RESOURCE AND PATIENT MANAGEMENT SYSTEM

IHS Clinical Reporting System

(BGP)

Meaningful Use Report–Stage 1 Performance Measure List and Definitions Hospital Measures

Version 11 Patch 3
June 2011

Office of Information Technology (OIT)
Division of Information Resource Management
Albuquerque, New Mexico

Revision History

Date	Revision	Description	Author
	N/A	Distribution to field leads for review.	J. Kimberly
	0.1	Minor edits.	A.M. Brough

Table of Contents

1.0   Performance Measure Topics and Definitions

The following sections define the performance measure topics and their definitions that are included in the CRS 2011 version 11 Patch 3 Meaningful Use Report, Stage 1.

1.1   Emergency Department Measures

1.1.1   Median Time/ED Arrival to ED Departure/ Admitted Patients (ED-1) NQF0495

Meaningful Use, Stage 1

Denominator

Not Applicable.

Numerators

Median elapsed time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department. Numerators are stratified as follows:

A) All ED patients except patients with mental disorders or placed into observation status
B) ED patients placed into observation status
C) ED patients with a mental disorder

Exclusions

See each of the stratifications for exclusion criteria.

Definition

Numerator Logic:

Numerator A Logic – All ED Patients except Patients with Mental Disorder or Placed into Observation Status:

1. MU searches through the emergency department file (ER VISIT) during the report time period and then determines if a subsequent inpatient admission (PATIENT_MOVEMENT) occurred within 24 hours.

2. MU identifies valid and non-null ED Visit Time and ED Departure Time. A record in which either value is null or not valid is excluded from the numerator.

3. MU performs the calculation ED Departure Time minus the ED Visit Time and determines the value in minutes. For each patient record, MU stores this value as the **Elapsed Time from ED Visit to ED Departure Time.**

4. MU calculates the median value from the set of **Elapsed Time from ED Visit to ED Departure Time.** If the set is empty, then MU reports a zero value.

Numerator A Exclusion Logic:

MU excludes patient records by searching the ER VISIT file for patients whose primary diagnosis contains a mental disorder ICD-9 code or where the patient has been placed into observation status. This is determined by:

--Mental Disorder ICD-9 primary diagnosis: BGPMU ED MENTAL DISORDERS taxonomy.

OR

--Observation Status: Check the PATIENT MOVEMENT.WARD LOCATION or WARD LOCATION.SPECIALTY files for an observation specialty. MU checks for the observation specialties:

18 - Neurology Observation
23 - Spinal Cord Injury Observation
24 - Medical Observation
36 - Blind Rehab Observation
41 - Rehab Medicine Observation
65 - Surgical Observation
94 - Psychiatric Observation

Numerator B Logic – ED Patients Placed into Observation Status:

1. MU searches through the emergency department file (ER VISIT) during the report time period and then determines if a subsequent inpatient admission (PATIENT_MOVEMENT.DATE/TIME) occurred within 24 hours. MU identifies valid and non-null ED Visit Time and ED Departure Time. A record in which either value is null or not valid is not considered.

2. MU identifies the set of patients who are placed into observation status. Patients in observation status can be identified by checking the PATIENT MOVEMENT.WARD LOCATION or WARD LOCATION.SPECIALTY files for an observation specialty.

3. MU performs the calculation ED Departure Time minus the ED Visit Time and determines the value in minutes. For each patient record, MU stores this value as the **Elapsed Time from ED Visit to ED Departure Time.**

4. MU calculates the median value from the set of **Elapsed Time from ED Visit to ED Departure Time.** If the set is empty, then MU reports a zero value.

Numerator C Logic – ED Patients with a Mental Disorder:

1. MU searches through the emergency department file (ER VISIT) during the report time period and then determines if a subsequent inpatient admission (PATIENT_MOVEMENT.DATE/TIME) occurred within 24 hours.

2. MU identifies valid and non-null ED Visit Time and ED Departure Time. A record in which either value is null or not valid is not considered.

3. MU searches ER VISIT file for patients who have a primary diagnosis code identifying them as having a mental disorder. ICD-9 codes for mental disorders are identified with BGPMU ED MENTAL DISORDERS taxonomy.

4. MU performs the calculation Inpatient Admission Time minus the ED Visit Time and determines the value in minutes. For each patient record, MU stores this value as the **Elapsed Time from ED Visit to ED Departure Time.**

5. MU calculates the median value from the set of **Elapsed Time from ED Visit to ED Departure Time.** If the set is empty, then MU reports a zero value.

Patient List Description

Elapsed times are stratified as follows: A) All ED patients excluding patients with mental disorders or placed into observation status, B) ED patients placed into observation status and C) ED patients with a mental disorder, if any.

1.1.2   Median Time/ED Admit Decision to ED Departure/Admitted Patients (ED-2) NQF00497

Meaningful Use, Stage 1

Denominator

Not Applicable

Numerator

Median elapsed time from emergency department admission decision time to time of departure from the emergency room for patients admitted to the facility from the emergency department. Numerators are stratified as follows:

A) All ED patients except patients with mental disorders or placed into observation status
B) ED patients placed into observation status
C) ED patients with a mental disorder

Exclusions

See each of the stratifications for exclusion criteria.

Definition

Numerator Logic:

Numerator A Logic – All ED Patients except Patients with Mental Disorder or Placed into Observation Status:

1. MU searches through the emergency department file (ER VISIT) during the report time period and then determines if a subsequent inpatient admission (PATIENT_MOVEMENT) occurred within 24 hours.

2. MU identifies valid and non-null ED Admission Order Time (ORDER FILE – ORDER DIALOG FIELD) and ED Departure Time (ER VISIT: DEPARTURE TIME). The order dialog (the 5th field) is checked to see if it contains the word ADMIT. If it is, this is the time used. A record in which either value is null or not valid is excluded from the numerator.

3. MU performs the calculation ED Departure Time minus the ED Admission Order Time and determines the value in minutes. For each patient record, MU stores this time as the **Elapsed Time from ED Admission Order Time to ED Departure Time.**

4. MU calculates the median value from the set of **Elapsed Time from ED Admission Order Time to ED Departure Time.** If the set is empty, then MU reports a zero value.

Numerator A Exclusion Logic:

MU excludes patient records by searching the ER VISIT file for patients whose primary diagnosis contains a mental disorder ICD-9 code or where the patient has been placed into observation status. This is determined by:
--Mental Disorder ICD-9 primary diagnosis: BGPMU ED MENTAL DISORDERS taxonomy.
OR
--Observation Status: Check the PATIENT MOVEMENT.WARD LOCATION or WARD LOCATION.SPECIALTY files for an observation specialty. MU checks for the observation specialties:
18 - Neurology Observation
23 - Spinal Cord Injury Observation
24 - Medical Observation
36 - Blind Rehab Observation
41 - Rehab Medicine Observation
65 - Surgical Observation
94 - Psychiatric Observation

Numerator B Logic – ED Patients Placed into Observation Status:

1. MU searches through the emergency department file (ER VISIT) during the report time period and then determines if a subsequent inpatient admission (PATIENT_MOVEMENT) occurred within 24 hours.

2. MU identifies valid and non-null ED Admission Order Time (ORDER FILE – ORDER DIALOG FIELD) and ED Departure Time (ER VISIT: DEPARTURE TIME). The order dialog (the 5th field) is checked to see if it contains the word ADMIT. If it is, this is the time used. A record in which either value is null or not valid is excluded from the numerator.

3. MU identifies the set of patients who are placed into observation status. Patients in observation status can be identified by checking the PATIENT MOVEMENT.WARD LOCATION or WARD LOCATION.SPECIALTY files for an observation specialty.

4. MU performs the calculation ED Departure Time minus the ED Admission Decision Time and determine the value in minutes. For each patient record, MU stores this time as the **Elapsed Time from ED Admission Order Time to ED Departure Time.**

5. MU calculates the median value from the set of **Elapsed Time from ED Admission Order Time to ED Departure Time.** If the set is empty, then MU reports a zero value.

Numerator C Logic – ED Patients with a Mental Disorder:

1. MU searches through the emergency department file (ER VISIT) during the report time period and then determines if a subsequent inpatient admission (PATIENT_MOVEMENT) occurred within 24 hours.

2. MU identifies valid and non-null ED Admission Order Time (ORDER FILE – ORDER DIALOG FIELD) and ED Departure Time (ER VISIT: DEPARTURE TIME). The order dialog (the 5th field) is checked to see if it contains the word ADMIT. If it is, this is the time used. A record in which either value is null or not valid is excluded from the numerator.

3. MU searches ER VISIT file for patients who have a primary diagnosis code identifying them has having a mental disorder. ICD-9 codes for mental disorders are identified with BGPMU ED MENTAL DISORDERS taxonomy.

