NQF

NATIONAL QUALITY FORUM

EMERGENCY CARE

National Voluntary Consensus Standards for Emergency Care

A CONSENSUS REPORT

Foreword

EMERGENCY CARE IS AN INTEGRAL PART of the healthcare delivery system. But demand and capacity issues have contributed to increased patient wait time and decreased physician productivity, placing patients at risk for poor outcomes. The National Quality Forum (NQF) sought consensus on standardized measures of the performance of emergency care providers and systems that will effectively improve patient care and reduce healthcare costs.

At the request of the Centers for Medicare & Medicaid Services, NQF undertook a multiphase consensus project to identify and endorse a collection of emergency care measures addressing the quality of hospital-based emergency department (ED) care and continuing in-hospital services, with particular emphasis on clinical quality, coordination, and efficiency. As with other NQF consensus projects, a Steering Committee representing a variety of healthcare constituencies was convened to recommend specific measures and research priorities to NQF Members and ultimately the Consensus Standards Approval Committee for consideration under NQF's Consensus Development Process.

This three-chapter report presents the consensus standards and research recommendations related to ED transfers (Phase 1) and the consensus standards and research recommendations related to hospital-based ED care (Phase 2).

NQF thanks the members of the Emergency Care Steering Committee and NQF Members for their invaluable work in helping to improve the quality of emergency care in this country.

Janet M. Corrigan, PhD, MBA
President and Chief Executive Officer

National Quality Forum

The mission of the National Quality Forum is to improve the quality of American healthcare by setting national priorities and goals for performance improvement, endorsing national consensus standards for measuring and publicly reporting on performance, and promoting the attainment of national goals through education and outreach programs.

This work was conducted under contract from the Centers for Medicare & Medicaid Services (www.cms.gov).

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Permissions
National Quality Forum
601 13th Street NW
Suite 500 North
Washington, DC 20005
Fax 202-783-3434
www.qualityforum.org

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Executive Summary

EMERGENCY CARE IS AN INTEGRAL PART of the healthcare delivery system. Hospital emergency departments (EDs) account for about 10 percent of all ambulatory medical care visits in the United States. From 1994 to 2004, the number of annual ED visits increased from 93.4 million to 110.2 million visits, or 18.0 percent. Yet the number of hospital EDs in the United States decreased by about 12.4 percent during the same period. Demand and capacity issues have contributed to increased patient wait time and decreased physician productivity, which place patients at risk for poor outcomes.

In July 2007, at the request of the Centers for Medicare & Medicaid Services, the National Quality Forum (NQF) launched a new, multiphase project to address the quality of hospital-based ED care and transitions to in-hospital services and ambulatory care, with particular emphasis on clinical quality, coordination, and efficiency. As part of Phase 1, in November 2007 NQF endorsed 12 national voluntary consensus standards related to ED transfers. As part of Phase 2, in October 2008 NQF endorsed 10 additional national voluntary consensus standards that address timeliness, access, communication, care coordination, and efficiency in hospital-based EDs. This report presents the 22 endorsed national voluntary consensus standards for emergency care. The purpose of these voluntary consensus standards is to improve the quality of healthcare—through accountability and public reporting—by standardizing quality measurement in all emergency departments.

National Voluntary Consensus Standards for Emergency Care

- Aspirin at arrival
- Median time to fibrinolysis
- Fibrinolytic therapy received within 30 minutes of ED arrival
- Median time to ECG
- Median time to transfer to another facility for acute coronary intervention
- Administrative communication
- Patient information

- Vital signs
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Chapter 1: National Voluntary Consensus Standards for Emergency Care

Background

EMERGENCY CARE IS AN INTEGRAL PART of the healthcare delivery system. Hospital emergency departments (EDs) account for about 10 percent of all ambulatory medical care visits in the United States. From 1994 to 2004, the number of annual ED visits increased from 93.4 million to 110.2 million visits, or 18.0 percent.[1] Yet the number of hospital EDs in the United States decreased by about 12.4 percent during the same period. Demand and capacity issues have contributed to increased patient wait time and decreased physician productivity, which place patients at risk for poor outcomes.[2] The National Quality Forum (NQF) sought consensus on standardized measures of the performance of emergency care providers and systems that will effectively improve the care of patients and reduce the costs of healthcare.

At the request of the Centers for Medicare & Medicaid Services (CMS), NQF undertook a multiphase consensus project to identify and endorse a collection of emergency care measures that address the quality of hospital-based ED care and continuing in-hospital services (e.g., trauma services), with particular emphasis on clinical quality, coordination, and efficiency. As with other NQF consensus projects, a Steering Committee representing a variety of healthcare constituencies was convened to ensure that input was obtained from relevant stakeholders, to advise NQF staff on whether measures met the evaluation criteria, and to recommend specific measures and research priorities to NQF Members and ultimately to the Consensus Standards Approval Committee for consideration under the Consensus Development Process.

This report is organized into three chapters. This chapter summarizes the strategic issues that will guide current and future activities, defines the criteria for the evaluation of national voluntary consensus standards, describes the relationship of this set of measures to other NQF-endorsed® consensus standards, and presents an overview of the performance

measures endorsed for emergency care. Chapter 2 presents the consensus standards and research recommendations related to ED transfers (Phase 1), and Chapter 3 presents the consensus standards and research recommendations related to hospital-based ED care (Phase 2). The complete measure specifications for these 22 measures can be found in Appendix A. See Appendix B for the Emergency Care Steering Committees listings.

Strategic Directions for NQF

As NQF nears completion of its first decade, consideration of strategic issues to guide current and future activities has resulted in an expansion of NQF's mission to include three parts: 1) setting national priorities and goals for performance improvement; 2) endorsing national consensus standards for measuring and publicly reporting on performance; and 3) promoting the attainment of national goals through education and outreach programs. As greater numbers of quality measures are developed and brought to NQF for consideration, NQF must assist stakeholders in measuring "what makes a difference" and addressing what is important to achieve the best outcomes for patients and populations. An updated Measurement Framework, reviewed by NQF Members in December 2007, promotes shared accountability and measurement across episodes of care with a focus on outcomes and patient engagement in decisionmaking, coupled with measures of the healthcare process and cost/resource use. For more information, see www.qualityforum.org.

Several strategic issues have been identified to guide the consideration of candidate consensus standards:

DRIVE TOWARD HIGH PERFORMANCE. Over time, the bar of performance expectations should be raised to encourage the achievement of higher levels of system performance.

EMPHASIZE COMPOSITE MEASURES. Composite measures provide much-needed summary information pertaining to multiple dimensions of performance and are more comprehensible to patients and consumers.

MOVE TOWARD OUTCOME MEASUREMENT. Outcome measures provide information of keen interest to consumers and purchasers, and, when coupled with healthcare process measures, they provide useful and actionable information to providers. Outcome measures also focus attention on much-needed system-level improvements, because achieving the best patient outcomes often requires carefully designed care processes, teamwork, and coordinated action on the part of many providers.

FOCUS ON DISPARITIES IN ALL THAT WE DO. Some of the greatest performance gaps relate to care of minority populations. Particular attention should be focused on the most relevant race/ethnicity/language/socioeconomic strata to identify relevant measures for reporting.

NQF's Consensus Development Process

Evaluating Potential Consensus Standards

Candidate consensus standards were solicited through an open Call for Measures for Phases 1 and 2 in July 2007 and December 2007, respectively, and were actively sought by NQF staff through a search of the National Quality Measures Clearinghouse. The Steering Committee evaluated the candidate standards using its standard criteria of importance, scientific acceptability, usability, and feasibility. Please refer to www.qualityforum.org/about/leadership/measure_evaluation.asp.

Relationship to Other NQF-Endorsed Consensus Standards

This report does not represent the entire scope of NQF work relevant to emergency care. Rather, it relates specifically to hospital-based ED care. NQF has completed or is currently working on separate projects that also are relevant to the quality of care for ED patients (Appendix C).

In 2003, as part of *National Voluntary Consensus Standards for Hospital Care: An Initial Performance Measure Set,* several consensus standards were endorsed that assessed the quality of care of patients admitted to the hospital who may have been seen in the ED. Additionally, *National Voluntary Consensus Standards for Hospital Care: Specialty Clinician Performance Measures* and *National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures* presented endorsed consensus standards that will facilitate efforts to improve the quality of care delivered in the hospital and ambulatory settings in four areas, including seven measures specific to care delivered in the ED (see Appendix C).

The full constellation of consensus standards, along with those endorsed in this report, provide a growing number of NQF-endorsed voluntary consensus standards that directly and indirectly reflect the importance of measuring and improving the quality of care in the ED. Organizations that adopt these consensus standards will promote the development of safer and higher-quality care for patients throughout the nation.

NQF-Endorsed Voluntary Consensus Standards for Emergency Care

Overview

This report presents 22 consensus standards for emergency care. The purpose of these consensus standards is to improve the quality of healthcare—through accountability and public reporting—by standardizing quality measurement in hospital-based EDs. All NQF-endorsed measures are fully disclosed and available for

use by any interested party. The emergency care consensus standards are intended for use at various levels of analysis, as indicated for each measure in this report. Levels of analysis vary from individual practitioner (e.g., physicians, midwives, and nurses) to small and large provider groups, to hospitals. Implementing organizations should decide rules of attribution, sample size requirements, and statistical significance based on the characteristics and goals of the measurement program.

References

1 McCaig LF, Nawar EN, National Hospital Ambulatory Medical Care Survey: 2004 emergency department summary, *Adv Data,* 2006;372:1-29, Hyattsville, MD: National Center for Health Statistics, p. 2.

2 Derlet RW, Richards JR, Overcrowding in the nation's emergency departments: complex causes and disturbing effects, *Ann Emerg Med,* 2000;35(1):63-68.

Chapter 2: National Voluntary Consensus Standards for Emergency Care—Phase 1: Emergency Department Transfer Measures

Introduction

THIS CHAPTER PRESENTS A SET OF 12 ENDORSED national voluntary consensus standards (Table 1) for emergency department (ED) transfer care in the topic areas of acute myocardial infarction (AMI) and ED communication; it also presents recommendations for further research and measure development.

These standards address the emergency care provided to patients who are transferred from an ED to another acute care hospital or ED (Phase 1). The endorsed ED transfer measures were adapted from the *National Voluntary Consensus Standards for Hospital Care: An Initial Performance Measure Set* to examine the quality of emergency care in settings that were not included in the hospital care consensus standards (i.e., small and rural hospitals).

An NQF Steering Committee established the initial approach to evaluating potential consensus standards. This approach included defining a specific purpose and scope for the performance measures and screening candidate consensus standards through the application of standardized evaluation criteria.

This set of voluntary consensus standards for ED transfers may be used to:

- evaluate the performance of an ED in providing care to patients who are transferred to another acute care hospital or ED as it relates to the Institute of Medicine's aims for healthcare quality (safety, benefit, patient-centeredness, timeliness, efficiency, equity)[i];
- improve ED care (e.g., patient safety, healthcare outcomes, patient satisfaction);

[i] The NQF Board of Directors has adopted the term "beneficial" as an alternative to the term "effective" used in the Institute of Medicine 2001 report *Crossing the Quality Chasm: A New Health System for the 21st Century.*

- serve as a mechanism for public accountability, including the selection and incentive-based reward of high-performing facilities, by supplying stakeholders with information that will enable them to better understand the quality of ED care;
- identify priority areas for needed research related to ED performance; and
- facilitate the benchmarking and sharing of best practices among ED transfer care providers.

The ED transfer measure set encompasses measures that:

- are fully open source or in the public domain;
- are structure, process, or outcome measures;
- can be fully developed for use (e.g., research and testing have been completed); and
- address ED transfers to another acute care hospital or ED, especially in the following areas: AMI, heart failure, pneumonia, respiratory compromise, and surgical/trauma conditions.

Because of limitations in the measures available for review, the endorsed measure set does not fill all of the quality measurement areas needed. The selection of consensus standards was guided by the measures' conformity with the phase's stated scope, priorities, and the standardized evaluation criteria of importance, scientific acceptability, feasibility, and usability and with the following characteristics:

- measures intended for accountability, as a driver of quality improvement;
- measures that address vulnerable populations;
- measures that address all relevant populations;
- measures that consider possible perverse incentives or unintended consequences;
- measures with clear and complete specifications;
- measures that have been pilot tested or are already in use; and
- measures that address high variation, including overuse and underuse.

Table 1: National Voluntary Consensus Standards for Emergency Care—Phase 1: Emergency Department Transfer Measures

ACUTE MYOCARDIAL INFARCTION

MEASURE TITLE	MEASURE ID[a]	MEASURE DESCRIPTION AND REVIEW NUMBER[b]	LEVEL OF ANALYSIS	IP OWNER(S)[c]
Aspirin at arrival	0286	Percentage of ED AMI or Chest Pain (with *Probable Cardiac Chest Pain*) adult (≥18 years old) patients without aspirin contraindications who received aspirin within 24 hours before ED arrival or administered prior to transfer (1)	Facility	CMS
Median time to fibrinolysis	0287	Median time (in minutes) from ED arrival to administration of fibrinolytic therapy in AMI adult (≥18 years old) patients with ST-segment elevation or LBBB on the ECG performed closest to ED arrival and prior to transfer (2)	Facility	CMS
Fibrinolytic therapy received within 30 minutes of ED arrival	0288	Percentage of ED AMI adult (≥18 years old) patients with ST-segment elevation or LBBB on the ECG whose time from ED arrival to fibrinolysis is 30 minutes or less (3)	Facility	CMS
Median time to ECG	0289	Median time (in minutes) from ED arrival to ECG (performed in the ED prior to transfer) for AMI or chest pain patients (with *Probable Cardiac Chest Pain*) (4)	Facility	CMS
Median time to transfer to another facility for acute coronary intervention	0290	Median time (in minutes) from ED arrival to transfer to another facility for acute coronary intervention (5)	Facility	CMS

more

[a] Upon NQF endorsement, each measure receives a unique NQF measure ID number.

[b] Review number.

[c] IP owner(s)—intellectual property owner(s) and copyright holder(s). For the most current specifications and supporting information, please refer to the IP owner(s):
CMS - Centers for Medicare & Medicaid Services (www.cms.hhs.gov)
UMRHRC - University of Minnesota Rural Health Research Center (www.hpm.umn.edu/rhrc)

Table 1: National Voluntary Consensus Standards for Emergency Care—Phase 1: Emergency Department Transfer Measures

ED COMMUNICATION

MEASURE TITLE	MEASURE ID[a]	MEASURE DESCRIPTION AND REVIEW NUMBER[b]	LEVEL OF ANALYSIS	IP OWNER(S)[c]
Administrative communication	0291	Percentage of patients transferred to another acute care hospital whose medical record documentation indicated that administrative information was communicated to the receiving hospital within 60 minutes of departure (6)	Facility	UMRHRC
Patient information	0294	Percentage of patients transferred to another acute care hospital whose medical record documentation indicated that patient information was communicated to the receiving hospital within 60 minutes of departure (7)	Facility	UMRHRC
Vital signs	0292	Percentage of patients transferred to another acute care hospital whose medical record documentation indicated that the entire vital signs record was communicated to the receiving hospital within 60 minutes of departure (8)	Facility	UMRHRC
Medication information	0293	Percentage of patients transferred to another acute care hospital whose medical record documentation indicated that medical information was communicated to the receiving hospital within 60 minutes of departure (9)	Facility	UMRHRC
Physician information	0295	Percentage of patients transferred to another acute care hospital whose medical record documentation indicated that physician information was communicated to the receiving hospital within 60 minutes of departure (10)	Facility	UMRHRC

more

Table 1: National Voluntary Consensus Standards for Emergency Care—Phase 1: Emergency Department Transfer Measures

ED COMMUNICATION

MEASURE TITLE	MEASURE ID[a]	MEASURE DESCRIPTION AND REVIEW NUMBER[b]	LEVEL OF ANALYSIS	IP OWNER(S)[c]
Nursing information	0296	Percentage of patients transferred to another acute care hospital whose medical record documentation indicated that nursing information was communicated to the receiving hospital within 60 minutes of departure (11)	Facility	UMRHRC
Procedures and tests	0297	Percentage of patients transferred to another acute care hospital whose medical record documentation indicated that procedure and test information was communicated to the receiving hospital within 60 minutes of departure (12)	Facility	UMRHRC

Endorsed Measures

The Centers for Medicare & Medicaid Services (CMS) submitted five measures regarding ED care and transport. Some of the measures simply remove transport as an exclusion from the existing hospital measures to allow for measurement of the care that is provided by the originating hospital prior to transport.

0286[ii] **Aspirin on arrival**

(CMS) *1*[iii]

Steering Committee members agreed that the intent of the measure was good, but they were concerned about the inclusion of atypical chest pain and chest pain as data elements. After discussing the rationale for the inclusion with the measure developer, the Steering Committee recommended the measure for endorsement if the measure inclusion criteria were modified to remove atypical chest pain and chest pain.

[ii] NQF measure ID number.

[iii] Review number.

0287 **Median time to fibrinolysis**
(CMS) *2*

The Steering Committee recommended the measure based on the clinical evidence.

0288 **Fibrinolytic therapy received within 30 minutes of arrival**
(CMS) *3*

The Steering Committee recommended the measure based on the clinical evidence.

0289 **Median time to ECG**
(CMS) *4*

The Steering Committee and measure developer agreed that although there is no scientific evidence that provides guidance for when an electrocardiogram (ECG) should be administered, sooner is better than later to determine treatment. The Steering Committee discussed the replacement of ECG administration with ECG interpretation in the performance measure. However, the measure developer provided feedback from data collection that indicated that the time of physician interpretation may not always be in the medical record. A Steering Committee member suggested that the time the physician reads the ECG should be documented, but other Steering Committee members pointed out that not all EDs have physicians on duty. An additional concern in the timing of ECG administration is that a patient may initially present with abdominal symptoms that turn out to be cardiac in nature. The measure developer stated that the measure is designed to diminish the impact of outliers by using the median time.

0290 **Median time to transfer to another facility for acute coronary intervention**
(CMS) *5*

During its August 17, 2007, conference call, the Steering Committee did not initially recommend this measure because of concerns regarding system issues related to transfers. Although the Steering Committee agreed with the intent of the measure—getting the patient to appropriate care as soon as possible—it identified issues believed to be out of the control of the hospital that needed to be addressed, such as the availability of the appropriate transport, distances between facilities, and weather delays. Also of concern was the fact that a hospital sometimes hands off to a helicopter team that may take 30 minutes before taking off. Some Steering Committee members in support of the measure believed it should be for ST-elevation myocardial infarctions (STEMIs) only.

Several reviewers strongly supported reconsideration of this measure. They believed that the measure could help transform the care of AMI in rural areas and is based on sound clinical evidence. Although Steering Committee members agreed with the clinical evidence supporting the measure, much of their concern regarding "median time to transfer to another facility for acute coronary intervention" was based on holding the transferring hospital accountable for factors out of its control. Subsequently, the measure developer clarified

the intent of the measure to be to examine the time the patient arrives in Hospital A's ED to the time the patient is transferred from Hospital A, not to the time the patient arrives in Hospital B. Based on this information, the Steering Committee recommended endorsing the measure with the following modifications:

- clarify the intent of the measure;
- limit the population to STEMI patients; and
- stratify results by elapsed time.

The Steering Committee also suggested revising the measure title to convey the intent of the measure (e.g., Median Time from ED Arrival to ED Departure for Transfer to Another Facility for Acute Coronary Intervention). The Steering Committee also cautioned against reporting at the individual hospital level when examining time to transfer from Hospital A to Hospital B.

291-297 **ED Communication**
(UMRHRC) *6-10*

The University of Minnesota Rural Health Research Center submitted seven measures that concern communication during transports. Although these measures were designed to be standalone, they share the same denominator, and general discussions were held on the set of measures en bloc. The Steering Committee believed that the measure set examines an important concept. The issue of the burden of data collection was discussed, and it was noted that automation would reduce this burden. One Steering Committee member noted that his hospital currently successfully collects this patient and clinical information pertinent to the transport by using additional questions and different levels of detail. It also was noted that although these data are captured as part of Emergency Medical Treatment and Active Labor Act requirements, this measure provides more specific collection elements.

A Steering Committee member questioned the inter-rater reliability (IRR) of such data collection. The measure developer provided feedback from field testing that showed good IRR. Another Steering Committee member raised concerns regarding the feasibility of implementing the measure with the included Emergency Room Transfer tool. The measure developer noted that the tool was not a requirement of the measure and had only been provided as an example of how data were collected during field testing. Discussion ensued regarding the use of the term "physician," because physicians are not onsite in many facilities. Another Steering Committee member recommended the inclusion of Glasgow Scores for all patients. Suggested modifications to the measures were to change "physician" to "practitioner" and to drop the APGAR score as currently stated (for all patients under 28 days) because it would not be appropriate in many cases. The measure developer stated that it was already considering dropping the APGAR based on continued feedback.

Some reviewers recommended using patient date of birth, as opposed to age, as a unique identifier. The measure developer commented that the measure was developed based on the insurance, demographic, and discharge code options used in the current CMS tools. Demographic information was collected using the standard CMS format. To ensure consistent

interpretation, the Steering Committee and measure developer agreed to change "age" to "date of birth."

Some reviewers requested clarification of the Vital Signs measure—specifically whether the first vital signs are sought at the outside institution or the last vital signs are sought prior to departure. Additionally, it was suggested that the Glasgow Coma Scale should be used for "head trauma patients," not "trauma patients" in general: Occasionally, an isolated extremity fracture must be transferred. The measure developer and Steering Committee agreed that all vital sign information (including vital signs from the transfer) should be included in the transfer documents. The measure developer also commented that the measure does not specify the timing of sending the vital signs. An alternative is that the hospital vital sign flow sheet be sent forward. It was agreed that the measure developer would provide clarification of this issue in the data abstraction definitions document. The measure developer and Steering Committee agreed that although it is valuable to measure vital signs prior to departure, assigning a time element is difficult. Additionally, the Steering Committee and measure developer agreed that the Glasgow Coma Scale is important for all trauma patients and often is factored into a trauma score. It also was noted that oxygen saturations are routinely conducted and represent good patient care.

A few reviewers believed that the Procedures and Tests measure could be improved with a more definite specification. It was suggested that the results of many lab tests may not be available at the time of transfer. The measure does not address how this situation would be accounted for. Receiving institutions want to receive patients as soon as possible; however, the measure might delay transfers by creating an incentive to hold patients until the results are available, or within 60 minutes of transfer. The measure developer and Steering Committee agreed that the results for certain laboratory tests (e.g., erythrocyte sedimentation rate, B-type natriuretic peptide) or certain studies (computer tomography scans, magnetic resonance imaging, ventilation-perfusion scans ["VQ"]) may not be available within 60 minutes and that patient transfer should not be delayed. The results can be called or faxed to the receiving hospital as soon as they are available. The measure developer has included the results as an abstraction option.

Recommendations

NQF offers the following recommendations for further research and measure development:

Gaps in Quality Measures for ED Transfer Care

Measures should be developed to close the gaps in quality measurement that exist in the following areas of ED transfers:

- assessment of the quality of care within the receiving institution;
- additional perfusion markers (beyond fibrinolysis);
- first door to balloon time; and
- consideration of the prehospital care provided by initial responders.

Data Stratification

- Stratify data by payer, separating private insurance from noncommercial payer sources.

Chapter 3: National Voluntary Consensus Standards for Emergency Care—Phase 2: Hospital-Based Emergency Department Care Measures

Introduction

IN PHASE 2 OF THIS PROJECT, NQF identified and endorsed measures for public accountability that address quality of hospital-based emergency department (ED) care, with particular emphasis on clinical quality, coordination, and efficiency.

This chapter presents 10 additional consensus standards suitable for the clinician and/or facility level of analysis (Table 2) in the following areas:

- safety and effectiveness of emergency care;
- efficient management of ED patient flow throughout the hospital and beyond, including patient throughput, wait time, overcrowding, boarding, and diversions;
- coordination of care and communication (including health information technology) among all providers/departments regarding an ED encounter;
- appropriateness of care, including the use of technology and imaging;
- outcomes, including complications of emergency care;
- care of children and adolescents; and
- care of vulnerable populations, including racial/ethnic minorities and Medicaid patients and patients in rural settings.

This chapter also presents recommendations for further measure research and development.

Table 2: National Voluntary Consensus Standards for Emergency Care—Phase 2: Hospital-Based Emergency Department Care Measures

MEASURE TITLE	MEASURE ID[a]	MEASURE DESCRIPTION AND REVIEW NUMBER[b]	LEVEL OF ANALYSIS	IP OWNER(S)[c]
Median time from ED arrival to ED departure for admitted ED patients*	0495	Median time from ED arrival to time of departure from the ED for patients admitted to the facility from the ED (ED-001-08)	Facility	CMS
Median time from ED arrival to ED departure for discharged ED patients*	0496	Median time from ED arrival to time of departure from the ED for patients discharged from the ED (ED-002-08)	Facility	CMS
Admit decision time to ED departure time for admitted patients*	0497	Median time from admit decision time to time of departure from the ED for ED patients admitted to inpatient status (ED-003-08)	Facility	CMS
Door to provider*	0498	Time of first contact in the ED to the time when the patient sees the physician (provider) for the first time (ED-005-08)	Facility	LSUHCSD
Left without being seen	0499	Percentage of patients leaving without being seen by a physician (ED-006-08)	Facility	LSUHCSD

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*Time-limited endorsement.

[a] Upon NQF endorsement, each measure receives a unique NQF measure ID number.

[b] Review number.

[c] IP owner(s)—intellectual property owner(s) and copyright holder(s). For the most current specifications and supporting information, please refer to the IP owner(s):

AAP - American Academy of Pediatrics (www.aap.org)

ACEP - American College of Emergency Physicians (www.acep.org)

CCF - Cleveland Clinic Foundation (http://my.clevelandclinic.org)

CMS - Centers for Medicare & Medicaid Services (www.cms.hhs.gov)

HFH - Henry Ford Hospital (www.henryford.com/homepage_hfh.cfm?id=37471)

LSUHCSD - Louisiana State University Health Care Services Division (www.lsuhospitals.org)

Table 2: National Voluntary Consensus Standards for Emergency Care—Phase 2: Hospital-Based Emergency Department Care Measures

MEASURE TITLE	MEASURE ID[a]	MEASURE DESCRIPTION AND REVIEW NUMBER[b]	LEVEL OF ANALYSIS	IP OWNER(S)[c]
Severe sepsis and septic shock: management bundle*	0500	Initial steps in the management of the patient presenting with infection (severe sepsis or septic shock) (ED-009-08)	Clinician	HFH
Confirmation of endotracheal tube placement*	0501	Any time an endotracheal tube is placed into an airway in the ED or an endotracheal tube is placed by an outside provider and that patient arrives already intubated (emergency medical services [EMS] or hospital transfer) or when an airway is placed after patient arrives in the ED, there should be some method attempted to confirm ETT placement (ED-013-08)	Facility or clinician	CCF
Pregnancy test for female abdominal pain patients*	0502	Percentage of women, ages 14–50 years, who present to the ED with a chief complaint of abdominal pain who have a pregnancy test (urine or serum) ordered in the ED (ED-018-08)	Facility, clinician, or group	ACEP
Anticoagulation for acute pulmonary embolus patients*	0503	Percentage of patients newly diagnosed with a pulmonary embolus in the ED or referred to the ED with a new diagnosis of pulmonary embolus who have orders for anticoagulation (heparin or low molecular weight heparin) for pulmonary embolus while in the ED (ED-019-08)	Facility, clinician, or group	ACEP
Pediatric weight in kilograms*	0504	Percentage of ED patients ≤13 years of age with a current weight in kilograms documented in the ED record (ED-020-08)	Facility, clinician, or group	AAP

Endorsed Measures

0495[i] Median time from ED arrival to ED departure for admitted ED patients

(CMS) *ED-001-08*[ii]

The Steering Committee noted that examining the median time from ED arrival to ED departure for admitted ED patients is important for assessing the prevalence of long patient stays in the ED. Evidence suggests that for patients with non-ST-segment-elevation myocardial infarction, long ED stays were associated with a decreased use of guideline-recommended therapies and a higher risk of recurrent myocardial infarction.[1] Additionally, 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.[2,3] Data from the 2003 National Hospital Ambulatory Medical Care (NHAMC) survey indicated that the median boarding time (e.g., time spent waiting for an inpatient bed to become available) was 160 minutes, and 58 percent of admitted patients boarded for more than 4 hours in the ED. Additionally, African American race, metropolitan statistical area, and for-profit status of the hospital were associated with prolonged ED boarding times.[4] Steering Committee members identified the feasibility of collecting this measure via electronic means as a strength of the measure. However, the Steering Committee believed that the measure lacked granularity and required more clarity.

To better understand the dynamics of boarding in the ED, the Steering Committee recommended that the measure be stratified as follows:

- global score;
- psychiatric population; and
- all others (includes nonpsychiatric population).

The Steering Committee discussed the fact that excessive wait times for psychiatric patients resulting from the lack of psychiatric services in the ED may skew performance results. In 2003, the U.S. Government Accounting Office reported that of 1,201 U.S. hospitals surveyed, 32 percent of them experienced problems with on-call physician specialty coverage in the ED in the area of psychiatry.[5] The Steering Committee accepted the measure developer's recommendation to stratify the measure as follows:

- global score (median time from ED arrival to ED departure—inpatient bill);
- psychiatric population;
- patients formally admitted to observation; and
- all others (includes nonpsychiatric populations, nontransfers, and nonobservation).

The measure developer noted that only the "all others" strata should be used for accountability. Additionally, the Steering Committee believed that there was no clear reason to exclude patients under 18 years of age, and it

[i] NQF measure ID number.
[ii] Review number.

suggested modifying the inclusion criteria to capture this population. The measure developer agreed to include all age groups. The Steering Committee also recommended that the measure developer exclude ED-based observation patients to preclude unintended consequences such as overcrowding that could result from boarding patients, as well as freestanding ED patients because of the potential difficulty in tracking them through multiple collection systems. The measure developer responded that freestanding ED patients cannot be excluded from this measure because of constraints associated with CMS's billing methodology. CMS is developing guidance to ensure that care received in freestanding EDs is accurately reflected. The measure developer clarified that when a patient's status is changed to observation or when the patient departs the ED, the time spent in the ED stops. The Steering Committee accepted this change.

Finally, the Steering Committee recommended changing the measure title to Median Time from ED Arrival to ED Departure for *Non-discharged* Patients. Nondischarged patients were defined as patients physically moved to areas outside the ED. The measure developer noted that CMS separates performance measures into two manuals[iii]: Hospital Inpatient and Hospital Outpatient. Measures in the inpatient manual include only those for patients who are admitted to the hospital. Measures in the outpatient manual include only those for patients who do not have an inpatient stay. Inpatient/outpatient status is determined through billing. The measure developer did not agree with changing the title, because the term *nondischarged* would create confusion. The Steering Committee accepted the rationale for maintaining the original title.

0496 **Median time from ED arrival to ED departure for discharged ED patients**

(CMS) *ED-002-08*

The Steering Committee noted that examining the median time from ED arrival to ED departure for discharged ED patients is important for assessing delays in delivering care in the ED. Evidence suggests that for patients with non-ST-segment-elevation myocardial infarction, long ED stays were associated with a decreased use of guideline-recommended therapies and a higher risk of recurrent myocardial infarction.[6] Data from the 2003 NHAMC survey indicated that the duration of 67.5 percent of ED visits was between one and six hours. On average, patients spent 3.2 hours in the ED.[7] Committee members identified the feasibility of collecting data for this measure and the shared responsibility for discharged patients between the facility and medical personnel as strengths of this measure.

To better understand the dynamics of boarding in the ED, the Steering Committee recommended that the measure be stratified as follows:

- psychiatric population;
- ED-based observation;
- patients who were transferred; and
- all others (includes nonpsychiatric population, nonobservation, and nontransfers).

[iii] See www.qualitynet.org.

The Committee discussed the fact that psychiatric and transferred patients may experience excessive wait times in the ED, which could skew performance results. The Steering Committee accepted the measure developer's recommendation to stratify the measure as follows:

- global score (median time of ED arrival to ED departure—no inpatient bill);
- psychiatric population;
- patients formally admitted to observation;
- patients who were transferred; and
- all others (includes nonpsychiatric population, nonobservation, and nontransfers).

The measure developer noted that only the "all others" strata should be used for accountability. Additionally, the Steering Committee believed that there was no clear reason to exclude patients under 18 years of age, and it suggested modifying the inclusion criteria to capture this population. The measure developer agreed to include all age groups.

0497 **Admit decision time to ED departure time for admitted patients**

(CMS) *ED-003-08*

Reducing the time that admitted patients remain in the ED can improve access to treatment and increase the quality of care.[8] The Steering Committee noted the importance of examining the median time from the admit decision time to the time of departure from the ED for patients admitted to inpatient status. A proxy for ED crowding includes the proportion and lengths of time patients remain in the ED after the decision to admit.[9] Studies have shown that boarding patients in the ED (instead of prompt admissions) can lead to longer hospital lengths of stay.[10,11] Reducing the time between the decision to admit and the patient's departure from the ED will improve access to care specific to the patient's condition and will increase the capability of facilities to provide additional treatment. Steering Committee members noted the ease in understanding the implications of the performance results of this measure. To better understand the dynamics of boarding in the ED, the Steering Committee recommended that the measure be stratified as follows:

- psychiatric population;
- patients who were transferred; and
- all others (includes nonpsychiatric population and nontransfers).

The Committee discussed the fact that psychiatric patients may experience excessive wait times in the ED, which could skew performance results. The Steering Committee accepted the measure developer's recommendation to stratify the measure as follows:

- global score (median time of ED arrival to ED departure—inpatient bill);
- psychiatric population;
- patients formally admitted to observation; and
- all others (nonpsychiatric, nontransfers, and nonobservation).

The measure developer noted that only the "all others" strata will be used for accountability. Additionally, the Steering Committee believed that there was no clear reason to exclude patients under 18 years of age, and it

suggested modifying the inclusion criteria to capture this population. The measure developer agreed to include all age groups. The Steering Committee also recommended that the measure developer exclude ED-based observation patients to preclude unintended consequences such as overcrowding because of the potential difficulty in tracking these patients through multiple collection systems. As previously noted, freestanding ED patients cannot be excluded because of constraints associated with CMS's billing methodology.

0498 **Door to provider**

(LSUHCSD) *ED-005-08*

The Steering Committee noted that measuring the time of first contact in the ED as the time when the patient first sees the physician (provider) is important and related to quality. Data from the 2003 NHAMC survey indicated that the median waiting room time was 27 minutes, and 57 percent of patients waited more than 30 minutes to see a provider. Additionally, African American race, female sex, metropolitan statistical area, and for-profit status of the hospital were associated with prolonged wait time to be seen by a provider (more than 30 minutes).[12] The measure developer provided data from 8 hospitals for the most recent 12 months in which the median time from triage or registration (whichever comes first) to the time first seen by a provider ranged from 65 minutes to 173 minutes, with an average of 132 minutes. The measure developer noted that the benchmark established by Karpiel Consulting Group was 45 minutes.[13] The Steering Committee supported the face validity of the measure for patient satisfaction. The Steering Committee also commented that the measure was actionable and could feasibly be incorporated into an ED tracking system. The Steering Committee initially recommended that the measure title be changed to Door to Diagnostic Evaluation by a Qualified Medical Personnel, because it believed that the measure should include not only physicians but also nurses and other staff. During its follow-up conference call, the Steering Committee discussed the interpretability of the term "qualified medical personnel." The Steering Committee considered it necessary to clarify which type of personnel should be included. The Steering Committee concluded that the title should remain Door to Provider, because a provider is defined as a person who can initiate a diagnostic evaluation or therapeutic plan (e.g., medical student, resident, nurse practitioner), excluding triage personnel. It was also suggested that the timing be defined as first documentation of contact with the provider. The intent of the Steering Committee was not to exclude personnel, but rather to highlight those most directly accountable. The Steering Committee also recommended stratifying the performance results by facility E&M code level to assess acuity and to reduce the potential for gaming (e.g., false-positive level 5). The measure developer modified the measure according to the Steering Committee's recommendations.

0499 **Left without being seen**

(LSUHCSD) *ED-006-08*

The Steering Committee noted that examining the number of patients who leave the ED without being seen was useful in assessing access

issues, which can result from the bottleneck created by overcrowding. The measure developer provided data from 8 hospitals for the most recent 12 months. The percentage of patients who left without being seen ranged from 3 percent to 16 percent, with an average of 8.5 percent. The measure developer noted that the benchmark was 1.25 percent. The Steering Committee recommended that the measure be used in conjunction with ED-001-08, ED-002-08, and ED-003-08 to determine why patients leave the ED. The Steering Committee initially suggested that the numerator be revised to read as "number of patients leaving without being seen (LWBS) by a qualified medical personnel." It was suggested that LWBS be defined as "time of arrival to initiation of contact with qualified medical personnel." During its follow-up conference call, the Steering Committee discussed the interpretability of the term "qualified medical personnel." The Steering Committee considered it necessary to clarify which type of personnel should be included. The Steering Committee recommended that LWBS be defined as "time of arrival to initiation of contact with a provider (e.g., medical student, resident, nurse practitioner)." Additionally, the Steering Committee recommended stratifying the performance results by triage level. The measure developer modified the specifications according to the Steering Committee's recommendations.

Overarching Issues

During the NQF Member and public comment period, several reviewers noted that the demands placed on EDs differ according to the communities that they serve. EDs in hospitals in large, urban areas likely have more demand, and thus longer patient wait times, than EDs in smaller communities. Triaging patients in large and busy EDs is more challenging than triaging patients in EDs located in areas with small patient populations. The commenters recommended that if these measures are to be publicly reported, they should be adjusted to reflect the different levels of demand faced by different hospital EDs, as well as the varying hospital characteristics (e.g., patient acuity, teaching status). The Steering Committee and measure developers recognized that there are numerous methods to "stratify" reporting of these performance measures by the number of licensed beds in the hospital or by some criteria of ED annual visit volume. However, they could not reach consensus on the best way to do so. The Steering Committee and measure developers agreed that further stratification should be conducted to assess various hospital characteristics (e.g., teaching status, urban versus rural, acuity, and facility infrastructure). Appropriate comparisons can be determined from the results of time-limited endorsement. The Steering Committee also recommended that ED-001-08, ED-002-08, ED-003-08, ED-005-08, and ED-006-08 be reported together to provide consumers and other stakeholders with actionable, distinguishable data on ED timeliness and performance.

0500 **Severe sepsis and septic shock: management bundle**

(HFH) *ED-009-08*

The Steering Committee believed that this measure would have a very high impact on improving the care of sepsis in the ED. Research has shown that sepsis affects almost

1 million adults per year in the United States and is associated with more than 210,000 deaths annually.[14] Rivers et al. have shown that absolute and relative reductions in mortality from sepsis can be reduced by 16 percent and 30 percent, respectively, when aggressive care is provided within 6 hours of hospital arrival.[15] Initially, the Steering Committee voiced multiple concerns about this measure, including taking accountability away from the intensive care unit (ICU), burden of data collection, and difficulties in determining the diagnosis.

The measure developer explained that resuscitation has been shown to have the greatest impact on decreasing mortality, and it remains the strongest recommendation of the American College of Emergency Physicians (ACEP), which contributes to the Surviving Sepsis Campaign recommendations. The evidence for resuscitation is far stronger than the evidence for antibiotic administration and appropriate cultures in decreasing mortality. Although the recommendation for corticosteroid use has been downgraded by a recent trial, it remains recommended in vasopressor-dependent patients who have been given adequate resuscitation after eight hours of aggressive resuscitation. In keeping with this eight-hour window, there should be a 13.8 percent reduction in vasopressor and corticosteroid use if early goal-directed therapy is provided. Many of these patients will be in the ICU at this stage; therefore, the measure is not mandatory but highly recommended. The measure developer further noted that if the intent of quality measures is to improve the outcomes of patients who present with severe sepsis and septic shock, hemodynamic optimization or some form of hemodynamic optimization should be part of this ED quality measure. Research has shown that a life can be saved in one out of every six patients presenting with severe sepsis and septic shock. In addition to reducing mortality, hemodynamic optimization has resulted in a decrease in health resource consumption, which has been shown in community hospitals of various sizes and in tertiary care hospitals. Finally, the measure developer responded that sepsis management is a hospital-wide initiative; EDs should be encouraged to collaborate with other departments within the hospital in order to provide best practices, as is done with stroke, trauma, and acute myocardial infarction.

The Steering Committee believed that the measure developer's response was compelling, and it noted the importance of measuring quality in this area and the need for evidence-based measures. The Steering Committee members discussed the feasibility of collecting all of the data elements (e.g., assessing time and physiologic levels) recommended for this measure. Many of the members thought that data collection would be burdensome. As previously stated, the Steering Committee believed that the measure may shift responsibility from the ICU and the hospital to the ED, which could result in more ICU patients staying longer in the ED and more interventions being done in the ED. To this end, the Steering Committee recommended that the numerator be defined as the "number of patients who had orders for measurement of lactate clearance, broad spectrum antibiotic(s), blood, urine, and appropriate culture, and fluids." Additionally, the denominator should be defined as the "number of patients diagnosed in the ED with sepsis." The measure developer accepted the Steering Committee's recommendation.

0501 **Confirmation of endotracheal tube placement**

(CCF) *ED-013-08*

The Steering Committee agreed that this is an important measure addressing patient safety. Research suggests a higher risk of failed airway for patients who arrive via emergency medical services. ACEP's *Verification of Endotracheal Tube (ETT) Placement* policy statement recommends that verification of ETT be completed in all intubated patients and that reconfirmation of ETT position be performed for all patients when their clinical status changes or when there is any concern about proper tube replacement.[16] The Steering Committee believed that data collection for this measure would be burdensome because of its dependence on medical record review and that processes for collecting the data may need to be developed in each individual ED. The Steering Committee and measure developer agreed that administrative claims need to be developed to confirm and document ETT. Some Steering Committee members believed that there was not enough evidence to prove the existence of a quality issue. The Steering Committee agreed that this measure would promote the reduction of adverse events associated with incorrect ETT placement, and it recommended that the measure developer specify the ETT type and define the type of evaluation. The measure developer noted in its response that the physician must confirm and document ETT placement for 1) all ETTs placed during the course of treatment and 2) all ETTs placed outside the ED (EMS and outside hospital transfers). Only three techniques would be suitable, and their use would depend on clinical circumstances: 1) capnometry, 2) esophageal detection devices, and 3) revisualization with direct laryngoscopy. The measure developer revised the numerator statement to read as "all patients with ET tube placement secondarily confirmed, i.e., patients who are intubated in the ED and patients who arrived intubated who have ET tube secondarily confirmed by: 1) capnometry, 2) esophageal detection devices, and 3) revisualization with direct laryngoscopy." The denominator statement was revised to read as "all patients with ET tubes, i.e., those ET tubes placed by ED physician or other allied health professional and patients who arrived with ET tube already in place (i.e., placed by EMS or outside hospital personnel) who are managed in the ED." The Steering Committee suggested modification of the numerator to read as "…confirmed by: 1) capnometry, 2) esophageal detection devices, *and/or* 3) revisualization with direct laryngoscopy."

