Rural Emergency Hospital Quality Program Specifications Manual
Release Notes Version 2.0

Release Notes Completed: June 10, 2024

Guidelines for Using Release Notes

Release Notes provide modifications to the Rural Emergency Hospital Quality Reporting (REHQR) Program Specifications Manual. They are provided as a reference tool and are not intended to be used as program abstraction tools. Please refer to the REHQR Specifications Manual for the complete and current technical specifications and abstraction information.

The notes are organized to follow the order of the Table of Contents. Within each topic section, a row represents a change that begins with general changes and is followed by data elements in alphabetical order. The **implementation date is 01/01/2025, unless otherwise specified**. The row headings are described below:

- **Impacts** – Used to identify which portion(s) of the Manual Section is impacted by the changes listed. Examples are Alphabetical Data Element List, Alphabetical Data Dictionary, Measure Information Form (MIF), and Flowchart (Algorithm). If any changes are made to a data element, the measure(s) affected are identified also.

- **Rationale** – Provided for the change being made.

- **Description of Changes** – Used to identify the section within the document where the change occurs. Examples are Definition, Data Collection Question, Allowable Value, and Denominator Data elements.

Data elements that cross multiple measures and contain the same changes are consolidated into one row. If those changes do not apply to all the measures listed in the Impacts row, the Description of Changes row identify the applicable measures.

Specifications Manual Acknowledgement and Program Background

Impacts: Acknowledgement

Rationale: This change is to update the access to the comprehensive listing of ICD-10-CM® codes.

Description of Change(s):

Acknowledgement

Change from: The International Classification of Diseases, 11th Revision, Clinical Modification (ICD-10-CM®) is published by the United States Government. A CD-ROM, which may be purchased through the Government Printing Office, is the only official Federal government version of the ICD-10-CM®. ICD-10-CM® is an official Health Insurance Portability and Accountability Act standard.

To: The International Classification of Diseases, 11th Revision, Clinical Modification (ICD-10-CM®) is published by the United States Government. A comprehensive listing of ICD-10-CM® codes may be obtained on the Centers for Disease Control and Prevention (CDC) website. ICD-10-CM® is an official Health Insurance Portability and Accountability Act standard.

Impacts: Program Background

Rationale: This change is to update language for clarity and remove outdated language.

Description of Change(s): Please refer to the Program Background section of the manual for updated language.

Section 1 – Measure Information Forms

Impacts: OP-10: Abdomen Computed Tomography (CT) - Use of Contrast Material

Rationale: This update is to correct references to object ID's (OID) from the Value Set Authority Center (VSAC) in the Numerator, Denominator, and Denominator Exclusion Codes Table headers.

Description of Change(s):

Numerator, Denominator, and Denominator Exclusion Codes Tables

Change from: Organizational ID

To: Object ID

Impacts: OP-32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy

Rationale: This update is to align language across the Outcome Claims-based Measure Information Forms in response to stakeholder feedback.

Description of Change(s): Please refer to the Measure Information Form for updated language.

Impacts: OP-36: Hospital Visits after Hospital Outpatient Surgery

Rationale: This update is to align language across the Outcome Claims-based Measure Information Forms in response to stakeholder feedback.

Description of Change(s): Please refer to the Measure Information Form for updated language.

Section 2 - Alphabetical Data Element List and Data Dictionary

Impacts: Sex

Rationale: This update is to remove the *Sex* data element from the *Alphabetical Data Elements List*. The *Sex* data element was replaced with *Sex Assigned at Birth*, effective with July 1, 2024, encounters.

Description of Change(s):

Remove: *Sex* data element from the *Alphabetical Data Elements List*

Section 5 - Rural Emergency Outpatient Quality Measure Data Transmission

Impacts: Introduction and Guidelines for Submission of Data

Rationale: This update is to include the Sex Assigned at Birth, Gender Identity, and Sexual Orientation data elements to the transmission documentation.

