered prior to transfer or unable to determine from medical record documentation.
Notes for Abstraction:	<ul style="list-style-type: none"> When unable to determine for certain whether aspirin was received within 24 hours prior to emergency department arrival (e.g., last dose noted as 02-27-2008 and patient arrived at emergency department on 02-28-2008 at 09:00), select "No." Exceptions: <ul style="list-style-type: none"> When aspirin is listed only as a "home" or "current" medication, and the exact timing of the last dose the patient took is not noted, infer that the patient took aspirin within the 24-hour timeframe, unless documentation suggests otherwise. When aspirin is noted only as received prior to emergency department arrival (e.g., in an ambulance or physician office), without information about the exact time it was received (e.g., "Baby ASA X 4" per the "Treatment Prior to Arrival" section of the Triage Assessment), infer that the patient took aspirin within the 24 hour timeframe, unless documentation suggests otherwise.
Suggested Data Sources:	<ul style="list-style-type: none"> Ambulance record Emergency Department record

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendix C, OP Table 1.1, Aspirin and Aspirin-Containing Medications.	None

Data Element Name: *Birthdate*

Collected For: All Records

Definition: The month, day, and year the patient was born.

NOTE: Patient Age on Outpatient Encounter Date (in years) is calculated by *Outpatient Encounter Date* minus *Birthdate*. The algorithm to calculate age must use the month and day portion of encounter date and birthdate to yield the most accurate age.

Suggested Data Collection Question: What is the patient's date of birth?

Format: **Length:** 10 – MM-DD-YYYY (includes dashes)
 Type: Date
 Occurs: 1

Allowable Values: MM= Month (01-12)
 DD= Day (01-31)
 YYYY = Year (1880-9999)

Notes for Abstraction: Because this data element is critical in determining the population for all measures, the abstractor should NOT assume that the claim information for the birthdate is correct. If the abstractor determines through chart review that the date is incorrect, correct and override the downloaded value. If the abstractor is unable to determine the correct birthdate through chart review, default to the date of birth on the claim information.

Suggested Data Sources:

- Outpatient record
- Emergency Department record

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Case Canceled*

Collected For: OP-6, OP-7

Definition: Documentation that the case was canceled prior to incision.

Suggested Data Collection Question: Was the case canceled prior to incision?

Format: **Length:** 1
 Type: Alphanumeric
 Occurs: 1

Allowable Values: Y (Yes) There is documentation that the case was canceled prior to incision.

 N (No) There is no documentation that the case was canceled prior to incision or unable to determine from medical record documentation.

Notes for Abstraction:

- If the case was canceled **after** incision, select “No.”
- If the abstractor is unable to determine from medical record documentation whether the case was canceled prior to incision, select “No.”

Suggested Data Sources:

- Outpatient record

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Clinical Trial*

Collected For: OP-6, OP-7

Definition: Documentation the patient was enrolled in a clinical trial during this outpatient encounter, relevant to the measure for this encounter. Clinical trials are organized studies to provide large bodies of clinical data for statistically valid evaluation or treatment. These studies are usually rigorously controlled tests of new drugs, invasive medical devices, or therapies on human subjects.

Suggested Data Collection Question: Was the patient enrolled in a clinical trial during this outpatient encounter relevant to the measure?

Format:

Length: 1

Type: Alphanumeric

Occurs: 1

Allowable Values:

Y (Yes) There is documentation at the time of this outpatient encounter that the patient was enrolled in a clinical trial relevant to the measure.

N (No) There is no documentation at the time of this outpatient encounter that the patient was enrolled in a clinical trial relevant to the measure, or unable to determine from medical record documentation.

Notes for Abstraction:

- This data element is used to exclude patients that are enrolled in a clinical trial at the time of this outpatient encounter relevant to the measure.
- If the patient was previously enrolled in a hospital outpatient clinical trial and has continued to take the medication for the trial, as documented on the trial protocol, select “Yes” only if documented during this encounter.
- If the patient was newly enrolled in a clinical trial during the encounter, select “Yes.”
- If it is not clear which study population that the clinical trial is enrolling, select “No.” Assumptions should not be made if it is not specified.
- Consider the patient enrolled in a clinical trial at the time of this encounter if documentation indicates:
 - Only capture patients enrolled in a trial of alternate types and routes of prophylactic antibiotics for surgical patients.

Suggested Data Sources: **Documentation from this Outpatient Encounter only:**

- Outpatient record

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: CPT[®] Code

Collected For: OP-6, OP-7

Definition: The Current Procedural Terminology (CPT[®]) code associated with this outpatient encounter.

Suggested Data Collection Question: What was the CPT[®] code selected for this outpatient encounter?

Format: **Length:** 5
 Type: Alphanumeric
 Occurs: 1

Allowable Values: Select the CPT[®] Code from Appendix A, OP Table 6.0.

Notes for Abstraction:

- If more than one procedure from OP Table 6.0 was performed during this encounter, select the procedure performed first chronologically.

Suggested Data Sources:

- Outpatient record

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendix A, OP Table 6.0.	None

Data Element Name: *Discharge Date and Time*

Collected For: OP-3

Definition: The month, day, year and the exact time (military time) represented in hours and minutes at which the patient was discharged from the emergency department.

Suggested Data Collection Question: What is the date and time the patient was discharged from the emergency department?

Format: **Length:** 16 – MM-DD-YYYY (includes dashes) and HH:MM (with or without colon) or UTD
Type: Date/Time
Occurs: 1

Allowable Values: MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (2000-9999)

HH = Hour (00-23)
MM = Minutes (00-59)

UTD = Unable to Determine

Time must be recorded in military time format.

With the exception of Midnight and Noon:

- If the time is in the a.m., conversion is not required.
- If the time is in the p.m., add 12 to the clock time hour.

Examples:

Midnight - 00:00

Noon - 12:00

5:31 am - 05:31

5:31 pm - 17:31

11:59 am - 11:59

11:59 pm - 23:59

Note:

00:00 = midnight. If the time is documented as 00:00 11-24-20XX, review supporting documentation to determine if the Discharge Date should remain 11-24-20XX or if it should be converted to 11-25-20XX.

When converting Midnight or 24:00 to 00:00 do not forget to change the Discharge Date.

Example: Midnight or 24:00 on 11-24-20XX = 00:00 on 11-25-20XX

Note:

Transmission of a case with an invalid date will be rejected from the OPPS Clinical Warehouse. Use of “UTD” for *Discharge Date and Time* allows the case to be accepted into the warehouse.

Notes for Abstraction:

Because this data element is critical in determining the population for the measure, the abstractor should NOT assume that the claim information for the discharge date and/or time is correct. If the abstractor determines through chart review that the date and/or time is incorrect, correct and override the downloaded value. If the abstractor is unable to determine the correct discharge date and/or time through chart review, default to the discharge date and/or time on the claim information or select UTD.

- For times that include “seconds”, remove the seconds and record the military time.

Example:

15:00:35 would be recorded as 15:00

- Discharge time is the time the patient **physically left the facility** (e.g., nurses notes state “1800 transfer of care to mediflight team” and other documentation includes a time that the patient left the ED to be loaded in the helicopter, abstract the later time).
- If the date and/or the time the patient was discharged is unable to be determined from medical record documentation, enter UTD.
- When more than one discharge time is documented abstract the latest time.

Example:

- o Two discharge times are found in the nurses notes: 12:03 and 12:20. Select the later time of 12:20.

- If patient expired, use the time of death as the discharge time.
- Do not use the time the discharge order was written because it may not represent the actual time of discharge.
- If the date of discharge is not documented, but you are able to determine the date from other documentation this is acceptable (e.g., you are able to identify from documentation the patient arrived and was transferred on the same day).

Suggested Data Sources:

- Emergency Department record
- UB-04

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	<i>Discharge Status</i>
Collected For:	OP-1, OP-2, OP-3, OP-4, OP-5
Definition:	The place or setting to which the patient was discharged from the emergency department.
Suggested Data Collection Question:	What was the patient's discharge disposition from the emergency department?
Format:	Length: 2 Type: Alphanumeric Occurs: 1
Allowable Values:	<p>01 Discharged to home care or self care (routine discharge) <u>Usage Note:</u> Includes discharge to home; home on oxygen if DME only; any other DME only; group home, foster care, independent living and other residential care arrangements; outpatient programs, such as partial hospitalization or outpatient chemical dependency programs.</p> <p>02 Discharged/transferred to a short term general hospital for inpatient care (Acute Care Facility)</p> <p>03 Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care <u>Usage Note:</u> Medicare indicates that the patient is discharged/transferred to a Medicare certified nursing facility. For hospitals with an approved swing bed arrangement, use Code 61-Swing Bed. For reporting other discharges/transfers to nursing facilities, see 04 and 64.</p> <p>04 Discharged/transferred to a facility that provides custodial or supportive care <u>Usage Note:</u> Includes intermediate care facilities (ICFs) if specifically designated at the state level. Also used to designate patients that are discharged/transferred to a nursing facility with neither Medicare nor Medicaid certification and for discharges/transfers to Assisted Living Facilities.</p> <p>05 Discharged/transferred to a designate cancer center or children's hospital <u>Usage Note:</u> Transfers to non-designated cancer hospitals should use Code 02. A list of (National Cancer Institute) Designated Cancer Centers can be found at http://www3.cancer.gov/cancercenters/centerslist.html</p>

- 06 **Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care**
Usage Note: Report this code when the patient is discharged/transferred to home **with a written plan of care** (tailored to the patient's medical needs) **for home care services.**
- 07 **Left against medical advice or discontinued care**
- 09 **Admitted as an inpatient to this hospital**
Usage Note: For use only on Medicare outpatient claims. Applies only to those Medicare outpatient services that begin greater than three days prior to an admission.
- 20 **Expired**
- 21 **Discharged/transferred to court/law enforcement**
Usage Note: Includes transfers to incarceration facilities such as jail, prison, or other detention facilities.
- 41 **Expired in a medical facility (e.g., hospital, SNF, ICF or freestanding hospice)**
Usage Note: For use only on Medicare and TRICARE claims for hospice care.
- 43 **Discharged/transferred to a Federal health care facility**
Usage Note: Discharges and transfers to a government operated health care facility such as a Department of Defense hospital, a Veteran's Administration hospital or a Veteran's Administration nursing facility. To be used whenever the destination at discharge is a federal health care facility, whether the patient resides there or not.
- 50 **Hospice - home**
- 51 **Hospice - medical facility (certified) providing hospice level of care**
- 61 **Discharged/transferred to hospital-based Medicare approved swing bed**
Usage Note: Medicare-used for reporting patients discharged/transferred to a SNF level of care within the hospital's approved swing bed arrangement.
- 62 **Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital**

- 63 **Discharged/transferred to a Medicare certified long term care hospital (LTCH)**
Usage Note: For hospitals that meet the Medicare criteria for LTCH certification.
- 64 **Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare**
- 65 **Discharged/transferred to a psychiatric hospital or psychiatric distinct part of a hospital**
- 66 **Discharged/transferred to a Critical Access Hospital (CAH)**
- 70 **Discharged/transferred to another type of Health Care Institution not Defined Elsewhere in this Code List (see code 05)**

Note:

CMS is aware that there are additional UB-04 allowable values for this data element; however, they are not used for the hospital outpatient measures at this time.

Notes for Abstraction:

- The values for *Discharge Status* are taken from the National Uniform Billing Committee (NUBC) manual which is used by the billing/HIM to complete the UB-04.
- Because this data element is critical in determining the population for these measures, the abstractor should NOT assume that the UB-04 value is what is reflected in the medical record. For abstraction purposes, it is important that the medical record reflect the appropriate discharge status. If the abstractor determines through chart review that the claim information discharge status is not what is reflected in the medical record, correct and override the downloaded value.

Suggested Data Sources:

- Emergency Department record
- UB-04

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *E/M Code*

Collected For: OP-1, OP-2, OP-3, OP-4, OP-5

Definition: The code used to report evaluation and management services provided in the hospital outpatient department clinic or emergency department.

Suggested Data Collection Question: What was the E/M Code documented for this outpatient encounter?

Format: **Length:** 5
 Type: Alphanumeric
 Occurs: 1

Allowable Values: Select the E/M code from Appendix A, OP Table 1.0.

Suggested Data Sources: • Outpatient record

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendix A, OP Table 1.0, E/M Codes.	None

- Data Element Name:** ECG
- Collected For:** OP-5
- Definition:** Documentation a 12-lead electrocardiogram (ECG) was performed prior to emergency department arrival or in the ED prior to transfer.
- Suggested Data Collection Question:** Was an ECG performed within 1 hour before emergency department arrival or in the ED prior to transfer?
- Format:** **Length:** 1
Type: Alphanumeric
Occurs: 1
- Allowable Values:**
- Y (Yes) There was an ECG performed within 1 hour before emergency department arrival or in the ED prior to transfer.
- N (No) There was not an ECG performed within 1 hour before emergency department arrival or in the ED prior to transfer or unable to determine from medical record documentation.
- Notes for Abstraction:**
- If there is an ECG performed exactly one hour prior to arrival select “Yes.”
 - If there are multiple ECGs performed within one hour prior to emergency department arrival and/or in the ED prior to transfer, select “Yes.”
- Suggested Data Sources:**
- Ambulance record
 - Emergency Department record

Guidelines for Abstraction:

Inclusion	Exclusion
<ul style="list-style-type: none"> • ECGs performed in the ambulance (within one hour prior to arrival) 	None

Data Element Name: *ECG Date and Time*

Collected For: OP-5

Definition: The documented month, day, year and time (military time) of the earliest 12-lead electrocardiogram (ECG).

Suggested Data Collection Question: What was the documented date and time of the earliest ECG?

Format: **Length:** 16 – MM-DD-YYYY (includes dashes) and HH:MM (with or without colon) or UTD
Type: Date/Time
Occurs: 1

Allowable Values: Enter the documented date and time of the earliest ECG
MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (2000-9999)

HH = Hour (00-23)
MM = Minutes (00-59)

UTD = Unable to Determine

Time must be recorded in military time format.
With the exception of Midnight and Noon:

- If the time is in the a.m., conversion is not required.
- If the time is in the p.m., add 12 to the clock time hour.

Examples:

Midnight - 00:00	Noon - 12:00
5:31 am - 05:31	5:31 pm - 17:31
11:59 am - 11:59	11:59 pm - 23:59

Note:
00:00 = midnight. If the time is documented as 00:00 11-24-20XX, review supporting documentation to determine if the ECG Date should remain 11-24-20XX or if it should be converted to 11-25-20XX.

When converting Midnight or 24:00 to 00:00 do not forget to change the ECG Date.
Example: Midnight or 24:00 on 11-24-20XX = 00:00 on 11-25-20XX

For times that include “seconds”, remove the seconds and record the military time.

Example: 15:00:35 would be recorded as 15:00

Note:

Transmission of a case with an invalid date will be rejected from the OPPS Clinical Warehouse. Use of “UTD” for *ECG Date and Time* allows the case to be accepted into the warehouse.

Notes for Abstraction:

- **In the event the patient had an ECG performed within 60 minutes prior to arrival at the emergency department, enter the date and time the patient arrived at this emergency department.**
- If the date and/or time of the ECG is unable to be determined from medical record documentation, abstract UTD.
Exception: If there are multiple ECGs done and the earlier ECG(s) do not have a date or time, but subsequent ECG(s) do, the next available ECG Date and Time may be used.
- Only collect ECGs performed within 60 minutes prior to arrival or prior to transfer.
- Abstract the ECG performed closest to arrival.
- If there are 2 ECGs performed (one prior to arrival and one after arrival) abstract the ECG performed prior to arrival.
- If there are multiple times documented for the same ECG, use the printed ECG strip time.
 - If there are multiple ECG times documented and the earlier time can be verified to be invalid, the subsequent time may be used (e.g., ECG strip time indicates the ECG took place three hours prior to the patient arrival and nurses’ notes indicate a time the patient was at the facility, this time may be used).

Suggested Data Sources:

- Ambulance record
- Emergency Department record

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Fibrinolytic Administration*

Collected For: OP-1, OP-2, OP-3

Definition: Fibrinolytic therapy is the administration of a pharmacological agent intended to cause lysis of a thrombus (destruction or dissolution of a blood clot).

Suggested Data Collection Question: Did the patient receive fibrinolytic therapy at this emergency department?

Format: **Length:** 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes) Fibrinolytic therapy was initiated at this emergency department.

N (No) There is no documentation fibrinolytic therapy was initiated at this emergency department, or unable to determine from medical record documentation.

- Notes for Abstraction:**
- In the event the patient was brought to the hospital via ambulance and fibrinolytic therapy was infusing at the time of arrival, select “Yes.”
 - In the event the patient was brought to the emergency department via ambulance and fibrinolytic therapy was infused during transport **but was completed** at the time of emergency department arrival, select “No.”
 - If the first dose of reteplase (Retavase) is given in the ambulance and the second dose is given in the emergency department, select “Yes.”

Suggested Data Sources: • Emergency Department record

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendix C, OP Table 1.3, Fibrinolytic Agents.	None

Data Element Name: *Fibrinolytic Administration Date and Time*

Collected For: OP-1, OP-2

Definition: The month, day, year and time fibrinolytic therapy was initiated at this emergency department. Fibrinolytic therapy is the administration of a pharmacological agent intended to cause lysis of a thrombus (destruction or dissolution of a blood clot).

Suggested Data Collection Question: What was the date and time fibrinolytic therapy was initiated at this emergency department?

Format: **Length:** 16 - MM-DD-YYYY (includes dashes) and HH:MM (with or without colon) or UTD
Type: Date/Time
Occurs: 1

Allowable Values: Enter the earliest documented date and time of fibrinolytic therapy
MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (2000-9999)

HH = Hour (00-23)
MM = Minutes (00-59)

UTD = Unable to Determine

Time must be recorded in military time format.
With the exception of Midnight and Noon:

- If the time is in the a.m., conversion is not required.
- If the time is in the p.m., add 12 to the clock time hour.

Examples:

Midnight - 00:00	Noon - 12:00
5:31 am - 05:31	5:31 pm - 17:31
11:59 am - 11:59	11:59 pm - 23:59

Note:
00:00 = midnight. If the time is documented as 00:00 11-24-20XX, review supporting documentation to determine if the Fibrinolytic Administration Date should remain 11-24-20XX or if it should be converted to 11-25-20XX.

When converting Midnight or 24:00 to 00:00 do not forget to change the Fibrinolytic Administration Date.
Example: Midnight or 24:00 on 11-24-20XX = 00:00 on 11-25-20XX

For times that include “seconds,” remove the seconds and record the military time.

Example: 15:00:35 would be recorded as 15:00

Note:

Transmission of a case with an invalid date as described above will be rejected from the OPSS Clinical Warehouse. Use of “UTD” for *Fibrinolytic Administration Date and Time* allows the case to be accepted into the warehouse.

Notes for Abstraction:

- If the date and time fibrinolytic therapy was initiated is unable to be determined from medical record documentation, enter UTD.
- If there were two different fibrinolytic administration episodes, enter the earliest date and time a fibrinolytic was initiated at this emergency department.
- In the event the patient was brought to the emergency department via ambulance and fibrinolytic therapy was infusing at the time of emergency department arrival, enter the date and time the patient arrived at this emergency department.

Suggested Data Sources:

- Ambulance record
- Emergency Department record

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *First Name*

Collected For: All Records

Definition: The patient's first name.

Suggested Data Collection Question: What is the patient's first name?

Format: **Length:** 30
 Type: Character
 Occurs: 1

Allowable Values: Enter the patient's first name.

Notes for Abstraction: None

Suggested Data Sources:

- Outpatient record
- Emergency Department record

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Hispanic Ethnicity*

Collected For: All Records

Definition: Documentation that the patient is of Hispanic ethnicity or Latino.

Suggested Data Collection Question: Is the patient of Hispanic ethnicity or Latino?

Format: **Length:** 1
 Type: Character
 Occurs: 1

Allowable Values: Y (Yes) Patient is of Hispanic ethnicity or Latino.
 N (No) Patient is not of Hispanic ethnicity or Latino or unable to determine from medical record documentation.

Notes for Abstraction: The data element, *Race*, is required in addition to this data element.

Suggested Data Sources: • Outpatient record
 • Emergency Department record

Guidelines for Abstraction:

Inclusion	Exclusion
A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term “Spanish origin” can be used in addition to “Hispanic or Latino.” Examples: <ul style="list-style-type: none"> • Black-Hispanic • Chicano • H • Hispanic • Latin American • Latino/Latina • Mexican-American • Spanish • White-Hispanic 	None

Data Element Name: *ICD-9-CM Other Diagnosis Codes*

Collected For: OP-4, OP-5

Definition: The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes associated with the diagnosis for this record.

Suggested Data Collection Question: What were the ICD-9-CM other diagnoses codes selected for this medical record?

Format: **Length:** 6 (with or without decimal)
Type: Alphanumeric
Occurs: 17

Allowable Values: Any valid ICD-9-CM diagnosis code

Notes for Abstraction: None

Suggested Data Sources:

- Outpatient record
- Emergency Department record
- UB-04, Field Locations: 67A-Q

NOTE: Medicare will only accept codes listed in fields A-H

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *ICD-9-CM Principal Diagnosis Code*

Collected For: OP-1, OP-2, OP-3, OP-4, OP-5

Definition: The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code associated with the diagnosis established after study to be chiefly responsible for the outpatient encounter.

Suggested Data Collection Question: What was the ICD-9-CM code selected as the principal diagnosis for this record?

Format: **Length:** 6 (with or without a decimal point)
Type: Alphanumeric
Occurs: 1

Allowable Values: Any valid ICD-9-CM diagnosis code

Notes for Abstraction: The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.”

Suggested Data Sources:

- Outpatient record
- Emergency Department record
- UB-04, Field Location: 67

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendix A, ICD-9-CM Code tables	None

Data Element Name: *Infection Prior to Anesthesia*

Collected For: OP-6, OP-7

Definition: Documentation the patient had an infection during this outpatient encounter, prior to surgery.

Suggested Data Collection Question: Did the patient have an infection during this outpatient encounter prior to surgery?

Format: **Length:** 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes) Physician/advanced practice nurse/physician assistant (physician/APN/PA) documentation that the patient had an infection during this outpatient encounter prior to surgery.

N (No) There is no physician/APN/PA documentation that the patient had an infection during this outpatient encounter prior to surgery, or unable to determine from medical record documentation.

- Notes for Abstraction:**
- If there is preoperative documentation of an infection or possible/suspected infection, select “Yes.”
 - Documentation of symptoms (example: fever, elevated white blood cells, etc.) should not be considered an infection unless documented as an infection or possible/suspected infection. Do not assume infection if a wound/surgical site is described as reddened, swollen and hot, as other conditions can also cause these symptoms.
 - The physician/APN/PA documentation of preoperative infection must be in place prior to surgery. Do not accept documentation of infection documented after incision time.
 - H&Ps timed/dated greater than 24 hours prior to arrival should not be used for this data element unless the physician updates the information contained in the document. The H & P should reflect that an infection or possible/suspected infection is current.

Suggested Data Sources: **PHYSICIAN/APN/PA DOCUMENTATION ONLY**

- Outpatient record

Excluded Data Sources:
Any documentation of an infection found in the Operative Report or Pathology Reports.

Guidelines for Abstraction:

Specifications Manual for Hospital Outpatient Department Quality Measures
Encounter dates 01-01-10 (1Q10) through 06-30-10 (2Q10) v.3.0a

Inclusion	Exclusion
<ul style="list-style-type: none"> • Abscess • Acute abdomen • Bloodstream infection • Bone infection • Cellulitis • Fecal Contamination • Gangrene • H. pylori • Necrotic/ischemic/infarcted bowel • Osteomyelitis • Other documented infection • Penetrating abdominal trauma • Pneumonia or other lung infection • Purulence/Pus • Sepsis • Surgical site or wound infection • Urinary tract infection (UTI) 	<ul style="list-style-type: none"> • Bacteria in urine/Bacteruria • Colonized MRSA • Fungal infections • History (Hx) of MRSA • Viral infections

Data Element Name:	<i>Initial ECG Interpretation</i>	
Collected For:	OP-1, OP-2, OP-3	
Definition:	ST-segment elevation or a left bundle branch block (LBBB) based on the documentation of the electrocardiogram (ECG) performed closest to emergency department arrival. The normal ECG is composed of a P wave (atrial depolarization), Q, R, and S waves (QRS complex, ventricular depolarization), and a T wave (ventricular repolarization). The ST-segment, the segment between the QRS complex and the T wave, may be elevated when myocardial injury (AMI) occurs. A bundle branch block (BBB) results from impaired conduction in one of the branches of the conduction system between the atria and the ventricles, which in turn results in abnormal ventricular depolarization. In LBBB, left ventricular depolarization is delayed, resulting in a characteristic widening of the QRS complex on the ECG. LBBB may be an electrocardiographic manifestation of an AMI.	
Suggested Data Collection Question:	Is there documentation of ST-segment elevation or left bundle branch block (LBBB) on the electrocardiogram (ECG) performed closest to emergency department arrival?	
Format:	Length:	1
	Type:	Alphanumeric
	Occurs:	1
Allowable Values:	Y (Yes)	ST-segment elevation or a LBBB on the interpretation of the 12-lead ECG performed closest to emergency department arrival.
	N (No)	No ST-elevation or LBBB on the interpretation of the 12-lead ECG performed closest to emergency department arrival, no interpretation or report available for the ECG performed closest to emergency department arrival or unable to determine from medical record documentation.
Notes for Abstraction:	Methodology:	
	<ol style="list-style-type: none"> 1. Identify the ECG performed closest to arrival, either before or after emergency department arrival, but not more than 1 hour prior to arrival. If unable to determine which ECG was performed closest to arrival, select “No.” 2. Start with review of the SIGNED tracing. Evaluate the findings line by line. Determine if the terms or phrases are Inclusions or Exclusions. If you have an Exclusion, select “No”, regardless of other documentation, and there is no need to review further. 	

3. In the absence of an exclusion on the tracing, proceed to other interpretations that you can say clearly refer to the closest to arrival ECG. Documentation which cannot be tied to the ECG performed closest to arrival should not be used. Do not cross reference findings between interpretations unless otherwise specified. If you encounter an Exclusion in any of the other interpretations, select “No”, regardless of other documentation, and there is no need to review further.
4. At the end of your review, if you have no Exclusions, and either the signed ECG tracing or interpretations of this ECG tracing include at least one Inclusion, select “Yes.” Otherwise, select “No.”
 - ECG interpretation is defined as:
 - 12-lead tracing with name/initials of the physician/advanced practice nurse/physician assistant (physician/APN/PA) who reviewed the ECG signed, stamped, or typed on the report, or
 - Physician/APN/PA documentation of ECG findings in another source (e.g., ED record, H&P).
 - Do not measure ST-segment elevation or attempt to determine if there is an LBBB from the tracing itself.
 - Consider a tracing 12-lead if it has the appropriate markings (the presence of multiple leads: I, II, III, AVR, AVL, AVF, V1-V6).
 - If ECG documentation outside of a tracing is not specified as 12-lead, assume it is 12-lead unless documentation indicates otherwise.
 - Disregard any description of an MI or ST-segment that is not on either the Inclusion list or the Exclusion list.
 - If documentation is contradictory (e.g., “ST-elevation” and “No ST-elevation”), select “No.”
 - If at least one interpretation describes an LBBB as old, chronic, or previously seen, all LBBB findings should be disregarded.
 - If any of the inclusion terms are described using the qualifier “possible,” disregard that finding (neither Inclusion nor Exclusion).
 - Do not consider “subendocardial” an MI “location” (e.g., “acute subendocardial MI” should be disregarded).

Suggested Data Sources: PHYSICIAN/APN/PA DOCUMENTATION ONLY

- ECG reports
- Emergency Department record

Guidelines for Abstraction:

Inclusion	Exclusion
ST-segment elevation <ul style="list-style-type: none"> • Myocardial infarction (MI), with any mention of location or combinations of 	ST-segment elevation <ul style="list-style-type: none"> • Non Q wave MI (NQWMI) • Non ST-elevation MI (NSTEMI)

<p>locations (e.g., anterior, apical, basal, inferior, lateral, posterior, or combination), IF DESCRIBED AS ACUTE/EVOLVING (e.g., “posterior AMI”)</p> <ul style="list-style-type: none"> • Q wave MI, IF DESCRIBED AS ACUTE/EVOLVING • ST ↑ • ST, ST abnormality, or ST changes consistent with injury or acute/evolving MI • ST-elevation (STE) • ST-elevation myocardial infarction (STEMI) • ST-segment noted as $\geq .10\text{mV}$ • ST-segment noted as $\geq 1\text{ mm}$ • Transmural MI, IF DESCRIBED AS ACUTE/EVOLVING <p>Left bundle branch block (LBBB)</p> <ul style="list-style-type: none"> • Intraventricular conduction delay of LBBB type • Variable LBBB 	<ul style="list-style-type: none"> • ST-elevation (ST ↑) clearly described as confined to ONE lead • ST-elevation (ST ↑) described as minimal, $< .10\text{mV}$, $< 1\text{ mm}$, non-diagnostic, or non-specific either in ALL leads noted to have ST-elevation or in GENERAL terms, where lead(s) are NOT specified (e.g., “minimal ST-elevation”) • ST-elevation (ST ↑) with mention of early repolarization, left ventricular hypertrophy (LVH), normal variant, pericarditis, or Prinzmetal/Prinzmetal's variant • ST-elevation (ST ↑), ST-Elevation (STE) or ST-segment noted as, $\geq .10\text{mV}$, $\geq 1\text{ mm}$, described using one of the following: borderline, cannot exclude, cannot rule out, could be, could have been, insignificant, may have, may have had, may indicate, questionable (?), risk of, ruled out (r'd/o, r/o'd), scant, slight, sub-clinical, subtle, suggestive of, suspect, suspicious, trace, or trivial either in ALL leads noted to have ST-elevation or in GENERAL terms, where lead(s) are not specified (e.g., “questionable ST-elevation”) • ST, ST abnormality, or ST changes consistent with injury or acute/evolving MI OR any of the “myocardial infarction” terms described as borderline, cannot exclude, cannot rule out, could be, could have been, insignificant, may have, may have had, may indicate, questionable (?), risk of, ruled out (r'd/o, r/o'd), scant, slight, sub-clinical, subtle, suggestive of, suspect, suspicious, trace, or trivial • ST-segment elevation, or any of the other ST-segment elevation inclusion terms, with mention of pacemaker/pacing (unless atrial only or nonfunctioning pacemaker) <p>Left bundle branch block (LBBB)</p> <ul style="list-style-type: none"> • Incomplete left bundle branch block
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	<p>(LBBB)</p> <ul style="list-style-type: none"> • Intraventricular conduction delay (IVCD) or block • Left bundle branch block (LBBB), or any of the other left bundle branch block inclusion terms, described using one of the following: borderline, cannot exclude, cannot rule out, could be, could have been, insignificant, may have, may have had, may indicate, questionable (?), risk of, ruled out (r'd/o, r/o'd), scant, slight, sub-clinical, subtle, suggestive of, suspect, suspicious, trace, or trivial. • Left bundle branch block (LBBB), or any of the other left bundle branch block inclusion terms, with mention of pacemaker/pacing (unless atrial only or nonfunctioning pacemaker)
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Data Element Name: *Last Name*

Collected For: All Records

Definition: The patient's last name.

Suggested Data Collection Question: What is the patient's last name?

Format: **Length:** 60
 Type: Character
 Occurs: 1

Allowable Values: Enter the patient's last name.

Notes for Abstraction: None

Suggested Data Sources:

- Outpatient record
- Emergency Department record

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Outpatient Encounter Date*

Collected For: All Records

Definition: The documented month, day and year the patient arrived in the hospital outpatient setting.

Suggested Data Collection Question: What was date the patient arrived in the hospital outpatient setting?

Format: **Length:** 10 – MM-DD-YYYY (includes dashes)
Type: Date
Occurs: 1

Allowable Values: MM= Month (01-12)
DD= Day (01-31)
YYYY = Year (2008-9999)

Notes for Abstraction:

- The intent of this data element is to determine the date the patient arrived in the hospital outpatient setting.
- UTD is NOT an allowable value.
- Consider the outpatient encounter date as the earliest documented date the patient arrived in the applicable hospital outpatient setting.

Suggested Data Sources:

- Outpatient record
- Emergency Department record

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Patient HIC#*

Collected For: Collected by CMS for patients with a *Payment Source* of Medicare who have a standard HIC number

Definition: The patient's Medicare health insurance claim number.

Suggested Data

Collection Question: What is the patient's Medicare/HIC number?

Format: **Length:** 7 - 12
Type: Character
Occurs: 1

Allowable Values:

General Rules

- No embedded dashes or spaces or special characters
- Must have both alpha and numeric characters
- Alpha characters must be upper case
- Length cannot be more than 12 or less than 7 characters
- For alphanumeric values, do not allow all numeric values to be 9's For example do not allow 1 alpha + 999999999, etc.

If First Character is Numeric

Suffix rules:

- If the **first character is numeric, (0-9)**, then the first 9 characters must be numeric.

For example:

HIC # length	Rule
10	9 numeric + 1 alpha
11	9 numeric + 1 alpha + 1 numeric Or 9 numeric + 2 alpha

If First Character is Alpha

Prefix rules:

- If the **first character is alpha**, there must be 1-3 alpha characters followed by 6 or 9 numbers.

For example:

HIC # length	Rule
7	1 alpha + 6 numeric
8	2 alpha + 6 numeric
9	3 alpha + 6 numeric
10	1 alpha + 9 numeric
11	2 alpha + 9 numeric
12	3 alpha + 9 numeric

Notes for Abstraction: *Patient HIC#* is required for data transmission of all cases that have a standard HIC#.

- Refer to the Hospital Outpatient Department Quality Measure Data Transmission sub-section, within the Transmission section, for further guidance.

Suggested Data Sources:

- Emergency Department record
- Face sheet
- UB-04, Field Location: 60A, B or C, which ever line corresponds to the Medicare entry

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Patient Identifier*

Collected For: All Records

Definition: The number used by the hospital to identify this patient's hospital outpatient encounter. The number provided will be used to identify the patient in communications with the hospital outpatient setting, e.g., Medical Record Number, Account Number, Unique Identifiable Number as determined by the facility, etc.

A patient identifier is required.

Suggested Data Collection Question: What was the number used to identify this outpatient encounter?

Format: **Length:** 40
 Type: Character
 Occurs: 1

Allowable Values: Up to 40 letters and/or numbers

Notes for Abstraction: None

Suggested Data Sources:

- Outpatient record
- Emergency Department record

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Payment Source*

Collected For: All Records

Definition: The source of payment for this **outpatient encounter**.

Suggested Data Collection Question: What is the patient's source of payment for this **outpatient encounter**?

Format: **Length:** 1
 Type: Alphanumeric
 Occurs: 1

Allowable Values: **1** Source of payment is Medicare.
 2 Source of payment is Non-Medicare.

Notes for Abstraction: • If Medicare is listed as the primary, secondary, tertiary, or even lower down on the list of payers, select "1."
 • If the patient is an Undocumented Alien or Illegal immigrant, select "1." Undocumented Alien: Section 1011 of the Medicare Modernization Act of 2003 allows for reimbursement for services rendered to patients who are: Undocumented or illegal aliens (immigrants), Aliens who have been paroled into a United States port of entry and Mexican citizens permitted to enter the United States on a laser visa.

Suggested Data Sources: Face sheet
 UB-04, Field Location: 50A, B or C

Guidelines for Abstraction:

Inclusion	Exclusion
Medicare includes, but is not limited to: <ul style="list-style-type: none"> • Black Lung • End Stage Renal Disease (ESRD) • Medicare Fee for Service (includes DRG or PPS) • Medicare HMO/Medicare Advantage • Medicare Secondary Payer • Railroad Retirement Board (RRB) 	None

Data Element Name: *Physician 1*

Collected For: All Records (Optional Element)

Definition: The first physician identifier

Suggested Data Collection Question: What is the first physician identifier?

Format: **Length:** 50
Type: Alphanumeric
Occurs: 1

Allowable Values: Enter the first physician identifier, as directed. Up to 50 letters and/ or numbers can be entered.