4. MU performs the calculation ED Departure Time minus the ED Admission Order Time and determine the value in minutes. For each patient record, MU stores this

time as the **Elapsed Time from ED Admission Order Time to ED Departure Time.**

5. MU calculates the median value from the set of **Elapsed Time from ED Admission Order Time to ED Departure Time.** If the set is empty, then MU reports a zero value.

Patient List Description

Elapsed times are stratified as follows: A) All ED patients excluding patients with mental disorders or placed into observation status, B) ED patients placed into observation status, and C) ED patients with a mental disorder, if any.

1.2 Stroke Measures

1.2.1 Discharge on Antithrombolytic Therapy (STK-2) NQF 0435

Meaningful Use, Stage 1

Denominator

Number of inpatient discharges for ischemic stroke patients.

Exclusions

The number of inpatient discharges for
- Patients under age 18
- Patients who had a Length of Stay greater than 120 Days
- Patients with Comfort Measures Only documented
- Patients enrolled in Clinical Trial
- Patients admitted for Elective Carotid Intervention. NOTE: Elective Surgery is assumed to be the admit reason.
- Patients discharged/transferred to another hospital for inpatient care
- Patients who left against medical advice or discontinued care
- Patients who expired
- Patients discharged/transferred to a federal healthcare facility
- Patients discharged/transferred to hospice
- Patients with a documented Reason for Not Prescribing Antithrombolytic Therapy at Discharge

Numerator

Number of inpatient discharges for ischemic stroke patients prescribed antithrombolytic therapy at hospital discharge.

Definition

Denominator Logic:

MU searches the TRANSACTION field in the PATIENT MOVEMENT file for transaction types of ADMISSION and DISCHARGE to identify inpatient discharges during the reporting period.

MU searches V POV for primary diagnosis of ischemic stroke for the inpatient visit. This is determined by meeting the criteria for ischemic stroke, primary diagnosis, and V POV modifier shown below.
--Ischemic Stroke ICD-9 codes: 433.0, 433.00, 433.01, 433.1, 433.10, 433.11, 433.2, 433.20, 433.21, 433.3, 433.30, 433.31, 433.8, 433.80, 433.81, 433.9, 433.90, 433.91, 434.0, 434.00, 434.01, 434.1, 434.10, 434.11, 434.9, 434.90, 434.91, 435.8, 435.9, 436, AND
--Diagnosis is Primary, AND
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

Denominator Exclusion Logic:

MU searches various files and excludes patient discharge records which have attributes which match any of the following criteria:

- Patients with age < 18, calculated as: Admission Date minus Birthdate.

- Patients who have a Length of Stay > 120 days, calculated as: Discharge Date/Time minus Admission Date/Time.

- Patients with Comfort Measures Only documented in the PROBLEM List (active problems only) or during the visit in the V POV and V CPT file. This is determined by:
--Palliative Care Measures Only – ICD-9 code: V66.7, AND
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious), OR
--Palliative Care Measures Only – CPT code: 1152F

- Patients enrolled in a Clinical Trial documented in the PROBLEM List (active problems only) or during the visit in the V POV file. This is determined by:
--ICD-9 code: V70.7, AND
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

- Patients admitted for Elective Carotid Intervention. MU searches for carotid intervention documented during the visit in the V PROCEDURE file with an elective admission. This is determined by:
--Carotid Intervention Procedure ICD-9 code: 00.61, 00.63, 38.02, 38.12, 38.22, 38.3, 38.42, 88.41, AND
--Admission Type-UB04 code: 3 (ELECTIVE ADMISSION).

- Patients discharged/transferred to another hospital for inpatient care, to a federal healthcare facility, to hospice, or who left against medical advice or discontinued care. This is determined by:
--Discharge Status-UB04 codes: 02 Transferred Gen Hospital, 03 Transferred SNF, 04 Transferred ICF, 05 Transferred Other, 07 Left AMA, 43 Transferred Federal Hospital, 50 Discharged to Hospice-Home, or 51 Discharged to Hospice Facility.

- Patients who expired. This is determined by any of the following:
--Discharge Status-UB04 codes: 20 Expired, 40 Expired at Home (Hospice Only), 41 Expired SNF, ICF, FS Hospice, or 42 Expired, Place Unknown.
--Date/Time of Death <= Discharge Date.

- Patients with a documented reason for not prescribing antithrombolytic therapy at discharge. This is determined by any of the following:
--Procedure CPT: 4012F, 4300F, 99363, 99364 documented on or within the past 180 days of the discharge date.
--Refusal: REF or NMI refusal of any stroke antithrombolytic medication included in taxonomy BGPMU ANTITHROMBOTIC NDCS documented during the visit.

Numerator Logic:

MU searches the PRESCRIPTION file for patients who were prescribed stroke antithrombolytic therapy at hospital discharge. Please refer to the BGPMU ANTITHROMBOTIC NDCS taxonomy for a list of the NDC codes.

Patient List Definition

> Ischemic stroke patients with atrial fibrillation/flutter who are prescribed anticoagulation therapy at hospital discharge, if any

1.2.2   Anticoagulation Therapy for Atrial Fibrillation/Flutter(STK-3) NQF0436

Meaningful Use, Stage 1

Denominator

Number of inpatient discharges for ischemic stroke patients with documented atrial fibrillation/flutter.

Exclusions

> Number of inpatient discharges for
> --Patients with Age < 18
> --Patients with Length of Stay > 120 Days
> --Patients with Comfort Measures Only documented
> --Patients enrolled in Clinical Trial

           --Patients admitted for Elective Carotid Intervention. NOTE: Elective Surgery is assumed to be the admit reason.
           --Patients discharged/transferred to another hospital for inpatient care
           --Patients who left against medical advice or discontinued care
           --Patients who expired
           --Patients discharged/transferred to a federal healthcare facility
           --Patients discharged/transferred to hospice
--Patients with a documented Reason for Not Prescribing Anticoagulation Therapy**.**

Numerator

Number of inpatient discharges for ischemic stroke patients prescribed antithrombolytic therapy at hospital discharge.

Definition

Denominator Logic:

MU searches the TRANSACTION field in the PATIENT MOVEMENT file for transaction types of ADMISSION and DISCHARGE to identify inpatient discharges during the reporting period.

MU searches V POV for primary diagnosis of ischemic stroke with documented atrial fibrillation/flutter for the inpatient visit. This is determined by meeting the criteria for ischemic stroke, primary diagnosis, V POV Modifier, AND any of the criteria for atrial fibrillation/flutter shown below.
--Ischemic Stroke ICD-9 codes: 433.0, 433.00, 433.01, 433.1, 433.10, 433.11, 433.2, 433.20, 433.21, 433.3, 433.30, 433.31, 433.8, 433.80, 433.81, 433.9, 433.90, 433.91, 434.0, 434.00, 434.01, 434.1, 434.10, 434.11, 434.9, 434.90, 434.91, 435.8, 435.9, 436, AND
--Diagnosis is Primary, AND
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious), AND
--Atrial Fibrillation/Flutter History and Finding Diagnosis ICD-9 codes: 427.31, 427.32, OR
--Atrial Fibrillation/Flutter Procedure CPT codes: 93610, 33254, 33255, 33256, 33257, 33258, 33265, 33266, 33206, 33208, 33212, 33215, OR
--Atrial Fibrillation/Flutter Procedure ICD-9 codes: 37.33, 37.34, 37.37, 37.72, 37.73, 37.76.

Denominator Exclusion Logic:

MU searches various files and excludes patient discharge records which have attributes which match any of the following criteria:

- Patients with age < 18, calculated as: Admission Date minus Birthdate.

- Patients who have a Length of Stay > 120 days, calculated as: Discharge Date/Time minus Admission Date/Time.

- Patients with Comfort Measures Only documented in the PROBLEM List (active problems only) or during the visit in the V POV and V CPT file. This is determined by:
--Palliative Care Measures Only – ICD-9 code: V66.7, AND
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious), OR
--Palliative Care Measures Only – CPT code: 1152F

- Patients enrolled in a Clinical Trial documented in the PROBLEM List (active problems only) or during the visit in the V POV file. This is determined by:
--ICD-9 code: V70.7, AND
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

- Patients admitted for Elective Carotid Intervention. MU searches for carotid intervention documented during the visit in the V PROCEDURE file with an elective admission. This is determined by:
--Carotid Intervention Procedure ICD-9 codes: 00.61, 00.63, 38.02, 38.12, 38.22, 38.3, 38.42, 88.41, AND
--Admission Type-UB04 code: 3 (ELECTIVE ADMISSION).