0502 **Pregnancy test for female abdominal pain patients**

(ACEP) *ED-018-08*

Ectopic or tubal pregnancy may be missed if the physician fails to consider the possibility of pregnancy. Patient history and physical examination are unreliable determinants of pregnancy. The rapid and readily available assays that detect the presence of human chorionic gonadotropin (hCG) are very sensitive. ACEP's clinical policy, *Critical Issues for the Initial Evaluation and Management of Patients Presenting with a Chief Complaint of Nontraumatic Acute Abdominal Pain,* states that women of childbearing age presenting to

the ED with abdominal pain should receive a urine test for pregnancy.[17] The Steering Committee supported this measure as addressing a critical area of patient safety, with some variations in care and racial disparities documented. The Steering Committee noted that data collection for this measure might be seen as burdensome because of the necessity to manually obtain information on diagnosis, age, and menopausal status for each patient. The Steering Committee recommended The Joint Commission's sampling methodology as a means to reduce this burden.[18] The measure developer accepted the use of sampling to report this measure. Additionally, the Steering Committee and the measure developer recognized that CPT II codes would need to be developed to capture the data relating to the denominator exclusions from claims. In the meantime, the data would be documented from the medical record or the electronic health record, where available.

0503 **Anticoagulation for acute pulmonary embolus patients**

(ACEP) *ED-019-08*

It is estimated that as many as 600,000 episodes of pulmonary embolism occur annually in the United States, resulting in 100,000 to 200,000 deaths.[19,20] The *Antithrombotic Therapy for Venous Thromboembolic Disease: The Seventh ACCP Conference on Antithrombotic and Thrombolytic Therapy* recommends IV unfractionated heparin or low molecular weight heparin for the initial treatment of pulmonary embolism.[21] The Steering Committee believed that this measure addressed a very important aspect of care and was highly feasible and usable. The definitive diagnosis of pulmonary embolism among the population was a noted strength of the measure. The Steering Committee does not expect 100 percent compliance with the measure because of potential contraindications. Additionally, the Steering Committee and the measure developer recognized that CPT II codes would need to be developed to capture the data relating to the denominator exclusions from claims. In the meantime, the data would be documented from the medical record or the electronic health record, where available.

0504 **Pediatric weight in kilograms**

(AAP) *ED-020-08*

Given that all pediatric medication dosages are based on weight in kilograms, accurate and safe administration of medications to children necessitates that a current weight in kilograms be documented in the ED record. Research shows that the potential for adverse drug events in the pediatric inpatient population is about three times as high as that in the hospitalized adult population.[22] Additionally, a study found an 11.1 percent rate of adverse drug events in pediatric patients. The study also showed that 22 percent of those adverse drug events could have been prevented, 17.8 percent could have been identified earlier, and 16.8 percent could have been mitigated more effectively.[23] The Joint Commission supports the implementation of this measure to prevent pediatric medication errors and their related adverse events in pediatric care settings.

The Steering Committee agreed that this measure is important and usable and would certainly encourage change. However, the

Steering Committee noted that data collection for the measure might be seen as burdensome because of the necessity to record a weight for every patient. The Steering Committee recommended using The Joint Commission's sampling methodology to reduce this burden.[24] The measure developer noted that children who are both admitted and discharged will be sampled. The Steering Committee also suggested modifying the numerator to include weight estimation based on Broselow tape or 50th percentile for age to allow for patients for whom weight cannot be measured (e.g., unconsciousness or uncooperative patients) and decreasing the age criterion to 13 to align with other pediatric measure initiatives. The measure developer accepted the outlined conditions.

During the follow-up conference call, the Steering Committee discussed the importance of assessing the total time patients spend in the ED. The Steering Committee strongly encouraged that the following measures be implemented together: ED-001-08, ED-002-08, ED-003-08, ED-005-08, and ED-006-08. These measures will allow an ED to comprehensively assess issues of timeliness, access, communication, care coordination, and efficiency.

Measures Not Endorsed

INPATIENT ADMISSION (LSUHCSD) *ED-004-08*

This measure examined the time from first contact in the ED to when the patient first sees the physician (provider). This time period is viewed as important because it is when the patient may leave without being seen. The Steering Committee believed that this measure did not assess the quality of care in the ED because of the varying types of patients seen. The Steering Committee noted that the measure could be routinely collected and that it could be used as part of a cohort stratification methodology for comparing EDs. Ultimately, the Steering Committee concluded that this measure would serve well as an internal hospital quality improvement initiative rather than for hospital comparison to assess the intensity or severity of the condition of its ED patients.

ED LENGTH OF STAY (LSUHCSD) *ED-007-08*

This measure examined the mean time between patient presentation to the ED and departure from the ED via admission, discharge, or transfer. The Steering Committee believed that the measure is easy to collect and addresses an important safety issue but lacks granularity. Ultimately, the Steering Committee concluded that the patient population and the intent of the measure were subsumed by measures ED-001-08, ED-002-08, and ED-003-08 and, therefore, did not recommend the measure for endorsement.

QUANTIFIABLE COMPUTER PROBABILITY ASSESSMENT TO REDUCE TESTING IN HEALTHY PATIENTS WITH CHIEF COMPLAINTS OF CHEST PAIN OR SHORTNESS OF BREATH (PREtest Consult, LLC) *ED-008-08*

This measure addressed the subject of healthy ED patients with chief complaints of chest pain or shortness of breath who received one or more multivariate analyses using a quantifiable computer probability assessment. Although the concept is important and the measure would be useful in examining cost containment, it is not supported by a sufficient evidence base.

Additionally, the measure was deemed to have low feasibility because of the required use of proprietary software to implement the measure and low usability resulting from the potential for variation in the interpretation of the results. The Steering Committee would prefer to see greater use of the measure before recommending it for endorsement.

SEVERE SEPSIS HOSPITAL SURVIVAL (HFH) *ED-010-08*

The Steering Committee agreed with the importance of the clinical area being addressed, but it believed that there are too many other factors involved in the survival of sepsis patients beyond the ED. The Steering Committee concluded that this measure would serve well as a measure of overall quality of the hospital.

PERCENTAGE OF PATIENTS WITH CHEST PAIN SYMPTOMS IN ED RECEIVING EARLY THERAPY INCLUDING IV, OXYGEN, NITROGLYCERIN, MORPHINE, AND A CHEWABLE ASPIRIN ON ARRIVAL (Institute for Clinical Systems Improvement [ICSI]) *ED-014-08*

The Steering Committee agreed that this measure requires further external, scientific evidence to show that these specific processes (e.g., chewable versus nonchewable aspirin) improve outcomes. Additionally, the Steering Committee believed that the numerator and the denominator were imprecisely specified. As specified, the measure may lead to inappropriate care. The Steering Committee also noted a burden associated with collecting data for the measure. The Steering Committee recommended that the measure developer revise the measure to assess 10 minute time to ECG for all ST-segment-elevation myocardial infarction patients, which would coincide with Outpatient Prospective Payment System measures for transferring hospitals. The Steering Committee's recommendations were forwarded to the measure developer following the in-person meeting. The measure developer was unable to act on the Steering Committee's feedback and to modify the measure at this time. The measure developer conveyed its interest in endorsement and noted that when its internal workgroup reconvenes, this measure will be evaluated.

PERCENTAGE OF PATIENTS WITH AMI RECEIVING THROMBOLYTICS WITH A "DOOR-TO-DRUG TIME" (TIME TO PRESENTATION TO ADMINISTRATION OF DRUG) OF LESS THAN 30 MINUTES (ICSI) *ED-015-08*

The Steering Committee stated that this measure is already captured by the currently endorsed NQF measure Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival, from Phase 1 of this project and the National Voluntary Consensus Standards for Hospital Care project.

MEDICAID ENCOUNTER DATA DRIVEN IMPROVEMENT CORE MEASURE SET (MEDDIC-MS) ASTHMA EMERGENCY DEPARTMENT CARE (WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES [WDHFS]) *ED-011-08*

MEDDIC-MS EMERGENCY DEPARTMENT CARE FOR DIABETES (WDHFS) *ED-012-08*

MEDDIC-MS FOR SOCIAL SECURITY INCOME (MEDDIC-MS SSI) ASTHMA EMERGENCY DEPARTMENT CARE (WDHFS) *ED-016-08*

MEDDIC-MS SSI EMERGENCY DEPARTMENT CARE FOR DIABETES (WDHFS) *ED-017-08*

Steering Committee members strongly agreed that these measures address important aspects of care, but they did not believe that these

measures assess the quality of ED care. The Steering Committee noted that the measures would be critical in assessing care coordination, Medicaid access, and outpatient follow-up. The Steering Committee also recommended better specifying the look-back period and incorporating ED-016-08 and ED-017-08 into ED-011-08 and ED-012-08, respectively, as a composite.

Recommendations

NQF offers the following recommendations for further measure research and development:

- Develop a measure that examines the diagnosis of sepsis at any point in the hospital system.
- Explore the prevention, diagnosis, and treatment of sepsis in the context of premature rupture of membranes in pregnant women.
- Develop a measure that examines the frequency of adverse events and airway failures associated with endotracheal tube placement.
- Develop a measure that examines ED readmission within seven days.
- Conduct further research to examine the effectiveness across healthcare facilities of using quantifiable computer probability assessment to reduce testing in healthy patients with chief complaints of chest pain or shortness of breath across healthcare facilities (ED-008-08).
- Examine quality issues associated with the unavailability of proper consult in the ED.
- Develop measures that assess regional diversion as part of a prehospital quality initiative (e.g., examine disparity between ED facility/staff capacity and demand on ED).
- Develop a standardized definition of diversion (e.g., EMS defines diversion if waiting is more than 30 minutes; hospital creates diversion because of overcrowding).
- Consider cohort stratification when examining ED quality (e.g., case-mix, hospital type, and patient conditions).
- Develop measures that examines ED medication error rates (e.g., management of emergent blood pressure [BP] in the ED in association with acute time-sensitive conditions and management of urgent/emergent BP that can be safely managed in the ED and the patient discharged home with additional follow-up).
- To ensure harmonization, an interdisciplinary group rather than condition-specific groups should examine special conditions (outcomes) that address multiple settings of care and/or specialty areas.
- Examine resource use (e.g., diagnostic imaging services) and decision-making in the ED.
- Examine the availability of appropriate interpreter language services in the ED.
- Establish an ED quality framework based on the aims of safe, beneficial, patient-centered, timely, efficient, and equitable healthcare to identify existing and needed ED measures.
- Create incentives to perpetuate the development of regional and/or community-wide metrics.
- Develop a measure that examines the utilization of ultrasound for central line placements in the ED.
- Develop a measure that examines the management of the febrile neonate or immunocompromised child.

- Develop measures that address the prompt diagnosis of ectopic pregnancy, the provision of accurate information about all recommended treatment options, and prompt treatment.
- Develop measures to explore hand-off/transition of care issues associated with high alert medications (e.g., anticoagulants).
- Develop a measure that examines the percentage of female victims of sexual assault who are offered and provided emergency contraception without delay.

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Appendix A
Specifications of the National Voluntary Consensus Standards for Emergency Care—Phase 1

THE FOLLOWING TABLE PRESENTS the detailed specifications for each of the National Quality Forum (NQF)-endorsed® *National Voluntary Consensus Standards for Emergency Care—Phase 1: Emergency Department Transfer Measures.* All information presented has been derived directly from measure sources/developers without modification or alteration (except when the measure developer agreed to such modification during the NQF Consensus Development Process [CDP]) and is current as of November 2007. All NQF-endorsed voluntary consensus standards are open source, meaning they are fully accessible and disclosed.

ACUTE MYOCARDIAL INFARCTION

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Aspirin at arrival	Measure ID #: 0286 Review #: 1	CMS	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.	Emergency Department AMI or Chest Pain patients (with *Probable Cardiac Chest Pain*) without aspirin contraindications. Included Populations: ▌ ICD-9-CM Principal or Other Diagnosis Code for AMI as defined in Appendix A1, OP Table 6.1, or an ICD-9-CM Principal or Other Diagnosis Code for Angina, Acute Coronary Syndrome, or Chest Pain as defined in Appendix A1, OP Table 6.1a, with *Probable Cardiac Chest Pain,* and ▌ E/M Code for emergency department encounter as defined in Appendix A1, Table 1.0a, and ▌ Patients discharged/transferred to a short-term general hospital for inpatient care, to a Federal healthcare facility, or to a Critical Access Hospital.	▌ Patients less than 18 years of age ▌ Patients with a *Contraindication to Aspirin* as defined in the Appendix A1.	Administrative and medical record data.

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[a] IP owner(s)—intellectual property owner(s) and copyright holder(s). For the most current specifications and supporting information, please refer to the IP owner(s):
CMS - Centers for Medicare & Medicaid Services (www.cms.gov)
UMRHRC - University of Minnesota Rural Health Research Center (www.hpm.umn.edu/rhrc/)

ACUTE MYOCARDIAL INFARCTION

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Median time to fibrinolysis	Measure ID #: 0287 Review #: 2	CMS	**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 ICD-9-CM Principal Diagnosis Code for AMI as defined in Appendix A1, OP Table 6.1, and ▌ An E/M Code for emergency department encounter as defined in Appendix A1, OP Table 1.0a, and ▌ ST-segment elevation or LBBB on the ECG performed closest to ED arrival, and ▌ *Fibrinolytic Administration* as defined in Appendix A1, and ▌ Patients discharged/transferred to a short-term general hospital for inpatient care, to a Federal healthcare facility, or to a Critical Access Hospital.		▌ 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 Appendix A1.	Administrative and medical record data.

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ACUTE MYOCARDIAL INFARCTION

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Fibrinolytic therapy received within 30 minutes of ED arrival	Measure ID #: 0288 Review #: 3	CMS	Emergency Department AMI patients whose time from ED arrival to fibrinolysis is 30 minutes or less.	Emergency Department AMI patients with ST-segment elevation or LBBB on the ECG who received fibrinolytic therapy. Included Populations: ▌ An ICD-9-CM Principal Diagnosis Code for AMI as defined in Appendix A1, OP Table 6.1, and ▌ An E/M Code for emergency department visit as defined in Appendix A1, OP Table 1.0a, and ▌ ST-segment elevation or LBBB on the ECG performed closest to ED arrival, and ▌ *Fibrinolytic Administration* as defined in Appendix Al, and ▌ Patients discharged/transferred to a short-term general hospital for inpatient care, to a Federal healthcare facility, or to a Critical Access Hospital.	▌ Patients less than 18 years of age ▌ Patients who did not receive *Fibrinolytic Administration* as defined in Appendix Al and had a *Reason for Delay in Fibrinolytic Therapy* as defined in Appendix Al.	Administrative and medical record data.

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ACUTE MYOCARDIAL INFARCTION

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Median time to ECG	Measure ID #: 0289 Review #: 4	CMS	**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*). Included Populations: ▌ ICD-9-CM Principal or Other Diagnosis Code for AMI as defined in Appendix A1, OP Table 6.1, or an ICD-9-CM Principal or Other Diagnosis Code for Angina, Acute Coronary Syndrome, or Chest Pain as defined in Appendix A1, OP Table 6.1a, and ▌ E/M Code for emergency department encounter as defined in Appendix A1, OP Table 1.0a, and ▌ Patients receiving an ECG as defined in Appendix A1, and ▌ Patients discharged/transferred to a short-term general hospital for inpatient care, to a Federal healthcare facility, or to a Critical Access Hospital.		▌ Patients less than 18 years of age.	Administrative and medical record data.
Median time to transfer to another facility for acute coronary intervention	Measure ID #: 0290 Review #: 5	CMS	**Continuous Variable Statement:** Time (in minutes) from emergency department arrival to transfer to another facility for acute coronary intervention. Included Populations: ▌ ICD-9-CM Principal Diagnosis Code for AMI as defined in Appendix A1, OP Table 6.1, and ▌ E/M Code for emergency department encounter as defined in Appendix A, OP Table 1.0a, and ▌ Patients discharged/transferred to a short-term general hospital for inpatient care, to a Federal healthcare facility, or to a Critical Access Hospital, and ▌ Patients not receiving *Fibrinolytic Administration* as defined in the Data Dictionary, and ▌ Patients with *Transfer for Acute Coronary Intervention* as defined in the Data Dictionary.		▌ Patients less than 18 years of age ▌ Patients receiving *Fibrinolytic Administration* as defined in the Data Dictionary.	Administrative and medical record data.

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ED COMMUNICATION

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Administrative communication	Measure ID #: 0291 Review #: 6	UMRHRC	Percentage of patients transferred to another acute hospital whose medical record documentation indicated that administrative information was communicated to the receiving hospital within 60 minutes of departure ▌ Nurse communication with receiving hospitals ▌ Practitioner communication with receiving practitioner or transfer coordinator.	All emergency department patients who are transferred to another acute care hospital.	None.	Medical record data, Paper medical record, Electronic Health Record (EHR).
Patient information	Measure ID #: 0294 Review #: 7	UMRHRC	Percentage of patients transferred to another acute hospital whose medical record documentation indicated that patient information was communicated to the receiving hospital within 60 minutes of departure ▌ Patient name ▌ Address ▌ Date of birth ▌ Gender ▌ Significant other contact information ▌ Health insurance information.	All emergency department patients who are transferred to another acute care hospital.	None.	Medical record data, Paper medical record, EHR.

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ED COMMUNICATION

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Vital signs	Measure ID #: 0292 Review #: 8	UMRHRC	Percentage of patients transferred to another acute hospital whose medical record documentation indicated that the entire vital signs record was communicated to the receiving hospital within 60 minutes of departure. ▌ Pulse ▌ Respiratory rate ▌ Blood pressure ▌ Oxygen saturation ▌ Temperature ▌ Glasgow score (where appropriate).	All emergency department patients who are transferred to another acute care hospital.	None.	Medical record data, Paper medical record, EHR.
Medication information	Measure ID #: 0293 Review #: 9	UMRHRC	Percentage of patients transferred to another acute hospital whose medical record documentation indicated that medication information was communicated to the receiving hospital within 60 minutes of departure ▌ Documentation regarding medication history ▌ Allergies ▌ Medications given (MAR).	All emergency department patients who are transferred to another acute care hospital.	None.	Medical record data, Paper medical record, EHR.

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ED COMMUNICATION

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[a]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Physician information	Measure ID #: 0295 Review #: 10	UMRHRC	Percentage of patients transferred to another acute hospital whose medical record documentation indicated that physician information was communicated to the receiving hospital within 60 minutes of departure ▌ Physician or practitioner history and physical ▌ Physician or practitioner orders and plan.	All emergency department patients who are transferred to another acute care hospital.	None.	Medical record data, Paper medical record, EHR.
Nursing information	Measure ID #: 0296 Review #: 11	UMRHRC	Percentage of patients transferred to another acute hospital whose medical record documentation indicated that nursing information was communicated to the receiving hospital within 60 minutes of departure ▌ Assessments/intervention/response ▌ Impairments ▌ Catheters ▌ Immobilizations ▌ Respiratory support ▌ Oral limitations.	All emergency department patients who are transferred to another acute care hospital.	None.	Medical record data, Paper medical record, EHR.
Procedures and tests	Measure ID #: 0297 Review #: 12	UMRHRC	Percentage of patients transferred to another acute hospital whose medical record documentation indicated that procedure and test information was communicated to the receiving hospital within 60 minutes of departure ▌ Tests and procedures done ▌ Tests and procedure results sent	All emergency department patients who are transferred to another acute care hospital.	None.	Medical record data, Paper medical record, EHR.

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Specifications of the National Voluntary Consensus Standards for Emergency Care—Phase 2

THE FOLLOWING TABLE PRESENTS the detailed specifications for the NQF-endorsed *National Voluntary Consensus Standards for Emergency Care—Phase 2: Hospital-Based Emergency Department Care Measures.* All information presented has been derived directly from measure sources/developers without modification or alteration (except when the measure developer agreed to such modification during the NQF CDP) and is current as of December 2008. All NQF-endorsed voluntary consensus standards are open source, meaning they are fully accessible and disclosed.

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[b]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Median time from ED arrival to ED departure for admitted ED patients*	Measure ID #: 0495 Review #: ED-001-08	CMS	Time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the ED. Report the following strata for the measure: ▌ global score (median time ED arrival to ED departure—inpatient bill); ▌ psychiatric population; ▌ patients formally admitted to observation; and ▌ all others (includes nonpsychiatric populations, nontransfers, and nonobservation). See Appendix A3.		None.	Medical Record, Laboratory.
Median time from ED arrival to ED departure for discharged ED patients*	Measure ID #: 0496 Review #: ED-002-08	CMS	Time (in minutes) from ED arrival to ED departure for patients discharged from the ED. Report the following strata for the measure: ▌ global score (median time ED arrival to ED departure—no inpatient bill); ▌ psychiatric population; ▌ patients formally admitted to observation; ▌ patients who were transferred; and ▌ all others (includes nonpsychiatric population, nonobservation, and nontransfers). See Appendix A3.		Patients who expired in the ED.	Medical Record, Administrative Claims Data, Laboratory.

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* Time-limited endorsement.

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AAP - American Academy of Pediatrics (www.aap.org)
ACEP - American College of Emergency Physicians (www.acep.org)
CCF - Cleveland Clinic Foundation (http://my.clevelandclinic.org)
CMS - Centers for Medicare & Medicaid Services (www.cms.hhs.gov)
HFH - Henry Ford Hospital (www.henryfordhealth.org/homepage_hfh.cfm?id=37471)
LSUHCSD - Louisiana State University Health Care Services Division (www.lsuhospitals.org)

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[b]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Admit decision time to ED departure time for admitted patients*	Measure ID #: 0497 Review #: ED-003-08	CMS	Time (in minutes) from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status. Report the following strata for the measure: ▌ global score (median time ED arrival to ED departure—inpatient bill); ▌ psychiatric population; ▌ patients formally admitted to observation; and ▌ all others (not psychiatric population, nontransfers, and nonobservation). See Appendix A3.		None.	Medical Record, Laboratory.
Door to provider*	Measure ID #: 0498 Review #: ED-005-08	LSUHCSD	Mean time between patient presentation to the ED and the first moment the patient is seen by a person who can initiate a diagnostic evaluation or therapeutic plan (e.g., medical student, resident, nurse practitioner) (excludes triage personnel). Report the following strata for the measure: ▌ Facility E&M code level.		No exclusions except to note: patients not seen, patients with presumed dirty data (numerator <0 or >1440).	Administrative Claims Data, Observational Data.
Left without being seen	Measure ID #: 0499 Review #: ED-006-08	LSUHCSD	Sum of all patients not seen by a provider (e.g., medical student, resident, nurse practitioner). Report the following strata for the measure: ▌ Triage level.	Sum of all patients triaged.	None.	Administrative Claims Data, Observational Data.
Severe sepsis and septic shock: management bundle*	Measure ID #: 0500 Review #: ED-009-08	HFH	Number of patients who meet criteria for severe sepsis and septic who had orders for: 1. Blood, urine and appropriate cultures, 2. Broad spectrum antibiotic(s), 3. Fluids, and 4. Measurement of lactate clearance.	Number of patients diagnosed in the ED with severe sepsis and septic shock.	Patients who do not have the clinical evidence of an infection (severe sepsis or septic shock).	Medical Record, Pharmacy, Clinical Database, Laboratory, EHR, Data Collection Instrument, Observational Data.

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MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[b]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Confirmation of endotracheal tube placement*	Measure ID #: 0501 Review #: ED-013-08	CCF	All patients with Endotracheal Tube (ETT) placement secondarily confirmed, i.e., patients who are intubated in the ED and patients who arrived intubated who have ET tube secondarily confirmed by: 1. capnometry, 2. esophageal detection devices, and/or 3. revisualization with direct laryngoscopy.	All patients with ET Tubes, i.e., those ET tubes placed by ED physician or other allied health professional and patients who arrived with ET tube already in place (i.e., placed by EMS or outside hospital personnel) who are managed in the ED.	None.	Medical Record, Administrative Claims Data.
Pregnancy test for female abdominal pain patients*	Measure ID #: 0502 Review #: ED-018-08	ACEP	Number of patients in the denominator who have a pregnancy test (urine or serum) ordered in the ED.	All women, ages 14-50 years old, who present to the ED with a chief complaint of abdominal pain. Denominator Coding: CPT E/M service codes: 99281, 99282, 99283, 99284, 99285, 99291 ICD-9 diagnosis codes: 789.	i. Females for whom pregnancy is already documented or reported (verbal report by patient is acceptable) ii. Females with documented or reported hysterectomy (verbal report by patient is acceptable) iii. Females documented or reported to be post-menopausal (verbal report by patient is acceptable) iv. Patient refusal v. Patients who do not complete their ED evaluation (Left before completion, Left AMA, etc.).	Medical Record, Administrative Claims Data, EHR.

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MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)[b]	NUMERATOR	DENOMINATOR	EXCLUSIONS	DATA SOURCE
Anticoagulation for acute pulmonary embolus patients*	Measure ID #: 0503 Review #: ED-019-08	ACEP	Number of patients in the denominator who have orders for anticoagulation (heparin or low-molecular weight heparin) for pulmonary embolus while in the ED.	i. All patients newly diagnosed with a pulmonary embolus in the ED ii. All patients referred to the ED with a new diagnosis of pulmonary embolus. CPT E/M service codes: 99281, 99282, 99283, 99284, 99285, 99291 ICD-9 diagnosis codes: 415.19.	i. Patients already adequately anticoagulated (orally or parenterally) ii. Patients with contraindication to anticoagulation iii. Patients deemed inappropriate anticoagulation candidates (e.g., hospice patients, cardiac arrest) iv. Patients for whom further consultation is necessary prior to the possible initiation of anticoagulation. v. Patients who are admitted from the ED with ED LOS less than 30 minutes from time of confirmed diagnosis vi. Patient refusal vii. Patients who do not complete their ED evaluation (Left before completion, Left AMA, etc.).	Medical Record, Administrative Claims Data, EHR.
Pediatric weight in kilograms*	Measure ID #: 0504 Review #: ED-020-08	AAP	Number of emergency department patients <13 years of age with a current weight in kilograms documented (measured or estimated based on Broselow tape or 50th percentile for age) in the ED record.	Number of emergency department patients <13 years of age; reporting timeframe is monthly.	None.	Medical Record, EHR.

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Appendix A1. Data Elements and Tables for ED Transfer Measures 0286 – 0290

Measure Information Form

Measure Set: Hospital Outpatient Department Measures

Measure ID#: 0286

Outpatient Setting: Emergency Department

Service Type: Not applicable

Performance Measure Name: Aspirin at Arrival

Description: Emergency Department acute myocardial infarction (AMI) patients or chest pain patients (with *Probable Cardiac Chest Pain*) without aspirin contraindications who received aspirin within 24 hours before ED arrival or prior to transfer.

Rationale: The early use of aspirin in patients with acute myocardial infarction 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). Despite these recommendations, aspirin remains under-utilized in eligible older patients hospitalized with AMI (Jencks, 2000).

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*) without aspirin contraindications

Included Populations:
- *ICD-9-CM Principal or Other Diagnosis Code* for AMI as defined in Appendix A, OP Table 6.1, or an *ICD-9-CM Principal or Other Diagnosis Code* for Angina, Acute Coronary Syndrome, or Chest Pain as defined in Appendix A, OP Table 6.1a, with *Probable Cardiac Chest Pain, and*
- E/M Code for emergency department encounter as defined in Appendix A, Table 1.0a, and
- Patients discharged/transferred to a short term general hospital for inpatient care, to a Federal healthcare facility, or to a Critical Access Hospital.

Excluded Populations:
- Patients less than 18 years of age
- Patients with a *Contraindication to Aspirin* as defined in the Data Dictionary

Data Elements:
- *Birthdate*
- *Contraindication to Aspirin*

- *Discharge Status*
- *E/M Code*
- *ICD-9-CM Other Diagnosis Code*
- *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.

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.
- Braunwald E, Antman EM, Beasley JW, Califf RM, Cheitlin MD, Hochman JS, Jones RH, Kereiakes D, Kupersmith J, Levin TN, Pepline CJ, Schaeffer JW, Smith EE III, Steward DE, Theroux P. ACC/AHA 2002 guideline update for the management of patients with unstable angina and non-ST-segment elevation myocardial infarction: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee on the Management of Patients with Unstable Angina). 2002. Available at http://www.acc.org/qualityandscience/clinical/guidelines/unstable/update_index.htm.
- Krumholz HM, Anderson JL, Brooks NH, Fesmir 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.
- Randomized trial of intravenous streptokinase, oral aspirin, both or neither among 17,187 cases of suspected acute myocardial infarction: ISIS-2. ISIS-2 (Second International Study of Infarct Survival) Collaborative Group. *Lancet*. 1988 Aug 13;2(8607):349-60.
- Jencks SJ, Cuerdon 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;284:1670-76.
- 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.

Measure Information Form

Measure Set: Hospital Outpatient Department Measures

Measure ID#: 0287

Outpatient Setting: Emergency Department

Service Type: Not applicable

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 1000 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 *ICD-9-CM Principal Diagnosis Code* for AMI as defined in Appendix A, OP Table 6.1, and
- An E/M Code for emergency department encounter as defined in Appendix A, OP Table 1.0a, and
- ST-segment elevation or LBBB on the ECG performed closest to ED arrival, and
- *Fibrinolytic Administration* as defined in the Data Dictionary, and
- Patients discharged/transferred to a short-term general hospital for inpatient care, to a Federal healthcare facility, or to a Critical Access Hospital.

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*
- *ED Arrival Time*
- *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-8). 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:

- 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.
- Jencks SJ, Cuerdon 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; 284:1670-76.
- Krumholz HM, Anderson JL, Brooks NH, Fesmir 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.

Measure Information Form

Measure Set: Hospital Outpatient Department Measures

Measure ID#: 0288

Outpatient Setting: Emergency Department

Service Type: Not applicable

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 1000 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:

- *ED Arrival Time*
- *Fibrinolytic Administration*
- *Fibrinolytic Administration Date and Time*

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

Included Populations:

- An *ICD-9-CM Principal Diagnosis Code* for AMI as defined in Appendix A, OP Table 6.1, and
- An E/M Code for emergency department visit as defined in Appendix A, OP Table 1.0a, and
- ST-segment elevation or LBBB on the ECG performed closest to ED arrival, and
- *Fibrinolytic Administration* as defined in the Data Dictionary, and
- Patients discharged/transferred to a short term general hospital for inpatient care, to a Federal healthcare facility, or to a Critical Access Hospital.

Excluded Populations:

- Patients less than 18 years of age
- Patients who did not receive *Fibrinolytic Administration* as defined in the Data Dictionary 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*
- *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 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-7). 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, Fesmir 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.

Measure Information Form

Measure Set: Hospital Outpatient Department Measures

Measure ID#: 0289

Outpatient Setting: Emergency Department

Service Type: Not applicable

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 (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 identification of ST-segment elevation myocardial infarction (Antman 2004). The diagnosis and management of ST-segment elevation myocardial infarction (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 acute myocardial infarction (AMI) or Chest Pain patients (with *Probable Cardiac Chest Pain*)

Included Populations:
- *ICD-9-CM Principal or Other Diagnosis Code* for AMI as defined in Appendix A, OP Table 6.1 or an *ICD-9-CM Principal or Other Diagnosis Code* for Angina, Acute Coronary Syndrome, or Chest Pain as defined in Appendix A, OP Table 6.1a, and
- E/M Code for emergency department encounter as defined in Appendix A, OP Table 1.0a, and
- Patients receiving an *ECG* as defined in the Data Dictionary, and
- Patients discharged/transferred to a short term general hospital for inpatient care, to a Federal healthcare facility, or to a Critical Access Hospital.

Excluded Populations:
- Patients less than 18 years of age

Data Elements:
- *Birthdate*
- *Discharge Status*
- *E/M Code*
- *ECG*
- *ECG Date and Time*
- *ED Arrival Time*
- *ICD-9-CM Other Diagnosis Code*
- *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.

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, Fesmir 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.

Measure Information Form

Measure Set: Hospital Outpatient Department Measures

Measure ID #: 0290

Outpatient Setting: Emergency Department

Service Type: Not applicable

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 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 percutaneous coronary intervention (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:
- *ICD-9-CM Principal Diagnosis Code* for AMI as defined in Appendix A, OP Table 6.1, and
- E/M Code for emergency department encounter as defined in Appendix A, OP Table 1.0a, and
- Patients discharged/transferred to a short-term general hospital for inpatient care, to a Federal healthcare facility, or to a Critical Access Hospital, and
- Patients not receiving *Fibrinolytic Administration* as defined in the Data Dictionary, 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:
- *Birthdate*
- *Discharge Date and Time*
- *Discharge Status*
- *E/M Code*
- *ED Arrival Time*
- *Fibrinolytic Administration*
- *ICD-9-CM Principal Diagnosis Code*
- *Outpatient Encounter Date*
- *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, Cuerdon 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, Fesmir 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.

Data Element Name: *Aspirin Received*

Collected For: **Measure – 0286**

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 reduces the risk of having a heart attack and improves chances of surviving 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:

- When unable to determine for certain whether aspirin was received within 24 hours prior to emergency department arrival (e.g., last dose noted as 02-27-2007 and patient arrived at emergency department on 02-28-2007 at 09:00), select "No."

Exceptions:

- 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:

- Ambulance record
- Emergency Department record

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendix C, OP Table 6.1 for a comprehensive list of Aspirin and Aspirin-Containing Medications.	None

Data Element Name: *Contraindication to Aspirin*

Collected For: **Measure – 0286**

Definition: Contraindications/reasons for not prescribing aspirin include: aspirin allergy, Coumadin/warfarin as pre-arrival medication, or other reasons documented by a physician/APN/PA or pharmacist for not giving aspirin.

Suggested Data Collection Question: Select one of the following potential contraindications or reasons for not prescribing aspirin.

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 another reason documented by a physician/APN/PA or pharmacist for not prescribing aspirin.

4 **No documented contraindication/reason or Unable to determine (UTD)**: There is no documentation of contraindication/reason for not prescribing aspirin 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).
- When there is documentation of an aspirin "allergy" or "sensitivity," regard this as documentation of an aspirin allergy regardless of what type of reaction might be noted: Do not attempt to distinguish between true allergies/sensitivities and intolerances, side effects, etc. (e.g., "Allergies: ASA – Upsets stomach" – select value "1").
- Notation of an aspirin allergy prior to arrival counts as a contraindication to 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 prescribing aspirin (e.g., ASA not prescribed because patient has a gastric ulcer).
  - There must be a documented reason. Documentation of "Aspirin not prescribed" or "do not give aspirin" will not be sufficient. Physician/APN/PA or pharmacist crossing out of an aspirin order counts as an "other reason" for not prescribing aspirin.
- Pre-arrival hold or discontinuation of aspirin or notation such as "No aspirin" counts as a reason for not prescribing aspirin.
- Pre-arrival "other reason" counts as reason for not prescribing aspirin (e.g., "Intolerance to aspirin" or "Hx GI bleeding with aspirin").
- 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 A1, OP Table 6.1 for a comprehensive list of Aspirin and Aspirin-Containing medications. Refer to Appendix A1, OP Table 6.2 for a comprehensive list of Warfarin medications.	None

Data Element Name: *Discharge Date and Time*

Collected For: **Measure – 0290**

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

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

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:

- 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:

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

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.

- 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:

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

- If the 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: *Discharge Status*

Collected For: **Measure – 0286, 0287, 0288, 0289, 0290**

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:

01 **Discharged to home care or self care (routine discharge)**
Usage Note: Includes discharge to home; jail or law enforcement; home on oxygen if DMS only; any other DMS only; group home, foster care, and other residential care arrangements; outpatient programs, such as partial hospitalization or outpatient chemical dependency programs; assisted living facilities that are not state-designated.

02 **Discharged/transferred to a short term general hospital for inpatient care (Acute Care Facility)**

03 **Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care**
Usage Note: 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.

04 **Discharged/transferred to an intermediate care facility (ICF)**
Usage Note: Typically defined at the state level for specifically designated intermediate care facilities. Also used to designate patients that are discharged/transferred to a nursing facility with neither Medicare nor Medicaid certification and for discharges/transfers to state designated Assisted Living Facilities.

05 **Discharged/transferred to a non-Medicare PPS children's hospital or a non-Medicare PPS cancer hospital for inpatient care.**

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**

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 healthcare institution not defined elsewhere in this code list (see code 05)**

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: **Measure – 0286, 0287, 0288, 0289, 0290**

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 A1, OP Tables 1.0 and 1.0a.

Suggested Data Sources:
- Outpatient record

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendix A1, OP Table 1.0 and 1.0a for a list of E/M codes.	None

Data Element Name: *ECG*

Collected For: **Measure – 0289**

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
ECGs performed in the ambulance (within one hour prior to arrival)	None

Data Element Name: *ECG Date and Time*

Collected For: **Measure – 0289**

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

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

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:
- 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:

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

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.
- 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 ECG report/printed ECG time.

Suggested Data Sources:
- Ambulance record
- Emergency Department record

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *ED Arrival Time*

Collected For: **Measure – 0287, 0288, 0289, 0290**

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

Suggested Data Collection Question: What was the **earliest** documented time the patient arrived at the 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. 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:

- 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:

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

Notes for Abstraction:

- If the time of 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:
  - Documentation indicates the *ED Arrival Time* was 3300. No other documentation in the medical record provides a valid time. Since the *ED 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."

NOTE: Medical record documentation should be carefully examined in determining the most correct time of emergency department arrival. *ED 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 emergency department, this time should not be used.

Suggested Data Sources: • Emergency Department record

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Fibrinolytic Administration*

Collected For: **Measure – 0287, 0288, 0290**

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 6.3 for a comprehensive list of Fibrinolytic Agents.	None

Data Element Name: *Fibrinolytic Administration Date and Time*

Collected For: **Measure – 0287 , 0288**

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

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

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:

- 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:

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

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 doses, 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: *ICD-9-CM Other Diagnosis Codes*

Collected For: **Measure – 0286, 0289**

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 or secondary codes selected for this medical record?

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

Allowable Values: 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
Refer to Appendix A1, for ICD-9-CM Code Tables	None

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

Collected For: **Measure – 0286, 0287, 0288, 0289, 0290**

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 or first listed 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 A1, for ICD-9-CM Code Tables	None

Data Element Name: *Initial ECG Interpretation*

Collected For: **Measure – 0287, 0288**

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. A new 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 deparment arrival.

N (No) No ST-elevation or LBBB on the interpretation of the 12-lead ECG performed closest to emegency 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:**

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, Exclusions or Not Addressed. 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, 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 tracing or the interpretations of this 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 • Myocardial infarction (MI), with any mention of location or combinations of locations (e.g., anterior, apical, basal, inferior, lateral, posterior, or combination), IF DESCRIBED AS ACUTE/EVOLVING (e.g., "posterior AMI") • Q wave MI, IF DESCRIBED AS ACUTE/EVOLVING • ST-elevation (STE) • ST-elevation myocardial infarction (STEMI) • ST-segment noted as ≥ .10mV • ST-segment noted as ≥ 1 mm • Transmural MI, IF DESCRIBED AS ACUTE/EVOLVING • ST ↑ • ST, ST abnormality, or ST changes with injury, infarct, or acute/evolving MI **Left bundle branch block (LBBB)** • Intraventricular conduction delay of LBBB type • Variable LBBB	**ST-segment elevation** • Non Q wave MI (NQWMI) • Non ST-elevation MI (NSTEMI) • ST-elevation (ST ↑) clearly described as confined to ONE lead • ST-elevation (ST ↑) described as minimal, < .10mV, < 1 mm, non-diagnostic, or non-specific in ALL leads noted to have ST-elevation • ST-elevation (ST ↑) described as minimal, < .10mV, < 1 mm, non-diagnostic, or non-specific in GENERAL terms, where lead(s) are NOT specified (e.g., "minimal ST-elevation," "ST ↑ .5 mm"), • ST-elevation with mention of early repolarization, left ventricular hypertrophy, normal variant, pericarditis, or Printzmetal/Printzmetal's variant • ST-segment elevation, or any of the other ST-segment elevation 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, possible, 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) **Left bundle branch block (LBBB)** • Incomplete left bundle branch block (LBBB) • Intraventricular conduction block • 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, possible, 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)

Data Element Name: *Outpatient Encounter Date*

Collected For: **Measure – 0286, 0287, 0288, 0289, 0290**

Definition: The documented month, day and year the patient was seen in the hospital outpatient department.

Suggested Data Collection Question: What was the date the patient What was date the patient was seen in the hospital outpatient department?

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

Allowable Values:
Enter the documented hospital outpatient department date
MM = Month (01-12)
DD = Day (01-31)

YYYY = Year (1880-9999)

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:
- UTD is NOT an allowable value.
- Consider the outpatient encounter date the earliest documented date the patient arrived in the applicable hospital outpatient department.

Suggested Data Sources:
- Outpatient record
- Emergency Department record

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Probable Cardiac Chest Pain*

Collected For: **Measure – 0287, 0289**

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:

- If there is documentation of a differential/working diagnosis of acute myocardial infarction select "Yes."
- Documentation must include one of the Acute Myocardial Infarction and Chest Pain Inclusions.
- If both Inclusion term(s) and Exclusion term(s) are documented select "Yes."

Suggested Data Sources:

NURSE or PHYSICIAN/APN/PA DOCUMENTATION ONLY

- Emergency Department record

Guidelines for Abstraction:

Inclusion	Exclusion
Acute Myocardial Infarction and Chest Pain Inclusions Acute coronary syndrome Acute myocardial infarction (AMI) Angina Heart attack Myocardial Infarction Ischemia Cardiac Cardiac Chest Pain Unstable angina The following qualifiers should be abstracted as ***positive findings*** if listed with any of the above inclusion terms; • Appears to have • Consider • Consistent with (c/w) • Diagnostic of • Evidence of • Indicative of • Likely • Most likely • Probable • Representative of • Cannot exclude • Cannot rule out • Could be • Could have been • May have • May have had • May indicate • Possible • Questionable (?) • Risk of • Rule(d) out (r/o) • Suggestive of • Suspect • Suspicious • Differential diagnosis • Working diagnosis • Versus (vs) • +	Atypical chest pain Chest pain musculoskeletal Chest pain Chest wall pain Non Cardiac Chest Pain

Data Element Name: *Reason for Delay in Fibrinolytic Therapy*

Collected For: **Measure – 0287, 0288**

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 afterpatient 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").
- Cardiopulmonary arrest or CPR within 30 minutes after ED arrival is an acceptable reason. In order for cardiopulmonary arrest or CPR occurring within 30 minutes after ED arrival to be considered a reason for delay, documentation that it occurred within 30 minutes after ED 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: • Cardiac arrest • Cardiopulmonary arrest • Cardiopulmonary resuscitation (CPR) • Code • Defibrillation • Endotracheal intubation • Respiratory arrest • Ventricular fibrillation (V-fib)	• Cardioversion • Shocked (to restore cardiac rhythm)

Data Element Name: *Transfer for Acute Coronary Intervention*

Collected For: **Measure – 0290**

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:

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:

- To select value "1", documentation must include a specifically defined reason for transfer such as "Percutaneous Coronary Intervention," "Angioplasty," or "for cardiac cath."