Notes for Abstraction: This data element may be used to capture physician information that might be helpful in internal analysis. This information is for internal analysis only and will not be shared with any external parties in any data output.

Suggested Data Sources: None

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Physician 2*

Collected For: All Records (Optional Element)

Definition: A second physician identifier

Suggested Data Collection Question: What is the second physician identifier?

Format: **Length:** 50
Type: Alphanumeric
Occurs: 1

Allowable Values: Enter the second physician identifier, as directed. Up to 50 letters and/or numbers can be entered.

Notes for Abstraction: This data element may be used to capture physician information that might be helpful in internal analysis. This information is for internal analysis only and will not be shared with any external parties in any data output.

Suggested Data Sources: None

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Postal Code*

Collected For: All Records

Definition: The postal code of the patient's residence. For United States zip codes, the hyphen is implied. If the patient is determined to not have a permanent residence, then the patient is considered homeless.

Suggested Data Collection Question: What is the postal code of the patient's residence?

Format: **Length:** 9
 Type: Character
 Occurs: 1

Allowable Values: Any valid five or nine digit postal code or "HOMELESS" if the patient is determined not to have a permanent residence. If the patient is not a resident of the United States, use "NON-US."

Notes for Abstraction: If the postal code of the patient is unable to be determined from medical record documentation, enter the provider's postal code.

Suggested Data Sources:

- Outpatient record
- Emergency Department record
- UB-04, Field Location: 09 (line 2d)

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	<i>Probable Cardiac Chest Pain</i>
Collected For:	OP-4, OP-5
Definition:	Documentation a nurse or physician/APN/PA presumed the patient's chest pain to be cardiac in origin.
Suggested Data Collection Question:	Was the patient's chest pain presumed to be cardiac in origin?
Format:	Length: 1 Type: Alphanumeric Occurs: 1
Allowable Values:	Y (Yes) There was nurse or physician/APN/PA documentation the chest pain was presumed to be cardiac in origin. N (No) There was no nurse or physician/APN/PA documentation the chest pain was presumed to be cardiac in origin or unable to determine from medical record documentation.
Notes for Abstraction:	<ul style="list-style-type: none"> • If there is documentation of a differential/working diagnosis of acute myocardial infarction select "Yes." • Disregard documentation of inclusions/exclusions described with terms indicating the condition is not acute, such as "history of."
Suggested Data Sources:	NURSE or PHYSICIAN/APN/PA DOCUMENTATION ONLY <ul style="list-style-type: none"> • Emergency Department record

Guidelines for Abstraction:

Inclusion	Exclusion
<p>Acute Myocardial Infarction and Chest Pain</p> <p>Inclusions</p> <ul style="list-style-type: none"> • Acute coronary syndrome • Acute myocardial infarction (AMI) • Angina • Cardiac • Cardiac Chest Pain • Chest Pain • Heart attack • Ischemia • Myocardial Infarction • Unstable angina <p>The following qualifiers should be abstracted as <i>positive findings</i> if listed with any of the above inclusion terms;</p> <ul style="list-style-type: none"> • Appears to have • Cannot exclude • Cannot rule out • Consider • Consistent with (c/w) • Could be • Could have been • Diagnostic of • Differential diagnosis • Evidence of • Indicative of • Likely • May have • May have had • May indicate • Most likely • Possible • Probable • Questionable (?) • Representative of • Risk of • Rule(d) out (r/o) • Suggestive of • Suspect • Suspicious • Versus (vs) • Working diagnosis • + 	<ul style="list-style-type: none"> • Atypical Chest Pain • Chest Pain musculoskeletal • Chest Pain qualified by a non-cardiac cause • Chest wall pain • Non Cardiac Chest Pain • Non-specific Chest Pain • Traumatic Chest Pain

Data Element Name:	<i>Race</i>
Collected For:	All Records
Definition:	Documentation of the patient's race.
Suggested Data Collection Question:	What is the patient's race?
Format:	Length: 1 Type: Character Occurs: 1
Allowable Values:	Select one: <ol style="list-style-type: none"> 1 White: Patient's race is White or the patient has origins in Europe, the Middle East, or North Africa. 2 Black or African American: Patient's race is Black or African American. 3 American Indian or Alaska Native: Patient's race is American Indian/Alaska Native. 4 Asian: Patient's race is Asian. 5 Native Hawaiian or Pacific Islander: Patient's race is Native Hawaiian/Pacific Islander. 7 UTD: Unable to determine the patient's race or not stated (e.g., not documented, conflicting documentation or patient unwilling to provide).
Notes for Abstraction:	<ul style="list-style-type: none"> • The data element <i>Hispanic Ethnicity</i> is required in addition to this data element. • If documentation indicates the patient has more than one race (e.g., Black-White, Indian-White), select the first listed race. • Although the terms "Hispanic" and "Latino" are actually descriptions of the patient's ethnicity, it is not uncommon to find them referenced as race. If the patient's race is documented only as Hispanic/Latino, select "White." If the race is documented as mixed Hispanic/Latino with another race, use whatever race is given (e.g., Black-Hispanic – select "Black"). Other terms for Hispanic/Latino include Chicano, Cuban, H (for Hispanic), Latin American, Latina, Mexican, Mexican-American, Puerto Rican, South or Central American, and Spanish.

- Suggested Data Sources:**
- Outpatient record
 - Emergency Department record

Guidelines for Abstraction:

Inclusion	Exclusion
<p>Black or African American A person having origins in any of the black racial groups of Africa. Terms such as “Haitian” or “Negro” can be used in addition to “Black or African American.”</p> <p>American Indian or Alaska Native A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment (e.g., any recognized tribal entity in North and South America [including Central America], Native American.)</p> <p>Asian A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.</p> <p>White A person having origins in any of the original peoples of Europe, the Middle East, or North Africa (e.g., Caucasian, Iranian, White).</p> <p>Native Hawaiian or Pacific Islander A person having origins in any of the other original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.</p>	<p>None</p>

Data Element Name:	<i>Reason for Delay in Fibrinolytic Therapy</i>
Collected For:	OP-1, OP-2
Definition:	Physician/advanced practice nurse/physician assistant (physician/APN/PA) documentation of a reason for a delay in initiating fibrinolytic therapy after patient arrival to emergency department. System reasons for delay are NOT acceptable.
Suggested Data Collection Question:	Is there physician/APN/PA documentation of a reason for a delay in initiating fibrinolytic therapy after patient arrival to the emergency department?
Format:	Length: 1 Type: Alphanumeric Occurs: 1
Allowable Values:	Y (Yes) There is physician/APN/PA documentation of a reason for a delay in initiating fibrinolytic therapy after patient arrival to the emergency department. N (No) There is no physician/APN/PA documentation of a reason for a delay in initiating fibrinolytic therapy after patient arrival to the emergency department, or unable to determine from medical record documentation.

Notes for Abstraction: The linkage between a non-system reason and the timing/delay of fibrinolysis must be made clear **somewhere** in the medical record. Abstractors should NOT make inferences from documentation of a sequence of events alone or otherwise attempt to interpret from documentation. Clinical judgment should not be used in abstraction.

Examples of acceptable reasons for delay (select “Yes”)

- “Hold on fibrinolytics. Will do CT scan to r/o bleed.”
- “Patient waiting for family and clergy to arrive – wishes to consult with them before fibrinolysis.”
- “Need to control blood pressure before administering fibrinolysis.”
- Initial patient/family refusal of fibrinolysis is an acceptable reason for delay (e.g., “Patient refusing fibrinolytics”).
- Physician/APN/PA documentation that a cardiopulmonary arrest, balloon pump insertion, or intubation occurred within 30 minutes after hospital arrival OR initial patient/family refusal of fibrinolysis/reperfusion (documented by a physician/APN/PA) are acceptable reasons for delay that do

NOT require documentation that a "hold," "delay," or "wait" in initiating fibrinolysis actually occurred. In order for cardiopulmonary arrest, balloon pump insertion, or intubation within 30 minutes after hospital arrival to be considered an automatic acceptable reason for delay, physician/APN/PA documentation that it occurred within 30 minutes after hospital arrival must be CLEAR.

Examples of unacceptable reasons for delay (select “No”)

- System reasons:
 - Equipment-related (e.g., IV pump malfunction)
 - Staff-related (e.g., waiting for fibrinolytic agent from pharmacy)
 - Consultation with other clinician
 - Prolonged ED wait time

Note: If unable to determine that a documented reason is system in nature, or if physician/APN/PA documentation does not establish a linkage between event(s)/condition(s) and the timing/delay in fibrinolysis, select “No.”

- Non-system reasons:
 - “Patient is discussing fibrinolysis with family.” (Effect on timing/delay of fibrinolysis not documented)
 - “ST-elevation on initial ECG resolved. Chest pain now recurring. Begin lytics.” (linkage to timing/delay of fibrinolysis requires clinical judgment)
 - “Fibrinolysis contraindicated – too high risk.” (Effect on timing/delay of fibrinolysis not documented)
 - “Lytic therapy not indicated.” (Effect on timing/delay of fibrinolysis not documented)

Suggested Data Sources: PHYSICIAN/APN/PA DOCUMENTATION ONLY

- Emergency Department record

Guidelines for Abstraction:

Inclusion	Exclusion
Documented within 30 minutes of ED arrival: Balloon pump <ul style="list-style-type: none"> • Aortic Balloon Pump • Intra-aortic balloon (IAB) • Intra-aortic balloon counterpulsation (IABC) • Intra-aortic balloon pump (IABP) • Intra-aortic counterpulsation (IAC) 	None

- Intra-aortic counterpulsation balloon pump (IACBP)

Cardiopulmonary arrest

- Cardiac arrest
- Cardiopulmonary resuscitation (CPR)
- Code
- Defibrillation
- Respiratory arrest
- Ventricular fibrillation (V-fib)

Intubation

- Endotracheal intubation (ETI)
- Mechanical ventilation
- Nasotracheal intubation (NTI)
- Orotracheal intubation

Data Element Name: *Reason for No Aspirin on Arrival*

Collected For: OP-4

Definition:

Reasons for not administering aspirin on arrival:

- Aspirin allergy
- Coumadin/Warfarin as pre-arrival medication
- Other reasons documented by a physician/advanced practice nurse/physician assistant (physician/APN/PA) or pharmacist

Aspirin reduces the tendency of blood to clot by blocking the action of a type of blood cell involved in clotting. Aspirin improves chances of surviving a heart attack and reduces the risk of occurrence in patients who have experienced a heart attack.

**Suggested Data
Collection Question:**

Select one of the following documented reasons for not administering aspirin on arrival.

Format:

Length: 1

Type: Alphanumeric

Occurs: 1

Allowable Values:

- 1 **Allergy/Sensitivity to aspirin:** There is documentation of an aspirin allergy/sensitivity.
- 2 **Documentation of Coumadin/Warfarin prescribed pre-arrival:** Coumadin/Warfarin is prescribed as a pre-arrival home medication.
- 3 **Other documented reasons:** There is documentation of a reason for not administering aspirin on arrival.
- 4 **No documented reason or Unable to determine (UTD):** There is no documentation of a reason for not administering aspirin on arrival or unable to determine from medical record documentation.

Notes for Abstraction:

- When conflicting information is documented in a medical record, a positive finding (aspirin allergy) should take precedence over a negative finding (no known allergy).
- Aspirin “allergy” or “sensitivity” documented anytime during the hospital stay counts as an allergy regardless of what type of reaction might be noted (e.g., “Allergies: ASA – Upsets stomach” – select value “1”).
- Notation of an aspirin allergy prior to arrival counts as a reason for not administering aspirin, select value “1.”

- Documentation of an allergy/sensitivity to one particular type of aspirin is acceptable to take as an allergy to the entire class of aspirin-containing medications (e.g., “Allergic to Empirin”).
- Other reasons include any physician/APN/PA or pharmacist documentation of a reason for not administering aspirin. (e.g., ASA not administered because patient has a gastric ulcer).
 - There must be a documented reason. Documentation of “Aspirin not administered” will not be sufficient. Physician/APN/PA or pharmacist crossing out of an aspirin order counts as an "other reason" for not administering aspirin.
- Pre-arrival hold or discontinuation of aspirin or notation such as "No aspirin" counts as a reason for not administering aspirin.
- Pre-arrival "other reason" counts as reason for not administering aspirin (e.g., "Intolerance to aspirin" or "Hx GI bleeding with aspirin").
- In situations where there is documentation that would support more than one of the allowable values, 1-4, select the lowest value. Example: Patient has a documented aspirin allergy and documentaiton of Coumadin as a pre-arrival medication, select value “1.”
- When determining whether Coumadin/warfarin was a pre-arrival home medication:
 - Refer to the patient’s medication regimen just prior to emergency department treatment. Include Coumadin/warfarin if the patient was on it at home, the nursing home, a transferring psychiatric hospital, etc. Do NOT include Coumadin/warfarin taken in the ambulance en route to the hospital.
 - Cases where there is documentation that the patient was prescribed Coumadin/warfarin at home but there is indication it was on temporary hold or the patient has been non-compliant or discontinued their medication (e.g., refusal, side effects, cost), select value “2.”

Suggested Data Sources: • Emergency Department record

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendix C, OP Table 1.1, Aspirin and Aspirin-Containing Medications.	None
Refer to Appendix C, OP Table 1.2, Warfarin medications.	

Data Element Name:	<i>Reason for Not Administering Fibrinolytic Therapy</i>
Collected For:	OP-3
Definition:	Contraindications/reasons for not administering fibrinolytic therapy include: patient refusal, cardiogenic shock, contraindications or other reasons documented by a physician/APN/PA or pharmacist for not giving fibrinolytics.
Suggested Data Collection Question:	Select one of the following potential contraindications or reasons for not administering fibrinolytic therapy.
Format:	Length: 1 Type: Alphanumeric Occurs: 1
Allowable Values:	<ol style="list-style-type: none"> 1 Documented contraindication/reason: There is a contraindication or other reason documented by a physician/APN/PA or pharmacist for not prescribing fibrinolytic therapy, including patient refusal. 2 Cardiogenic Shock: There is physician/APN/PA documentation the patient has a diagnosis of cardiogenic shock. 3 No documented contraindication/reason or Unable to determine (UTD): There is no documentation of contraindication/reason for not prescribing fibrinolytic therapy or unable to determine from medical record documentation.
Notes for Abstraction:	<ul style="list-style-type: none"> • When conflicting information is documented in a medical record, a positive finding (fibrinolytic allergy) should take precedence over a negative finding (no known allergy). • Only use reasons/contraindications listed in the data element. • In situations where there is documentation that would support more than one of the allowable values, 1-3, select the lowest value. Example: Patient has a documented contraindication from the inclusion list and a diagnosis of cardiogenic shock, select value “1.”
Suggested Data Sources:	<ul style="list-style-type: none"> • Emergency Department record

Guidelines for Abstraction:

Inclusion	Exclusion
<p>Contraindications</p> <ul style="list-style-type: none"> • Any prior intracranial hemorrhage • Known structural cerebral vascular lesion (e.g. AVM) • Known malignant intracranial neoplasm (primary or metastatic) • Ischemic stroke within 3 months EXCEPT acute ischemic stroke within 3 hours • Suspected aortic dissection • Active bleeding or bleeding diathesis (excluding menses) • Significant closed head trauma or facial trauma within 3 months • History of chronic, severe, poorly controlled hypertension • History of prior ischemic stroke \geq 3 months, dementia, or known intracranial pathology not covered in contraindications • Traumatic or prolonged (\geq 10 minutes) CPR or major surgery ($<$ 3 Weeks) • Recent (within 2 to 4 weeks) internal bleeding • Noncompressible vascular punctures • For streptokinase/anistreplase: prior expose (\geq 5 days ago) or prior allergic reaction to these agents • Pregnancy • Active peptic ulcer • Current use of anticoagulants prior to arrival: the higher the INR, the higher the risk of bleeding <p>Risk</p> <ul style="list-style-type: none"> • Cardiogenic shock 	<ul style="list-style-type: none"> • Transfer for Acute Coronary Intervention, PCI

Data Element Name: Replacement

Collected For: OP-6, OP-7

Definition: The procedure performed is a replacement of the gastrostomy tube and not the initial placement.

Suggested Data

Collection Question: Is this procedure a replacement of a previously placed gastrostomy tube?

Format: **Length:** 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

Y (Yes) The procedure performed was a replacement of a previously placed gastrostomy tube.

N (No) The procedure performed was not a replacement of a previously placed gastrostomy tube or unable to determine from medical record documentation.

Notes for Abstraction:

- If this procedure is to replace a tube that has been placed previously and does not require an incision to replace, answer “Yes.”
- If this procedure is NOT to replace a gastrostomy tube, answer “No.”

Suggested Data Sources:

- Outpatient record

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Sex*

Collected For: All Records

Definition: The patient's documented sex on arrival at the hospital.

Suggested Data Collection Question: What was the patient's sex on arrival?

Format: **Length:** 1
Type: Character
Occurs: 1

Allowable Values: M = Male
F = Female
U = Unknown

Notes for Abstraction:

- Collect the documented patient's sex at admission or the first documentation after arrival.
- Consider the sex to be unable to be determined and select "Unknown" if:
 - o The patient refuses to provide their sex.
 - o Documentation is contradictory.
 - o Documentation indicates the patient is a Transsexual.
 - o Documentation indicates the patient is a Hermaphrodite.

Suggested Data Sources:

- Consultation notes
- Emergency department record
- Face sheet
- History and physical
- Nursing admission notes
- Progress notes
- UB-04, Field Location: 11

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	<i>Transfer for Acute Coronary Intervention</i>
Collected For:	OP-3
Definition:	Documentation the patient was transferred from this facility's emergency department to another facility for acute coronary intervention.
Suggested Data Collection Question:	Was there documentation the patient was transferred from this facility's emergency department to another facility for acute coronary intervention?
Format:	Length: 1 Type: Alphanumeric Occurs: 1
Allowable Values:	<ol style="list-style-type: none"> 1 There was documentation the patient was transferred from this facility's emergency department to another facility specifically for acute coronary intervention. 2 There was documentation the patient was admitted to observation status prior to transfer. 3 There was documentation the patient was transferred from this facility's emergency department to another facility for reasons other than acute coronary intervention, or the specific reason for transfer was unable to be determined from medical record documentation.
Notes for Abstraction:	<ul style="list-style-type: none"> • To select value "1," documentation must include a specifically defined reason for transfer such as "Percutaneous Coronary Intervention," "Angioplasty," or "for cardiac cath." • To select value "2", there must be documentation of a physician/APN/PA order to admit to observation status.
Suggested Data Sources:	<ul style="list-style-type: none"> • Emergency Department record

Guidelines for Abstraction:

Inclusion	Exclusion
<ul style="list-style-type: none">• Acute angiogram• Acute cardiac intervention• Acute coronary intervention• Angioplasty• Cath lab• Cardiac catheterization• Interventional cardiology• Percutaneous Coronary Intervention• Primary Percutaneous Coronary Intervention• Primary PCI• PCI	None

Data Element Name: *Vancomycin*

Collected For: OP-7

Definition: The documented rationale for using Vancomycin as antimicrobial prophylaxis.

Suggested Data Collection Question: What reason was documented for using Vancomycin?

Format: **Length:** 1
Type: Alphanumeric
Occurs: 7

Allowable Values: **Select all that apply:**

- 1 Documentation of beta-lactam (penicillin or cephalosporin) allergy
- 2 Physician/APN/PA or pharmacist documentation of MRSA colonization or infection
- 3 Documentation of patient being high-risk due to acute inpatient hospitalization within the last year
- 4 Documentation of patient being high-risk due to nursing home or extended care facility setting within the last year, prior to admission
- 5 Physician/APN/PA or pharmacist documentation of increased MRSA rate, either facility-wide or operation-specific
- 6 Physician/APN/PA or pharmacist documentation of chronic wound care or dialysis
- 8 Other physician/APN/PA or pharmacist documented reason
- 9 No documented reason/Unable to Determine

Notes for Abstraction:

- For this data element, documentation by an infection control practitioner is acceptable (in addition to physician/APN/PA or pharmacist documentation) if it is specifically designated as “infection control” (ICP) documentation. An infection control practitioner may be a medical technician, nurse, physician/APN/PA, or pharmacist.
- Where applicable to the outpatient setting, in order to select Allowable Values 2, 5, 6 and 8, there must be physician/APN/PA, pharmacist, or infection control practitioner (ICP) documentation of the reason vancomycin

was used for prophylaxis.

- Physician/APN/PA, pharmacist or infection control practitioner documentation of the reason for the use of Vancomycin as prophylaxis must have been entered in the medical record preoperatively to select Allowable Values 2, 5, 6 and 8. If the documentation was not entered preoperatively, select Value 9- No documented reason/Unable to Determine.
- In order to select allowable value “1” for “Documentation of beta-lactam (penicillin or cephalosporin) allergy,” the answer to the data element *Antibiotic Allergy* must be “Yes.”
- No value should be selected more than once. A maximum of 7 entries should be recorded. If a value of “9” is selected, no other selection should be recorded.

Suggested Data Sources: WHERE SPECIFIED IN ALLOWABLE VALUES ABOVE, ONLY PHYSICIAN/APN/PA, PHARMACIST, OR INFECTION CONTROL PRACTITIONER DOCUMENTATION IS ALLOWED.

- Outpatient record

Guidelines for Abstraction:

Inclusion	Exclusion
<p>Hospitalization</p> <ul style="list-style-type: none"> • Acute inpatient • Federal or VA facility • Hospice- Acute facility • Inpatient drug rehabilitation • Inpatient rehabilitation unit or facility • Long-term care hospital <p>Nursing Home or Extended Care Facility</p> <ul style="list-style-type: none"> • Hospice- Skilled/Respite • Intermediate care facility (ICF) • Respite care • Skilled nursing facility (SNF) or SNF rehabilitation unit • Sub-acute care • Swing bed/unit • Transitional care unit (TCU) 	<ul style="list-style-type: none"> • Assisted Living • Board and Care • Group home/personal care homes • Hospice at home • Psychiatric unit or facility • Residential care • Residential or outpatient chemical dependency treatment

Missing and Invalid Data

Introduction

Missing data are data elements required for calculating a hospital outpatient measure that have no values present for one or more encounter. Invalid data are data element values required for calculating a hospital outpatient measure that fall outside of the range of allowable values defined for that data element.

Reducing the levels of missing and invalid data is important as it minimizes measure rate bias. Because records with missing or invalid data cannot be included in the calculation of the observed measure rate, a measure's observed rate may not accurately reflect the patient population, if the excluded records differ significantly from the records with no missing data that were included in the measure calculation (i.e., the records remaining are not representative of the actual population).

Data Collection and the Unable to be Determined (UTD) Allowable Value

Abstractors provide an answer to every data element that is applicable per the combined skip logic for all measures in a hospital outpatient measure set for the record to be deemed complete and to not be rejected. While there is an expectation that all data elements are collected, it is recognized that in certain situations information may not be available (dates, times, codes, etc.). If, after due diligence, the abstractor determines that a value is not documented or is not able to determine the answer value, the abstractor must select "UTD" as the answer. Note that some data elements do not allow a "UTD" value for data transmission. The "UTD" allowable value is used as follows:

- *Antibiotic Name, Birthdate, CPT[®] Code, E/M Code, ICD-9-CM Principal and Other Diagnosis Codes and Outpatient Encounter Date* do not have a "UTD" allowable value for data transmission. Encounter records containing "UTD" for any of these data elements are rejected when submitted.
- Date, time, and numeric data elements, other than *Birthdate* and *Outpatient Encounter Date*, have a "UTD" allowable value option.
 - Rate-based algorithms evaluate records to a Measure Category Assignment = "D" (failed) when a date, time, or numeric data element containing an allowable value of "UTD" is evaluated.
 - Continuous variable algorithms evaluate records to a Measure Category Assignment = "Y" (UTD value exists) when a date, time, or numeric data element containing an allowable value of "UTD" is evaluated.
 - The method by which data collection software collects "UTD" information is determined by each software vendor; except the **software cannot automatically default to a "UTD" answer**. The decision to enter a "UTD" for each data element must be made by the abstractor, not the software.

- Yes/No data elements: The allowable value “No” incorporates “UTD” into the definition. Refer to the measure algorithms in which each Yes/No data element is used to determine how the record is treated.
- Data elements containing two or more categorical values: The “UTD” value is either classified as a separate allowable value (e.g., *Antibiotic Route*) or included in the same category as “None of the above/Not documented.” Refer to the measure algorithms in which each categorical data element is used to determine how the record is treated.

Missing and Invalid Data

For rejected data to be accepted, errors must be corrected and the data resubmitted before the transmission deadline.

- The majority of general data elements that are missing data* cause the encounter record to be rejected. Refer to the Data Dictionary Introduction in this manual for the complete list of general data elements.
- In addition, if both the *ICD-9-CM Principal Diagnosis Code* and the *CPT® Code* data elements are missing data*, the entire record will be rejected.
- Not all patients have *ICD-9-CM Other Diagnosis Codes*. Records will be accepted for missing data for this data element.
- Measure-specific data elements that are missing data* cause the record to be rejected if any measure algorithm results in a Measure Category Assignment = “X” (missing data). If no measure evaluates to a category assignment of “X”, the record will be accepted.
- General and measure-specific data elements that contain invalid data cause the record to be rejected.
- All cases submitted with data related to Antibiotic Administration are required to be complete. *Antibiotic Name* and *Antibiotic Route* must be complete for each dose of antibiotic submitted. A dose is considered any row of antibiotics that contain allowable answer values for the above two listed data elements. If a case is submitted with missing data for any dose of antibiotics, the case will be rejected. If the abstractor, after due diligence, is not able to determine an answer, a value of “UTD,” if a valid allowable value, may be selected for the applicable data element.

Note:

*A missing value occurs when the abstractor does not select an answer for a data element (leaves it blank) or the software incorrectly transmits a “null” instead of the correct value for a data element. A “UTD” allowable value is not considered missing data.

Abstraction Software Skip Logic and Missing Data

Skip logic allows hospitals and vendors to minimize abstraction burden by using vendor software edit logic to bypass abstraction of data elements not utilized in the measure algorithm. However, these bypassed elements will negatively impact data quality and the hospital's CMS chart audit validation results when elements are incorrectly abstracted and subsequent data elements are bypassed and left blank.

The use of skip logic by hospitals and vendors is optional and not required. Hospitals should be aware of the potential impact of skip logic on data quality, abstraction burden, and CMS chart audit validation scores. Vendors and hospitals utilizing skip logic should closely monitor the accuracy rate of abstracted data elements, particularly data elements placed higher in the algorithm flow.

Missing, Invalid, UTD Data Summary:

Missing Data	Invalid Data	UTD
No data element value is present (blank or "null")	The data element value falls outside of the range of defined allowable values.	The allowable value of "UTD" is present for the data element.

Population and Sampling Specifications

Introduction

Population

Defining the population is the first step to estimate a hospital's performance. A population is generally defined as a collection of patients sharing a common set of universally measured characteristics, such as an ICD-9-CM Principal Diagnosis or CPT® Codes. The outpatient population and diagnosis/CPT® codes meet this description for the outpatient department quality measures. For the purpose of measuring outpatient department quality measures, the term "outpatient population" is defined below:

- An "outpatient population" refers to all patients (Medicare and non-Medicare) who share a common set of specified, administratively derived data elements. This may include ICD-9-CM diagnosis codes, CPT® codes, or other population characteristics such as age. For example, the population for the Acute Myocardial Infarction (AMI) outpatient OP-1, 2, 3, 4, and 5 measures include all patients with an *E/M Code* on Appendix A, OP Table 1.0, an *ICD-9-CM Principal Diagnosis Code* as defined in Appendix A, OP Table 1.1, and a Patient Age (*Outpatient Encounter Date – Birthdate*) ≥ 18 years.

Three outpatient population sampling algorithms have been developed for the selected seven measures. Each algorithm defines the initial population on the basis of a limited number of criteria such as age, CPT® codes (including Evaluation/Management [E/M] codes), and ICD-9-CM codes. These basic data elements could be easily obtained from electronic files (e.g., from the billing department) and usually allow a computer-based sampling process to be employed. The three sampling populations reflect the two measure topics presented in Table 1 below.

Table 1: Measure Topic, Measure Population, and Measure		
Measure Topic	Measure Population	Measure
Emergency Department (ED)	AMI	OP-1/OP-2/OP-3/OP-4/OP-5
Emergency Department (ED)	Chest Pain (CP)	OP-4/OP-5
Surgical	Surgical	OP-6/OP-7

For the definition of the outpatient population for each sampling population, refer to the appropriate outpatient population discussion in the Measure Information section of this manual.

Submission Threshold

In order to reduce the burden on hospitals that treat a low number of patients but otherwise meet the submission requirements for a particular quality measure, hospitals that have five or fewer cases (both Medicare and non-Medicare) for any measure included in a measure topic (i.e., ED and Surgical) in a quarter will NOT be required to submit patient-level data for the entire measure topic for that quarter. For example, hospitals with five or fewer cases (both Medicare and non-Medicare) for the ED measure topic (i.e., AMI and CP Outpatient Populations) in a quarter will NOT be required to submit patient-level data for both the AMI and CP Outpatient Populations for that quarter. For additional submission threshold examples refer to the Submission Threshold Examples subsection below. Even if hospitals are not required to submit

patient-level data because they have five or fewer cases (both Medicare and non-Medicare) for any measure included in a measure topic in a quarter, they may voluntarily do so.

Submission Threshold Examples

- A hospital's total number of cases for the ED measure topic (i.e., AMI and CP Outpatient Populations combined) is five (5) patients during the quarter; therefore, submission of patient-level data is NOT required. However, the hospital may still choose to submit the data.
- A hospital identified four (4) patients in the AMI Outpatient Population and three (3) patients in the CP Outpatient Population. Since the total ED measure topic (i.e., AMI and CP Outpatient Populations combined) is seven (7), the hospital is required to submit patient-level data for both the AMI and CP Outpatient Populations.
- A hospital identified two (2) patients in the AMI Outpatient Population, two (2) patients in the CP Outpatient Population, and six (6) patients in the Surgical Outpatient Population. Since the total ED measure topic (i.e., AMI and CP Outpatient Populations combined) is four (4), the hospital is NOT required to submit patient-level data for the AMI and CP Outpatient Populations; however, the hospital is required to submit patient-level data for the Surgical Outpatient Population.

Sampling

Sampling is a process of selecting a representative part of a population in order to estimate the hospital's performance, without collecting data for its entire population. Using a statistically valid sample, a hospital can measure its performance in an effective and efficient manner. Sampling is a particularly useful technique for performance measures that require primary data collection from a source such as the medical record. Sampling should not be used unless the hospital has a large number of cases in the outpatient population because a fairly large number of sample cases are needed to achieve a representative sample of the population. For the purpose of sampling outpatient department quality measures, the terms "sample," "effective sample," and "case" are defined below:

- The "sample" is the fraction of the population that is selected for further study.
- "Effective sample" refers to the part of the sample that makes it into the denominator of an outpatient measure set. This is defined as the sample for an outpatient measure set minus all the exclusions and contraindications for the outpatient measure set in the sample.
- A "case" refers to a single record (or an encounter) within the population. For example, during the first quarter a hospital may have 100 patients who had a principal diagnosis associated with the OP-1, 2, 3, 4, and 5 measures. The hospital's outpatient population would include 100 cases or 100 outpatient records for these measures during the first quarter.

To obtain statistically valid sample data, the sample size should be carefully determined and the sample cases should be randomly selected in such a way that the individual cases in the population have an equal chance of being selected. Only when the sample data truly represent the whole population can the sample-based performance outpatient measure set data be meaningful and useful. Each hospital is ultimately responsible for adhering to the sampling requirements outlined in this manual.

As a general rule/policy of CMS, providers are encouraged to submit as many cases as possible up to the entire population of cases if reasonably feasible. For example, if the raw data can be easily extracted from an existing electronic database or the abstraction burden is manageable, providers should consider submitting the entire population of cases that meet the initial selection criteria. Otherwise, a statistically valid sample can be selected.

Note: Hospitals are NOT required to sample their data if they elect to include all eligible cases. For example, a hospital has 100 cases for the quarter and must select a sample of 80 cases. The hospital may choose to use all 100 cases given the minimal benefit sampling would offer.

Order of Data Flow

Each outpatient measure set has a unique definition of outpatient population. However, the same data flow or process steps can be used to identify the data that are transmitted to the OPSS Clinical Warehouse. These process steps are:

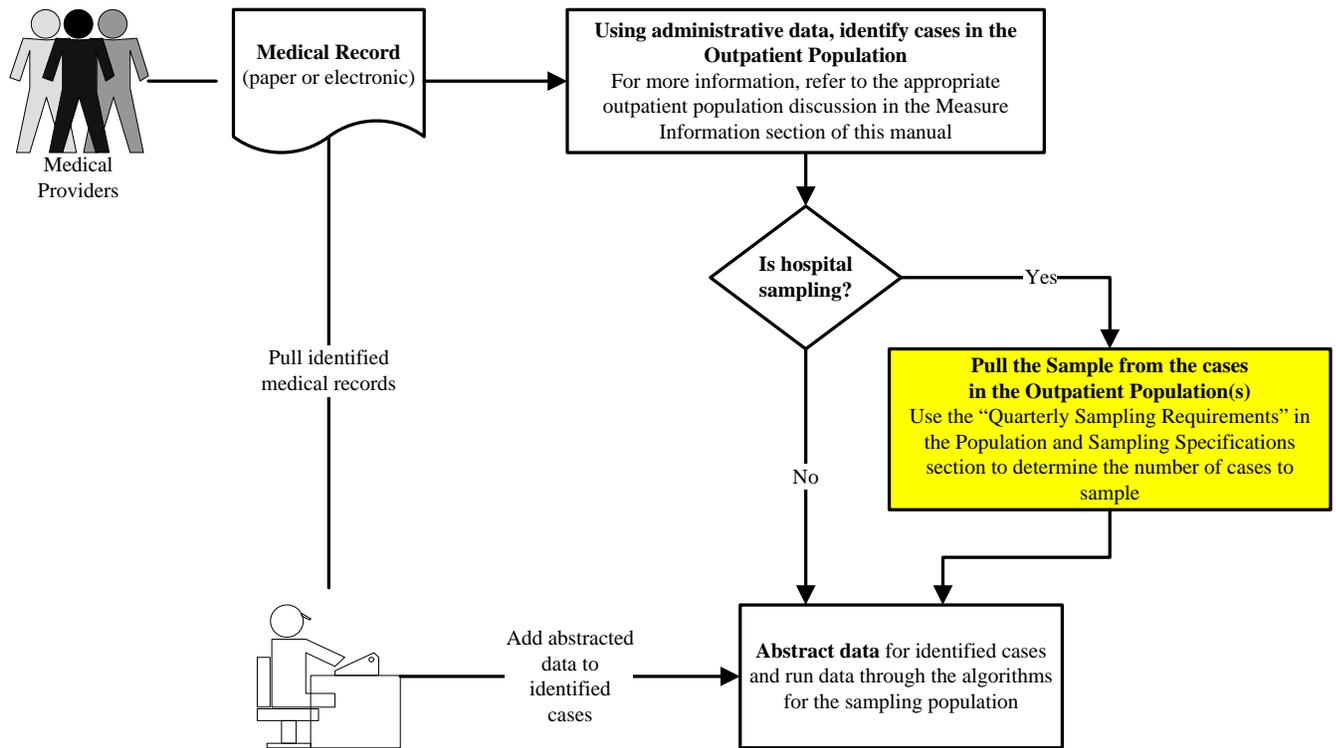
- First, identify the outpatient population for the outpatient measure set. An outpatient population is defined for each outpatient measure set and the count is collected in the *Outpatient Population Size* data element. This data pull utilizes administrative data such as ICD-9-CM diagnosis codes, CPT[®] codes, outpatient encounter date, and birthdate.

All ICD-9-CM diagnosis codes and CPT[®] codes included in the appropriate outpatient population definition must be applied. This identification process must be completed prior to the application of the data integrity filter, the outpatient measure set exclusions, and the sampling methodology.

For specific outpatient measure set definitions, refer to the appropriate outpatient population discussion in the Measure Information section of this manual.