Description of Change(s):

Hospital Outpatient Clinical Data XML File Layout

Add:

4. **sex-birth –** Sub-element of "*patient*" identifying the patient's sex assigned at birth. This is a **required** sub-element of "*patient*" and has no attributes.

5. **gender-identity –** Sub-element of "*patient*" describing the gender-identity of the patient. This is not a required sub-element of "*patient*" and has no attributes.

6. **sexual-orientation –** Sub-element of "*patient*" describing the patient's sexual orientation. This is not a required sub-element of "*patient*" and has no attributes.

Example of nested Hospital Outpatient Clinical XML file elements

Add:

o sex-birth

o gender-identity

o sexual-orientation

Appendices

Impacts: Appendix A

Rationale: This change is to note the 2025 ICD-10-CM® code updates effective October 1, 2024 through September 30, 2025 will be published in the fall of 2024.

Description of Change(s):

Add The CY 2025 ICD-10-CM® code updates effective October 1, 2024 through September 30, 2025 will be published in the fall of 2024

Rural Emergency Hospital Quality Program Specifications Manual
Release Notes Version 2.0a

Release Notes Completed: December 16, 2024

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Section 1 – Measure Information Forms

Impacts: OP-43: Screening for Social Drivers of Health

Rationale: This new measure was finalized in the CY 2025 Hospital OPPS and ASC Payment System Final Rule. Voluntary reporting begins with CY 2025 reporting period. Mandatory reporting begins with CY 2026 reporting period/CY 2028 payment determination.

Add OP-43: Screening for Social Drivers of Health Measure Information Form to the CY 2025 Specifications Manual v2.0a.

Impacts: OP-44: Screen Positive Rate for Social Drivers of Health

Rationale: This new measure was finalized in the CY 2025 Hospital OPPS and ASC Payment System Final Rule. Voluntary reporting begins with the CY 2025 reporting period. Mandatory reporting begins with CY 2026 reporting period/CY 2028 payment determination.

Add OP-44: Screen Positive Rate for Social Drivers of Health Measure Information Form to the CY 2025 Specifications Manual v2.0a.

Impacts: OP-45: Hospital Commitment to Health Equity

Rationale: This new measure was finalized in the Calendar Year (CY) 2025 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Final Rule. Mandatory reporting begins with CY 2025 reporting period/CY 2027 payment determination.

Add OP-45: Hospital Commitment to Health Equity Measure Information Form to the CY 2025 Specifications Manual v2.0a.

Appendices

Impacts: Appendix A

Rationale: This change is to include the 2025 ICD-10-CM® code updates effective October 1, 2024, through September 30, 2025.

Description of Change(s):

Add The CY 2025 ICD-10-CM® code updates effective October 1, 2024, through September 30, 2025.

Rural Emergency Hospital Quality Reporting Specifications Manual

Version 2.0a

Encounter Dates: 01-01-25 (1Q25) through 12-31-25 (4Q25)

Table of Contents

Section 4: Population and Sampling Specifications

Section 5: Rural Emergency Hospital Quality Measure Data Transmission

Section 6: Alphabetical Tools and Resources

Appendices

Acknowledgement

The *Rural Emergency Hospital Quality Reporting (REHQR) Program Specifications Manual* was developed by the Centers for Medicare & Medicaid Services (CMS) to provide technical information regarding quality measures implemented in the Rural Emergency Hospital (REH) setting to promote high quality care for patients receiving services.

IMPORTANT SUBMISSION ALERT!

To submit REHQR Program measures to CMS, files must meet the specifications found only in this CMS manual. Otherwise, the files will be rejected for not meeting CMS quality data submission requirements.

Program Background

Rural Emergency Hospitals

Background

The Consolidated Appropriations Act (CAA), 2021, established the Medicare provider type Rural Emergency Hospitals (REHs) to help address barriers in access to health care that result from rural hospital closures, and subsequently, observed inequities in health care in rural areas.

Beginning January 3, 2023, CAHs and eligible subsection (d) hospitals were able to convert to an REH to furnish emergency department and observation care, and other specified outpatient medical and health services as elected by the REH that do not exceed an annual per patient average of 24 hours and receive an adjusted payment fee schedule.