Suggested Data Sources:

- Emergency Department record

Guidelines for Abstraction:

Inclusion	Exclusion
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

OP Table 1.0a E/M Codes for Emergency Department Encounter

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

Measure 0286 – 0290 AMI Diagnosis Codes

OP Table 6.1 Acute Myocardial Infarction (AMI)		
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

Measure 0286, 0289 Chest Pain Codes

OP Table 6.1a Chest Pain, Angina, Acute Coronary Syndrome		
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
786.52	Painful Respiration	PAINFUL RESPIRATION

786.59	Chest pain, other	CHEST PAIN NEC

OP Table 6.1 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
Aspirin Enteric Coated
Aspirin Litecoat
Aspirin Lo-Dose
Aspirin Low Strength
Aspirin Tri-Buffered
Aspirin, Extended Release
Aspirin/Butalbital/Caffeine
Aspirin/caffeine
Aspirin/Pravachol
Aspirin/Pravastatin
Aspirtab
Azdone
Bayer Aspirin
Bayer Aspirin PM Extra Strength
Bayer Children’s
Bayer EC

OP Table 6.1 Aspirin and Aspirin-Containing Medications
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
Ecotrin
Ecotrin Low Strength Adult
Effervescent Pain & Antacid
Empirin
Encaprin
Endodan
Entab
Entaprin
Entercote
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

OP Table 6.1 Aspirin and Aspirin-Containing Medications
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
Percodan
Percodan-Demi
Pravigard
Pravigard PAC
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 6.2 Warfarin
Barr Warfarin Sodium
Coumadin
Dicumarol
Jantoven
Panwarfin
Warfarin

OP Table 6.3 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

Appendix A2. Data Abstraction Definitions for ED Transfer Measures 0291 – 0296

QUESTION	INSTRUCTIONS	RECOMMENDED LOCATIONS	INCLUSIONS	EXCLUSIONS
What is your provider (hospital) name?	Enter your hospital's name. This is the sending hospital.	ER record	None	None
What is your hospital's Medicare Provider Number?	Enter your hospital's six-digit acute care Medicare Provider Number.		None	None
What is the patient's first name?	Enter the patient's first name.	ER record	None	None
What is the patient's last name?	Enter the patient's last name.	ER record	None	None
What was the ICD-9-CM code selected as the principal diagnosis for this record?	Enter the ICD-9-CM code that identifies the principal diagnosis selected for this medical record. **Notes:** 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."	ER record	All transferred patients	None
What was the ICD-9-CM other diagnoses codes selected for this record?	Enter all of the ICD-9-CM other diagnoses codes for this medical record.	ER record	None	None
What is the patient's date of birth?	Enter the date in MM/DD/YYYY format.	ER record	None	None
What is the patient's sex?	**Male:** Select this option if the patient is male. **Female:** Select this option if the patient is female.	ER record	None	None

QUESTION	INSTRUCTIONS	RECOMMENDED LOCATIONS	INCLUSIONS	EXCLUSIONS
What is the patient's race?	*Select one option:* **African American:** Select this option if the patient's race is Black or African American. **American Indian/Alaska Native:** Select this option if the patient's race is American Indian/Alaska Native. **Asian:** Select this option if the patient's race is Asian. **White:** Select this option if the patient's race is White or the patient has origins in Europe, the Middle East, or North Africa. **Native Hawaiian/Pacific Islander:** Select this option if the patient's race is Native Hawaiian/Pacific Islander. **UTD:** Select this option if unable to determine the patient's race or not stated (e.g., not documented, conflicting documentation or patient is unwilling to provide).	ER record	**African American:** A person having origins in any of the black racial groups of Africa. Terms such as "Black or African American" or " Haitian", or "Negro" can be used. **American Indian/ 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 or South America, including Central America; Native American. **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent including Cambodian, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. **White:** A person having origins in any of the original peoples of Europe, or the Middle east, or North Africa (e.g., Caucasian, Iranian, White). **Native Hawaiian/ Pacific Islander:** A person having origins in any of the original peoples of the Guam, Hawaiian, Samoa or other Pacific Islands.	None

QUESTION	INSTRUCTIONS	RECOMMENDED LOCATIONS	INCLUSIONS	EXCLUSIONS
Is the patient of Hispanic ethnicity?	**Yes:** Select this option if the patient is of Hispanic ethnicity. **No/UTD:** Select this option if: • The patient is not of Hispanic ethnicity, **OR** • Unable to determine from medical record documentation.	ER record	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: Black-Hispanic, Chicano, Hispanic, Latino/Latina, Mexican-American, South American, Spanish, White-Hispanic.	None
What is the patient's zip code?	Enter any valid five or nine digit postal code or "homeless" if the patient is determined not to have a permanent residence.	ER record	None	None
What is the patient's medical record number?	Enter the patient's medical record number. Include any appropriate alpha characters. Exclude hyphens or other punctuation.	ER record	None	None
What is the patient's Social Security number?	Enter patient's Social Security number.	ER record	None	None
What is the patient's Medicare/HIC number?	Enter patient's Medicare/HIC number.	ER record	None	None
What is the source of payment for the patient's services?	*Select all that apply:* **Medicare:** Select this option if Medicare is listed as a payment source. This would include Medicare Fee for Service (include DRG or PPS), Medicare HMO/Medicare + Choice, and Medicare coverage as a secondary payer. **Medicaid:** Select this option if Medicaid is listed as a payment source. **Other:** Select this option if there is a payment source other than Medicare or Medicaid (e.g., Veterans Administration [VA], CHAMPUS, Workers' Compensation or private insurance). **No Insurance/Not documented/UTD:** Select this option if the patient has no insurance coverage, the payment source is not documented, unable to determine the payment source, or the payment source does not coincide with one of the above options.	ER record	None	None

QUESTION	INSTRUCTIONS	RECOMMENDED LOCATIONS	INCLUSIONS	EXCLUSIONS
What was the source of admission for the patient?	*Select one option:* **1 = Physician referral** Select this option if the patient was admitted to this facility upon recommendation of his or her personal physician. **2 = Clinic referral** Select this option if the patient was admitted to this facility upon recommendation of this facility's clinic physician. **3 = HMO referral** Select this option if the patient was admitted to this facility upon recommendation of a health maintenance organization physician. **4 = Transfer from a hospital** Select this option if the patient was admitted to this facility as a hospital transfer from an acute care facility where he or she was an inpatient. **5 = Transfer from skilled nursing facility** Select this option if the patient was admitted to this facility as a transfer from a skilled nursing facility where he or she was an inpatient. **6 = Transfer from another health care facility** Select this option if the patient was admitted to this facility as a transfer from a health care facility other than an acute care facility or a skilled nursing facility. This includes transfers from nursing homes, long term care facilities and skilled nursing facility patients that are at a non-skilled level of care. **8 = Court/law enforcement** Select this option if the patient was admitted to this facility upon the direction of a court of law or upon the request of a law enforcement agency representative. **9 = Information not available** Select this option if the means by which the patient was admitted to this hospital is not known. **A = Transfer from a critical access hospital** Select this option if the patient was admitted to this facility as a transfer from a Critical Access Hospital where he or she was an inpatient. **B = From Home** Select this option if the patient was admitted to this facility from home.	ER record	None	None
Did the patient arrive by ambulance?	**Yes:** Select this option if the patient arrived to the ER by ambulance. **No:** Select this option if the patient did not arrive to the ER by ambulance	Ambulance record ER record	None	None

QUESTION	INSTRUCTIONS	RECOMMENDED LOCATIONS	INCLUSIONS	EXCLUSIONS
What was the **earliest** documented **date** the patient arrived at the hospital?	Enter the **earliest** documented date in MM/DD/YYYY format. **Notes:** – Review only the acceptable sources to determine the earliest date the patient arrived at the hospital. This may differ from the admission date. – When reviewing ED records do NOT include any documentation from external sources (e.g., ambulance records, physician office record, laboratory reports or **ECG/EKG's**) obtained prior to arrival. The intent is to utilize any documentation, which reflects processes that occurred in the ED or hospital. – Do NOT include addressographs/stamps. ▪ The value "99/99/9999" is NOT allowed for this data element.	ER record	None	None
What was the **earliest** documented **time** the patient arrived at the hospital?	Enter the **earliest** documented time of arrival in military format (e.g., midnight as 0000, one minute after midnight as 0001, etc.). **Notes:** – Review only the acceptable sources to determine the earliest time the patient arrived at the hospital. This may differ from the admission time. – When reviewing ED records do NOT include any documentation from external sources (e.g., ambulance records, physician office record, laboratory reports or **ECG/EKG's**) obtained prior to arrival. The intent is to utilize any documentation, which reflects processes that occurred in the ED or hospital. – Do NOT include addressographs/stamps. ▪ The value "9999" is NOT allowed for this data element.	ER record	None	None
What is the date the patient was discharged from the emergency room, left against medical advice (AMA), or expired?	Enter the date in MM/DD/YYYY format: ▪ The value "99/99/9999" is NOT allowed for this data element.	ER record	None	None
What is the time the patient was discharged from the emergency room, left against medical advice (AMA), or expired?	Enter the time of discharge in military format (e.g., midnight as 0000, one minute after midnight as 0001, etc.): ▪ The value "9999" is NOT allowed for this data element.	ER record	None	None

QUESTION	INSTRUCTIONS	RECOMMENDED LOCATIONS	INCLUSIONS	EXCLUSIONS
What was the patient's discharge disposition?	*Select one option:* **01 = Discharged to home care or self care (routine discharge)** Select if the patient was discharged to home care or self care. **02 = Discharged/transferred to another short term general hospital for inpatient care** Select if the patient was discharged/transferred to another acute care facility. **03 = Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification** Select if the patient was discharged/transferred to SNF. **04 = Discharged/transferred to an intermediate care facility (ICF)** Select if the patient was discharged/transferred to a nursing facility providing intermediate or respite care and for discharges/transfers to state designated Assisted Living Facilities. **05 = Discharged/transferred to another type of institution for inpatient care** Select if the patient was discharged/transferred to a psychiatric hospital, rehabilitation hospital, children's hospital, or cancer hospital. **06 = Discharged/transferred to home under the care of organized home health service organization** Select if the patient was discharged/transferred to home under the care of organized home health services. **07 = Left against medical advice or discontinued care** Select this option if the patient left AMA. **08 = Discharged/transferred to home under care of home IV provider** Select this option if the patient was discharged/ transferred to home health services for IV drug therapy. **09 = Admitted as an inpatient to this hospital** Select this option if the patient was admitted to this hospital from the ER. **20 = Expired** Select this option if the patient was NOT a hospice patient and expired prior to discharge. **41 = Hospice patients who expired in a medical facility such as hospital, SNF, ICF, or freestanding hospice** Select this option if the patient was a hospice patient and expired prior to discharge. **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 nursing facility. To be used whenever the destination at discharge is a federal health care facility, whether the patient resides there or not.	ER record	None	None

QUESTION	INSTRUCTIONS	RECOMMENDED LOCATIONS	INCLUSIONS	EXCLUSIONS
	50 = Hospice – home **51 = Hospice – medical facility** **61 = Discharged/transferred within this institution to hospital-based Medicare approved swing bed** 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 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 unit of a hospital**	ER record	None	None
Does the medical record documentation indicate that nurse-to-nurse communication occurred prior to the transfer of the patient from the ER to another facility?	**Yes:** Select this option if there is documentation of the ER nurse giving report to the nursing staff of the receiving facility. Must include minimally the date and time report was given, and the communication means (i.e., phone, fax, other). **No:** Select this option if there is no documentation of the ER nurse giving report to the nursing staff of the receiving facility. Must include minimally the date and time report was given, and the communication means (i.e., phone, fax, other).	Nursing note Transfer summary document	None	None
Does the medical record documentation indicate that physician or practitioner-to-physician, practitioner, or transfer coordinator communication occurred prior to the transfer of the patient from the ER to another facility?	**Yes:** Select this option if there is documentation of the ER physician's or mid-level practitioner's discussion of the patient's condition with physician or mid-level staff at the receiving facility. Must include minimally the names of the two providers, the date and time of communication, and the communication means (i.e., phone fax or other). If there is documentation of communication with the receiving hospital personnel such as a "transfer coordinator" who after receiving clinical information approved the transfer. **No:** Select this option if there is no documentation of the ER physician's or mid-level practitioner's discussion of the patient's condition with physician or mid-level staff at the receiving facility. Must include minimally the names of the two providers, the date and time of communication, and the communication means (i.e., phone fax or other).	Physician's or practitioner's note Transfer summary document Physician's or practitioner's orders	None	None

QUESTION	INSTRUCTIONS	RECOMMENDED LOCATIONS	INCLUSIONS	EXCLUSIONS
Does the medical record documentation indicate the name of the receiving hospital involved in the transfer documented in the chart?	**Yes:** Select this option if the record shows the name of the receiving hospital. **No:** Select this option if the record does not show the name of the receiving hospital.	Transfer summery MD or practitioner orders and notes Nursing notes	None	None
Does the medical record documentation indicate that patient information including name, address, DOB, gender was sent with the patient?	**Yes:** Select this option for each of the 4 elements sent with the patient, name, address, DOB, gender. **No:** Select this option for each of the 4 elements not sent with the patient: name, address, age, gender. **Not available**. Select this option if patient is a John/Jane Doe and/or is altered neurologically or has potential brain/head injury.	Face sheet	None	None
Does the medical record documentation indicate that contact information for significant others and family members was sent with the patient?	**Yes:** Select this option if the name and phone number for at least one of the patient's family or friends are sent with the patient. **No:** Select this option if the name and phone number for at least one of the patient's family or friends are not sent with the patient. **Not available**. Select this option if patient is a John/Jane Doe and/or is altered neurologically or has potential brain/head injury.	Face Sheet Nursing notes	None	None
Does the medical record documentation indicate that insurance information was sent with the patient?	**Yes:** Select this option if insurance company and number are sent with the patient. **No:** Select this option if insurance company and number are not sent with the patient. **Not available.** Select this option if patient is a John/Jane Doe and/or is altered neurologically or has potential brain/head injury.	Face Sheet Copy of insurance card	None	None

For the remaining questions 'sent' refers to medical record documentation that indicates information went with the patient or was communicated via fax or phone within 60 minutes of the patient's departure.

QUESTION	INSTRUCTIONS	RECOMMENDED LOCATIONS	INCLUSIONS	EXCLUSIONS
Does the medical record documentation indicate that the entire vital sign record sent with the patient?	**Yes:** Select this option if the entire vital signs record was documented as sent including: P R BP and 02 sats. If infection, hypothermia, or heat disorder is suspected from the physician notes, a temperature is required. Otherwise answer for Temp is **Not Applicable**. **No:** Select this option if vital signs documented as sent does not include: P R BP and 02 sats.	ER flow sheet Nursing notes	None	None
Does the medical record documentation indicate that appropriate other assessments were done and sent with the patient?	**Yes:** Select this option if vital signs documented as sent include: a. Glasgow coma scale or neuro flow sheet if patient has altered consciousness. See attached documentation for Glasgow details. Not applicable if patient not at risk for altered consciousness. (This is needed for all trauma patients and all neurological patients.) **No:** Select this option if vital signs documented as sent do not include: a. Glasgow coma scale or neuro flow sheet if patient has altered consciousness. See attached documentation for Glasgow details. **Not applicable** if patient not at risk for altered consciousness. (This is needed for all trauma patients.)	Flow sheets Nursing notes MD or practitioner orders and notes Flow sheets Nursing notes MD or practitioner orders and notes	All patients with altered consciousness levels or with possible brain/ head injury. Patients post seizure. All trauma patients	None
Does the medical record documentation indicate that physician or practitioner communication was sent with the patient?	**Yes:** Select this option if information documented as sent includes minimally: a. History and Physical (includes focused physical exam, history of current ER episode, and relevant chronic conditions). Chronic conditions may be excluded if patient is neurologically altered. b. Reason for the transfer and/or a plan of care (may include suggestions for care to be received at the receiving hospital). **No:** Select this option if information documented as sent does not includes minimally: a. History and Physical (includes focused physical exam, history of current ER episode, and relevant chronic conditions).Chronic conditions may be excluded if patient is neurologically altered. b. Reason for the transfer and/or a plan of care (may include suggestions for care to be received at the receiving hospital). Not Available – if patient ins neurologically altered information on chronic conditions should be labeled NA.	MD or practitioner notes Transfer summary	None	None

QUESTION	INSTRUCTIONS	RECOMMENDED LOCATIONS	INCLUSIONS	EXCLUSIONS
Does the medical record documentation indicate that nursing communication was sent with the patient?	**Yes:** Select this option if information documented as sent includes minimally a. Medication history (including complementary medications, OTC medications and oxygen). This may be not available (NA) if patient is neurologically altered. b. Allergies (food, medication, other), reactions. This may be not available (NA) if patient is neurologically altered. c. Impairments (mental, speech, hearing, vision, sensation). Nurse notes. For example: nurse assessment/ intervention/response or SOAP. **No:** Select this option if information documented as sent does not includes minimally: a. Medication history (including complementary medications, OTC medications and oxygen). This may be not available (NA) if patient is neurologically altered. b. Allergies (food, medication, other) reactions. This may be not available (NA) if patient is neurologically altered. c. Impairments (mental, speech, hearing, vision, sensation). d. Nurse notes. For example: nurse assessment/ intervention/response or SOAP.	Nurse notes Flow sheets MD or practitioner orders and notes	None	None
Does the medical record documentation indicate that information was sent on the treatment provided in the originating hospital?	**Yes:** Select this option if information documented as sent includes minimally: a. Medication administration record (MAR). b. Catheters (IV, IT, Urinary). c. Oral restrictions (NPO, clear liquids, etc.). d. Immobilizations (Splints, neck brace, back board etc.). e. Respiratory support provided (ventilator support, intubations, Bronchial drainage etc.). **No:** Select this option if information documented as sent does not includes minimally: a. Medication administration record, (MAR). b. Catheters (IV, IT, Urinary). c. Oral restrictions (NPO, clear liquids, etc.). d. Immobilizations (Splints, neck brace, back board etc.). e. Respiratory support provided (ventilator support, intubations, Bronchial drainage etc.). **Not applicable**: Select this option if no treatment provided in the originating ER. **Not applicable**: Select this option if these treatments are not relevant to the patient's condition.	Nursing notes Flow sheets MAR	None	None

QUESTION	INSTRUCTIONS	RECOMMENDED LOCATIONS	INCLUSIONS	EXCLUSIONS
Does the medical record documentation indicate that information was sent on the tests and procedures that were done in the ER (and are pertinent to the emergency condition)?	**Yes:** Select this option if information documented as sent includes minimally: List of labs, X-rays and procedures completed in the ER prior to transfer. **No:** Select this option if information documented as sent does not includes minimally: List of labs, X-rays and procedures completed in the ER prior to transfer. **Not applicable:** Select this option if no tests, X-rays, or procedures were performed.	MD or practitioner orders and notes Nursing notes Flow sheets Lab documentation	None	None
Does the medical record documentation indicate that results from the completed tests and procedures that are done in the ER (and are pertinent to the emergency condition) were sent?	**Yes:** Select this option if information documented as sent includes minimally: Documentation of the results being sent either with the patient or communicated when available. **No:** Select this option if information documented as sent does not includes minimally: Documentation of the results being sent either with the patient or communicated when available. **Not applicable:** Select this option if no tests, X-rays or procedures were performed.	MD or practitioner orders and notes Nursing notes Flow sheets Lab documentation	None	None

For Question 8a:

Glasgow Coma Score

The Glasgow Coma Score (GCS) is scored between 3 and 15, with 3 being the worst and 15 the best. It is composed of three parameters: Best Eye R
Best Verbal Response, and Best Motor Response, as given below:

Best Eye Response. (4)

1. No eye opening.
2. Eye opening to pain.
3. Eye opening to verbal command.
4. Eyes open spontaneously.

Best Verbal Response. (5)

1. No verbal response
2. Incomprehensible sounds.
3. Inappropriate words.
4. Confused.
5. Orientated.

Best Motor Response. (6)

1. No motor response.
2. Extension to pain.
3. Flexion to pain.
4. Withdrawal from pain.
5. Localizing pain.
6. Obeys Commands.

Note that the phrase 'GCS of 11' is essentially meaningless, and it is important to break the figure down into its components, such as E3V3M5 = GCS 11.

A Coma Score of 13 or higher correlates with a mild brain injury; 9 to 12 is a moderate injury and 8 or less a severe brain injury.

Appendix

Case Identification

Include all patients with a discharge code of 02 (Transfer to another acute care facility).

Individual hospitals will need to define pull criteria based on their system capabilities.

EMERGENCY DEPARTMENT NATIONAL HOSPITAL INPATIENT QUALITY MEASURES

NQF Measure ID #	Set Measure ID #	Measure Short Name
0495	**ED-1a**	Median Time from ED Arrival to ED Departure for Admitted ED Patients – Overall Rate
	ED-1b	Median Time from ED Arrival to ED Departure for Admitted ED Patients – Reporting Measure
	ED-1c	Median Time from ED Arrival to ED Departure for Admitted ED Patients – Observation Patients
	ED-1d	Median Time from ED Arrival to ED Departure for Admitted ED Patients – Psychiatric/Mental Health Patients
0497	**ED-2a**	Admit Decision Time to ED Departure Time for Admitted Patients – Overall Rate
	ED-2b	Admit Decision Time to ED Departure Time for Admitted Patients – Reporting Measure
	ED-2c	Admit Decision Time to ED Departure Time for Admitted Patients – Psychiatric/Mental Health Patients

ED DATA ELEMENT LIST

General Data Element Name	Collected For:
Admission Date	All Records
Birthdate	All Records
Discharge Date	All Records
Discharge Status	All Records
First Name	All Records
Hispanic Ethnicity	All Records
Hospital Patient Identifier	All Records
ICD-9-CM Other Diagnosis Codes	All Records
ICD-9-CM Other Procedure Codes	All Records
ICD-9-CM Other Procedure Dates	All Records
ICD-9-CM Principal Diagnosis Code	All Records
ICD-9-CM Principal Procedure Code	All Records
ICD-9-CM Principal Procedure Date	All Records
Last Name	All Records
Patient HIC #	All Records Collected by CMS for patients with a standard HIC#
Payment Source	All Records
Physician 1	Optional for All Records
Physician 2	Optional for All Records
Point of Origin for Admission or Visit	All Records
Postal Code	All Records
Race	All Records
Sample	Used in transmission of the Hospital Clinical Data file
Sex	All Records

Algorithm Output Data Element Name	Collected For:
Measure Category Assignment	Used in the calculation of aggregate data and in the transmission of the Hospital Clinical Data File
Measurement Value	*Used in the calculation of aggregate data, Continuous Variable Measures (ED-1, ED-2) and in the transmission of the Hospital Clinical Data file*

ED DATA ELEMENT LIST

ED Data Element Name	Collected For:
Arrival Date	ED-1
Arrival Time	ED-1
Decision to Admit Date	ED-2
Decision to Admit Time	ED-2
ED Departure Date	ED-1, ED-2
ED Departure Time	ED-1, ED-2
ED Patient	ED-1, ED-2
Observation Services	ED-1, ED-2

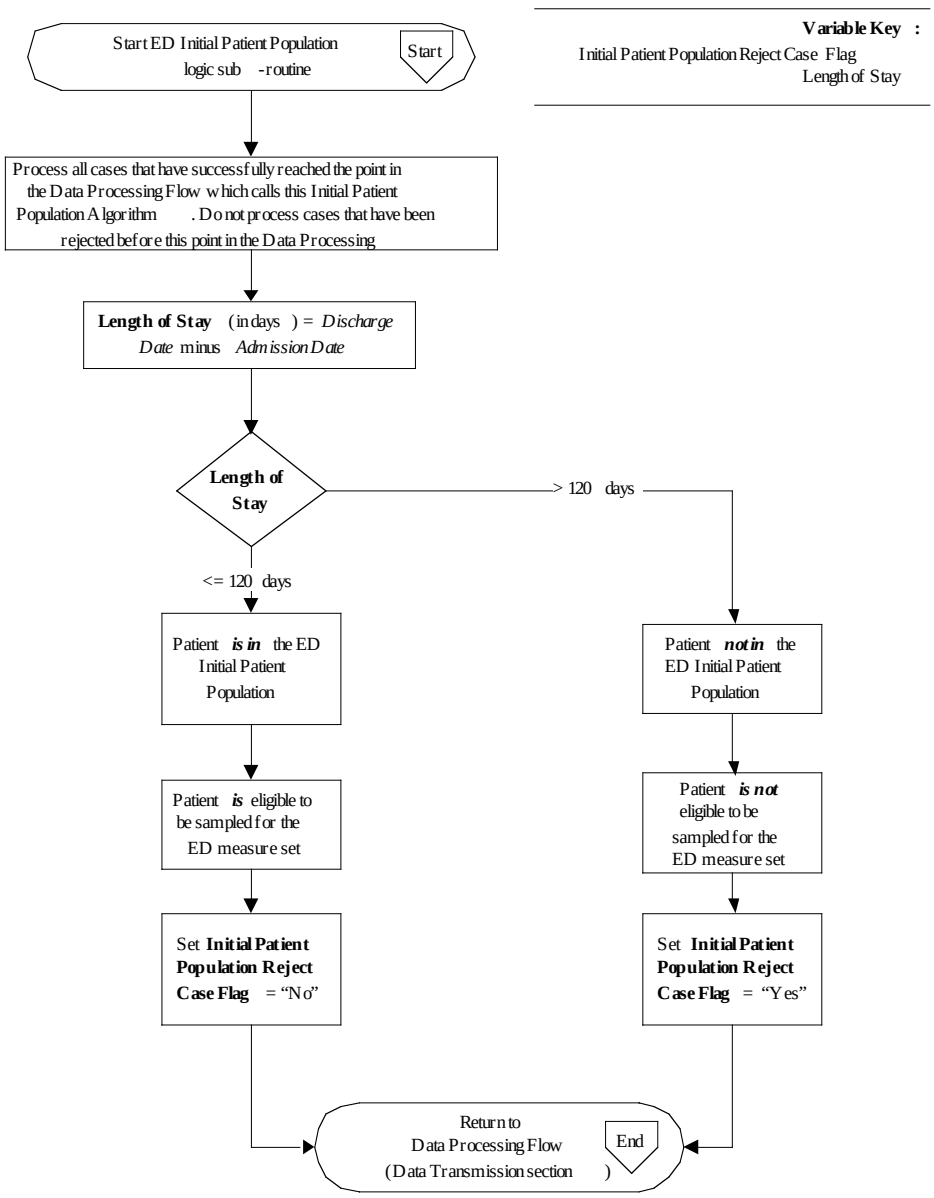
Emergency Department (ED) Initial Patient Population

The population of the ED measure set is identified using 2 data elements:

- *Admission Date*
- *Discharge Date*

All patients discharged from acute inpatient care are included in the ED Initial Patient Population and are eligible to be sampled if they have:

- A Length of Stay (*Discharge Date* - *Admission Date*) <= 120 days


Variable Key :
Initial Patient Population Reject Case Flag
Length of Stay
Start ED Initial Patient Population logic sub-routine
Start
Process all cases that have successfully reached the point in the Data Processing Flow which calls this Initial Patient Population Algorithm. Do not process cases that have been rejected before this point in the Data Processing
Length of Stay (in days) = Discharge Date minus Admission Date
Length of Stay
> 120 days
<= 120 days
Patient is in the ED Initial Patient Population
Patient not in the ED Initial Patient Population
Patient is eligible to be sampled for the ED measure set
Patient is not eligible to be sampled for the ED measure set
Set Initial Patient Population Reject Case Flag = "No"
Set Initial Patient Population Reject Case Flag = "Yes"
Return to Data Processing Flow (Data Transmission section)
End

ED Sample Size Requirements

The sampling requirements for the ED measures will be provided when these measures are finalized for implementation.

Measure Information Form

Measure Set: Emergency Department

Set Measure ID #: ED-1 (0495)

Set Measure ID #	Performance Measure Name
ED-1a	Median Time from ED Arrival to ED Departure for Admitted ED Patients – Overall Rate
ED-1b	Median Time from ED Arrival to ED Departure for Admitted ED Patients – Reporting Measure
ED-1c	Median Time from ED Arrival to ED Departure for Admitted ED Patients – Observation Patients
ED-1d	Median Time from ED Arrival to ED Departure for Admitted ED Patients – Psychiatric/Mental Health Patients

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

Description: Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility 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. Approximately one third of hospitals in the US 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. 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. 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 admitted to the facility from the emergency department.

Included Populations:

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

Excluded Populations:

- None

Data Elements:

- *Arrival Date*
- *Arrival Time*
- *ED Departure Date*
- *ED Departure Time*
- *ED Patient*
- *ICD-9-CM Principal Diagnosis Code*
- *Observation Services*

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.

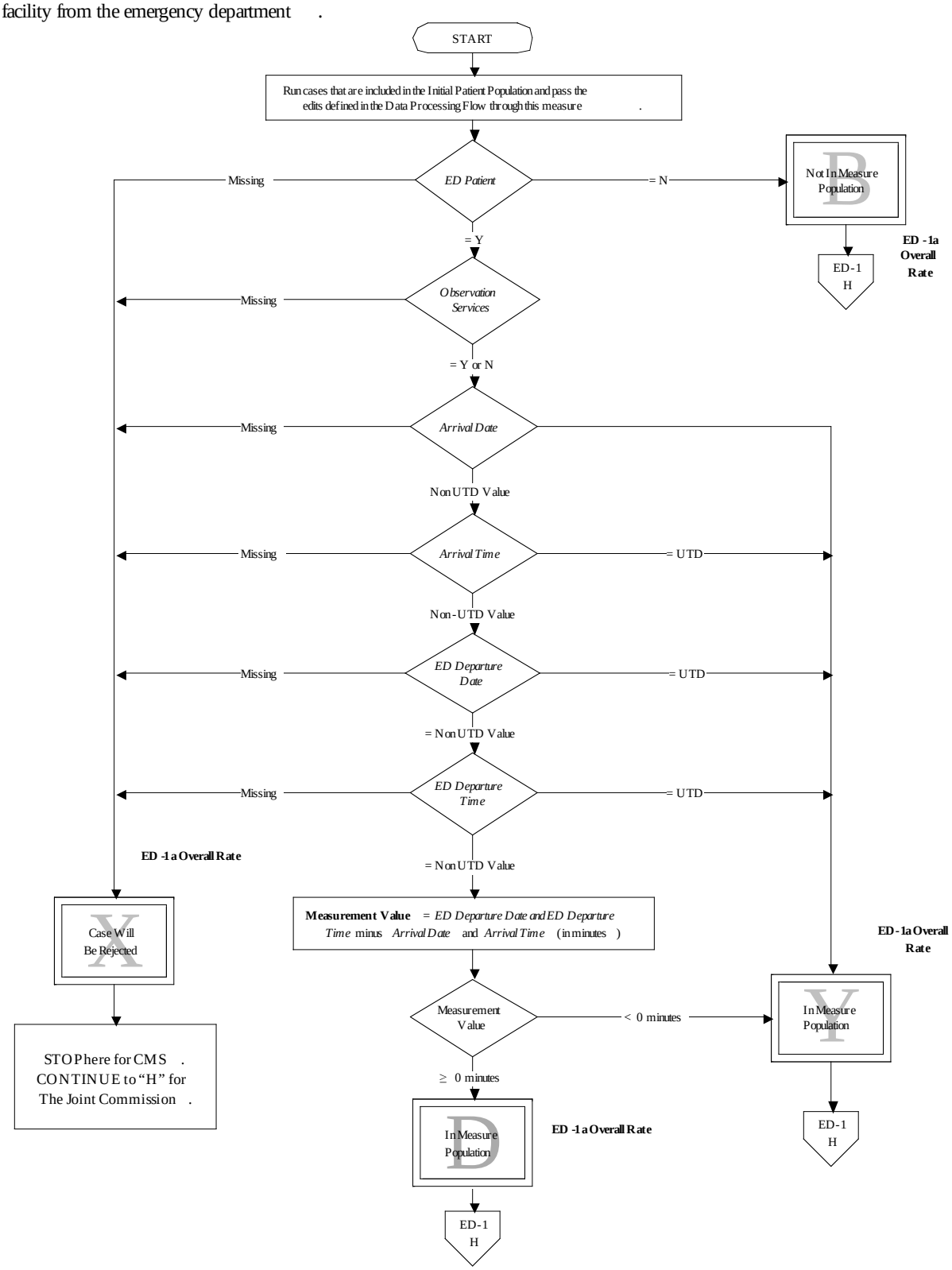
Data Reported As: Aggregate measure of central tendency.

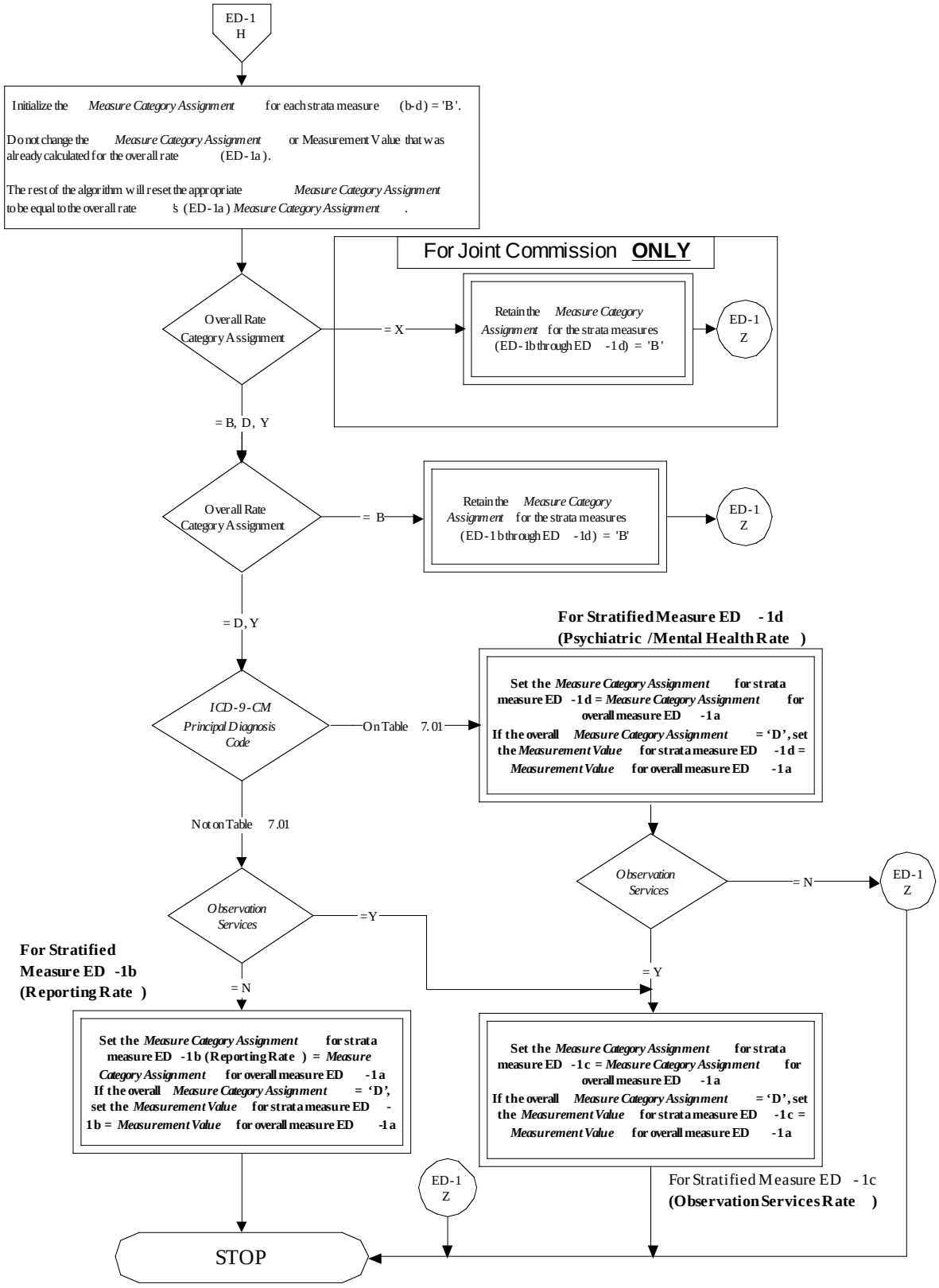
Selected References:

- Diercks DB, et al. Prolonged emergency department stays of non-ST-segment-elevation myocardial infarction patients are associated with worse adherence to the American College of Cardiology/American Heart Association guidelines for management and increased adverse events. *Ann Emerg Med*. 2007;50:489-96.
- Derlet RW, Richards JR. Emergency department overcrowding in Florida, New York, and Texas. *South Med J*. 2002;95:846-9.
- Derlet RW, Richards JR. Overcrowding in the nation's emergency departments: complex causes and disturbing effects. *Ann Emerg Med*. 2000;35:63-8.
- Fatovich DM, Hirsch RL. Entry overload, emergency department overcrowding, and ambulance bypass. *Emerg Med J*. 2003;20:406-9.
- Hwang U, Richardson LD, Sonuyi TO, Morrison RS. The effect of emergency department crowding on the management of pain in older adults with hip fracture. *J Am Geriatr Soc*. 2006;54:270-5.
- Institute of Medicine of the National Academies. Future of emergency care: Hospital-based emergency care at the breaking point. *The National Academies Press* 2006.
- Kyriacou DN, Ricketts V, Dyne PL, McCollough MD, Talan DA. A 5-year time study analysis of emergency department patient care efficiency. *Ann Emerg Med*. 1999;34:326-35.
- Pines JM, et al. ED crowding is associated with variable perceptions of care compromise. *Acad Emerg Med*. 2007;14:1176-81.
- Pines JM, et al. Emergency department crowding is associated with poor care for patients with severe pain. *Ann Emerg Med*. 2008;51:6-7.
- Schull MJ, et al. Emergency department crowding and thrombolysis delays in acute myocardial infarction. *Ann Emerg Med*. 2004;44:577-85.
- Siegel B, et al. Enhancing work flow to reduce crowding. *Jt Comm J Qual Patient Saf*. 2007;33(11 Suppl):57-67.
- Trzeciak S, Rivers EP. Emergency department overcrowding in the United States: an emerging threat to patient safety and public health. *Emerg Med J*. 2003;20:402-5.
- 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.

ED-1: **Median Time from ED Arrival to ED Departure for Admitted ED Patients**

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




ED-1 H
Initialize the Measure Category Assignment for each strata measure (b-d) = 'B'.
Do not change the Measure Category Assignment or Measurement Value that was already calculated for the overall rate (ED-1a).
The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall rate's (ED-1a) Measure Category Assignment.
For Joint Commission ONLY
Overall Rate Category Assignment
= X
Retain the Measure Category Assignment for the strata measures (ED-1b through ED-1d) = 'B'
ED-1 Z
= B, D, Y
Overall Rate Category Assignment
= B
Retain the Measure Category Assignment for the strata measures (ED-1b through ED-1d) = 'B'
ED-1 Z
= D, Y
For Stratified Measure ED-1d (Psychiatric/Mental Health Rate)
ICD-9-CM Principal Diagnosis Code
On Table 7.01
Set the Measure Category Assignment for strata measure ED-1d = Measure Category Assignment for overall measure ED-1a
If the overall Measure Category Assignment = 'D', set the Measurement Value for strata measure ED-1d = Measurement Value for overall measure ED-1a
Not on Table 7.01
Observation Services
= N
ED-1 Z
Observation Services
= Y
= Y
For Stratified Measure ED-1b (Reporting Rate)
= N
Set the Measure Category Assignment for strata measure ED-1b (Reporting Rate) = Measure Category Assignment for overall measure ED-1a
If the overall Measure Category Assignment = 'D', set the Measurement Value for strata measure ED-1b = Measurement Value for overall measure ED-1a
Set the Measure Category Assignment for strata measure ED-1c = Measure Category Assignment for overall measure ED-1a
If the overall Measure Category Assignment = 'D', set the Measurement Value for strata measure ED-1c = Measurement Value for overall measure ED-1a
For Stratified Measure ED-1c (Observation Services Rate)
ED-1 Z
STOP

Measure Information Form

Measure Set: Emergency Department

Set Measure ID #: ED-2 (0497)

Set Measure ID #	Performance Measure Name
ED-2a	Admit Decision Time to ED Departure Time for Admitted Patients – Overall Rate
ED-2b	Admit Decision Time to ED Departure Time for Admitted Patients – Reporting Measure
ED-2c	Admit Decision Time to ED Departure Time for Admitted Patients –Psychiatric/Mental Health Patients

Performance Measure Name: Admit Decision Time to ED Departure Time for Admitted Patients

Description: Median time from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status.

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. Approximately one third of hospitals in the US 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. 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. 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 admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status.