- Second, if the hospital is sampling, use the outpatient population identified above and pull the sample of medical records for each outpatient measure set using the **quarterly** requirements defined in the '**Quarterly Sampling** Requirements' discussion.
- Third, collect or abstract from the identified medical records the general and outpatient measure set specific data elements that are needed for the sampling population. The count of the number of cases used in this step is collected in the **Outpatient Sample Size** data elements.
 - If the hospital is not sampling, use the medical records identified in the first data pull.
 - If the hospital is sampling, use the medical records from the cases in the identified sample.

Order of Data Flow/Process Steps



Sample Size Requirements

Each hospital is ultimately responsible for meeting or exceeding the quarterly sample size requirement outlined in Table 2. Hospital samples must be monitored to ensure that sampling procedures consistently produce statistically valid and useful data. As a general rule and based on prior experience with CMS hospital inpatient measures, sample size requirements for this project are based on commonly accepted sampling criteria for surveys:

- A 5 percent margin of error is recommended. The margin of error is the extent of error the investigator is willing to tolerate. Lower margins of error (e.g., 3 percent) would require substantially larger sample sizes and generate more reliable results from the samples, but the burden of abstraction may not be acceptable for most providers. Inversely, higher margins of error would require relatively smaller sample sizes but less reliable results from those samples.
- The size of the population, also referred to as the universe population, is the volume of eligible patients from which the sample will be drawn. This number is obviously expected to vary widely among providers. Different sample size estimates are provided for various populations. See Table 2 for sample size requirements per quarter. Table 3 provides sample size guidelines per month.

Given that the number of cases in the sample could further be reduced during the analysis phase due to missing data in the medical records and additional outpatient measure set-specific exclusion criteria, hospitals are strongly advised to overestimate their sample sizes by 10 to 20 percent, or as much as possible.

A hospital may choose to use a larger sample size than is required. Hospitals whose outpatient population size is less than the minimum number of cases for the sampling population must include all eligible cases in their data.

At this time there are no requirements for stratified sampling by surgery type (OP-6/OP-7 sampling population) at the hospital level. Stratified sampling for surgery types would be considered only if the initial project volume of patients for one particular surgery type is unexpectedly and excessively low to generate reliable results at the state or national level, not at the hospital level.

As a quality check to ensure that sampling methodology was applied correctly, the provider must run a basic comparative analysis of common demographic variables including age distribution, gender ratio, race/ethnicity distribution, and the proportion of Medicare patients between the sampled set and the population of eligible patients. The relative frequencies or distribution of these common variables should be very close between the two data sets. Any significant discrepancy should trigger a review and a restart of the sampling process.

As indicated earlier, the adequacy of the sample size will be monitored as the project progresses and revised, as needed. Providers that choose to sample are responsible for the sampling process. However, for each sampled case, providers are required to clearly indicate the sample size (n) to which the case belongs, the population size (N) from which the sample was drawn, and the proportion of Medicare and non-Medicare patients in the sample.

Quarterly Sampling Requirements

A hospital may choose to use a larger sample size than is required. Hospitals whose population size is less than the minimum number of cases per quarter for the measure set cannot sample. Refer to Table 2 to determine the minimum number of cases that need to be sampled for each population per quarter per hospital.

Population per Quarter	Quarterly Sample Size
≤ 80	use all cases
81-100	80
101-125	95
126-150	109
151-175	121
176-200	132
201-225	143
226-250	152
251-275	161
276-300	169
301-325	177
326-350	184
351-375	191
376-400	197
401-425	203
426-450	208
451-500	218
501-600	235
601-700	249
701-800	260
801-900	270
901-1,000	278
1,001-2,000	323
2,001-3,000	341
3,001-4,000	351
4,001-5,000	357
5,001-10,000	370
10,001-20,000	377

* Computations based on a Web-based free sample size calculator by Raosoft (raosoft.com).

Monthly Sampling Guidelines

It is important to point out that if a hospital elects to use the monthly sampling guidelines, the hospital is still required to meet the minimum quarterly sampling requirements. A hospital may choose to use a larger sample size than is required. Hospitals whose population size is less than the minimum number of cases per quarter for the measure set cannot sample (i.e., the entire population of cases must be selected). Given the potential for substantial variation in monthly population sizes, the monthly sample sizes should be based on the known or anticipated quarterly population size. When necessary, appropriate oversampling should be employed to ensure that the hospital meets the minimum quarterly sample size requirements. Refer to Table 3 below for guidelines in determining the number of cases that need to be sampled for each population per month per hospital based on the quarterly population size.

Population per Quarter	Monthly Sample Size
≤ 80	use all cases
81-100	27
101-125	32
126-150	37
151-175	41
176-200	44
201-225	48
226-250	51
251-275	54
276-300	57
301-325	59
326-350	62
351-375	64
376-400	66
401-425	68
426-450	70
451-500	73
501-600	79
601-700	83
701-800	87
801-900	90
901-1,000	93
1,001-2,000	108
2,001-3,000	114
3,001-4,000	117
4,001-5,000	119
5,001-10,000	124
10,001-20,000	126

Sample Size Examples

- A hospital's Chest Pain outpatient population size is 100 patients during the second quarter. Using Table 2, the required sample size is seen to be a minimum of 80 Chest Pain patients for this quarter.
- A hospital's outpatient population size for the surgery sampling population is 800 during the second quarter. According to Table 2, the required sample size would be a minimum of 260 patients for this quarter.
- A hospital's outpatient population for AMI is ten (10) patients during the quarter. According to Table 2, the required quarterly sample size would be 100 percent of the AMI patient population or ten (10) cases for the quarter.

Sampling Approaches

As previously stated in this section, hospitals have the option to sample from their population, or submit their entire population. Hospitals that choose to sample must ensure that the sampled data represent their outpatient population by using either the simple random sampling or systematic random sampling method and that the sampling techniques are applied consistently within a quarter. For example, quarterly samples for a sampling population must use consistent sampling techniques across the quarterly submission period.

- Simple random sampling - selecting a sample size (n) from a population of size (N) in such a way that every case has the same chance of being selected.
- Systematic random sampling - selecting every k^{th} record from a population of size (N) in such a way that a sample size of n is obtained, where $k = N/n$ rounded to the lower digit. The first sample record (i.e., the starting point) must be randomly selected before taking every k^{th} record. This is a two-step process:
 - a) Randomly select the starting point by choosing a number between one and k using a table of random numbers or a computer-generated random number; and
 - b) Then select every k^{th} record thereafter until the selection of the sample size is completed.

Each hospital is ultimately responsible that the sampling techniques applied for their hospital adhere to the sampling requirements outlined in this manual. Performance measurement systems are responsible for ensuring that the sampling techniques are applied consistently across their client hospitals.

Sampling Approach Examples

For a hospital with a surgery outpatient population size of 800 per quarter, the sample size would be 260. To select a random sample of 260 surgery outpatients:

- Simple random sampling:
 1. Generate random numbers for individual surgery outpatient records from a random number function using a statistical software package or computer programming language.
 2. Sort data by the random numbers either in an increasing or decreasing order.
 3. Select the first 260 surgery outpatient records as the random sample.

- Systematic random sampling:
 1. In this example, the hospital's outpatient population size = 800 and the sample size = 260. Divide the outpatient population size by the sample size and take the quotient (i.e., the integer portion) as the sampling interval k . The sampling interval $k = 800/260 = 3.1$. Thus, every third surgery outpatient record will be selected from the outpatient population until 260 cases are selected.
 2. To ensure that each surgery outpatient has an equal chance of being selected, the "starting point" must be randomly determined before selecting every third surgery outpatient record. This can be done using a computer random number generator or a random number table to randomly choose a number between 1 and 3 as the starting point.

Transmission of Outpatient Population and Sample Data Elements

Refer to the QualityNet Web site or the Hospital Outpatient Quality Measure Data Transmission section of this manual for the most current CMS HOP QDRP submission requirements for transmission of outpatient population and sample count data elements to the OPSS Clinical Warehouse. Transmission of outpatient population and sample count data elements are used to assist in evaluating completeness of submission in accordance with CMS sampling requirements.

All ICD-9-CM diagnosis codes and CPT[®] codes included in the appropriate outpatient population definition must be applied. This identification process must be completed prior to the application of data integrity filter, outpatient measure set exclusions, and the application of sampling methodology. For specific definitions, refer to the appropriate outpatient population in this manual.

The outpatient population and sample data elements are:

- *Outpatient Population Size – Medicare Only*
- *Outpatient Population Size – Non-Medicare Only*
- *Outpatient Sampling Frequency*
- *Outpatient Sample Size – Medicare Only*
- *Outpatient Sample Size – Non-Medicare Only*

Outpatient Sampling Frequency indicates whether the hospital sampled its original population, whether the entire population was used for the specified time period, or the hospital had five or fewer encounters for the encounter quarter and did not submit patient-level data.

Outpatient Population and Sample Size Examples

Example 1 – Hospital does not sample

A hospital uses the surgery CPT[®] Codes (as listed in Appendix A, OP Table 6.0) and Patient Age to identify 125 cases in the surgery outpatient population during the second quarter. The hospital does not sample the surgery outpatient measure set, so data for all 125 cases are collected and used to calculate the hospital’s rate for the outpatient measure set. Forty of the 125 cases in the surgery outpatient population are Medicare patients.

The breakdown of data by month and Medicare/Non-Medicare is:

	April	May	June	Total
Outpatient Population – Medicare patients	10	15	15	40
Outpatient Population – Non-Medicare patients	20	30	35	85
Total Outpatient Population Size	30	45	50	125
<i>Outpatient Sample Size – Medicare patients</i>	10	15	15	40
<i>Outpatient Sample Size – Non-Medicare patients</i>	20	30	35	85
Total Sample Size	30	45	50	125

The following is transmitted for each month in the quarter:

	April	May	June
<i>Outpatient Population Size – Medicare Only</i>	10	15	15
<i>Outpatient Population Size – Non-Medicare Only</i>	20	30	35
<i>Outpatient Sampling Frequency (2 = not sampling)</i>	2	2	2
<i>Outpatient Sample Size – Medicare Only</i>	10	15	15
<i>Outpatient Sample Size – Non-Medicare Only</i>	20	30	35

Example 2 – Hospital samples

A hospital uses the surgery CPT® Codes (as listed in Appendix A, OP Table 6.0) and Patient Age to identify 125 cases in the surgery outpatient population during the second quarter. From these 125 cases, the hospital randomly selects a sample of 95 cases. Data for these 95 cases are collected and are then used to calculate the hospital’s rate for each surgery outpatient measure. Forty of the 125 cases in the surgery outpatient population are Medicare patients and 25 of these cases were included in the sample.

The breakdown of data by month and Medicare/Non-Medicare is:

	April	May	June	Total
Outpatient Population – Medicare patients	10	15	15	40
Outpatient Population – Non-Medicare patients	20	30	35	85
Total Outpatient Population Size	30	45	50	125
Outpatient Sample Size – Medicare patients	5	10	10	25
Outpatient Sample Size – Non-Medicare patients	15	25	30	70
Total Sample Size	20	35	40	95

The following is transmitted for each month in the quarter:

	April	May	June
<i>Outpatient Population Size – Medicare Only</i>	10	15	15
<i>Outpatient Population Size – Non-Medicare Only</i>	20	30	35
Outpatient <i>Sampling Frequency</i> (1 = sampled data)	1	1	1
Outpatient <i>Sample Size – Medicare Only</i>	5	10	10
Outpatient <i>Sample Size – Non-Medicare Only</i>	15	25	30

Hospital Outpatient Department Quality Measure Data Transmission

Introduction

This section of the manual is provided to highlight the unique data transmission specifications for hospital outpatient measure data for the Centers for Medicare & Medicaid Services (CMS) and the OPSS Clinical Warehouse.

This section is divided into three parts: Guidelines for Submission of Data, Transmission Data Element List, and Transmission Data Processing Flow.

The Guidelines for Submission of Data section provides the user with the data standards required for submission to the OPSS Clinical Warehouse. It includes an overview of the data required for submission to the OPSS Clinical Warehouse, as well as the Hospital Outpatient Clinical Data XML file layout and the Hospital Outpatient Population Data XML file layout.

The Transmission Data Element List describes the data elements that are either used to identify the hospital and hospital outpatient measure set associated to the transmitted data or is calculated by the vendor using the hospital's patient-level data and measure results. These data elements are not used in the Population Algorithms or Measure Algorithms.

The Transmission Data Processing Flow contains information regarding the order in which the OPSS Clinical Warehouse evaluates the hospital outpatient measures.

IMPORTANT SUBMISSION ALERT!!

At this time, for submission of the Hospital Outpatient Measures to CMS under the Hospital Outpatient Quality Data Reporting Program, files must meet the specifications in this CMS manual only. Otherwise, the files will be rejected as not meeting CMS quality data submission requirements for receiving the full payment update.

Providers who are planning to also submit the Hospital Outpatient Measures to The Joint Commission must refer to the transmission section separately issued by The Joint Commission. This is important because at this time, CMS can only accept files which meet the CMS transmission manual specifications and such files cannot contain the additional Joint Commission transmission data elements (e.g., vendor tracking ID, measure category assignment, measurement value).

Guidelines for Submission of Data

Data collected for CMS is transmitted to the OPSS Clinical Warehouse. All data submitted are required to meet transmission requirements. The file layout requirements are included in the sections that follow.

Submission of Hospital Outpatient Clinical Data

Hospital Outpatient Clinical Data are submitted to the OPSS Clinical Warehouse on a quarterly submission schedule. All clinical data submitted to the OPSS Clinical Warehouse must adhere to the *Hospital Outpatient Clinical Data XML file layout* specifications provided later in the transmission section. Each case must have a separate XML file. For example, if you have 12 records that you have abstracted, you must have 12 separate XML files. If you have abstracted more than one hospital outpatient measure set for a patient encounter, then a separate XML file must be created for each hospital outpatient measure set. Each hospital outpatient measure set can only be abstracted once for the same medical record.

Submission of Hospital Outpatient Population Data

CMS collects population size and declaration of sampling, by hospital outpatient measure set on a quarterly basis. For hospitals submitting the Hospital Outpatient Population Data, information may be submitted via an XML file to the OPSS Clinical Warehouse. All population data submitted to the OPSS Clinical Warehouse must adhere to the *Hospital Outpatient Population Data XML file layout* specifications provided later in the transmission section. Each file may contain data for only one provider.

Additional guidelines related to the submission of Hospital Outpatient Clinical Data and Hospital Outpatient Population Data are outlined below.

Overview

The below guidelines are for the submission of Hospital Outpatient Clinical Data and Hospital Outpatient Population Data to CMS.

CMS Guidelines for Submission of Hospital Outpatient Clinical Data	
Data Submission Verification	Prior to processing measure outcomes all data will be verified according to the rules in the data transmission section and the edits documents. Cases submitted to the OPSS Clinical Warehouse that do not meet the requirements outlined in these documents will be rejected.
Requirements for XML Tags and Associated Data	Do not put spaces between XML tags and associated data. Cases with inappropriate spaces will be rejected from the OPSS Clinical Warehouse.
Export File Character Limitations	Cases exported for submission to the OPSS Clinical Warehouse may not have greater than 50 characters in the file name.
Missing Data Policy	<p>All cases submitted to the OPSS Clinical Warehouse must have all data required to calculate the measures. Files submitted which are missing data required to calculate measures (any case that would result in a Measure Category “X” assignment) will be rejected from the warehouse. These cases should be reviewed by the provider, corrected and resubmitted prior to the submission deadline with an allowable value indicated for any data element that was missing. Please refer to the Missing and Invalid Data Section for additional information.</p> <p>In addition, all cases submitted with data related to antibiotic administration are required to be complete when submitted to the OPSS Clinical Warehouse. If the abstractor, after due diligence, is not able to determine an answer, a value of “UTD” must be selected for the applicable data element. This includes:</p> <ul style="list-style-type: none"> • Cases related to the patient’s receipt of antibiotics. <i>Antibiotic Name</i> and <i>Antibiotic Route</i> must be complete for each dose of antibiotics submitted. A dose is considered any row of antibiotics that contain all allowable answer values for the above listed data elements. If a case is submitted to the OPSS Clinical Warehouse with missing data for any dose of antibiotics, the case will be rejected.

CMS Guidelines for Submission of Hospital Outpatient Clinical Data														
Required Patient Identifiers Based on Payment Source	<ol style="list-style-type: none"> All cases submitted to the OPDS Clinical Warehouse are required to include the <i>Patient Identifier</i>. Please refer to the data dictionary for the definition of this data element. <i>Patient HIC#</i> (PTHIC) is required for all patients with a standard HIC. (Refer to Definition of Valid Patient HIC below.) 													
Definition of Valid Patient HIC (PTHIC)	General Rules <ul style="list-style-type: none"> No embedded dashes or spaces or special characters Must have both alpha and numeric characters Alpha characters must be upper case Length cannot be more than 12 or less than 7 characters For alphanumeric values, do not allow all numeric values to be 9's. For example do not allow 1 alpha + 999999999, etc. 													
	If First Character is Numeric Suffix rules: <ul style="list-style-type: none"> If the first character is numeric, (0-9), then the first 9 characters must be numeric. For example: <table border="0"> <thead> <tr> <th>HIC # length</th> <th>Rule</th> </tr> </thead> <tbody> <tr> <td>10</td> <td>9 numeric + 1 alpha</td> </tr> <tr> <td>11</td> <td>9 numeric + 1 alpha + 1 numeric Or 9 numeric + 2 alpha</td> </tr> </tbody> </table>	HIC # length	Rule	10	9 numeric + 1 alpha	11	9 numeric + 1 alpha + 1 numeric Or 9 numeric + 2 alpha							
	HIC # length	Rule												
10	9 numeric + 1 alpha													
11	9 numeric + 1 alpha + 1 numeric Or 9 numeric + 2 alpha													
If First Character is Alpha Prefix rules: <ul style="list-style-type: none"> If the first character is alpha, there must be 1-3 alpha characters followed by 6 or 9 numbers. For example: <table border="0"> <thead> <tr> <th>HIC # length</th> <th>Rule</th> </tr> </thead> <tbody> <tr> <td>7</td> <td>1 alpha + 6 numeric</td> </tr> <tr> <td>8</td> <td>2 alpha + 6 numeric</td> </tr> <tr> <td>9</td> <td>3 alpha + 6 numeric</td> </tr> <tr> <td>10</td> <td>1 alpha + 9 numeric</td> </tr> <tr> <td>11</td> <td>2 alpha + 9 numeric</td> </tr> <tr> <td>12</td> <td>3 alpha + 9 numeric</td> </tr> </tbody> </table>	HIC # length	Rule	7	1 alpha + 6 numeric	8	2 alpha + 6 numeric	9	3 alpha + 6 numeric	10	1 alpha + 9 numeric	11	2 alpha + 9 numeric	12	3 alpha + 9 numeric
HIC # length	Rule													
7	1 alpha + 6 numeric													
8	2 alpha + 6 numeric													
9	3 alpha + 6 numeric													
10	1 alpha + 9 numeric													
11	2 alpha + 9 numeric													
12	3 alpha + 9 numeric													
Unique Record Key (What fields make a record unique?)	<i>CMS Certification Number, Patient Identifier, Arrival Time, Outpatient Encounter Date, and Outpatient Measure Set</i>													

CMS Guidelines for Submission of Hospital Outpatient Clinical Data		
Principal and Other Diagnosis Codes	<i>Effective March 1, 2007, the National Uniform Billing Committee implemented a Present on Admission (POA) indicator for Principal and Other Diagnosis codes. These POA indicators do not apply to outpatient billing and should not be present on outpatient claims. Therefore, data submitted to the OPSS Clinical Warehouse must have any POA Indicator removed prior to submission. Failure to remove the indicator will result in cases being rejected from the OPSS Clinical Warehouse.</i>	
Hospital Outpatient Clinical Data XML file layout The XML file layout is divided into the following main sections (Please refer to Hospital Outpatient Clinical Data XML file layout for details).	submission	<ol style="list-style-type: none"> 1. type – Describes the setting for which the data is being submitted (OUTPATIENT) 2. data – Describes the type of data being submitted (CLINICAL) 3. version – The version of the file layout 4. action-code – Describes the intended action of the file being submitted. Options include: <ol style="list-style-type: none"> a. ADD (applicable to a file submitted for the first time for the hospital/time period or to a file being submitted as a replacement of an existing file already submitted for a provider) b. DELETE (utilize when the file is submitted for the purpose of deleting a file already submitted to the OPSS Clinical Warehouse) <p>Note: In order to replace or delete an existing file utilizing the ADD or DELETE action codes, the files must match on the following fields: <i>CMS Certification Number, Patient Identifier, Arrival Time, Outpatient Encounter Date, and Outpatient Measure Set.</i></p>
	file-audit-data Note: This section is not required	<ol style="list-style-type: none"> 1. create-date – The month, day and year the file was created 2. create-time – The hour and minutes representing the time the file was created 3. create-by – The entity who created the file 4. version – The version of the file being submitted 5. create-by-tool – Tool used to create the XML file

CMS Guidelines for Submission of Hospital Outpatient Clinical Data		
	<p>abstraction-audit-data</p> <p>Note: This section is not required</p>	<ol style="list-style-type: none"> 1. abstraction-date – The month, day and year the XML file was abstracted 2. abstractor-id – User id of who abstracted this encounter 3. total-abstraction-time – Total time it took for the encounter to be abstracted 4. comment – Comments about the abstraction
	<p>provider</p>	<p>Data elements in this section of the XML file relate to provider identification. These data elements include:</p> <ol style="list-style-type: none"> 1. provider-id – Used to identify the provider 2. npa – National Provider Identifier as assigned by CMS
	<p>patient</p>	<p>Data elements in this section of the XML file relate to patient demographic information such as:</p> <ol style="list-style-type: none"> 1. first-name – The patient’s first name 2. last-name – The patient’s last name 3. birthdate – The month, day and year the patient was born 4. sex – The patient’s sex 5. race – Documentation of the patient’s race 6. ethnic – Documentation that the patient is of Hispanic or Latino ethnicity 7. postal-code – The postal code of the patient’s residence

CMS Guidelines for Submission of Hospital Outpatient Clinical Data		
	encounter	<p>Data in this section of the XML file relate to the outpatient encounter and clinical data associated with the encounter. Examples of associated data elements include:</p> <ol style="list-style-type: none"> 1. measure-set – The code for the outpatient measure set submitted 2. encounter-date – The month, day and year the patient was seen in the hospital outpatient department 3. pthic – HIC# of the patient 4. patient-id – Identifier used to identify the patient at the hospital 5. arrival-time – The time the patient arrived at the hospital outpatient or emergency department. 6. Clinical Questions and answer codes

Guidelines for Submission of Hospital Outpatient Population Data

CMS Guidelines for Submission of Hospital Outpatient Population Data		
<p>Hospital Outpatient Population Data XML file layout</p> <p>The XML file layout is divided into the following main sections (Please refer to Hospital Outpatient Population Data XML file layout for details).</p>	<p>submission</p>	<ol style="list-style-type: none"> 1. type – Describes the setting for which the data is being submitted (OUTPATIENT) 2. data – Describes the type of data being submitted (POPULATION) 3. version – The version of the file layout 4. action-code – Describes the intended action of the file being submitted. Options include: <ol style="list-style-type: none"> a. ADD (applicable to a file submitted for the first time for the hospital/time period or to a file being submitted as a replacement of an existing file already submitted for a provider) b. DELETE (utilize when the file is submitted for the purpose of deleting a file already submitted to the OPSS Clinical Warehouse) <p>Note: In order to replace or delete an existing file utilizing the ADD or DELETE action codes, the files must match on the following fields: <i>CMS Certification Number</i>, time-period and <i>Outpatient Measure Set</i>.</p>
	<p>file-audit-data</p> <p>Note: This section is not required.</p>	<ol style="list-style-type: none"> 1. create-date – The month, day and year the file was created 2. create-time – The hour and minutes representing the time the file was created 3. create-by – The entity who created the file 4. version – The version of the file being submitted 5. create-by-tool – Tool used to create the file
	<p>provider</p>	<p>Data elements in this section of the XML file relate to provider identification. These data elements include:</p> <ol style="list-style-type: none"> 1. provider-id – Used to identify the provider 2. npi – National Provider Identifier as assigned by CMS

CMS Guidelines for Submission of Hospital Outpatient Population Data		
	time-period	<p>Time-period – Dates in this field should reflect the encounter time period related to the data being submitted. Time period start and end dates must reflect full month increments and not be greater than one month. Files submitted to the OPDS Clinical Warehouse are required to contain three one-month time-periods comprising the calendar quarter for which data are being submitted.</p> <p>Example: If the Hospital Outpatient Population Data file is being submitted for second quarter 2008, the file must contain the following time periods and appropriate associated data (including all data elements as the Population Details section that follows): April 2008 May 2008 June 2008</p> <p>Files submitted with time-periods that do not meet the above requirements will be rejected from the OPDS Clinical Warehouse.</p>
	encounter	<p>1. measure-set – Used to identify which outpatient measure set the case was abstracted for</p> <p>Additional data elements include <i>Outpatient Population Size – Medicare, Outpatient Population Size – Non-Medicare, Outpatient Sampling Frequency, Outpatient Sample Size – Medicare, and Outpatient Sample Size – Non-Medicare</i>. Please refer to the Transmission Data Element List for further definition of these data elements. Please refer to Hospital Outpatient Population Data XML file layout for further information on details of the XML file format. All data elements are based on encounters that occurred during the associated time-period.</p>

Transmission Data Element List

These data elements are either used to identify the hospital and hospital outpatient measure set associated to the transmitted data or; are calculated by the vendor using the hospital's patient-level data and measure results. These data elements are not used in the Outpatient Population Algorithms or Measure Algorithms.

Element Name	Page #	Collected For:
<i>CMS Certification Number</i>	11	All Records
<i>National Provider Identifier (NPI)</i>	12	All Records
<i>Outpatient Measure Set</i>	13	Used in transmission of the Hospital Outpatient Population Data XML file and the Hospital Outpatient Clinical Data XML file
<i>Outpatient Population Size – Medicare Only</i>	14	Used in transmission of the Hospital Outpatient Population Data XML file
<i>Outpatient Population Size – Non-Medicare Only</i>	16	Used in transmission of the Hospital Outpatient Population Data XML file
<i>Outpatient Sample Size – Medicare Only</i>	17	Used in transmission of the Hospital Outpatient Population Data XML file
<i>Outpatient Sample Size – Non-Medicare Only</i>	18	Used in transmission of the Hospital Outpatient Population Data XML file
<i>Outpatient Sampling Frequency</i>	19	Used in transmission of the Hospital Outpatient Population Data XML file

IMPORTANT SUBMISSION ALERT!!

At this time, for submission of the Hospital Outpatient Measures to CMS under the Hospital Outpatient Quality Data Reporting Program, files must meet the specifications in this CMS manual only. Otherwise, the files will be rejected as not meeting CMS quality data submission requirements for receiving the full payment update.

Providers who are planning to also submit the Hospital Outpatient Measures to The Joint Commission must refer to the transmission section separately issued by The Joint Commission. This is important because at this time, CMS can only accept files which meet the CMS transmission manual specifications and such files cannot contain the additional Joint Commission transmission data elements (e.g., vendor tracking ID, measure category assignment, measurement value).

Data Element Name: *CMS Certification Number*

Collected For: All Records

Definition: Hospital's six digit acute care CMS Certification Number (CCN).

Suggested Data

Collection Question: What is the hospital's six digit acute care CMS Certification Number?

Format: **Length:** 6
 Type: Character
 Occurs: 1

Allowable Values: Any valid six digit CMS Certification Number.

The first two digits 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).

Notes for Abstraction: None

Suggested Data Sources: None

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *National Provider Identifier (NPI)*

Collected For: All Records

Definition: All Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered healthcare providers must obtain an NPI. The NPI may be provided in addition to the Medicare provider number.

Suggested Data Collection Question: What is the NPI for this provider?

Format: **Length:** 10
 Type: Character
 Occurs: 1

Allowable Values: Any valid 10 digit NPI number.
The 10th digit is a numeric check digit based off the first 9 digits.

Notes for Abstraction: None

Suggested Data Sources: UB-04, Field Location: 56

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Outpatient Measure Set*

Collected For: Used in transmission of the Hospital Outpatient Population Data XML file and the Hospital Outpatient Clinical Data XML file.

Definition: Indicates which hospital outpatient measure set is being transmitted for hospital.

Suggested Data Collection Question: Not Applicable

Format: **Length:** 22
 Type: Character
 Occurs: 1

Allowable Values: Refer to the Hospital Outpatient Clinical Data XML file and the Hospital Outpatient Population Data XML file layouts located just after the Transmission Data Processing Flow portion of this section.

Notes for Abstraction: None

Suggested Data Sources: Not Applicable

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	<i>Outpatient Population Size – Medicare Only</i>
Collected For:	Used in transmission of the Hospital Outpatient Population Data XML file. Note: Refer to the Hospital Outpatient Population Data XML file layout located just after the Transmission Data Processing Flow portion of this section.
Definition:	Indicates the number of encounter records identified for a hospital with Medicare listed as a payment source prior to the application of data integrity filters, measure exclusions, and/or sampling methodology for the specified time period. The data element is based on the hospital's initial identification of Medicare encounter records for a hospital outpatient measure set. <i>Outpatient Population Size – Medicare Only</i> includes all patients that are billed under Medicare or Title 18. Medicare can be listed as a primary, secondary, tertiary or lower on the list of payment sources for the patient. In addition, patients who are participating as a member of a Medicare HMO/Medicare Advantage are included in the Medicare counts, e.g., Medicare Blue, Humana Gold, Secure Horizons, AARP, Coventry Advantra, etc. This initial data pull utilizes administrative data such as ICD-9-CM diagnosis codes, CPT® codes, outpatient encounter date, and birthdate. For specific hospital outpatient measure set definitions, refer to the appropriate outpatient population discussion in the Measurement Information section of this manual. Note: If the hospital's data have been sampled, this field contains the population from which the sample was originally drawn, NOT the sample size.
Suggested Data Collection Question:	Not Applicable
Format:	Length: 6 Type: Numeric Occurs: One <i>Outpatient Population Size – Medicare Only</i> per hospital outpatient measure set.
Allowable Values:	0 through 999,999
Notes for Abstraction:	<i>Outpatient Population Size – Medicare Only</i> must contain the actual number of patients in the population.
Suggested Data Sources:	Not Applicable

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Outpatient Population Size – Non-Medicare Only*

Collected For: Used in transmission of the Hospital Outpatient Population Data XML file.

Note: Refer to the Hospital Outpatient Population Data XML file layout located just after the Transmission Data Processing Flow portion of this section

Definition: Indicates the number of encounter records identified for a hospital with Medicare NOT listed as a payment source prior to the application of data integrity filters, measure exclusions, and/or sampling methodology for the specified time period.

The data element is based on the hospital's initial identification of non-Medicare encounter records for a hospital outpatient measure set. This initial data pull utilizes administrative data such as ICD-9-CM diagnosis codes, CPT® codes, outpatient encounter date, and birthdate.

For specific hospital outpatient measure set definitions, refer to the appropriate outpatient population discussion in the Measurement Information section of this manual.

Note: If the hospital's data have been sampled, this field contains the population from which the sample was originally drawn, NOT the sample size.

Suggested Data Collection Question: Not Applicable

Format: **Length:** 6
Type: Numeric
Occurs: One *Outpatient Population Size – Non-Medicare Only* per hospital outpatient measure set.

Allowable Values: 0 through 999,999

Notes for Abstraction: *Outpatient Population Size – Non-Medicare Only* must contain the actual number of patients in the population.

Suggested Data Sources: Not Applicable

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Outpatient Sample Size – Medicare Only*

Collected For: Used in transmission of the Hospital Outpatient Population Data XML file.

Note: For more information refer to the Population and Sampling Specifications section and Hospital Outpatient Population Data XML file layout located just after the Transmission Data Processing Flow portion of this section.

Definition: Indicates the number of encounter records identified for a hospital with Medicare listed as a payment source for a hospital to perform data abstraction on. This count is after the appropriate sampling methodology, if any, has been applied for the specific time period.

Notes:

- If the hospital **is** sampling the hospital outpatient measure set, then the *Outpatient Sample Size – Medicare Only* will be less than the *Outpatient Population Size – Medicare Only* for the hospital outpatient measure set.
- If the hospital **is not** sampling the hospital outpatient measure set, then the *Outpatient Sample Size – Medicare Only* will equal the *Outpatient Population Size – Medicare Only* for the hospital outpatient measure set.

Suggested Data Collection Question:

Not Applicable

Format:

Length: 6

Type: Numeric

Occurs: One *Outpatient Sample Size – Medicare Only* per hospital outpatient measure set.

Allowable Values: 0 through 999,999

Notes for Abstraction: When *Outpatient Sampling Frequency* = 'N/A' because the hospital decided to not submit patient-level data, *Outpatient Sample Size – Medicare Only* equals zero.

Suggested Data Sources: Not Applicable

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Outpatient Sample Size – Non-Medicare Only*

Collected For: Used in transmission of the Hospital Outpatient Population Data XML file.

Note: For more information, refer to the Population and Sampling Specifications section and the Hospital Outpatient Population Data XML file layout located just after the Transmission Data Processing Flow portion of this section.

Definition: Indicates the number of encounter records identified for a hospital with Medicare NOT listed as a payment source for a hospital to perform data abstraction on. This count is after the appropriate sampling methodology, if any, has been applied for the specific time period.

Notes:

- If the hospital **is** sampling the hospital outpatient measure set, then the *Outpatient Sample Size – Non-Medicare Only* will be less than the *Outpatient Population Size – Non-Medicare Only* for the hospital outpatient measure set.
- If the hospital **is not** sampling the hospital outpatient measure set, then the *Outpatient Sample Size – Non-Medicare Only* will equal the *Outpatient Population Size – Non-Medicare Only* for the hospital outpatient measure set.

Suggested Data Collection Question: Not Applicable

Format: **Length:** 6
Type: Numeric
Occurs: One *Outpatient Sample Size – Non-Medicare Only* per hospital outpatient measure set.

Allowable Values: 0 through 999,999

Notes for Abstraction: When *Outpatient Sampling Frequency* = ‘N/A’ because the hospital decided to not submit patient-level data, *Outpatient Sample Size – Non-Medicare Only* equals zero.

Suggested Data Sources: Not Applicable

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Outpatient Sampling Frequency*

Collected For: Used in transmission of the Hospital Outpatient Population Data XML file.

Note: Refer to the Population and Sampling Specifications section and the Hospital Outpatient Population Data XML file layout located just after the Transmission Data Processing Flow portion of this section.

Definition: Indicates if the data being transmitted for a hospital has been sampled or represents an entire population for the specified time period.

Suggested Data Collection Question: Not Applicable

Format: **Length:** 1
Type: Character
Occurs: One *Outpatient Sampling Frequency* per hospital outpatient measure set.

- Allowable Values:**
- 1 Yes, the hospital is sampling.
 - 2 No, the hospital is not sampling.
 - 3 N/A, submission of patient-level data is not required.

Notes for Abstraction: Hospitals that have five or fewer cases (both Medicare and non-Medicare) for any measure included in a measure topic (i.e., ED and Surgical) in a quarter will not be required to submit patient-level data for the entire measure topic for that quarter. For example, hospitals with five or fewer cases (both Medicare and non-Medicare) for the ED measure topic (i.e., AMI and CP Outpatient Populations combined) in a quarter will not be required to submit patient-level data for both the AMI and CP Outpatient Populations for that quarter.

Suggested Data Sources: Not Applicable

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Transmission Data Processing Flow

Introduction

This section contains information regarding the order in which the OPPS Clinical Warehouse evaluates the hospital outpatient measures.

The data processing flow ensures that only valid data are used in the measure algorithms. Each case that is rejected by the process will be listed on a report along with a brief description of the problem. The OPPS Clinical Warehouse has reports available to assist the submitter to determine how the data was processed. For the OPPS Clinical Warehouse, please refer to QualityNet.org for more information about the data upload process and these reports.

Data Processing Flow

All data transmitted pass through the following process:

1. If appropriate, files are verified to be proper ZIP and XML files.
 - If the files are invalid, reject the file(s) and stop processing.
 - If the files are valid, continue processing.