Statutory Authority

Section 125 of Division CC of the CAA, 2021, amended section 1861(kkk) to the Social Security Act (the Act) to define an REH as a facility that as of December 27, 2020 was: (1) a Critical Access Hospital (CAH) or a subsection (d) hospital with not more than 50 beds located in a county (or equivalent unit of local government) in a rural area (defined in section 1886(d)(2)(D) of the Act); or (2) a subsection (d) hospital with not more than 50 beds that was treated as being in a rural area pursuant to section 1886(d)(8)(E) of the Act. In addition, the facility must be enrolled in the Medicare program as an REH; not provide any acute care inpatient services (other than post-hospital extended care services furnished in a distinct part unit licensed as a skilled nursing facility (SNF)); have a transfer agreement in effect with a level I or level II trauma center; meet certain licensure requirements; meet requirements of a staffed emergency department; meet staff training and certification requirements established by the Secretary of the Department of Health and Human Services; and meet certain conditions of participation (CoPs) applicable to hospital emergency departments and CAHs with respect to emergency services.

Additional details regarding REH CoPs can be found in 42 CFR 485.500 through 485.546 and the CY 2023 OPPS/ASC final rule (87 FR 72293).

Quality Reporting

The REH Quality Reporting (REHQR) Program seeks to collect data and publicly report on quality metrics so that the information is available to support consumer decision-making and provider improvements regarding the quality and efficiency of care in REHs.

Quality Measurement

Section 1861(kkk)(7)(A) of the Act authorizes the Secretary to implement a quality reporting program requiring REHs to submit data on measures in accordance with the Secretary's requirements in section 1861(kkk)(7). Section 1861(kkk)(7)(B)(ii) requires REHs to submit quality measure data to the Secretary "in a form and manner, and at a time, specified by the Secretary."

Related Activities

Measures Management System

The Measures Management System (MMS) is a standardized system for developing and maintaining the quality measures used in various CMS initiatives and programs. MMS also supports quality-related activities across the agency. Quality measures are tools that help improve the quality of healthcare through an approach that is consistent and accountable. The primary goals of the MMS are to:

- Provide support and guidance to measure developers to help them produce high caliber healthcare quality measures; and
- Educate and inform interested parties to promote involvement in and awareness of the Measure Lifecycle.

Paperwork Reduction Act (PRA) Disclosure

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Business (OMB) control number. The pending OMB control number for this information collection is **0938-1454**; final approval of this collection requirement request is subject to OMB review and its status can be found on www.reginfo.gov. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, MD 21244-1650.

Using the Manual

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

Section 1 – Measurement Information

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

MIFs describe the purpose, use, and clinical rationale for specific measures. They also identify populations assessed and improvements demonstrated by the measure.

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

Section 2 – Data Dictionary

This section describes the patient-level data elements required to capture and calculate individual measurements; it specifies data elements that must be collected for each patient who falls into a selected population and data elements needed for a specific measure.

Section 3 – Missing and Invalid Data

This section addresses the steps to approach missing and invalid data. Missing data refer to data elements, required for calculating a measure, that have no values present for one or more encounters. Invalid data refer to data element values, required for calculating a measure, that fall outside of the range of allowable values defined for that data element. Reducing missing and invalid data minimizes the bias to a measure rate because records with missing or invalid data cannot be included in the calculation of the observed measure rate. This section describes preventing missing and invalid data in detail.

Section 4 – Population and Sampling Specifications

This section provides guidance on defining the hospital's population and the order of data flow. Defining the population is the first step to estimate a hospital's performance. A population is defined as a collection of patients sharing a common set of universally measured characteristics, such as an International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Principal Diagnosis or Current Procedural Terminology (CPT®) Codes. The population and diagnosis/CPT® codes meet this description for the rural emergency hospital measures. Additional information regarding population and sampling are found in this section.