Included Populations:

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

Excluded Populations:

- Patients placed into *Observation Services*

Data Elements:

- *Decision to Admit Date*
- *Decision to Admit Time*
- *ED Departure Date*
- *ED Departure Time*
- *ED Patient*
- *ICD-9-CM Principal Diagnosis Code*
- *Observation Services*

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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- Hwang U, Richardson LD, Sonuyi TO, Morrison RS. The effect of emergency department crowding on the management of pain in older adults with hip fracture. *J Am Geriatr Soc*. 2006;54:270-5.
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- Krochmal P, Riley TA. Increased health care costs associated with ED overcrowding. *Am J Emerg Med*. 1994;12:265-6.
- Kyriacou DN, Ricketts V, Dyne PL, McCollough MD, Talan DA. A 5-year time study analysis of emergency department patient care efficiency. *Ann Emerg Med*. 1999;34:326-35.
- Nawar ED, Niska RW, Xu J. National Hospital Ambulatory Medical Care Survey: 2005 emergency department summary. *Adv Data*. 2007;(386):1-32.
- Richardson DB. Increase in patient mortality at 10 days associated with emergency department overcrowding. *Med J Aust*. 2006;184:213-6.
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- Trzeciak S, Rivers EP. Emergency department overcrowding in the United States: an emerging threat to patient safety and public health. *Emerg Med J*. 2003;20:402-5.
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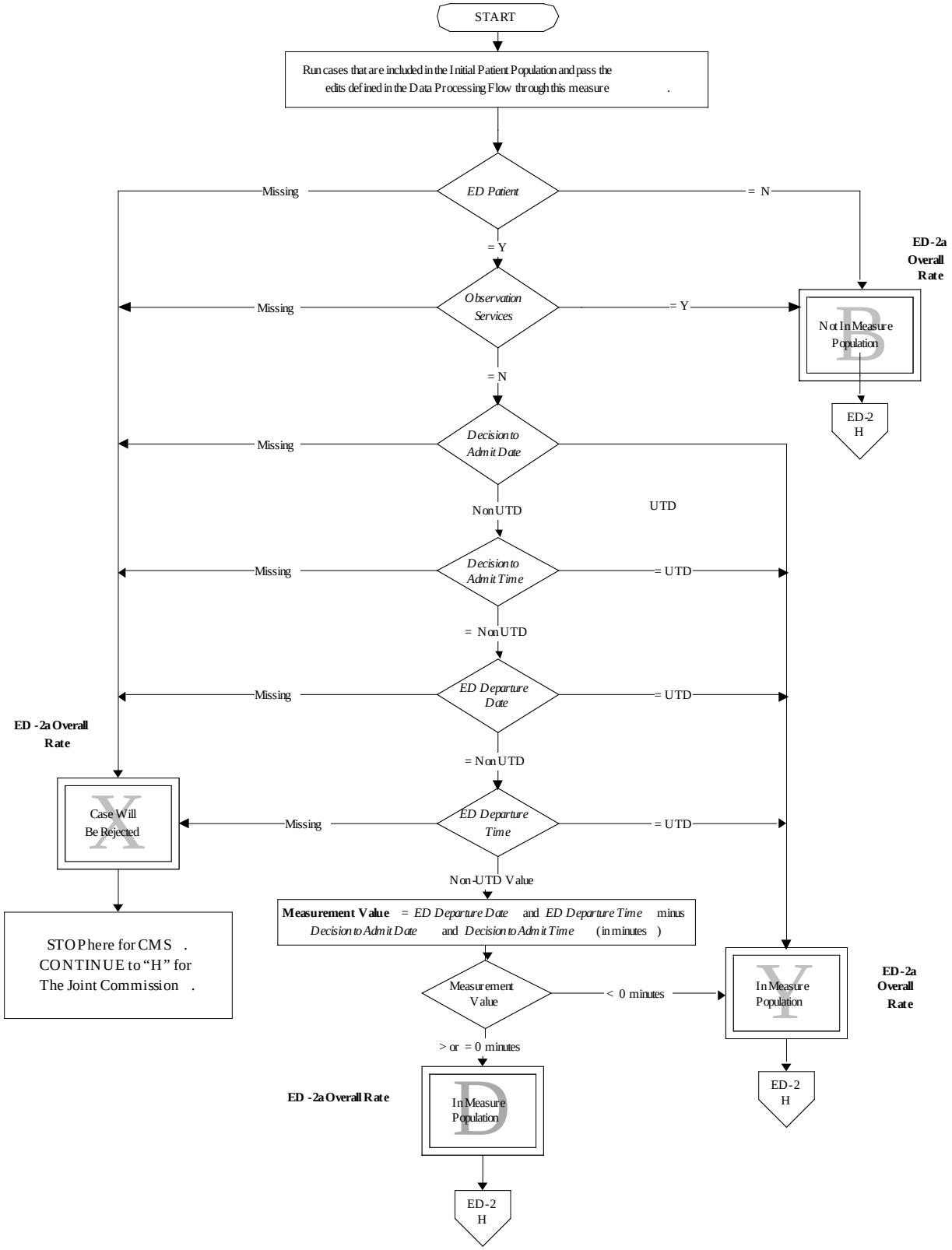
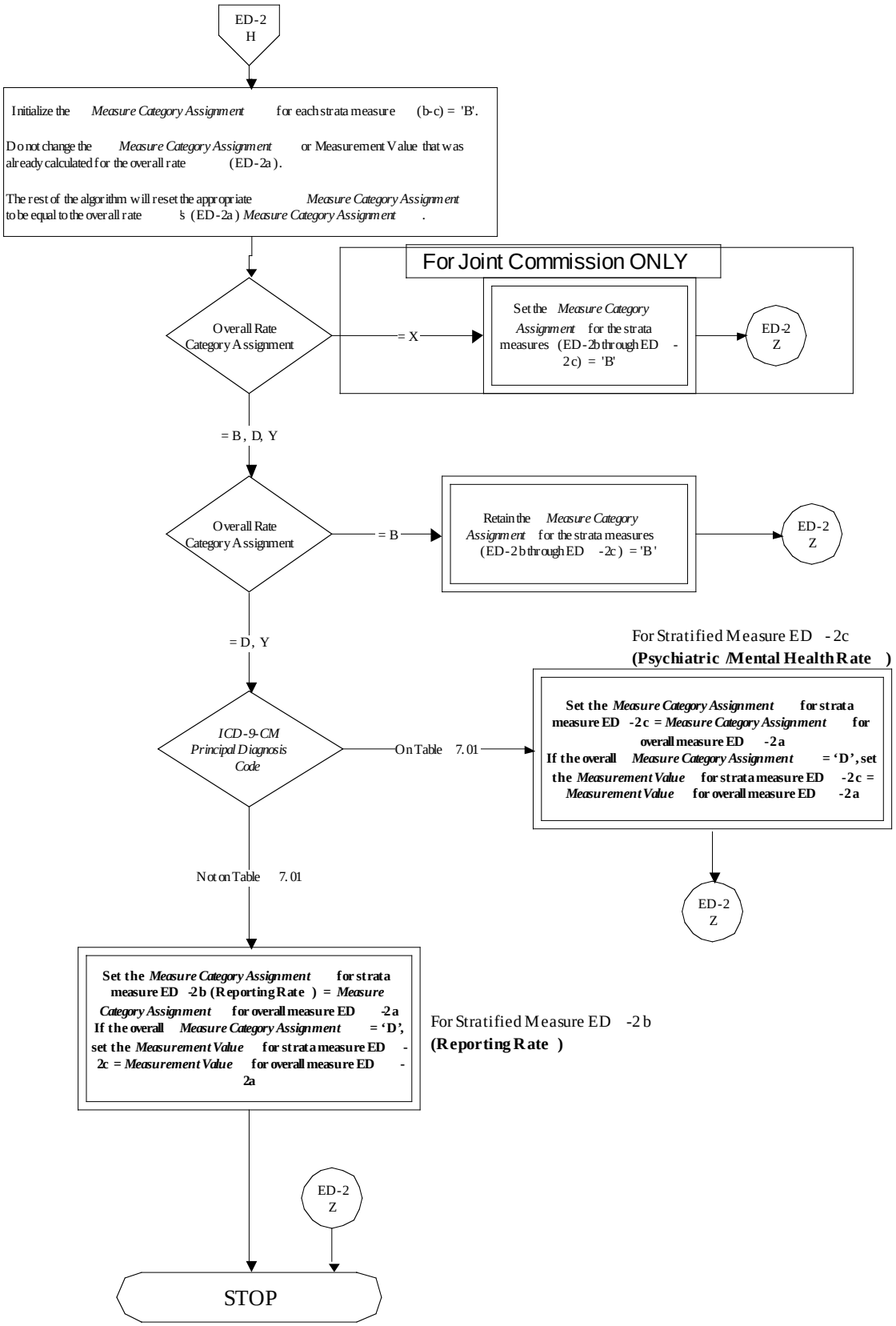
- Wilper AP, Woolhandler S, Lasser KE, McCormick D, Cutrona SL, Bor DH, Himmelstein DU. Waits to see an emergency department physician: U.S. trends and predictors, 1997-2004. *Health Aff* (Millwood). 2008;27:w84-95.

ED -2: Admit Decision Time to ED Departure Time for Non -discharged Patients

Continuous Variable Statement : Time (in minutes) from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status .




ED-2 H
Initialize the *Measure Category Assignment* for each strata measure (b-c) = 'B'.
Do not change the *Measure Category Assignment* or Measurement Value that was already calculated for the overall rate (ED-2a).
The rest of the algorithm will reset the appropriate *Measure Category Assignment* to be equal to the overall rate's (ED-2a) *Measure Category Assignment*.
For Joint Commission ONLY
Overall Rate Category Assignment
= X
Set the *Measure Category Assignment* for the strata measures (ED-2b through ED-2c) = 'B'
ED-2 Z
= B, D, Y
Overall Rate Category Assignment
= B
Retain the *Measure Category Assignment* for the strata measures (ED-2b through ED-2c) = 'B'
ED-2 Z
= D, Y
For Stratified Measure ED-2c
(Psychiatric /Mental Health Rate)
ICD-9-CM Principal Diagnosis Code
On Table 7.01
Set the *Measure Category Assignment* for strata measure ED-2c = *Measure Category Assignment* for overall measure ED-2a
If the overall *Measure Category Assignment* = 'D', set the *Measurement Value* for strata measure ED-2c = *Measurement Value* for overall measure ED-2a
ED-2 Z
Not on Table 7.01
Set the *Measure Category Assignment* for strata measure ED-2b (Reporting Rate) = *Measure Category Assignment* for overall measure ED-2a
If the overall *Measure Category Assignment* = 'D', set the *Measurement Value* for strata measure ED-2c = *Measurement Value* for overall measure ED-2a
For Stratified Measure ED-2b
(Reporting Rate)
ED-2 Z
STOP

Data Element Name: *Arrival Date*

Collected For: **CMS/The Joint Commission:** AMI-1, AMI-7, AMI-7a, AMI-8, AMI-8a, PN-3a, PN-3b, PN-5, PN-5c, PN-6, PN-6a, PN-6b
The Joint Commission Only: STK-4, STK-5
Informational Only: ED-1 (0495)

Definition: The earliest documented month, day, and year the patient arrived at the hospital.

Suggested Data Collection Question: What was the **earliest** documented date the patient arrived at the hospital?

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

Allowable Values: Enter the earliest documented date

MM =	Month (01-12)
DD =	Day (01-31)
YYYY =	Year (2001 – Current Year)
UTD =	Unable to Determine

Notes for Abstraction:

- If the date of arrival is unable to be determined from medical record documentation, select "UTD."
- The medical record must be abstracted as documented (taken at "face value"). When the date documented is obviously in error (not a valid format/range or outside of the parameters of care [after the *Discharge Date*]) **and** no other documentation is found that provides this information, the abstractor should select "UTD."
  Examples:
  - Documentation indicates the *Arrival Date* was 03-**42**-20XX. No other documentation in the list of ONLY ACCEPTABLE SOURCES provides a valid date. Since the *Arrival Date* is outside of the range listed in the Allowable Values for "Day", it is not a valid date and the abstractor should select "UTD."
  - Patient expires on 02-12-20XX and all documentation within the ONLY ACCEPTABLE SOURCES indicates the *Arrival Date* was 03-12-20XX. Other documentation in the medical record supports the date of death as being

accurate. Since the *Arrival Date* is after the *Discharge Date* (death), it is outside of the parameter of care and the abstractor should select "UTD."

Note:
Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" for *Arrival Date* allows the case to be accepted into the warehouse.

- Review only the acceptable sources to determine the earliest date the patient arrived at the hospital. This may differ from the admission date.

Note:

Notes for Abstraction continued:

Medical record documentation from all of the "only acceptable sources" should be carefully examined in determining the most correct date of arrival. Arrival date should NOT be abstracted simply as the earliest date in the acceptable sources, without regard to other (i.e., ancillary services) substantiating documentation. If documentation suggests that the earliest date in the acceptable sources does not reflect the date the patient arrived at the hospital, this date should not be used.

- When reviewing ED records 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 in the ED or hospital.
- If the patient is in an outpatient setting of the hospital, except for observation status, (e.g., undergoing dialysis, chemotherapy, cardiac cath) and is subsequently admitted to acute inpatient, use the date the patient presents to the ED or arrives on the floor for inpatient care as arrival date.
- If the patient is in an observation status and is subsequently admitted to the hospital:
  - If the patient was admitted to observation from an outpatient setting of the hospital, use the date the patient presents to the ED or arrived on the floor for observation care as the arrival date.
  - If the patient was admitted to observation from the ED of the hospital, use the date the patient presented to the ED as the arrival date.
  - If the patient was a direct admit to observation, use the earliest date the patient arrived at the hospital.
- If the patient is a "Direct Admit" to the cath lab, as a transfer from another ED or acute care hospital, use the date the patient presents to the cath lab as the arrival date.
- For "Direct Admits" to acute inpatient, use the earliest date the patient arrives at the hospital.

Notes for Abstraction continued:

- The source "Any ED documentation" includes ED vital sign record, ED/Outpatient Registration form, triage record and ECG reports, laboratory reports, x-ray reports, etc., if these ancillary services were rendered while the patient was an ED patient.
- The source "Procedure notes" refers to formal documents that describe a procedure that was done (e.g., endoscopy, cardiac cath). ECG and x-ray reports should NOT be considered procedures notes.

Suggested Data Sources:

ONLY ACCEPTABLE SOURCES:

- Any ED documentation
- Nursing admission assessment/admitting note
- Observation record
- Procedure notes
- Vital signs graphic record

For "Direct Admits," in addition to the above suggested data sources, the following may also be utilized:

- Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	Addressographs/stamps

Data Element Name: *Arrival Time*

Collected For: **CMS/The Joint Commission:** AMI-7, AMI-7a, AMI-8, AMI-8a, PN-3a, PN-3b, PN-5, PN-5c, PN 6, PN-6a, PN-6b
The Joint Commission Only: STK-4
Informational Only: ED-1 (0495)

Definition: The earliest documented time (military time) the patient arrived at the hospital.

Suggested Data Collection Question: What was the **earliest** documented time the patient arrived at the hospital?

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

Note:
00:00 = midnight. If the time is documented as 00:00 11-24-20XX, review supporting documentation to determine if the *Arrival 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 *Arrival Date.*
Example:
Midnight or 24:00 on 11-24-20XX = 00:00 on 11-25-20XX

Notes for Abstraction:

- For times that include "seconds", remove the seconds and record the time as is.
  Example:
  15:00:35 would be recorded as 15:00
- If the time of arrival is unable to be determined from medical record documentation, select "UTD."
- The medical record must be abstracted as documented (taken at "face value"). When the time documented is obviously in error (not a valid format/range) **and** no other documentation is found that provides this information, the abstractor should select "UTD."
  Example:
  Documentation indicates the *Arrival Time* was 3300. No other documentation in the list of ONLY ACCEPTABLE SOURCES provides a valid time. Since the *Arrival Time* is outside of the range in the Allowable Values for "Hour," it is not a valid time and the abstractor should select "UTD."
  Note:
  Transmission of a case with an invalid time as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" for *Arrival Time* allows the case to be accepted into the warehouse.
- Review only the acceptable sources to determine the earliest time the patient arrived at the hospital. This may differ from the admission time.
  Note:
  Medical record documentation from all of the "only acceptable sources" should be carefully examined in determining the most correct time of arrival. 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 hospital, this time should not be used.
- When reviewing ED records 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 in the ED or hospital.
- If the patient is in an outpatient setting of the hospital, except for observation status, (e.g., undergoing dialysis, chemotherapy, cardiac cath) and is subsequently admitted to acute inpatient, use the time the patient presents to the ED or arrives on the floor for acute inpatient care as the arrival time.

Notes for Abstraction continued:

- If the patient is in an observation status and is subsequently admitted to the hospital:

- If the patient was admitted to observation from an outpatient setting of the hospital, use the time the patient presents to the ED or arrived on the floor for observation care as the arrival time.
- If the patient was admitted to observation from the ED of the hospital, use the time the patient presented to the ED as the arrival time.
- If the patient was a direct admit to observation, use the earliest time the patient arrived at the hospital.

- If the patient is a "Direct Admit" to the cath lab, as a transfer from another ED or acute care hospital, use the time the patient presents to the cath lab as the arrival time.
- For "Direct Admits" to acute inpatient, use the earliest time the patient arrives at the hospital.
- The source "Any ED documentation" includes ED vital sign record, ED/Outpatient Registration form, triage record and ECG reports, laboratory reports, x-ray reports, etc., if these ancillary services were rendered while the patient was an ED patient.
- The source "Procedure notes" refers to formal documents that describe a procedure that was done (e.g., endoscopy, cardiac cath). ECG and x-ray reports should NOT be considered procedure notes.

Suggested Data Sources: **ONLY ACCEPTABLE SOURCES:**

- Any ED documentation
- Nursing admission assessment/admitting note
- Observation record
- Procedure notes
- Vital signs graphic record

For "Direct Admits," in addition to the above suggested data sources, the following may also be utilized:

- Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	Addressographs/stamps

Data Element Name:	*Decision to Admit Date*
Collected For:	**Informational Only:** ED-2 (0497)
Definition:	The documented date the decision to admit occurred. Decision to admit date is the date on which the physician/APN/PA makes the decision to admit the patient from the emergency department to the hospital as an inpatient.
Suggested Data Collection Question:	What was the earliest documented month, day, and year of the decision to admit?
Format:	**Length:** 10 – MM-DD-YYYY (includes dashes) or UTD **Type:** Date **Occurs:** 1
Allowable Values:	Enter the documented date of the decision to admit MM = Month (01-12) YYYY = Year (2001-Current Year) UTD = Unable to Determine
Notes for Abstraction:	• If the date of the decision to admit is unable to be determined from medical record documentation, abstract "UTD." • If it can be determined that the patient arrived on the same date and departed on the same date, the arrival date can be used as the decision to admit date. • If there are multiple dates documented for the decision to admit abstract the earliest date. • For purposes of this data element *Decision to Admit Date* is the date on which the physician/APN/PA makes the decision to admit the patient from the emergency department to the hospital as an inpatient. This will not necessarily coincide with the date the patient is officially admitted to inpatient status. • If the decision to admit the patient is made, but the actual request for a bed is delayed until an inpatient bed is available, record the date the physician/APN/PA made the decision to admit. • If the decision to admit date is dated prior to the date of patient arrival or after the date of departure, abstract UTD.
Notes for Abstraction continued:	• The inclusion and exclusion lists are not to be considered comprehensive lists of inclusions and exclusions.

Suggested Data Sources: **ONLY ACCEPTABLE SOURCES:**
Emergency Department record

Guidelines for Abstraction:

Inclusion	Exclusion
• Bed Request Date • Call for room Date	• Direct admit patients seen in the ED • Bed assignment Date • Admit Orders Date • Admit to Observation Date

Data Element Name: *Decision to Admit Time*

Collected For: **Informational Only:** ED-2 (0497)

Definition: The documented time (military time) the decision to admit occurred. Decision to admit time is the time at which the physician/APN/PA makes the decision to admit the patient from the emergency department to the hospital as an inpatient.

Suggested Data Collection Question: What was the earliest documented time of the decision to admit?

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

Allowable Values: 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 *Decision to Admit 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 *Decision to Admit Date.*
Example:
Midnight or 24:00 on 11-24-20xx = 00:00 on 11-25-20xx

Notes for Abstraction:

- For times that include "seconds," remove the seconds and record the military time
  Example: 15:00:35 would be recorded as 15:00
- If the time of the decision to admit is unable to be determined

from medical record documentation, abstract UTD.

- If there are multiple times documented for the decision to admit abstract the earliest time.
- For purposes of this data element "decision to admit time" is the time the physician/APN/PA makes the decision to admit the patient from the emergency department to the hospital as an inpatient. This will not necessarily coincide with the time the patient is officially admitted to inpatient status.
- If the decision to admit the patient is made, but the actual request for a bed is delayed until an inpatient bed is available, record the time the physician/APN/PA made the decision to admit.
- If documentation of the decision to admit time is prior to arrival or after departure from the ED, abstract UTD.
- The inclusion and exclusion lists are not to be considered comprehensive lists of inclusions and exclusions

Suggested Data Sources: **ONLY ACCEPTABLE SOURCES:**
Emergency Department record

Guidelines for Abstraction:

Inclusion	Exclusion
• Bed Request Time • Call for room time	• Direct admit patients seen in the ED • Bed assignment time • Admit Orders Time • Report Called Time • Admit to Observation Time

Data Element Name:	*ED Departure Date*
Collected For:	**Informational Only:** ED-1 (0495), ED-2 (0497)
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-Current) UTD = Unable to Determine
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). • If there is documentation the patient left against medical advice and it cannot be determined what time the patient left against medical advice, abstract "UTD." • For patients who are placed into observation outside the services of the emergency department, abstract the date of departure from the emergency department. • For patients who are placed into observation under the services of the emergency department, abstract the date of departure from the observation services (e.g., patient is seen in the ED and admitted to an observation unit of the ED on 01-01-20XX then is discharged from the observation unit on 01-03-20XX abstract 01-03-20XX as the departure date. • The inclusion and exclusion lists are not to be considered comprehensive lists of inclusions and exclusions
Suggested Data Sources:	**ONLY ACCEPTABLE SOURCES:** Emergency Department record

Guidelines for Abstraction:

Inclusion	Exclusion
• ED Departure Date • ED Discharge Date • ED Leave Time	None

Data Element Name: *ED Departure Time*

Collected For: **Informational Only:** ED-1 (0495), ED-2 (0497)

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:
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 *ED Departure Time* 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 *ED Departure Time.*
Example:
Midnight or 24:00 on 11-24-20XX = 00:00 on 11-25-20XX

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 "18:00 transfer to floor-room 300" and other documentation includes a time that the patient left the ED via stretcher,**

Notes for Abstraction continued:

abstract the later time or nurses notes state "18:00 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 acceptable emergency department departure/discharge time is documented abstract the latest time.

  Example:
  - Two departure times are found in the nurse's notes: 12:03 via wheelchair and 12:20 via wheelchair. 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.
- For patients who are placed into observation outside the services of the emergency department, abstract the time of departure from the emergency department.
  - 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.
- For patients who are placed into observation under the services of the emergency department, abstract the time of departure from the observation services.
  If a patient is seen in the ED and admitted to an observation unit of the ED, then discharged from the observation unit, abstract the time they depart the observation unit.

  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.
- **The inclusion and exclusion lists are not to be considered comprehensive lists of inclusions and exclusions**

Suggested Data Sources:

ONLY ACCEPTABLE SOURCES:
Emergency Department record

Guidelines for Abstraction:

Inclusion	Exclusion
• ED Leave Time • ED Discharge Time • ED Departure Time • ED Check Out Time	• Report Called Time

Data Element Name: *ED Patient*

Collected For: **The Joint Commission Only:** STK-4
Informational Only: ED-1 (0495), ED-2 (0497)

Definition: Patient received 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 Urgent Care, ER Fast Track, etc. 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".

Guidelines for Abstraction:

Inclusion	Exclusion
None	• Urgent Care • Fast Track ED • Terms synonomous with Urgent Care

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

Collected For: **CMS/The Joint Commission:** All Records
Used in Algorithms for:
The Joint Commision Only: STK-2, STK-3, STK-4, STK-5, STK-6, All VTE Measures

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 occasioning the admission of the patient for this hospitalization.

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 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:
- Discharge summary
- Face sheet
- UB-04, Field Location: 67

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendix A, for ICD-9-CM Code Tables (AMI, HF, PN, STK, VTE).	Refer to Appendix A, for ICD-9-CM Code Tables (SCIP).

Data Element Name: *Observation Services*

Collected For: **Informational Only**: ED-1 (0495), ED-2 (0497)

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 was documentation the patient was placed into observation services in this facility's emergency department.

N (No) There was no documentation the patient was placed into observation services in this facility's emergency department or unable to determine from medical record documentation.

Notes for Abstraction:

- If there is documentation the patient was placed into observation services and received care in observation provide by the emergency department or an observation unit of the emergency department, select "Yes."
- If there is documentation the patient is being admitted for observation outside the emergency department, select "No."
- If there is no documentation the patient received services in observation either in the emergency department or was to be admitted to another department for observation, select "No."
- The intent is to capture emergency department patients placed into observation services prior to admission to the facility as an inpatient.

Suggested Data Sources: **ONLY ALLOWABLE SOURCES:**
Emergency Department record

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

EMERGENCY DEPARTMENT NATIONAL HOSPITAL QUALITY MEASURES

NQF Measure ID #	Set Measure ID #	Measure Short Name
0496	**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:
Arrival Time	All Records
Birthdate	All Records
CMS Certification Number	All Records
First Name	All Records
Hispanic Ethnicity	All Records
Last Name	All Records
National Provider Identifier	All Records
Outpatient Encounter Date	All Records
Patient HIC#	All Records
Patient Identifier	All Records
Payment Source	All Records
Postal Code	All Records
Race	All Records
Sex	All Records

OP EMERGENCY DEPARTMENT SPECIFIC DATA ELEMENT LIST

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

Measure Information Form

Measure Set: Emergency Department

Set Measure ID #: OP-X (0496)

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:

- Diercks DB, et al. Prolonged emergency department stays of non-ST-segment-elevation myocardial infarction patients are associated with worse adherence to the American College of Cardiology/American Heart Association guidelines for management and increased adverse events. *Ann Emerg Med*. 2007;50:489-96.
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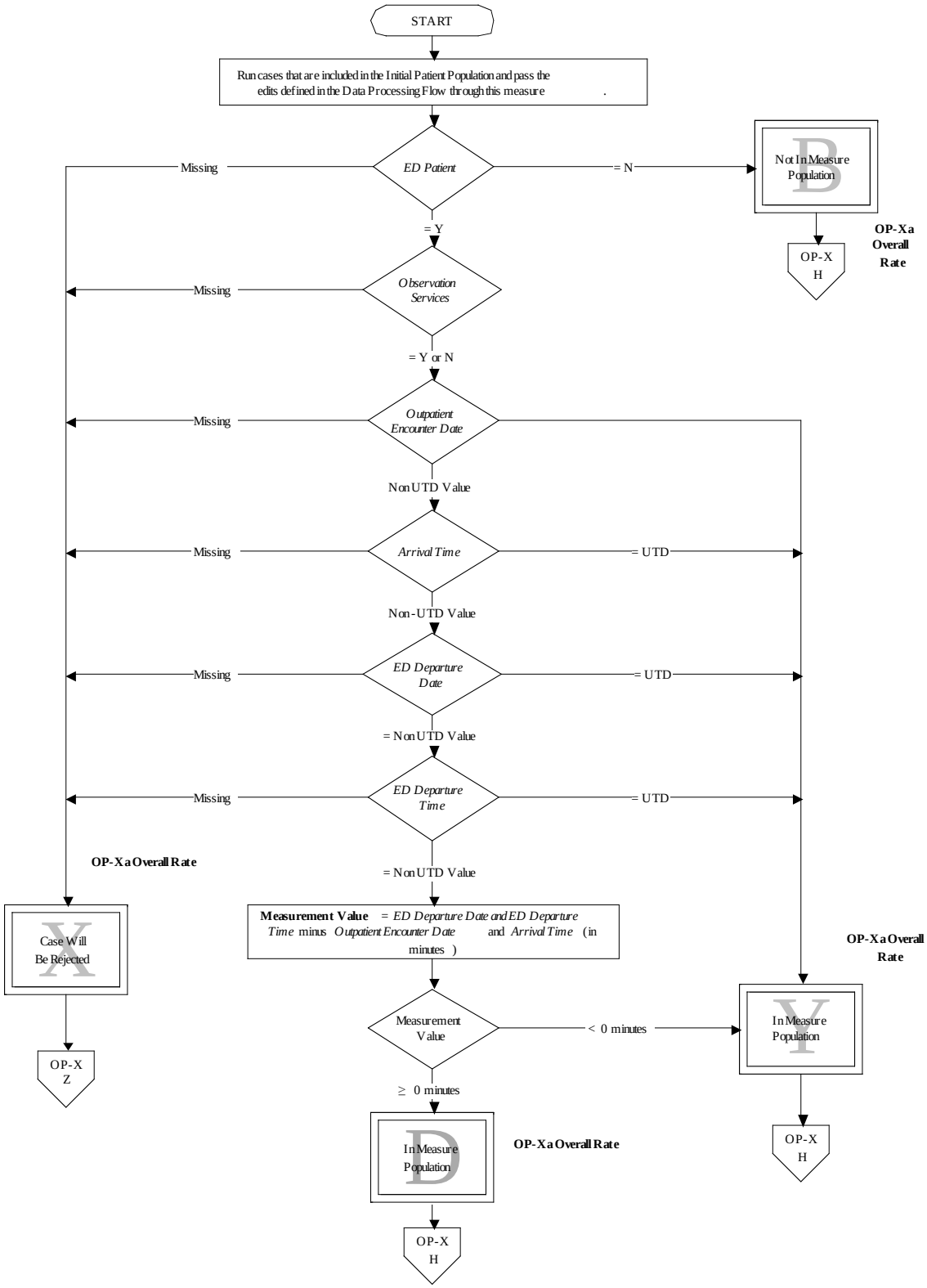
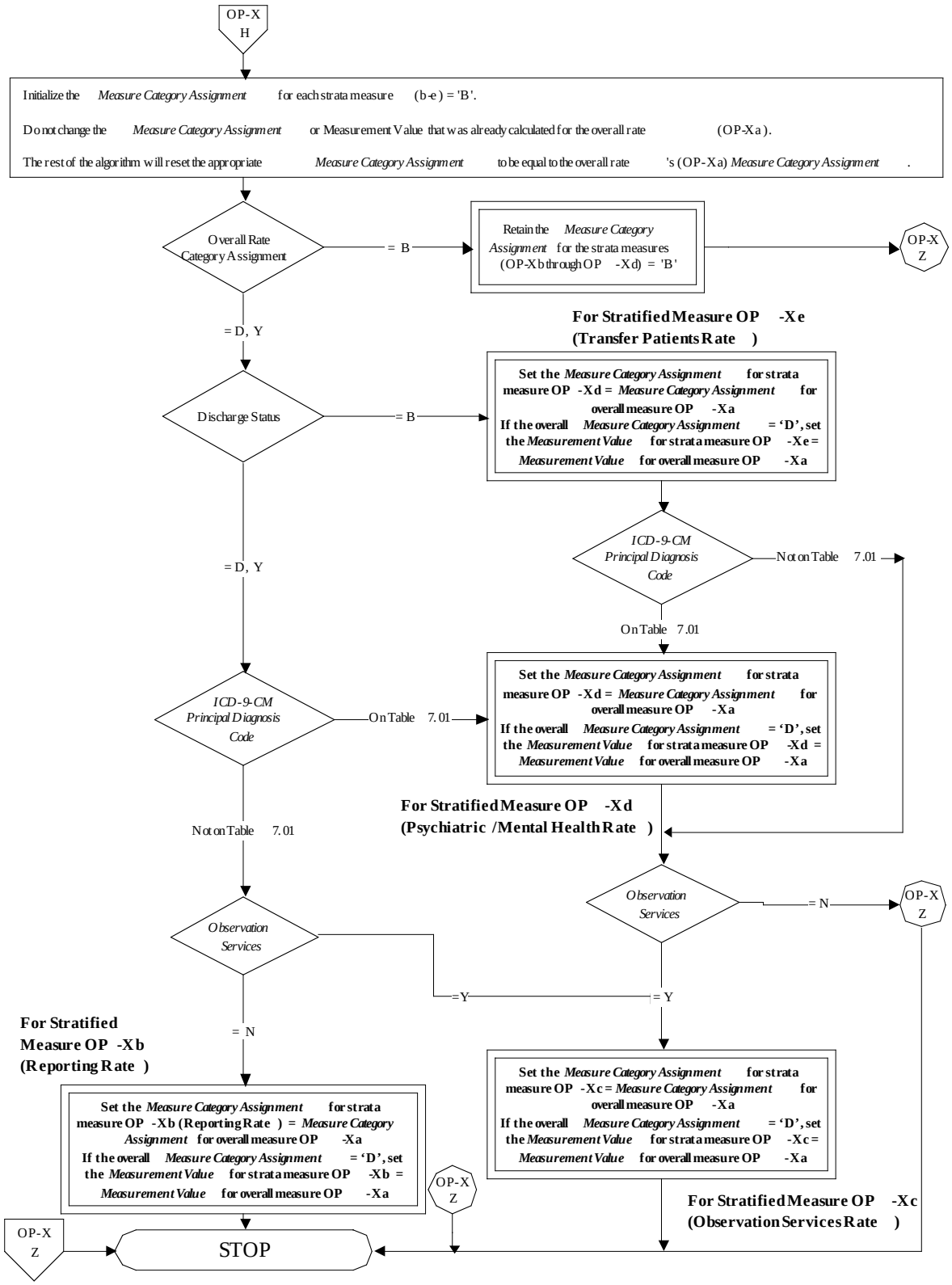
- Fatovich DM, Hirsch RL. Entry overload, emergency department overcrowding, and ambulance bypass. *Emerg Med J*. 2003;20:406-9.
- Hwang U, Richardson LD, Sonuyi TO, Morrison RS. The effect of emergency department crowding on the management of pain in older adults with hip fracture. *J Am Geriatr Soc*. 2006;54:270-5.
- Institute of Medicine of the National Academies. Future of emergency care: Hospital-based emergency care at the breaking point. *The National Academies Press* 2006.
- Kyriacou DN, Ricketts V, Dyne PL, McCollough MD, Talan DA. A 5-year time study analysis of emergency department patient care efficiency. *Ann Emerg Med*. 1999;34:326-35.
- Pines JM, et al. ED crowding is associated with variable perceptions of care compromise. *Acad Emerg Med*. 2007;14:1176-81.
- Pines JM, et al. Emergency department crowding is associated with poor care for patients with severe pain. *Ann Emerg Med*. 2008;51:6-7.
- Schull MJ, et al. Emergency department crowding and thrombolysis delays in acute myocardial infarction. *Ann Emerg Med.* 2004;44:577-85.
- Siegel B, et al. Enhancing work flow to reduce crowding. *Jt Comm J Qual Patient Saf*. 2007;33(11 Suppl):57-67.
- Trzeciak S, Rivers EP. Emergency department overcrowding in the United States: an emerging threat to patient safety and public health. *Emerg Med J*. 2003;20:402-5.
- 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.




OP-X H
Initialize the Measure Category Assignment for each strata measure (b-e) = 'B'.
Do not change the Measure Category Assignment or Measurement Value that was already calculated for the overall rate (OP-Xa).
The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall rate 's (OP-Xa) Measure Category Assignment.
Overall Rate Category Assignment
= B
Retain the Measure Category Assignment for the strata measures (OP-Xb through OP-Xd) = 'B'
OP-X Z
= D, Y
For Stratified Measure OP-Xe (Transfer Patients Rate)
Discharge Status
= B
Set the Measure Category Assignment for strata measure OP-Xd = Measure Category Assignment for overall measure OP-Xa
If the overall Measure Category Assignment = 'D', set the Measurement Value for strata measure OP-Xe = Measurement Value for overall measure OP-Xa
= D, Y
ICD-9-CM Principal Diagnosis Code
Not on Table 7.01
On Table 7.01
ICD-9-CM Principal Diagnosis Code
On Table 7.01
Set the Measure Category Assignment for strata measure OP-Xd = Measure Category Assignment for overall measure OP-Xa
If the overall Measure Category Assignment = 'D', set the Measurement Value for strata measure OP-Xd = Measurement Value for overall measure OP-Xa
For Stratified Measure OP-Xd (Psychiatric /Mental Health Rate)
Not on Table 7.01
Observation Services
= N
OP-X Z
Observation Services
=Y
= Y
For Stratified Measure OP-Xb (Reporting Rate)
= N
Set the Measure Category Assignment for strata measure OP-Xc = Measure Category Assignment for overall measure OP-Xa
If the overall Measure Category Assignment = 'D', set the Measurement Value for strata measure OP-Xc = Measurement Value for overall measure OP-Xa
Set the Measure Category Assignment for strata measure OP-Xb (Reporting Rate) = Measure Category Assignment for overall measure OP-Xa
If the overall Measure Category Assignment = 'D', set the Measurement Value for strata measure OP-Xb = Measurement Value for overall measure OP-Xa
OP-X Z
For Stratified Measure OP-Xc (Observation Services Rate)
OP-X Z
STOP

Data Element Name: *Arrival Time*

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

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 OPPS 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:

- 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: *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: *Discharge Status*

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:

01 **Discharged to home care or self care (routine discharge)**
Usage Note: Includes discharge to home; jail or law enforcement; home on oxygen if DMS only; any other DMS only; group home, foster care, and other residential care arrangements; outpatient programs, such as partial hospitalization or outpatient chemical dependency programs; assisted living facilities that are not state-designated.

02 **Discharged/transferred to a short term general hospital for inpatient care (Acute Care Facility)**

03 **Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care**
Usage Note: 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.

04 **Discharged/transferred to an intermediate care facility (ICF)**
Usage Note: Typically defined at the state level for specifically designated intermediate care facilities. Also used to designate patients that are discharged/transferred to a nursing facility with neither Medicare nor Medicaid certification and for discharges/transfers to state designated Assisted Living Facilities.

05 **Discharged/transferred to a designate cancer center or children's hospital**
Usage Note: 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

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**

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: *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)

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: *ED Departure Time*

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:

- 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:

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

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 mediflight 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:
  - 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: *ICD-9-CM Principal Diagnosis Code*

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

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: *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

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

Table 7.01 Mental Disorders		
Code	ICD-9-CM Description	Shortened Description
290.0	Senile dementia, uncomplicated, Senile dementia: NOS, simple type	SENILE DEMENTIA UNCOMP
290.10	Presenile dementia, uncomplicated, Presenile dementia: NOS, Presenile dementia: simple type	PRESENILE DEMENTIA
290.11	Presenile dementia with delirium, Presenile dementia with acute confusional state	PRESENILE DELIRIUM
290.12	Presenile dementia with delusional features, Presenile dementia, paranoid type	PRESENILE DELUSION
290.13	Presenile dementia with depressive features, Presenile dementia, depressed type	PRESENILE DEPRESSION
290.20	Senile dementia with delusional features, Senile dementia, paranoid type, Senile psychosis NOS	SENILE DELUSION
290.21	Senile dementia with depressive features	SENILE DEPRESSIVE
290.3	Senile dementia with delirium, Senile dementia with acute confusional state	SENILE DELIRIUM
290.40	Vascular dementia, uncomplicated, Arteriosclerotic dementia: NOS, simple type	VASCULAR DEMENTIA,UNCOMP
290.41	Vascular dementia with delirium, Arteriosclerotic dementia with acute confusional state	VASC DEMENTIA W DELIRIUM
290.42	Vascular dementia with delusions, Arteriosclerotic dementia, paranoid type	VASC DEMENTIA W DELUSION
290.43	Vascular dementia with depressed mood, Arteriosclerotic dementia, depressed type	VASC DEMENTIA W DEPRESSN
290.8	Other specified senile psychotic conditions, Presbyophrenic psychosis	SENILE PSYCHOSIS NEC

Table 7.01 Mental Disorders (Cont)		
Code	ICD-9-CM Description	Shortened Description
290.9	Unspecified senile psychotic condition	SENILE PSYCHOT COND NOS
291.0	Alcohol withdrawal delirium, Alcoholic delirium, Delirium tremens	DELIRIUM TREMENS
291.1	Alcohol induced persisting amnestic disorder, Alcoholic polyneuritic psychosis, Korsakoff's syndrome (alcoholic), Wernicke-Korsakoff syndrome (alcoholic)	ALCOHOL AMNESTIC DISORDR
291.2	Alcohol induced persisting dementia, Alcoholic dementia NOS, Alcoholism associated with dementia NOS, Chronic alcoholic brain syndrome	ALCOHOL PERSIST DEMENTIA
291.3	Alcohol induced psychotic disorder with hallucinations, Alcoholic: hallucinosis (acute), Alcoholic: psychosis with hallucinosis	ALCOH PSY DIS W HALLUCIN
291.4	Idiosyncratic alcohol intoxication, Pathologic: alcohol intoxication, Pathologic: drunkenness	PATHOLOGIC ALCOHOL INTOX
291.5	Alcohol induced psychotic disorder with delusions, Alcoholic: paranoia, Alcoholic: psychosis paranoid type	ALCOH PSYCH DIS W DELUS
291.81	Alcohol withdrawal, Alcohol: abstinence syndrome or symptoms, withdrawal syndrome or symptoms	ALCOHOL WITHDRAWAL

Table 7.01 Mental Disorders (Cont)

Code	ICD-9-CM Description	Shortened Description
291.82	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	Other, Alcohol induced anxiety disorder, Alcohol induced mood disorder, Alcohol induced sexual dysfunction	ALCOHOL MENTAL DISOR NEC
291.9	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 withdrawal, Drug: abstinence syndrome or symptoms, withdrawal syndrome or symptoms	DRUG WITHDRAWAL
292.11	Drug induced psychotic disorder with delusions, Paranoid state induces by drugs	DRUG PSYCH DISOR W DELUS
292.12	Drug induced psychotic disorder with hallucinations, Hallucinatory state induced by drugs	DRUG PSY DIS W HALLUCIN
292.2	Pathological drug intoxication, Drug reaction: NOS, idiosyncratic, pathologic-resulting in brief psychotic states	PATHOLOGIC DRUG INTOX
292.81	Drug induced delirium	DRUG-INDUCED DELIRIUM
292.82	Drug induced persisting dementia disorder	DRUG PERSISTING DEMENTIA
292.83	Drug induced persisting amnestic disorder	DRUG PERSIST AMNESTC DIS
292.84	Drug induced mood disorders, Depressive state induced by drugs	DRUG-INDUCED MOOD DISORD
292.85	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	Other, Drug induced anxiety disorder, Drug induced organic personality syndrome, Drug induced sexual dysfunction, Drug intoxication	DRUG MENTAL DISORDER NEC
292.9	Unspecified drug induced mental disorder, Drug related disorder NOS, Organic psychosis NOS due to or associated with drugs	DRUG MENTAL DISORDER NOS
293.0	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	Subacute delirium, Subacute: confusional state, infective psychosis, organic reaction, posttraumatic syndrome, psychosis associated with endocrine or metabolic disorder	SUBACUTE DELIRIUM
293.81	Psychotic disorder with delusions in conditions classified elsewhere, Transient organic psychotic condition, paranoid type	PSY DIS W DELUS OTH DIS
293.82	Psychotic disorder with hallucinations in conditions classified elsewhere, Transient organic psychotic condition, hallucinatory type	PSY DIS W HALLUC OTH DIS

Table 7.01 Mental Disorders (Cont)

Code	ICD-9-CM Description	Shortened Description
293.83	Mood disorder in conditions classified elsewhere, Transient organic psychotic condition, depressive type	MOOD DISORDER OTHER DIS
293.84	Anxiety disorder in conditions classified elsewhere	ANXIETY DISORDER OTH DIS
293.89	Other, Catatonic disorder in conditions classified elsewhere	TRANSIENT MENTAL DIS NEC
293.9	Unspecified transient mental disorder in conditions classified elsewhere, Organic psychosis: infective NOS, posttraumatic NOS, Organic psychosis: transient NOS, Psycho-organic syndrome	TRANSIENT MENTAL DIS NOS
294.0	Amnestic disorder in conditions classified elsewhere, Korsakoff's psychosis or syndrome (nonalcoholic)	AMNESTIC DISORD OTH DIS
294.10	Dementia in conditions classified elsewhere without behavioral disturbance, Dementia in conditions classified elsewhere NOS	DEMENTIA W/O BEHAV DIST
294.11	Dementia in conditions classified elsewhere with behavioral disturbance, Aggressive behavior, Combative behavior, Violent behavior, Wandering off	DEMENTIA W BEHAVIOR DIST
294.8	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	Unspecified persistent mental disorders due to conditions classified elsewhere, Cognitive disorder NOS, Organic psychosis (chronic)	MENTAL DISOR NOS OTH DIS
295.00	Simple type, Schizophrenia simplex, unspecified	SIMPL SCHIZOPHREN-UNSPEC
295.01	Simple type, Schizophrenia simplex, subchronic	SIMPL SCHIZOPHREN-SUBCHR
295.02	Simple type, Schizophrenia simplex, chronic	SIMPLE SCHIZOPHREN-CHR
295.03	Simple type, Schizophrenia simplex, subchronic with acute exacerbation	SIMP SCHIZ-SUBCHR/EXACER
295.04	Simple type, Schizophrenia simplex, chronic with acute exacerbation	SIMPL SCHIZO-CHR/EXACERB
295.05	Simple type, Schizophrenia simplex, in remission	SIMPL SCHIZOPHREN-REMISS
295.10	Disorganized type, Hebephrenia, Hebephrenic type schizophrenia, unspecified	HEBEPHRENIA-UNSPEC
295.11	Disorganized type, Hebephrenia, Hebephrenic type schizophrenia, subchronic	HEBEPHRENIA-SUBCHRONIC
295.12	Disorganized type, Hebephrenia, Hebephrenic type schizophrenia, chronic	HEBEPHRENIA-CHRONIC
295.13	Disorganized type, Hebephrenia, Hebephrenic type schizophrenia, subchronic with acute exacerbation	HEBEPHREN-SUBCHR/EXACERB
295.14	Disorganized type, Hebephrenia, Hebephrenic type schizophrenia, chronic with acute exacerbation	HEBEPHRENIA-CHR/EXACERB
295.15	Disorganized type, Hebephrenia, Hebephrenic type schizophrenia in remission	HEBEPHRENIA-REMISSION
295.20	Catatonic type, Catatonic (schizophrenia): agitation, excitation, excited type, stupor, withdrawn type, Schizophrenic: catalepsy, catatonia, flexibilitas cerea, unspecified	CATATONIA-UNSPEC

Table 7.01 Mental Disorders (Cont)