Starting with this step, processing is per case (individual XML file):

2. Data are evaluated to ensure the quarter associated to the *Outpatient Encounter Date* is open for data transmission.
 - If the Data Collection quarter is closed, reject the XML file and stop processing.
 - If the Data Collection quarter is open, continue processing.
3. Data are evaluated to ensure the *Outpatient Measure Set* is expected from the submitter for the time frame (*Outpatient Encounter Date*) in question. In addition, the OPPS Clinical Warehouse verifies the data is expected for the *CMS Certification Number*.
 - If the data are not expected, reject the XML file and stop processing.
 - If the data are expected, continue processing.
4. Check the action-code
 - If the action-code = ADD, continue with step #5.
 - If the action-code = DELETE, continue with step #12.

The following steps are performed if the record's action-code = ADD:

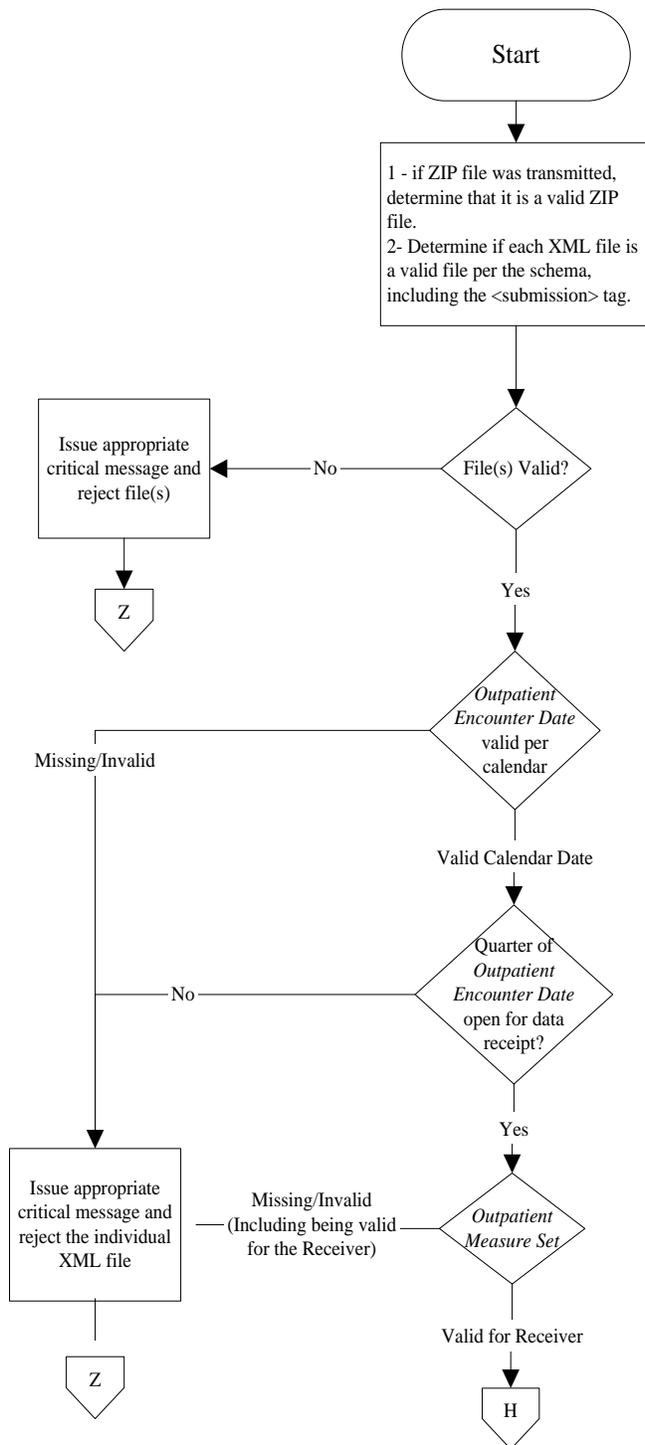
5. The general data elements, as defined in the Data Dictionary section, are evaluated to ensure they exist and contain valid allowable values. These data elements are generally required for all hospital outpatient measures (with the exception of *NPI*).
 - If any general data element is missing or invalid, reject the XML file and stop processing.
 - If all general data elements exist and contain valid allowable values, continue processing.
6. The Outpatient Population Algorithm associated to the *Outpatient Measure Set* is evaluated to ensure that the data is in the population of the set. Refer to the appropriate *Outpatient Measure Set* Data Element List for the algorithm.
 - If the Outpatient Population Algorithm returns an **Outpatient Population Reject Case Flag** = “Yes” (case is not in the outpatient population), reject the XML file and stop processing.
 - If the Outpatient Population Algorithm returns an **Outpatient Population Reject Case Flag** = “No” (case is in the outpatient population), continue processing.
7. The *Outpatient Measure Set* specific data elements are evaluated to ensure they contain valid allowable values. This step does not evaluate for missing data because that process is performed by the measure algorithms.
 - If any outpatient measure set specific data elements are invalid, reject the XML file and stop processing.
 - If all outpatient measure set specific data elements contain valid allowable values, continue processing.
8. If appropriate for the *Outpatient Measure Set*, grid data elements are evaluated to ensure each row does not contain missing data. This step does not ensure that the entire grid is empty because that process is performed by the measure algorithms.
 - If any row of the grid is missing data, reject the XML file and stop processing.
 - If all data elements exist in each row, continue processing.
9. Each XML file is evaluated for unexpected data. While a case may be in the population of more than one outpatient measure set, each XML file is associated to only one set.
 - If any data exists that is not expected for the *Outpatient Measure Set*, reject the XML file and stop processing.
 - If no unexpected data for the *Outpatient Measure Set* exists, continue processing.
10. Execute each measure algorithm associated to the measures the hospital has selected for the *Outpatient Measure Set*. Refer to the appropriate Measure Information Forms for the *Outpatient Measure Set* for the measure algorithms.
 - If any measure evaluates with a Measure Category Assignment = “X”, reject the XML file and stop processing.
 - If all measures evaluate with Measure Category Assignment = “B”, “D”, “E”, and/or “Y”, continue processing.

11. The case is accepted into the OPDS Clinical Warehouse.

The following steps are performed if the record's action-code = DELETE:

12. The remaining data elements that are part of the Unique Record Key are evaluated to ensure they exist and contain valid allowable values. These data elements are required for all *Outpatient Measure Sets*.
- If any Unique Record Key data element is missing or invalid, reject the XML file and stop processing.
 - If all Unique Record Key data elements exist and contain valid allowable values, continue processing.
13. The database is checked to see if a record with the same Unique Record Key already exists.
- If the case does not already exist in the database, then the transmitted DELETE record is rejected.
 - If the record already exists in the database, it is deleted.

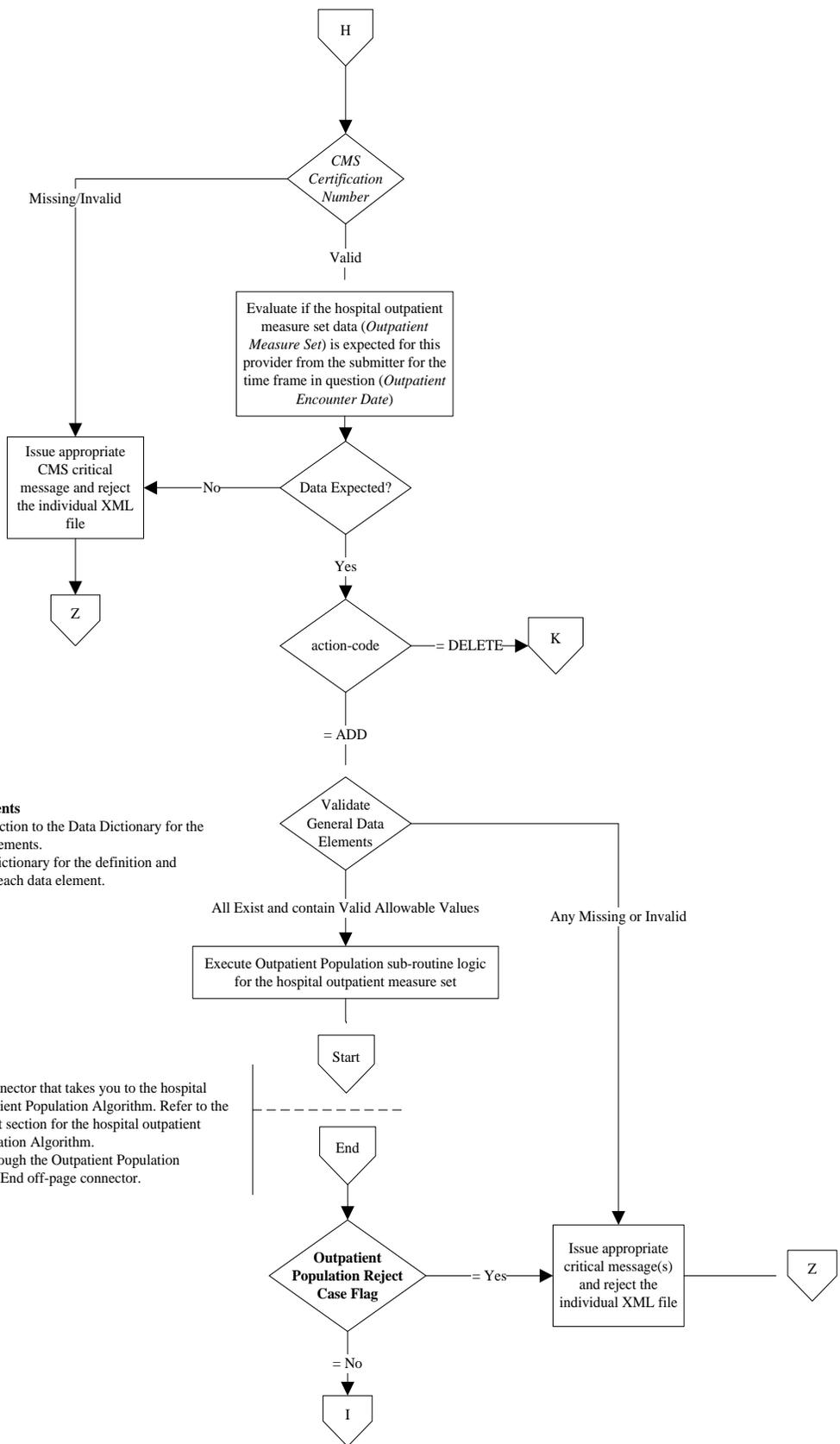
Data Processing Flow



Variable Key:
 Outpatient Population Reject Flag
 (returned from the Outpatient Population logic subroutines)

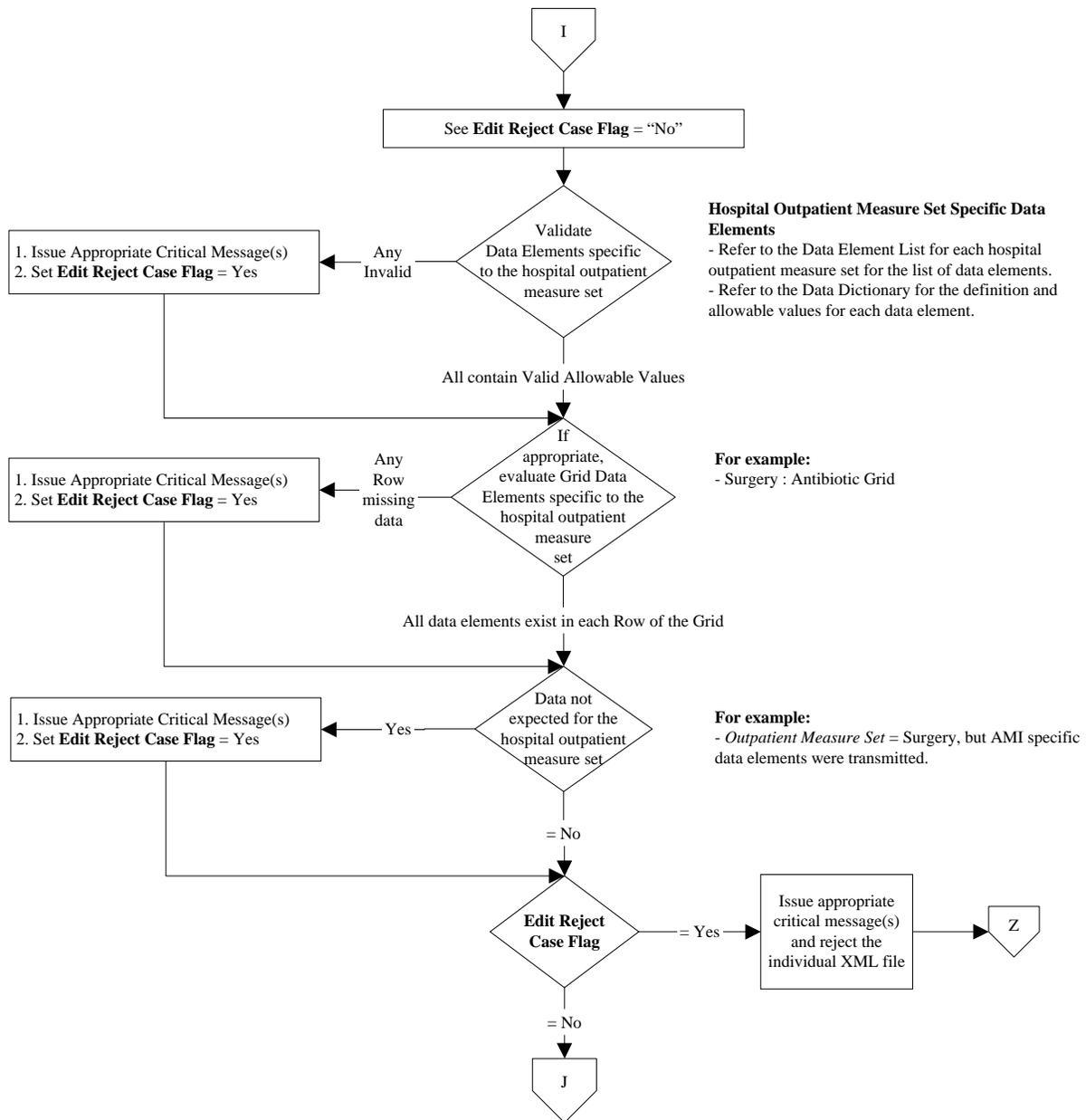
Edit Reject Case Flag

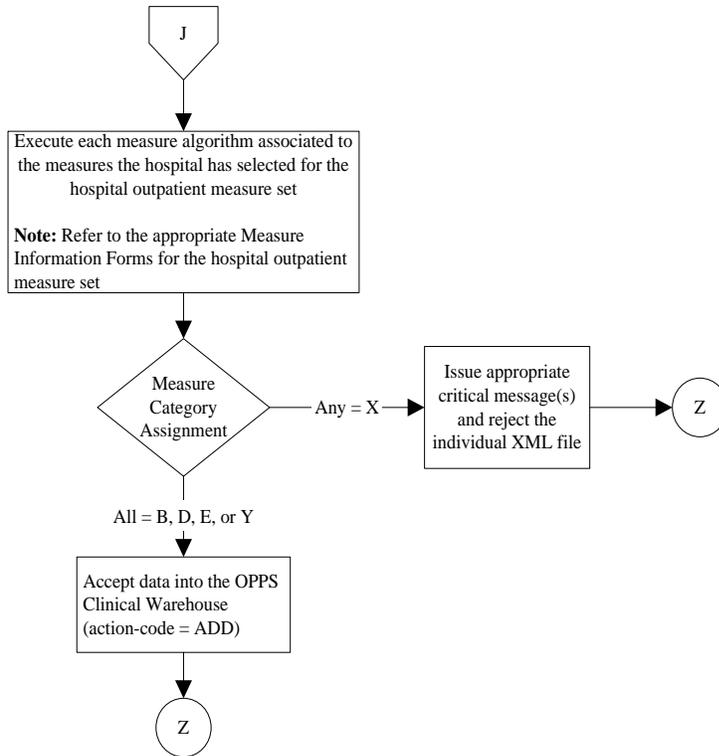
Measure Category Assignment
 (returned from each measure algorithm)



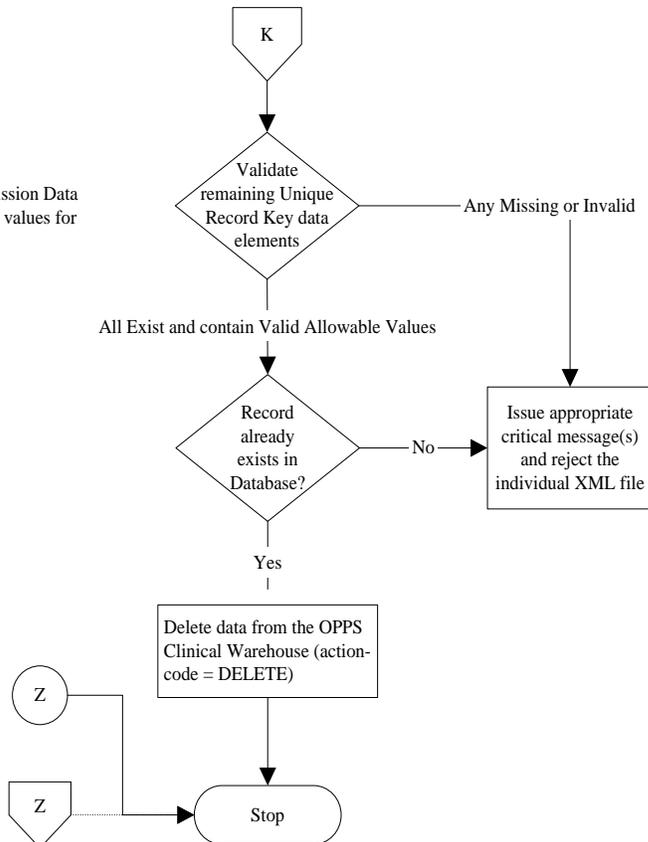
General Data Elements
 - Refer to the Introduction to the Data Dictionary for the list of general data elements.
 - Refer to the Data Dictionary for the definition and allowable values for each data element.

Note: Start is an off-page connector that takes you to the hospital outpatient measure set Outpatient Population Algorithm. Refer to the appropriate Data Element List section for the hospital outpatient measure set Outpatient Population Algorithm. When finished processing through the Outpatient Population Algorithm, return back to the End off-page connector.





Key Data Elements
 - Refer to the Data Dictionary and Transmission Data Dictionary for the definition and allowable values for each data element.



Appendix A

ICD-9-CM Diagnosis and CPT® Code Tables

OP Table 1.0: E/M Codes for Emergency Department Encounters

Code	E/M Code Description
99281	Emergency department visit, new or established patient
99282	Emergency department visit, new or established patient
99283	Emergency department visit, new or established patient
99284	Emergency department visit, new or established patient
99285	Emergency department visit, new or established patient
99291	Critical care, evaluation and management

OP Table 1.1: Acute Myocardial Infarction (AMI) Diagnosis Codes

Code	ICD-9-CM Description	Shortened Description
410.00	Anterolateral wall, acute myocardial infarction-episode of care unspecified	AMI ANTEROLATERAL, UNSPEC
410.01	Anterolateral wall, acute myocardial infarction-initial episode	AMI ANTEROLATERAL, INIT
410.10	Other anterior wall, acute myocardial infarction-episode of care unspecified	AMI ANTERIOR WALL, UNSPEC
410.11	Other anterior wall, acute myocardial infarction-initial episode	AMI ANTERIOR WALL, INIT
410.20	Inferolateral wall, acute myocardial infarction-episode of care unspecified	AMI INFEROLATERAL, UNSPEC
410.21	Inferolateral wall, acute myocardial infarction-initial episode	AMI INFEROLATERAL, INIT
410.30	Inferoposterior wall, acute myocardial infarction-episode of care unspecified	AMI INFEROPOST, UNSPEC
410.31	Inferoposterior wall, acute myocardial infarction-initial episode	AMI INFEROPOST, INITIAL
410.40	Other inferior wall, acute myocardial infarction-episode of care unspecified	AMI INFERIOR WALL, UNSPEC
410.41	Other inferior wall, acute myocardial infarction-initial episode	AMI INFERIOR WALL, INIT
410.50	Other lateral wall, acute myocardial infarction-episode of care unspecified	AMI LATERAL NEC, UNSPEC
410.51	Other lateral wall, acute myocardial infarction-initial episode	AMI LATERAL NEC, INITIAL
410.60	True posterior wall, acute myocardial infarction-episode of care unspecified	TRUE POST INFARCT, UNSPEC
410.61	True posterior wall, acute myocardial infarction-initial episode	TRUE POST INFARCT, INIT
410.70	Subendocardial, acute myocardial infarction-episode of care unspecified	SUBENDO INFARCT, UNSPEC
410.71	Subendocardial, acute myocardial infarction-initial episode	SUBENDO INFARCT, INITIAL

410.80	Other specified sites, acute myocardial infarction-episode of care unspecified	AMI NEC, UNSPECIFIED
410.81	Other specified sites, acute myocardial infarction-initial episode	AMI NEC, INITIAL
410.90	Unspecified site, acute myocardial infarction-episode of care unspecified	AMI NOS, UNSPECIFIED
410.91	Unspecified site, acute myocardial infarction-initial episode	AMI NOS, INITIAL

OP Table 1.1a: Chest Pain, Angina, Acute Coronary Syndrome Codes

Code	ICD-9-CM Description	Shortened Description
411.1	Intermediate coronary syndrome	INTERMED CORONARY SYND
411.89	Acute ischemic heart disease other	AC ISCHEMIC HRT DIS NEC
413.9	Other and unspecified angina pectoris	ANGINA PECTORIS NEC/NOS
786.50	Chest pain, unspecified	CHEST PAIN NOS
786.51	Precordial Chest Pain	PRECORDIAL PAIN
786.52	Painful Respiration	PAINFUL RESPIRATION
786.59	Chest pain, other	CHEST PAIN NEC

OP Table 6.0: Surgery Procedure Codes

Code	Description
21454	Open treatment of mandibular fracture with external fixation
21461	Open treatment of mandibular fracture; without interdental fixation
21462	With interdental fixation
21465	Open treatment of mandibular condylar fracture
21470	Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and/or wiring of dentures or splints
22206	Osteotomy of spine, posterior or posterolateral approach, three columns, one vertebral segment (eg, pedicle/vertebral body subtraction); thoracic
22207	Lumbar
22208	Each additional vertebral segment
27235	Percutaneous skeletal fixation of femoral fracture, proximal end, neck
27269	Open treatment of femoral fracture, proximal end, head, includes internal fixation, when performed
27440	Arthroplasty, knee, tibial plateau;
27441	With debridement and partial synovectomy
27442	Arthroplasty, femoral condyles or tibial plateau(s), knee;
27443	With debridement and partial synovectomy
27446	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment
27702	With implant (total ankle)
27758	Open treatment of tibial shaft fracture (with or without fibular fracture), with plate/screws, with or without cerclage
27759	Treatment of tibial shaft fracture (with or without fibular fracture) by intramedullary implant, with or without interlocking screws and/or cerclage
28293	Resection of joint with implant
28415	Open treatment of calcaneal fracture, includes internal fixation, when performed
28420	With primary iliac or other autogenous bone graft (includes obtaining graft)

Code	Description
28445	Open treatment of talus fracture, includes internal fixation, when performed
28465	Open treatment of tarsal bone fracture (except talus and calcaneus) includes internal fixation, when performed, each
28485	Open treatment of metatarsal fracture, includes internal fixation, when performed, each
28505	Open treatment of fracture, great toe, phalanx or phalanges, includes internal fixation, when performed
28525	Open treatment of fracture, phalanx or phalanges, other than great toe, includes internal fixation, when performed, each
28531	Open treatment of sesamoid fracture, with or without internal fixation
28555	Open treatment of tarsal bone dislocation, includes internal fixation, when performed
28585	Open treatment of talotarsal joint dislocation, includes internal fixation, when performed
28615	Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed
28645	Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed
28675	Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed
28705	Arthrodesis; pantalar
28715	Triple
28725	Subtalar
28730	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse
28735	With osteotomy (eg, flatfoot correction)
28737	Arthrodesis, with tendon lengthening and advancement, midtarsal, tarsal navicular-cuneiform (eg, Miller type procedure)
33206	Insertion or replacement of permanent pacemaker with transvenous electrode(s); atrial
33207	Ventricular
33208	Atrial and ventricular
33212	Insertion or replacement of pacemaker pulse generator only; single chamber, atrial or ventricular
33213	Dual chamber
33214	Upgrade of implanted pacemaker system, conversion of single chamber system to dual chamber system (includes removal of previously placed pulse generator, testing of existing lead, insertion of new lead, insertion of new pulse generator)
33215	Repositioning of previously implanted transvenous pacemaker or pacing cardioverter-defibrillator (right atrial or right ventricular) electrode
33216	Insertion of a single transvenous electrode, permanent pacemaker or cardioverter-defibrillator
33217	Insertion of 2 transvenous electrodes, permanent pacemaker or cardioverter-defibrillator
33218	Repair of single transvenous electrode for a single chamber, permanent pacemaker or single chamber pacing cardioverter-defibrillator
33220	Repair of 2 transvenous electrodes for a dual chamber permanent pacemaker or dual chamber pacing cardioverter-defibrillator
33222	Revision or relocation of skin pocket for pacemaker
33223	Revision of skin pocket for cardioverter-defibrillator
33233	Removal of permanent pacemaker pulse generator
33234	Removal of transvenous pacemaker electrode(s); single lead system, atrial or ventricular
33235	Dual lead system
33240	Insertion of single or dual chamber pacing cardioverter-defibrillator pulse generator
33241	Subcutaneous removal of single or dual chamber pacing cardioverter-defibrillator pulse generator
33244	By transvenous extraction

Code	Description
33249	Insertion or repositioning of electrode lead(s) for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator
36830	Nonautogenous graft (eg, biological collagen, thermoplastic graft)
43130	Diverticulectomy of hypopharynx or esophagus, with or without myotomy; cervical approach
43246	Upper gastrointestinal endoscopy with directed placement of percutaneous gastrostomy tube
43832	With construction of gastric tube (eg, Janeway procedure)
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)
54401	Inflatable (self-contained)
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders and reservoir
54406	Removal of all components of a multi-component inflatable penile prosthesis without replacement of prosthesis
54408	Repair of component(s) of a multi-component, inflatable penile prosthesis
54410	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session
54415	Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis
54416	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session
55700	Biopsy, prostate; needle or punch, single or multiple, any approach
55705	Incisional, any approach
57288	Sling operation for stress incontinence (e.g., fascia or synthetic)
57423	Paravaginal defect repair (including repair of cystocele, if performed), laparoscopic approach
58260	Vaginal hysterectomy, for uterus 250 g or less;
58262	With removal of tube(s) and/or ovary(s)
58263	With removal of tube(s), and/or ovary(s), with repair of enterocele
58270	With repair of enterocele
58290	Vaginal hysterectomy, for uterus greater than 250 g;
58291	With removal of tube(s) and/or ovary(s)
58292	With removal of tube(s) and/or ovary(s), with repair of enterocele
58293	With colpo-urethrocystopexy (Marshall-Marchetti-Kranz type, Pereyro type) with or without endoscopic control
58294	With repair of enterocele
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less;
58552	With removal of tube(s) and/or ovary(s)
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g;
58554	With removal of tube(s) and/or ovary(s)
58570	Laparoscopy, surgical, with total hysterectomy for uterus 250 g or less
58571	With removal of tube(s) and/or ovary(s)
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g
58573	With removal of tube(s) and/or ovary(s)
62230	Replacement or revision of cerebrospinal fluid shunt, obstructed valve, or distal catheter in shunt system
62360	Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir
62361	Non-programmable pump
62362	Programmable pump, including preparation of pump, with or without programming

Code	Description
63001	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equine, without facetectomy, foraminotomy or discectomy, (eg, spinal stenosis), 1 or 2 vertebral segments; cervical
63003	Thoracic
63005	Lumbar, except for spondylolisthesis
63011	Sacral
63012	Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equine and nerve roots for spondylolisthesis, lumbar (Gill type procedure)
63015	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equine, without facetectomy, foraminotomy or discectomy, (e.g., spinal stenosis), more than 2 vertebral segments; cervical
63016	Thoracic
63017	Lumbar
63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; including open and endoscopically-assisted approaches; 1 interspace, cervical
63030	1 interspace, lumbar
63040	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical
63042	Lumbar
63045	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equine and/or nerve root(s), (e.g., spinal or lateral recess stenosis)), single vertebral segment; cervical
63046	Thoracic
63047	Lumbar
63056	Lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disc)
63075	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace

OP Table 6.1: Cardiac Codes

Code	Description
33206	Insertion or replacement of permanent pacemaker with transvenous electrode(s); atrial
33207	Ventricular
33208	Atrial and ventricular
33212	Insertion or replacement of pacemaker pulse generator only; single chamber, atrial or ventricular
33213	Dual chamber
33214	Upgrade of implanted pacemaker system, conversion of single chamber system to dual chamber system (includes removal of previously placed pulse generator, testing of existing lead, insertion of new lead, insertion of new pulse generator)
33215	Repositioning of previously implanted transvenous pacemaker or pacing cardioverter-defibrillator (right atrial or right ventricular) electrode
33216	Insertion of a single transvenous electrode, permanent pacemaker or cardioverter-defibrillator

Code	Description
33217	Insertion of 2 transvenous electrodes, permanent pacemaker or cardioverter-defibrillator
33218	Repair of single transvenous electrode for a single chamber, permanent pacemaker or single chamber pacing cardioverter-defibrillator
33220	Repair of 2 transvenous electrodes for a dual chamber permanent pacemaker or dual chamber pacing cardioverter-defibrillator
33222	Revision or relocation of skin pocket for pacemaker
33223	Revision of skin pocket for cardioverter-defibrillator
33233	Removal of permanent pacemaker pulse generator
33234	Removal of transvenous pacemaker electrode(s); single lead system, atrial or ventricular
33235	Dual lead system
33240	Insertion of single or dual chamber pacing cardioverter-defibrillator pulse generator
33241	Subcutaneous removal of single or dual chamber pacing cardioverter-defibrillator pulse generator
33244	By transvenous extraction
33249	Insertion or repositioning of electrode lead(s) for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator
36830	Nonautogenous graft (eg, biological collagen, thermoplastic graft)

OP Table 6.2: Orthopedic Codes

Code	Description
22206	Osteotomy of spine, posterior or posterolateral approach, three columns, one vertebral segment (eg, pedicle/vertebral body subtraction); thoracic
22207	Lumbar
22208	Each additional vertebral segment
27235	Percutaneous skeletal fixation of femoral fracture, proximal end, neck
27269	Open treatment of femoral fracture, proximal end, head, includes internal fixation, when performed
27440	Arthroplasty, knee, tibial plateau;
27441	With debridement and partial synovectomy
27442	Arthroplasty, femoral condyles or tibial plateau(s), knee;
27443	With debridement and partial synovectomy
27446	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment
27702	With implant (total ankle)
27758	Open treatment of tibial shaft fracture (with or without fibular fracture), with plate/screws, with or without cerclage
27759	Treatment of tibial shaft fracture (with or without fibular fracture) by intramedullary implant, with or without interlocking screws, and/or cerclage
28293	Resection of joint with implant
28415	Open treatment of calcaneal fracture, includes internal fixation, when performed
28420	With primary iliac or other autogenous bone graft (includes obtaining graft)
28445	Open treatment of talus fracture, includes internal fixation, when performed
28465	Open treatment of tarsal bone fracture (except talus and calcaneus) includes internal fixation, when performed, each
28485	Open treatment of metatarsal fracture, includes internal fixation, when performed, each
28505	Open treatment of fracture, great toe, phalanx or phalanges, includes internal fixation, when

Code	Description
	performed
28525	Open treatment of fracture, phalanx or phalanges, other than great toe, includes internal fixation, when performed, each
28531	Open treatment of sesamoid fracture, with or without internal fixation
28555	Open treatment of tarsal bone dislocation, includes internal fixation, when performed
28585	Open treatment of talotarsal joint dislocation, includes internal fixation, when performed
28615	Open treatment of tarsometatarsal joint dislocation, includes internal fixation, when performed
28645	Open treatment of metatarsophalangeal joint dislocation, includes internal fixation, when performed
28675	Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed
28705	Arthrodesis; pantalar
28715	Triple
28725	Subtalar
28730	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse
28735	With osteotomy (eg, flatfoot correction)
28737	Arthrodesis, with tendon lengthening and advancement, midtarsal, tarsal navicular-cuneiform (eg, Miller type procedure)

OP Table 6.3: Genitourinary – Transrectal biopsy, prostate

Code	Description
55700	Biopsy, prostate; needle or punch, single or multiple, any approach
55705	Incisional, any approach

OP Table 6.3a: Genitourinary – Penile prosthesis insertion, removal, revision

Code	Description
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)
54401	Inflatable (self-contained)
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders and reservoir
54406	Removal of all components of a multi-component inflatable penile prosthesis without replacement of prosthesis
54408	Repair of component(s) of a multi-component, inflatable penile prosthesis
54410	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session
54415	Removal of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis, without replacement of prosthesis
54416	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session

OP Table 6.4: Gastric/biliary – PEG placement

Code	Description
43246	Upper gastrointestinal endoscopy with directed placement of percutaneous gastrostomy tube
43832	With construction of gastric tube (eg, Janeway procedure)

OP Table 6.5: Gynecological – LAVH, Vaginal Hysterectomy

Code	Description
58260	Vaginal hysterectomy, for uterus 250 g or less;
58262	With removal of tube(s) and/or ovary(s)
58263	With removal of tube(s), and/or ovary(s), with repair of enterocele
58270	With repair of enterocele
58290	Vaginal hysterectomy, for uterus greater than 250 g;
58291	With removal of tube(s) and/or ovary(s)
58292	With removal of tube(s) and/or ovary(s), with repair of enterocele
58293	With colpo-urethrocytopexy (Marshall-Marchetti-Kranz type, Pereyro type) with or without endoscopic control
58294	With repair of enterocele
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less;
58552	With removal of tube(s) and/or ovary(s)
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g;
58554	With removal of tube(s) and/or ovary(s)
58570	Laparoscopy, surgical, with total hysterectomy for uterus 250 g or less
58571	With removal of tube(s) and/or ovary(s)
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g
58573	With removal of tube(s) and/or ovary(s)

OP Table 6.5a: Gynecological – Pubovaginal sling

Code	Description
57288	Sling operation for stress incontinence (e.g., fascia or synthetic)
57423	Paravaginal defect repair (including repair of cystocele, if performed), laparoscopic approach

OP Table 6.6: Head and Neck

Code	Description
21454	Open treatment of mandibular fracture with external fixation
21461	Open treatment of mandibular fracture; without interdental fixation
21462	With interdental fixation
21465	Open treatment of mandibular condylar fracture
21470	Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and/or wiring of dentures or splints
43130	Diverticulectomy of hypopharynx or esophagus, with or without myotomy; cervical approach

OP Table 6.7: Neurological

Code	Description
62230	Replacement or revision of cerebrospinal fluid shunt, obstructed valve, or distal catheter in shunt system
62360	Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir
62361	Non-programmable pump
62362	Programmable pump, including preparation of pump, with or without programming
63001	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equine, without facetectomy, foraminotomy or discectomy, (e.g., spinal stenosis), 1 or 2 vertebral segments; cervical
63003	Thoracic
63005	Lumbar, except for spondylolisthesis
63011	Sacral
63012	Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equine and nerve roots for spondylolisthesis, lumbar (Gill type procedure)
63015	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equine, without facetectomy, foraminotomy or discectomy, (e.g., spinal stenosis), more than 2 vertebral segments; cervical
63016	Thoracic
63017	Lumbar
63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; including open and endoscopically-assisted approaches; 1 interspace, cervical
63030	1 interspace, lumbar
63040	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical
63042	Lumbar
63045	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equine and/or nerve root(s), (e.g., spinal or lateral recess stenosis)), single vertebral segment; cervical
63046	Thoracic
63047	Lumbar
63056	Lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disc)
63075	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace

Appendix B

Glossary of Terms

accuracy (of data) The extent to which data are free of identifiable errors.

acute myocardial infarction (AMI) Death of heart muscle resulting from insufficient blood supply to the heart. For purposes of this measure, acute myocardial infarction is identified by the ICD-9-CM codes in Appendix A, Table 1.1.

administrative/billing data (data source) Data that generally reflect the content of discharge abstracts (for example, demographic information on patients such as age, sex, zip code; information about the episode of care such as admission source, length of stay, charges, discharge status; and diagnostic and procedural codes). Namely, the Uniform Hospital Discharge Data Set and the Uniform Bill of the Health Care Financing Administration (UB-04) provide specifications for the abstraction of administrative/billing data.

algorithm An ordered sequence of data element retrieval and aggregation through which numerator and denominator events or continuous variable values are identified by a measure. The algorithms are depicted using flowcharting symbols.

allowable values A list of acceptable responses for a data element.