- Patients discharged/transferred to another hospital for inpatient care, to a federal healthcare facility, to hospice, or who left against medical advice or discontinued care. This is determined by:
--Discharge Status-UB04 codes: 02 Transferred Gen Hospital, 03 Transferred SNF, 04 Transferred ICF, 05 Transferred Other, 07 Left AMA, 43 Transferred Federal Hospital, 50 Discharged to Hospice-Home, or 51 Discharged to Hospice Facility.

- Patients who expired. This is determined by any of the following:
--Discharge Status-UB04 codes: 20 Expired, 40 Expired at Home (Hospice Only), 41 Expired SNF, ICF, FS Hospice, or 42 Expired, Place Unknown.
--Date/Time of Death <= Discharge Date.

- Patients with a documented reason for not prescribing anticoagulation therapy at discharge. This is determined by any of the following:
--Procedure CPT codes: 4012F, 4300F, 99363, 99364 documented on or within the past 180 days of the discharge date.
--Refusal: REF or NMI refusal of any stroke anticoagulation medication included in taxonomy BGPMU ANTICOAG NDCS documented during the visit.

Numerator Logic:

MU searches V MEDICATION for patients who were prescribed stroke anticoagulation therapy at hospital discharge. Please refer to the BGPMU ANTICOAG NDCS taxonomy for a list of the NDC codes.

Patient List Definition

Ischemic stroke patients 18+ with atrial fibrillation/flutter who are prescribed anticoagulation therapy at hospital discharge, if any.

1.2.3   Thrombolytic Therapy (STK-4) NQF 0437

Meaningful Use, Stage 1

Denominator

Number of inpatient discharges for acute ischemic stroke patients whose time of arrival is within 2 hours (< =120 minutes) of time last known well.

Exclusions

Number of inpatient discharges for:
- Patients with Age < 18
- Patients with Length of Stay > 120 Days
- Patients enrolled in Clinical Trial
- Patients admitted for Elective Carotid Intervention. NOTE: Elective Surgery is assumed to be the admit reason.
- Time last known well to arrival in the emergency department greater than (>) 2 hours [120 minutes]
- Patients with a documented Reason for Not Initiating IV Thrombolytic

Numerator

Number of inpatient discharges for acute ischemic stroke patients for whom IV thrombolytic therapy was initiated at this hospital within 3 hours (<= 180 minutes) of time last known well.

Definition

Denominator Logic:

MU searches the TRANSACTION field in the PATIENT MOVEMENT file for transaction types of ADMISSION and DISCHARGE to identify inpatient discharges during the reporting period.

MU searches V POV for primary diagnosis of ischemic stroke. This is determined by meeting the criteria for ischemic stroke, primary diagnosis, and V POV Modifier shown below.
--Ischemic Stroke ICD-9 codes: 433.0, 433.00, 433.01, 433.1, 433.10, 433.11, 433.2, 433.20, 433.21, 433.3, 433.30, 433.31, 433.8, 433.80, 433.81, 433.9, 433.90, 433.91, 434.0, 434.00, 434.01, 434.1, 434.10, 434.11, 434.9, 434.90, 434.91, 435.8, 435.9, 436, AND
--Diagnosis is Primary, AND
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

Denominator Exclusion Logic:

MU searches various files and excludes patient discharge records which have attributes which match any of the following criteria:

- Patients with age < 18, calculated as: Admission Date minus Birthdate.

- Patients who have a Length of Stay > 120 days, calculated as: Discharge Date/Time minus Admission Date/Time.

- Patients enrolled in a Clinical Trial documented in the PROBLEM List (active problems only) or during the visit in the V POV file. This is determined by:
--ICD-9 code: V70.7, AND
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

- Patients admitted for Elective Carotid Intervention. MU searches for carotid intervention documented during the visit in the V PROCEDURE file with an elective admission. This is determined by:
--Carotid Intervention Procedure ICD-9 codes: 00.61, 00.63, 38.02, 38.12, 38.22, 38.3, 38.42, 88.41, AND
--Admission Type-UB04 code: 3 (ELECTIVE ADMISSION).

- Time last known well of the patient to arrival in the emergency department is greater than 2 hours. MU searches V MEASUREMENT for documentation of the patient's LAST KNOWN WELL and searches ER VISIT to determine if a patient's time last known well to arrival in the emergency department is greater than 2 hours.
This is determined by:
--Emergency Department Patient Class Clinic Code: 30, AND
--Admission Type-UB04 code: 1 (EMERGENCY), AND
--ER Arrival Date/Time minus V MEASUREMENT LAST KNOWN WELL > 120 minutes.

- Patients with a documented Reason for Not Initiating IV Thrombolytic. This is determined by any of the following documented during the visit:
--Procedure CPT codes: 4012F, 4300F, 99363, 99364 documented on or within the past 180 days of the discharge date, OR
--Problem or Diagnosis ICD-9 code: V58.61 documented on or within the past 180 days of the discharge date, OR
--Stroke Thrombolytic (t-PA) Medication NDC codes: 50242-0044-06, 50242-0044-13, 50242-0085-25, 50242-0085-27, AND
--IV Administration Route IV Flag: Yes, AND
--Refusal: REF or NMI refusal of any stroke thrombolytic (t-PA) medication documented during the visit.

Numerator Logic:

MU searches V MEASUREMENT for documentation of the patient's LAST KNOWN WELL and searches BCMA MEDICATION LOG for patients for whom IV thrombolytic therapy was

initiated at this hospital within 3 hours (<=180 minutes) of time last known well, calculated as: Medication Administered Date/Time minus LAST KNOWN WELL result value. This is determined by:
--Stroke Thrombolytic (t-PA) Medication NDC codes: 50242-0044-06, 50242-0044-13, 50242-0085-25, 50242-0085-27, AND
--IV Administration Route IV Flag: Yes, AND
--Medication Administered Date/Time minus Last Known Well is <=180 minutes.

Patient List Definition

Acute ischemic stroke patients who arrive at this hospital within 2 hours of time last known well and for whom IV t-PA was initiated at this hospital within 3 hours of time last known well, if any.

1.2.4   Antithrombolytic Therapy by End of Hospital Day 2 (STK-5) NQF 0438

Meaningful Use, Stage 1

Denominator

Number of inpatient discharges for ischemic stroke patients.

Exclusions

> Number of inpatient discharges for
> --Patients with Age < 18
> --Patients with Length of Stay > 120 Days
> --Patients Discharged by End of Hospital Day 2 (duration of stay)
> --Patients with Comfort Measures Only documented on day of or day after arrival
> --Patients enrolled in Clinical Trial
> --Patients admitted for Elective Carotid Intervention. NOTE: Elective Surgery is assumed to be the admit reason.

--Patients with IV OR IA Thrombolytic (t-PA) Therapy Administered at This Hospital or Within 24 Hours Prior to Arrival
> --Patients with a documented Reason For Not Administering Antithrombolytic Therapy By End Of Hospital Day 2

Numerator

Number of inpatient discharges for ischemic stroke patients who had antithrombolytic therapy administered by end of hospital day 2.

Definition

> Denominator Logic:

MU searches the TRANSACTION field in the PATIENT MOVEMENT file for transaction types of ADMISSION and DISCHARGE to identify inpatient discharges during the reporting period.

MU searches V POV for primary diagnosis of ischemic stroke for the inpatient visit. This is determined by meeting the criteria for ischemic stroke, primary diagnosis, and V POV Modifier shown below.
--Ischemic Stroke ICD-9 codes: 433.0, 433.00, 433.01, 433.1, 433.10, 433.11, 433.2, 433.20, 433.21, 433.3, 433.30, 433.31, 433.8, 433.80, 433.81, 433.9, 433.90, 433.91, 434.0, 434.00, 434.01, 434.1, 434.10, 434.11, 434.9, 434.90, 434.91, 435.8, 435.9, 436, AND
--Diagnosis is Primary, AND
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

Denominator Exclusion Logic:

MU searches various files and excludes patient discharge records which have attributes which match any of the following criteria:

- Patients with age < 18, calculated as: Admission Date minus Birthdate.

- Patients who have a Length of Stay > 120 days, calculated as: Discharge Date/Time minus Admission Date/Time.

- Patients discharged by end of hospital day 2 (duration of stay), calculated as: Discharge Date minus Arrival Date/Time is < 2 days.

- Patients with Comfort Measures Only documented in the PROBLEM List (active problems only) or on day of or day after arrival in the V POV and V CPT file. This is determined by:
--Palliative Care Measures Only – ICD-9 code: V66.7, AND
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious), OR
--Palliative Care Measures Only – CPT code: 1152F

- Patients enrolled in a Clinical Trial documented in the PROBLEM List (active problems only) or during the visit in the V POV file. This is determined by:
--ICD-9 code: V70.7, AND
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

- Patients admitted for Elective Carotid Intervention. MU searches for carotid intervention documented during the visit in the V PROCEDURE file with an elective admission. This is determined by:

--Carotid Intervention Procedure ICD-9 codes: 00.61, 00.63, 38.02, 38.12, 38.22, 38.3, 38.42, 88.41, AND
--Admission Type-UB04 code: 3 (ELECTIVE ADMISSION).