Code	ICD-9-CM Description	Shortened Description
295.21	Catatonic type, Catatonic (schizophrenia): agitation, excitation, excited type, stupor, withdrawn type, Schizophrenic: catalepsy, catatonia, flexibilitas cerea, subchronic	CATATONIA-SUBCHRONIC
295.22	Catatonic type, Catatonic (schizophrenia): agitation, excitation, excited type, stupor, withdrawn type, Schizophrenic: catalepsy, catatonia, flexibilitas cerea, chronic	CATATONIA-CHRONIC
295.23	Catatonic type, Catatonic (schizophrenia): agitation, excitation, excited type, stupor, withdrawn type, Schizophrenic: catalepsy, catatonia, flexibilitas cerea, subchronic with acute exacerbation	CATATONIA-SUBCHR/EXACERB
295.24	Catatonic type, Catatonic (schizophrenia): agitation, excitation, excited type, stupor, withdrawn type, Schizophrenic: catalepsy, catatonia, flexibilitas cerea, chronic with acute exacerbation	CATATONIA-CHR/EXACERB
295.25	Catatonic type, Catatonic (schizophrenia): agitation, excitation, excited type, stupor, withdrawn type, Schizophrenic: catalepsy, catatonia, flexibilitas cerea, in remission	CATATONIA-REMISSION
295.30	Paranoid type, Paraphrenic schizophrenia, unspecified	PARANOID SCHIZO-UNSPEC
295.31	Paranoid type, Paraphrenic schizophrenia, subchronic	PARANOID SCHIZO-SUBCHR
295.32	Paranoid type, Paraphrenic schizophrenia, chronic	PARANOID SCHIZO-CHRONIC
295.33	Paranoid type, Paraphrenic schizophrenia, subchronic with acute exacerbation	PARAN SCHIZO-SUBCHR/EXAC
295.34	Paranoid type, Paraphrenic schizophrenia, chronic with acute exacerbation	PARAN SCHIZO-CHR/EXACERB
295.35	Paranoid type, Paraphrenic schizophrenia, in remission	PARANOID SCHIZO-REMISS
295.40	Schizophreniform disorder, Oneirophrenia, Schizophreniform: attack, Schizophreniform: psychosis, confusional type, unspecified	SCHIZOPHRENIFORM DIS NOS
295.41	Schizophreniform disorder, Oneirophrenia, Schizophreniform: attack, Schizophreniform: psychosis, confusional type, subchronic	SCHIZOPHRENIC DIS-SUBCHR
295.42	Schizophreniform disorder, Oneirophrenia, Schizophreniform: attack, Schizophreniform: psychosis, confusional type, chronic	SCHIZOPHREN DIS-CHRONIC
295.43	Schizophreniform disorder, Oneirophrenia, Schizophreniform: attack, Schizophreniform: psychosis, confusional type, subchronic with acute exacerbation	SCHIZO DIS-SUBCHR/EXACER
295.44	Schizophreniform disorder, Oneirophrenia, Schizophreniform: attack, Schizophreniform: psychosis, confusional type, chronic with acute exacerbation	SCHIZOPHR DIS-CHR/EXACER
295.45	Schizophreniform disorder, Oneirophrenia, Schizophreniform: attack, Schizophreniform: psychosis, confusional type, in remission	SCHIZOPHRENIC DIS-REMISS
295.50	Latent schizophrenia, Latent schizophrenic reaction, Schizophrenia: borderline, incipient, prepsychotic, prodromal, pseudoneurotic, pseudopsychopathic, unspecified	LATENT SCHIZOPHREN-UNSP

Table 7.01 Mental Disorders (Cont)

Code	ICD-9-CM Description	Shortened Description
295.51	Latent schizophrenia, Latent schizophrenic reaction, Schizophrenia: borderline, incipient, prepsychotic, prodromal, pseudoneurotic, pseudopsychopathic, subchronic	LAT SCHIZOPHREN-SUBCHR
295.52	Latent schizophrenia, Latent schizophrenic reaction, Schizophrenia: borderline, incipient, prepsychotic, prodromal, pseudoneurotic, pseudopsychopathic, chronic	LATENT SCHIZOPHREN-CHR
295.53	Latent schizophrenia, Latent schizophrenic reaction, Schizophrenia: borderline, incipient, prepsychotic, prodromal, pseudoneurotic, pseudopsychopathic, subchronic with acute exacerbation	LAT SCHIZO-SUBCHR/EXACER
295.54	Latent schizophrenia, Latent schizophrenic reaction, Schizophrenia: borderline, incipient, prepsychotic, prodromal, pseudoneurotic, pseudopsychopathic, chronic with acute exacerbation	LATENT SCHIZO-CHR/EXACER
295.55	Latent schizophrenia, Latent schizophrenic reaction, Schizophrenia: borderline, incipient, prepsychotic, prodromal, pseudoneurotic, pseudopsychopathic, in remission	LAT SCHIZOPHREN-REMISS
295.60	Residual type, Chronic undifferentiated schizophrenia, Restzustand (schizophrenic), Schizophrenic residual state, unspecified	SCHIZOPHR DIS RESID NOS
295.61	Residual type, Chronic undifferentiated schizophrenia, Restzustand (schizophrenic), Schizophrenic residual state, subchronic	SCHIZOPH DIS RESID-SUBCH
295.62	Residual type, Chronic undifferentiated schizophrenia, Restzustand (schizophrenic), Schizophrenic residual state, chronic	SCHIZOPHR DIS RESID-CHR
295.63	Residual type, Chronic undifferentiated schizophrenia, Restzustand (schizophrenic), Schizophrenic residual state, subchronic with acute exacerbation	SCHIZO RESID SUBCHR/EXAC
295.64	Residual type, Chronic undifferentiated schizophrenia, Restzustand (schizophrenic), Schizophrenic residual state, chronic with acute exacerbation	SCHIZOPH RESID-CHRO/EXAC
295.65	Residual type, Chronic undifferentiated schizophrenia, Restzustand (schizophrenic), Schizophrenic residual state, in remission	SCHIZOPH DIS RESID-REMIS
295.70	Schizoaffective disorder, Cyclic schizophrenia, Mixed schizophrenic and affective psychosis, Schizo-affective psychosis, Schizophreniform psychosis, affective type, unspecified	SCHIZOAFFECTIVE DIS NOS
295.71	Schizoaffective disorder, Cyclic schizophrenia, Mixed schizophrenic and affective psychosis, Schizo-affective psychosis, Schizophreniform psychosis, affective type, subchronic	SCHIZOAFFECTV DIS-SUBCHR
295.72	Schizoaffective disorder, Cyclic schizophrenia, Mixed schizophrenic and affective psychosis, Schizo-affective psychosis, Schizophreniform psychosis, affective type, chronic	SCHIZOAFFECTIVE DIS-CHR

Table 7.01 Mental Disorders (Cont)

Code	ICD-9-CM Description	Shortened Description
295.73	Schizoaffective disorder, Cyclic schizophrenia, Mixed schizophrenic and affective psychosis, Schizo-affective psychosis, Schizophreniform psychosis, affective type, subchronic with acute exacerbation	SCHIZOAFF DIS-SUBCH/EXAC
295.74	Schizoaffective disorder, Cyclic schizophrenia, Mixed schizophrenic and affective psychosis, Schizo-affective psychosis, Schizophreniform psychosis, affective type, chronic with acute exacerbation	SCHIZOAFFTV DIS-CHR/EXAC
295.75	Schizoaffective disorder, Cyclic schizophrenia, Mixed schizophrenic and affective psychosis, Schizo-affective psychosis, Schizophreniform psychosis, affective type, in remission	SCHIZOAFFECTVE DIS-REMIS
295.80	Other specified types of schizophrenia, Acute (undifferentiated) schizophrenia, Atypical schizophrenia, Cenesthopathic schizophrenia, unspecified	SCHIZOPHRENIA NEC-UNSPEC
295.81	Other specified types of schizophrenia, Acute (undifferentiated) schizophrenia, Atypical schizophrenia, Cenesthopathic schizophrenia, subchronic	SCHIZOPHRENIA NEC-SUBCHR
295.82	Other specified types of schizophrenia, Acute (undifferentiated) schizophrenia, Atypical schizophrenia, Cenesthopathic schizophrenia, chronic	SCHIZOPHRENIA NEC-CHR
295.83	Other specified types of schizophrenia, Acute (undifferentiated) schizophrenia, Atypical schizophrenia, Cenesthopathic schizophrenia, subchronic with acute exacerbation	SCHIZO NEC-SUBCHR/EXACER
295.84	Other specified types of schizophrenia, Acute (undifferentiated) schizophrenia, Atypical schizophrenia, Cenesthopathic schizophrenia, chronic with acute exacerbation	SCHIZO NEC-CHR/EXACERB
295.85	Other specified types of schizophrenia, Acute (undifferentiated) schizophrenia, Atypical schizophrenia, Cenesthopathic schizophrenia, in remission	SCHIZOPHRENIA NEC-REMISS
295.90	Unspecified schizophrenia, Schizophrenia: NOS, mixed NOS, undifferentiated NOS, undifferentiated type, Schizophrenic reaction NOS, Schizophreniform psychosis NOS, unspecified	SCHIZOPHRENIA NOS-UNSPEC
295.91	Unspecified schizophrenia, Schizophrenia: NOS, mixed NOS, undifferentiated NOS, undifferentiated type, Schizophrenic reaction NOS, Schizophreniform psychosis NOS, subchronic	SCHIZOPHRENIA NOS-SUBCHR
295.92	Unspecified schizophrenia, Schizophrenia: NOS, mixed NOS, undifferentiated NOS, undifferentiated type, Schizophrenic reaction NOS, Schizophreniform psychosis NOS, chronic	SCHIZOPHRENIA NOS-CHR

Table 7.01 Mental Disorders (Cont)

Code	ICD-9-CM Description	Shortened Description
295.93	Unspecified schizophrenia, Schizophrenia: NOS, mixed NOS, undifferentiated NOS, undifferentiated type, Schizophrenic reaction NOS, Schizophreniform psychosis NOS, subchronic with acute exacerbation	SCHIZO NOS-SUBCHR/EXACER
295.94	Unspecified schizophrenia, Schizophrenia: NOS, mixed NOS, undifferentiated NOS, undifferentiated type, Schizophrenic reaction NOS, Schizophreniform psychosis NOS, chronic with acute exacerbation	SCHIZO NOS-CHR/EXACERB
295.95	Unspecified schizophrenia, Schizophrenia: NOS, mixed NOS, undifferentiated NOS, undifferentiated type, Schizophrenic reaction NOS, Schizophreniform psychosis NOS, in remission	SCHIZOPHRENIA NOS-REMISS
296.00	Bipolar I disorder, single manic episode, Hypomania (mild) NOS, Hypomanic psychosis, Mania (monopolar) NOS, Manic-depressive psychosis or reaction: hypomanic, manic-single episode or unspecified, unspecified	BIPOL I SINGLE MANIC NOS
296.01	Bipolar I disorder, single manic episode, Hypomania (mild) NOS, Hypomanic psychosis, Mania (monopolar) NOS, Manic-depressive psychosis or reaction: hypomanic, manic-single episode or unspecified, mild	BIPOL I SINGLE MANC-MILD
296.02	Bipolar I disorder, single manic episode, Hypomania (mild) NOS, Hypomanic psychosis, Mania (monopolar) NOS, Manic-depressive psychosis or reaction: hypomanic, manic-single episode or unspecified, moderate	BIPOL I SINGLE MANIC-MOD
296.03	Bipolar I disorder, single manic episode, Hypomania (mild) NOS, Hypomanic psychosis, Mania (monopolar) NOS, Manic-depressive psychosis or reaction: hypomanic, manic-single episode or unspecified, severe, without mention of psychotic behavior	BIPOL I SING-SEV W/O PSY
296.04	Bipolar I disorder, single manic episode, Hypomania (mild) NOS, Hypomanic psychosis, Mania (monopolar) NOS, Manic-depressive psychosis or reaction: hypomanic, manic-single episode or unspecified, severe, specified as with psychotic behavior	BIPO I SIN MAN-SEV W PSY
296.05	Bipolar I disorder, single manic episode, Hypomania (mild) NOS, Hypomanic psychosis, Mania (monopolar) NOS, Manic-depressive psychosis or reaction: hypomanic, manic-single episode or unspecified, in partial or unspecified remission	BIPOL I SING MAN REM NOS
296.06	Bipolar I disorder, single manic episode, Hypomania (mild) NOS, Hypomanic psychosis, Mania (monopolar) NOS, Manic-depressive psychosis or reaction: hypomanic, manic-single episode or unspecified, in full remission	BIPOL I SINGLE MANIC REM
296.10	Manic disorder, recurrent episode, Any condition classifiable to 296.0, stated to be recurrent, unspecified	RECUR MANIC DIS-UNSPEC
296.11	Manic disorder, recurrent episode, Any condition classifiable to 296.0, stated to be recurrent, mild	RECUR MANIC DIS-MILD

Table 7.01 Mental Disorders (Cont)

Code	ICD-9-CM Description	Shortened Description
296.12	Manic disorder, recurrent episode, Any condition classifiable to 296.0, stated to be recurrent, moderate	RECUR MANIC DIS-MOD
296.13	Manic disorder, recurrent episode, Any condition classifiable to 296.0, stated to be recurrent, severe, without mention of psychotic behavior	RECUR MANIC DIS-SEVERE
296.14	Manic disorder, recurrent episode, Any condition classifiable to 296.0, stated to be recurrent, severe, specified as with psychotic behavior	RECUR MANIC-SEV W PSYCHO
296.15	Manic disorder, recurrent episode, Any condition classifiable to 296.0, stated to be recurrent, in partial or unspecified remission	RECUR MANIC-PART REMISS
296.16	Manic disorder, recurrent episode, Any condition classifiable to 296.0, stated to be recurrent, in full remission	RECUR MANIC-FULL REMISS
296.20	Major depressive disorder, single episode, Depressive psychosis, Endogenous depression, Involutional melancholia, Manic-depressive psychosis or reaction, depressed type, Monopolar depression, Psychotic depression-single episode or unspecified, unspecified	DEPRESS PSYCHOSIS-UNSPEC
296.21	Major depressive disorder, single episode, Depressive psychosis, Endogenous depression, Involutional melancholia, Manic-depressive psychosis or reaction, depressed type, Monopolar depression, Psychotic depression-single episode or unspecified, mild	DEPRESS PSYCHOSIS-MILD
296.22	Major depressive disorder, single episode, Depressive psychosis, Endogenous depression, Involutional melancholia, Manic-depressive psychosis or reaction, depressed type, Monopolar depression, Psychotic depression-single episode or unspecified, moderate	DEPRESSIVE PSYCHOSIS-MOD
296.23	Major depressive disorder, single episode, Depressive psychosis, Endogenous depression, Involutional melancholia, Manic-depressive psychosis or reaction, depressed type, Monopolar depression, Psychotic depression-single episode or unspecified, severe, without mention of psychotic behavior	DEPRESS PSYCHOSIS-SEVERE
296.24	Major depressive disorder, single episode, Depressive psychosis, Endogenous depression, Involutional melancholia, Manic-depressive psychosis or reaction, depressed type, Monopolar depression, Psychotic depression-single episode or unspecified, severe, specified as with psychotic behavior	DEPR PSYCHOS-SEV W PSYCH
296.25	Major depressive disorder, single episode, Depressive psychosis, Endogenous depression, Involutional melancholia, Manic-depressive psychosis or reaction, depressed type, Monopolar depression, Psychotic depression-single episode or unspecified, in partial or unspecified remission	DEPR PSYCHOS-PART REMISS

Table 7.01 Mental Disorders (Cont)

Code	ICD-9-CM Description	Shortened Description
296.26	Major depressive disorder, single episode, Depressive psychosis, Endogenous depression, Involutional melancholia, Manic-depressive psychosis or reaction, depressed type, Monopolar depression, Psychotic depression-single episode or unspecified, in full remission	DEPR PSYCHOS-FULL REMISS
296.30	Major depressive disorder, recurrent episode, Any condition classifiable to 296.2, stated to be recurrent, unspecified	RECURR DEPR PSYCHOS-UNSP
296.31	Major depressive disorder, recurrent episode, Any condition classifiable to 296.2, stated to be recurrent, mild	RECURR DEPR PSYCHOS-MILD
296.32	Major depressive disorder, recurrent episode, Any condition classifiable to 296.2, stated to be recurrent, moderate	RECURR DEPR PSYCHOS-MOD
296.33	Major depressive disorder, recurrent episode, Any condition classifiable to 296.2, stated to be recurrent, severe, without mention of psychotic behavior	RECUR DEPR PSYCH-SEVERE
296.34	Major depressive disorder, recurrent episode, Any condition classifiable to 296.2, stated to be recurrent, severe, specified as with psychotic behavior	REC DEPR PSYCH-PSYCHOTIC
296.35	Major depressive disorder, recurrent episode, Any condition classifiable to 296.2, stated to be recurrent, in partial or unspecified remission	RECUR DEPR PSYC-PART REM
296.36	Major depressive disorder, recurrent episode, Any condition classifiable to 296.2, stated to be recurrent, in full remission	RECUR DEPR PSYC-FULL REM
296.40	Bipolar I disorder, most recent episode (or current) manic, Bipolar disorder, now manic, Manic-depressive psychosis, circular type by currently manic, unspecified	BIPOL I CURRNT MANIC NOS
296.41	Bipolar I disorder, most recent episode (or current) manic, Bipolar disorder, now manic, Manic-depressive psychosis, circular type by currently manic, mild	BIPOL I CURNT MANIC-MILD
296.42	Bipolar I disorder, most recent episode (or current) manic, Bipolar disorder, now manic, Manic-depressive psychosis, circular type by currently manic, moderate	BIPOL I CURRNT MANIC-MOD
296.43	Bipolar I disorder, most recent episode (or current) manic, Bipolar disorder, now manic, Manic-depressive psychosis, circular type by currently manic, severe, without mention of psychotic behavior	BIPOL I MANC-SEV W/O PSY
296.44	Bipolar I disorder, most recent episode (or current) manic, Bipolar disorder, now manic, Manic-depressive psychosis, circular type by currently manic, severe, specified as with psychotic behavior	BIPOL I MANIC-SEV W PSY
296.45	Bipolar I disorder, most recent episode (or current) manic, Bipolar disorder, now manic, Manic-depressive psychosis, circular type by currently manic, in partial or unspecified remission	BIPOL I CUR MAN PART REM

Table 7.01 Mental Disorders (Cont)

Code	ICD-9-CM Description	Shortened Description
296.46	Bipolar I disorder, most recent episode (or current) manic, Bipolar disorder, now manic, Manic-depressive psychosis, circular type by currently manic, in full remission	BIPOL I CUR MAN FULL REM
296.50	Bipolar I disorder most recent episode (or current) depressed, Bipolar disorder, now depressed, Manic-depressive psychosis, circular type but currently depressed, unspecified	BIPOL I CUR DEPRES NOS
296.51	Bipolar I disorder most recent episode (or current) depressed, Bipolar disorder, now depressed, Manic-depressive psychosis, circular type but currently depressed, mild	BIPOL I CUR DEPRESS-MILD
296.52	Bipolar I disorder most recent episode (or current) depressed, Bipolar disorder, now depressed, Manic-depressive psychosis, circular type but currently depressed, moderate	BIPOL I CUR DEPRESS-MOD
296.53	Bipolar I disorder most recent episode (or current) depressed, Bipolar disorder, now depressed, Manic-depressive psychosis, circular type but currently depressed, severe, without mention of psychotic behavior	BIPOL I CURR DEP W/O PSY
296.54	Bipolar I disorder most recent episode (or current) depressed, Bipolar disorder, now depressed, Manic-depressive psychosis, circular type but currently depressed, severe, specified as with psychotic behavior	BIPOL I CURRNT DEP W PSY
296.55	Bipolar I disorder most recent episode (or current) depressed, Bipolar disorder, now depressed, Manic-depressive psychosis, circular type but currently depressed, in partial or unspecified remission	BIPOL I CUR DEP REM NOS
296.56	Bipolar I disorder most recent episode (or current) depressed, Bipolar disorder, now depressed, Manic-depressive psychosis, circular type but currently depressed, in full remission	BIPOL I CURRNT DEP REMIS
296.60	Bipolar I disorder, most recent episode (or current) mixed, Manic-depressive psychosis, circular type, mixed, unspecified	BIPOL I CURRNT MIXED NOS
296.61	Bipolar I disorder, most recent episode (or current) mixed, Manic-depressive psychosis, circular type, mixed, mild	BIPOL I CURRNT MIX-MILD
296.62	Bipolar I disorder, most recent episode (or current) mixed, Manic-depressive psychosis, circular type, mixed, moderate	BIPOL I CURRNT MIXED-MOD
296.63	Bipolar I disorder, most recent episode (or current) mixed, Manic-depressive psychosis, circular type, mixed, severe, without mention of psychotic behavior	BIPOL I CUR MIX W/O PSY
296.64	Bipolar I disorder, most recent episode (or current) mixed, Manic-depressive psychosis, circular type, mixed, severe, specified as with psychotic behavior	BIPOL I CUR MIXED W PSY

Table 7.01 Mental Disorders (Cont)

Code	ICD-9-CM Description	Shortened Description
296.65	Bipolar I disorder, most recent episode (or current) mixed, Manic-depressive psychosis, circular type, mixed, in partial or unspecified remission	BIPOL I CUR MIX-PART REM
296.66	Bipolar I disorder, most recent episode (or current) mixed, Manic-depressive psychosis, circular type, mixed, in full remission	BIPOL I CUR MIXED REMISS
296.7	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	Bipolar disorder, unspecified, Bipolar disorder NOS, Manic-depressive: reaction NOS, syndrome NOS	BIPOLAR DISORDER NOS
296.81	Atypical manic disorder	ATYPICAL MANIC DISORDER
296.82	Atypical depressive disorder	ATYPICAL DEPRESSIVE DIS
296.89	Other, Bipolar II disorder, Manic-depressive psychosis, mixed type	BIPOLAR DISORDER NEC
296.90	Unspecified episodic mood disorder, Affective psychosis NOS, Melancholia NOS, Mood disorder NOS	EPISODIC MOOD DISORD NOS
296.99	Other specified episodic mood disorder, Mood swings brief compensatory, Mood swings: rebound	EPISODIC MOOD DISORD NEC
297.0	Paranoid state, simple	PARANOID STATE, SIMPLE
297.1	Delusional disorder, Chronic paranoid psychosis, Sander's disease, Systematized delusions	DELUSIONAL DISORDER
297.2	Paraphrenia, Involutional paranoid state, Late paraphrenia, Paraphrenia (involutional)	PARAPHRENIA
297.3	Shared psychotic disorder, Folie à deux, Induced psychosis or paranoid disorder	SHARED PSYCHOTIC DISORD
297.8	Other specified paranoid states, Paranoia querulans, Sensitiver Beziehungswahn	PARANOID STATES NEC
297.9	Unspecified paranoid state, Paranoid: disorder NOS, psychosis NOS, Paranoid: reaction NOS, state NOS	PARANOID STATE NOS
298.0	Depressive type psychosis, Psychogenic depressive psychosis, Psychotic reactive depression, Reactive depressive psychosis	REACT DEPRESS PSYCHOSIS
298.1	Excitative type psychosis, Acute hysterical psychosis, Psychogenic excitation, Reactive excitation	EXCITATIV TYPE PSYCHOSIS
298.2	Reactive confusion, Psychogenic twilight state	REACTIVE CONFUSION
298.3	Acute paranoid reaction, Acute psychogenic paranoid psychosis, Bouffée délirante	ACUTE PARANOID REACTION
298.4	Psychogenic paranoid psychosis, Protracted reactive paranoid psychosis	PSYCHOGEN PARANOID PSYCH
298.8	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	Unspecified psychosis, Atypical psychosis, psychosis NOS, Psychotic disorder NOS	PSYCHOSIS NOS
299.00	Autistic disorder, Childhood autism, Infantile psychosis, Kanner's syndrome, current or active state	AUTISTIC DISORD-CURRENT

Table 7.01 Mental Disorders (Cont)

Code	ICD-9-CM Description	Shortened Description
299.01	Autistic disorder, Childhood autism, Infantile psychosis, Kanner's syndrome, residual state	AUTISTIC DISORD-RESIDUAL
299.10	Childhood disintegrative disorder, Heller's syndrome, current or active state	CHILDHD DISINTEGR-ACTIVE
299.11	Childhood disintegrative disorder, Heller's syndrome, residual state	CHILDHD DISINTEGR-RESID
299.80	Other specified pervasive developmental disorders, Asperger's disorder, Atypical childhood psychosis, Borderline psychosis of childhood, current or active state	PERVASV DEV DIS-CUR NEC
299.81	Other specified pervasive developmental disorders, Asperger's disorder, Atypical childhood psychosis, Borderline psychosis of childhood, residual state	PERVASV DEV DIS-RES NEC
299.90	Unspecified pervasive developmental disorder, Child psychosis NOS, Pervasive developmental disorder NOS, Schizophrenia, childhood type NOS, Schizophrenic syndrome of childhood NOS, current or active state	PERVASV DEV DIS-CUR NOS
299.91	Unspecified pervasive developmental disorder, Child psychosis NOS, Pervasive developmental disorder NOS, Schizophrenia, childhood type NOS, Schizophrenic syndrome of childhood NOS, residual state	PERVASV DEV DIS-RES NOS
300.00	Anxiety state, unspecified, Anxiety: neurosis, reaction, Anxiety: state (neurotic), Atypical anxiety disorder	ANXIETY STATE NOS
300.01	Panic disorder without agoraphobia, Panic: attack, Panic: state	PANIC DIS W/O AGORPHOBIA
300.02	Generalized anxiety disorder	GENERALIZED ANXIETY DIS
300.09	Other	ANXIETY STATE NEC
300.10	Hysteria, unspecified	HYSTERIA NOS
300.11	Conversion disorder, Astasia-abasia, hysterical, Conversion hysteria or reaction, Hysterical: blindness, deafness, paralysis	CONVERSION DISORDER
300.12	Dissociative amnesia, Hysterical amnesia	DISSOCIATIVE AMNESIA
300.13	Dissociative fugue, Hysterical fugue	DISSOCIATIVE FUGUE
300.14	Dissociative identity disorder	DISSOCIATVE IDENTITY DIS
300.15	Dissociative disorder or reaction, unspecified	DISSOCIATIVE REACT NOS
300.16	Factitious disorder with predominantly psychological signs and symptoms, Compensation neurosis, Ganser's syndrome, hysterical	FACTITIOUS DIS W SYMPTOM
300.19	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	Phobia, unspecified, Anxiety-hysteria NOS, Phobia NOS	PHOBIA NOS
300.21	Agoraphobia with panic disorder, Fear of: open spaces, streets, travel-with panic attacks	AGORAPHOBIA W PANIC DIS
300.22	Agoraphobia without mention of panic attacks, Any condition classifiable to 300.21 without mention of panic attacks	AGORAPHOBIA W/O PANIC
300.23	Social phobia, Fear of: eating in public, pubic speaking, Fear of: washing in public	SOCIAL PHOBIA

Table 7.01 Mental Disorders (Cont)

Code	ICD-9-CM Description	Shortened Description
300.29	Other isolated or specific phobias, Acrophobia, Animal phobias, Claustrophobia, Fear of crowds	ISOLATED/SPEC PHOBIA NEC
300.3	Obsessive-compulsive disorders, Anancastic neurosis, Compulsive neurosis, Obsessional phobia (any)	OBSESSIVE-COMPULSIVE DIS
300.4	Dysthymic disorder, Anxiety depression, Depression with anxiety, Depressive reaction, Neurotic depressive state, Reactive depression	DYSTHYMIC DISORDER
300.5	Neurasthenia, Fatigue neurosis, Nervous debility, Psychogenic: asthenia, Psychogenic: general fatigue	NEURASTHENIA
300.6	Depersonalization disorder, Derealization (neurotic), Neurotic state with depersonalization episode	DEPERSONALIZATION DISORD
300.7	Hypochondriasis, Body dysmorphic disorder	HYPOCHONDRIASIS
300.81	Somatization disorder, Briquet's disorder, Severe somatoform disorder	SOMATIZATION DISORDER
300.82	Undifferentiated somatoform disorder, Atypical somatoform disorder, Somatoform disorder NOS	UNDIFF SOMATOFORM DISRDR
300.89	Other somatoform disorders, Occupational neurosis, including writers' cramp, Psychasthenia, Psychasthenic neurosis	SOMATOFORM DISORDERS NEC
300.9	Unspecified nonpsychotic mental disorder, Psychoneurosis NOS	NONPSYCHOTIC DISORD NOS
301.0	Paranoid personality disorder, Fanatic personality, Paranoid personality (disorder), Paranoid traits	PARANOID PERSONALITY
301.10	Affective personality disorder	AFFECTIV PERSONALITY NOS
301.11	Chronic hypomanic personality disorder, Chronic hypomanic disorder, Hypomanic personality	CHRONIC HYPOMANIC PERSON
301.12	Chronic depressive personality disorder, Chronic depressive disorder, Depressive character or personality	CHR DEPRESSIVE PERSON
301.13	Cyclothymic disorder, Cycloid personality, Cyclothymia, Cyclothymic personality	CYCLOTHYMIC DISORDER
301.20	Schizoid personality disorder, unspecified	SCHIZOID PERSONALITY NOS
301.21	Introverted personality	INTROVERTED PERSONALITY
301.22	Schizotypal personality disorder	SCHIZOTYPAL PERSON DIS
301.3	Explosive personality disorder, Aggressive: personality, reaction, Aggressiveness, Emotional instability (excessive), Pathological emotionality, Quarrelsomeness	EXPLOSIVE PERSONALITY
301.4	Obsessive-compulsive personality disorder, Anancastic personality, Obsessional personality	OBSESSIVE-COMPULSIVE DIS
301.50	Histrionic personality disorder, unspecified, Hysterical personality NOS	HISTRIONIC PERSON NOS
301.51	Chronic factitious illness with physical symptoms, Hospital addiction syndrome, Multiple operations syndrome, Munchausen syndrome	CHR FACTITIOUS ILLNESS
301.59	Other histrionic personality disorder, Personality: emotionally unstable, labile, Personality: psychoinfantile	HISTRIONIC PERSON NEC
301.6	Dependent personality disorder, Asthenic personality, Inadequate personality, Passive personality	DEPENDENT PERSONALITY

Table 7.01 Mental Disorders (Cont)

Code	ICD-9-CM Description	Shortened Description
301.7	Antisocial personality disorder, Amoral personality, Asocial personality, Dyssocial personality, Personality disorder with predominantly sociopathic or asocial manifestation	ANTISOCIAL PERSONALITY
301.81	Narcissistic personality disorder	NARCISSISTIC PERSONALITY
301.82	Avoidant personality disorder	AVOIDANT PERSONALITY DIS
301.83	Borderline personality disorder	BORDERLINE PERSONALITY
301.84	Passive-aggressive personality	PASSIVE-AGGRESSIV PERSON
301.89	Other, Personality: eccentric, "haltlose" type, immature, Personality: masochistic, psychoneurotic	PERSONALITY DISORDER NEC
301.9	Unspecified personality disorder, Pathological personality NOS, Personality disorder NOS, Psychopathic: constitutional state, personality (disorder)	PERSONALITY DISORDER NOS
302.0	Ego-dystonic sexual orientation, Ego-dystonic lesbianism, Sexual orientation conflict disorder	EGO-DYSTONIC SEX ORIENT
302.1	Zoophilia, Bestiality	ZOOPHILIA
302.2	Pedophilia	PEDOPHILIA
302.3	Transvestic fetishism	TRANSVESTIC FETISHISM
302.4	Exhibitionism	EXHIBITIONISM
302.50	With unspecified sexual history	TRANS-SEXUALISM NOS
302.51	With asexual history	TRANS-SEXUALISM, ASEXUAL
302.52	With homosexual history	TRANS-SEXUAL, HOMOSEXUAL
302.53	With heterosexual history	TRANS-SEX, HETEROSEXUAL
302.6	Gender identity disorder in children, Feminism in boys, Gender identity disorder NOS	GENDR IDENTITY DIS-CHILD
302.70	Psychosexual dysfunction, unspecified, Sexual dysfunction NOS	PSYCHOSEXUAL DYSFUNC NOS
302.71	Hypoactive sexual desire disorder	HYPOACTIVE SEX DESIRE
302.72	With inhibited sexual excitement, Female sexual arousal disorder, Frigidity, Impotence, Male erectile disorder	INHIBITED SEX EXCITEMENT
302.73	Female orgasmic disorder	FEMALE ORGASMIC DISORDER
302.74	Male orgasmic disorder	MALE ORGASMIC DISORDER
302.75	Premature ejaculation	PREMATURE EJACULATION
302.76	Dyspareunia, psychogenic	DYSPAREUNIA, PSYCHOGENIC
302.79	With other specified psychosexual dysfunctions, Sexual aversion disorders	PSYCHOSEXUAL DYSFUNC NEC
302.81	Fetishism	FETISHISM
302.82	Voyeurism	VOYEURISM
302.83	Sexual masochism	SEXUAL MASOCHISM
302.84	Sexual sadism	SEXUAL SADISM
302.85	Gender identity disorder in adolescents or adults	GEND IDEN DIS, ADOL/ADULT
302.89	Other, Frotteurism, Nymphomania, Satyriasis	PSYCHOSEXUAL DIS NEC
302.9	Unspecified psychosexual disorder, Paraphilia NOS, Pathologic sexuality NOS, Sexual deviation NOS, Sexual disorder NOS	PSYCHOSEXUAL DIS NOS
306.0	Musculoskeletal, Psychogenic paralysis, Psychogenic torticollis	PSYCHOGEN MUSCULSKEL DIS
306.1	Respiratory, Psychogenic: air hunger, cough, hiccough, Psychogenic: hyperventilation, yawning	PSYCHOGENIC RESPIR DIS

Table 7.01 Mental Disorders (Cont)

Code	ICD-9-CM Description	Shortened Description
306.2	Cardiovascular, Cardiac neurosis, Cardiovascular neurosis, Neurocirculatory asthenia, Psychogenic cardiovascular disorder	PSYCHOGEN CARDIOVASC DIS
306.3	Skin, Psychogenic pruritus	PSYCHOGENIC SKIN DISEASE
306.4	Gastrointestinal, Aerophagy, Cyclical vomiting, psychogenic, Diarrhea, psychogenic, Nervous gastritis, Psychogenic dyspepsia	PSYCHOGENIC GI DISEASE
306.50	Psychogenic genitourinary malfunction, unspecified	PSYCHOGENIC GU DIS NOS
306.51	Psychogenic vaginismus, Functional vaginismus	PSYCHOGENIC VAGINISMUS
306.52	Psychogenic dysmenorrheal	PSYCHOGENIC DYSMENORRHEA
306.53	Psychogenic dysuria	PSYCHOGENIC DYSURIA
306.59	Other	PSYCHOGENIC GU DIS NEC
306.6	Endocrine	PSYCHOGEN ENDOCRINE DIS
306.7	Organs of special sense	PSYCHOGENIC SENSORY DIS
306.8	Other specified psychophysiological malfunction, Bruxism, Teeth grinding	PSYCHOGENIC DISORDER NEC
306.9	Unspecified psychophysiological malfunction, Psychophysiological disorder NOS, Psychosomatic disorder NOS	PSYCHOGENIC DISORDER NOS
307.0	Stuttering	STUTTERING
307.1	Anorexia nervosa	ANOREXIA NERVOSA
307.20	Tic disorder, unspecified, Tic disorder NOS	TIC DISORDER NOS
307.21	Transient tic disorder	TRANSIENT TIC DISORDER
307.22	Chronic motor or vocal tic disorder	CHR MOTOR/VOCAL TIC DIS
307.23	Tourette's disorder, Motor-verbal tic disorder	TOURETTE'S DISORDER
307.3	Stereotypic movement disorder, Body rocking, Head banging, Spasmus nutans, Stereotypes NOS	STEREOTYPIC MOVEMENT DIS
307.40	Nonorganic sleep disorder, unspecified	NONORGANIC SLEEP DIS NOS
307.41	Transient disorder of initiating or maintaining sleep, Adjustment insomnia, Hyposomnia, Insomnia, Sleeplessness-associated with intermittent emotional reactions or conflicts	TRANSIENT INSOMNIA
307.42	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	Transient disorder of initiating or maintaining wakefulness, Hypersomnia associated with acute or intermittent emotional reactions or conflicts	TRANSIENT HYPERSOMNIA
307.44	Persistent disorder of initiating or maintaining wakefulness, Hypersomnia associated with depression (major) (minor), Insufficient sleep syndrome, Primary hypersomnia	PERSISTENT HYPERSOMNIA
307.45	Circadian rhythm sleep disorder of nonorganic origin	NONORGANIC CIRCADIAN RHY

Table 7.01 Mental Disorders (Cont)

Code	ICD-9-CM Description	Shortened Description
307.46	Sleep arousal disorder, Night terror disorder, Night terrors, Sleep terror disorder, Sleepwalking, Somnambulism	SLEEP AROUSAL DISORDER
307.47	Other dysfunctions of sleep stages or arousal from sleep, Nightmare disorder, Nightmares: NOS, REM-sleep type, sleep drunkenness	SLEEP STAGE DYSFUNC NEC
307.48	Repetitive intrusions of sleep, Repetitive intrusion of sleep with : atypical polysomnographic features, environmental disturbances, repeated REM-sleep interruptions	REPETIT SLEEP INTRUSION
307.49	Other, "Short-sleeper", Subjective insomnia complaint	NONORGANIC SLEEP DIS NEC
307.50	Eating disorder, unspecified, Eating disorder NOS	EATING DISORDER NOS
307.51	Bulimia nervosa, Overeating of nonorganic origin	BULIMIA NERVOSA
307.52	Pica, Perverted appetite of nonorganic origin	PICA
307.53	Rumination disorder, Regurgitation, of Nonorganic origin, of food with reswallowing	RUMINATION DISORDER
307.54	Psychogenic vomiting	PSYCHOGENIC VOMITING
307.59	Other, Feeding disorder of infancy or early childhood of Nonorganic origin, Infantile feeding disturbances, Loss of appetite-of Nonorganic origin	EATING DISORDER NEC
307.6	Enuresis, Enuresis (primary) (secondary) of nonorganic origin	ENURESIS
307.7	Encopresis, Encoporisis (continuous) (discontinuous) of nonorganic origin	ENCOPRESIS
307.80	Psychogenic pain, site unspecified	PSYCHOGENIC PAIN NOS
307.81	Tension headache	TENSION HEADACHE
307.89	Other, Code first to site of pain	PSYCHOGENIC PAIN NEC
307.9	Other and unspecified special symptoms or syndromes, not elsewhere classified, Communication disorder NOS, Hair plucking, Lalling, Lisping, Masturbation, Nail-biting, Thumb-sucking	SPECIAL SYMPTOM NEC/NOS
308.0	Predominant disturbance of emotions, Anxiety, Emotional crisis, Panic state-as acute reaction to exceptional [gross] stress	STRESS REACT, EMOTIONAL
308.1	Predominant disturbance of consciousness, Fugues as acute reaction to exceptional [gross] stress	STRESS REACTION, FUGUE
308.2	Predominant psychomotor disturbance, Agitation states, Stupor-as acute reaction to exceptional [gross] stress	STRESS REACT, PSYCHOMOT
308.3	Other acute reactions to stress, Acute situational disturbance, Acute stress disorder	ACUTE STRESS REACT NEC
308.4	Mixed disorders as reaction to stress	STRESS REACT, MIXED DIS
308.9	Unspecified acute reaction to stress	ACUTE STRESS REACT NOS
309.0	Adjustment disorder with depressed mood, Grief reaction	ADJUSTMNT DIS W DEPRESSN
309.1	Prolonged depressive reaction	PROLONG DEPRESSIVE REACT
309.21	Separation anxiety disorder	SEPARATION ANXIETY
309.22	Emancipation disorder of adolescence and early adult life	EMANCIPATION DISORDER

Table 7.01 Mental Disorders (Cont)

Code	ICD-9-CM Description	Shortened Description
309.23	Specific academic or work inhibition	ACADEMIC/WORK INHIBITION
309.24	Adjustment disorder with anxiety	ADJUSTMENT DIS W ANXIETY
309.28	Adjustment disorder with mixed anxiety and depressed mood	ADJUST DIS W ANXIETY/DEP
309.29	Other, Culture shock	ADJ REACT-EMOTION NEC
309.3	Adjustment disorder with disturbance of conduct, Conduct disturbance, Destructiveness-as adjustment reaction	ADJUST DISOR/DIS CONDUCT
309.4	Adjustment disorder with mixed disturbance of emotions and conduct	ADJ DIS-EMOTION/CONDUCT
309.81	Posttraumatic stress disorder, Chronic posttraumatic stress disorder, Concentration camp syndrome, Posttraumatic stress disorder NOS	POSTTRAUMATIC STRESS DIS
309.82	Adjustment reaction with physical symptoms	ADJUST REACT-PHYS SYMPT
309.83	Adjustment reaction with withdrawal, Elective mutism as adjustment reaction, Hospitalism (in children) NOS	ADJUST REACT-WITHDRAWAL
309.89	Other	ADJUSTMENT REACTION NEC
309.9	Unspecified adjustment reaction, Adaptation reaction NOS, Adjustment reaction NOS	ADJUSTMENT REACTION NOS
310.0	Fontal lobe syndrome, Lobotomy syndrome, Postleucotomy syndrome [state]	FRONTAL LOBE SYNDROME
310.1	Personality change due to conditions classified elsewhere, Cognitive or personality change of other type, of nonpsychotic severity, Organic psychosyndrome of nonpsychotic severity, Presbyophrenia NOS, Senility with mental changes of nonpsychotic severity	PERSONALITY CHG OTH DIS
310.2	Postconcussion syndrome, Postcontusion syndrome or encephalopathy, Posttraumatic brain syndrome, nonpsychotic, Satus postcommotio cerebri	POSTCONCUSSION SYNDROME
310.8	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	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	Undersocialized conduct disorder, aggressive type, Aggressive outburst, Anger reaction, Unsocialized aggressive disorder, unspecified	UNSOCIAL AGGRESS-UNSPEC
312.01	Undersocialized conduct disorder, aggressive type, Aggressive outburst, Anger reaction, Unsocialized aggressive disorder, mild	UNSOCIAL AGGRESSION-MILD
312.02	Undersocialized conduct disorder, aggressive type, Aggressive outburst, Anger reaction, Unsocialized aggressive disorder, moderate	UNSOCIAL AGGRESSION-MOD

Table 7.01 Mental Disorders (Cont)

Code	ICD-9-CM Description	Shortened Description
312.03	Undersocialized conduct disorder, aggressive type, Aggressive outburst, Anger reaction, Unsocialized aggressive disorder, severe	UNSOCIAL AGGRESS-SEVERE
312.10	Undersocialized conduct disorder, unaggressive type, Childhood truancy, unsocialized, Solitary stealing, Tantrums, unspecified	UNSOCIAL UNAGGRESS-UNSP
312.11	Undersocialized conduct disorder, unaggressive type, Childhood truancy, unsocialized, Solitary stealing, Tantrums, mild	UNSOCIAL UNAGGRESS-MILD
312.12	Undersocialized conduct disorder, unaggressive type, Childhood truancy, unsocialized, Solitary stealing, Tantrums, moderate	UNSOCIAL UNAGGRESS-MOD
312.13	Undersocialized conduct disorder, unaggressive type, Childhood truancy, unsocialized, Solitary stealing, Tantrums, severe	UNSOCIAL UNAGGR-SEVERE
312.20	Socialized conduct disorder, Childhood truancy, socialized, Group delinquency, unspecified	SOCIAL CONDUCT DIS-UNSP
312.21	Socialized conduct disorder, Childhood truancy, socialized, Group delinquency, mild	SOCIAL CONDUCT DIS-MILD
312.22	Socialized conduct disorder, Childhood truancy, socialized, Group delinquency, moderate	SOCIAL CONDUCT DIS-MOD
312.23	Socialized conduct disorder, Childhood truancy, socialized, Group delinquency, severe	SOCIAL CONDUCT DIS-SEV
312.30	Impulse control disorder, unspecified	IMPULSE CONTROL DIS NOS
312.31	Pathological gambling	PATHOLOGICAL GAMBLING
312.32	Kleptomania	KLEPTOMANIA
312.33	Pyromania	PYROMANIA
312.34	Intermittent explosive disorder	INTERMITT EXPLOSIVE DIS
312.35	Isolated explosive disorder	ISOLATED EXPLOSIVE DIS
312.39	Other, Trichotillomania	IMPULSE CONTROL DIS NEC
312.4	Mixed disturbance of conduct and emotions, Neurotic delinquency	MIX DIS CONDUCT/EMOTION
312.81	Conduct disorder, childhood onset type	CNDCT DSRDR CHLDHD ONST
312.82	Conduct disorder, adolescent onset type	CNDCT DSRDR ADLSCNT ONST
312.89	Other conduct disorder, Conduct disorder or unspecified onset	OTHER CONDUCT DISORDER
312.9	Unspecified disturbance of conduct, Delinquency (juvenile)	CONDUCT DISTURBANCE NOS
313.0	Overanxious disorder, Anxiety and fearfulness, Overanxious disorder-of childhood and adolescence	OVERANXIOUS DISORDER
313.1	Misery and unhappiness disorder	MISERY & UNHAPPINESS DIS
313.21	Shyness disorder of childhood, Sensitivity reaction of childhood or adolescence	SHYNESS DISORDER-CHILD
313.22	Introverted disorder of childhood, Social withdrawal, Withdrawal reaction –of childhood or adolescence	INTROVERTED DIS-CHILD
313.23	Selective mutism	SELECTIVE MUTISM
313.3	Relationship problems, Sibling jealousy	RELATIONSHIP PROBLEMS
313.81	Oppositional defiant disorder	OPPOSITION DEFIANT DISOR
313.82	Identity disorder, Identity problem	IDENTITY DISORDER