ANSI X12 The American National Standards Institute's standard for transmitting data electronically, or electronic data interchange (EDI).

binary outcome Events or conditions that occur in one or two possible states often labeled 0 or 1. Such data are frequently encountered in medical research. Common examples include dead or alive, and improved or not improved.

central tendency A property of the distribution of a variable, usually measured by statistics such as the mean, median, and mode.

clinical measures Measures designed to evaluate the processes or outcomes of care associated with the delivery of clinical services; allow for intra- and interorganizational comparisons to be used to continuously improve patient health outcomes; may focus on the appropriateness of clinical decision making and implementation of these decisions; must be condition specific, procedure specific, or address important functions of patient care (e.g., medication use, infection control, patient assessment, etc.).

confounding factors Intervening variables that distort the true relationship between/among the variables of interest. They are related to the outcome of interest, but extraneous to the study question and are non-randomly distributed among the groups being compared. They can hide a true correlation or give the appearance of a correlation when none actually exists.

continuous variable An aggregate data measure in which the value of each measurement can fall anywhere along a continuous scale (e.g., the time [in minutes] from emergency department arrival to administration of fibrinolytics).

continuous variable data elements Those data elements required to construct the measure as stated in the section labeled “Continuous Variable Statement.”

contraindication A factor or condition that may render the administration of a drug or agent or the performance of a procedure or other practice inadvisable, improper, and/or undesirable.

Current Procedural Terminology (CPT®) code A listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians.

critical access hospital (CAH) Hospitals that offer limited services to include round-the-clock emergency care services and are, by definition, located more than 35 miles from a hospital or another critical access hospital, or are certified by the state as being a necessary provider of health care services to residents in the area. They maintain no more than 25 beds for acute (hospital-level) inpatient care, subject to a 96-hour average length of stay for acute care patients. For CAHs with swing bed agreements, any of its beds may be used to furnish either inpatient acute care or swing bed services. Hospitals certified by the Secretary of the Department of Health and Human Services (DHHS) as critical access hospitals are eligible for cost-based reimbursement from Medicare if they meet a specific set of federal Conditions of Participation (COPs).

data collection The act or process of capturing raw or primary data from a single or number of sources; also called “data gathering.”

data collection effort The availability and accessibility of the required data elements, the relative effort required, and associated cost of abstracting or collecting the data.

data editing The process of correcting erroneous or incomplete *existing* data, exclusive of data entry input edits.

data element A discrete piece of data, such as patient birthdate or principal diagnosis. See also *denominator data elements, numerator data elements, and continuous variable data elements.*

data entry The process by which data are transcribed or transferred into an electronic format.

data point The representation of a value for a set of observations or measurements at a specific time interval (e.g., perioperative mortality rate for the month of June 2004).

data quality The accuracy and completeness of measure data on performance in the context of the analytic purposes for which they will be used.

data sources The primary source document(s) used for data collection (for example, billing or administrative data, encounter form, enrollment forms, and medical record). See also *administrative data, clinical survey, medical record, patient survey, provider data, and registry/log data.*

data transmission The process by which data are electronically sent from one organization to another

denominator The lower part of a fraction used to calculate a rate, proportion, or ratio. Also the population for a rate-based measure.

denominator data elements Those data elements required to construct the denominator.

discrete variable See *rate-based measure*.

electronic data interchange (EDI) An instance of data being sent electronically between parties, normally according to predefined industry standards.

electrocardiogram (ECG) A graphic tracing of the heart's electrical impulses.

emergency department A department that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

episode of care (EOC) A patient or case-level record submitted to the database.

Evaluation and Management (E/M) codes Codes used to report evaluation and management services provided in the physician's office, or in an outpatient or other ambulatory facility.

excluded populations Detailed information describing the populations that should not be included in the indicator. For example, specific age groups, ICD-9-CM procedure or diagnostic codes, or certain time periods could be excluded from the general population drawn upon by the indicator.

fibrinolytic therapy Administration of a pharmacological agent intended to cause lysis of a thrombus (destruction or dissolution of a blood clot). Refer to Appendix C, Table 1.3 for a listing of fibrinolytic agents.

format Specifies the character length of a specific data element; the type of information the data element contains: numeric, decimal number, date, time, or alphanumeric; and the frequency with which the data element occurs.

general data elements Data elements that must be collected by hospitals for each patient record. These data are patient demographic data, hospital identifiers, and patient identifiers.

health care organization (HCO) The business entity which is participating in a performance measurement system (e.g., health care organization level data describes information about the business entity).

hospital A health care organization that has a governing body, an organized medical and professional staff and inpatient facilities, and provides medical, nursing, and related services for

ill and injured patients 24 hours per day, seven days per week. For licensing purposes, each state has its own definition of a hospital.

hospitalist A physician whose main practice provides care for hospitalized patients.

ICD-9-CM codes A two-part classification system in current use for coding patient medical information used in abstracting systems and for classifying patients into diagnosis-related groups (DRGs). The first part is a comprehensive list of diseases with corresponding codes compatible with the World Health Organization's list of disease codes. The second part contains procedure codes independent of the disease codes.

included populations Detailed information describing the population(s) that the indicator intends to measure. Details could include such information as specific age groups, diagnoses, ICD-9-CM diagnostic and procedure codes, CPT[®] codes, enrollment periods, insurance and health plan groups, etc.

invalid data Values for data elements that are required for calculating and/or risk adjusting a core measure that fall outside of the acceptable range of values defined for that data element. Refer to the Missing and Invalid Data section for further information.

mean A measure of central tendency for a continuous variable measure. The mean is the sum of the values divided by the number of observations.

measure information form Tool to provide specific clinical and technical information on a measure. The information contained includes: performance measure name, description, rationale, numerator/denominator/continuous variable statements, included populations, excluded populations, data elements, risk adjustment, sampling, data accuracy, and selected references.

measure of performance See *performance measure*.

measure-related feedback Measure-related information on performance that is available, on a timely basis, to organizations actively participating in the performance measurement system for use in the organization's ongoing efforts to improve patient care and organization performance. Feedback can be reflective of information within individual organizations (intraorganizational) and/or across organizations (interorganizational).

measure-specific data elements Data elements used by one specific measure or several measures in one specific measure set, such as the OP Surgical measures.

median The value in a group of ranked observations that divides the data into two equal parts.

missing data No values present for one or more data elements that are required for calculating and/or risk adjusting a national hospital quality measure. Refer to the Missing and Invalid Data section for further information.

mode The most frequently occurring response for that data element.

module A set of measures under a common group/topic area (e.g., infection module).

monthly data point The representation of a value for a set of observations or measurements for a calendar month.

multivariate analysis The analysis of the simultaneous relationships among variables.

national quality measure A standardized performance measure that meets the Centers for Medicare & Medicaid Services evaluation criteria, has precisely defined specifications, can be uniformly embedded in extant systems, has standardized data collection protocols to permit uniform implementation by health care organizations and permit comparisons of health care organization performance over time through the establishment of a national comparative data base.

nosocomial infection An infection acquired by a patient in a health care organization, especially a hospital. This infection is not present or incubating before admission to a hospital.

numerator The upper portion of a fraction used to calculate a rate, proportion, or ratio.

numerator data elements Those data elements necessary or required to construct the numerator.

observed rate The observed rate is the measure rate that is based on a hospital's aggregated data for the reporting period. This is calculated as the number of measure numerator cases for the reporting period divided by the number of denominator cases. Observed rates are used to measure hospital performances.

outpatient record (data source) Data obtained from the records or documentation maintained on a patient in the hospital outpatient department setting (for example, hospital-based outpatient surgery, hospital-based clinic, emergency department). Includes automated and paper medical record systems.

parenteral Not through the alimentary canal but rather by injection through some other route, as subcutaneous, intramuscular, intraorbital, intracapsular, intraspinal, intrasternal, intravenous, etc.

patient factor A variable describing some characteristic of individual patients that may influence health care related outcomes. Patient factors can include:

- **complications** Conditions arising after the beginning of health care observation and treatment that modifies the course of the patient's health or illness and the intervention/care required.
- **co-morbidities** Pre-existing diseases or conditions.
- **severity of illness classifications** Seriousness or stage of illness at the time of the beginning of health care observation or treatment (for example, *AJCC staging* for oncology patients, *NYHA class* for cardiovascular patients, *ASA-PS classification* for surgical patients).
- **functional status** Factors related to health status including physical functioning, role

disability due to physical-health problems, bodily pain, general health perceptions, vitality, social functioning, role disability due to emotional problems, and general mental health.

- **patient demographics** Age, ethnicity, gender, location, etc.

patient level data Collection of data elements that depict the health care services provided to an individual (patient). Patient level data are aggregated to generate hospital level data and comparison group data.

percentile A value on a scale of 100 that indicates the percentage of a distribution that is equal to or below it.

performance measure A quantitative tool (for example, rate, ratio, index, percentage) that provides an indication of an organization's performance in relation to a specified process or outcome. See the *process measure* and the *outcome measure*.

performance measurement system An entity consisting of an automated database(s), that facilitates performance improvement in health care organizations through the collection and dissemination of process and/or outcome measures of performance. Measurement systems must be able to generate internal comparisons of organization performance over time, and external comparisons of performance among participating organizations at comparable times.

performance measure-related feedback See *measure-related feedback*.

predicted value The statistically expected response or outcome for a patient after the risk adjustment model has been applied and the patient's unique set of risk factors have been taken into account.

prophylactic antibiotic An antibiotic used to prevent, rather than treat or cure, disease. For the purposes of OP-6 and OP-7, antibiotics given to prevent postoperative infection will be collected. Because the overuse of antibiotics can lead to resistance, antibiotics taken to prevent infection should be used only for a short time.

process An interrelated series of events, activities, actions, mechanisms, or steps that transform inputs into outputs.

proportion measure A measure which shows the number of occurrences over the entire group within which the occurrence should take place (e.g., patients delivered by cesarean section over all deliveries).

provider data (data source) Data obtained from other provider-generated records that are not necessarily contained in the medical record (e.g., pharmacy patient medication profiles, nursing care plans).

randomization A technique for selecting or assigning cases such that each case has an equal probability of being selected or assigned. It is done to stimulate chance distribution, reduce the effects of confounding factors, and produce unbiased statistical data.

range A measure of the spread of a data set; the difference between the smallest and largest observation.

rate-based (measure) An aggregate data measure in which the value of each measurement is expressed as a proportion or as a ratio. In a proportion, the numerator is expressed as a subset of the denominator (for example, patients with cesarean section, divided by all patient who deliver). In a ratio, the numerator and denominator measure different phenomena (for example, the number of patients with central lines who develop infections divided by the number of central line days).

ratio A relationship between two counted sets of data, which may have a value of zero or greater. In a ratio, the numerator is not necessarily a subset of the denominator (e.g., pints of blood transfused to number of patients discharged).

registry/log data (data source) Data obtained from local, regional or national disease or procedure- related registries. Data obtained from the health care organizations' daily recordings (logs). Examples of such data include tumor, trauma, and cardiology registries. Examples of log data include infusion therapy, central line infection, and labor and delivery logs.

regression coefficients Synonym for regression weight which is derived from statistical modeling and expresses the change in a patient's response or outcome corresponding to a unit of change in the appropriate explanatory variable (i.e., patient risk factor).

relevance The applicability and/or pertinence of the indicator to its users and customers.

reliability The ability of the indicator to accurately and consistently identify the events it was designed to identify across multiple health care settings.

reporting period The defined time period which describes the patient's end-of-service.

reperfusion Reestablishing blood flow in an obstructed coronary artery. It may be accomplished with thrombolytic therapy or percutaneous coronary intervention.

risk adjusted measures Measures that are risk adjusted using statistical modeling or stratification methods.

risk adjusted rate A rate that takes into account differences in case mix to allow for more valid comparisons between groups.

sampling frequency If a hospital chooses to sample, they may sample data on either a monthly or quarterly basis. Refer to the "Sample Size Requirements" discussion in the Population and Sampling Specifications section for further information.

sampling method Describes the process used to select a sample. Sampling approaches for national hospital quality measures are simple random sampling, and systematic sampling. Refer to the "Sampling Approaches" discussion in the Population and Sampling Specifications section for further information.

sample size The number of individuals or particular patients included in a study. Usually chosen so that the study has a particular statistical power of detecting an effect of a particular size. Refer to the “Sample Size Requirements” discussion in the Population and Sampling Specifications for further information.

score A rating, usually expressed as a number, and based on the degree to which certain qualities or attributes are present (e.g., Glasgow coma, ASA scores).

severity The degree of biomedical risk, or mortality of medical treatment.

simple random sample A process in which a sample of data is selected from the total population in such a way that every case has the same chance of being selected and that the sample size is met. Refer to the “Sampling Approaches” discussion in the Population and Sampling Specifications section for further information.

standard deviation A measure of variability that indicates the dispersion, spread, or variation in a distribution.

strata See stratified measure.

stratification A form of risk adjustment, which involves classifying data into strata based on one or more characteristics, variables, or other categories.

stratification based approach for risk adjustment The process of dividing or classifying subgroups known as strata in order to facilitate more valid comparisons. For example, a measure’s outcome may be divided into type of surgery-specific categories or strata.

stratified measure A performance measure that is classified into a number of strata to assist in analysis and interpretation. The overall or un-stratified measure evaluates all of the strata together. The stratified measure or each stratum consists of a subset of the overall measure.

stratum See stratified measure.

structure measure A measure that assesses whether organizational resources and arrangements are in place to deliver health care, such as the number, type, and distribution of medical personnel, equipment, and facilities.

systematic random sampling A process in which the starting case is selected randomly, and the next cases are selected according to a fixed interval that is based upon the number of cases in the population. For example, the starting case is the second patient that arrives at the hospital. This patient and every subsequent fifth patient becomes part of the random sample until the sample size is reached. Refer to the “Sampling Approaches” discussion in the Population and Sampling Specifications section for further information.

test cases Fictitious patient level data composed of clinical data elements that yield an expected result for a specific core measure algorithm.

therapeutic antibiotic Antibiotic treatment tailored to a specific confirmed diagnosis or a known pathogen.

thrombolytic therapy *See fibrinolytic therapy*

transmission schedule The schedule of dates on which data are expected to be transmitted.

Unable to be determined (UTD) Each data element that is applicable per the algorithm for each of the measures within a topic must be “touched” by the abstractor. While there is an expectation that all data elements are collected, it is recognized that in certain situations information may not be available (i.e., dates, times, codes, etc.). If, after due diligence, the abstractor determines that a value is not documented or is not able to determine the answer value, the abstractor must select “Unable to Determine (UTD)” as the answer.

validation The process by which the integrity and correctness of data are established. Validation processes can occur immediately after a data item is collected or after a complete set of data are collected. The Centers for Medicare & Medicaid Services (CMS) chart level validation will validate the data at several levels. There are consistency and internal edit checks to assure the integrity of the submitted data; there are external edit checks to verify expectations about the volume of the data received, and, there will be chart level audits to assure the reliability of the submitted data. Information on these procedures is available on www.qnetexchange.org.

validity Ability to identify opportunities for improvement in the quality of care; demonstration that the indicator use results in improvements in outcomes and/or quality of care.

variance Equal to the square of the standard deviation.

verification The process used to ensure consistent implementation of core measure algorithms specified in this manual across disparate measurement systems.

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Appendix C Medication Tables

Note: The medication tables are not meant to be inclusive lists of all available therapeutic agents. Discrepancies must be reported.

OP Table 1.1 Aspirin and Aspirin-Containing Medications
Acetylsalicylic Acid
Acuprin 81
Alka-Seltzer
Alka-Seltzer Morning Relief
Anacin
Arthritis Foundation Aspirin
Arthritis Pain Ascriptin
Arthritis Pain Formula
ASA
ASA Baby
ASA Baby Chewable
ASA Baby Coated
ASA Bayer
ASA Bayer Children's
ASA Buffered
ASA Children's
ASA EC
ASA Enteric Coated
ASA/Maalox
Ascriptin
Aspergum
Aspir-10
Aspir-Low
Aspir-Lox
Aspir-Mox
Aspir-Trin
Aspirbuf
Aspircaf
Aspirin
Aspirin Baby
Aspirin Bayer
Aspirin Bayer Children's
Aspirin Buffered
Aspirin Child
Aspirin Child Chewable
Aspirin Children's
Aspirin EC

OP Table 1.1 Aspirin and Aspirin-Containing Medications
Aspirin Enteric Coated
Aspirin Litecoat
Aspirin Lo-Dose
Aspirin Low Strength
Aspirin Tri-Buffered
Aspirin, Extended Release
Aspirin/Butalbital/Caffeine
Aspirin/caffeine
Aspirinab
Azdone
Bayer Aspirin
Bayer Aspirin PM Extra Strength
Bayer Children's
Bayer EC
Bayer Enteric Coated
Bayer Low Strength
Bayer Plus
BC Allergy Sinus Cold Powder
BC Arthritis Strength Powder
BC Powder
BC Sinus Cold Powder
Buffered ASA
Buffered Aspirin
Buffered Baby ASA
Bufferin
Bufferin Arthritis Strength
Bufferin Extra Strength
Buffex
Butal Compound
Butalbital, Aspirin And Caffeine
Butalbital, Aspirin, Caffeine, And Codeine Phosphate
Cama Arthritis Reliever
Carisoprodol And Aspirin
Carisoprodol, Aspirin And Codeine Phosphate
Child's Aspirin
Coated Aspirin
Compound-65 Pulvules
Cosprin
CTD Aspirin
Darvon Compound-65
Dasprin
Doans Pills
Easprin
EC ASA

OP Table 1.1 Aspirin and Aspirin-Containing Medications
Ecotrin
Ecotrin Low Strength Adult
Effervescent Pain & Antacid
Empirin
Encaprin
Endodan
Entab
Entaprin
Enterocote
Enteric Coated Aspirin
Enteric Coated Baby Aspirin
Equagesic
Excedrin
Excedrin Extra Strength
Excedrin Geltab
Excedrin Migraine
Extra Strength Bayer
Fiorinal
Fiormor
Fiortal
Fortabs
Genacote
Genprin
Goody's Body Pain Formula Powder
Goody's Extra Strength Headache Powder
Goody's Extra Strength Pain Relief Tablets
Halfprin
Invagesic
Invagesic Forte
Lanorinal
Lifecoat Aspirin
Low Dose ASA
Magnaprin
Med Aspirin
Methocarbamol And Aspirin
Norgesic
Norgesic Forte
Norwich Aspirin
Orphenadrine Citrate, Aspirin, And Caffeine
Orphengesic
Orphengesic Forte
Oxycodone And Aspirin
Pain Relief (Effervescent)
Pain Relief with Aspirin

OP Table 1.1 Aspirin and Aspirin-Containing Medications
Percodan
Percodan-Demi
Propoxyphene Compound 65
Robaxisal
Sloprin
Soma Compound
Soma Compound W/ Codeine
St. Joseph Aspirin
Stanback Analgesic
Synalgos-DC
Therapy Bayer
Tri Buffered Aspirin
Uni-As
Uni-Buff
Uni-Tren
Vanquish
Zorprin

OP Table 1.2 Warfarin
Warfarin Sodium
Coumadin
Jantoven
Warfarin

OP Table 1.3 Fibrinolytic Agents
Abbokinase
Activase
Alteplase
Anistreplase
Anisoylated Plasminogen-Streptokinase Activator Complex
APSAC
Eminase
Kabikinase
Retavase
Reteplase
rPA (RPA)
Streptase
Streptokinase
Tenecteplase
Tissue plasminogen activator
TNKase
tPA (TPA)
UK
Urokinase

OP Table 6.0 Antimicrobial Medications	
Antibiotic Selection Options (includes trade & generic name)	Generic Name Crosswalk
Achromycin	Tetracycline
Achromycin V	Tetracycline
Adoxa	Doxycycline
Alatrofloxacin	Alatrofloxacin
Alatrofloxacin Mesylate	Alatrofloxacin
Amficot	Ampicillin
Amikacin	Amikacin
Amikacin Sulfate	Amikacin
Amikin	Amikacin
Amoxicillin	Amoxicillin
Amoxicillin/Clavulanate Potassium	Amoxicillin/Clavulanate Potassium
Amoxicillin Trihydrate	Amoxicillin
Amoxil	Amoxicillin
Ampicillin	Ampicillin
Ampicillin (Anhydrous)	Ampicillin
Ampicillin/Probenecid	Ampicillin
Ampicillin Sodium	Ampicillin
Ampicillin/Sulbactam	Ampicillin/Sulbactam
Ampicillin Trihydrate	Ampicillin
Ampicin	Ampicillin
Ancef	Cefazolin
Anspor	Cephadrine
Antibiotic Not Otherwise Specified (NOS)	None
Apo-Ampi	Ampicillin
Apo-Nitrofurantoin	Nitrofurantoin
Apo-Sulfatrim	Sulfamethoxazole Trimethoprim
Atovaquone	Atovaquone
Augmentin	Amoxicillin/Clavulanate Potassium
Augmentin XR	Amoxicillin/Clavulanate Potassium
Avelox	Moxifloxacin
Azactam	Aztreonam
Azithromycin	Azithromycin
Aztreonam	Aztreonam
Bacampicillin	Bacampicillin
Bacampicillin Hydrochloride	Bacampicillin
Bacitracin	Bacitracin
Baci-IM	Bacitracin
Bactocill	Oxacillin
Bactrim	Sulfamethoxazole Trimethoprim
Bactrim DS	Sulfamethoxazole Trimethoprim
Beepen-VK	Penicillin V Potassium

OP Table 6.0 Antimicrobial Medications	
Antibiotic Selection Options (includes trade & generic name)	Generic Name Crosswalk
Benzylpenicillin	Benzylpenicillin
Biaxin	Clarithromycin
Biaxin XL	Clarithromycin
Bicillin C-R	Penicillin G Benzathine/Penicillin G Procaine
Bicillin L-A	Penicillin G Benzathine
Biocef	Cephalexin
Biomox	Amoxicillin
Bismuth Subcitrate Potassium/Metronidazole/TCN	Metronidazole
C-Lexin	Cephalexin
Carbenicillin	Carbenicillin
Carbenicillin Indanyl Sodium	Carbenicillin
Ceclor	Cefaclor
Ceclor CD	Cefaclor
Ceclor Pulvules	Cefaclor
Cedax	Ceftibuten
Cefaclor	Cefaclor
Cefaclor ER	Cefaclor
Cefadroxil	Cefadroxil
Cefadroxil Monohydrate	Cefadroxil
Cefadyl	Cephapirin
Cefanex	Cephalexin
Cefazolin	Cefazolin
Cefazolin Sodium	Cefazolin
Cefdinir	Cefdinir
Cefditoren	Cefditoren
Cefditoren Pivoxil	Cefditoren
Cefepime	Cefepime
Cefepime Hydrochloride	Cefepime
Cefixime	Cefixime
Cefizox	Ceftizoxime
Cefobid	Cefoperazone
Cefonicid	Cefonicid
Cefonicid Sodium	Cefonicid
Cefoperazone	Cefoperazone
Cefoperazone Sodium	Cefoperazone
Cefotan	Cefotetan
Cefotaxime	Cefotaxime
Cefotaxime Sodium	Cefotaxime
Cefotetan	Cefotetan
Cefotetan Disodium	Cefotetan

OP Table 6.0 Antimicrobial Medications	
Antibiotic Selection Options (includes trade & generic name)	Generic Name Crosswalk
Cefoxitin	Cefoxitin
Cefoxitin Sodium	Cefoxitin
Cefpodoxime	Cefpodoxime
Cefpodoxime Proxetil	Cefpodoxime
Cefprozil	Cefprozil
Ceftazidime	Ceftazidime
Ceftazidime Sodium	Ceftazidime
Ceftibuten	Ceftibuten
Ceftin	Cefuroxime
Ceftizoxime	Ceftizoxime
Ceftizoxime Sodium	Ceftizoxime
Ceftriaxone	Ceftriaxone
Ceftriaxone Sodium	Ceftriaxone
Cefuroxime	Cefuroxime
Cefuroxime Axetil	Cefuroxime
Cefuroxime Sodium	Cefuroxime
Cefzil	Cefprozil
Cephalexin	Cephalexin
Cephalexin Hydrochloride	Cephalexin
Cephalexin Monohydrate	Cephalexin
Cephalothin	Cephalothin
Cephalothin Sodium	Cephalothin
Cephapirin	Cephapirin
Cephapirin Sodium	Cephapirin
Cephradine	Cephradine
Cephradine Sodium	Cephradine
Ceptaz	Ceftazidime
Ciloxan	Ciprofloxacin
Cinobac	Cinoxacin
Cinoxacin	Cinoxacin
Cipro	Ciprofloxacin
Ciprofloxacin	Ciprofloxacin
Ciprofloxacin Hydrochloride	Ciprofloxacin
Claforan	Cefotaxime
Clarithromycin	Clarithromycin
Cleocin	Clindamycin
Cleocin HCL	Clindamycin
Cleocin Phosphate	Clindamycin
Clindamycin	Clindamycin
Clindamycin Hydrochloride	Clindamycin
Clindamycin Phosphate	Clindamycin
Cloxacillin	Cloxacillin

OP Table 6.0 Antimicrobial Medications	
Antibiotic Selection Options (includes trade & generic name)	Generic Name Crosswalk
Cloxacillin Sodium	Cloxacillin
Cloxapen	Cloxacillin
Colistimethate	Colistimethate
Colistin	Colistin
Coly-Mycin M	Colistimethate
Co-Trimoxazole	Sulfamethoxazole Trimethoprim
Cotrim	Sulfamethoxazole Trimethoprim
Cotrim DS	Sulfamethoxazole Trimethoprim
Crystapen	Penicillin G Sodium
Cubicin	Daptomycin
Cystex	Methenamine
Daptomycin	Daptomycin
Dicloxacillin	Dicloxacillin
Dicloxacillin Sodium	Dicloxacillin
Dirithromycin	Dirithromycin
Doribax	Doripenem
Doripenem	Doripenem
Doryx	Doxycycline
DoxyCaps	Doxycycline
Doxycycline	Doxycycline
Doxycycline Calcium	Doxycycline
Doxycycline Hyclate	Doxycycline
Doxycycline Hydrochloride	Doxycycline
Doxycycline Monohydrate	Doxycycline
Duricef	Cefadroxil
Dycill	Penicillin
Dynabac	Dirithromycin
Dynacin	Minocycline
Dynapen	Dicloxacillin
E-Mycin	Erythromycin
Ed A-Ceph	Cephalexin
EES	Erythromycin
E.E.S.	Erythromycin
Ertapenem	Ertapenem
Ertapenem Sodium	Ertapenem
ERYC	Erythromycin
EryPed	Erythromycin
Erytab	Erythromycin
Erythrocin	Erythromycin
Erythromycin	Erythromycin
Erythromycin Base	Erythromycin
Erythromycin Estolate	Erythromycin

OP Table 6.0 Antimicrobial Medications	
Antibiotic Selection Options (includes trade & generic name)	Generic Name Crosswalk
Erythromycin Ethylsuccinate	Erythromycin
Erythromycin Gluceptate	Erythromycin Gluceptate
Erythromycin Lactobionate	Erythromycin
Erythromycin Stearate	Erythromycin
Erythromycin/Sulfisoxazole	Erythromycin
Factive	Gemifloxacin
Fatroximin	Rifaximin
Flagyl	Metronidazole
Floxin	Ofloxacin
Fortaz	Ceftazidime
Fosfomycin Tromethamine	Fosfomycin Tromethamine
Furadantin	Nitrofurantoin
Furalan	Nitrofurantoin
Furatoin	Nitrofurantoin
G-Mycin	Gentamicin
Gantanol	Sulfamethoxazole
Gantrisin	Sulfisoxazole
Garamycin	Gentamicin
Gemifloxacin	Gemifloxacin
Gentamicin	Gentamicin
Gentamicin Sulfate	Gentamicin
Gentamicin Sulfate Sodium Chloride	Gentamicin
Genticin	Gentamicin
Geocillin	Carbenicillin Indanyl Sodium
Grepafloxacin	Grepafloxacin
Hiprex	Methenamine
Ilosone	Erythromycin
Ilotycin	Erythromycin Gluceptate
Imipenem	Imipenem/Cilastatin
Imipenem/Cilastatin	Imipenem/Cilastatin
Invanz	Ertapenem
Kanamycin	Kanamycin
Kantrex	Kanamycin
Keflet	Cephalexin
Keflex	Cephalexin Monohydrate
Keflin	Cephalexin
Keftab	Cephalexin Hydrochloride
Kefurox	Cefuroxime
Kefzol	Cefazolin
Ketek	Telithromycin
Ledercillin VK	Penicillin
Levaquin	Levofloxacin

OP Table 6.0 Antimicrobial Medications	
Antibiotic Selection Options (includes trade & generic name)	Generic Name Crosswalk
Levofloxacin	Levofloxacin
Lincocin	Lincomycin
Lincomycin	Lincomycin
Lincorex	Lincomycin
Linezolid	Linezolid
Lomefloxacin	Lomefloxacin
Lomefloxacin Hydrochloride	Lomefloxacin
Lorabid	Loracarbef
Lorabid Pulvules	Loracarbef
Loracarbef	Loracarbef
Lyphocin	Vancomycin
Macrobid	Nitrofurantoin
Macrodantin	Nitrofurantoin
Mandelamine	Methenamine
Marcillin	Ampicillin
Maxaquin	Lomefloxacin
Maxipime	Cefepime
Mefoxin	Cefoxitin
Meropenem	Meropenem
Mepron	Atovaquone
Merrem	Meropenem
Methenamine	Methenamine
Methicillin	Methicillin
Methicillin Sodium	Methicillin
Metizol	Metronidazole
Metronidazole	Metronidazole
Mezlin	Mezlocillin
Mezlocillin	Mezlocillin
Mezlocillin Sodium	Mezlocillin
Minocin	Minocycline
Minocycline	Minocycline
Minocycline HCL	Minocycline
Monocid	Cefonicid
Monodox	Doxycycline
Monurol	Fosfomycin Tromethamine
Moxifloxacin	Moxifloxacin
Moxifloxacin Hydrochloride	Moxifloxacin
Mycifradin	Neomycin
Nafcil	Nafcillin
Nafcillin	Nafcillin
Nafcillin Sodium	Nafcillin
Nalidixic Acid	Nalidixic Acid

OP Table 6.0 Antimicrobial Medications	
Antibiotic Selection Options (includes trade & generic name)	Generic Name Crosswalk
Nallpen	Nafcillin
Nebcin	Tobramycin
Neggram	Nalidixic Acid
Neo-Fradin	Neomycin
Neomycin	Neomycin
Neomycin Sulfate	Neomycin
Neo-Tabs	Neomycin
Nitrofurantoin	Nitrofurantoin
Norfloxacin	Norfloxacin
Normix	Rifaximin
Noroxin	Norfloxacin
Novo Ampicillin	Ampicillin
Novodoxylin	Doxycycline
Novo-Furantoin	Nitrofurantoin
Nu-Ampi	Ampicillin
Ofloxacin	Ofloxacin
Omnicef	Cefdinir
Omnipen	Ampicillin
Omnipen-N	Ampicillin
Oxacillin	Oxacillin
Oxacillin Sodium	Oxacillin
Oxytetracycline	Oxytetracycline
Panmycin	Tetracycline
Pathocil	Dicloxacillin
PC Pen VK	Penicillin
PCE	Erythromycin
Pediamycin	Erythromycin
Pediazole	Erythromycin
Pefloxacin	Pefloxacin
Pen Vee K	Penicillin
Pen-V	Penicillin
Penbritin	Ampicillin
Penicillin	Penicillin
Penicillin G	Penicillin
Penicillin G Benzathine	Penicillin
Penicillin G Benzathine/Penicillin G Procaine	Penicillin G Benzathine/Penicillin G Procaine
Penicillin G Potassium	Penicillin
Penicillin G Procaine	Penicillin
Penicillin G Sodium	Penicillin
Penicillin V	Penicillin
Penicillin V Potassium	Penicillin

OP Table 6.0 Antimicrobial Medications	
Antibiotic Selection Options (includes trade & generic name)	Generic Name Crosswalk
Periostat	Doxycycline
Permapen	Penicillin
Pfizerpen	Penicillin
Piperacillin	Piperacillin
Piperacillin Sodium	Piperacillin
Piperacillin/Tazobactam	Piperacillin/Tazobactam
Pipracil	Piperacillin
Polycillin	Ampicillin
Polycillin-PRB	Ampicillin/Probenicid
Polymox	Amoxicillin
Polymyxin	Polymyxin
Polymyxin B	Polymyxin
Primaxin	Imipenem/Cilastatin
Principen	Ampicillin
Proloprim	Trimethoprim
ProQuin XR	Ciprofloxacin
Prostaphlin	Oxacillin
Protostat	Metronidazole
Quinupristin/Dalfopristin	Quinupristin/Dalfopristin
Raxar	Grepafloxacin
Rifacol	Rifaximin
Rifadin	Rifampin
Rifamixin	Rifaximin
Rifampin	Rifampin
Rifamycin	Rifaximin
Rifaxidin	Rifaximin
Rifaximin	Rifaximin
Rimactane	Rifampin
Ritacol	Rifaximin
Robicillin VK	Penicillin
Robimycin	Erythromycin
Rocephin	Ceftriaxone
Septra	Sulfamethoxazole Trimethoprim
Septra DS	Sulfamethoxazole Trimethoprim
SMZ-TMP	Sulfamethoxazole Trimethoprim
Sparfloxacin	Sparfloxacin
Spectrobid	Bacampicillin
Spectracef	Cefditoren
Staphcillin	Methicillin
Streptograminis	Streptograminis
Streptomycin	Streptomycin
Streptomycin Sulfate	Streptomycin

OP Table 6.0 Antimicrobial Medications	
Antibiotic Selection Options (includes trade & generic name)	Generic Name Crosswalk
Sulfamethoxazole	Sulfamethoxazole
Sulfamethoxazole Trimethoprim	Sulfamethoxazole Trimethoprim
Sulfatrim	Sulfamethoxazole Trimethoprim
Sulfisoxazole	Sulfisoxazole
Sulfisoxazole/Erythromycin Ethylsuccinate	Erythromycin
Sumycin	Tetracycline
Suprax	Cefixime
Synercid	Quinupristin/Dalfopristin
TAO	Troleandomycin
Tazicef	Ceftazidime
Tazidime	Ceftazidime
TCN	Tetracycline
Tegopen	Cloxacillin
Telithromycin	Telithromycin
Terramycin	Oxytetracycline
Tetracycline	Tetracycline
Tetracycline Hydrochloride	Tetracycline
Ticar	Ticarcillin
Ticarcillin	Ticarcillin
Ticarcillin/Clavulanate	Ticarcillin/Clavulanate
Ticarcillin Disodium	Ticarcillin
Tigecycline	Tigecycline
Timentin	Ticarcillin/Clavulanate
Tobi	Tobramycin
Tobra	Tobramycin
Tobramycin	Tobramycin
Tobramycin Sulfate	Tobramycin
Totacillin	Ampicillin
Totacillin-N	Ampicillin
Trimethoprim	Trimethoprim
Trimox	Amoxicillin
Trimpex	Trimethoprim
Troleandomycin	Troleandomycin
Tygacil	Tigecycline
Ultracef	Cefadroxil
Unasyn	Ampicillin/Sulbactam
Unipen	Nafcillin
Uroplus DS	Sulfamethoxazole Trimethoprim
Uroplus SS	Sulfamethoxazole Trimethoprim
V-Cillin K	Penicillin
Vancocin	Vancomycin
Vancocin HCL	Vancomycin