- MU searches BCMA MEDICATION LOG file for patients with IV OR IA Thrombolytic (t-PA) Therapy Administered at this hospital or within 24 hours prior to arrival, calculated as: Medication Administered Date/Time minus Arrival Date/Time. This is determined by:
--Stroke Thrombolytic (t-PA) Medication NDC codes: 50242-0044-06, 50242-0044-13, 50242-0085-25, 50242-0085-27.
--IV Administration Route IV Flag: Yes.
--Medication Administered Date/Time: BCMA MEDICATION LOG.

- Patients with a documented Reason for Not Administering Antithrombolytic Therapy by End of Hospital Day 2, calculated as: Medication Administered Date/Time minus Arrival Date/Time. This is determined by any of the following documented during the visit:
--Procedure CPT codes: 4012F, 4300F, 99363, 99364 documented on or within the past 180 days of the discharge date.
--Refusal: REF or NMI refusal of any stroke antithrombolytic medication included in taxonomy BGPMU ANTITHROMBOLYTIC NDCS documented <=48 hours of the arrival date/time.

Numerator Logic:

MU searches BCMA MEDICATION LOG file for patients who had stroke antithrombolytic therapy administered by end of hospital day 2, calculated as Medication Administered Date/Time minus Arrival Date/Time is <=2 days. Please refer to the BGPMU ANTITHROMBOLYTIC NDCS taxonomy for a list of the NDC codes.

Patient List Definition

Ischemic stroke patients administered antithrombolytic therapy by the end of hospital day 2, if any.

1.2.5   Discharged on Statin Medication (STK-6) NQF 0439

Meaningful Use, Stage 1

Denominator

Number of inpatient discharges for ischemic stroke patients with an LDL cholesterol >= 100, or LDL not measured, or who were on a lipid-lowering medication prior to hospital arrival.

Exclusions

Number of inpatient discharges for

--Patients with age < 18
--Patients with length of stay > 120 days
--Patients Comfort Measures Only documented
--Patients enrolled in Clinical Trial
--Patients admitted for Elective Carotid intervention. NOTE: Elective Surgery is assumed to be the admit reason.
--Patients without Evidence of Atherosclerosis
--Patients discharged/transferred to another hospital for inpatient care
--Patients who left against medical advice or discontinued care
--Patients who expired
--Patients discharged/transferred to a federal healthcare facility
--Patient discharged/transferred to a hospice
--Patients with a Reason for Not Prescribing Statin Medication at Discharge

Numerator

Number of inpatient discharges for patients prescribed statin medication at hospital discharge.

Definition
Denominator Logic:

Age is calculated as of the beginning and as of the end of the reporting period to determine if the patient turned two years of age during this period.

To be included in the denominator, the patient must meet ALL conditions shown below.

1. MU searches for the inpatient (VISIT) file with a service category equal to "H" during the reporting period.

2. MU searches V POV for primary diagnosis of ischemic stroke for the inpatient visit. This is determined by meeting the criteria for ischemic stroke, primary diagnosis, AND V POV Modifier shown below.
--Ischemic Stroke ICD-9 codes: 433.0, 433.00, 433.01, 433.1, 433.10, 433.11, 433.2, 433.20, 433.21, 433.3, 433.30, 433.31, 433.8, 433.80, 433.81, 433.9, 433.90, 433.91, 434.0, 434.00, 434.01, 434.1, 434.10, 434.11, 434.9, 434.90, 434.91, 435.8, 435.9, 436, AND
--Diagnosis is Primary, AND
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

3. MU searches V LAB and V MEDICATION for any of the following:
--LDL cholesterol >= 100 within the first 48 hours of hospital arrival date/time or within 30 days prior to hospital arrival date/time, OR
--LDL not measured within the first 48 hours of hospital arrival date/time or within 30 days prior to hospital arrival date/time, OR
--Who were on a lipid-lowering medication prior to hospital arrival.

LDL Cholesterol and lipid-lowering medication are defined with:
--LDL Cholesterol Laboratory Test LOINC codes: 13457-7, 18261-8, 18262-6, 2089-1,
49132-4.
--Stroke Lipid Lowering Agent NDC: BGPMU LIPID LOWERING NDCS

Numerator Logic:

MU searches V MEDICATION for patients prescribed stroke statin medication at hospital discharge. Please refer to the BGPMU STATIN NDCS taxonomy for a list of the NDC codes.

Exclusion Logic:

MU searches the Inpatient (VISIT) file and excludes patient discharge records which have attributes which match any of the following criteria:

- Patients with age < 18, calculated as: Admission Date minus Birthdate.

- Patients who have a Length of Stay > 120 days, calculated as: Discharge Date/Time minus Admission Date/Time.

- Patients with Comfort Measures Only documented in the PROBLEM List (active problems only) or during the visit in the V POV and V CPT file. This is determined by:
--Palliative Care Measures Only – ICD-9 code: V66.7, AND
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious), OR
--Palliative Care Measures Only – CPT code: 1152F

- Patients enrolled in a Clinical Trial documented in the PROBLEM List (active problems only) or during the visit in the V POV file. This is determined by:
--ICD-9 code: V70.7, AND
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

- Patients admitted for Elective Carotid Intervention. MU searches for carotid intervention documented during the visit in the V PROCEDURE file with an elective admission. This is determined by:
--Carotid Intervention Procedure ICD-9 codes: 00.61, 00.63, 38.02, 38.12, 38.22, 38.3, 38.42, 88.41, AND.
--Admission Type-UB92 code: 3 (ELECTIVE ADMISSION).

- Patients without evidence of Atherosclerosis. MU searches V POV and PROBLEM List (active problems only) for any of the codes shown below documented prior to the discharge date. If none of the codes are found, the patient is treated as an exclusion and will not be included in

the denominator. If any of the codes are found, the patient is not excluded and will be included in the denominator.

--Evidence of Atherosclerosis ICD-9 codes: [250.70 & 443.81], [250.80 & 443.9], [250.81 & 443.89], [414.06 & 996.83], [434.91 & 784.51], [414.00 & 997.1], 342.80, 414.01, 414.05, 414.9, 416.0, 433.10, 437.0, 440.0, 440.1, 440.20, 440.29, 440.8, 440.9, 442.9, 444.21, 444.22, 447.5, 459.89, 746.85, AND

> --V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

- Patients discharged/transferred to another hospital for inpatient care, to a federal healthcare facility, to hospice, or who left against medical advice or discontinued care. This is determined by:

--Discharge Status-UB92 codes: 02 Transferred Gen Hospital, 03 Transferred SNF, 04 Transferred ICF, 05 Transferred Other, 07 Left AMA, 43 Transferred Federal Hospital, 50 Discharged to Hospice-Home, or 51 Discharged to Hospice Facility.

- Patients who expired. This is determined by any of the following:

--Discharge Status-UB92 codes: 20 Expired, 40 Expired at Home (Hospice Only), 41 Expired SNF, ICF, FS Hospice, or 42 Expired, Place Unknown.

--Date/Time of Death <= Discharge Date.

- Patients with a documented reason for not prescribing statin medication at discharge. This is determined by any of the following documented during the visit:

--Refusal: REF or NMI refusal of any stroke statin medication included in taxonomy BGPMU STATIN NDCS documented during the visit.

Patient List Description

Ischemic stroke patients with LDL >= 100 mg/dL, or LDL not measured, or, who were on a lipid-lowering medication prior to hospital arrival who are prescribed statin medication at hospital discharge, if any.

1.2.6   Stroke Education (STK-8) NQF0440

Meaningful Use, Stage 1

Denominator

> Number of inpatient discharges for ischemic stroke or hemorrhagic stroke patients discharged home.

Exclusions

> Number of inpatient discharges for
> --Patients with Age < 18
> --Patients with Length of Stay > 120 Days
> --Patients with Comfort Measures Only documented
> --Patients enrolled in Clinical Trial

--Patients admitted for Elective Carotid Intervention. NOTE: Elective Surgery is assumed to be the admit reason

Numerator

Number of inpatient discharges for ischemic or hemorrhagic stroke patients with documentation that they or their caregivers were given educational material addressing all of the following:
--Activation of emergency medical system
--Need for follow-up after discharge
--Medications prescribed at discharge
--Risk factors for stroke
--Warning signs for stroke.

Definitions

Denominator Logic:

To be included in the denominator, the patient must meet ALL conditions shown below.

1. MU searches the TRANSACTION field in the PATIENT MOVEMENT file for transaction types of ADMISSION and DISCHARGE to identify inpatient discharges during the reporting period.