Table 7.01 Mental Disorders (Cont)

Code	ICD-9-CM Description	Shortened Description
313.83	Academic underachievement disorder	ACADEMIC UNDERACHIEVMENT
313.89	Other, Reactive attachment disorder of infancy or early childhood	EMOTIONAL DIS CHILD NEC
313.9	Unspecified emotional disturbance of childhood or adolescence, Mental disorder of infancy, childhood or adolescence NOS	EMOTIONAL DIS CHILD NOS
314.00	Without mention of hyperactivity, Predominantly inattentive type	ATTN DEFIC NONHYPERACT
314.01	With hyperactivity, Combined type, Overactivity NOS, Predominantly hyperactive/impulsive type, Simple disturbance of attention with overactivity	ATTN DEFICIT W HYPERACT
314.1	Hyperkinesis with developmental delay, Developmental disorder of hyperkinesis, Use additional code to identify any associated neurological disorder	HYPERKINET W DEVEL DELAY
314.2	Hyperkinetic conduct disorder, Hyperkinetic, conduct disorder without developmental delay	HYPERKINETIC CONDUCT DIS
314.8	Other specified manifestations of hyperkinetic syndrome	OTHER HYPERKINETIC SYND
314.9	Unspecified hyperkinetic syndrome, Hyperkinetic reaction of childhood or adolescence NOS, Hyperkinetic syndrome NOS	HYPERKINETIC SYND NOS
315.00	Reading disorder, unspecified	READING DISORDER NOS
315.01	Alexia	ALEXIA
315.02	Developmental dyslexia	DEVELOPMENTAL DYSLEXIA
315.09	Other, Specific spelling difficulty	READING DISORDER NEC
315.1	Mathematics disorder, Dyscalculia	MATHEMATICS DISORDER
315.2	Other specific learning difficulties, Disorder of written expression	OTH LEARNING DIFFICULTY
315.31	Expressive language disorder, Developmental aphasia, Word deafness	EXPRESSIVE LANGUAGE DIS
315.32	Mixed receptive-expressive language disorder	RECP-EXPRES LANGUAGE DIS
315.34	Speech and language developmental delay due to hearing loss	SPEECHDEL D/T HEAR LOSS
315.39	Other, Developmental articulation disorder, Dyslalia, Phonological disorder	SPEECH/LANGUAGE DIS NEC
315.4	Developmental coordination disorder, Clumsiness syndrome, Dyspraxia syndrome, Specific motor development disorder	DEVEL COORDINATION DIS
315.5	Mixed development disorder	MIXED DEVELOPMENT DIS
315.8	Other specified delays in development	DEVELOPMENT DELAYS NEC
315.9	Unspecified delay in development, Developmental disorder NOS, Learning disorder NOS	DEVELOPMENT DELAY NOS
316	Psychic factors associated with diseases classified elsewhere, Psychologic factors in physical conditions classified elsewhere, Use additional code to identify the associated physical conditions as: psychogenic: asthma, dermatitis, duodenal ulcer, eczema, gastric ulcer, mucous colitis, paroxysmal tachycardia, ulcerative colitis, urticaria, psychosocial dwarfism	PSYCHIC FACTOR W OTH DIS

Table 7.01 Mental Disorders (Cont)

Code	ICD-9-CM Description	Shortened Description
317	Mild mental retardation, High-grade defect, IQ 50-70, Mild mental subnormality	MILD MENTAL RETARDATION
318.0	Moderate mental retardation, IQ 35-49, Moderate mental subnormality	MOD MENTAL RETARDATION
318.1	Severe mental retardation, IQ 20-34, Severe mental subnormality	SEVERE MENTAL RETARDAT
318.2	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

Table 7.02 Obstetrics		
Code	ICD-9-CM Description	Shortened Description
638.0	Failed attempted abortion, complicated by genital tract and pelvic infection, unspecified	ATTEM ABORT W PELVIC INF
638.1	Failed attempted abortion, complicated by delayed or excessive hemorrhage, unspecified	ATTEM ABORT W HEMORRHAGE
638.2	Failed attempted abortion, complicated by damage to pelvic organs or tissues, unspecified	ATTEM ABORT W PELV DAMAG
638.3	Failed attempted abortion, complicated by renal failure, unspecified	ATTEM ABORT W RENAL FAIL
638.4	Failed attempted abortion, complicated by metabolic disorder, unspecified	ATTEM ABOR W METABOL DIS
638.5	Failed attempted abortion, complicated by shock, unspecified	ATTEM ABORTION W SHOCK
638.7	Failed attempted abortion w/other specified complications	ATTEMP ABORT W COMPL NEC
638.8	Failed attempted abortion w/unspecified complication	ATTEMP ABORT W COMPL NOS
638.9	Failed attempted abortion w/o mention of complication	ATTEMPTED ABORT UNCOMPL
640.00	Hemorrhage in early pregnancy, Threatened abortion, unspecified as to episode of care or not applicable	THREATENED ABORT-UNSPEC
640.01	Hemorrhage in early pregnancy, Threatened abortion, delivered with or without mention of antepartum condition	THREATENED ABORT-DELIVER
640.80	Hemorrhage in early pregnancy, Other specified hemorrhage in early pregnancy, unspecified as to episode of care not applicable	HEM EARLY PREG NEC-UNSP
640.81	Hemorrhage in early pregnancy, Other specified hemorrhage in early pregnancy, delivered w/ or w/o mention of antepartum condition	HEM EARLY PREG NEC-DELIV
640.90	Hemorrhage in early pregnancy, Unspecified hemorrhage in early pregnancy, unspecified as to episode of care or not applicable	HEMORR EARLY PREG-UNSPEC
640.91	Hemorrhage in early pregnancy, Unspecified hemorrhage in early pregnancy, delivered w/ or w/o mention of antepartum condition	HEM EARLY PREG-DELIVERED
641.00	Antepartum hemorrhage, abruption placentae, and placenta previa, Placenta previa w/o hemorrhage, unspecified as to episode of care or not applicable	PLACENTA PREVIA-UNSPEC
641.01	Antepartum hemorrhage, abruption placentae, and placenta previa, Placenta previa w/o hemorrhage, delivered w/ or w/out mention of antepartum condition	PLACENTA PREVIA-DELIVER
641.03	Antepartum hemorrhage, abruption placentae, and placenta previa, Placenta previa w/o hemorrhage, antepartum condition or complication	PLACENTA PREVIA-ANTEPART
641.10	Hemorrhage from placenta previa, unspecified as to episode of care or not applicable	PLACENTA PREV HEM-UNSPEC
641.11	Hemorrhage from placenta previa, delivered w/ or w/out mention of antepartum condition	PLACENTA PREV HEM-DELIV
641.13	Hemorrhage from placenta previa, antepartum	PLACEN PREV HEM-ANTEPART

	condition or complication	
641.20	Premature separation of placenta, unspecified as to episode of care or not applicable	PREM SEPAR PLACEN-UNSPEC
641.21	Premature separation of placenta, delivered, w/ or w/out mention of antepartum condition	PREM SEPAR PLACEN-DELIV

Table 7.02 Obstetrics (Cont)

Code	ICD-9-CM Description	Shortened Description
641.23	Premature separation of placenta, antepartum condition or complication	PREM SEPAR PLAC-ANTEPART
641.30	Antepartum hemorrhage associated w/coagulation defects, unspecified as to episode of care or not applicable	COAG DEF HEMORR-UNSPEC
641.31	Antepartum hemorrhage associated w/coagulation defects, delivered w/ or w/out mention of antepartum condition	COAG DEF HEMORR-DELIVER
641.33	Antepartum hemorrhage associated w/coagulation defects, antepartum condition or complication	COAG DEF HEMORR-ANTEPART
641.80	Other antepartum hemorrhage, unspecified as to episode of care or not applicable	ANTEPART HEM NEC-UNSPEC
641.81	Other antepartum hemorrhage, delivered w/ or w/out mention of antepartum condition	ANTEPARTUM HEM NEC-DELIV
641.83	Other antepartum hemorrhage, antepartum condition or complication	ANTEPART HEM NEC-ANTEPAR
641.90	Unspecified antepartum hemorrhage, unspecified as to episode of care or not applicable	ANTEPART HEM NOS-UNSPEC
641.91	Unspecified antepartum hemorrhage, delivered w/ or w/out mention of antepartum condition	ANTEPARTUM HEM NOS-DELIV
641.93	Unspecified antepartum hemorrhage, antepartum condition or complication	ANTEPART HEM NOS-ANTEPAR
642.00	Benign essential hypertension complicating pregnancy, childbirth, & puerperium, unspecified as to episode of care or not applicable	ESSEN HYPERTEN PREG-UNSP
642.01	Benign essential hypertension complicating pregnancy, childbirth, & puerperium, delivered w/or w/out mention of antepartum condition	ESSEN HYPERTEN-DELIVERED
642.02	Benign essential hypertension complicating pregnancy, childbirth, & puerperium, delivered w/mention of postpartum complication	ESSEN HYPERTEN-DEL W P/P
642.03	Benign essential hypertension complicating pregnancy, childbirth, & puerperium, antepartum condition or complication	ESSEN HYPERTEN-ANTEPART
642.04	Benign essential hypertension complicating pregnancy, childbirth, & puerperium, postpartum condition or complication	ESSEN HYPERTEN-POSTPART
642.10	Hypertension secondary to renal disease, complicating pregnancy, childbirth, and the puerperium, unspecified as to episode of care or not applicable	RENAL HYPERTEN PREG-UNSP
642.11	Hypertension secondary to renal disease, complicating pregnancy, childbirth, and the puerperium, delivered w/ or w/out mention of antepartum condition	RENAL HYPERTEN PG-DELIV
642.12	Hypertension secondary to renal disease, complicating pregnancy, childbirth, and the puerperium, delivered w/mention of postpartum complication	RENAL HYPERTEN-DEL P/P
642.13	Hypertension secondary to renal disease, complicating pregnancy, childbirth, and the puerperium, antepartum condition or complication	RENAL HYPERTEN-ANTEPART

Table 7.02 Obstetrics (Cont)

Code	ICD-9-CM Description	Shortened Description
642.14	Hypertension secondary to renal disease, complicating pregnancy, childbirth, and the puerperium, postpartum condition or complication	RENAL HYPERTEN-POSTPART
642.20	Other pre-existing hypertension complicating pregnancy, childbirth & puerperium, unspecified as to episode of care or not applicable	OLD HYPERTEN PREG-UNSPEC
642.21	Other pre-existing hypertension complicating pregnancy, childbirth & puerperium, delivered w/ or w/out mention of antepartum condition	OLD HYPERTEN NEC-DELIVER
642.22	Other pre-existing hypertension complicating pregnancy, childbirth & puerperium, delivered w/mention of postpartum complication	OLD HYPERTEN-DELIV W P/P
642.23	Other pre-existing hypertension complicating pregnancy, childbirth & puerperium, antepartum condition or complication	OLD HYPERTEN NEC-ANTEPAR
642.24	Other pre-existing hypertension complicating pregnancy, childbirth & puerperium, postpartum condition or complication	OLD HYPERTEN NEC-POSTPAR
642.30	Transient hypertension of pregnancy, unspecified as to episode of care or not applicable	TRANS HYPERTEN PREG-UNSP
642.31	Transient hypertension of pregnancy, delivered w/ or w/out mention of antepartum condition	TRANS HYPERTEN-DELIVERED
642.32	Transient hypertension of pregnancy, delivered w/mention of postpartum complication	TRANS HYPERTEN-DEL W P/P
642.33	Transient hypertension of pregnancy, antepartum condition or complication	TRANS HYPERTEN-ANTEPART
642.34	Transient hypertension of pregnancy, postpartum condition or complication	TRANS HYPERTEN-POSTPART
642.40	Mild or unspecified pre-eclampsia, unspecified as to episode of care or not applicable	MILD/NOS PREECLAMP-UNSP
642.41	Mild or unspecified pre-eclampsia, delivered w/ or w/out mention of antepartum condition	MILD/NOS PREECLAMP-DELIV
642.42	Mild or unspecified pre-eclampsia, delivered w/mention of postpartum complication	MILD PREECLAMP-DEL W P/P
642.43	Mild or unspecified pre-eclampsia, antepartum condition or complication	MILD/NOS PREECLAMP-ANTEP
642.44	Mild or unspecified pre-eclampsia, postpartum condition or complication	MILD/NOS PREECLAMP-P/P
642.50	Severe pre-eclampsia, unspecified as to episode of care or not applicable	SEVERE PREECLAMP-UNSPEC
642.51	Severe pre-eclampsia, delivered w/ or w/out mention of antepartum condition	SEVERE PREECLAMP-DELIVER
642.52	Severe pre-eclampsia, delivered w/mention of postpartum complication	SEV PREECLAMP-DEL W P/P
642.53	Severe pre-eclampsia, antepartum condition or complication	SEV PREECLAMP-ANTEPARTUM
642.54	Severe pre-eclampsia, postpartum condition or complication	SEV PREECLAMP-POSTPARTUM
642.60	Eclampsia, unspecified as to episode of care or not applicable	ECLAMPSIA-UNSPECIFIED

Table 7.02 Obstetrics (Cont)

Code	ICD-9-CM Description	Shortened Description
642.61	Eclampsia, delivered w/ or w/out mention of antepartum condition	ECLAMPSIA-DELIVERED
642.62	Eclampsia, delivered w/mention of postpartum complication	ECLAMPSIA-DELIV W P/P
642.63	Eclampsia, antepartum condition or complication	ECLAMPSIA-ANTEPARTUM
642.64	Eclampsia, postpartum condition or complication	ECLAMPSIA-POSTPARTUM
642.70	Pre-eclampsia or eclampsia superimposed on pre-existing hypertension, unspecified as to episode of care or not applicable	TOX W OLD HYPERTEN-UNSP
642.71	Pre-eclampsia or eclampsia superimposed on pre-existing hypertension, delivered w/ or w/out mention of antepartum condition	TOX W OLD HYPERTEN-DELIV
642.72	Pre-eclampsia or eclampsia superimposed on pre-existing hypertension, delivered w/mention of postpartum complication	TOX W OLD HYPERTEN-DELIV
642.73	Pre-eclampsia or eclampsia superimposed on pre-existing hypertension, antepartum condition or complication	TOX W OLD HYPER-ANTEPART
642.74	Pre-eclampsia or eclampsia superimposed on pre-existing hypertension, postpartum condition or complication	TOX W OLD HYPER-POSTPART
642.90	Unspecified hypertension complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable	HYPERTEN PREG NOS-UNSPEC
642.91	Unspecified hypertension complicating pregnancy, childbirth, or the puerperium, delivered w/ or w/out mention of antepartum condition	TOX W OLD HYP-DEL W P/P
642.92	Unspecified hypertension complicating pregnancy, childbirth, or the puerperium, delivered w/mention of postpartum complication	HYPERTENS NOS-DEL W P/P
642.93	Unspecified hypertension complicating pregnancy, childbirth, or the puerperium, antepartum condition or complication	HYPERTENS NOS-ANTEPARTUM
642.94	Unspecified hypertension complicating pregnancy, childbirth, or the puerperium, postpartum condition or complication	HYPERTENS NOS-POSTPARTUM
643.00	Mild hyperemesis gravidarum, unspecified as to episode of care or not applicable	MILD HYPEREM GRAV-UNSPEC
643.01	Mild hyperemesis gravidarum, delivered w/ or w/out mention of antepartum condition	MILD HYPEREM GRAV-DELIV
643.03	Mild hyperemesis gravidarum, antepartum condition or complication	MILD HYPEREMESIS-ANTEPAR
643.10	Hyperemesis gravidarum w/metabolic disturbance, unspecified as to episode of care or not applicable	HYPEREM W METAB DIS-UNSP
643.11	Hyperemesis gravidarum w/metabolic disturbance, delivered w/ or w/out mention of antepartum condition	HYPEREM W METAB DIS-DEL
643.13	Hyperemesis gravidarum w/metabolic disturbance, antepartum condition or complication	HYPEREM W METAB-ANTEPART
643.20	Late vomiting of pregnancy, unspecified as to episode	LATE VOMIT OF PREG-UNSP

Table 7.02 Obstetrics (Cont)

Code	ICD-9-CM Description	Shortened Description
	of care or not applicable	
643.21	Late vomiting of pregnancy, delivered w/ or w/out mention of antepartum condition	LATE VOMIT OF PREG-DELIV
643.23	Late vomiting of pregnancy, antepartum condition or complication	LATE VOMIT PREG-ANTEPART
643.80	Other vomiting complicating pregnancy, unspecified as to episode of care or not applicable	VOMIT COMPL PREG-UNSPEC
643.81	Other vomiting complicating pregnancy, delivered w/ or w/out mention of antepartum condition	VOMIT COMPL PREG-DELIVER
643.83	Other vomiting complicating pregnancy, antepartum condition or complication	VOMIT COMPL PREG-ANTEPAR
643.90	Unspecified vomiting of pregnancy, unspecified as to episode of care or not applicable	VOMIT OF PREG NOS-UNSPEC
643.91	Unspecified vomiting of pregnancy, delivered w/ or w/out mention of antepartum condition	VOMIT OF PREG NOS-DELIV
643.93	Unspecified vomiting of pregnancy, antepartum condition or complication	VOMIT OF PG NOS-ANTEPART
644.00	Threatened premature labor, unspecified as to episode of care or not applicable	THREAT PREM LABOR-UNSPE
644.03	Threatened premature labor, antepartum condition or complication	THRT PREM LABOR-ANTEPART
644.10	Early or threatened labor, other threatened labor, unspecified as to episode of care or not applicable	THREAT LABOR NEC-UNSPEC
644.13	Early or threatened labor, other threatened labor, antepartum condition or complication	THREAT LABOR NEC-ANTEPAR
644.20	Early onset of delivery, unspecified as to episode of care or not applicable	EARLY ONSET DELIV-UNSPEC
644.21	Early onset of delivery, delivered, w/ or w/out mention of antepartum condition	EARLY ONSET DELIVERY-DEL
645.10	Post term pregnancy, unspecified as to episode of care or not applicable	POST TERM PREG-UNSP
645.11	Post term pregnancy, delivered, w/ or w/out mention of antepartum condition	POST TERM PREG-DEL
645.13	Post term pregnancy, antepartum condition or complication	POST TERM PREG-ANTEPAR
645.20	Prolonged pregnancy, unspecified as to episode of care or not applicable	PROLONGED PREG-UNSP
645.21	Prolonged pregnancy, delivered w/ or w/out mention of antepartum condition	PROLONGED PREG-DEL
645.23	Prolonged pregnancy, antepartum condition or complication	PROLONGED PREG-ANTEPAR
646.00	Papyraceous fetus, unspecified as to episode of care or not applicable	PAPYRACEOUS FETUS-UNSPEC
646.01	Papyraceous fetus, delivered w/ or w/out mention of antepartum condition	PAPYRACEOUS FETUS-DELIV
646.03	Papyraceous fetus, antepartum condition or complication	PAPYRACEOUS FET-ANTEPAR
646.10	Edema or excessive weight gain in pregnancy, w/out mention of hypertension, unspecified as to episode of care or not applicable	EDEMA IN PREG-UNSPEC

Table 7.02 Obstetrics (Cont)

Code	ICD-9-CM Description	Shortened Description
646.11	Edema or excessive weight gain in pregnancy, w/out mention of hypertension, delivered w/ or w/out mention of antepartum condition	EDEMA IN PREG-DELIVERED
646.12	Edema or excessive weight gain in pregnancy, w/out mention of hypertension, delivered w/mention of postpartum complication	EDEMA IN PREG-DEL W P/P
646.13	Edema or excessive weight gain in pregnancy, w/out mention of hypertension, antepartum condition or complication	EDEMA IN PREG-ANTEPARTUM
646.14	Edema or excessive weight gain in pregnancy, w/out mention of hypertension, postpartum condition or complication	EDEMA IN PREG-POSTPARTUM
646.20	Unspecified renal disease in pregnancy, w/out mention of hypertension, unspecified as to episode of care or not applicable	RENAL DIS PREG NOS-UNSP
646.21	Unspecified renal disease in pregnancy, w/out mention of hypertension, delivered w/ or w/out mention of antepartum condition	RENAL DIS NOS-DELIVERED
646.22	Unspecified renal disease in pregnancy, w/out mention of hypertension, delivered w/mention of postpartum complication	RENAL DIS NOS-DEL W P/P
646.23	Unspecified renal disease in pregnancy, w/out mention of hypertension, antepartum condition or complication	RENAL DIS NOS-ANTEPARTUM
646.24	Unspecified renal disease in pregnancy, w/out mention of hypertension, postpartum condition or complication	RENAL DIS NOS-POSTPARTUM
646.30	Habitual aborter, unspecified as to episode of care or not applicable	HABITUAL ABORTER-UNSPEC
646.31	Habitual aborter, delivered w/ or w/out mention of antepartum condition	HABITUAL ABORTER-DELIVER
646.33	Habitual aborter, antepartum condition or complication	HABITUAL ABORT-ANTEPART
646.40	Peripheral neuritis in pregnancy, unspecified as to episode of care or not applicable	NEURITIS OF PREG-UNSPEC
646.41	Peripheral neuritis in pregnancy, delivered w/ or w/out mention of antepartum condition	NEURITIS-DELIVERED
646.42	Peripheral neuritis in pregnancy, delivered w/mention of postpartum complication	NEURITIS-DELIVERED W P/P
646.43	Peripheral neuritis in pregnancy, antepartum condition or complication	NEURITIS OF PREG-ANTEPAR
646.44	Peripheral neuritis in pregnancy, postpartum condition or complication	NEURITIS OF PREG-POSTPAR
646.50	Asymptomatic bacteriuria in pregnancy, unspecified as to episode of care or not applicable	BACTERIURIA PREG-UNSPEC
646.51	Asymptomatic bacteriuria in pregnancy, delivered w/ or w/out mention of antepartum condition	ASYM BACTERIURIA-DELIVER
646.52	Asymptomatic bacteriuria in pregnancy, delivered w/mention of postpartum complication	ASY BACTERURIA-DEL W P/P
646.53	Asymptomatic bacteriuria in pregnancy, antepartum condition or complication	ASY BACTERIURIA-ANTEPART
646.54	Asymptomatic bacteriuria in pregnancy, postpartum condition or complication	ASY BACTERIURIA-POSTPART

Table 7.02 Obstetrics (Cont)

Code	ICD-9-CM Description	Shortened Description
646.60	Infections of genitourinary tract in pregnancy, unspecified as to episode of care or not applicable	GU INFECT IN PREG-UNSPEC
646.61	Infections of genitourinary tract in pregnancy, delivered w/ or w/out mention of antepartum condition	GU INFECTION-DELIVERED
646.62	Infections of genitourinary tract in pregnancy, delivered w/mention of postpartum complication	GU INFECTION-DELIV W P/P
646.63	Infections of genitourinary tract in pregnancy, antepartum condition or complication	GU INFECTION-ANTEPARTUM
646.64	Infections of genitourinary tract in pregnancy, postpartum condition or complication	GU INFECTION-POSTPARTUM
646.70	Liver disorders in pregnancy, unspecified as to episode of care or not applicable	LIVER DIS IN PREG-UNSPEC
646.71	Liver disorders in pregnancy, delivered w/ or w/out mention of antepartum condition	LIVER DISORDER-DELIVERED
646.73	Liver disorders in pregnancy, antepartum condition or complication	LIVER DISORDER-ANTEPART
646.80	Other specified complications of pregnancy, unspecified as to episode of care or not applicable	PREG COMPL NEC-UNSPEC
646.81	Other specified complications of pregnancy, delivered w/ or w/out mention of antepartum condition	PREG COMPL NEC-DELIVERED
646.82	Other specified complications of pregnancy, delivered w/mention of postpartum complication	PREG COMPL NEC-DEL W P/P
646.83	Other specified complications of pregnancy, antepartum condition or complication	PREG COMPL NEC-ANTEPART
646.84	Other specified complications of pregnancy, postpartum condition or complication	PREG COMPL NEC-POSTPART
646.90	Unspecified complication of pregnancy, unspecified as to episode of care or not applicable	PREG COMPL NOS-UNSPEC
646.91	Unspecified complication of pregnancy, delivered w/ or w/out mention of antepartum condition	PREG COMPL NOS-DELIVERED
646.93	Unspecified complication of pregnancy, antepartum condition or complication	PREG COMPL NOS-ANTEPART
647.00	Syphilis, unspecified as to episode of care or not applicable	SYPHILIS IN PREG-UNSPEC
647.01	Syphilis, delivered w/ or w/out mention of antepartum condition	SYPHILIS-DELIVERED
647.02	Syphilis, delivered w/mention of postpartum complication	SYPHILIS-DELIVERED W P/P
647.03	Syphilis, antepartum condition or complication	SYPHILIS-ANTEPARTUM
647.04	Syphilis, postpartum condition or complication	SYPHILIS-POSTPARTUM
647.10	Gonorrhea, unspecified as to episode of care or not applicable	GONORRHEA IN PREG-UNSPEC
647.11	Gonorrhea, delivered w/ or w/out mention of antepartum condition	GONORRHEA-DELIVERED
647.12	Gonorrhea, delivered w/mention of postpartum complication	GONORRHEA-DELIVER W P/P
647.13	Gonorrhea, antepartum condition or complication	GONORRHEA-ANTEPARTUM
647.14	Gonorrhea, postpartum condition or complication	GONORRHEA-POSTPARTUM
647.20	Other venereal diseases, unspecified as to episode of	OTHER VD IN PREG-UNSPEC

Table 7.02 Obstetrics (Cont)

Code	ICD-9-CM Description	Shortened Description
	care or not applicable	
647.21	Other venereal diseases, delivered w/ or w/out mention of antepartum condition	OTHER VD-DELIVERED
647.22	Other venereal diseases, delivered w/mention of postpartum complication	OTHER VD-DELIVERED W P/P
647.23	Other venereal diseases, antepartum condition or complication	OTHER VD-ANTEPARTUM
647.24	Other venereal diseases, postpartum condition or complication	OTHER VD-POSTPARTUM
647.30	Tuberculosis, unspecified as to episode of care or not applicable	TB IN PREG-UNSPECIFIED
647.31	Tuberculosis, delivered w/ or w/out mention of antepartum condition	TUBERCULOSIS-DELIVERED
647.32	Tuberculosis, delivered w/mention of postpartum complication	TUBERCULOSIS-DELIV W P/P
647.33	Tuberculosis, antepartum condition or complication	TUBERCULOSIS-ANTEPARTUM
647.34	Tuberculosis, postpartum condition or complication	TUBERCULOSIS-POSTPARTUM
647.40	Malaria, unspecified as to episode of care or not applicable	MALARIA IN PREG-UNSPEC
647.41	Malaria, delivered w/ or w/out mention of antepartum condition	MALARIA-DELIVERED
647.42	Malaria, delivered w/mention of postpartum complication	MALARIA-DELIVERED W P/P
647.43	Malaria, antepartum condition or complication	MALARIA-ANTEPARTUM
647.44	Malaria, postpartum condition or complication	MALARIA-POSTPARTUM
647.50	Rubella, unspecified as to episode of care or not applicable	RUBELLA IN PREG-UNSPEC
647.51	Rubella, delivered w/ or w/out mention of antepartum condition	RUBELLA-DELIVERED
647.52	Rubella, delivered w/mention of postpartum complication	RUBELLA-DELIVERED W P/P
647.53	Rubella, antepartum condition or complication	RUBELLA-ANTEPARTUM
647.54	Rubella, postpartum condition or complication	RUBELLA-POSTPARTUM
647.60	Other viral diseases, unspecified as to episode of care or not applicable	OTH VIRUS IN PREG-UNSPEC
647.61	Other viral diseases, delivered w/ or w/out mention of antepartum condition	OTH VIRAL DIS-DELIVERED
647.62	Other viral diseases, delivered w/mention of postpartum complication	OTH VIRAL DIS-DEL W P/P
647.63	Other viral diseases, antepartum condition or complication	OTH VIRAL DIS-ANTEPARTUM
647.64	Other viral diseases, postpartum condition or complication	OTH VIRAL DIS-POSTPARTU
647.80	Other specified infections and parasitic diseases, unspecified as to episode of care or not applicable	INF DIS IN PREG NEC-UNSP
647.81	Other specified infections and parasitic diseases, delivered w/ or w/out mention of antepartum condition	INFECT DIS NEC-DELIVERED

Table 7.02 Obstetrics (Cont)

Code	ICD-9-CM Description	Shortened Description
647.82	Other specified infections and parasitic diseases, delivered w/mention of postpartum complication	INFECT DIS NEC-DEL W P/P
647.83	Other specified infections and parasitic diseases, antepartum condition or complication	INFECT DIS NEC-ANTEPART
647.84	Other specified infections and parasitic diseases, postpartum condition or complication	INFECT DIS NEC-POSTPART
647.90	Unspecified infection or infestation, unspecified as to episode of care or not applicable	INFECT IN PREG NOS-UNSP
647.91	Unspecified infection or infestation, delivered w/ or w/out mention of antepartum condition	INFECT NOS-DELIVERED
647.92	Unspecified infection or infestation, delivered w/mention of postpartum complication	INFECT NOS-DELIVER W P/P
647.93	Unspecified infection or infestation, antepartum condition or complication	INFECT NOS-ANTEPARTUM
647.94	Unspecified infection or infestation, postpartum condition or complication	INFECT NOS-POSTPARTUM
648.00	Diabetes mellitus, unspecified as to episode of care or not applicable	DIABETES IN PREG-UNSPEC
648.01	Diabetes mellitus, delivered with or without mention of antepartum condition	DIABETES-DELIVERED
648.02	Diabetes mellitus, delivered with mention of postpartum condition	DIABETES-DELIVERED W P/P
648.10	Thyroid dysfunction, unspecified as to episode of care or not applicable	THYROID DYSFUN PREG-UNSP
648.11	Thyroid dysfunction, delivered with or without mention of antepartum condition	THYROID DYSFUNC-DELIVER
648.12	Thyroid dysfunction, delivered with mention of postpartum condition	THYROID DYSFUN-DEL W P/P
648.20	Anemia, unspecified as to episode of care or not applicable	ANEMIA IN PREG-UNSPEC
648.21	Anemia, delivered w/ or w/out mention of antepartum condition	ANEMIA-DELIVERED
648.22	Anemia, delivered w/mention of postpartum complication	ANEMIA-DELIVERED W P/P
648.30	Drug dependence, unspecified as to episode of care or not applicable	DRUG DEPEND PREG-UNSPEC
648.31	Drug dependence, delivered w/ or w/out mention of antepartum condition	DRUG DEPENDENCE-DELIVER
648.32	Drug dependence delivered w/mention of postpartum complication	DRUG DEPENDEN-DEL W P/P
648.40	Mental disorders, unspecified as to episode of care or not applicable	MENTAL DIS PREG-UNSPEC
648.41	Mental disorders, delivered w/ or w/out mention of antepartum condition	MENTAL DISORDER-DELIVER
648.42	Mental disorders, delivered w/mention of postpartum complication	MENTAL DIS-DELIV W P/P
648.50	Congenital cardiovascular disorders, unspecified as to episode of care or not applicable	CONGEN CV DIS PREG-UNSP
648.51	Congenital cardiovascular disorders, delivered w/ or w/out mention of antepartum condition	CONGEN CV DIS-DELIVERED

Table 7.02 Obstetrics (Cont)

Code	ICD-9-CM Description	Shortened Description
648.52	Congenital cardiovascular disorders, delivered w/mention of postpartum complication	CONGEN CV DIS-DEL W P/P
648.60	Other cardiovascular diseases, unspecified as to episode of care or not applicable	CV DIS NEC PREG-UNSPEC
648.61	Other cardiovascular diseases, delivered w/ or w/o mention of antepartum condition	CV DIS NEC PREG-DELIVER
648.62	Other cardiovascular diseases, delivered w/mention of postpartum complication	CV DIS NEC-DELIVER W P/P
648.70	Bone and joint disorders of back, pelvis, and lower limbs, unspecified as to episode of care or not applicable	BONE DISORD IN PREG-UNSP
648.71	Bone and joint disorders of back, pelvis, and lower limbs, delivered w/ or w/out mention of antepartum condition	BONE DISORDER-DELIVERED
648.72	Bone and joint disorders of back, pelvis, and lower limbs, delivered w/mention of postpartum complication	BONE DISORDER-DEL W P/P
648.80	Abnormal glucose tolerance, unspecified as to episode of care or not applicable	ABN GLUCOSE IN PREG-UNSP
648.81	Abnormal glucose tolerance, delivered w/ or w/o mention of antepartum condition	ABN GLUCOSE TOLER-DELIV
648.82	Abnormal glucose tolerance, delivered w/mention of postpartum complication	ABN GLUCOSE-DELIV W P/P
648.90	Other current conditions classifiable elsewhere, unspecified as to episode of care or not applicable	OTH CURR COND PREG-UNSP
648.91	Other current conditions classifiable elsewhere, delivered w/ or w/out mention of antepartum condition	OTH CURR COND-DELIVERE
648.92	Other current conditions classifiable elsewhere, delivered w/mention of postpartum complication	OTH CURR COND-DEL W P/P
649.00	Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable	TOBACCO USE DISORD-UNSPEC
649.01	Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition	TOBACCO USE DISOR-DELIV
649.02	Tobacco use disorder complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication	TOBACCO USE DIS-DEL-P/P
649.10	Obesity complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable	OBESITY-UNSPECIFIED
649.11	Obesity complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition	OBESITY-DELIVERED
649.12	Obesity complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication	OBESITY-DELIVERED W P/P
649.20	Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable	BARIATRIC SURG STAT-UNSP

Table 7.02 Obstetrics (Cont)

Code	ICD-9-CM Description	Shortened Description
649.21	Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition	BARIATRIC SURG STAT-DEL
649.22	Bariatric surgery status complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication	BARIATRIC SURG-DEL W P/P
649.30	Coagulation defects complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable	COAGULATION DEF-UNSPEC
649.31	Coagulation defects complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition	COAGULATION DEF-DELIV
649.32	Coagulation defects complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication	COAGULATN DEF-DEL W P/P
649.40	Epilepsy complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care or not applicable	EPILEPSY-UNSPECIFIED
649.41	Epilepsy complicating pregnancy, childbirth, or the puerperium, delivered, with or without mention of antepartum condition	EPILEPSY-DELIVERED
649.42	Epilepsy complicating pregnancy, childbirth, or the puerperium, delivered, with mention of postpartum complication	EPILEPSY-DELIVERED W P/P
649.50	Spotting complicating pregnancy, unspecified as to episode of care or not applicable	SPOTTING-UNSPECIFIED
649.51	Spotting complicating pregnancy, delivered, with or without mention of antepartum condition	SPOTTING-DELIVERED
649.53	Spotting complicating pregnancy, antepartum condition or complication	SPOTTING-ANTEPARTUM
649.60	Uterine size date discrepancy, unspecified as to episode of care or not applicable	UTERINE SIZE DESCRP-UNSP
649.61	Uterine size date discrepancy, delivered, with or without mention of antepartum condition	UTERINE SIZE DESCREP-DEL
649.62	Uterine size date discrepancy, delivered, with mention of postpartum complication	UTERINE SIZE-DEL W P/P
650	Delivery in a completely normal case	NORMAL DELIVERY
651.00	Multiple gestation, twin pregnancy, unspecified as to episode of care or not applicable	TWIN PREGNANCY-UNSPEC
651.01	Multiple gestation, twin pregnancy, delivered with or without mention of antepartum condition	TWIN PREGNANCY-DELIVERED
651.03	Multiple gestation, twin pregnancy, antepartum condition or complication	TWIN PREGNANCY-ANTEPART
651.10	Multiple gestation, triplet pregnancy, unspecified as to episode of care or not applicable	TRIPLET PREGNANCY-UNSPEC
651.11	Multiple gestation, triplet pregnancy, delivered with or without mention of antepartum condition	TRIPLET PREGNANCY-DELIV
651.13	Multiple gestation, triplet pregnancy, antepartum condition or complication	TRIPLET PREG-ANTEPARTUM
651.20	Multiple gestation, quadruplet pregnancy, unspecified	QUADRUPLET PREG-UNSPEC

Table 7.02 Obstetrics (Cont)

Code	ICD-9-CM Description	Shortened Description
	as to episode of care or not applicable	
651.21	Multiple gestation, quadruplet pregnancy, delivered with or without mention of antepartum condition	QUADRUPLET PREG-DELIVER
651.23	Multiple gestation, quadruplet pregnancy, antepartum condition or complication	QUADRUPLET PREG-ANTEPART
651.30	Multiple gestation, twin pregnancy with fetal loss and retention of one fetus, unspecified as to episode of care or not applicable	TWINS W FETAL LOSS-UNSP
651.31	Multiple gestation, twin pregnancy w/fetal loss and retention of 1 fetus, delivered with or without mention of antepartum condition	TWINS W FETAL LOSS-DEL
651.33	Multiple gestation, twin pregnancy with fetal loss and retention of one fetus, antepartum condition or complication	TWINS W FETAL LOSS-ANTE
651.40	Multiple gestation, triplet pregnancy with fetal loss and retention of one or more fetus(es), unspecified as to episode of care or not applicable	TRIPLETS W FET LOSS-UNSP
651.41	Multiple gestation, triplet pregnancy, w/fetal loss and retention of one or more fetus (es), delivered with or without mention of antepartum condition	TRIPLETS W FET LOSS-DEL
651.43	Multiple gestation, triplet pregnancy with fetal loss and retention of one or more fetus(es), antepartum condition or complication	TRIPLETS W FET LOSS-ANTE
651.50	Multiple gestation, quadruplet pregnancy with fetal loss and retention of one or more fetus(es), unspecified as to episode of care or not applicable	QUADS W FETAL LOSS-UNSP
651.51	Multiple gestation, quadruplet pregnancy, w/fetal loss and retention of 1 or more fetus(es), delivered with or without mention of antepartum condition	QUADS W FETAL LOSS-DEL
651.53	Multiple gestation, quadruplet pregnancy with fetal loss and retention of one or more fetus(es), antepartum condition or complication	QUADS W FETAL LOSS-ANTE
651.60	Multiple gestation, Other multiple pregnancy with fetal loss and retention of one or more fetus(es), unspecified as to episode of care or not applicable	MULT GES W FET LOSS-UNSP
651.61	Multiple gestation, other multiple pregnancy, w/fetal loss and retention of 1 or more fetus(es), delivered with or without mention of antepartum condition	MULT GES W FET LOSS-DEL
651.63	Multiple gestation, other multiple pregnancy with fetal loss and retention of one or more fetus(es), antepartum condition or complication	MULT GES W FET LOSS-ANTE
651.70	Multiple gestation following (elective) fetal reduction, unspecified as to episode of care or not applicable	MUL GEST-FET REDUCT UNSP
651.71	Multiple gestation following (elective) fetal reduction, delivered without mention of antepartum condition	MULT GEST-FET REDUCT DEL
651.73	Multiple gestation following (elective) fetal reduction, antepartum condition or complication	MUL GEST-FET REDUCT ANTE
651.80	Multiple gestation, other specified multiple gestation, unspecified as to episode of care or not applicable	MULTI GESTAT NEC-UNSPEC
651.81	Multiple gestation, other specified multiple gestation,	MULTI GESTAT NEC-DELIVER

Table 7.02 Obstetrics (Cont)

Code	ICD-9-CM Description	Shortened Description
	delivered with or without mention of antepartum condition	
651.83	Multiple gestation, other specified multiple gestation, antepartum condition or complication	MULTI GEST NEC-ANTEPART
651.90	Multiple gestation, unspecified multiple gestation, unspecified as to episode of care or not applicable	MULTI GESTAT NOS-UNSPEC
651.91	Multiple gestation, unspecified multiple gestation, delivered with or without mention of antepartum condition	MULT GESTATION NOS-DELIV
651.93	Multiple gestation, unspecified multiple gestation, antepartum condition or complication	MULTI GEST NOS-ANTEPART
652.00	Unstable lie, unspecified as to episode of care or not applicable	UNSTABLE LIE-UNSPECIFIED
652.01	Unstable lie, delivered, w/ or w/out mention of antepartum condition	UNSTABLE LIE-DELIVERED
652.03	Unstable lie, antepartum condition or complication	UNSTABLE LIE-ANTEPARTUM
652.10	Breech or other malpresentation successfully converted to cephalic presentation, unspecified as to episode of care or not applicable	CEPHALIC VERS NOS-UNSPEC
652.11	Breech or other malpresentation successfully converted to cephalic presentation, delivered, w/ or w/out mention of antepartum condition	CEPHALIC VERS NOS-DELIV
652.13	Breech or other malpresentation successfully converted to cephalic presentation, antepartum condition or complication	CEPHAL VERS NOS-ANTEPART
652.20	Breech presentation without mention of version, unspecified as to episode of care or not applicable	BREECH PRESENTAT-UNSPEC
652.21	Breech presentation w/o mention of version, delivered, w/ or w/out mention of antepartum condition	BREECH PRESENTAT-DELIVER
652.23	Breech presentation without mention of version, antepartum condition or complication	BREECH PRESENT-ANTEPART
652.30	Transverse or oblique presentation, unspecified as to episode of care or not applicable	TRANSV/OBLIQ LIE-UNSPEC
652.31	Transverse or oblique presentation, delivered, w/ or w/out mention of antepartum condition	TRANSVER/OBLIQ LIE-DELIV
652.33	Transverse or oblique presentation, antepartum condition or complication	TRANSV/OBLIQ LIE-ANTEPAR
652.40	Face or brow presentation, unspecified as to episode of care or not applicable	FACE/BROW PRESENT-UNSPEC
652.41	Face or brow presentation, delivered, w/ or w/o mention of antepartum condition	FACE/BROW PRESENT-DELIV
652.43	Face or brow presentation, antepartum condition or complication	FACE/BROW PRES-ANTEPART
652.50	High head at term, unspecified as to episode of care or not applicable	HIGH HEAD AT TERM-UNSPEC
652.51	High head at term, delivered, w/ or w/out mention of antepartum condition	HIGH HEAD AT TERM-DELIV
652.53	High head at term, antepartum condition or complication	HIGH HEAD TERM-ANTEPART
652.60	Multiple gestation with malpresentation of one fetus or	MULT GEST MALPRESEN-UNSP

Table 7.02 Obstetrics (Cont)