OP Table 6.0 Antimicrobial Medications	
Antibiotic Selection Options (includes trade & generic name)	Generic Name Crosswalk
Vancoled	Vancomycin
Vancomycin	Vancomycin
Vancomycin Hydrochloride	Vancomycin
Vantin	Cefpodoxime
Vectrin	Minocycline
Veetids	Penicillin
Velosef	Cephadrine
Vibramycin	Doxycycline
Vibra-Tabs	Doxycycline
Wycillin	Penicillin
Wymox	Amoxicillin
Xifaxan	Rifaximin
Z-pak	Azithromycin
Zagam	Sparfloxacin
Zinacef	Cefuroxime
Zithromax	Azithromycin
Zithromax TRI-PAK	Azithromycin
Zolicef	Cefazolin
Zosyn	Piperacillin/Tazobactam
Zosyn Add-Vantage	Piperacillin/Tazobactam
Zyvox	Linezolid

OP Table 6.1 Antibiotic Allergy
Amficot
Amoxicillin
Amoxicillin Trihydrate
Amoxicillin/Clavulanate Potassium
Amoxil
Ampicillin
Ampicillin (Anhydrous)
Ampicillin/Probenecid
Ampicillin Sodium
Ampicillin/Sulbactam
Ampicillin Trihydrate
Ampicin
Ancef
Apo-Ampi
Augmentin
Augmentin XR
Bacampicillin
Bacampicillin Hydrochloride
Bactocill

OP Table 6.1 Antibiotic Allergy
Beepen-VK
Benzympenicillin
Bicillin C-R
Bicillin L-A
Biocef
Biomox
C-Lexin
Carbenicillin
Carbenicillin Indanyl Sodium
Ceclor
Ceclor CD
Ceclor Pulvules
Cedax
Cefaclor
Cefaclor ER
Cefadroxil
Cefadroxil Monohydrate
Cefadyl
Cefanex
Cefazolin
Cefazolin Sodium
Cefdinir
Cefditoren
Cefditoren Pivoxil
Cefepime
Cefepime Hydrochloride
Cefixime
Cefizox
Cefobid
Cefonicid
Cefonicid Sodium
Cefoperazone
Cefoperazone Sodium
Cefotan
Cefotaxime
Cefotaxime Sodium
Cefotetan
Cefotetan Disodium
Cefoxitin
Cefoxitin Sodium
Cefpodoxime
Cefpodoxime Proxetil
Cefprozil
Ceftazidime

OP Table 6.1 Antibiotic Allergy
Ceftazidime Sodium
Ceftibuten
Ceftin
Ceftizoxime
Ceftizoxime Sodium
Ceftriaxone
Ceftriaxone Sodium
Cefuroxime
Cefuroxime Axetil
Cefuroxime Sodium
Cefzil
Cephalexin
Cephalexin Hydrochloride
Cephalexin Monohydrate
Cephalothin
Cephalothin Sodium
Cephapirin
Cephapirin Sodium
Cephradine
Cephradine Sodium
Ceptaz
Claforan
Cloxacillin
Cloxacillin Sodium
Cloxapen
Crystapen
Dicloxacillin
Dicloxacillin Sodium
Duricef
Dycill
Dynapen
Ed A-Ceph
Ertapenem
Ertapenem Sodium
Fortaz
Geocillin
Imipenem
Imipenem/Cilastatin
Invanz
Keflet
Keflex
Keflin
Keftab
Kefurox

OP Table 6.1 Antibiotic Allergy
Kefzol
Ledercillin VK
Lorabid
Lorabid Pulvules
Loracarbef
Marcillin
Maxipime
Mefoxin
Meropenem
Merrem
Methicillin
Methicillin Sodium
Mezlin
Mezlocillin
Mezlocillin Sodium
Monocid
Nafcil
Nafcillin
Nafcillin Sodium
Nallpen
Novo Ampicillin
Nu-Ampi
Omnicef
Omnipen
Omnipen-N
Oxacillin
Oxacillin Sodium
Pathocil
PC Pen VK
Pen-V
Pen Vee K
Penbritin
Penicillin
Penicillin G
Penicillin G Benzathine
Penicillin G Potassium
Penicillin G Procaine
Penicillin G Sodium
Penicillin V
Penicillin V Potassium
Permapen
Pfizerpen
Piperacillin
Piperacillin Sodium

OP Table 6.1 Antibiotic Allergy
Piperacillin/Tazobactam
Pipracil
Polycillin
Polycillin-PRB
Polymox
Primaxin
Principen
Prostaphlin
Robicillin VK
Rocephin
Spectracef
Spectrobid
Staphcillin
Suprax
Tazicef
Tazidime
Tegopen
Ticar
Ticarcillin
Ticarcillin Disodium
Ticarcillin/Clavulanate
Timentin
Totacillin
Totacillin-N
Trimox
Ultracef
Unasyn
Unipen
Vantin
V-Cillin K
Veetids
Velosef
Wycillin
Wymox
Zinacef
Zolicef
Zosyn
Zosyn Add-Vantage

OP Table 6.2 Aminoglycosides	
Antibiotic Selection Options (includes trade & generic name)	Generic Name Crosswalk
Amikacin	Amikacin
Amikacin Sulfate	Amikacin

OP Table 6.2 Aminoglycosides	
Antibiotic Selection Options (includes trade & generic name)	Generic Name Crosswalk
Amikin	Amikacin
Garamycin	Gentamicin
Gentamicin	Gentamicin
Gentamicin Sulfate	Gentamicin
Gentamicin Sulfate Sodium Chloride	Gentamicin
Genticin	Gentamicin
G-Mycin	Gentamicin
Nebcin	Tobramycin
Tobra	Tobramycin
Tobramycin	Tobramycin
Tobramycin Sulfate	Tobramycin

OP Table 6.3 Ampicillin/Sulbactam, Ticarcillin/Clavulanate, Piperacillin/Tazobactam	
Antibiotic Selection Options (includes trade & generic name)	Generic Name Crosswalk
Ampicillin/Sulbactam	Ampicillin/Sulbactam
Piperacillin/Tazobactam	Piperacillin/Tazobactam
Ticarcillin/Clavulanate	Ticarcillin/Clavulanate
Timentin	Ticarcillin/Clavulanate
Unasyn	Ampicillin/Sulbactam
Zosyn	Piperacillin/Tazobactam
Zosyn Add-vantage	Piperacillin/Tazobactam

OP Table 6.3a Ampicillin/Sulbactam	
Antibiotic Selection Options (includes trade & generic name)	Generic Name Crosswalk
Ampicillin/Sulbactam	Ampicillin/Sulbactam
Unasyn	Ampicillin/Sulbactam

OP Table 6.4 Cefoxitin- Cefotetan	
Antibiotic Selection Options (includes trade & generic name)	Generic Name Crosswalk
Cefoxitin	Cefoxitin
Cefoxitin Sodium	Cefoxitin
Mefoxin	Cefoxitin
Cefotan	Cefotetan
Cefotetan	Cefotetan
Cefotetan Disodium	Cefotetan

OP Table 6.5 Aztreonam	
Antibiotic Selection Options (includes trade & generic name)	Generic Name Crosswalk
Aztreonam	Aztreonam
Azactam	Aztreonam

OP Table 6.6 Cefazolin- Cefuroxime	
Antibiotic Selection Options (includes trade & generic name)	Generic Name Crosswalk
Ancef	Cefazolin
Cefazolin	Cefazolin
Cefazolin Sodium	Cefazolin
Ceftin	Cefuroxime
Cefuroxime	Cefuroxime
Cefuroxime Axetil	Cefuroxime
Cefuroxime Sodium	Cefuroxime
Kefurox	Cefuroxime
Kefzol	Cefazolin
Zinacef	Cefuroxime
Zolicef	Cefazolin

OP Table 6.6a - 1st Generation Cephalosporins	
Antibiotic Selection Options (includes trade & generic name)	Generic Name Crosswalk
Ancef	Cefazolin
Anspor	Cephradine
Biocef	Cephalexin
C-Lexin	Cephalexin
Cefadroxil	Cefadroxil
Cefadroxil Monohydrate	Cefadroxil
Cefanex	Cephalexin
Cefazolin	Cefazolin
Cefazolin Sodium	Cefazolin
Cephalexin	Cephalexin
Cephalexin Hydrochloride	Cephalexin
Cephalexin Monohydrate	Cephalexin
Cephradine	Cephradine
Cephradine Sodium	Cephradine
Duricef	Cefadroxil
Ed A-Ceph	Cephalexin
Keflet	Cephalexin
Keflex	Cephalexin Monohydrate
Keflin	Cephalexin

OP Table 6.6a - 1st Generation Cephalosporins	
Antibiotic Selection Options (includes trade & generic name)	Generic Name Crosswalk
Keftab	Cephalexin Hydrochloride
Kefzol	Cefazolin
Ultracef	Cefadroxil
Velosef	Cephadrine
Zolicef	Cefazolin

OP Table 6.6b - 2nd Generation Cephalosporins	
Antibiotic Selection Options (includes trade & generic name)	Generic Name Crosswalk
Ceclor	Cefaclor
Ceclor CD	Cefaclor
Ceclor Pulvules	Cefaclor
Cefaclor	Cefaclor
Cefaclor ER	Cefaclor
Cefotan	Cefotetan
Cefotetan	Cefotetan
Cefotetan Disodium	Cefotetan
Cefoxitin	Cefoxitin
Cefoxitin Sodium	Cefoxitin
Cefprozil	Cefprozil
Ceftin	Cefuroxime
Cefuroxime	Cefuroxime
Cefuroxime Axetil	Cefuroxime
Cefuroxime Sodium	Cefuroxime
Cefzil	Cefprozil
Kefurox	Cefuroxime
Mefoxin	Cefoxitin
Zinacef	Cefuroxime

OP Table 6.6c - 3rd Generation Cephalosporins	
Antibiotic Selection Options (includes trade & generic name)	Generic Name Crosswalk
Cefizox	Ceftizoxime
Cefotaxime	Cefotaxime
Cefotaxime Sodium	Cefotaxime
Ceftazidime	Ceftazidime
Ceftazidime Sodium	Ceftazidime
Ceftizoxime	Ceftizoxime
Ceftizoxime Sodium	Ceftizoxime
Ceftriaxone	Ceftriaxone
Ceftriaxone Sodium	Ceftriaxone

OP Table 6.6c - 3rd Generation Cephalosporins	
Antibiotic Selection Options (includes trade & generic name)	Generic Name Crosswalk
Ceptaz	Ceftazidime
Claforan	Cefotaxime
Fortaz	Ceftazidime
Rocephin	Ceftriaxone
Tazicef	Ceftazidime
Tazidime	Ceftazidime

OP Table 6.7 Clindamycin	
Antibiotic Selection Options (includes trade & generic name)	Generic Name Crosswalk
Cleocin	Clindamycin
Cleocin HCL	Clindamycin
Cleocin Phosphate	Clindamycin
Clindamycin	Clindamycin
Clindamycin Hydrochloride	Clindamycin
Clindamycin Phosphate	Clindamycin

OP Table 6.8 Nafcillin-Oxacillin	
Antibiotic Selection Options (includes trade & generic name)	Generic Name Crosswalk
Bactocill	Oxacillin
Nafcil	Nafcillin
Nafcillin	Nafcillin
Nafcillin Sodium	Nafcillin
Nallpen	Nafcillin
Oxacillin	Oxacillin
Oxacillin Sodium	Oxacillin
Prostaphlin	Oxacillin
Unipen	Nafcillin

OP Table 6.9 Metronidazole	
Antibiotic Selection Options (includes trade & generic name)	Generic Name Crosswalk
Flagyl	Metronidazole
Metizol	Metronidazole
Metronidazole	Metronidazole
Protostat	Metronidazole

OP Table 6.11 Quinolones	
Antibiotic Selection Options (includes trade & generic name)	Generic Name Crosswalk
Alatrofloxacin	Alatrofloxacin
Alatrofloxacin Mesylate	Alatrofloxacin
Avelox	Moxifloxacin
Ciloxan	Ciprofloxacin
Ciprofloxacin	Ciprofloxacin
Ciprofloxacin Hydrochloride	Ciprofloxacin
Cipro	Ciprofloxacin
Floxin	Ofloxacin
Levaquin	Levofloxacin
Levofloxacin	Levofloxacin
Moxifloxacin	Moxifloxacin
Moxifloxacin Hydrochloride	Moxifloxacin
Ofloxacin	Ofloxacin
ProQuin XR	Ciprofloxacin

OP Table 6.12 Vancomycin	
Antibiotic Selection Options (includes trade & generic name)	Generic Name Crosswalk
Lyphocin	Vancomycin
Vancocin	Vancomycin
Vancocin HCL	Vancomycin
Vancoled	Vancomycin
Vancomycin	Vancomycin
Vancomycin Hydrochloride	Vancomycin

Appendix P Measure Preview Section

The measure preview section provides measure information forms and includes additional data collection information on the developmental measure(s). The measure(s) identified in this section are not currently collected. Placement in this appendix does not assume the measure(s) will be implemented into a future manual.

EMERGENCY DEPARTMENT NATIONAL HOSPITAL QUALITY MEASURES

Set Measure ID #	Measure Short Name
OP-X	Median Time from ED Arrival to ED Departure for Discharged ED Patients

OP EMERGENCY DEPARTMENT GENERAL DATA ELEMENT LIST

General Data Element Name	Collected For:
<i>Arrival Time</i>	All Records
<i>Birthdate</i>	All Records
<i>CMS Certification Number</i>	All Records
<i>First Name</i>	All Records
<i>Hispanic Ethnicity</i>	All Records
<i>Last Name</i>	All Records
<i>National Provider Identifier</i>	All Records
<i>Outpatient Encounter Date</i>	All Records
<i>Patient HIC#</i>	All Records
<i>Patient Identifier</i>	All Records
<i>Payment Source</i>	All Records
<i>Postal Code</i>	All Records
<i>Race</i>	All Records
<i>Sex</i>	All Records

OP EMERGENCY DEPARTMENT SPECIFIC DATA ELEMENT LIST

OP Emergency Department Data Element Name	Collected For:
<i>Discharge Status</i>	OP-1, OP-2, OP-3, OP-4, OP-5, OP-X
<i>ED Departure Date</i>	OP-X
<i>ED Departure Time</i>	OP-X
<i>ED Patient</i>	OP-X
<i>ICD-9-CM Principal Diagnosis Code</i>	OP-1, OP-2, OP-3, OP-4, OP-5, OP-X
<i>Observation Services</i>	OP-X

Measure Information Form

Measure Set: Emergency Department

Set Measure ID #: OP-X

Set Measure ID #	Performance Measure Name
OP-Xa	Median Time from ED Arrival to ED Departure for Discharged ED Patients – Overall Rate
OP-Xb	Median Time from ED Arrival to ED Departure for Discharged ED Patients – Reporting Measure
OP-Xc	Median Time from ED Arrival to ED Departure for Discharged ED Patients – Observation Patients
OP-Xd	Median Time from ED Arrival to ED Departure for Discharged ED Patients – Psychiatric/Mental Health Patients
OP-Xe	Median Time from ED Arrival to ED Departure for Discharged ED Patients – Transfer Patients

Performance Measure Name: Median Time from ED Arrival to ED Departure for Discharged ED Patients

Description: Median time from emergency department arrival to time of departure from the emergency room for patients discharged from the emergency department.

Rationale: Reducing the time patients remain in the emergency department (ED) can improve access to treatment and increase quality of care. Reducing this time potentially improves access to care specific to the patient condition and increases the capability to provide additional treatment. In recent times, EDs have experienced significant overcrowding. Although once only a problem in large, urban, teaching hospitals, the phenomenon has spread to other suburban and rural healthcare organizations. According to a 2002 national U.S. survey, more than 90 percent of large hospitals report EDs operating "at" or "over" capacity. Overcrowding and heavy emergency resource demand have led to a number of problems, including ambulance refusals, prolonged patient waiting times, increased suffering for those who wait, rushed and unpleasant treatment environments, and potentially poor patient outcomes. Approximately one third of hospitals in the U.S. report increases in ambulance diversion in a given year, whereas up to half report crowded conditions in the ED. In a recent national survey, 40 percent of hospital leaders viewed ED crowding as a symptom of workforce shortages. ED crowding may result in delays in the administration of medication such as antibiotics for pneumonia and has been associated with perceptions of compromised emergency care. For patients with non-ST-segment-elevation myocardial infarction, long ED stays were associated with decreased use of guideline-recommended therapies and a higher risk of recurrent myocardial infarction. When EDs are overwhelmed, their ability to respond to community emergencies and disasters may be compromised.

Type of Measure: Process

Improvement Noted As: A decrease in the median value

Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.

Included Populations:

- Any *ED Patient* from the facility's emergency department

Excluded Populations:

- Patients who expired in the emergency department

Data Elements:

- *Arrival Time*
- *Birthdate*
- *Discharge Status*
- *ED Departure Date*
- *ED Departure Time*
- *ED Patient*
- *ICD-9-CM Principal Diagnosis Code*
- *Observation Services*
- *Outpatient Encounter Date*

Risk Adjustment: No

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical records. Some facilities may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunity for improvement at the point of care/service.

Data Accuracy: None

Measure Analysis Suggestions: None

Sampling: Yes, for additional information see the Population and Sampling Specifications section.

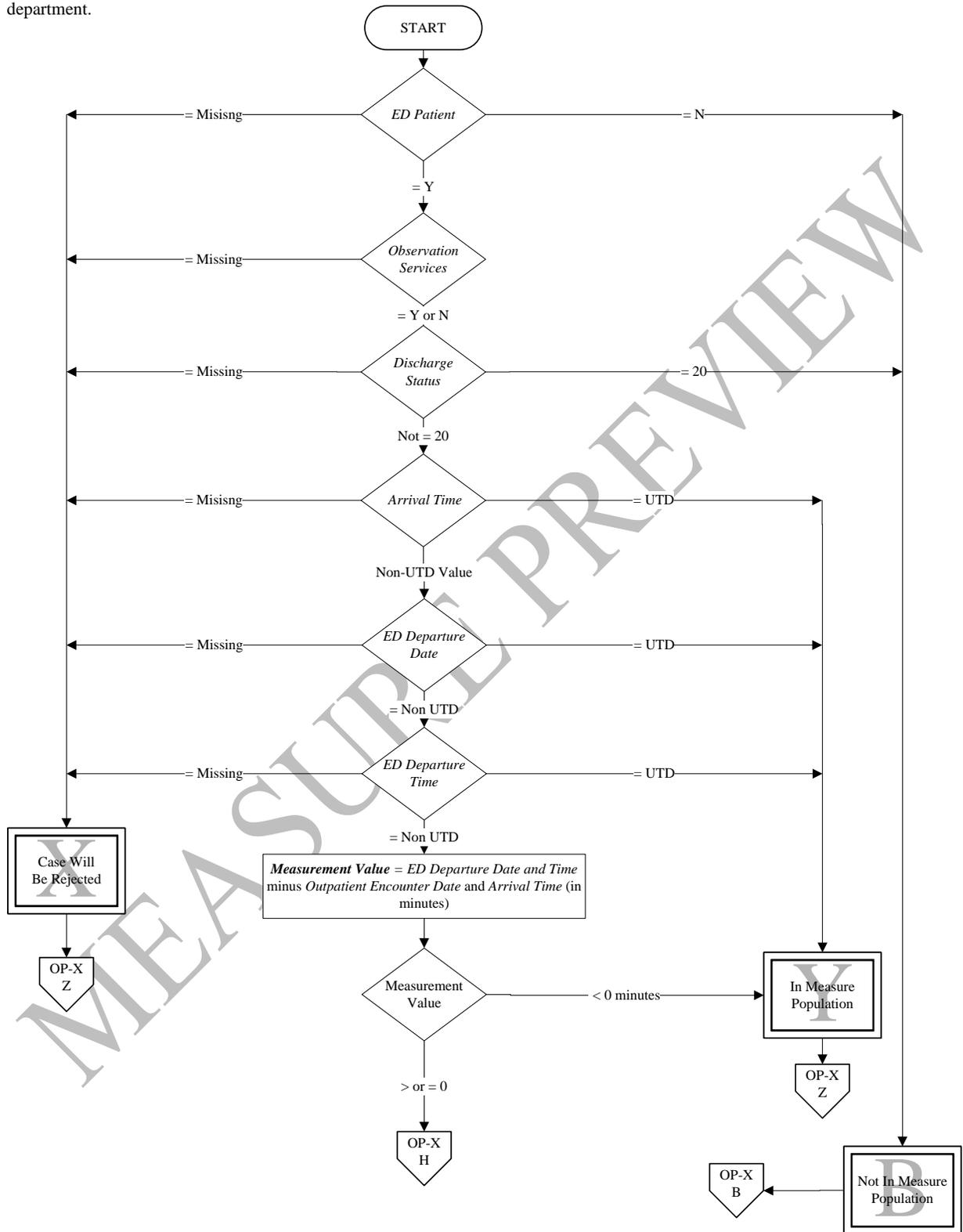
Data Reported As: Aggregate measure of central tendency

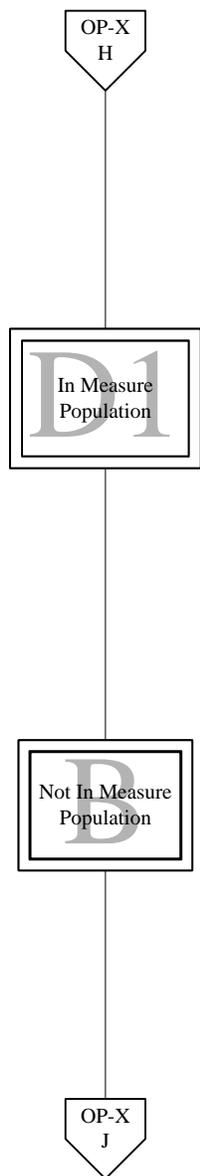
Selected References:

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- Wilper AP, Woolhandler S, Lasser KE, McCormick D, Cutrona SL, Bor DH, Himmelstein DU. Waits to see an emergency department physician: U.S. trends and predictors, 1997-2004. *Health Aff (Millwood).* 2008;27:w84-95.

OP-X: Median Time from ED Arrival to ED Departure for Discharged ED Patients

Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.

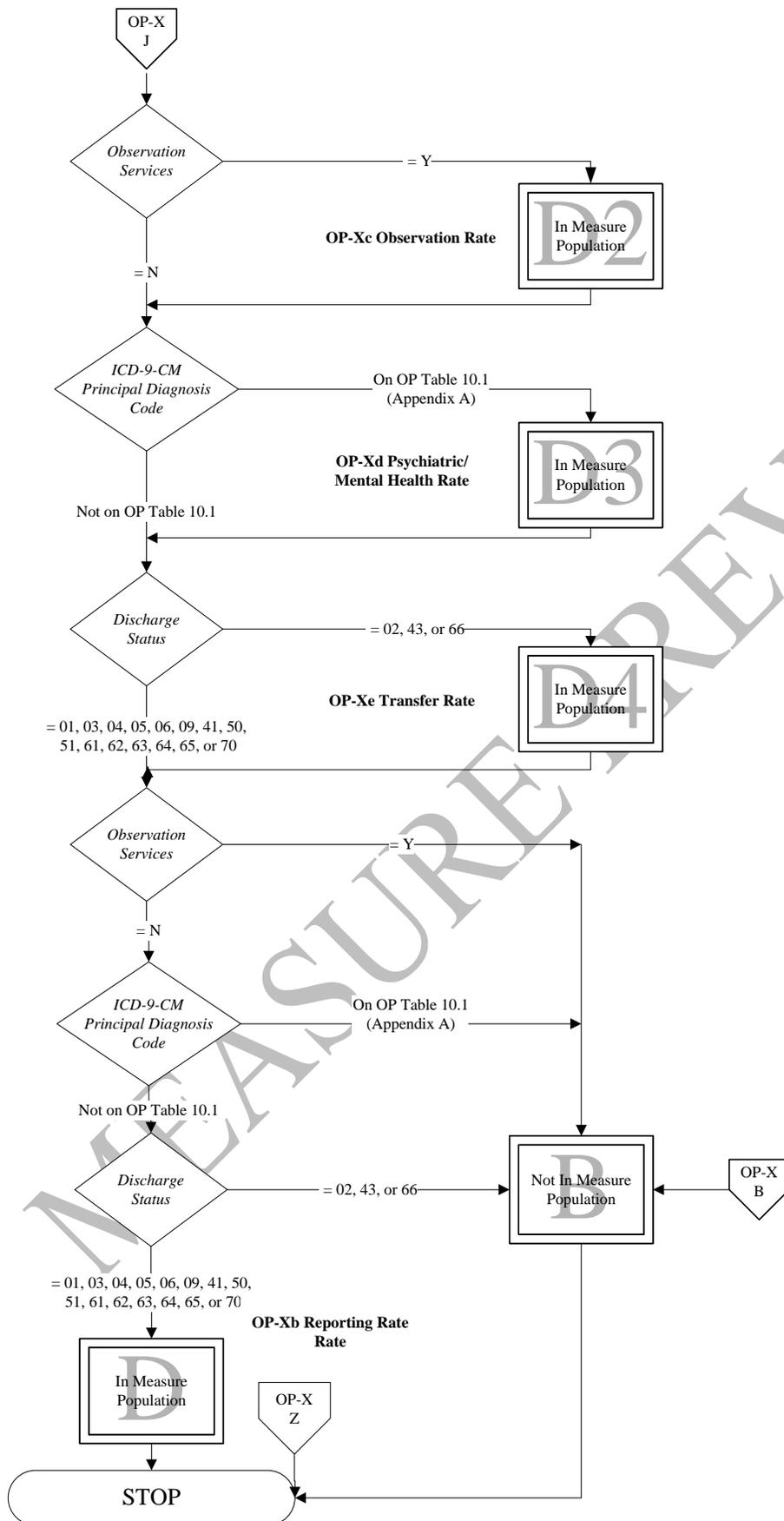




Note: Initialize the *Measure Category Assignment* for OP-Xb, OP-Xc, OP-Xd, and OP-Xe = 'B'.

Do not change the *Measure Category Assignment* that was already calculated for the overall rate (OP-Xa).

MEASURE PREVIEW



Data Element Name: *ED Departure Date*

Collected For: OP-X

Definition: The month, day, and year at which the patient departed from the emergency department.

Suggested Data Collection Question: What is the date the patient departed from the emergency department?

Format: **Length:** 10 – MM-DD-YYYY (includes dashes) or UTD
Type: Date
Occurs: 1

Allowable Values: Enter the documented date of the ED Departure
MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (2000-9999)

UTD = Unable to Determine

Dates must be recorded in the following format: MM-DD-YYYY.
Example: July 4, 2007 would be recorded as 07-04-2007

Notes for Abstraction:

- If the date the patient departed is unable to be determined from medical record documentation, enter UTD.
- If the date of departure is not documented, but you are able to determine the date from other documentation this is acceptable (e.g., you are able to identify from documentation the patient arrived and was transferred on the same day).

Suggested Data Sources:

- Emergency Department record

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	<i>ED Departure Time</i>						
Collected For:	OP-X						
Definition:	The time (military time) represented in hours and minutes at which the patient departed from the emergency department.						
Suggested Data Collection Question:	What is the time the patient departed from the emergency department?						
Format:	Length: 5 – HH:MM (with or without colon) or UTD Type: Time Occurs: 1						
Allowable Values:	Enter the documented time of the ED Departure HH = Hour (00-23) MM = Minutes (00-59) UTD = Unable to Determine Time must be recorded in military time format. Military Time – A 24-hour period from midnight to midnight using a 4-digit number of which the first two digits indicate the hour and the last two digits indicate the minute. Converting clock time to military time: With the exception of Midnight and Noon: <ul style="list-style-type: none"> • If the time is in the a.m., conversion is not required. • If the time is in the p.m., add 12 to the clock time hour. Example: 3:00 p.m. would be recorded as 15:00 Midnight: When converting 24:00 to 00:00 do not forget to change the date. Example: Midnight or 24:00 on 11-24-2007 = 00:00 on 11-25-2007 Examples: <table border="0" style="margin-left: 40px;"> <tr> <td>Midnight - 00:00</td> <td>Noon - 12:00</td> </tr> <tr> <td>5:31 am - 05:31</td> <td>5:31 pm - 17:31</td> </tr> <tr> <td>11:59 am - 11:59</td> <td>11:59 pm - 23:59</td> </tr> </table> For times that include “seconds”, remove the seconds and record the military time. Example: 15:00:35 would be recorded as 15:00	Midnight - 00:00	Noon - 12:00	5:31 am - 05:31	5:31 pm - 17:31	11:59 am - 11:59	11:59 pm - 23:59
Midnight - 00:00	Noon - 12:00						
5:31 am - 05:31	5:31 pm - 17:31						
11:59 am - 11:59	11:59 pm - 23:59						

Notes for Abstraction:

- The intention is to capture the latest time at which the patient was receiving care in the emergency department, under the care of emergency department services, or awaiting transport to services/care.
- ED Departure Time is the time the patient **physically left the emergency department** (e.g., nurses notes state “1800 transfer of care to medflight team” and other documentation includes a time that the patient left the ED to be loaded in the helicopter, abstract the later time or nurses notes state “1800 transport to unit” and other documentation includes a time that the patient actually left the ED to be transferred, abstract the later time).
- If the time the patient departed is unable to be determined from medical record documentation, enter UTD.
- When more than one emergency department departure/discharge time is documented abstract the latest time.
Example:
 - o Two departure times are found in the nurse’s notes: 12:03 and 12:20. Select the later time of 12:20.
- If patient expired in the ED, use the time of death as the departure time.
- Do not use the time the discharge order was written because it may not represent the actual time of departure.
- If a patient is placed into observation services in the emergency department and is subsequently transferred to another unit abstract the time they depart for the unit (i.e. leave the ED).
- If the patient is placed into observation services and remains in the ED or in a unit of the ED abstract the time they depart the ED or ED unit for the floor/surgery etc. Do not abstract the time they are placed into observation services.

Suggested Data Sources:

- Emergency Department record

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *ED Patient*

Collected For: OP-X

Definition: Patients receiving care in a dedicated emergency department of the facility.

Suggested Data Collection Question: Was the patient an *ED Patient* at the facility?

Format: **Length:** 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes) There is documentation the patient was an *ED Patient*.
 N (No) There is no documentation the patient was an *ED Patient* or unable to determine from medical record documentation.

- Notes for Abstraction:**
- For the purposes of this data element an ED Patient is defined as any patient receiving care or services in the Emergency Department.
 - Patients seen in an off campus emergency department (i.e. ER Fast Track, Urgent Care) are not considered an ED Patient unless they received services in the emergency department at the facility (e.g., patient treated at an urgent care and transferred to the main campus ED is considered an ED patient, but a patient seen at the urgent care and transferred to the hospital as a direct admit would not be considered an ED Patient).
 - Patients presenting to the ED who do not receive care or services in the ED abstract as a NO (e.g., patient is sent to hospital from physician office and presents to ED triage and is instructed to proceed straight to floor.)
 - Patients presenting to the ED for outpatient services such as lab work etc. will abstract as a YES.

- Suggested Data Sources:**
- Emergency department record
 - Face sheet
 - Registration form
 - UB-04

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Observation Services*

Collected For: OP-X

Definition: Observation services are those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient.

Suggested Data Collection Question: Was there documentation the patient was placed in observation services during the encounter or hospitalization?

Format: **Length:** 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes) There is documentation the patient was placed into observation services.
N (No) There is no documentation the patient was placed into observation services or unable to determine from medical record documentation.

Notes for Abstraction:

- If there is documentation the patient was placed into observation services after care provided in the emergency department, select "No". (E.g., Patient is seen in the ED and admitted to a medical surgical unit as an inpatient and is later converted to observation status).
- The intent is to capture emergency department patients placed into observation services prior to admission to the facility as an inpatient.