2. MU searches V POV for primary diagnosis of ischemic or hemorrhagic stroke for the inpatient visit. This is determined by meeting the criteria for ischemic or hemorrhagic stroke, primary diagnosis, AND V POV modifier shown below.
--Ischemic Stroke ICD-9 codes: 433.0, 433.00, 433.01, 433.1, 433.10, 433.11, 433.2, 433.20, 433.21, 433.3, 433.30, 433.31, 433.8, 433.80, 433.81, 433.9, 433.90, 433.91, 434.0, 434.00, 434.01, 434.1, 434.10, 434.11, 434.9, 434.90, 434.91, 435.8, 435.9, 436.
--Hemorrhagic Stroke ICD-9 codes: 430-432.99
--Diagnosis is Primary
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

3. MU searches PATIENT MOVEMENT for patients discharged to home care or self-care. This is determined by:
--Discharge Status-UB04 codes: 01 DISCHARGED HOME, 06 UNDER CARE OF HOME HEALTH ORG.

Denominator Exclusion Logic:

MU searches various files and excludes patient discharge records which have attributes which match any of the following criteria:

- Patients with age < 18, calculated as: Admission Date minus Birthdate.

- Patients who have a Length of Stay > 120 days, calculated as: Discharge Date/Time minus Admission Date/Time.

- Patients with Comfort Measures Only documented in the PROBLEM List (active problems only) or during the visit in the V POV and V CPT file. This is determined by:
--Palliative Care Measures Only – ICD-9 code: V66.7, AND
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious), OR
--Palliative Care Measures Only – CPT code: 1152F

- Patients enrolled in a Clinical Trial documented in the PROBLEM List (active problems only) or during the visit in the V POV file. This is determined by:
--ICD-9 code: V70.7, AND
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

- Patients admitted for Elective Carotid Intervention. MU searches for carotid intervention documented during the visit in the V PROCEDURE file with an elective admission. This is determined by:
--Carotid Intervention Procedure ICD-9 codes: 00.61, 00.63, 38.02, 38.12, 38.22, 38.3, 38.42, 88.41, AND
--Admission Type-UB04 code: 3 (ELECTIVE ADMISSION).

Numerator Logic:

MU searches V PATIENT ED for the TOPIC of STROKE-L to determine if patients or their caregivers were given educational material addressing all of the following:
--Activation of emergency medical system
--Need for follow-up after discharge
--Medications prescribed at discharge
--Risk factors for stroke
--Warning signs for stroke

Patient List Definition

Ischemic or hemorrhagic stroke patients or their caregivers who were given educational materials during the hospital stay addressing all of the following: activation of emergency medical system, need for follow-up after discharge, medications prescribed at discharge, risk factors for stroke, and warning signs and symptoms of stroke, if any.

1.2.7   Assessed for Rehabilitation (STK-10) NQF00441

Meaningful Use, Stage 1

Denominator

Number of inpatient discharges for ischemic or hemorrhagic stroke patients.

Exclusions

> Number of inpatient discharges for
> --Patients with Age < 18
> --Patients with Length of Stay > 120 Days
> --Patients with Comfort Measures Only documented
> --Patients enrolled in Clinical Trial
> --Patients admitted for Elective Carotid Intervention. NOTE: Elective Surgery is
> assumed to be the admit reason.
> --Patients discharged/transferred to another hospital for inpatient care
> --Patients who left against medical advice or discontinued care
> --Patients who expired
> --Patients discharged/transferred to a federal healthcare facility

--Patients discharged/transferred to hospice.

Numerator

Number of inpatient discharges for ischemic or hemorrhagic stroke patients assessed for or who received rehabilitation services.

Definitions

Denominator Logic:

MU searches the TRANSACTION field in the PATIENT MOVEMENT file for transaction types of ADMISSION and DISCHARGE to identify inpatient discharges during the reporting period.

MU searches V POV for primary diagnosis of ischemic or hemorrhagic stroke for the inpatient visit. This is determined by meeting the criteria for ischemic or hemorrhagic stroke, primary diagnosis, AND V POV modifier shown below.
--Ischemic Stroke ICD-9 codes: 433.0, 433.00, 433.01, 433.1, 433.10, 433.11, 433.2, 433.20, 433.21, 433.3, 433.30, 433.31, 433.8, 433.80, 433.81, 433.9, 433.90, 433.91, 434.0, 434.00, 434.01, 434.1, 434.10, 434.11, 434.9, 434.90, 434.91, 435.8, 435.9, 436.
--Hemorrhagic Stroke ICD-9 codes: 430-432.99
--Diagnosis is Primary
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

Denominator Exclusion Logic:

MU searches numerous files and excludes patient records which have attributes which match any of the following criteria:

- Patients with age < 18, calculated as: Admission Date minus Birthdate.

- Patients who have a Length of Stay > 120 days, calculated as: Discharge Date/Time minus Admission Date/Time.

- Patients with Comfort Measures Only documented in the PROBLEM List (active problems only) or during the visit in the V POV and V CPT file. This is determined by:
--Palliative Care Measures Only – ICD-9 code: V66.7, AND
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious), OR
--Palliative Care Measures Only – CPT code: 1152F

- Patients enrolled in a Clinical Trial documented in the PROBLEM List (active problems only) or during the visit in the POV file. This is determined by:
--ICD-9 code: V70.7, AND
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

- Patients admitted for Elective Carotid Intervention. MU searches for carotid intervention documented during the visit in the V PROCEDURE file with an elective admission. This is determined by:
--Carotid Intervention Procedure ICD-9 codes: 00.61, 00.63, 38.02, 38.12, 38.22, 38.3, 38.42, 88.41, AND
--Admission Type-UB04 code: 3 (ELECTIVE ADMISSION).

- Patients discharged/transferred to another hospital for inpatient care, to a federal healthcare facility, to hospice, or who left against medical advice or discontinued care. This is determined by:
--Discharge Status-UB04 codes: 02 Transferred Gen Hospital, 03 Transferred SNF, 04 Transferred ICF, 05 Transferred Other, 07 Left AMA, 43 Transferred Federal Hospital, 50 Discharged to Hospice-Home, or 51 Discharged to Hospice Facility.

- Patients who expired. This is determined by any of the following:
--Discharge Status-UB04 codes: 20 Expired, 40 Expired at Home (Hospice Only), 41 Expired SNF, ICF, FS Hospice, or 42 Expired, Place Unknown.
--Date/Time of Death <= Discharge Date.

Numerator Logic:

MU searches V CPT for patients assessed for or who received rehabilitation services during the reporting period. This is determined by
--Assessed for Rehabilitation Services CPT code: 4079F.

Patient List Definition

Ischemic or hemorrhagic stroke patients who were assessed for rehabilitation services, if any.

1.3   VTE Measures

1.3.1   VTE Prophylaxis (VTE-1) NQF0371

Meaningful Use, Stage 1

Denominator

Number of inpatient discharges for all patients.

Numerator

Number of inpatient discharges for patients who received VTE prophylaxis or have
documentation why no VTE prophylaxis was given
--the day of or the day after hospital admission
--the day of or the day after surgery end date for surgeries that start the day of or the day after
hospital admission

Exclusions

The number of inpatient discharges for
          --Patients with Age < 18
          --Patients who have a Length of Stay < 2 days
          --Patients with Length of Stay > 120 Days
          --Patients with Comfort Measures Only documented on day of or day after hospital
          arrival
          --Patients enrolled in Clinical Trial
          --Patients who are direct admits to intensive care unit (ICU), or transferred to ICU the
          day of or the day after hospital admission with ICU length of stay ≥ 1 day
          --Patients with Principal Diagnosis of Mental Disorders [Patients with Service
          Delivery of Behavioral Health]
          --Patients with Principal Diagnosis of Hemorrhagic or Ischemic Stroke
          --Patients with Principal Diagnosis of Obstetrics [Patients with Service Delivery of
          Obstetrics]
          --Patients with Principal Diagnosis of VTE

Definitions

Denominator Logic:

MU searches the TRANSACTION field in the PATIENT MOVEMENT file for transaction
types of ADMISSION and DISCHARGE to identify inpatient discharges during the reporting
period.

Numerator Logic:

To be included in the numerator, the patient must meet at least one condition shown below.

1. MU searches PHARMACY PATIENT file for patients who received VTE prophylaxis medication included in taxonomy BGPMU VTE PROPHYLAXIS
--the day of or the day after hospital admission, calculated as: VTE Prophylaxis Date/Time minus Admit Date/Time
--the day of or the day after surgery end date for surgeries that start the day of or the day after hospital admission, calculated as: VTE Prophylaxis Date/Time minus Procedure Date/Time AND Procedure Date/Time minus Admit Date/Time.