Code	ICD-9-CM Description	Shortened Description
	more, unspecified as to episode of care or not applicable	
652.61	Multiple gestation w/malpresentation of 1 fetus or more, delivered, w/ or w/out mention of antepartum condition	MULT GEST MALPRES-DELIV
652.63	Multiple gestation with malpresentation of one fetus or more, antepartum condition or complication	MULT GES MALPRES-ANTEPAR
652.70	Prolapsed arm, unspecified as to episode of care or not applicable	PROLAPSED ARM-UNSPEC
652.71	Prolapsed arm, delivered, w/ or w/out mention of antepartum condition	PROLAPSED ARM-DELIVERED
652.73	Prolapsed arm, antepartum condition or complication	PROLAPSED ARM-ANTEPART
652.80	Other specified malposition or malpresentation, unspecified as to episode of care or not applicable	MALPOSITION NEC-UNSPEC
652.81	Other specified malposition or malpresentation, delivered, w/ or w/out mention of antepartum condition	MALPOSITION NEC-DELIVER
652.83	Other specified malposition or malpresentation, antepartum condition or complication	MALPOSITION NEC-ANTEPART
652.90	Unspecified malposition or malpresentation, unspecified as to episode of care or not applicable	MALPOSITION NOS-UNSPEC
652.91	Unspecified malposition or malpresentation, delivered, w/ or w/out mention of antepartum condition	MALPOSITION NOS-DELIVER
652.93	Unspecified malposition or malpresentation, antepartum condition or complication	MALPOSITION NOS-ANTEPART
653.00	Major abnormality of bony pelvis, not further specified, unspecified as t episode of care or not applicable	PELVIC DEFORM NOS-UNSPEC
653.01	Major abnormality of bony pelvis, not further specified, delivered, w/ or w/o mention of antepartum condition	PELVIC DEFORM NOS-DELIV
653.03	Major abnormality of bony pelvis, not further specified, antepartum condition or complication	PELV DEFORM NOS-ANTEPART
653.10	Generally contracted pelvis, unspecified as to episode of care or not applicable	CONTRACT PELV NOS-UNSPEC
653.11	Generally contracted pelvis, delivered, w/ or w/o mention of antepartum condition	CONTRACT PELV NOS-DELIV
653.13	Generally contracted pelvis, antepartum condition or complication	CONTRAC PELV NOS-ANTEPAR
653.20	Inlet contraction of pelvis, unspecified as to episode of care or not applicable	INLET CONTRACTION-UNSPEC
653.21	Inlet contraction of pelvis, delivered, w/ or w/o mention of antepartum condition	INLET CONTRACTION-DELIV
653.23	Inlet contraction of pelvis, antepartum condition or complication	INLET CONTRACT-ANTEPART
653.30	Outlet contraction of pelvis, unspecified as to episode of care or not applicable	OUTLET CONTRACTION-UNSP
653.31	Outlet contraction of pelvis, delivered, w/ or w/o mention of antepartum condition	OUTLET CONTRACTION-DELIV
653.33	Outlet contraction of pelvis, antepartum condition or complication	OUTLET CONTRACT-ANTEPAR
653.40	Fetopelvic disproportion, unspecified as to episode of care or not applicable	FETOPELV DISPROP-UNSPEC

Table 7.02 Obstetrics (Cont)

Code	ICD-9-CM Description	Shortened Description
653.41	Fetopelvic disproportion, delivered, w/ or w/o mention of antepartum condition	FETOPELV DISPROPOR-DELIV
653.43	Fetopelvic disproportion, antepartum condition or complication	FETOPEL DISPROP-ANTEPART
653.50	Unusually large fetus causing disproportion, unspecified as to episode of care or not applicable	FETAL DISPROP NOS-UNSPEC
653.51	Unusually large fetus causing disproportion, delivered, w/ or w/o mention of antepartum condition	FETAL DISPROP NOS-DELIV
653.53	Unusually large fetus causing disproportion, antepartum condition or complication	FETAL DISPRO NOS-ANTEPAR
653.60	Hydrocephalic fetus causing disproportion, unspecified as to episode of care or not applicable	HYDROCEPHAL FETUS-UNSPEC
653.61	Hydrocephalic fetus causing disproportion, delivered, w/ or w/o mention of antepartum condition	HYDROCEPH FETUS-DELIVER
653.63	Hydrocephalic fetus causing disproportion, antepartum condition or complication	HYDROCEPH FETUS-ANTEPART
653.70	Other fetal abnormality causing disproportion, unspecified as to episode of care or not applicable	OTH ABN FET DISPROP-UNSP
653.71	Other fetal abnormality causing disproportion, delivered, w/ or w/o mention of antepartum condition	OTH ABN FET DISPRO-DELIV
653.73	Other fetal abnormality causing disproportion, antepartum condition or complication	OTH ABN FET DISPRO-ANTEP
653.80	Disproportion of other origin, unspecified as to episode of care or not applicable	DISPROPORTION NEC-UNSPEC
653.81	Disproportion of other origin, delivered, w/ or w/o mention of antepartum condition	DISPROPORTION NEC-DELIV
653.83	Disproportion of other origin, antepartum condition or complication	DISPROPOR NEC-ANTEPARTUM
653.90	Unspecified disproportion, unspecified as to episode of care or not applicable	DISPROPORTION NOS-UNSPEC
653.91	Unspecified disproportion, delivered, w/ or w/o mention of antepartum condition	DISPROPORTION NOS-DELIV
653.93	Unspecified disproportion, antepartum condition or complication	DISPROPOR NOS-ANTEPARTUM
654.00	Congenital abnormalities of uterus, unspecified as to episode of care or not applicable	CONG ABN UTER PREG-UNSP
654.01	Congenital abnormalities of uterus, delivered w/ or w/o mention of antepartum condition	CONGEN ABN UTERUS-DELIV
654.02	Congenital abnormalities of uterus, delivered w/mention of postpartum complication	CONG ABN UTER-DEL W P/P
654.03	Congenital abnormalities of uterus, antepartum condition or complication	CONGEN ABN UTER-ANTEPART
654.04	Congenital abnormalities of uterus, postpartum condition or complication	CONGEN ABN UTER-POSTPART
654.10	Tumors of body of uterus, unspecified as to episode of care or not applicable	UTER TUMOR IN PREG-UNSP
654.11	Tumors of body of uterus, delivered w/ or w/o mention of antepartum condition	UTERINE TUMOR-DELIVERED
654.12	Tumors of body of uterus, delivered w/mention of postpartum complication	UTERINE TUMOR-DEL W P/P

Table 7.02 Obstetrics (Cont)

Code	ICD-9-CM Description	Shortened Description
654.13	Tumors of body of uterus, antepartum condition or complication	UTERINE TUMOR-ANTEPARTUM
654.14	Tumors of body of uterus, postpartum condition or complication	UTERINE TUMOR-POSTPARTUM
654.20	Previous cesarean delivery, unspecified as to episode of care or not applicable	PREV C-DELIVERY UNSPEC
654.21	Previous cesarean delivery, delivered w/ or w/o mention of antepartum condition	PREV C-DELIVERY-DELIVRD
654.23	Previous cesarean delivery, antepartum condition or complication	PREV C-DELIVERY-ANTEPART
654.30	Retroverted and incarcerated gravid uterus, unspecified as to episode of care or not applicable	RETROVERT UTERUS-UNSPEC
654.31	Retroverted and incarcerated gravid uterus, delivered w/ or w/o mention of antepartum condition	RETROVERT UTERUS-DELIVER
654.32	Retroverted and incarcerated gravid uterus, delivered w/mention of postpartum complication	RETROVERT UTER-DEL W P/P
654.33	Retroverted and incarcerated gravid uterus, antepartum condition or complication	RETROVERT UTER-ANTEPART
654.34	Retroverted and incarcerated gravid uterus, postpartum condition or complication	RETROVERT UTER-POSTPART
654.40	Other abnormalities in shape or position of gravid uterus and of neighboring structures, unspecified as to episode of care or not applicable	ABN GRAV UTERUS NEC-UNSP
654.41	Other abnormalities in shape or position of gravid uterus and of neighboring structures, delivered w/ or w/o mention of antepartum condition	ABN UTERUS NEC-DELIVERED
654.42	Other abnormalities in shape or position of gravid uterus and of neighboring structures, delivered w/mention of postpartum complication	ABN UTERUS NEC-DEL W P/P
654.43	Other abnormalities in shape or position of gravid uterus and of neighboring structures, antepartum condition or complication	ABN UTERUS NEC-ANTEPART
654.44	Other abnormalities in shape or position of gravid uterus and of neighboring structures, postpartum condition or complication	ABN UTERUS NEC-POSTPART
654.50	Cervical incompetence, unspecified as to episode of care or not applicable	CERV INCOMPET PREG-UNSP
654.51	Cervical incompetence, delivered w/ or w/o mention of antepartum condition	CERVICAL INCOMPET-DELIV
654.52	Cervical incompetence, delivered w/mention of postpartum complication	CERV INCOMPET-DEL W P/P
654.53	Cervical incompetence, antepartum condition or complication	CERV INCOMPET-ANTEPARTUM
654.54	Cervical incompetence, postpartum condition or complication	CERV INCOMPET-POSTPARTUM
654.60	Other congenital or acquired abnormality of cervix, unspecified as to episode of care or not applicable	ABN CERVIX NEC PREG-UNSP
654.61	Other congenital or acquired abnormality of cervix, delivered w/ or w/o mention of antepartum condition	ABN CERVIX NEC-DELIVERED
654.62	Other congenital or acquired abnormality of cervix,	ABN CERVIX NEC-DEL W P/P

Table 7.02 Obstetrics (Cont)

Code	ICD-9-CM Description	Shortened Description
	delivered w/mention of postpartum complication	
654.63	Other congenital or acquired abnormality of cervix, antepartum condition or complication	ABN CERVIX NEC-ANTEPART
654.64	Other congenital or acquired abnormality of cervix, postpartum condition or complication	ABN CERVIX NEC-POSTPART
654.70	Congenital or acquired abnormality of vagina, unspecified as to episode of care or not applicable	ABN VAGINA IN PREG-UNSP
654.71	Congenital or acquired abnormality of vagina, delivered w/ or w/o mention of antepartum condition	ABNORM VAGINA-DELIVERED
654.72	Congenital or acquired abnormality of vagina, delivered w/mention of postpartum complication	ABNORM VAGINA-DEL W P/P
654.73	Congenital or acquired abnormality of vagina, antepartum condition or complication	ABNORM VAGINA-ANTEPARTUM
654.74	Congenital or acquired abnormality of vagina, postpartum condition or complication	ABNORM VAGINA-POSTPARTUM
654.80	Congenital or acquired abnormality of vulva, unspecified as to episode of care or not applicable	ABN VULVA IN PREG-UNSPEC
654.81	Congenital or acquired abnormality of vulva, delivered w/ or w/o mention of antepartum condition	ABNORMAL VULVA-DELIVERED
654.82	Congenital or acquired abnormality of vulva, delivered w/mention of postpartum complication	ABNORMAL VULVA-DEL W P/P
654. 83	Congenital or acquired abnormality of vulva, antepartum condition or complication	ABNORMAL VULVA-ANTEPART
654.84	Congenital or acquired abnormality of vulva, postpartum condition or complication	ABNORMAL VULVA-POSTPART
654.90	Other and unspecified, unspecified as to episode of care or not applicable	ABN PEL NEC IN PREG-UNSP
654.91	Other and unspecified abnormality of organs and soft tissues of pelvis, delivered w/ or w/o mention of antepartum condition	ABN PELV ORG NEC-DELIVER
654.92	Other and unspecified abnormality of organs and soft tissues of pelvis, delivered w/mention of postpartum complication	ABN PELV NEC-DELIV W P/P
654.93	Other and unspecified, antepartum condition or complication	ABN PELV ORG NEC-ANTEPAR
654.94	Other and unspecified, postpartum condition or complication	ABN PELV ORG NEC-POSTPAR
655.00	Central nervous system malformation in fetus, unspecified as to episode of care or not applicable	FETAL CNS MALFORM-UNSPEC
655.01	Central nervous system malformation in fetus, delivered, w/ or w/o mention of antepartum condition	FETAL CNS MALFORM-DELIV
655.03	Central nervous system malformation in fetus, antepartum condition or complication	FETAL CNS MALFOR-ANTEPAR
655.10	Chromosomal abnormality in fetus, unspecified as to episode of care or not applicable	FETAL CHROMOS ABN-UNSPEC
655.11	Chromosomal abnormality in fetus, delivered w/ or w/o mention of antepartum condition	FETAL CHROMOSO ABN-DELIV
655.13	Chromosomal abnormality in fetus, antepartum condition or complication	FET CHROMO ABN-ANTEPART
655.20	Hereditary disease in family possibly affecting fetus,	FAMIL HEREDIT DIS-UNSPEC

Table 7.02 Obstetrics (Cont)

Code	ICD-9-CM Description	Shortened Description
	unspecified as to episode of care or not applicable	
655.21	Hereditary disease in family possibly affecting fetus, delivered w/ or w/o mention of antepartum condition	FAMIL HEREDIT DIS-DELIV
655.23	Hereditary disease in family possibly affecting fetus, antepartum condition or complication	FAMIL HEREDIT DIS-ANTEPART
655.30	Suspected damage to fetus from viral disease in the mother, unspecified as to episode of care or not applicable	FET DAMG D/T VIRUS-UNSP
655.31	Suspected damage to fetus from viral disease in the mother, delivered w/ or w/o mention of antepartum condition	FET DAMG D/T VIRUS-DELIV
655.33	Suspected damage to fetus from viral disease in the mother, antepartum condition or complication	FET DAMG D/T VIRUS-ANTEP
655.40	Suspected damage to fetus from other disease in the mother, unspecified as to episode of care or not applicable	FET DAMG D/T DIS-UNSPEC
655.41	Suspected damage to fetus from other disease in the mother, delivered w/ or w/o mention of antepartum condition	FET DAMG D/T DIS-DELIVER
655.43	Suspected damage to fetus from other disease in the mother, antepartum condition or complication	FET DAMG D/T DIS-ANTEPAR
655.50	Suspected damage to fetus from drugs, unspecified as to episode of care or not applicable	FETAL DAMG D/T DRUG-UNSP
655.51	Suspected damage to fetus from drugs, delivered w/ or w/o mention of antepartum condition	FET DAMAG D/T DRUG-DELIV
655.53	Suspected damage to fetus from drugs, antepartum condition or complication	FET DAMG D/T DRUG-ANTEPA
655.60	Suspected damage to fetus from radiation, unspecified as to episode of care or not applicable	RADIAT FETAL DAMAG-UNSP
655.61	Suspected damage to fetus from radiation, delivered w/ or w/o mention of antepartum condition	RADIAT FETAL DAMAG-DELIV
655.63	Suspected damage to fetus from radiation, antepartum condition or complication	RADIAT FET DAMAG-ANTEPAR
655.70	Decreased fetal movements, unspecified as to episode of care or not applicable	DECREASE FETL MOVMT UNSP
655.71	Decreased fetal movements, delivered w/ or w/o mention of antepartum condition	DECREASE FETAL MOVMT DEL
655.73	Decreased fetal movements, antepartum condition or complication	DEC FETAL MOVMT ANTEPART
655.80	Other known or suspected fetal abnormality, not elsewhere classified, unspecified as to episode of care or not applicable	FETAL ABNORM NEC-UNSPEC
655.81	Other known or suspected fetal abnormality, not elsewhere classified, delivered w/ or w/o mention of antepartum condition	FETAL ABNORM NEC-DELIVER
655.83	Other known or suspected fetal abnormality, not elsewhere classified, antepartum condition or complication	FETAL ABNORM NEC-ANTEPAR
655.90	Unspecified known or suspected fetal abnormality, unspecified as to episode of care or not applicable	FETAL ABNORM NOS-UNSPEC

Table 7.02 Obstetrics (Cont)

Code	ICD-9-CM Description	Shortened Description
655.91	Unspecified known or suspected fetal abnormality, delivered w/ or w/o mention of antepartum condition	FETAL ABNORM NOS-DELIV
655.93	Unspecified, antepartum condition or complication	FETAL ABNORM NOS-ANTEPAR
656.00	Fetal-maternal hemorrhage, unspecified as to episode of care or not applicable	FETAL-MATERNAL HEM-UNSPEC
656.01	Fetal-maternal hemorrhage, delivered, w/ or w/o mention of antepartum condition	FETAL-MATERNAL HEM-DELIV
656.03	Fetal-maternal hemorrhage, antepartum condition or complication	FETAL-MATERNAL HEM-ANTEPAR
656.10	Rhesus isoimmunization, unspecified as to episode of care or not applicable	RH ISOIMMUNIZAT-UNSPEC
656.11	Rhesus isoimmunization, delivered, w/ or w/o mention of antepartum condition	RH ISOIMMUNIZAT-DELIV
656.13	Rhesus isoimmunization, antepartum condition or complication	RH ISOIMMUNIZAT-ANTEPART
656.20	Isoimmunization from other and unspecified blood-group incompatibility, unspecified as to episode of care or not applicable	ABO ISOIMMUNIZATION-UNSPEC
656.21	Isoimmunization from other and unspecified blood-group incompatibility, delivered, w/ or w/o mention of antepartum condition	ABO ISOIMMUNIZAT-DELIV
656.23	Isoimmunization from other and unspecified blood-group incompatibility, antepartum condition or complication	ABO ISOIMMUNIZAT-ANTEPAR
656.30	Fetal distress, unspecified as to episode of care or not applicable	FETAL DISTRESS-UNSPEC
656.31	Fetal distress, delivered, w/ or w/o mention of antepartum condition	FETAL DISTRESS-DELIV
656.33	Fetal distress, antepartum condition or complication	FETAL DISTRESS-ANTEPART
656.40	Intrauterine death, unspecified as to episode of care or not applicable	INTRAUTERINE DEATH-UNSPEC
656.41	Intrauterine death, delivered, w/ or w/o mention of antepartum condition	INTRAUTER DEATH-DELIV
656.43	Intrauterine death, antepartum condition or complication	INTRAUTER DEATH-ANTEPART
656.50	Poor fetal growth, unspecified as to episode of care or not applicable	POOR FETAL GROWTH-UNSPEC
656.51	Poor fetal growth, delivered, w/ or w/o mention of antepartum condition	POOR FETAL GROWTH-DELIV
656.53	Poor fetal growth, antepartum condition or complication	POOR FETAL GRTH-ANTEPART
656.60	Excessive fetal growth, unspecified as to episode of care or not applicable	EXCESS FETAL GRTH-UNSPEC
656.61	Excessive fetal growth, delivered, w/ or w/o mention of antepartum condition	EXCESS FETAL GRTH-DELIV
656.63	Excessive fetal growth, antepartum condition or complication	EXCESS FET GRTH-ANTEPART
656.70	Other placental conditions, unspecified as to episode of care or not applicable	OTH PLACENT COND-UNSPEC

Table 7.02 Obstetrics (Cont)

Code	ICD-9-CM Description	Shortened Description
656.71	Other placental conditions, delivered, w/ or w/o mention of antepartum condition	OTH PLACENT COND-DELIV
656.73	Other placental conditions, antepartum condition or complication	OTH PLACENT COND-ANTEPAR
656.80	Other specified fetal and placental problems, unspecified as to episode of care or not applicable	FET/PLAC PROB NEC-UNSPEC
656.81	Other specified fetal and placental problems, delivered, w/ or w/o mention of antepartum condition	FET/PLAC PROB NEC-DELIV
656.83	Other specified fetal and placental problems, antepartum condition or complication	FET/PLAC PROB NEC-ANTEPA
656.90	Unspecified fetal and placental problem, unspecified as to episode of care or not applicable	FET/PLAC PROB NOS-UNSPEC
656.91	Unspecified fetal and placental problem, delivered, w/ or w/o mention of antepartum condition	FET/PLAC PROB NOS-DELIV
656.93	Unspecified fetal and placental problem, antepartum condition or complication	FET/PLAC PROB NOS-ANTEPA
657.00	Polyhydramnios, unspecified as to episode of care or not applicable	POLYHYDRAMNIOS-UNSPEC
657.01	Polyhydramnios, delivered w/ or w/o mention of antepartum condition	POLYHYDRAMNIOS-DELIV
657.03	Polyhydramnios, antepartum condition or complication	POLYHYDRAMNIOS-ANTEPART
658.00	Oligohydramnios, unspecified as to episode of care or not applicable	OLIGOHYDRAMNIOS-UNSPEC
658.01	Oligohydramnios, delivered w/ or w/o mention of antepartum condition	OLIGOHYDRAMNIOS-DELIV
658.03	Oligohydramnios, antepartum condition or complication	OLIGOHYDRAMNIOS-ANTEPAR
658.10	Premature rupture of membranes, unspecified as to episode of care or not applicable	PREM RUPT MEMBRAN-UNSPEC
658.11	Premature rupture of membranes, delivered w/ or w/o mention of antepartum condition	PREM RUPT MEMBRAN-DELIV
658.13	Premature rupture of membranes, antepartum condition or complication	PREM RUPT MEMB-ANTEPART
658.20	Delayed delivery after spontaneous or unspecified rupture of membranes, unspecified as to episode of care or not applicable	PROLONG RUPT MEMB-UNSPEC
658.21	Delayed delivery after spontaneous or unspecified rupture of membranes, delivered w/ or w/o mention of antepartum condition	PROLONG RUPT MEMB-DELIV
658.23	Delayed delivery after spontaneous or unspecified rupture of membranes, antepartum condition or complication	PROLONG RUP MEMB-ANTEPAR
658.30	Delayed delivery after artificial rupture of membranes, unspecified as to episode of care or not applicable	ARTIFIC RUPT MEMBR-UNSP
658.31	Delayed delivery after artificial rupture of membranes, delivered w/ or w/o mention of antepartum condition	ARTIFIC RUPT MEMBR-DELIV
658.33	Delayed delivery after artificial rupture of membranes, antepartum condition or complication	ARTIF RUPT MEMB-ANTEPART
658.40	Infection of amniotic cavity, unspecified as to episode of care or not applicable	AMNIOTIC INFECTION-UNSP

Table 7.02 Obstetrics (Cont)

Code	ICD-9-CM Description	Shortened Description
658.41	Infection of amniotic cavity, delivered w/ or w/o mention of antepartum condition	AMNIOTIC INFECTION-DELIV
658.43	Infection of amniotic cavity, antepartum condition or complication	AMNIOTIC INFECT-ANTEPART
658.80	Other, unspecified as to episode of care or not applicable	AMNIOTIC PROB NEC-UNSPEC
658.81	Other problems associated w/amniotic cavity and membranes, delivered w/ or w/o mention of antepartum condition	AMNIOTIC PROB NEC-DELIV
658.83	Other, antepartum condition or complication	AMNION PROB NEC-ANTEPART
658.90	Unspecified, unspecified as to episode of care or not applicable	AMNIOTIC PROB NOS-UNSPEC
658.91	Unspecified problems associated w/amniotic cavity and membranes, delivered w/ or w/o mention of antepartum condition	AMNIOTIC PROB NOS-DELIV
658.93	Unspecified, antepartum condition or complication	AMNION PROB NOS-ANTEPART
659.00	Failed mechanical induction, unspecified as to episode of care or not applicable	FAIL MECHAN INDUCT-UNSP
659.01	Failed mechanical induction, delivered w/ or w/o mention of antepartum condition	FAIL MECH INDUCT-DELIVER
659.03	Failed mechanical induction, antepartum condition or complication	FAIL MECH INDUCT-ANTEPAR
659.10	Failed medical or unspecified induction, unspecified as to episode of care or not applicable	FAIL INDUCTION NOS-UNSP
659.11	Failed medical or unspecified induction, delivered w/ or w/o mention of antepartum condition	FAIL INDUCTION NOS-DELIV
659.13	Failed medical or unspecified induction, antepartum condition or complication	FAIL INDUCT NOS-ANTEPART
659.20	Maternal pyrexia during labor, unspecified, unspecified as to episode of care or not applicable	PYREXIA IN LABOR-UNSPEC
659.21	Maternal pyrexia during labor, unspecified, delivered w/ or w/o mention of antepartum condition	PYREXIA IN LABOR-DELIVER
659.23	Maternal pyrexia during labor, unspecified, antepartum condition or complication	PYREXIA IN LABOR-ANTEPAR
659.30	Generalized infection during labor, unspecified as to episode of care or not applicable	SEPTICEMIA IN LABOR-UNSP
659.31	Generalized infection during labor, delivered w/ or w/o mention of antepartum condition	SEPTICEM IN LABOR-DELIV
659.33	Generalized infection during labor, antepartum condition or complication	SEPTICEM IN LABOR-ANTEPA
659.40	Grand multiparity, unspecified as to episode of care or not applicable	GRAND MULTIPARITY-UNSPEC
659.41	Grand multiparity, delivered w/ or w/o mention of antepartum condition	GRAND MULTIPARITY-DELIV
659.43	Grand multiparity, antepartum condition or complication	GRAND MULTIPARITY-ANTEPA
659.50	Elderly primigravida, unspecified as to episode of care or not applicable	ELDERLY PRIMIGRAVID-UNSP
659.51	Elderly primigravida, delivered w/ or w/o mention of antepartum condition	ELDERLY PRIMIGRAVIDA-DEL

Table 7.02 Obstetrics (Cont)

Code	ICD-9-CM Description	Shortened Description
659.53	Elderly primigravida, antepartum condition or complication	ELDER PRIMIGRAVID-ANTEPA
659.60	Elderly multigravida, unspecified as to episode of care or not applicable	ELDERLY MULTIGRAVIDA-UNS
659.61	Elderly multigravida, delivered w/ or w/o mention of antepartum condition	ELDERLY MULTIGRAVIDA-DEL
659.63	Elderly multigravida, antepartum condition or complication	ELDERLY MULTIGRAVD-ANTEP
659.70	Abnormality in fetal heart rate or rhythm, unspecified as to episode of care or not applicable	ABN FTL HRT RATE/RHY-UNS
659.71	Abnormality in fetal heart rate or rhythm, delivered w/ or w/o mention of antepartum condition	ABN FTL HRT RATE/RHY-DEL
659.73	Abnormality in fetal heart rate or rhythm, antepartum condition or complication	ABN FTL HRT RATE/RHY-ANT
659.80	Other specified indications for care or intervention related to labor and delivery, unspecified as to episode of care or not applicable	COMPLIC LABOR NEC-UNSP
659.81	Other specified indications for care or intervention related to labor and delivery, delivered w/ or w/o mention of antepartum condition	COMPLIC LABOR NEC-DELIV
659.83	Other specified indications for care or intervention related to labor and delivery, antepartum condition or complication	COMPL LABOR NEC-ANTEPART
659.90	Unspecified indication for care or intervention related to labor and delivery, unspecified as to episode of care or not applicable	COMPLIC LABOR NOS-UNSPEC
659.91	Unspecified indication for care or intervention related to labor and delivery, delivered w/ or w/o mention of antepartum condition	COMPLIC LABOR NOS-DELIV
659.93	Unspecified indication for care or intervention related to labor and delivery, antepartum condition or complication	COMPL LABOR NOS-ANTEPART
660.00	Obstruction caused by malposition of fetus at onset of labor, unspecified as to episode of care or not applicable	OBSTRUCT/FET MALPOS-UNSPEC
660.01	Obstructed labor, obstructions caused by malposition of fetus at onset of labor, delivered with or without mention of antepartum condition	OBSTRUC/FET MALPOS-DELIV
660.03	Obstructed labor, obstructions caused by malposition of fetus at onset of labor, antepartum condition or complication	OBSTRUC/FET MALPOS-ANTEP
660.10	Obstruction by bony pelvis, unspecified as to episode of care or not applicable	BONY PELV OBSTRUC-UNSPEC
660.11	Obstructed labor, obstruction by bony pelvis, delivered with or without mention of antepartum condition	BONY PELV OBSTRUCT-DELIV
660.13	Obstructed labor, obstruction by bony pelvis, antepartum condition or complication	BONY PELV OBSTRUC-ANTEPA
660.20	Obstruction by abnormal pelvic soft tissues, unspecified as to episode of care or not applicable	ABN PELV TISS OBSTR-UNSPEC
660.21	Obstructed labor, obstruction by abnormal pelvic soft tissues, delivered with or without mention of	ABN PELV TIS OBSTR-DELIV

Table 7.02 Obstetrics (Cont)

Code	ICD-9-CM Description	Shortened Description
	antepartum condition	
660.23	Obstructed labor, obstruction by abnormal pelvic soft tissues, antepartum condition or complication	ABN PELV TIS OBSTR-ANTEP
660.30	Obstructed labor, deep transverse arrest and persistent occipitoposterior position, unspecified as to episode of care or not applicable	PERSIST OCCIPTPOST-UNSPEC
660.31	Obstructed labor, deep transverse arrest and persistent occipitoposterior position, delivered with or without mention of antepartum condition	PERSIST OCCIPTPOST-DELIV
660.33	Obstructed labor, deep transverse arrest and persistent occipitoposterior position, antepartum condition or complication	PERSIST OCCIPTPOST-ANTEP
660.40	Shoulder (girdle) dystocia, unspecified as to episode of care or not applicable	SHOULDER DYSTOCIA-UNSPEC
660.41	Shoulder (girdle) dystocia, delivered w/ or w/o mention of antepartum condition	SHOULDER DYSTOCIA-DELIV
660.43	Shoulder (girdle) dystocia, antepartum condition or complication, antepartum condition or complication	SHOULDER DYSTOCIA-ANTEPA
660.50	Locked twins, unspecified as to episode of care or not applicable	LOCKED TWINS-UNSPECIFIED
660.51	Locked twins, delivered w/ or w/o mention of antepartum condition	LOCKED TWINS-DELIVERED
660.53	Locked twins, antepartum condition or complication	LOCKED TWINS-ANTEPARTUM
660.60	Failed trial of labor, unspecified, unspecified as to episode of care or not applicable	FAIL TRIAL LAB NOS-UNSP
660.61	Failed trial of labor, unspecified, delivered w/ or w/o mention of antepartum condition	FAIL TRIAL LAB NOS-DELIV
660.63	Failed trial of labor, unspecified, antepartum condition or complication	FAIL TRIAL LAB NOS-ANTEP
660.70	Failed forceps or vacuum extractor, unspecified, unspecified as to episode of care or not applicable	FAILED FORCEP NOS-UNSPEC
660.71	Failed forceps or vacuum extractor, unspecified, delivered w/ or w/o mention of antepartum condition	FAILED FORCEPS NOS-DELIV
660.73	Failed forceps or vacuum extractor, unspecified, antepartum condition or complication	FAIL FORCEPS NOS-ANTEPAR
660.80	Other causes of obstructed labor, unspecified as to episode of care or not applicable	OBSTRUC LABOR NEC-UNSPEC
660.81	Other causes of obstructed labor, delivered w/ or w/o mention of antepartum condition	OBSTRUCT LABOR NEC-DELIV
660.83	Other causes of obstructed labor, antepartum condition or complication	OBSTRUC LABOR NEC-ANTEPA
660.90	Unspecified obstructed labor, unspecified as to episode of care or not applicable	OBSTRUC LABOR NOS-UNSPEC
660.91	Unspecified obstructed labor, delivered w/ or w/o mention of antepartum condition	OBSTRUCT LABOR NOS-DELIV
660.93	Unspecified obstructed labor, antepartum condition or complication	OBSTRUC LABOR NOS-ANTEPA
661.00	Primary uterine inertia, unspecified as to episode of care or not applicable	PRIM UTERINE INERT-UNSP

Table 7.02 Obstetrics (Cont)

Code	ICD-9-CM Description	Shortened Description
661.01	Primary uterine inertia, delivered w/ or w/o mention of antepartum condition	PRIM UTERINE INERT-DELIV
661.03	Primary uterine inertia, antepartum condition or complication	PRIM UTER INERT-ANTEPART
661.10	Secondary uterine inertia, unspecified as to episode of care or not applicable	SEC UTERINE INERT-UNSPEC
661.11	Secondary uterine inertia, delivered w/ or w/o mention of antepartum condition	SEC UTERINE INERT-DELIV
661.13	Secondary uterine inertia, antepartum condition or complication	SEC UTERINE INERT-ANTEPA
661.20	Other and unspecified uterine inertia, unspecified as to episode of care or not applicable	UTERINE INERTIA NEC-UNSP
661.21	Other and unspecified uterine inertia, delivered w/ or w/o mention of antepartum condition	UTERINE INERT NEC-DELIV
661.23	Other and unspecified uterine inertia, antepartum condition or complication	UTERINE INERT NEC-ANTEPA
661.30	Precipitate labor, unspecified as to episode of care or not applicable	PRECIPITATE LABOR-UNSPEC
661.31	Precipitate labor, delivered w/ or w/o mention of antepartum condition	PRECIPITATE LABOR-DELIV
661.33	Precipitate labor, antepartum condition or complication	PRECIPITATE LABOR-ANTEPA
661.40	Hypertonic, incoordinate, or prolonged uterine contractions, unspecified as to episode of care not applicable	UTER DYSTOCIA NOS-UNSPEC
661.41	Hypertonic, incoordinate, or prolonged uterine contractions, delivered w/ or w/o mention of antepartum condition	UTER DYSTOCIA NOS-DELIV
661.43	Hypertonic, incoordinate, or prolonged uterine contractions, antepartum condition or complication	UTER DYSTOCIA NOS-ANTEPA
661.90	Unspecified abnormality of labor, unspecified as to episode of care not applicable	ABNORMAL LABOR NOS-UNSP
661.91	Unspecified abnormality of labor, delivered w/ or w/o mention of antepartum condition	ABNORMAL LABOR NOS-DELIV
661.93	Unspecified abnormality of labor, antepartum condition or complication	ABNORM LABOR NOS-ANTEPAR
662.00	Prolonged first stage, unspecified as to episode of care not applicable	PROLONGED 1ST STAGE-UNSP
662.01	Prolonged first stage, delivered w/ or w/o mention of antepartum condition	PROLONG 1ST STAGE-DELIV
662.03	Prolonged first stage, antepartum condition or complication	PROLONG 1ST STAGE-ANTEPA
662.10	Prolonged labor, unspecified, unspecified as to episode of care not applicable	PROLONGED LABOR NOS-UNSP
662.11	Prolonged labor, unspecified, delivered w/ or w/o mention of antepartum condition	PROLONG LABOR NOS-DELIV
662.13	Prolonged labor, unspecified, antepartum condition or complication	PROLONG LABOR NOS-ANTEPA
662.20	Prolonged second stage, unspecified as to episode of care not applicable	PROLONGED 2ND STAGE-UNSP
662.21	Prolonged second stage, delivered w/ or w/o mention	PROLONG 2ND STAGE-DELIV

Table 7.02 Obstetrics (Cont)

Code	ICD-9-CM Description	Shortened Description
	of antepartum condition	
662.23	Prolonged second stage, antepartum condition or complication	PROLONG 2ND STAGE-ANTEPA
662.30	Delayed delivery of second twin, triplet, etc., unspecified as to episode of care not applicable	DELAY DEL 2ND TWIN-UNSP
662.31	Delayed delivery of second twin, triplet, etc., delivered w/ or w/o mention of antepartum condition	DELAY DEL 2ND TWIN-DELIV
662.33	Delayed delivery of second twin, triplet, etc., antepartum condition or complication	DELAY DEL 2 TWIN-ANTEPAR
663.00	Prolapse of cord, unspecified as to episode of care not applicable	CORD PROLAPSE-UNSPEC
663.01	Prolapse of cord, delivered, w/ or w/o mention of antepartum condition	CORD PROLAPSE-DELIVERED
663.03	Prolapse of cord, antepartum condition or complication	CORD PROLAPSE-ANTEPARTUM
663.10	Cord around neck, w/compression, unspecified as to episode of care not applicable	CORD AROUND NECK-UNSP
663.11	Cord around neck, w/compression, delivered, w/ or w/o mention of antepartum condition	CORD AROUND NECK-DELIVER
663.13	Cord around neck, w/compression, antepartum condition or complication	CORD AROUND NECK-ANTEPAR
663.20	Other and unspecified cord entanglement, with compression, unspecified as to episode of care not applicable	CORD COMPRESS NEC-UNSPEC
663.21	Other and unspecified cord entanglement, w/compression, delivered, w/ or w/o mention of antepartum condition	CORD COMPRESS NEC-DELIV
663.23	Other and unspecified cord entanglement, w/compression, antepartum condition or complication	CORD COMPRES NEC-ANTEPAR
663.30	Other and unspecified cord entanglement, without mention of compression, unspecified as to episode of care not applicable	CORD ENTANGLE NEC-UNSPEC
663.31	Other and unspecified cord entanglement, w/o compression, delivered, w/ or w/o mention of antepartum condition	CORD ENTANGLE NEC-DELIV
663.33	Other and unspecified cord entanglement, w/o compression, antepartum condition or complication	CORD ENTANGL NEC-ANTEPAR
663.40	Short cord, unspecified as to episode of care not applicable	SHORT CORD-UNSPECIFIED
663.41	Short cord, delivered, w/ or w/o mention of antepartum condition	SHORT CORD-DELIVERED
663.43	Short cord, antepartum condition or complication	SHORT CORD-ANTEPARTUM
663.50	Vasa previa, unspecified as to episode of care not applicable	VASA PREVIA-UNSPECIFIED
663.51	Vasa previa, delivered, w/ or w/o mention of antepartum condition	VASA PREVIA-DELIVERED
663.53	Vasa previa, antepartum condition or complication	VASA PREVIA-ANTEPARTUM
663.60	Vascular lesions of cord, unspecified as to episode of care not applicable	VASC LESION CORD-UNSPEC
663.61	Vascular lesions of cord, delivered, w/ or w/o mention of antepartum condition	VASC LESION CORD-DELIVER

Table 7.02 Obstetrics (Cont)

Code	ICD-9-CM Description	Shortened Description
663.63	Vascular lesions of cord, antepartum condition or complication	VASC LESION CORD-ANTEPAR
663.80	Other umbilical cord complications, unspecified as to episode of care not applicable	CORD COMPLICAT NEC-UNSP
663.81	Other umbilical cord complications, delivered, w/ or w/o mention of antepartum condition	CORD COMPLICAT NEC-DELIV
663.83	Other umbilical cord complications, antepartum condition or complication	CORD COMPL NEC-ANTEPART
663.90	Unspecified umbilical cord complication, unspecified as to episode of care not applicable	CORD COMPLICAT NOS-UNSP
663.91	Unspecified umbilical cord complication, delivered, w/ or w/o mention of antepartum condition	CORD COMPLICAT NOS-DELIV
663.93	Unspecified umbilical cord complication, antepartum condition or complication	CORD COMPL NOS-ANTEPART
664.00	First-degree perineal laceration, unspecified as to episode of care not applicable	DEL W 1 DEG LACERAT-UNSP
664.01	First degree perineal laceration, delivered w/ or w/o mention of antepartum condition	DEL W 1 DEG LACERAT-DEL
664.04	First degree perineal laceration, postpartum condition or complication	DEL W 1 DEG LAC-POSTPART
664.10	Second-degree perineal laceration, unspecified as to episode of care not applicable	DEL W 2 DEG LACERAT-UNSP
664.11	Second degree perineal laceration, delivered w/ or w/o mention of antepartum condition	DEL W 2 DEG LACERAT-DEL
664.14	Second degree perineal laceration, postpartum condition or complication	DEL W 2 DEG LAC-POSTPART
664.20	Third-degree perineal laceration, unspecified as to episode of care not applicable	DEL W 3 DEG LACERAT-UNSP
664.21	Third degree perineal laceration, delivered w/ or w/o mention of antepartum condition	DEL W 3 DEG LACERAT-DEL
664.24	Third degree perineal laceration, postpartum condition or complication	DEL W 3 DEG LAC-POSTPART
664.30	Fourth-degree perineal laceration, unspecified as to episode of care not applicable	DEL W 4 DEG LACERAT-UNSP
664.31	Fourth degree perineal laceration, delivered w/ or w/o mention of antepartum condition	DEL W 4 DEG LACERAT-DEL
664.34	Fourth degree perineal laceration, postpartum condition or complication	DEL W 4 DEG LAC-POSTPART
664.40	Unspecified perineal laceration, unspecified as to episode of care not applicable	OB PERINEAL LAC NOS-UNSP
664.41	Unspecified perineal laceration, delivered w/ or w/o mention of antepartum condition	OB PERINEAL LAC NOS-DEL
664.44	Unspecified perineal laceration, postpartum condition or complication	PERINEAL LAC NOS-POSTPAR
664.50	Vulval and perineal hematoma, unspecified as to episode of care not applicable	OB PERINEAL HEMATOM-UNSP
664.51	Vulval and perineal hematoma, delivered w/ or w/o mention of antepartum condition	OB PERINEAL HEMATOMA-DEL
664.54	Vulval and perineal hematoma, postpartum condition or complication	PERIN HEMATOMA-POSTPART

Table 7.02 Obstetrics (Cont)

Code	ICD-9-CM Description	Shortened Description
664.80	Other specified trauma to perineum and vulva, unspecified as to episode of care not applicable	OB PERIN TRAUM NEC-UNSP
664.81	Other specified trauma to perineum and vulva, delivered w/ or w/o mention of antepartum condition	OB PERINEAL TRAU NEC-DEL
664.84	Other specified trauma to perineum and vulva, postpartum condition or complication	PERIN TRAUM NEC-POSTPART
664.90	Unspecified trauma to perimeum and vulva, unspecified as to episode of care not applicable	OB PERIN TRAUM NOS-UNSP
664.91	Unspecified trauma to perineum and vulva, delivered w/ or w/o mention of antepartum condition	OB PERINEAL TRAU NOS-DEL
664.94	Unspecified trauma to perineum and vulva, postpartum condition or complication	PERIN TRAUM NOS-POSTPART
665.00	Rupture of uterus before onset of labor, unspecified as to episode of care not applicable	PRELABOR RUPT UTER-UNSP
665.01	Rupture of uterus before onset of labor, delivered, w/ or w/o mention of antepartum condition	PRELABOR RUPT UTERUS-DEL
665.03	Rupture of uterus before onset of labor, antepartum condition or complication	PRELAB RUPT UTER-ANTEPAR
665.10	Rupture of uterus during labor, unspecified as to episode of care not applicable	RUPTURE UTERUS NOS-UNSP
665.11	Rupture of uterus during labor, delivered, w/ or w/o mention of antepartum condition	RUPTURE UTERUS NOS-DELIV
665.20	Inversion of uterus, unspecified as to episode of care not applicable	INVERSION OF UTERUS-UNSP
665.22	Inversion of uterus, delivered, w/mention of postpartum complication	INVERS UTERUS-DEL W P/P
665.24	Inversion of uterus, postpartum condition or complication	INVERS UTERUS-POSTPART
665.30	Laceration of cervix, unspecified as to episode of care not applicable	LACERAT OF CERVIX-UNSPEC
665.31	Laceration of cervix, delivered, w/ or w/o mention of antepartum condition	LACERAT OF CERVIX-DELIV
665.34	Laceration of cervix, postpartum condition or complication	LACER OF CERVIX-POSTPART
665.40	High vaginal laceration, unspecified as to episode of care not applicable	HIGH VAGINAL LACER-UNSP
665.41	High vaginal laceration, delivered, w/ or w/o mention of antepartum condition	HIGH VAGINAL LACER-DELIV
665.44	High vaginal laceration, postpartum condition or complication	HIGH VAGINAL LAC-POSTPAR
665.50	Other injury to pelvic organs, unspecified as to episode of care not applicable	OB INJ PELV ORG NEC-UNSP
665.51	Other injury to pelvic organs, delivered, w/ or w/o mention of antepartum condition	OB INJ PELV ORG NEC-DEL
665.54	Other injury to pelvic organs, postpartum condition or complication	INJ PELV ORG NEC-POSTPAR
665.60	Damage to pelvic joints and ligaments, unspecified as to episode of care not applicable	DAMAGE TO PELVIC JT-UNSP
665.61	Damage to pelvic joints and ligaments, delivered, w/ or w/o mention of antepartum condition	DAMAGE TO PELVIC JT-DEL