Suggested Data Sources: Emergency Department Record

Guidelines for Abstraction:

Inclusion	Exclusion

ICD-9-CM Diagnosis Code Tables

Table 10.1: Psychiatric/Mental Health

Table 10.1 Psychiatric/Mental Health		
Code	ICD-9-CM Description	Shortened Description
290.0	Dementias, Senile dementia, uncomplicated, Senile dementia: NOS simple type	SENILE DEMENTIA UNCOMP
290.10	Dementias, Presenile dementia, uncomplicated, Presenile dementia: NOS simple type	PRESENILE DELIRIUM
290.11	Dementias, Presenile dementia with delirium, Presenile dementia with acute confusional state	PRESENILE DELIRIUM
290.12	Dementias, Presenile dementia with delusional features, Presenile dementia, paranoid type	PRESENILE DELUSION
290.13	Dementias, Presenile dementia with depressive features, Presenile dementia, depressed type	PRESENILE DEPRESSION
290.20	Dementias, Senile dementia with delusional or depressive features, Senile dementia, paranoid type, Senile psychosis NOS	SENILE DELUSION
290.21	Dementias, Senile dementia with depressive features,	SENILE DEPRESSIVE
290.3	Dementias, Senile dementia with delirium, Senile dementia with acute confusional state	SENILE DELIRIUM
290.40	Dementias, Vascular dementia, uncomplicated, Arteriosclerotic dementia: NOS simple type	VASCULAR DEMENTIA,UNCOMP
290.41	Dementias, Vascular dementia with delirium, Arteriosclerotic dementia with acute confusional state	VASC DEMENTIA W DELIRIUM
290.42	Dementias, Vascular dementia with delusions, Arteriosclerotic dementia, paranoid type	VASC DEMENTIA W DELUSION
290.43	Dementias, Vascular dementia with depressed mood, Arteriosclerotic dementia, depressed type	VASC DEMENTIA W DEPRESSN
290.8	Dementias, Other specified senile psychotic conditions, Presbyophrenic psychosis	SENILE PSYCHOSIS NEC
290.9	Unspecified senile psychotic condition	SENILE PSYCHOT COND NOS
291	Alcohol-induced mental disorders	
290.1	Alcohol-induced mental disorders, Alcohol withdrawal delirium, Alcoholic delirium Delirium tremens	DELIRIUM TREMENS
291.1	Alcohol-induced mental disorders, Alcohol-induced persisting amnestic disorder, Alcoholic polyneuritic psychosis, Korsakoff's psychosis, alcoholic Wernicke-Korsakoff syndrome (alcoholic)	ALCOHOL AMNESTIC DISORDR
291.2	Alcohol-induced mental disorders, Alcohol-induced persisting dementia, Alcoholic dementia NOS, Alcoholism associated with dementia NOS, Chronic alcoholic brain syndrome	ALCOHOL PERSIST DEMENTIA
291.3	Alcohol-induced mental disorders, Alcohol-induced psychotic disorder with hallucinations Alcoholic: hallucinosis (acute), psychosis with hallucinosis	ALCOH PSY DIS W HALLUCIN
291.4	Alcohol-induced mental disorders, Idiosyncratic alcohol intoxication, Pathologic: alcohol intoxication, drunkenness	PATHOLOGIC ALCOHOL INTOX
291.5	Alcohol-induced mental disorders, Alcohol-induced psychotic disorder with delusions, Alcoholic: paranoia, psychosis, paranoid type	ALCOH PSYCH DIS W DELUS
291.81	Alcohol-induced mental disorders, Other specified alcohol-induced mental disorders, Alcohol withdrawal, Alcohol: abstinence syndrome or symptoms, withdrawal syndrome or	ALCOHOL WITHDRAWAL

	symptoms	
291.82	Alcohol-induced mental disorders, Other specified alcohol-induced mental disorders, Alcohol induced sleep disorders, Alcohol induced circadian rhythm sleep disorders, Alcohol induced hypersomnia, Alcohol induced insomnia, Alcohol induced parasomnia	ALCOH INDUCE SLEEP DISOR
291.89	Alcohol-induced mental disorders, Other specified alcohol-induced mental disorders, Other	ALCOHOL MENTAL DISOR NEC
291.9	Alcohol-induced mental disorders, Unspecified alcohol-induced mental disorders, Alcoholic: mania NOS, psychosis NOS, Alcoholism (chronic) with psychosis, Alcohol-related disorder NOS	ALCOHOL MENTAL DISOR NOS
292.0	Drug-induced mental disorders, Drug withdrawal, Drug: abstinence syndrome or symptoms, withdrawal syndrome or symptoms	DRUG WITHDRAWAL
292.11	Drug-induced mental disorders, Drug-induced psychotic disorders, Drug-induced psychotic disorder with delusions Paranoid state induced by drugs	DRUG PSYCH DISOR W DELUS
292.12	Drug-induced mental disorders, Drug-induced psychotic disorders, Drug-induced psychotic disorder with delusions, Hallucinatory state induced by drugs	DRUG PSY DIS W HALLUCIN
292.2	Pathological drug intoxication, Drug reaction resulting in brief psychotic states NOS, idiosyncratic, pathologic	PATHOLOGIC DRUG INTOX
292.81	Drug-induced mental disorders, Other specified drug-induced mental disorders, Drug-induced delirium	DRUG-INDUCED DELIRIUM
292.82	Drug-induced mental disorders, Other specified drug-induced mental disorders, Drug-induced persisting dementia	DRUG PERSISTING DEMENTIA
292.83	Drug-induced mental disorders, Other specified drug-induced mental disorders, Drug-induced persisting amnesic disorder	DRUG PERSIST AMNESTC DIS
292.84	Drug-induced mental disorders, Other specified drug-induced mental disorders, Drug-induced mood disorder, Depressive state induced by drugs	DRUG-INDUCED MOOD DISORD
292.85	Drug-induced mental disorders, Other specified drug-induced mental disorders, Drug induced sleep disorders , Drug induced circadian rhythm sleep disorder, Drug induced hypersomnia, Drug induced insomnia, Drug induced parasomnia	DRUG INDUCED SLEEP DISOR
292.89	Drug-induced mental disorders, Other specified drug-induced mental disorders, Other, Drug-induced anxiety disorder, Drug-induced organic personality syndrome, Drug-induced sexual dysfunction, Drug intoxication	DRUG MENTAL DISORDER NEC
292.9	Drug-induced mental disorders, Unspecified drug-induced mental disorder	DRUG MENTAL DISORDER NOS
293.0	Transient mental disorders due to conditions classified elsewhere , Delirium due to conditions classified elsewhere Acute: confusional state, infective psychosis, organic reaction posttraumatic organic, psychosis, psycho-organic syndrome, Acute psychosis associated with endocrine, metabolic, or cerebrovascular disorder Epileptic: confusional state, twilight state	DELIRIUM D/T OTHER COND
293.1	Transient mental disorders due to conditions classified elsewhere, Subacute delirium, Subacute: confusional state, infective psychosis, organic reaction, posttraumatic organic psychosis, psycho-organic syndrome, psychosis associated with endocrine or metabolic disorder	SUBACUTE DELIRIUM

293.81	Transient mental disorders due to conditions classified elsewhere, Other specified transient mental disorders due to conditions classified elsewhere, Psychotic disorder with delusions in conditions classified elsewhere, Transient organic psychotic condition, paranoid type	PSY DIS W DELUS OTH DIS
293.82	Transient mental disorders due to conditions classified elsewhere, Other specified transient mental disorders due to conditions classified elsewhere, Psychotic disorder with hallucinations in conditions classified elsewhere Transient organic psychotic condition, hallucinatory type	PSY DIS W HALLUC OTH DIS
293.83	Transient mental disorders due to conditions classified elsewhere, Other specified transient mental disorders due to conditions classified elsewhere, Mood disorder in conditions classified elsewhere Transient organic psychotic condition, depressive type	MOOD DISORDER OTHER DIS
293.84	Transient mental disorders due to conditions classified elsewhere, Other specified transient mental disorders due to conditions classified elsewhere, Anxiety disorder in conditions classified elsewhere	ANXIETY DISORDER OTH DIS
293.89	Transient mental disorders due to conditions classified elsewhere, Other specified transient mental disorders due to conditions classified elsewhere, Other Catatonic disorder in conditions classified elsewhere	TRANSIENT MENTAL DIS NEC
293.9	Transient mental disorders due to conditions classified elsewhere, Unspecified transient mental disorder in conditions classified elsewhere Organic psychosis: infective NOS, posttraumatic NOS, transient NOS, Psycho-organic syndrome	TRANSIENT MENTAL DIS NOS
294.0	Persistent mental disorders due to conditions classified elsewhere, Amnestic disorder in conditions classified elsewhere Korsakoff's psychosis or syndrome (nonalcoholic)	AMNESTIC DISORD OTH DIS
294.10	Persistent mental disorders due to conditions classified elsewhere, Dementia in conditions classified elsewhere without behavioral disturbance Dementia in conditions classified elsewhere NOS	DEMENTIA W/O BEHAV DIST
294.11	Persistent mental disorders due to conditions classified elsewhere	DEMENTIA W BEHAVIOR DIST
294.8	Persistent mental disorders due to conditions classified elsewhere, Other persistent mental disorders due to conditions classified elsewhere, Amnestic disorder NOS, Dementia NOS Epileptic psychosis NOS, Mixed paranoid and affective organic psychotic states	MENTAL DISOR NEC OTH DIS
294.9	Persistent mental disorders due to conditions classified elsewhere, Unspecified persistent mental disorders due to conditions classified elsewhere, Cognitive disorder NOS, Organic psychosis (chronic)	MENTAL DISOR NOS OTH DIS
295.00	Schizophrenic disorders , Simple type schizophrenia, unspecified state	SIMPL SCHIZOPHREN-UNSPEC
295.01	Schizophrenic disorders , Simple type schizophrenia, subchronic state	SIMPL SCHIZOPHREN-SUBCHR
295.02	Schizophrenic disorders , Simple type schizophrenia, chronic state	SIMPLE SCHIZOPHREN-CHR
295.03	Schizophrenic disorders , Simple type schizophrenia, subchronic with acute exacerbation	SIMP SCHIZ-SUBCHR/EXACER
295.04	Schizophrenic disorders , Simple type schizophrenia, chronic with acute exacerbation	SIMPL SCHIZO-CHR/EXACERB
295.05	Schizophrenic disorders , Simple type schizophrenia, in	SIMPL SCHIZOPHREN-REMISS

	remission	
295.10	Schizophrenic disorders , Disorganized type schizophrenia, unspecified state	HEBEPHRENIA-UNSPEC
295.11	Schizophrenic disorders , Disorganized type schizophrenia, subchronic state	HEBEPHRENIA-SUBCHRONIC
295.12	Schizophrenic disorders , Disorganized type schizophrenia,, chronic state	HEBEPHRENIA-CHRONIC
295.13	Schizophrenic disorders , Disorganized type schizophrenia, subchronic with acute exacerbation	HEBEPHREN-SUBCHR/EXACERB
295.14	Schizophrenic disorders , Disorganized type schizophrenia, chronic with acute exacerbation	HEBEPHRENIA-CHR/EXACERB
295.15	Schizophrenic disorders , Disorganized type schizophrenia, in remission	HEBEPHRENIA-REMISSION
295.20	Schizophrenic disorders, catatonic type schizophrenia, unspecified state	CATATONIA-UNSPEC
295.21	Schizophrenic disorders, catatonic type schizophrenia, subchronic state	CATATONIA-SUBCHRONIC
295.22	Schizophrenic disorders, catatonic type schizophrenia, chronic state	CATATONIA-CHRONIC
295.23	Schizophrenic disorders, catatonic type schizophrenia, subchronic state with acute exacerbation	CATATONIA-SUBCHR/EXACERB
295.24	Schizophrenic disorders, catatonic type schizophrenia, chronic state with acute exacerbation	CATATONIA-CHR/EXACERB
295.25	Schizophrenic disorders, catatonic type schizophrenia, in remission	CATATONIA-REMISSION
295.30	Schizophrenic disorders, paranoid type, schizophrenia, unspecified state	PARANOID SCHIZO-UNSPEC
295.31	Schizophrenic disorders, paranoid type, schizophrenia, subchronic state	PARANOID SCHIZO-SUBCHR
295.32	Schizophrenic disorders, paranoid type schizophrenia, chronic state	PARANOID SCHIZO-CHRONIC
295.33	Schizophrenic disorders, paranoid type schizophrenia, subchronic state with acute exacerbation	PARAN SCHIZO-SUBCHR/EXAC
295.34	Schizophrenic disorders, paranoid type schizophrenia, chronic state with acute exacerbation	PARAN SCHIZO-CHR/EXACERB
295.35	Schizophrenic disorders, paranoid type schizophrenia, in remission	PARANOID SCHIZO-REMISS
295.40	Schizophrenic disorders, Schizophreniform disorder, unspecified state	SCHIZOPHRENIFORM DIS NOS
295.41	Schizophrenic disorders, Schizophreniform disorder, subchronic state	SCHIZOPHRENIC DIS-SUBCHR
295.42	Schizophrenic disorders, Schizophreniform disorder, chronic state	SCHIZOPHREN DIS-CHRONIC
295.43	Schizophrenic disorders, Schizophreniform disorder, subchronic state with acute exacerbation	SCHIZO DIS-SUBCHR/EXACER
295.44	Schizophrenic disorders, Schizophreniform disorder, chronic state with acute exacerbation	SCHIZOPHR DIS-CHR/EXACER
295.45	Schizophrenic disorders, Schizophreniform disorder, in remission	SCHIZOPHRENIC DIS-REMISS
295.50	Schizophrenic disorders, Latent schizophrenia, unspecified state	LATENT SCHIZOPHREN-UNSP
295.51	Schizophrenic disorders, Latent schizophrenia, subchronic state	LAT SCHIZOPHREN-SUBCHR
295.52	Schizophrenic disorders, Latent schizophrenia, chronic state	LATENT SCHIZOPHREN-CHR
295.53	Schizophrenic disorders, Latent schizophrenia, subchronic	LAT SCHIZO-SUBCHR/EXACER

	state with acute exacerbation	
295.54	Schizophrenic disorders, Latent schizophrenia, chronic state with acute exacerbation	LATENT SCHIZO-CHR/EXACER
295.55	Schizophrenic disorders, Latent schizophrenia, in remission	LAT SCHIZOPHREN-REMISS
295.60	Schizophrenic disorders, residual type, unspecified state	SCHIZOPHR DIS RESID NOS
295.61	Schizophrenic disorders, residual type, subchronic state	SCHIZOPH DIS RESID-SUBCH
295.62	Schizophrenic disorders, residual type, chronic state	SCHIZOPHR DIS RESID-CHR
295.63	Schizophrenic disorders, residual type, subchronic state with acute exacerbation	SCHIZO RESID SUBCHR/EXAC
295.64	Schizophrenic disorders, residual type, chronic state with acute exacerbation	SCHIZOPH RESID-CHRO/EXAC
295.65	Schizophrenic disorders, residual type, in remission	SCHIZOPH DIS RESID-REMISS
295.70	Schizophrenic disorders, Schizoaffective disorder, unspecified state	SCHIZOAFFECTIVE DIS NOS
295.71	Schizophrenic disorders, Schizoaffective disorder, subchronic state	SCHIZOAFFECTV DIS-SUBCHR
295.72	Schizophrenic disorders, Schizoaffective disorder, chronic state	SCHIZOAFFECTIVE DIS-CHR
295.73	Schizophrenic disorders, Schizoaffective disorder, subchronic state with acute exacerbation	SCHIZOAFV DIS-SUBCHR/EXAC
295.74	Schizophrenic disorders, Schizoaffective disorder, chronic state with acute exacerbation	SCHIZOAFV DIS-CHR/EXAC
295.75	Schizophrenic disorders, Schizoaffective disorder, in remission	SCHIZOAFFECTIVE DIS-REMISS
295.80	Schizophrenic disorders, schizophrenia, unspecified state	SCHIZOPHRENIA NEC-UNSPEC
295.81	Schizophrenic disorders, schizophrenia, subchronic state	SCHIZOPHRENIA NEC-SUBCHR
295.82	Schizophrenic disorders, schizophrenia, chronic state	SCHIZOPHRENIA NEC-CHR
295.83	Schizophrenic disorders, schizophrenia, subchronic state with acute exacerbation	SCHIZO NEC-SUBCHR/EXACER
295.84	Schizophrenic disorders, schizophrenia, chronic state with acute exacerbation	SCHIZO NEC-CHR/EXACERB
295.85	Schizophrenic disorders, schizophrenia, in remission	SCHIZOPHRENIA NEC-REMISS
295.90	Schizophrenic disorders, unspecified type schizophrenia, unspecified state	SCHIZOPHRENIA NOS-UNSPEC
295.91	Schizophrenic disorders, unspecified type schizophrenia, subchronic state	SCHIZOPHRENIA NOS-SUBCHR
295.92	Schizophrenic disorders, unspecified type schizophrenia, chronic state	SCHIZOPHRENIA NOS-CHR
295.93	Schizophrenic disorders, unspecified type schizophrenia, subchronic state with acute exacerbation	SCHIZO NOS-SUBCHR/EXACER
295.94	Schizophrenic disorders, unspecified type schizophrenia, chronic state with acute exacerbation	SCHIZO NOS-CHR/EXACERB
295.95	Schizophrenic disorders, unspecified type schizophrenia, in remission	SCHIZOPHRENIA NOS-REMISS
296.0	Episodic mood disorders, Bipolar I disorder, single manic episode, Hypomania (mild) NOS single episode or unspecified, Hypomanic psychosis single episode or unspecified, Mania (monopolar) NOS single episode or unspecified, Manic-depressive psychosis or reaction, single episode or unspecified: hypomanic, single episode or unspecified, manic, single episode or unspecified	BIPOL I
296.00	Episodic mood disorders, Bipolar I disorder, single manic episode, unspecified	BIPOL I SINGLE MANIC NOS

296.01	Episodic mood disorders, Bipolar I disorder, single manic episode, mild	BIPOL I SINGLE MANC-MILD
296.02	Episodic mood disorders, Bipolar I disorder, single manic episode, moderate	BIPOL I SINGLE MANIC-MOD
296.03	Episodic mood disorders, Bipolar I disorder, single manic episode, severe, without psychotic behavior	BIPOL I SING-SEV W/O PSY
296.04	Episodic mood disorders, Bipolar I disorder, single manic episode, severe with psychotic behavior	BIPO I SIN MAN-SEV W PSY
296.05	Episodic mood disorders, Bipolar I disorder, single manic episode, in partial/unspecified remission	BIPOL I SING MAN REM NOS
296.06	Episodic mood disorders, Bipolar I disorder, single manic episode, in full remission	BIPOL I SINGLE MANIC REM
296.10	Episodic mood disorders, Manic disorder, Manic affective disorder, recurrent episode, unspecified	RECUR MANIC DIS-UNSPEC
296.11	Episodic mood disorders, Manic disorder, Manic affective disorder, recurrent episode, mild	RECUR MANIC DIS-MILD
296.12	Episodic mood disorders, Manic disorder, Manic affective disorder, recurrent episode, moderate	RECUR MANIC DIS-MOD
296.13	Episodic mood disorders, Manic disorder, Manic affective disorder, recurrent episode, severe, without psychotic behavior	RECUR MANIC DIS-SEVERE
296.14	Episodic mood disorders, Manic disorder, Manic affective disorder, recurrent episode, severe with psychotic behavior	RECUR MANIC-SEV W PSYCHO
296.15	Episodic mood disorders, Manic disorder, Manic affective disorder, recurrent episode, in partial/unspecified remission	RECUR MANIC-PART REMISS
296.16	Episodic mood disorders, Manic disorder, Manic affective disorder, recurrent episode, in full remission	RECUR MANIC-FULL REMISS
296.20	Episodic mood disorders, Major depressive disorder, single episode, Major depressive affective disorder, single episode, unspecified	DEPRESS PSYCHOSIS-UNSPEC
296.21	Episodic mood disorders, Major depressive disorder, single episode, Major depressive affective disorder, single episode, mild	DEPRESS PSYCHOSIS-MILD
296.22	Episodic mood disorders, Major depressive disorder, single episode, Major depressive affective disorder, single episode, moderate	DEPRESSIVE PSYCHOSIS-MOD
296.23	Episodic mood disorders, Major depressive disorder, single episode, Major depressive affective disorder, single episode, severe, without psychotic behavior	DEPRESS PSYCHOSIS-SEVERE
296.24	Episodic mood disorders, Major depressive disorder, single episode, Major depressive affective disorder, single episode, severe with psychotic behavior	DEPR PSYCHOS-SEV W PSYCH
296.25	Episodic mood disorders, Major depressive disorder, single episode, Major depressive affective disorder, single episode, in partial/unspecified remission	DEPR PSYCHOS-PART REMISS
296.26	Episodic mood disorders, Major depressive disorder, single episode, Major depressive affective disorder, single episode, in full remission	DEPR PSYCHOS-FULL REMISS
296.30	Episodic mood disorders, Major depressive disorder, recurrent episode, Major depressive affective disorder, recurrent episode, unspecified	DEPR PSYCHOS-FULL REMISS
296.31	Episodic mood disorders, Major depressive disorder, recurrent episode, Major depressive affective disorder, recurrent episode, mild	RECURR DEPR PSYCHOS-MILD
296.32	Episodic mood disorders, Major depressive disorder, recurrent episode, Major depressive affective disorder, recurrent	RECURR DEPR PSYCHOS-MOD

	episode, moderate	
296.33	Episodic mood disorders, Major depressive disorder, recurrent episode, Major depressive affective disorder, recurrent episode, severe, without psychotic behavior	RECUR DEPR PSYCH-SEVERE
296.34	Episodic mood disorders, Major depressive disorder, recurrent episode, Major depressive affective disorder, recurrent episode, severe, with psychotic behavior	REC DEPR PSYCH-PSYCHOTIC
296.35	Episodic mood disorders, Major depressive disorder, recurrent episode, Major depressive affective disorder, recurrent episode, in partial/unspecified remission	RECUR DEPR PSYC-PART REM
296.36	Episodic mood disorders, Major depressive disorder, recurrent episode, Major depressive affective disorder, recurrent episode, in full remission	RECUR DEPR PSYC-FULL REM
296.40	Episodic mood disorders, Bipolar I disorder, most recent episode (or current) manic, unspecified	BIPOL I CURRNT MANIC NOS
296.41	Episodic mood disorders, Bipolar I disorder, most recent episode (or current) manic, mild	BIPOL I CURRNT MANIC-MILD
296.42	Episodic mood disorders, Bipolar I disorder, most recent episode (or current) manic, moderate	BIPOL I CURRNT MANIC-MOD
296.43	Episodic mood disorders, Bipolar I disorder, most recent episode (or current) manic, severe without psychotic behavior	BIPOL I MANC-SEV W/O PSY
296.44	Episodic mood disorders, Bipolar I disorder, most recent episode (or current) manic, severe with psychotic behavior	BIPOL I MANIC-SEV W PSY
296.45	Episodic mood disorders, Bipolar I disorder, most recent episode (or current) manic, in partial/unspecified remission	BIPOL I CUR MAN PART REM
296.46	Episodic mood disorders, Bipolar I disorder, most recent episode (or current) manic, in full remission	BIPOL I CUR MAN FULL REM
296.50	Episodic mood disorders, Bipolar I disorder, most recent episode (or current) depressed, unspecified	BIPOL I CUR DEPRES NOS
296.51	Episodic mood disorders, Bipolar I disorder, most recent episode (or current) depressed, mild	BIPOL I CUR DEPRESS-MILD
296.52	Episodic mood disorders, Bipolar I disorder, most recent episode (or current) depressed, moderate	BIPOL I CUR DEPRESS-MOD
296.53	Episodic mood disorders, Bipolar I disorder, most recent episode (or current) depressed, severe without psychotic behavior	BIPOL I CURR DEP W/O PSY
296.54	Episodic mood disorders, Bipolar I disorder, most recent episode (or current) depressed, severe with psychotic behavior	BIPOL I CURRNT DEP W PSY
296.55	Episodic mood disorders, Bipolar I disorder, most recent episode (or current) depressed, in partial/unspecified remission	BIPOL I CUR DEP REM NOS
296.56	Episodic mood disorders, Bipolar I disorder, most recent episode (or current) depressed, in full remission	BIPOL I CURRNT DEP REMIS
296.60	Episodic mood disorders, Bipolar I disorder, most recent episode (or current) mixed	BIPOL I CURRNT MIXED NOS
296.61	Episodic mood disorders, Bipolar I disorder, most recent episode (or current) mixed, mild	BIPOL I CURRNT MIX-MILD
296.62	Episodic mood disorders, Bipolar I disorder, most recent episode (or current) mixed, moderate	BIPOL I CURRNT MIXED-MOD
296.63	Episodic mood disorders, Bipolar I disorder, most recent episode (or current) mixed, severe without psychotic behavior	BIPOL I CUR MIX W/O PSY
296.64	Episodic mood disorders, Bipolar I disorder, most recent episode (or current) mixed, with psychotic behavior	BIPOL I CUR MIXED W PSY
296.65	Episodic mood disorders, Bipolar I disorder, most recent	BIPOL I CUR MIX-PART REM

	episode (or current) mixed, in partial/unspecified remission	
296.66	Episodic mood disorders, Bipolar I disorder, most recent episode (or current) mixed, in full remission	BIPOL I CUR MIXED REMISS
296.7	Episodic mood disorders, Bipolar I disorder, most recent episode (or current) unspecified, Atypical bipolar affective disorder NOS, Manic-depressive psychosis, circular type, current condition not specified as either manic or depressive	BIPOLOR I CURRENT NOS
296.80	Episodic mood disorders, Bipolar disorder, unspecified, Bipolar disorder NOS, Manic-depressive: reaction NOS, syndrome NOS	BIPOLAR DISORDER NOS
296.81	Episodic mood disorders, Other and unspecified bipolar disorders, Atypical manic disorder	ATYPICAL MANIC DISORDER
296.82	Episodic mood disorders, Other and unspecified bipolar disorders, Atypical depressive disorder	ATYPICAL DEPRESSIVE DIS
296.89	Episodic mood disorders, Other and unspecified bipolar disorders, Other Bipolar II disorder, Manic-depressive psychosis, mixed type	BIPOLAR DISORDER NEC
296.90	Episodic mood disorders, Other and unspecified episodic mood disorder, Unspecified episodic mood disorder, Affective psychosis NOS, Melancholia NOS, Mood disorder NOS	EPISODIC MOOD DISORD NOS
296.99	Episodic mood disorders, Other and unspecified episodic mood disorder, Other specified episodic mood disorder, Mood swings: brief compensatory rebound	EPISODIC MOOD DISORD NEC
297.0	Delusional disorders, Paranoid state, simple	PARANOID STATE, SIMPLE
297.1	Delusional disorders, Delusional disorder, Chronic paranoid psychosis, Sander's disease, Systematized delusions	DELUSIONAL DISORDER
297.2	Delusional disorders, Paraphrenia, Involutional paranoid state Late paraphrenia, Paraphrenia (involutional)	PARAPHRENIA
297.3	Delusional disorders, Shared psychotic disorder, Folie à deux, Induced psychosis or paranoid disorder	SHARED PSYCHOTIC DISORD
297.8	Delusional disorders, Other specified paranoid states, Paranoia querulans, Sensitiver Beziehungswahn	PARANOID STATES NEC
297.9	Delusional disorders, Unspecified paranoid state, Paranoid: disorder NOS, psychosis NOS, reaction NOS, state NOS	PARANOID STATE NOS
298.0	Other nonorganic psychoses, Depressive type psychosis, Psychogenic depressive psychosis, Psychotic reactive depression, Reactive depressive psychosis	REACT DEPRESS PSYCHOSIS
298.1	Other nonorganic psychoses, Excitative type psychosis, Acute hysterical psychosis, Psychogenic excitation, Reactive excitation	EXCITATIV TYPE PSYCHOSIS
298.2	Other nonorganic psychoses, Reactive confusion, Psychogenic confusion, Psychogenic twilight state	REACTIVE CONFUSION
298.3	Other nonorganic psychoses, Acute paranoid reaction, Acute psychogenic paranoid psychosis, Bouffée délirante	ACUTE PARANOID REACTION
298.4	Other nonorganic psychoses, Psychogenic paranoid psychosis Protracted reactive paranoid psychosis	PSYCHOGEN PARANOID PSYCH
298.8	Other nonorganic psychoses, Other and unspecified reactive psychosis, Brief psychotic disorder, Brief reactive psychosis NOS, Hysterical psychosis, Psychogenic psychosis NOS, Psychogenic stupor	REACT PSYCHOSIS NEC/NOS
298.9	Other nonorganic psychoses, Unspecified psychosis, Atypical psychosis, Psychosis NOS, Psychotic disorder NOS	PSYCHOSIS NOS
299.00	Pervasive developmental disorders, autistic disorder, current/active state	AUTISTIC DISORD-CURRENT

299.01	Pervasive developmental disorders, autistic disorder residual state	AUTISTIC DISORD-RESIDUAL
299.10	Pervasive developmental disorders, Childhood disintegrative disorder, current/active state	CHILDDHD DISINTEGR-ACTIVE
299.11	Pervasive developmental disorders, Childhood disintegrative disorder, residual state	CHILDDHD DISINTEGR-RESID
299.80	Pervasive developmental disorders, Other specified pervasive developmental disorders, pervasive developmental disorder, current/active state	PERVASV DEV DIS-CUR NEC
299.81	Pervasive developmental disorders, Other specified pervasive developmental disorders, pervasive developmental disorder, residual state	PERVASV DEV DIS-RES NEC
299.90	Pervasive developmental disorders, Unspecified pervasive developmental disorder, current/active state	PERVASV DEV DIS-CUR NOS
299.91	Pervasive developmental disorders, Unspecified pervasive developmental disorder, residual state	PERVASV DEV DIS-RES NOS
300.00	Anxiety, dissociative and somatoform disorders, Anxiety states, Anxiety state, unspecified, Anxiety: neurosis reaction, state (neurotic), Atypical anxiety disorder	ANXIETY STATE NOS
300.01	Anxiety, dissociative and somatoform disorders, Anxiety states, Panic disorder without agoraphobia, Panic: attack state	PANIC DIS W/O AGORPHOBIA
300.02	Anxiety, dissociative and somatoform disorders, Anxiety states, Generalized anxiety disorder	GENERALIZED ANXIETY DIS
300.09	Anxiety, dissociative and somatoform disorders, Anxiety states, Other	ANXIETY STATE NEC
300.10	Anxiety, dissociative and somatoform disorders, Dissociative, conversion and factitious disorders, Hysteria, unspecified	HYSTERIA NOS
300.11	Anxiety, dissociative and somatoform disorders, Dissociative, conversion and factitious disorders, Conversion disorder, Astasia-abasia, hysterical, Conversion hysteria or reaction Hysterical: blindness, deafness, paralysis	CONVERSION DISORDER
300.12	Anxiety, dissociative and somatoform disorders, Dissociative, conversion and factitious disorders, Dissociative amnesia, Hysterical amnesia	DISSOCIATIVE AMNESIA
300.13	Anxiety, dissociative and somatoform disorders, Dissociative, conversion and factitious disorders, Dissociative fugue, Hysterical fugue	DISSOCIATIVE FUGUE
300.14	Anxiety, dissociative and somatoform disorders, Dissociative, conversion and factitious disorders, Dissociative identity disorder	DISSOCIATIVE IDENTITY DIS
300.15	Anxiety, dissociative and somatoform disorders, Dissociative, conversion and factitious disorders, Dissociative disorder or reaction, unspecified	DISSOCIATIVE REACT NOS
300.16	Anxiety, dissociative and somatoform disorders, Dissociative, conversion and factitious disorders, Factitious disorder with predominantly psychological signs and symptoms, Compensation neurosis, Ganser's syndrome, hysterical	FACTITIOUS DIS W SYMPTOM
300.19	Anxiety, dissociative and somatoform disorders, Dissociative, conversion and factitious disorders, Other and unspecified factitious illness, Factitious disorder (with combined psychological and physical signs and symptoms) (with predominantly physical signs and symptoms) NOS	FACTITIOUS ILL NEC/NOS
300.20	Anxiety, dissociative and somatoform disorders, Phobic disorders, Phobia, unspecified, Anxiety-hysteria NOS, Phobia NOS	PHOBIA NOS

300.21	Anxiety, dissociative and somatoform disorders, Phobic disorders, Agoraphobia with panic disorder Fear of: open spaces with panic attacks streets with panic attacks travel with panic attacks Panic disorder with agoraphobia	AGORAPHOBIA W PANIC DIS
300.22	Anxiety, dissociative and somatoform disorders, Phobic disorders, Agoraphobia without mention of panic attacks	AGORAPHOBIA W/O PANIC
300.23	Anxiety, dissociative and somatoform disorders, Phobic disorders, Social phobia, Fear of: eating in public, public speaking, washing in public	SOCIAL PHOBIA
300.29	Anxiety, dissociative and somatoform disorders, Phobic disorders, Other isolated or specific phobias, Acrophobia, Animal phobias, Claustrophobia, Fear of crowds	ISOLATED/SPEC PHOBIA NEC
300.3	Anxiety, dissociative and somatoform disorders, Obsessive-compulsive disorders, Anancastic neurosis, Compulsive neurosis, Obsessional phobia [any]	OBSESSIVE-COMPULSIVE DIS
300.4	Anxiety, dissociative and somatoform disorders, Dysthymic disorder, Anxiety depression, Depression with anxiety, Depressive reaction, Neurotic depressive state, Reactive depression	DYSTHYMIC DISORDER
300.5	Anxiety, dissociative and somatoform disorders, Neurasthenia Fatigue neurosis, Nervous debility, Psychogenic: asthenia general fatigue	NEURASTHENIA
300.6	Anxiety, dissociative and somatoform disorders, Depersonalization disorder, Derealization (neurotic), Neurotic state with depersonalization episode	DEPERSONALIZATION DISORD
300.7	Hypochondriasis, body dysmorphic disorder	HYPOCHONDRIASIS
300.81	Anxiety, dissociative and somatoform disorders, Somatoform disorders, Somatization disorder, Briquet's disorder, Severe somatoform disorder	SOMATIZATION DISORDER
300.82	Anxiety, dissociative and somatoform disorders, Somatoform disorders, Undifferentiated somatoform disorder, Atypical somatoform disorder, Somatoform disorder NOS	UNDIFF SOMATOFORM DISRDR
300.89	Anxiety, dissociative and somatoform disorders, Somatoform disorders, Other somatoform disorders, Occupational neurosis, including writers' cramp, Psychasthenia Psychasthenic neurosis	SOMATOFORM DISORDERS NEC
300.9	Anxiety, dissociative and somatoform disorders, Unspecified nonpsychotic mental disorder, Psychoneurosis NOS	NONPSYCHOTIC DISORD NOS
301.10	Personality disorder, affective personality disorder, unspecified	AFFECTIV PERSONALITY NOS
301.11	Personality disorders, affective personality disorder, Chronic hypomanic personality disorder	CHRONIC HYPOMANIC PERSON
301.12	Personality disorders, affective personality disorder, Chronic depressive personality disorder	CHR DEPRESSIVE PERSON
301.13	Personality disorders, affective personality disorder, Cyclothymic disorder	CYCLOTHYMIC DISORDER
301.20	Personality disorders, Schizoid personality disorder, unspecified	SCHIZOID PERSONALITY NOS
301.21	Personality disorders, Schizoid personality disorder, Introverted personality	INTROVERTED PERSONALITY
301.22	Personality disorders, Schizoid personality disorder, Schizotypal personality disorder	SCHIZOTYPAL PERSON DIS

301.3	Personality disorders, Explosive personality disorder	EXPLOSIVE PERSONALITY
301.4	Personality disorders, Obsessive-Compulsive personality disorder	OBSESSIVE-COMPULSIVE DIS
301.50	Personality disorders, Histrionic personality disorder, unspecified	HISTRIONIC PERSON NOS
301.51	Personality disorders, Histrionic personality disorder, Chronic factitious illness with physical symptoms	CHR FACTITIOUS ILLNESS
301.59	Personality disorders, Histrionic personality disorder, Other histrionic personality disorder	HISTRIONIC PERSON NEC
301.6	Personality disorders, Dependent personality disorder	DEPENDENT PERSONALITY
301.7	Personality disorders, Antisocial personality disorder	ANTISOCIAL PERSONALITY
301.81	Personality disorders, Other personality disorders, Narcissistic personality disorder	NARCISSISTIC PERSONALITY
301.82	Personality disorders, Other personality disorders, avoidant personality disorder	AVOIDANT PERSONALITY DIS
301.83	Personality disorders, Other personality disorders, Borderline personality disorder	BORDERLINE PERSONALITY
301.84	Personality disorders, Other personality disorders, Passive-aggressive personality	PASSIVE-AGGRESSIV PERSON
301.89	Personality disorders, Other personality disorders, Other	PERSONALITY DISORDER NEC
301.9	Personality disorders, Unspecified personality disorder	PERSONALITY DISORDER NOS
302.0	Sexual and gender identity disorders, Ego-dystonic sexual orientation, Ego-dystonic lesbianism, Sexual orientation conflict disorder	EGO-DYSTONIC SEX ORIENT
302.1	Sexual and gender identity disorders, Zoophilia Bestiality	ZOOPHILIA
302.3	Sexual and gender identity disorders, Pedophilia	PEDOPHILIA
302.23	Sexual and gender identity disorders, Transvestic fetishism	TRANSVESTIC FETISHISM
302.4	Sexual and gender identity disorders, Exhibitionism	EXHIBITIONISM
302.50	Sexual and gender identity disorders, Trans-sexualism, With unspecified sexual history	TRANS-SEXUALISM NOS
302.51	Sexual and gender identity disorders, Trans-sexualism, With asexual history	TRANS-SEXUALISM, ASEXUAL
302.52	Sexual and gender identity disorders, Trans-sexualism, With homosexual history	TRANS-SEXUAL, HOMOSEXUAL
302.53	Sexual and gender identity disorders, Trans-sexualism, With heterosexual history	TRANS-SEX, HETEROSEXUAL
302.6	Sexual and gender identity disorders, Gender identity disorder in children, Feminism in boys, Gender identity disorder NOS	GENDR IDENTITY DIS-CHILD
302.70	Sexual and gender identity disorders, Psychosexual dysfunction, unspecified Sexual dysfunction NOS	PSYCHOSEXUAL DYSFUNC NOS
302.71	Sexual and gender identity disorders, Psychosexual dysfunction, Hypoactive sexual desire disord	HYPOACTIVE SEX DESIRE
302.72	Sexual and gender identity disorders, Psychosexual dysfunction, With inhibited sexual excitement, Female sexual arousal disorder, Frigidity, Impotence, Male erectile disorder	INHIBITED SEX EXCITEMENT
302.73	Sexual and gender identity disorders, Psychosexual dysfunction, Female orgasmic disorder	FEMALE ORGASMIC DISORDER
302.74	Sexual and gender identity disorders, Psychosexual dysfunction, Male orgasmic disorder	MALE ORGASMIC DISORDER
302.75	Sexual and gender identity disorders, Psychosexual dysfunction, Premature ejaculation	PREMATURE EJACULATION