2. MU searches PATIENT REFUSALS for refusal of VTE Prophylaxis. This is determined by:
--VTE Prophylaxis - Application of Mechanical Device ICD-9 code: 93.59
--VTE Prophylaxis - Application of Mechanical Device CPT code: E0676
--Refusal: REF or NMI refusal of any VTE prophylaxis medication included in taxonomy BGPMU VTE PROPHYLAXIS.

3. MU searches V POV for a reason for not VTE Prophylaxis – Hospital Admission Surgery. This is determined by:
--Reason for no VTE Prophylaxis – Mechanical ICD-9 codes: V49.70, V49.75, V49.76, V49.89, 443.9, 459.9, 897.6, 897.7, 959.7.
--Reason for no VTE Prophylaxis – Pharmacologic ICD-9 codes: 286.7, 286.9, 289.84, 431.2, 434.91, 459.0, 593.9, 790.99, 995.27.
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

Exclusion Logic
MU searches numerous files and excludes patient discharge records which have attributes which match any of the following criteria:

- Patients with age < 18, calculated as: Admission Date minus Birthdate.

- Patients who have a Length of Stay < 2 days, calculated as: Discharge Date/Time minus Admission Date/Time.

- Patients who have a Length of Stay > 120 days, calculated as: Discharge Date/Time minus Admission Date/Time.

- Patients with Comfort Measures Only documented in the PROBLEM List (active problems only) on day of or day after arrival in the V POV and/or V CPT file. This is determined by:
--Palliative Care Measures Only – ICD-9 code: V66.7
--Palliative Care Measures Only – CPT code: 1152F
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

- Patients enrolled in a Clinical Trial documented in the PROBLEM List (active problems only) or during the visit in the V POV file. This is determined by:
--ICD-9: V70.7

--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

- MU searches for all of the following during the visit:

1. MU searches the PATIENT MOVEMENT file for patients who are direct admits to intensive care unit (ICU), or transferred to ICU the day of or the day after hospital admission with ICU length of stay greater than or equal to one day, calculated as: ICU Admit Date minus Admit Date AND ICU Admit Date minus ICU Discharge Date. In facility location - ICU is determined by searching the PATIENT MOVEMENT file for ward names that contain "ICU".

AND

2. MU searches PATIENT REFUSALS for refusal of VTE Prophylaxis. This is determined by:
--VTE Prophylaxis - Application of Mechanical Device ICD-9 code: 93.59
--VTE Prophylaxis - Application of Mechanical Device CPT code: E0676
--Refusal: REF or NMI refusal documented during the visit of any VTE prophylaxis medication with NDC codes included in taxonomy BGPMU VTE PROPHYLAXIS.

AND

3. MU searches V POV for a reason for not VTE Prophylaxis – Hospital Admission Surgery. This is determined by:
--Reason for no VTE Prophylaxis – Mechanical ICD-9 codes: V49.70, V49.75, V49.76, V49.89, 443.9, 459.9, 897.6, 897.7, 959.7.
--Reason for no VTE Prophylaxis – Pharmacologic ICD-9 codes: 286.7, 286.9, 289.84, 431.2, 434.91, 459.0, 593.9, 790.99, 995.27.
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

- MU searches for patients with a diagnosis of mental disorders (Patients with service delivery of behavioral health) during the visit by checking FACILITY TREATING SPECIALTY in the PATIENT MOVEMENT file for mental health names: "MENTAL HEALTH", "ALCOHOLISM", "BEHAVIORAL HEALTH", and "SUBSTANCE ABUSE".

- MU searches for primary diagnosis of ischemic or hemorrhagic stroke during the visit. This is determined by meeting the criteria for ischemic or hemorrhagic stroke, primary diagnosis, V POV modifier, AND discharge status shown below.
--Ischemic Stroke ICD-9 codes: 433.0, 433.00, 433.01, 433.1, 433.10, 433.11, 433.2, 433.20, 433.21, 433.3, 433.30, 433.31, 433.8, 433.80, 433.81, 433.9, 433.90, 433.91, 434.0, 434.00, 434.01, 434.1, 434.10, 434.11, 434.9, 434.90, 434.91, 435.8, 435.9, 436
--Hemorrhagic Stroke ICD-9 codes: 430-432.99.
--Diagnosis is Primary
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

- MU searches V POV for patients with a diagnosis of obstetrics (Patients with service delivery of obstetrics) during the visit. This is determined by:

--Obstetric Inpatient Treatment Locations included in BGPMU VTE OB DXS taxonomy.

--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

- MU searches for primary diagnosis of VTE during the visit. This is determined by meeting the criteria for VTE confirmed, primary diagnosis, and V POV modifier shown below:

--VTE Confirmed ICD-9 codes: 453.40-453.42, 453.50-453.52, 453.6, 453.71-453.79, 453.81-453.89

--Diagnosis is Primary

--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

1.3.2   Intensive Care Unit (ICU) VTE Prophylaxis (VTE-2) NQF0372

Meaningful Use, Stage 1

Denominator

Number of inpatient discharges for all patients.

Numerator

Number of inpatient discharges for patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given:

--the day of or the day after ICU admission (or transfer)

--the day of or the day after surgery end date for surgeries that start the day of or the day after ICU admission (or transfer)

Exclusions

Number of inpatient discharges for

--Patients with Age < 18

--Patients who have a Length of Stay < 2 days

--Patients with Length of Stay > 120 Days

--Patients with Comfort Measures Only documented on day of or day after hospital arrival

--Patients enrolled in Clinical Trial

--Patients with ICU LOS < 1 day without VTE prophylaxis administered and (without) documentation for no VTE prophylaxis

--Patients with Principal Diagnosis of Obstetrics

--Patients with Principal Diagnosis of VTE

Definitions

Denominator Logic:

MU searches the TRANSACTION field in the PATIENT MOVEMENT file for transaction types of ADMISSION and DISCHARGE to identify inpatient discharges during the reporting period.

Numerator Logic:

To be included in the numerator, the patient must meet ALL conditions shown below.

1. MU searches PATIENT MOVEMENT for ward names that contain "ICU" and searches PHARMACY PATIENT file for patients who received VTE prophylaxis included in taxonomy BGPMU VTE PROPHYLAXIS
--the day of or the day after ICU admission (or transfer), calculated as: VTE Prophylaxis Date/Time minus ICU Admit Date/Time
--the day of or the day after surgery end date for surgeries that start the day of or the day after ICU admission (or transfer), calculated as: VTE Prophylaxis Date/Time minus Procedure End Date/Time AND Procedure Start Date/Time minus ICU Admit Date/Time

2. MU searches PATIENT REFUSALS for refusal of VTE Prophylaxis. This is determined by:
--VTE Prophylaxis - Application of Mechanical Device ICD-9 code: 93.59
--VTE Prophylaxis - Application of Mechanical Device CPT code: E0676
--Refusal: REF or NMI refusal of any VTE prophylaxis medication included in taxonomy BGPMU VTE PROPHYLAXIS documented during the visit.

3. MU searches V POV for a reason for not VTE Prophylaxis – ICU. This is determined by:
--Reason for no VTE Prophylaxis – Mechanical ICD-9 codes: V49.70, V49.75, V49.76, V49.89, 443.9, 459.9, 897.6, 897.7, 959.7.
--Reason for no VTE Prophylaxis – Pharmacologic ICD-9 codes: 286.7, 286.9, 289.84, 431.2, 434.91, 459.0, 593.9, 790.99, 995.27.
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

        Exclusion Logic:

MU searches various files and excludes patient discharge records which have attributes which match any of the following criteria:

- Patients with age < 18, calculated as: Admission Date minus Birthdate.

- Patients who have a Length of Stay < 2 days, calculated as: Discharge Date/Time minus Admission Date/Time.

- Patients who have a Length of Stay > 120 days, calculated as: Discharge Date/Time minus Admission Date/Time.

- Patients with Comfort Measures Only documented in the PROBLEM List (active problems only) on day of or day after arrival in the V POV and V CPT file. This is determined by:

--Palliative Care Measures Only – ICD-9 code: V66.7
--Palliative Care Measures Only – CPT code: 1152F
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

- Patients enrolled in a Clinical Trial documented in the PROBLEM List (active problems only) or during the visit in the POV file. This is determined by:
--ICD-9 code: V70.7
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

- MU searches for all of the following during the visit:

1. MU searches PATIENT MOVEMENT file for patients with ICU length of stay less than 1 day, calculated as: ICU Discharge Date minus ICU Admit Date equal to zero. In facility location - ICU is determined by searching the PATIENT MOVEMENT file for ward names that contain "ICU".

AND

2. MU searches PATIENT REFUSALS for refusal of VTE Prophylaxis. This is determined by:
--VTE Prophylaxis - Application of Mechanical Device ICD-9 code: 93.59
--VTE Prophylaxis - Application of Mechanical Device CPT code: E0676
--Refusal: REF or NMI refusal documented during the visit of any VTE prophylaxis medication with NDC codes included in taxonomy BGPMU VTE PROPHYLAXIS.