Table 7.02 Obstetrics (Cont)

Code	ICD-9-CM Description	Shortened Description
665.64	Damage to pelvic joints and ligaments, postpartum condition or complication	DAMAGE PELVIC JT-POSTPAR
665.70	Pelvic hematoma, unspecified as to episode of care not applicable	OB PELVIC HEMATOMA-UNSP
665.71	Pelvic hematoma, delivered, w/ or w/o mention of antepartum condition	OB PELVIC HEMATOMA-DELIV
665.72	Pelvic hematoma, delivered, w/mention of postpartum complication	PELVIC HEMATOM-DEL W PP
665.74	Pelvic hematoma, postpartum condition or complication	PELVIC HEMATOMA-POSTPART
665.80	Other specified obstetrical trauma, unspecified as to episode of care not applicable	OB TRAUMA NEC-UNSPEC
665.81	Other specified obstetrical trauma, delivered, w/ or w/o mention of antepartum condition	OB TRAUMA NEC-DELIVERED
665.82	Other specified obstetrical trauma, delivered, w/mention of postpartum complication	OB TRAUMA NEC-DEL W P/P
665.83	Other specified obstetrical trauma, antepartum condition or complication	OB TRAUMA NEC-ANTEPARTUM
665.84	Other specified obstetrical trauma, postpartum condition or complication	OB TRAUMA NEC-POSTPARTUM
665.90	Unspecified obstetrical trauma, unspecified as to episode of care not applicable	OB TRAUMA NOS-UNSPEC
665.91	Unspecified obstetrical trauma, delivered, w/ or w/o mention of antepartum condition	OB TRAUMA NOS-DELIVERED
665.92	Unspecified obstetrical trauma, delivered, w/mention of postpartum complication	OB TRAUMA NOS-DEL W P/P
665.93	Unspecified obstetrical trauma, antepartum condition or complication	OB TRAUMA NOS-ANTEPARTUM
665.94	Unspecified obstetrical trauma, postpartum condition or complication	OB TRAUMA NOS-POSTPARTUM
666.00	Third-stage hemorrhage, unspecified as to episode of care not applicable	THIRD-STAGE HEM-UNSPEC
666.02	Third stage hemorrhage, delivered w/mention of postpartum complication	THRD-STAGE HEM-DEL W P/P
666.04	Third stage hemorrhage, postpartum condition or complication	THIRD-STAGE HEM-POSTPART
666.10	Other immediate postpartum hemorrhage, unspecified as to episode of care not applicable	POSTPARTUM HEM NEC-UNSP
666.12	Other immediate postpartum hemorrhage, delivered w/mention of postpartum complication	POSTPA HEM NEC-DEL W P/P
666.14	Other immediate postpartum hemorrhage, postpartum condition or complication	POSTPART HEM NEC-POSTPAR
666.20	Delayed and secondary postpartum hemorrhage, unspecified as to episode of care not applicable	DELAY P/PART HEM-UNSPEC
666.22	Delayed and secondary postpartum hemorrhage, delivered w/mention of postpartum complication	DELAY P/P HEM-DEL W P/P
666.24	Delayed and secondary postpartum hemorrhage, postpartum condition or complication	DELAY P/PART HEM-POSTPAR
666.30	Postpartum coagulation defects, unspecified as to episode of care not applicable	POSTPART COAGUL DEF-UNSP

Table 7.02 Obstetrics (Cont)

Code	ICD-9-CM Description	Shortened Description
666.32	Postpartum coagulation defects, delivered w/mention of postpartum complication	P/P COAG DEF-DEL W P/P
666.34	Postpartum coagulation defects, postpartum condition or complication	POSTPART COAG DEF-POSTPA
667.00	Retained placenta without hemorrhage, unspecified as to episode of care not applicable	RETAIN PLACENTA NOS-UNSP
667.02	Retained placenta, w/o hemorrhage, delivered w/mention of postpartum complication	RETND PLAC NOS-DEL W P/P
667.04	Retained placenta, w/o hemorrhage, postpartum condition or complication	RETAIN PLAC NOS-POSTPART
667.10	Retained portions of placenta or membranes, without hemorrhage, unspecified as to episode of care not applicable	RETAIN PROD CONCEPT-UNSP
667.12	Retained portions of placenta or membranes, w/o hemorrhage, delivered w/mention of postpartum complication	RET PROD CONC-DEL W P/P
667.14	Retained portions of placenta or membranes, w/o hemorrhage, postpartum condition or complication	RET PROD CONCEPT-POSTPAR
668.00	Pulmonary complications, unspecified as to episode of care not applicable	PULM COMPL IN DEL-UNSPEC
668.01	Pulmonary complications, delivered w/ or w/o mention of antepartum condition	PULM COMPL IN DEL-DELIV
668.02	Pulmonary complications, delivered w/mention of postpartum complication	PULM COMPLIC-DEL W P/P
668.10	Cardiac complications, unspecified as to episode of care not applicable	HEART COMPL IN DEL-UNSP
668.11	Cardiac complications, delivered w/ or w/o mention of antepartum condition	HEART COMPL IN DEL-DELIV
668.12	Cardiac complications, delivered w/mention of postpartum complication	HEART COMPL-DEL W P/P
668.20	Central nervous system complications, unspecified as to episode of care not applicable	CNS COMPL LABOR/DEL-UNSP
668.21	Central nervous system complications, delivered w/ or w/o mention of antepartum condition	CNS COMPL LAB/DEL-DELIV
668.22	Central nervous system complications, delivered w/mention of postpartum complication	CNS COMPLIC-DEL W P/P
668.80	Other complications of anesthesia or other sedation in labor and delivery, unspecified as to episode of care not applicable	ANESTH COMP DEL NEC-UNSP
668.81	Other complications of anesthesia or other sedation in labor and delivery, delivered w/ or w/o mention of antepartum condition	ANESTH COMPL NEC-DELIVER
668.82	Other complications of anesthesia or other sedation in labor and delivery, delivered w/mention of postpartum complication	ANESTH COMPL NEC-DEL P/P
668.83	Other complications of anesthesia or other sedation in labor and delivery, antepartum condition or complication	ANESTH COMPL ANTEPARTUM
668.84	Other complications of anesthesia or other sedation in labor and delivery, postpartum condition or	ANESTH COMPL-POSTPARTUM

Table 7.02 Obstetrics (Cont)

Code	ICD-9-CM Description	Shortened Description
	complication	
668.90	Unspecified complication of anesthesia and other sedation, unspecified as to episode of care not applicable	ANESTH COMP DEL NOS-UNSP
668.91	Unspecified complications of anesthesia and other sedation, delivered w/ or w/o mention of antepartum condition	ANESTH COMPL NOS-DELIVER
668.92	Unspecified complications of anesthesia and sedation, delivered w/mention of postpartum complication	ANESTH COMPL NOS-DEL P/P
668.93	Unspecified complications of anesthesia and other sedation, antepartum condition or complication	ANESTH COMPL-ANTEPARTUM
668.94	Unspecified complications of anesthesia and other sedation, postpartum condition or complication	ANESTH COMPL-POSTPARTUM
669.00	Maternal distress, unspecified as to episode of care not applicable	MATERNAL DISTRESS-UNSPEC
669.01	Maternal distress, delivered w/ or w/o mention of antepartum condition	MATERNAL DISTRESS-DELIV
669.02	Maternal distress, delivered w/mention of postpartum complication	MATERN DISTRES-DEL W P/P
669.03	Maternal distress, antepartum condition or complication	MATERN DISTRESS-ANTEPAR
669.04	Maternal distress, postpartum condition or complication	MATERN DISTRESS-POSTPART
669.10	Shock during or following labor and delivery, unspecified as to episode of care not applicable	OBSTETRIC SHOCK-UNSPEC
669.11	Shock during or following labor and delivery, delivered w/ or w/o mention of antepartum condition	OBSTETRIC SHOCK-DELIVER
669.12	Shock during or following labor and delivery, delivered w/mention of postpartum complication	OBSTET SHOCK-DELIV W P/P
669.20	Maternal hypotension syndrome, unspecified as to episode of care not applicable	MATERN HYPOTENS SYN-UNSP
669.21	Maternal hypotension syndrome, delivered w/ or w/o mention of antepartum condition	MATERN HYPOTEN SYN-DELIV
669.22	Maternal hypotension syndrome, delivered w/mention of postpartum complication	MATERN HYPOTEN-DEL W P/P
669.23	Maternal hypotension syndrome, antepartum condition or complication	MATERN HYPOTENS-ANTEPAR
669.24	Maternal hypotension syndrome, postpartum condition or complication	MATERN HYPOTENS-POSTPART
669.30	Acute renal failure following labor and delivery, unspecified as to episode of care not applicable	AC REN FAIL W DELIV-UNSP
669.32	Acute renal failure following labor and delivery, delivered w/mention of postpartum complication	AC REN FAIL-DELIV W P/P
669.40	Other complications of obstetrical surgery and procedures, unspecified as to episode of care not applicable	OTH OB SURG COMPL-UNSPEC
669.41	Other complications of obstetrical surgery and procedures, delivered w/ or w/o mention of antepartum condition	OTH OB COMPL-DELIVERED
669.42	Other complications of obstetrical surgery and procedures, delivered w/mention of postpartum complication	OTH OB COMPL-DELIV W P/P

Table 7.02 Obstetrics (Cont)

Code	ICD-9-CM Description	Shortened Description
669.43	Other complications of obstetrical surgery and procedures, antepartum condition or complication	COMPLC OB SURG ANTEPRTM
669.44	Other complications of obstetrical surgery and procedures, postpartum condition or complication	OTH OB SURG COMPL-POSTPA
669.50	Forceps or vacuum extractor delivery without mention of indication, unspecified as to episode of care not applicable	FORCEP DELIV NOS-UNSPEC
669.51	Forceps or vacuum extractor delivery w/o mention of indication, delivered w/ or w/o mention of antepartum condition	FORCEP DELIV NOS-DELIVER
669.60	Breech extraction, without mention of indication, unspecified as to episode of care not applicable	BREECH EXTR NOS-UNSPEC
669.61	Breech extraction, w/o mention of indication, delivered w/ or w/o mention of antepartum condition	BREECH EXTR NOS-DELIVER
669.70	Cesarean delivery, without mention of indication, unspecified as to episode of care not applicable	CESAREAN DELIV NOS-UNSP
669.71	Cesarean delivery, w/o mention of indication, delivered w/ or w/o mention of antepartum condition	CESAREAN DELIVERY NOS
669.80	Other complications of labor and delivery, unspecified as to episode of care not applicable	COMPL LAB/DELIV NEC-UNSP
669.81	Other complications of labor and delivery, delivered w/ or w/o mention of antepartum condition	COMP LAB/DELIV NEC-DELIV
669.82	Other complications of labor and delivery, delivered w/mention of postpartum complication	COMPL DEL NEC-DEL W P/P
669.83	Other complications of labor and delivery, antepartum condition or complication	COMPL DELIV NEC-ANTEPAR
669.84	Other complications of labor and delivery, postpartum condition or complication	COMPL DELIV NEC-POSTPART
669.90	Unspecified complication of labor and delivery, unspecified as to episode of care not applicable	COMPL LAB/DELIV NOS-UNSP
669.91	Unspecified complication of labor and delivery, delivered w/ or w/o mention of antepartum condition	COMP LAB/DELIV NOS-DELIV
669.92	Unspecified complication of labor and delivery, delivered w/mention of postpartum complication	COMPL DEL NOS-DEL W P/P
669.93	Unspecified complication of labor and delivery, antepartum condition or complication	COMPL DELIV NOS-ANTEPAR
669.94	Unspecified complication of labor and delivery, postpartum condition or complication	COMPL DELIV NOS-POSTPART
670.00	Major puerperal infection, unspecified as to episode of care or not applicable	MAJOR PUERP INFECT-UNSP
670.02	Major puerperal infection, delivered, with mention of postpartum complication	MAJOR PUERP INF-DEL P/P
670.03	Major puerperal infection, antepartum condition or complication	MAJOR PUERP-ANTEPAR
670.04	Major puerperal infection, postpartum condition or complication	MAJOR PUERP-POSTPART
671.00	Varicose veins of legs, unspecified as to episode of care or not applicable	VARIC VEIN LEG PREG-UNSP
671.01	Varicose veins of legs, delivered, with or without mention of antepartum condition	VARICOSE VEIN LEG-DELIV

Table 7.02 Obstetrics (Cont)

Code	ICD-9-CM Description	Shortened Description
671.02	Varicose veins of legs, delivered, with mention of postpartum complication	VARIC VEIN LEG-DEL W P/P
671.10	Varicose veins of vulva and perineum, unspecified as to episode of care or not applicable	VARIC VULVA PREG-UNSPEC
671.11	Varicose veins of vulva and perineum, delivered with or without mention of antepartum condition	VARICOSE VULVA-DELIVERED
671.12	Varicose veins of vulva and perineum, delivered w/mention of postpartum complication	VARICOSE VULVA-DEL W P/P
671.20	Superficial thrombophlebitis, unspecified as to episode of care or not applicable	THROMBOPHLEB PREG-UNSPEC
671.21	Superficial thrombophlebitis, delivered w/ or w/o mention of antepartum condition	THROMBOPHLEBITIS-DELIVER
671.22	Superficial thrombophlebitis, delivered w/mention of postpartum condition	THROMBOPHLEB-DELIV W P/P
671.80	Other venous complication, unspecified as to episode of care or not applicable	VENOUS COMPL NEC-UNSPEC
671.81	Other venous complication, delivered w/ or w/o mention of antepartum condition	VENOUS COMPL NEC-DELIVER
671.82	Other venous complication, delivered w/mention of postpartum complication	VEN COMP NEC-DELIV W P/P
672.00	Pyrexia of unknown origin during the puerperium, unspecified as to episode of care or not applicable	PUERPERAL PYREXIA-UNSPEC
672.02	Pyrexia of unknown origin during the puerperium, delivered w/mention of postpartum complication	PUERP PYREXIA-DEL W P/P
673.00	Obstetrical air embolism, unspecified as to episode of care or not applicable	OB AIR EMBOLISM-UNSPEC
673.01	Obstetrical air embolism, delivered w/ or w/o mention of antepartum condition	OB AIR EMBOLISM-DELIVER
673.02	Obstetrical air embolism, delivered w/mention of postpartum complication	OB AIR EMBOL-DELIV W P/P
673.10	Amniotic fluid embolism, unspecified as to episode of care or not applicable	AMNIOTIC EMBOLISM-UNSPEC
673.11	Amniotic fluid embolism, delivered w/ or w/o mention of antepartum condition	AMNIOTIC EMBOLISM-DELIV
673.12	Amniotic fluid embolism, delivered w/mention of postpartum complication	AMNIOT EMBOL-DELIV W P/P
673.30	Obstetrical pyemic and septic embolism, unspecified as to episode of care or not applicable	OB PYEMIC EMBOL-UNSPEC
673.31	Obstetrical pyemic and septic embolism, delivered w/ or w/o mention of antepartum condition	OB PYEMIC EMBOL-DELIVER
673.32	Obstetrical pyemic and septic embolism, delivered w/mention of postpartum complication	OB PYEM EMBOL-DEL W P/P
673.33	Obstetrical pyemic and septic embolism, delivered w/mention of postpartum complication	OB PYEM EMBOL-DEL W P/P
673.34	Other pulmonary embolism, obstetrical pyemic and septic embolism, postpartum condition or complication	OB PYEMIC EMBOL-POSTPART
673.80	Other pulmonary embolism, unspecified as to episode of care or not applicable	PULMON EMBOL NEC-UNSP
673.81	Other pulmonary embolism, delivered w/ or w/o mention of antepartum condition	PULMON EMBOL NEC-DELIVER

Table 7.02 Obstetrics (Cont)

Code	ICD-9-CM Description	Shortened Description
673.82	Other pulmonary embolism, delivered w/mention of postpartum complication	PULM EMBOL NEC-DEL W P/P
674.00	Cerebrovascular disorders in the puerperuim, unspecified as to episode of care or not applicable	PUERP CEREBVASC DIS-UNSP
674.01	Cerebrovascular disorders in the puerperium, delivered w/ or w/o mention of antepartum condition	PUERP CEREBVAS DIS-DELIV
674.02	Cerebrovascular disorders in the puerperium, delivered w/mention of postpartum complication	CEREBVAS DIS-DELIV W P/P
674.10	Disruption of cesarean wound, unspecified as to episode of care or not applicable	DISRUPT C-SECT WND-UNSP
674.12	Disruption of cesarean wound, delivered w/mention of postpartum complication	DISRUPT C-SECT-DEL W P/P
674.20	Disruption of perineal wound, unspecified as to episode of care or not applicable	DISRUPT PERINEUM-UNSPEC
674.22	Disruption of perineal wound, delivered, with mention of postpartum complication	DISRUPT PERIN-DEL W P/P
674.30	Other complications of obstetrical surgical wounds, unspecified as to episode of care or not applicable	OB SURG COMPL NEC-UNSPEC
674.32	Other complications of obstetrical surgical wounds, delivered, with mention of postpartum complication	OB SURG COMPL-DEL W P/P
674.40	Placental polyp, unspecified as to episode of care or not applicable	PLACENTAL POLYP-UNSPEC
674.42	Placental polyp, delivered, with mention of postpartum complication	PLACENT POLYP-DEL W P/P
674.50	Peripartum cardiomyopathy, unspecified as to episode of care or not applicable	PERIPART CARDIOMY-UNSPEC
674.51	Peripartum cardiomyopathy, delivered w/ or w/o mention of antepartum condition	PERIPARTUM CARDIOMY-DEL
674.52	Peripartum cardiomyopathy, with mention of postpartum complication	PERIPART CARD DEL W P/P
674.80	Other, unspecified as to episode of care or not applicable	PUERP COMPL NEC-UNSPEC
674.82	Other, delivered, with mention of postpartum complication	PUERP COMP NEC-DEL W P/P
674.90	Unspecified, unspecified as to episode of care or not applicable	PUERP COMPL NOS-UNSPEC
674.92	Unspecified, delivered, with mention of postpartum complication	PUERP COMP NOS-DEL W P/P
675.00	Infections of nipple, unspecified as to episode of care or not applicable	INFECT NIPPLE PREG-UNSP
675.01	Infections of nipple, delivered w/ or w/o mention of antepartum condition	INFECT NIPPLE-DELIVERED
675.02	Infections of nipple, delivered w/mention of postpartum complication	INFECT NIPPLE-DEL W P/P
675.10	Abscess of breast, unspecified as to episode of care or not applicable	BREAST ABSCESS PREG-UNSPEC
675.11	Abscess of breast, delivered w/ or w/o mention of antepartum condition	BREAST ABSCESS-DELIVERED
675.12	Abscess of breast, delivered w/mention of postpartum complication	BREAST ABSCESS-DEL W P/P

Table 7.02 Obstetrics (Cont)

Code	ICD-9-CM Description	Shortened Description
675.20	No purulent mastitis, unspecified as to episode of care or not applicable	MASTITIS IN PREG-UNSPEC
675.21	No purulent mastitis, delivered w/ or w/o mention of antepartum condition	MASTITIS-DELIVERED
675.22	No purulent mastitis, delivered w/mention of postpartum complication	MASTITIS-DELIV W P/P
675.80	Other specified infections of the breast and nipple, unspecified as to episode of care or not applicable	BREAST INF PREG NEC-UNSPEC
675.81	Other specified infections of the breast and nipple, delivered w/ or w/o mention of antepartum condition	BREAST INFECT NEC-DELIV
675.82	Other specified infections of the breast and nipple, delivered w/mention of postpartum complication	BREAST INF NEC-DEL W P/P
675.90	Unspecified infection of the breast and nipple, unspecified as to episode of care or not applicable	BREAST INF PREG NOS-UNSP
675.91	Unspecified infection of the breast and nipple, delivered w/ or w/o mention of antepartum condition	BREAST INFECT NOS-DELIV
675.92	Unspecified infection of the breast and nipple, delivered w/mention of postpartum complication	BREAST INF NOS-DEL W P/P
676.00	Retracted nipple, unspecified as to episode of care or not applicable	RETRACT NIPPLE PREG-UNSP
676.01	Retracted nipple, delivered w/ or w/o mention of antepartum condition	RETRACTED NIPPLE-DELIV
676.02	Retracted nipple, delivered w/mention of postpartum complication	RETRACT NIPPLE-DEL W P/P
676.03	Retracted nipple, antepartum condition or complication	RETRACT NIPPLE-ANTEPART
676.04	Retracted nipple, postpartum condition or complication	RETRACT NIPPLE-POSTPART
676.10	Cracked nipple, unspecified as to episode of care or not applicable	CRACKED NIPPLE PREG-UNSP
676.11	Cracked nipple, delivered w/ or w/o mention of antepartum condition	CRACKED NIPPLE-DELIV
676.12	Cracked nipple, delivered w/mention of postpartum complication	CRACKED NIPPLE-DEL W P/P
676.13	Cracked nipple, antepartum condition or complication	CRACKED NIPPLE-ANTEPART
676.14	Cracked nipple, postpartum condition or complication	CRACKED NIPPLE-POSTPART
676.20	Engorgement of breasts, unspecified as to episode of care or not applicable	BREAST ENGORGE-UNSPEC
676.21	Engorgement of breasts, delivered w/ or w/o mention of antepartum condition	BREAST ENGORGE-DELIV
676.22	Engorgement of breasts, delivered w/mention of postpartum complication	BREAST ENGORGE-DEL W P/P
676.23	Engorgement of breasts, antepartum condition or complication	BREAST ENGORGE-ANTEPART
676.24	Engorgement of breasts, postpartum condition or complication	BREAST ENGORGE-POSTPART
676.30	Other and unspecified disorder of breast, unspecified as to episode of care or not applicable	BREAST DIS PREG NEC-UNSP
676.31	Other and unspecified disorder of breast, delivered w/ or w/o mention of antepartum condition	BREAST DIS NEC-DELIV
676.32	Other and unspecified disorder of breast, delivered	BREAST DIS NEC-DEL W P/P

Table 7.02 Obstetrics (Cont)

Code	ICD-9-CM Description	Shortened Description
	w/mention of postpartum complication	
676.33	Other and unspecified disorder of breast, antepartum condition or complication	BREAST DIS NEC-ANTEPART
676.34	Other and unspecified disorder of breast, postpartum condition or complication	BREAST DIS NEC-POSTPART
676.40	Failure of lactation, unspecified as to episode of care or not applicable	LACTATION FAIL-UNSPEC
676.41	Failure of lactation, delivered w/ or w/o mention of antepartum condition	LACTATION FAIL-DELIVERED
676.42	Failure of lactation, delivered w/mention of postpartum complication	LACTATION FAIL-DEL W P/P
676.43	Failure of lactation, antepartum condition or complication	LACTATION FAILURE-ANTEPART
676.44	Failure of lactation, postpartum condition or complication	LACTATION FAILURE-POSTPART
676.50	Suppressed lactation, unspecified as to episode of care or not applicable	SUPPR LACTATION-UNSPEC
676.51	Suppressed lactation, delivered w/ or w/o mention of antepartum condition	SUPPR LACTATION-DELIVER
676.52	Suppressed lactation, delivered w/mention of postpartum complication	SUPPR LACTAT-DEL W P/P
676.53	Suppressed lactation, antepartum condition or complication	SUPPR LACTATION-ANTEPAR
676.54	Suppressed lactation, postpartum condition or complication	SUPPR LACTATION-POSTPART
676.60	Galactorrhea, unspecified as to episode of care or not applicable	GALACTORRHEA PREG-UNSPEC
676.61	Galactorrhea, delivered w/ or w/o mention of antepartum condition	GALACTORRHEA-DELIVERED
676.62	Galactorrhea, delivered w/mention of postpartum complication	GALACTORRHEA-DEL W P/P
676.63	Galactorrhea, antepartum condition or complication	GALACTORRHEA-ANTEPARTUM
676.64	Galactorrhea, postpartum condition or complication	GALACTORRHEA-POSTPARTUM
676.80	Other disorders of lactation, unspecified as to episode of care or not applicable	LACTATION DIS NEC-UNSPEC
676.81	Other disorders of lactation, delivered w/ or w/o mention of antepartum condition	LACTATION DIS NEC-DELIV
676.82	Other disorders of lactation, delivered w/mention of postpartum complication	LACTAT DIS NEC-DEL W P/P
676.83	Other disorders of lactation, antepartum condition or complication	LACTAT DIS NEC-ANTEPART
676.84	Other disorders of lactation, postpartum condition or complication	LACTAT DIS NEC-POSTPART
676.90	Unspecified disorder of lactation, unspecified as to episode of care or not applicable	LACTATION DIS NOS-UNSPEC
676.91	Unspecified disorder of lactation, delivered w/ or w/o mention of antepartum condition	LACTATION DIS NOS-DELIV
676.92	Unspecified disorder of lactation, delivered w/mention	LACTAT DIS NOS-DEL W P/P

Table 7.02 Obstetrics (Cont)		
Code	ICD-9-CM Description	Shortened Description
	of postpartum complication	
676.93	Unspecified disorder of lactation, antepartum condition or complication	LACTAT DIS NOS-ANTEPART
676.94	Unspecified disorder of lactation, postpartum condition or complication	LACTAT DIS NOS-POSTPART
677	Late effect of complication of pregnancy, childbirth, and the puerperium	LATE EFFECT CMPLCATN PREG

Release Notes: Venous Thromboembolism (VTE) Code Table – Version 3.0

Table 7.03 Venous Thromboembolism (VTE)		
Code	ICD-9-CM Description	Shortened Description
415.11	Iatrogenic Pulmonary Embolism and Infarction	IATROGEN PULM EMB/INFARC
415.12	Pulmonary Embolism and Infarction, Other	PULM EMBOL/INFARCT NEC
451.11	Phlebitis and Thrombophlebitis of deep vessels of lower extremities – Femoral vein (deep) (superficial)	FEMORAL VEIN PHLEBITIS
451.19	Phlebitis and Thrombophlebitis of deep vessels of lower extremities – other	DEEP PHLEBITIS-LEG NEC
451.2	Phlebitis and Thrombophlebitis of lower extremities, unspecified	THROMBOPHLEBITIS LEG NOS
451.81	Phlebitis and Thrombophlebitis of iliac vein	ILIAC THROMBOPHLEBITIS
451.9	Phlebitis and Thrombophlebitis of unspecified sites	THROMBOPHLEBITIS NOS
453.40	Venous embolism and thrombosis of unspecified deep vessels of lower extremity – Not Otherwise Specified (NOS)	DVT/EMBLSM LOWER EXT NOS
453.41	Venous embolism and thrombosis of deep vessels of proximal lower extremity	DVT/EMB PROX LOWER EXT
453.8	Venous embolism and thrombosis of other specified veins	VENOUS THROMBOSIS NEC
453.9	Venous embolism and thrombosis of unspecified site	VENOUS THROMBOSIS NOS

Release Notes: Obstetrics – VTE Code Table Version 3.0

Table 7.04 Obstetrics - VTE		
Code	ICD-9-CM Description	Shortened Description
634.60	Spontaneous abortion, complicated by embolism, unspecified	SPON ABORT W EMBOL-UNSPEC
634.61	Spontaneous abortion, complicated by embolism, incomplete	SPON ABORT W EMBOL-INC
634.62	Spontaneous abortion, complicated by embolism, complete	SPON ABORT W EMBOL-COMP
635.60	Legally induced abortion, complicated by embolism, unspecified	LEGAL ABORT W EMBOL-UNSPEC
635.61	Legally induced abortion, complicated by embolism, incomplete	LEGAL ABORT W EMBOL-INC
635.62	Legally induced abortion, complicated by embolism,	LEGAL ABORT W EMBOL-COMP

	complete	
636.60	Illegally induced abortion, complicated by embolism, unspecified	ILLEG AB W EMBOLISM-UNSPEC
636.61	Illegally induced abortion, complicated by embolism, incomplete	ILLEG AB W EMBOLISM-INC
636.62	Illegally induced abortion, complicated by embolism, complete	ILLEG AB W EMBOLISM-COMP
637.60	Unspecified abortion, complicated by embolism, unspecified	AB NOS W EMBOLISM-UNSP
637.61	Unspecified abortion, complicated by embolism, incomplete	AB NOS W EMBOLISM-INC
637.62	Unspecified abortion, complicated by embolism, complete	AB NOS W EMBOLISM-COMP
638.6	Failed attempted abortion, complicated by embolism	ATTEMP ABORT W EMBOLISM
639.6	Complications following abortion and ectopic and molar pregnancies, embolism	POSTABORTION EMBOLISM
671.30	Venous complications in pregnancy and puerperium, deep phlebothrombosis, antepartum, unspecified as to episode of care or not applicable	DEEP THROMB ANTEPAR-UNSPEC

Table 7.04 Obstetrics – VTE (cont)

Code	ICD-9-CM Description	Shortened Description
671.31	Venous complications in pregnancy and puerperium, deep phlebothrombosis, antepartum, delivered with or without mention of antepartum condition	DEEP THROM ANTEPAR-DELIV
671.33	Venous complications in pregnancy and puerperium, deep phlebothrombosis, antepartum, antepartum condition or complication	DEEP VEIN THROMB-ANTEPAR
671.40	Venous complications in pregnancy and puerperium, deep phlebothrombosis, postpartum, unspecified as to episode of care or not applicable	DEEP THROMB POSTPAR-UNSPEC
671.42	Venous complications in pregnancy and puerperium, deep phlebothrombosis, postpartum, delivered with mention of postpartum complication	THROMB POSTPAR-DEL W P/P
671.44	Venous complications in pregnancy and puerperium, deep phlebothrombosis, postpartum condition or complication	DEEP VEIN THROMB-POSTPAR
671.50	Venous complications in pregnancy and puerperium, other phlebitis and thrombus, unspecified as to episode of care or not applicable	THROMBOSIS NEC PREG-UNSPEC
671.51	Venous complications in pregnancy and puerperium, other phlebitis and thrombus, delivered with or without mention of antepartum condition	THROMBOSIS NEC-DELIV
671.52	Venous complications in pregnancy and puerperium, other phlebitis and thrombus, delivered with mention of postpartum complication	THROMB NEC-DELIV W P/P
671.53	Venous complications in pregnancy and puerperium, other phlebitis and thrombus, antepartum condition or complication	THROMBOSIS NEC-ANTEPART
671.54	Venous complications in pregnancy and puerperium, other phlebitis and thrombus, postpartum condition or complication	THROMBOSIS NEC-POSTPART

671.90	Venous complications in pregnancy and puerperium, unspecified venous complication, unspecified as to episode of care or not applicable	VEN COMPL PREG NOS-UNSPEC
671.91	Venous complications in pregnancy and puerperium, unspecified venous complication, delivered with or without mention of antepartum condition	VENOUS COMPL NOS-DELIVER
671.92	Venous complications in pregnancy and puerperium, unspecified venous complication, delivered with mention of postpartum complication	VEN COMP NOS-DELIV W P/P
671.93	Venous complications in pregnancy and puerperium, unspecified venous complication, antepartum condition or complication	VENOUS COMPL NOS-ANTEPAR
671.94	Venous complications in pregnancy and puerperium, unspecified venous complication, postpartum condition or complication	VENOUS COMPL NOS-POSTPAR
673.20	Obstetrical pulmonary embolism, obstetrical blood-clot embolism, unspecified	OB PULM EMBOL NOS-UNSPEC
673.21	Obstetrical pulmonary embolism, obstetrical blood-clot embolism, delivered with or without mention of antepartum condition	PULM EMBOL NOS-DELIV
673.22	Obstetrical pulmonary embolism, obstetrical blood-clot embolism, delivered with mention of postpartum complication	PULM EMBOL NOS-DELIV W P/P
673.23	Obstetrical pulmonary embolism, obstetrical blood-clot embolism, antepartum condition or complication	PULM EMBOL NOS-ANTEPART
673.24	Obstetrical pulmonary embolism, obstetrical blood-clot embolism, postpartum condition or complication	PULM EMBOL NOS-POSTPART
Table 7.04 Obstetrics – VTE (cont)		
Code	ICD-9-CM Description	Shortened Description
673.33	Obstetrical pyemic and septic embolism, antepartum condition or complication	OB PYEMIC EMBOL-ANTEPART
673.34	Obstetrical pulmonary embolism, obstetrical pyemic and septic embolism, postpartum condition or complication	OB PYEMIC EMBOL-POSTPART

Release Notes: Ischemic Stroke Code Table

Table 8.1 Ischemic Stroke (STK)		
Code	ICD-9-CM Description	Shortened Description
433.01	Occlusion and stenosis of basilar artery with cerebral infarction	OCL BSLR ART W INFRCT
433.10	Occlusion and stenosis of carotid artery without cerebral infarction	OCL CRTD ART WO INFRCT
433.11	Occlusion and stenosis of carotid artery with cerebral infarction	OCL CRTD ART W INFRCT
433.21	Occlusion and stenosis of vertebral artery with cerebral infarction	OCL VRTB ART W INFRCT
433.31	Occlusion and stenosis of multiple and bilateral precerebral arteries with cerebral infarction	OCL MLT BI ART W INFRCT

433.81	Occlusion and stenosis of other specified precerebral artery with cerebral infarction	OCL SPCF ART W INFRCT
433.91	Occlusion and stenosis of unspecified precerebral artery with cerebral infarction	OCL ART NOS W INFRCT
434.00	Cerebral thrombosis without mention of cerebral infarction	CRBL THRMBS WO INFRCT
434.01	Cerebral thrombosis with cerebral infarction	CRBL THRMBS W INFRCT
434.11	Cerebral embolism with cerebral infarction	CRBL EMBLSM W INFRCT
434.91	Cerebral artery occlusion unspecified with cerebral infarction	CRBL ART OCL NOS W INFRC
436	Acute, but ill-defined, cerebrovascular disease	CVA

Release Notes: Hemorrhagic Stroke Code Table Version 3.0

Table 8.2 Hemorrhagic Stroke (STK)		
Code	ICD-9-CM Description	Shortened Description
430	Subarachnoid hemorrhage	SUBARACHNOID HEMORRHAGE
431	Intracerebral hemorrhage	INTRACEREBRAL HEMORRHAGE

Appendix B
Emergency Care Steering Committees

PHASE 1: EMERGENCY DEPARTMENT TRANSFER MEASURES

Sherri-Lynne Almeida, DrPH, RN, MSN (Co-Chair)
Director
Cardinal Health, Inc.
Houston, TX

John Moorhead, MD (Co-Chair)
Professor, Emergency Medicine
Oregon Health & Science University
Portland, OR

Forrest Calico, MD
National Rural Health Association
Kansas City, MO

Andrew Eisenberg, MD, MHA
Gulf Coast Emergency Physicians
Sarasota, FL

Charles Emerman, MD
Associate Chief of Staff for Quality Management
MetroHealth Medical Center
Cleveland, OH

Jay Goldman, MD
National Medical Director, Ambulance Services/EMS
Kaiser Permanente
Oakland, CA

Martin Landa, MD
Medical Director Quality Programs
St. Mary's Hospital
Green Bay, WI

Lewis Marshall, JD, MD, MS
Chairman of Emergency Medicine
The Brookdale University Hospital and Medical Center
Brooklyn, NY

Robert Rowland, Jr., MD
Assistant Director, ED
Harris Methodist H.E.B
Bedford, TX

David Siegel, JD, MD
Senior Vice President for Clinical Effectiveness and Medical Affairs
Meridian Health System
Neptune, NJ

Mary Wakefield, PhD, RN
Director, Center for Rural Health
University of North Dakota
Grand Forks, ND

Gary Wingrove, EMT-P
Government Relations & Affairs
Mayo Clinic Medical Transport
Buffalo, MN

PHASE 2: HOSPITAL-BASED EMERGENCY DEPARTMENT CARE MEASURES

John Moorhead, MD (Co-Chair)
Professor, Emergency Medicine
Oregon Health & Science University
Portland, OR

Suzanne Stone-Griffith, RN, MSN (Co-Chair)
Assistant Vice President, Clinical Services
Hospital Corporation of America
Nashville, TN

James Adams, MD
Chair of the Department of Emergency Medicine
Northwestern Memorial Healthcare
Chicago, IL

Evaline Alessandrini, MD, MSCE
Associate Professor of Pediatrics and Emergency Medicine
Children's Hospital of Philadelphia
Philadelphia, PA

Peter Angood, MD
Vice President and Chief Medical Officer
The Joint Commission
Oakbrook Terrace, IL

Brent Asplin, MD, MPH
Medical Director Department of Emergency Medicine
Regions Hospital
St. Paul, MN

Stephen Cantrill, MD
Program Director
Denver Health Medical Center
Denver, CO

Robert Goodman, DO, MHSA
Associate Medical Director
Blue Care Network of Michigan
Southfield, MI

Mary Jagim, RN
Consultant
MeritCare Hospital
Fargo, ND

Patricia Kunz Howard, PhD, RN
Operations Manager-Emergency and Trauma Services
University of Kentucky Hospital
Lexington, KY

John Kusske, MD
Professor Emeritus of Neurological Surgery
American Association of Neurological Surgeons
Orange, CA

David Levine, MD
Medical Director-Adult Emergency Services
John H. Stroger Hospital of Cook County
Chicago, IL

Doris Lotz, MD, MPH
Medicaid Medical Director
New Hampshire Department of Health and Human Services
Concord, NH

Michael Phelan, MD
Quality Review Officer Emergency Services Institute
Cleveland Clinic Foundation
Cleveland, OH

Ramanathan Raju, MBA, MD
Executive Vice President/Chief Medical Officer
New York City Health and Hospital Corporation
New York, NY

James Scheulen, PA-C
Chief Administrative Officer
Johns Hopkins Hospital
Baltimore, MD

Sarah Somers, JD
Staff Attorney
National Health Law Program
Chapel Hill, NC

Christine Woodard, MS
Deputy Chief, EMS Administration
Fairfax County Fire & Rescue Department
Fairfax, VA

PROJECT STAFF

Helen Burstin, MD, MPH
Senior Vice President, Performance Measures

Del M. Conyers, MPH
Senior Program Director

Reva Winkler, MD, MPH
Clinical Consultant

Lisa Hines, BSN, MS
Consultant (during Phase 1)

Appendix C
Other NQF-Endorsed Measures for Emergency Care

Measures Previously Endorsed as Part of *National Voluntary Consensus Standards for Ambulatory Care: Specialty Clinician Performance Measures*[a]

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)	NUMERATOR	DENOMINATOR
Electrocardiogram performed for non-traumatic chest pain	0090	ACEP AMA PCPI NCQA	Patients who had an ECG performed.	All patients aged 40 years and older with an emergency department discharge diagnosis of non-traumatic chest pain.
Aspirin at arrival for acute myocardial infarction	0092	ACEP AMA PCPI NCQA	Patients who had documentation of receiving aspirin within 24 hours before emergency department arrival or during emergency department stay.	All patients with an emergency department discharge diagnosis of acute myocardial infarction.
Electrocardiogram performed for syncope	0093	ACEP AMA PCPI NCQA	Patients who had an ECG performed.	All patients aged 60 years and older with an emergency department discharge diagnosis of syncope.
Assessment of oxygen saturation for community-acquired bacterial pneumonia	0094	ACEP AMA PCPI NCQA	Patients with oxygen saturation documented and reviewed.	All patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia.
Assessment of mental status for community-acquired bacterial pneumonia	0095	ACEP AMA PCPI NCQA	Patients with mental status assessed.	All patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia.
Empiric antibiotic for community-acquired bacterial pneumonia	0096	ACEP AMA PCPI NCQA	Patients with an appropriate empiric antibiotic prescribed.	All patients 18 years and older with the diagnosis of community-acquired bacterial pneumonia.

[a] Endorsed May 2007.

Measures Previously Endorsed as Part of *National Voluntary Consensus Standards for Hospital Care: Specialty Clinician Performance Measures*[a]

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)	NUMERATOR	DENOMINATOR
Electrocardiogram performed for non-traumatic chest pain	0090	ACEP AMA PCPI NCQA	Patients who had an electrocardiogram (ECG) performed.	All patients aged 40 years and older with an emergency department discharge diagnosis of non-traumatic chest pain.
Aspirin at arrival for acute myocardial infarction	0092	ACEP AMA PCPI NCQA	Patients who had documentation of receiving aspirin within 24 hours before emergency department arrival or during emergency department stay.	All patients with an emergency department discharge diagnosis of AMI.
Vital signs for community-acquired bacterial pneumonia	0232	ACEP AMA PCPI NCQA	Patients with vital signs (temperature, pulse, respiratory rate, and blood pressure) documented and reviewed.	All patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia.
Assessment of oxygen saturation for community-acquired bacterial pneumonia	0094	ACEP AMA PCPI NCQA	Patients with oxygen saturation documented and reviewed.	All patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia.
Assessment of mental status for community-acquired bacterial pneumonia	0095	ACEP AMA PCPI NCQA	Patients with mental status assessed.	All patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia.
Empiric antibiotic for community-acquired bacterial pneumonia	0096	ACEP AMA PCPI NCQA	Patients with an appropriate empiric antibiotic prescribed.	All patients 18 years and older with the diagnosis of community-acquired bacterial pneumonia.

[a] Endorsed October 2002. Reviewed in maintenance July 2006.

Measures Previously Endorsed as Part of *National Voluntary Consensus Standards for Hospital Care: An Initial Performance Measure Set*[a]

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)	NUMERATOR	DENOMINATOR
Aspirin at arrival for acute myocardial infarction (AMI)	0132	CMS-QIOs and The Joint Commission (ORYX)	AMI patients who received aspirin within 24 hours before or after hospital arrival.	AMI patients without aspirin contraindications.
Aspirin prescribed at discharge for AMI	0142	CMS-QIOs and The Joint Commission (ORYX)	AMI patients who are prescribed aspirin at hospital discharge.	AMI patients without aspirin contraindications.
Beta blocker at arrival for AMI	0153	CMS-QIOs and The Joint Commission (ORYX)	AMI patients who received a beta blocker within 24 hours after hospital arrival.	AMI patients without beta blocker contraindications.
Beta blocker prescribed at discharge for AMI	0160	CMS-QIOs and The Joint Commission (ORYX)	AMI patients who are prescribed a beta blocker at hospital discharge.	AMI patients without beta blocker contraindications.
AMI inpatient mortality (risk-adjusted)[b]	0161	The Joint Commission (ORYX)	Inpatient mortality of AMI patients.	AMI patients.

[a] Endorsed October 2002. Reviewed in maintenance July 2006.

[b] The Joint Commission risk-adjustment methodology based on a logistic regression model; weights for risk factors vary based on data set used.

more

Measures Previously Endorsed as Part of *National Voluntary Consensus Standards for Hospital Care: An Initial Performance Measure Set*[a]

MEASURE TITLE	MEASURE NUMBERS	IP OWNER(S)	NUMERATOR	DENOMINATOR
Primary PCI within 90 minutes of hospital arrival	0163	The Joint Commission (ORYX)	AMI patients whose time from hospital arrival to Percutaneous Coronary Intervention (PCI) is 90 minutes or less.	Principal discharge diagnosis of AMI.
Fibrinolytic therapy received within 30 minutes of hospital arrival	0164	The Joint Commission (ORYX)	AMI patients whose time from hospital arrival to fibrinolysis is 30 minutes or less.	Principal diagnosis of AMI and ST segment elevation or LBBB on the ECG performed closest to hospital arrival; and fibrinolytic therapy within 6 hours after hospital arrival.

[a] Endorsed October 2002. Reviewed in maintenance July 2006.

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NATIONAL QUALITY FORUM
601 13th Street NW
Suite 500 North
Washington, DC 20005
202-783-1300
www.qualityforum.org

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