302.76	Sexual and gender identity disorders, Psychosexual dysfunction, Dyspareunia, psychogenic	DYSPAREUNIA,PSYCHOGENIC
302.79	Sexual and gender identity disorders, Psychosexual dysfunction, With other specified psychosexual dysfunctions Sexual aversion disorder	PSYCHOSEXUAL DYSFUNC NEC
302.81	Sexual and gender identity disorders, Other specified psychosexual disorders, Fetishism	FETISHISM
302.82	Sexual and gender identity disorders, Other specified psychosexual disorders, Voyeurism	VOYEURISM
302.83	Sexual and gender identity disorders, Other specified psychosexual disorders, Sexual masochism	SEXUAL MASOCHISM
302.84	Sexual and gender identity disorders, Other specified psychosexual disorders, Sexual sadism	SEXUAL SADISM
302.85	Sexual and gender identity disorders, Other specified psychosexual disorders, Gender identity disorder in adolescents or adults	GEND IDEN DIS,ADOL/ADULT
302.89	Sexual and gender identity disorders, Other specified psychosexual disorders, Other, Frotteurism, Nymphomania, Satyriasis	PSYCHOSEXUAL DIS NEC
302.9	Sexual and gender identity disorders, Unspecified psychosexual disorder, Paraphilia NOS, Pathologic sexuality NOS, Sexual deviation NOS, Sexual disorder NOS	PSYCHOSEXUAL DIS NOS
303.00	Alcohol dependence syndrome, Acute alcoholic intoxication in alcoholism, unspecified use	AC ALCOHOL INTOX-UNSPEC
303.01	Alcohol dependence syndrome, Acute alcoholic intoxication in alcoholism, continuous use	AC ALCOHOL INTOX-CONTIN
303.02	Alcohol dependence syndrome, Acute alcoholic intoxication in alcoholism, episodic use	AC ALCOHOL INTOX-EPISOD
303.03	Alcohol dependence syndrome, Acute alcoholic intoxication in alcoholism, in remission	AC ALCOHOL INTOX-REMISS
303.90	Alcohol dependence syndrome, Other and unspecified alcohol dependence, unspecified alcohol dependence, unspecified use	ALCOH DEP NEC/NOS-UNSPEC
303.91	Alcohol dependence syndrome, Other and unspecified alcohol dependence, unspecified alcohol dependence, continuous use	ALCOH DEP NEC/NOS-CONTIN
303.92	Alcohol dependence syndrome, Other and unspecified alcohol dependence, unspecified alcohol dependence, episodic use	ALCOH DEP NEC/NOS-EPISOD
303.93	Alcohol dependence syndrome, Other and unspecified alcohol dependence, unspecified alcohol dependence, in remission	ALCOH DEP NEC/NOS-REMISS
304.00	Drug dependence, Opioid type dependence, unspecified use	OPIOID DEPENDENCE-UNSPEC
304.01	Drug dependence, Opioid type dependence, continuous use	OPIOID DEPENDENCE-CONTIN
304.02	Drug dependence, Opioid type dependence, episodic use	OPIOID DEPENDENCE-EPISOD
304.03	Drug dependence, Opioid type dependence, in remission	OPIOID DEPENDENCE-REMISS
304.10	Drug dependence, Sedative, hypnotic or anxiolytic dependence, unspecified use	SED,HYP,ANXIOLYT DEP-NOS
304.11	Drug dependence, Sedative, hypnotic or anxiolytic dependence, continuous use	SED,HYP,ANXIOLYT DEP-CON
304.12	Drug dependence, Sedative, hypnotic or anxiolytic dependence, episodic use	SED,HYP,ANXIOLYT DEP-EPI
304.13	Drug dependence, Sedative, hypnotic or anxiolytic dependence, in remission	SED,HYP,ANXIOLYT DEP-REM
304.20	Drug dependence, Cocaine dependence, unspecified use	COCAINE DEPEND-UNSPEC
304.21	Drug dependence, Cocaine dependence, continuous use	COCAINE DEPEND-CONTIN
304.22	Drug dependence, Cocaine dependence, episodic use	COCAINE DEPEND-EPISODIC

304.23	Drug dependence, Cocaine dependence	COCAINE DEPEND-REMISS
304.30	Drug dependence, Cannabis dependence, unspecified use	CANNABIS DEPEND-UNSPEC
304.31	Drug dependence, Cannabis dependence, continuous use	CANNABIS DEPEND-CONTIN
304.32	Drug dependence, Cannabis dependence, episodic use	CANNABIS DEPEND-EPISODIC
304.33	Drug dependence, Cannabis dependence, in remission	CANNABIS DEPEND-REMISS
304.40	Drug dependence, Amphetamine and other psychostimulant dependence, unspecified use	AMPHETAMIN DEPEND-UNSPEC
304.41	Drug dependence, Amphetamine and other psychostimulant dependence, continuous use	AMPHETAMIN DEPEND-CONTIN
304.42	Drug dependence, Amphetamine and other psychostimulant dependence, episodic use	AMPHETAMIN DEPEND-EPISOD
304.43	Drug dependence, Amphetamine and other psychostimulant dependence, in remission	AMPHETAMIN DEPEND-REMISS
304.50	Drug dependence, Hallucinogen dependence, unspecified use	HALLUCINOGEN DEP-UNSPEC
304.51	Drug dependence, Hallucinogen dependence, continuous use	HALLUCINOGEN DEP-CONTIN
304.52	Drug dependence, Hallucinogen dependence, episodic use	HALLUCINOGEN DEP-EPISOD
304.53	Drug dependence, Hallucinogen dependence, in remission	HALLUCINOGEN DEP-REMISS
304.60	Drug dependence, Other specified drug dependence, unspecified use	DRUG DEPEND NEC-UNSPEC
304.61	Drug dependence, Other specified drug dependence, continuous use	DRUG DEPEND NEC-CONTIN
304.62	Drug dependence, Other specified drug dependence, episodic use	DRUG DEPEND NEC-EPISODIC
304.63	Drug dependence, Other specified drug dependence, in remission	DRUG DEPEND NEC-IN REM
304.70	Drug dependence, Combinations of opioid type drug with any other, unspecified use	OPIOID/OTHER DEP-UNSPEC
304.71	Drug dependence, Combinations of opioid type drug with any other, continuous use	OPIOID/OTHER DEP-CONTIN
304.72	Drug dependence, Combinations of opioid type drug with any other, episodic use	OPIOID/OTHER DEP-EPISOD
304.73	Drug dependence, Combinations of opioid type drug with any other, in remission	OPIOID/OTHER DEP-REMISS
304.80	Drug dependence, Combinations of drug dependence excluding opioid type drug, unspecified use	COMB DRUG DEP NEC-UNSPEC
304.81	Drug dependence, Combinations of drug dependence excluding opioid type drug, continuous use	COMB DRUG DEP NEC-CONTIN
304.82	Drug dependence, Combinations of drug dependence excluding opioid type drug, episodic use	COMB DRUG DEP NEC-EPISOD
304.83	Drug dependence, Combinations of drug dependence excluding opioid type drug, in remission	COMB DRUG DEP NEC-REMISS
304.90	Drug dependence, Unspecified drug dependence, Drug addiction NOS, Drug dependence NOS, unspecified use	DRUG DEPEND NOS-UNSPEC
304.91	Drug dependence, Unspecified drug dependence, Drug addiction NOS, Drug dependence NOS, continuous use	DRUG DEPEND NOS-CONTIN
304.92	Drug dependence, Unspecified drug dependence, Drug addiction NOS, Drug dependence NOS, episodic use	DRUG DEPEND NOS-EPISODIC
304.93	Drug dependence, Unspecified drug dependence, Drug addiction NOS, Drug dependence NOS, in remission	DRUG DEPEND NOS-REMISS
305.00	Nondependent abuse of drugs, Alcohol abuse unspecified use	ALCOHOL ABUSE-UNSPEC
305.01	Nondependent abuse of drugs, Alcohol abuse continuous use	ALCOHOL ABUSE-CONTINUOUS
305.02	Nondependent abuse of drugs, Alcohol abuse episodic use	ALCOHOL ABUSE-EPISODIC

305.03	Nondependent abuse of drugs, Alcohol abuse in remission	ALCOHOL ABUSE-IN REMISS
305.1	Nondependent abuse of drugs, Tobacco use disorder, Tobacco dependence	TOBACCO USE DISORDER
305.20	Nondependent abuse of drugs, Cannabis abuse, cannabis (marihuana) abuse unspecified use	CANNABIS ABUSE-UNSPEC
305.21	Nondependent abuse of drugs, Cannabis abuse, cannabis (marihuana) abuse continuous use	CANNABIS ABUSE-CONTIN
305.22	Nondependent abuse of drugs, Cannabis abuse, cannabis (marihuana) abuse episodic use	CANNABIS ABUSE-EPISODIC
305.23	Nondependent abuse of drugs, Cannabis abuse, cannabis (marihuana) abuse in remission	CANNABIS ABUSE-IN REMISS
305.30	Nondependent abuse of drugs, Hallucinogen abuse unspecified use	HALLUCINOGEN ABUSE-UNSPEC
305.31	Nondependent abuse of drugs, Hallucinogen abuse continuous use	HALLUCINOGEN ABUSE-CONTIN
305.32	Nondependent abuse of drugs, Hallucinogen abuse episodic use	HALLUCINOGEN ABUSE-EPISOD
305.33	Nondependent abuse of drugs, Hallucinogen abuse in remission	HALLUCINOGEN ABUSE-REMISS
305.40	Nondependent abuse of drugs, Sedative, hypnotic or anxiolytic abuse, Sedative, hypnotic or anxiolytic abuse, Sedative/hypnotic/anxiolytic abuse, unspecified use	SED,HYP,ANXIOLYTIC AB-NOS
305.41	Nondependent abuse of drugs, Sedative, hypnotic or anxiolytic abuse, Sedative, hypnotic or anxiolytic abuse, Sedative/hypnotic/anxiolytic abuse, continuous use	SED,HYP,ANXIOLYTIC AB-CON
305.42	Nondependent abuse of drugs, Sedative, hypnotic or anxiolytic abuse, Sedative, hypnotic or anxiolytic abuse, Sedative/hypnotic/anxiolytic abuse, episodic use	SED,HYP,ANXIOLYTIC AB-EPI
305.43	Nondependent abuse of drugs, Sedative, hypnotic or anxiolytic abuse, Sedative, hypnotic or anxiolytic abuse, Sedative/hypnotic/anxiolytic abuse, in remission	SED,HYP,ANXIOLYTIC AB-REM
305.50	Nondependent abuse of drugs, Opioid abuse unspecified use	OPIOID ABUSE-UNSPEC
305.51	Nondependent abuse of drugs, Opioid abuse continuous use	OPIOID ABUSE-CONTINUOUS
305.52	Nondependent abuse of drugs, Opioid abuse episodic use	OPIOID ABUSE-EPISODIC
305.53	Nondependent abuse of drugs, Opioid abuse in remission	OPIOID ABUSE-IN REMISS
305.60	Nondependent abuse of drugs, Cocaine abuse unspecified use	COCAINE ABUSE-UNSPEC
305.61	Nondependent abuse of drugs, Cocaine abuse continuous use	COCAINE ABUSE-CONTINUOUS
305.62	Nondependent abuse of drugs, Cocaine abuse episodic use	COCAINE ABUSE-EPISODIC
305.63	Nondependent abuse of drugs, Cocaine abuse in remission	COCAINE ABUSE-IN REMISS
305.70	Nondependent abuse of drugs, Amphetamine or related acting sympathomimetic abuse, amphetamine/sympathomimetic abuse unspecified use	AMPHETAMINE ABUSE-UNSPEC
305.71	Nondependent abuse of drugs, Amphetamine or related acting sympathomimetic abuse, amphetamine/sympathomimetic abuse continuous use	AMPHETAMINE ABUSE-CONTIN
305.72	Nondependent abuse of drugs, Amphetamine or related acting sympathomimetic abuse, amphetamine/sympathomimetic abuse episodic use	AMPHETAMINE ABUSE-EPISOD
305.73	Nondependent abuse of drugs, Amphetamine or related acting sympathomimetic abuse, amphetamine/sympathomimetic abuse in remission	AMPHETAMINE ABUSE-REMISS
305.80	Nondependent abuse of drugs, Antidepressant type abuse, antidepressant abuse unspecified use	ANTIDEPRESS ABUSE-UNSPEC

305.81	Nondependent abuse of drugs, Antidepressant type abuse, antidepressant abuse continuous use	ANTIDEPRESS ABUSE-CONTIN
305.82	Nondependent abuse of drugs, Antidepressant type abuse, antidepressant abuse episodic use	ANTIDEPRESS ABUSE-EPISOD
305.83	Nondependent abuse of drugs, Antidepressant type abuse, antidepressant abuse in remission	ANTIDEPRESS ABUSE-REMISS
305.90	Nondependent abuse of drugs, mixed/unspecified drug abuse unspecified use	DRUG ABUSE NEC-UNSPEC
305.91	Nondependent abuse of drugs, mixed/unspecified drug abuse continuous use	DRUG ABUSE NEC-CONTIN
305.92	Nondependent abuse of drugs, mixed/unspecified drug abuse episodic use	DRUG ABUSE NEC-EPISODIC
305.93	Nondependent abuse of drugs, mixed/unspecified drug abuse in remission	DRUG ABUSE NEC-IN REMISS
306.0	Physiological malfunction arising from mental factors, Musculoskeletal, Psychogenic paralysis, Psychogenic torticollis	PSYCHOGEN MUSCULSKEL DIS
306.1	Physiological malfunction arising from mental factors, Respiratory, Psychogenic: air hunger, cough, hiccough, hyperventilation, yawning	PSYCHOGENIC RESPIR DIS
306.2	Physiological malfunction arising from mental factors, Cardiovascular, Cardiac neurosis, Cardiovascular neurosis, Neurocirculatory asthenia, Psychogenic cardiovascular disorder	PSYCHOGEN CARDIOVASC DIS
306.3	Physiological malfunction arising from mental factors, Skin, Psychogenic pruritus	PSYCHOGENIC SKIN DISEASE
306.4	Physiological malfunction arising from mental factors, Gastrointestinal, Aerophagy, Cyclical vomiting, psychogenic Diarrhea, psychogenic Nervous gastritis, Psychogenic dyspepsia	PSYCHOGENIC GI DISEASE
306.50	Physiological malfunction arising from mental factors, Genitourinary, Psychogenic genitourinary malfunction, unspecified	PSYCHOGENIC GU DIS NOS
306.51	Physiological malfunction arising from mental factors, Genitourinary, Psychogenic vaginismus, Functional vaginismus	PSYCHOGENIC VAGINISMUS
306.52	Physiological malfunction arising from mental factors, Genitourinary, Psychogenic dysmenorrhea	PSYCHOGENIC DYSMENORRHEA
306.53	Physiological malfunction arising from mental factors, Genitourinary, Psychogenic dysuria	PSYCHOGENIC DYSURIA
305.59	Physiological malfunction arising from mental factors, Genitourinary, Other	PSYCHOGENIC GU DIS NEC
306.6	Physiological malfunction arising from mental factors, Endocrine	PSYCHOGEN ENDOCRINE DIS
306.7	Physiological malfunction arising from mental factors, Organs of special sense	PSYCHOGENIC SENSORY DIS
306.8	Physiological malfunction arising from mental factors, Other specified psychophysiological malfunction, Bruxism, Teeth grinding	PSYCHOGENIC DISORDER NEC
306.9	Physiological malfunction arising from mental factors, Unspecified psychophysiological malfunction, Psychophysiological disorder NOS, Psychosomatic disorder NOS	PSYCHOGENIC DISORDER NOS
307.0	Special symptoms or syndromes, not elsewhere classified, Stuttering	STUTTERING

307.1	Special symptoms or syndromes, not elsewhere classified, Anorexia nervosa	ANOREXIA NERVOSA
307.20	Special symptoms or syndromes, not elsewhere classified, Tic disorder, unspecified, Tic disorder NOS	TIC DISORDER NOS
307.21	Special symptoms or syndromes, not elsewhere classified, Transient tic disorder	TRANSIENT TIC DISORDER
307.22	Special symptoms or syndromes, not elsewhere classified, Chronic motor or vocal tic disorder	CHR MOTOR/VOCAL TIC DIS
307.23	Special symptoms or syndromes, not elsewhere classified, Tourette's disorder, Motor-verbal tic disorder	TOURETTE'S DISORDER
307.3	Special symptoms or syndromes, not elsewhere classified, Stereotypic movement disorder, Body-rocking, Head banging Spasmus nutans, Stereotypes NOS	STEREOTYPIC MOVEMENT DIS
307.40	Special symptoms or syndromes, not elsewhere classified, Specific disorders of sleep of nonorganic origin, Nonorganic sleep disorder, unspecified	NONORGANIC SLEEP DIS NOS
307.41	Special symptoms or syndromes, not elsewhere classified, Specific disorders of sleep of nonorganic origin, Transient disorder of initiating or maintaining sleep, Adjustment insomnia, Hyposomnia associated with acute or intermittent emotional reactions or conflicts, Insomnia associated with acute or intermittent emotional reactions or conflicts, Sleeplessness associated with acute or intermittent emotional reactions or conflicts	TRANSIENT INSOMNIA
307.42	Special symptoms or syndromes, not elsewhere classified, Specific disorders of sleep of nonorganic origin, Persistent disorder of initiating or maintaining sleep, Hyposomnia, insomnia, or sleeplessness associated with: anxiety, conditioned arousal, depression (major) (minor), psychosis Idiopathic insomnia, Paradoxical insomnia, Primary insomnia Psychophysiological insomnia	PERSISTENT INSOMNIA
307.43	Special symptoms or syndromes, not elsewhere classified, Specific disorders of sleep of nonorganic origin, Transient disorder of initiating or maintaining wakefulness, Hypersomnia associated with acute or intermittent emotional reactions or conflicts	TRANSIENT HYPERSOMNIA
307.44	Special symptoms or syndromes, not elsewhere classified, Specific disorders of sleep of nonorganic origin, Persistent disorder of initiating or maintaining wakefulness, Hypersomnia associated with depression (major) (minor) Insufficient sleep syndrome, Primary hypersomnia	PERSISTENT HYPERSOMNIA
307.45	Special symptoms or syndromes, not elsewhere classified, Specific disorders of sleep of nonorganic origin, Circadian rhythm sleep disorder of nonorganic origin	NONORGANIC CIRCADIAN RHY
307.46	Special symptoms or syndromes, not elsewhere classified, Specific disorders of sleep of nonorganic origin, Sleep arousal disorder, Night terror disorder, Night terrors, Sleep terror disorder, Sleepwalking, Somnambulism	SLEEP AROUSAL DISORDER
307.47	Special symptoms or syndromes, not elsewhere classified, Specific disorders of sleep of nonorganic origin, Other dysfunctions of sleep stages or arousal from sleep, Nightmare disorder, Nightmares: NOS, REM-sleep type, Sleep drunkenness	SLEEP STAGE DYSFUNC NEC
307.48	Special symptoms or syndromes, not elsewhere classified, Specific disorders of sleep of nonorganic origin, Repetitive intrusions of sleep, Repetitive intrusion of sleep with: atypical	REPETIT SLEEP INTRUSION

	polysomnographic features, environmental disturbances, repeated REM-sleep interruptions	
307.49	Special symptoms or syndromes, not elsewhere classified, Specific disorders of sleep of nonorganic origin, Other "Short-sleeper", Subjective insomnia complaint	NONORGANIC SLEEP DIS NEC
307.50	Special symptoms or syndromes, not elsewhere classified, Other and unspecified disorders of eating, Eating disorder, unspecified, Eating disorder NOS	EATING DISORDER NOS
307.51	Special symptoms or syndromes, not elsewhere classified, Other and unspecified disorders of eating, Bulimia nervosa Overeating of nonorganic origin	BULIMIA NERVOSA
307.52	Special symptoms or syndromes, not elsewhere classified, Other and unspecified disorders of eating, Pica, Perverted appetite of nonorganic origin	PICA
307.53	Special symptoms or syndromes, not elsewhere classified, Other and unspecified disorders of eating, Rumination disorder, Regurgitation, of nonorganic origin, of food with reswallowing	RUMINATION DISORDER
307.54	Special symptoms or syndromes, not elsewhere classified, Other and unspecified disorders of eating, Psychogenic vomiting	PSYCHOGENIC VOMITING
307.59	Special symptoms or syndromes, not elsewhere classified, Other and unspecified disorders of eating, Psychogenic vomiting	EATING DISORDER NEC
307.6	Special symptoms or syndromes, not elsewhere classified, Enuresis, Enuresis (primary) (secondary) of nonorganic origin	ENURESIS
307.7	Special symptoms or syndromes, not elsewhere classified, Encopresis, Encopresis (continuous) (discontinuous) of nonorganic origin	ENCOPRESIS
307.80	Special symptoms or syndromes, not elsewhere classified, Pain disorders related to psychological factors, Psychogenic pain, site unspecified	PSYCHOGENIC PAIN NOS
307.81	Special symptoms or syndromes, not elsewhere classified, Pain disorders related to psychological factors, Tension headache	TENSION HEADACHE
307.89	Special symptoms or syndromes, not elsewhere classified, Pain disorders related to psychological factors, Other Code first to type or site of pain	PSYCHOGENIC PAIN NEC
307.9	Special symptoms or syndromes, not elsewhere classified, Other and unspecified special symptoms or syndromes, not elsewhere classified, Communication disorder NOS, Hair plucking, Lalling, Lispering, Masturbation, Nail-biting, Thumb-sucking	SPECIAL SYMPTOM NEC/NOS
308.0	Acute reaction to stress, Predominant disturbance of emotions Anxiety as acute reaction to exceptional [gross] stress Emotional crisis as acute reaction to exceptional [gross] stress Panic state as acute reaction to exceptional [gross] stress	STRESS REACT, EMOTIONAL
308.1	Acute reaction to stress, Predominant disturbance of consciousness Fugues as acute reaction to exceptional [gross] stress	STRESS REACTION, FUGUE
308.2	Acute reaction to stress, Predominant psychomotor disturbance, Agitation states as acute reaction to exceptional [gross] stress, Stupor as acute reaction to exceptional [gross]	STRESS REACT, PSYCHOMOT
308.3	Acute reaction to stress, Other acute reactions to stress Acute situational disturbance, Acute stress disorder	ACUTE STRESS REACT NEC
308.4	Acute reaction to stress, Mixed disorders as reaction to stress	STRESS REACT, MIXED DIS

308.9	Acute reaction to stress, Unspecified acute reaction to stress	ACUTE STRESS REACT NOS
309.0	Adjustment reaction, Adjustment disorder with depressed mood, Grief reaction	ADJUSTMNT DIS W DEPRESSN
309.1	Adjustment reaction, Prolonged depressive reaction	PROLONG DEPRESSIVE REACT
309.21	Adjustment reaction, With predominant disturbance of other emotions, Separation anxiety disorder	SEPARATION ANXIETY
309.22	Adjustment reaction, With predominant disturbance of other emotions, Emancipation disorder of adolescence and early adult life	EMANCIPATION DISORDER
309.23	Adjustment reaction, With predominant disturbance of other emotions, Specific academic or work inhibition	ACADEMIC/WORK INHIBITION
309.24	Adjustment reaction, With predominant disturbance of other emotions, Adjustment disorder with anxiety	ADJUSTMENT DIS W ANXIETY
309.28	Adjustment reaction, With predominant disturbance of other emotions, Adjustment disorder with mixed anxiety and depressed mood, Adjustment reaction with anxiety and depression	ADJUST DIS W ANXIETY/DEP
309.29	Adjustment reaction, With predominant disturbance of other emotions, Other, Culture shock	ADJ REACT-EMOTION NEC
309.3	Adjustment reaction, Adjustment disorder with disturbance of conduct, Conduct disturbance as adjustment reaction, Destructiveness as adjustment reaction	ADJUST DISOR/DIS CONDUCT
309.4	Adjustment reaction, Adjustment disorder with mixed disturbance of emotions and conduct	ADJ DIS-EMOTION/CONDUCT
309.81	Adjustment reaction, Other specified adjustment reactions, Posttraumatic stress disorder, Chronic posttraumatic stress disorder, Concentration camp syndrome, Post-Traumatic Stress Disorder (PTSD), Posttraumatic stress disorder NOS	POSTTRAUMATIC STRESS DIS
309.82	Adjustment reaction, Other specified adjustment reactions, Adjustment reaction with physical symptoms	ADJUST REACT-PHYS SYMPT
309.83	Adjustment reaction, Other specified adjustment reactions, Adjustment reaction with withdrawal, Elective mutism as adjustment reaction, Hospitalism (in children) NOS	ADJUST REACT-WITHDRAWAL
309.89	Adjustment reaction, Other specified adjustment reactions, Other	ADJUSTMENT REACTION NEC
309.9	Adjustment reaction, Unspecified adjustment reaction Adaptation reaction NOS, Adjustment reaction NOS	ADJUSTMENT REACTION NOS
310.0	Specific nonpsychotic mental disorders due to brain damage, Frontal lobe syndrome, Lobotomy syndrome, Postleucotomy syndrome [state]	FRONTAL LOBE SYNDROME
310.1	Specific nonpsychotic mental disorders due to brain damage, Personality change due to conditions classified elsewhere Cognitive or personality change of other type, of onpsychotic severity, Organic psychosyndrome of nonpsychotic severity Presbyophrenia NOS, Senility with mental changes of nonpsychotic severity	PERSONALITY CHG OTH DIS
310.2	Specific nonpsychotic mental disorders due to brain damage, Postconcussion syndrome, Postcontusion syndrome or encephalopathy, Posttraumatic brain syndrome, nonpsychotic Status postcommotio cerebri	POSTCONCUSSION SYNDROME
310.8	Specific nonpsychotic mental disorders due to brain damage, Other specified nonpsychotic mental disorders following organic brain damage, Mild memory disturbance, Postencephalitic syndrome, Other focal (partial) organic psychosyndromes	NONPSYCHOT BRAIN SYN NEC

310.9	Specific nonpsychotic mental disorders due to brain damage, Unspecified nonpsychotic mental disorder following organic brain damage	NONPSYCHOT BRAIN SYN NOS
311	Depressive disorder, not elsewhere classified, Depressive disorder NOS, Depressive state NOS, Depression NOS	DEPRESSIVE DISORDER NEC
312.00	Disturbance of conduct, not elsewhere classified, Undersocialized conduct disorder, aggressive type, Aggressive outburst, Anger reaction, Unsocialized aggressive disorder, Undersocialized conduct disorder unspecified	UNSOCIAL AGGRESS-UNSPEC
312.01	Disturbance of conduct, not elsewhere classified, Undersocialized conduct disorder, aggressive type, Aggressive outburst, Anger reaction, Unsocialized aggressive disorder, Undersocialized conduct disorder mild	UNSOCIAL AGGRESSION-MILD
312.02	Disturbance of conduct, not elsewhere classified, Undersocialized conduct disorder, aggressive type, Aggressive outburst, Anger reaction, Unsocialized aggressive disorder, Undersocialized conduct disorder moderate	UNSOCIAL AGGRESSION-MOD
312.03	Disturbance of conduct, not elsewhere classified, Undersocialized conduct disorder, aggressive type, Aggressive outburst, Anger reaction, Unsocialized aggressive disorder, Undersocialized conduct disorder severe	UNSOCIAL AGGRESS-SEVERE
312.10	Disturbance of conduct, not elsewhere classified, Undersocialized conduct disorder, unaggressive type, Childhood truancy, unsocialized, Solitary stealing, Tantrums Undersocialized conduct disorder, unaggressive type unspecified	UNSOCIAL UNAGGRESS-UNSP
312.11	Disturbance of conduct, not elsewhere classified, Undersocialized conduct disorder, unaggressive type, Childhood truancy, unsocialized, Solitary stealing, Tantrums Undersocialized conduct disorder, unaggressive type mild	UNSOCIAL UNAGGRESS-MILD
312.12	Disturbance of conduct, not elsewhere classified, Undersocialized conduct disorder, unaggressive type, Childhood truancy, unsocialized, Solitary stealing, Tantrums Undersocialized conduct disorder, unaggressive type moderate	UNSOCIAL UNAGGRESS-MOD
312.13	Disturbance of conduct, not elsewhere classified, Undersocialized conduct disorder, unaggressive type, Childhood truancy, unsocialized, Solitary stealing, Tantrums Undersocialized conduct disorder, unaggressive type severe	UNSOCIAL UNAGGR-SEVERE
312.20	Disturbance of conduct, not elsewhere classified, Socialized conduct disorder, Childhood truancy, socialized, Group delinquency, Socialized conduct disorder unspecified	SOCIAL CONDUCT DIS-UNSP
312.21	Disturbance of conduct, not elsewhere classified, Socialized conduct disorder, Childhood truancy, socialized Group delinquency, Socialized conduct disorder mild	SOCIAL CONDUCT DIS-MILD
312.22	Disturbance of conduct, not elsewhere classified, Socialized conduct disorder, Childhood truancy, socialized Group delinquency, Socialized conduct disorder moderate	SOCIAL CONDUCT DIS-MOD
312.23	Disturbance of conduct, not elsewhere classified, Socialized conduct disorder, Childhood truancy, socialized Group delinquency, Socialized conduct disorder severe	SOCIAL CONDUCT DIS-SEV
312.30	Disturbance of conduct, not elsewhere classified, Disorders of impulse control, not elsewhere classified	IMPULSE CONTROL DIS NOS
312.31	Disturbance of conduct, not elsewhere classified, Disorders of impulse control, not elsewhere classified	PATHOLOGICAL GAMBLING
312.32	Disturbance of conduct, not elsewhere classified, Disorders of	KLEPTOMANIA

	impulse control, not elsewhere classified	
312.33	Disturbance of conduct, not elsewhere classified, Disorders of impulse control, not elsewhere classified	PYROMANIA
312.34	Disturbance of conduct, not elsewhere classified, Disorders of impulse control, not elsewhere classified	INTERMITT EXPLOSIVE DIS
312.35	Disturbance of conduct, not elsewhere classified, Disorders of impulse control, not elsewhere classified	ISOLATED EXPLOSIVE DIS
312.39	Disturbance of conduct, not elsewhere classified, Disorders of impulse control, not elsewhere classified	IMPULSE CONTROL DIS NEC
312.4	Disturbance of conduct,, not elsewhere classified, mixed disturbance of conduct and emotions, neurotic delinquency	MIX DIS CONDUCT/EMOTION
312.81	Disturbance of conduct, not elsewhere classified, Other specified disturbances of conduct, not elsewhere classified, Conduct disorder, childhood onset type	CNDCT DSRDR CHLDHD ONST
312.82	Disturbance of conduct, not elsewhere classified, Other specified disturbances of conduct, not elsewhere classified, Conduct disorder, adolescent onset type	CNDCT DSRDR ADLSCNT ONST
312.89	Disturbance of conduct, not elsewhere classified, Other specified disturbances of conduct, not elsewhere classified, Other conduct disorder, Conduct disorder of unspecified onset	OTHER CONDUCT DISORDER
312.9	Disturbance of conduct, not elsewhere classified, Unspecified disturbance of conduct Delinquency (juvenile) Disruptive behavior disorder NOS	CONDUCT DISTURBANCE NOS
313.0	Disturbance of emotions specific to childhood and adolescence, Overanxious disorder, Anxiety and fearfulness of childhood and adolescence, Overanxious disorder of childhood and adolescence	OVERANXIOUS DISORDER
313.1	Disturbance of emotions specific to childhood and adolescence, Misery and unhappiness disorder	MISERY & UNHAPPINESS DIS
313.21	Disturbance of emotions specific to childhood and adolescence, Sensitivity, shyness, and social withdrawal disorder, Shyness disorder of childhood, Sensitivity reaction of childhood or adolescence	SHYNESS DISORDER-CHILD
313.22	Disturbance of emotions specific to childhood and adolescence, Sensitivity, shyness, and social withdrawal disorder, Introverted disorder of childhood, Social withdrawal of childhood or adolescence, Withdrawal reaction of childhood or adolescence	INTROVERTED DIS-CHILD
313.23	Disturbance of emotions specific to childhood and adolescence, Sensitivity, shyness, and social withdrawal disorder, Selective mutism	SELECTIVE MUTISM
313.3	Disturbance of emotions specific to childhood and adolescence, Relationship problems, Sibling jealousy	RELATIONSHIP PROBLEMS
313.81	Disturbance of emotions specific to childhood and adolescence, Other or mixed emotional disturbances of childhood or adolescence, Oppositional defiant disorder	OPPOSITION DEFIANT DISOR
313.82	Disturbance of emotions specific to childhood and adolescence, Other or mixed emotional disturbances of childhood or adolescence, Identity disorder, Identity problem	IDENTITY DISORDER
313.83	Disturbance of emotions specific to childhood and adolescence, Other or mixed emotional disturbances of childhood or adolescence, Academic underachievement disorder	ACADEMIC UNDERACHIEVMENT
313.89	Disturbance of emotions specific to childhood and adolescence, Other or mixed emotional disturbances of	EMOTIONAL DIS CHILD NEC

	childhood or adolescence, Other, Reactive attachment disorder of infancy or early childhood	
313.9	Disturbance of emotions specific to childhood and adolescence, Unspecified emotional disturbance of childhood or adolescence, Mental disorder of infancy, childhood or adolescence NOS	EMOTIONAL DIS CHILD NOS
314.00	Hyperkinetic syndrome of childhood, Attention deficit disorder, Adult, Child, Without mention of hyperactivity Predominantly inattentive type	ATTN DEFIC NONHYPERACT
314.01	Hyperkinetic syndrome of childhood, Hyperkinetic syndrome of childhood, Attention deficit disorder, Adult, Child, With hyperactivity, Combined type, Overactivity NOS, Predominantly hyperactive/impulsive type, Simple disturbance of attention with overactivity	ATTN DEFICIT W HYPERACT
314.1	Hyperkinetic syndrome of childhood, Hyperkinesia with developmental delay, Developmental disorder of hyperkinesia	HYPERKINET W DEVEL DELAY
314.2	Hyperkinetic syndrome of childhood, Hyperkinetic conduct disorder, Hyperkinetic conduct disorder without developmental delay	HYPERKINETIC CONDUCT DIS
314.8	Hyperkinetic syndrome of childhood, Other specified manifestations of hyperkinetic syndrome	OTHER HYPERKINETIC SYND
314.9	Hyperkinetic syndrome of childhood, Unspecified hyperkinetic syndrome, Hyperkinetic reaction of childhood or adolescence NOS, Hyperkinetic syndrome NOS	HYPERKINETIC SYND NOS
315.00	Specific delays in development, Specific reading disorder, Reading disorder, unspecified	READING DISORDER NOS
315.01	Specific delays in development, Specific reading disorder, Alexia	ALEXIA
315.02	Specific delays in development, Specific reading disorder, Developmental dyslexia	DEVELOPMENTAL DYSLEXIA
315.09	Specific delays in development, Specific reading disorder, Other, Specific spelling difficulty	READING DISORDER NEC
315.1	Specific delays in development, Mathematics disorder Dyscalculia	MATHEMATICS DISORDER
315.2	Specific delays in development, Other specific learning difficulties, Disorder of written expression	OTH LEARNING DIFFICULTY
315.31	Specific delays in development, Developmental speech or language disorder, Expressive language disorder Developmental aphasia, Word deafness	EXPRESSIVE LANGUAGE DIS
315.32	Specific delays in development, Developmental speech or language disorder, Mixed receptive-expressive language disorder, Central auditory processing disorder	RECP-EXPRES LANGUAGE DIS
315.34	Specific delays in development, Developmental speech or language disorder, Speech and language development delay due to hearing loss	SPEECH DEL D/T HEAR LOSS
315.39	Specific delays in development, Developmental speech or language disorder, Other Developmental articulation disorder, Dyslalia, Phonological disorder	SPEECH/LANGUAGE DIS NEC
315.4	Specific delays in development, Developmental coordination disorder, Clumsiness syndrome, Dyspraxia syndrome, Specific motor development disorder	DEVEL COORDINATION DIS
315.5	Specific delays in development, Mixed development disorder	MIXED DEVELOPMENT DIS
315.8	Specific delays in development, Other specified delays in development	DEVELOPMENT DELAYS NEC
315.9	Specific delays in development, Unspecified delay in	DEVELOPMENT DELAY NOS

	development, Developmental disorder NOS, Learning disorder NOS	
316	Psychic factors associated with diseases classified elsewhere, Psychologic factors in physical conditions classified elsewhere	PSYCHIC FACTOR W OTH DIS
317	Mild mental retardation, High-grade defect, IQ 50-70, Mild mental subnormality	MILD MENTAL RETARDATION
318.0	Other specified mental retardation, Moderate mental retardation, IQ 35-49, Moderate mental subnormality	MOD MENTAL RETARDATION
318.1	Other specified mental retardation, Severe mental retardation, IQ 20-34, Severe mental subnormality	SEVERE MENTAL RETARDAT
318.2	Other specified mental retardation, Profound mental retardation, IQ under 20, Profound mental subnormality	PROFOUND MENTAL RETARDAT
319	Unspecified mental retardation, Mental deficiency, NOS, Mental subnormality, NOS	MENTAL RETARDATION NOS