AND

3. MU searches V POV for a reason for not VTE Prophylaxis – ICU. This is determined by:
--Reason for no VTE Prophylaxis – Mechanical ICD-9 codes: V49.70, V49.75, V49.76, V49.89, 443.9, 459.9, 897.6, 897.7, 959.7.
--Reason for no VTE Prophylaxis – Pharmacologic ICD-9 codes: 286.7, 286.9, 289.84, 431.2, 434.91, 459.0, 593.9, 790.99, 995.27.
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

- MU searches V POV for patients with a diagnosis of obstetrics (Patients with service delivery of obstetrics) during the visit. This is determined by:
--Obstetric Inpatient Treatment Locations included in taxonomy BGPMU VTE OB DXS.
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

- MU searches for primary diagnosis of VTE during the visit. This is determined by meeting the criteria for VTE confirmed, primary diagnosis, and V POV modifier shown below:
--VTE Confirmed ICD-9 codes: 453.40-453.42, 453.50-453.52, 453.6, 453.71-453.79, 453.81-453.89.

--Diagnosis is Primary
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

1.3.3   VTE with Anticoagulation Overlap Therapy (VTE-3) NQF0373

Meaningful Use, Stage 1

Denominator

Number of inpatient discharges for patients with confirmed VTE who received warfarin.

Numerator

Number of inpatient discharges for patients who received overlap therapy.

Exclusions

Number of inpatient discharges
>   --Patients with Age < 18
>   --Patients with Length of Stay > 120 Days
>   --Patients with Comfort Measures Only
>   --Patients enrolled in Clinical Trial
>   -- Patients without warfarin therapy during hospitalization
>   --Patients without warfarin prescribed at discharge
>   --Patients without VTE confirmed by diagnostic testing

Definitions

Denominator Logic:

>   To be included in the denominator, the patient must meet ALL conditions shown below.

1. MU searches the TRANSACTION field in the PATIENT MOVEMENT file for transaction types of ADMISSION and DISCHARGE to identify inpatient discharges during the reporting period.

2. MU searches V POV for primary diagnosis of VTE during the inpatient visit. This is determined by meeting the criteria for VTE confirmed, primary diagnosis, and V POV modifier shown below:
--VTE Confirmed ICD-9 codes: 453.40-453.42, 453.50-453.52, 453.6, 453.71-453.79, 453.81-453.89.
--Diagnosis is Primary
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

3. MU searches V CPT and/or radiology orders for patients with VTE confirmed by diagnostic testing during the visit. This is determined by:

--VTE Diagnostic Test CPT codes: 35476, 71250 - 71275, 71550 - 71552, 73718 - 73720, 75741 - 75746, 75820 - 75822, 75825, 75827, 75945, 75946, 75952, 78456 - 78458, 78580 - 78594, 93922 - 93924, 93965 - 93971.

4. MU searches PRESCRIPTION, PHARMACY PATIENT, and V MED for patients who received warfarin medication after discharge. This is determined by the Warfarin Medication NDC codes in the BGPMU WARFARIN NDCS taxonomy.

5. MU searches PHARMACY PATIENT for both IV and unit dose orders of warfarin therapy during the visit. This is determined by the Warfarin Medication NDC codes in the BGPMU WARFARIN NDCS taxonomy.

Numerator Logic:

        To be included in the numerator, the patient must meet at least one of the following three conditions shown below.

MU searches PHARMACY PATIENT for patients who received warfarin and parenteral anticoagulation, calculated by checking each day of the inpatient stay to see if a warfarin and other anticoagulation drug was active on those days. This is determined by:
--Warfarin Medication NDC codes: BGPMU WARFARIN NDCS taxonomy.
--Anticoagulant Medications - VTE NDC codes: BGPMU ANTICOAG NDCS taxonomy.

AND

MU searches the LABORATORY DATA file for a list of INR values during the hospitalization. This is determined by:
--INR Laboratory Test Result LOINC codes: 34714-6, 38875-1, 46418-0, 52129-4, 6301-6.
--Anticoagulant Medications - VTE NDC codes: BGPMU ANTICOAG NDCS taxonomy.

AND

MU searches PRESCRIPTION, PHARMACY PATIENT, and V MED for an active prescription of overlap therapy on the discharge date. This is determined by:
--Anticoagulant Medications - VTE NDC codes: BGPMU ANTICOAG NDCS taxonomy.

To be included in the numerator, the patient must meet at least one of the following three conditions shown below.

1. The concurrent day count was 5 or more and the last INR was greater or equal to 2.

2. The concurrent day count was 5 or more and the last INR was less than 2 and the patient was discharged on overlap therapy.

3. The concurrent day count was less than 5 and the patient was discharged on overlap therapy.

        Exclusion Logic:

MU searches various files and excludes patient discharge records which have attributes which match any of the following criteria:

- Patients with age < 18, calculated as: Admission Date minus Birthdate.

- Patients who have a Length of Stay < 2 days, calculated as: Discharge Date/Time minus Admission Date/Time.

- Patients who have a Length of Stay > 120 days, calculated as: Discharge Date/Time minus Admission Date/Time.

- Patients with Comfort Measures Only documented in the PROBLEM List (active problems only) or during the visit in the V POV and V CPT file. This is determined by:
--Palliative Care Measures Only – ICD-9 code: V66.7
--Palliative Care Measures Only – CPT code: 1152F
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

- Patients enrolled in a Clinical Trial documented in the PROBLEM List (active problems only) or during the visit in the V POV file. This is determined by:
--ICD-9 code: V70.7
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

1.3.4   VTE UFH with Dosage/Platelet Count Monitoring by Protocol (VTE-4) NQF0374

Meaningful Use, Stage 1

Denominator

Number of inpatient discharges for patients with confirmed VTE receiving IV UFH therapy.

Numerator

Number of inpatient discharges for patients who have their IV UFH therapy dosages AND platelet counts monitored according to defined parameters such as a nomogram or protocol.

Exclusions

> Number of inpatient discharges for
> --Patients with Age < 18
> --Patients with Length of Stay > 120 Days
> --Patients with Comfort Measures Only
> --Patients enrolled in Clinical Trial
> --Patients without UFH Therapy Administration

--Patients without VTE confirmed by diagnostic testing

Definitions

Denominator Logic:

To be included in the denominator, the patient must meet ALL conditions shown below.

1. MU searches the TRANSACTION field in the PATIENT MOVEMENT file for transaction types of ADMISSION and DISCHARGE to identify inpatient discharges during the reporting period.

2. MU searches V POV for any diagnosis of VTE during the inpatient visit. This is determined by meeting the criteria for VTE confirmed and V POV modifier shown below:
--VTE Confirmed ICD-9 codes: 453.40-453.42, 453.50-453.52, 453.6, 453.71-453.79, 453.81-453.89.
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

3. MU searches PHARMACY PATIENT for patients receiving IV unfractionated heparin (UFH) therapy during the inpatient visit. UFH NDC codes are included in the BGPMU HEPAIN NDCS taxonomy.

Numerator Logic:

To be included in the numerator, the patient must meet ALL conditions shown below.

1. MU searches PHARMACY PATIENT for patients who have their IV unfractionated heparin therapy dosages monitored during the visit according to defined parameters such as a nomogram or protocol. This is determined by:
--Unfractionated Heparin Medication NDC codes: BGPMU HEPARIN NDCS taxonomy.

2. MU searches V LAB for patients who have their platelet counts monitored during the visit according to defined parameters such as a nomogram or protocol. This is determined by:
--Platelet Count Laboratory Test Result LOINC codes: 15201-7, 24317-0, 24361-8, 26515-7, 32207-3, 32623-1, 32712-2, 34167-7, 34527-2, 40741-1, 48386-7, 49497-1, 51632-8, 53800-9, 777-3, 778-1, 9317-9.

Exclusion Logic

MU searches various files and excludes patient discharge records which have attributes which match any of the following criteria:

- Patients with age < 18, calculated as: Admission Date minus Birthdate.

- Patients who have a Length of Stay < 2 days, calculated as: Discharge Date/Time minus Admission Date/Time.

- Patients who have a Length of Stay > 120 days, calculated as: Discharge Date/Time minus Admission Date/Time.

- Patients with Comfort Measures Only documented in the PROBLEM List (active problems only) or during the visit in the V POV and V CPT file. This is determined by:
--Palliative Care Measures Only – ICD-9 code: V66.7
--Palliative Care Measures Only – CPT code: 1152F
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

- Patients enrolled in a Clinical Trial documented in the PROBLEM List (active problems only) or during the visit in the V POV file. This is determined by:
--ICD-9 code: V70.7
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

- MU searches PRESCRIPTION, PHARMACY PATIENT, and V MED for patients without an unfractionated heparin therapy administration prescription active as of midnight on the day after visit discharge. This is determined by:
--Unfractionated Heparin Medication NDC codes: BGPMU HEPARIN NDCS taxonomy.

- MU searches V CPT and/or radiology orders for patients without VTE confirmed by diagnostic testing during the visit. This is determined by:
--VTE Diagnostic Test CPT codes: 35476, 71250 - 71275, 71550 - 71552, 73718 - 73720, 75741 - 75746, 75820 - 75822, 75825, 75827, 75945, 75946, 75952, 78456 - 78458, 78580 - 78594, 93922 - 93924, 93965 - 93971.

1.3.5   VTE Discharge Instructions (VTE-5) NQF0375

Meaningful Use, Stage 1

Denominator

Number of inpatient discharges for patients with confirmed VTE discharged on warfarin therapy.

Numerator

> Number of inpatient discharges for patients with documentation that they or their caregivers were given written discharge instructions or other educational material about warfarin that addressed all of the following:
> --compliance issues
> --dietary advice
> --follow-up monitoring

--potential for adverse drug reactions and interactions

Exclusions

> Number of inpatient discharges for
> --Patients with Age < 18
> --Patients with Length of Stay > 120 Days
> --Patients enrolled in Clinical Trial
> --Patients without Warfarin Prescribed at Discharge
>
> --Patients without VTE confirmed by diagnostic testing

Definitions

Denominator Logic:

> To be included in the denominator, the patient must meet ALL conditions shown below.

1. MU searches the TRANSACTION field in the PATIENT MOVEMENT file for transaction types of ADMISSION and DISCHARGE to identify inpatient discharges during the reporting period.

2. MU searches V POV for any diagnosis of VTE during the inpatient visit. This is determined by meeting the criteria for VTE confirmed and V POV modifier shown below:
--VTE Confirmed ICD-9 codes: 453.40-453.42, 453.50-453.52, 453.6, 453.71-453.79, 453.81-453.89.
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

3. MU searches V MEDICATION for patients with a warfarin prescription active as of midnight on the day after discharge. This is determined by:
-- Warfarin Medication NDC codes: BGPMU WARFARIN NDCS taxonomy.

4. MU searches PATIENT MOVEMENT for patients discharged to home care or self-care defined by Discharge Status-UB04 codes: 01 DISCHARGED HOME, 06 UNDER CARE OF HOME HEALTH ORG, 50 HOSPICE - HOME.

Numerator Logic:

MU searches V PATIENT ED to determine if patients or their caregivers were given educational material addressing all of the following:
--compliance issue
--dietary advice
--follow-up monitoring
--potential for adverse drug reactions and interactions

This is determined by TOPIC:
M-(any code) or any code with –M or –MEDICATION
-N or –NUTRITION or -MNT or –MEDICAL NUTRITION THERAPY

Exclusion Logic:

MU searches various files and excludes patient records which have attributes which match any of the following criteria:

- Patients with age < 18, calculated as: Admission Date minus Birthdate.

- Patients who have a Length of Stay > 120 days, calculated as: Discharge Date/Time minus Admission Date/Time.

- Patients enrolled in a Clinical Trial documented in the PROBLEM List (active problems only) or during the visit in the V POV file. This is determined by:
--ICD-9 code: V70.7
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

- MU searches PRESCRIPTION, PHARMACY PATIENT, and V MED for patients without a warfarin prescription active as of midnight on the day after visit discharge. This is determined by:
--Discharge Medication NDC codes: BGPMU WARFARIN NDCS taxonomy

- MU searches V CPT and/or radiology orders for patients without VTE confirmed by diagnostic testing during the visit. This is determined by:
-- VTE Diagnostic Test CPT codes: 35476, 71250 - 71275, 71550 - 71552, 73718 - 73720, 75741 - 75746, 75820 - 75822, 75825, 75827, 75945, 75946, 75952, 78456 - 78458, 78580 - 78594, 93922 - 93924, 93965 - 93971.

1.3.6   Incidence of Potentially-Preventable VTE (VTE-6) NQF0376

Meaningful Use, Stage 1

Denominator

Number of inpatient discharges for patients who developed confirmed VTE during hospitalization.

Numerator

Number of inpatient discharges for patients who received no VTE prophylaxis prior to the VTE diagnostic test order date.

Exclusions

Number of inpatient discharges for
--Patients with Age < 18
--Patients with Length of Stay > 120 Days
--Patients enrolled in Clinical Trial

--Patients with Comfort Measures Only documented

--Patients with VTE Present on Arrival

--Patients with reasons for not administering mechanical and pharmacologic prophylaxis

--Patients without VTE confirmed by diagnostic testing

Definitions

Denominator Logic:

To be included in the denominator, the patient must meet both conditions shown below.

1. MU searches the TRANSACTION field in the PATIENT MOVEMENT file for transaction types of ADMISSION and DISCHARGE to identify inpatient discharges during the reporting period.

2. MU searches V POV for patients who developed VTE during the inpatient visit. This is determined by meeting the criteria for VTE confirmed and V POV modifier shown below:
--VTE Confirmed ICD-9 codes: 453.40-453.42, 453.50-453.52, 453.6, 453.71-453.79, 453.81-453.89.
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious

Numerator Logic:

MU searches PHARMACY PATIENT file for patients who received no VTE prophylaxis prior to the VTE diagnostic test order date, calculated as: VTE Prophylaxis Date/Time greater than Arrival Date/Time AND VTE Prophylaxis Date/Time greater than or equal to VTE Diagnostic Test Order Date minus 1 day.

This is determined by:
-- VTE Diagnostic Test CPT codes: 35476, 71250 - 71275, 71550 - 71552, 73718 - 73720, 75741 - 75746, 75820 - 75822, 75825, 75827, 75945, 75946, 75952, 78456 - 78458, 78580 - 78594, 93922 - 93924, 93965 - 93971.

Exclusion Logic

MU searches various files and excludes patient records which have attributes which match any of the following criteria:

- Patients with age < 18, calculated as: Admission Date minus Birthdate.

- Patients who have a Length of Stay < 2 days, calculated as: Discharge Date/Time minus Admission Date/Time.

- Patients who have a Length of Stay > 120 days, calculated as: Discharge Date/Time minus Admission Date/Time.

- Patients with Comfort Measures Only documented in the PROBLEM List (active problems only) or during the visit in the V POV and V CPT file. This is determined by:
--Palliative Care Measures Only – ICD-9 code: V66.7
--Palliative Care Measures Only – CPT code: 1152F
--POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

- Patients enrolled in a Clinical Trial documented in the PROBLEM List (active problems only) or during the visit in the V POV file. This is determined by:
--ICD-9 code: V70.7
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

- MU searches V POV for patients with VTE present on visit arrival, calculated as: Problem/Diagnosis Date/Time less than or equal to Arrival Date/Time. This is determined by:
--VTE Confirmed ICD-9 codes: 453.40-453.42, 453.50-453.52, 453.6, 453.71-453.79, 453.81-453.89.
--VTE Suspected ICD-9 codes: 453.40-453.42, 453.50-453.52, 453.6, 453.71-453.79, 453.81-453.89.

- MU searches for both of the following during the visit:

1. MU searches PATIENT REFUSALS for refusal of VTE Prophylaxis. This is determined by:
--VTE Prophylaxis - Application of Mechanical Device ICD-9 code: 93.59
--VTE Prophylaxis - Application of Mechanical Device CPT code: E0676
--Refusal: REF or NMI refusal documented during the visit of any VTE prophylaxis medication included in taxonomy BGPMU VTE PROPHYLAXIS.

AND

2. MU searches V POV for reasons for not administering mechanical and pharmacologic prophylaxis. This is determined by:
--Reason for no VTE Prophylaxis – Mechanical ICD-9 codes: V49.70, V49.75, V49.76, V49.89, 443.9, 459.9, 897.6, 897.7, 959.7.
--Reason for no VTE Prophylaxis – Pharmacologic ICD-9 codes: 286.7, 286.9, 289.84, 431.2, 434.91, 459.0, 593.9, 790.99, 995.27.
--V POV Modifier, if present, is not equal to: C (Consider), D (Doubtful), M (Maybe, Possible, Perhaps), O (Rule Out), P (Probable) or S (Suspect, Suspicious)

- MU searches V CPT and/or radiology orders for patients without VTE confirmed by diagnostic testing during the visit. This is determined by:

--VTE Diagnostic Test CPT codes: 35476, 71250 - 71275, 71550 - 71552, 73718 - 73720, 75741 - 75746, 75820 - 75822, 75825, 75827, 75945, 75946, 75952, 78456 - 78458, 78580 - 78594, 93922 - 93924, 93965 - 93971.

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