Section 5 – Rural Emergency Hospital (REH) Quality Measure Data Transmission

This section provides guidelines for transmitting measure data. It highlights the unique data transmission specifications for REH measure data for the CMS Hospital Quality Reporting (HQR) site. It is divided into three parts: Guidelines for Submission of Data, Transmission Data Element List, and Transmission Data Processing Flow. This section provides specific information regarding data transmission.

Appendix A – ICD-10-CM Diagnosis and CPT® Code Tables

For many of the measures, eligibility for inclusion or exclusion in the REH population of interest is defined by the presence of certain ICD-10-CM diagnosis codes and CPT® codes, including Evaluation and Management (E/M) codes within the patient-level record. Appendix A contains the code tables that define the populations for all measures. There is a description of the codes, as defined in the applicable coding manual, and a shortened description that may be used in a data abstraction tool. The Measure Information section also refers to the codes or tables provided in this section. The code tables in this Appendix are evaluated periodically and modified as indicated.

Appendix B – Glossary of Terms

ED-Throughput		
Measure	OP-18	Median Time from ED Arrival to ED Departure for Discharged ED Patients

Imaging Efficiency		
Measure	OP-10	Abdomen CT – Use of Contrast Material

Health Equity Measures Submitted via a Web-Based Tool		
Measures	HCHE	Hospital Commitment to Health Equity
	SDOH	Screening for Social Drivers of Health
	SDOH	Screen Positive Rate for Social Drivers of Health

Outcome		
Measures	OP-32	Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
	OP-36	Hospital Visits after Hospital Outpatient Surgery

Measure Information Forms

Overview

An algorithm provides the logical steps, data element evaluation, arithmetic calculations, and data manipulation steps that are required to calculate a given measure. The algorithms and data elements needed to calculate each of the measures are identified in the Measure Information Form (MIF). Below is a defined overview of the MIF and Flowchart (Algorithm) formats.

Measure Set – The specific rural emergency hospital quality measure set to which an individual measure belongs (e.g., Imaging Efficiency, ED-Throughput).

Set Measure ID # – A unique alphanumeric identifier assigned to a measure. Information associated with a measure is identified by this unique alphanumeric number.

Performance Measure Name – A brief title that uniquely identifies the measure.

Description – A brief explanation of the measure's focus, such as the activity or the area on which the measure centers attention (e.g., median time from ED arrival to ED departure time for discharged ED patients).

Rationale – The reason for performing a specified process to improve the quality-of-care outcome. This may include specific literature references, evidence-based information, expert consensus, etc.

Type of Measure – Indicates what is being evaluated by the measure.

- **Process:** A measure used to assess a goal-directed, interrelated series of actions, events, mechanisms, or steps, such as a measure of performance that describes what is done to, for, or by patients, as in performance of a procedure.
- **Outcome:** A measure that indicates the result of performance (or non-performance) of a function(s) or process(es).

Improvement Noted As – Describes how improvement would be indicated by the measure.

- An increase in the rate/score/number of occurrences.
- A decrease in the rate/score/number of occurrences.
- Either an increase or a decrease in the rate/score/number of occurrences, depending upon the context of the measure (e.g., utilization).

Numerator Statement – Represents the portion of the denominator that satisfies the conditions of the performance measure.

- **Included Population in Numerator:** Specific information describing the population(s) comprising the numerator, not contained in the numerator statement, or not applicable.
- **Excluded Population in Numerator:** Specific information describing the population(s) that should not be included in the numerator, or none.
- **Data Elements:** Those data elements necessary or required to determine (or establish) the numerator.

Note: If the measure is reported as a rate (proportion or ratio), the Numerator and Denominator Statements are completed. If a performance measure does not have both a numerator and a denominator, then a Continuous Variable Statement is completed.

Denominator Statement – Represents the population evaluated by the performance measure.

Included Population in Denominator: Specific information describing the population(s) comprising the denominator, not contained in the denominator statement, or not applicable.

- **Excluded Population in Denominator:** Specific information describing the population(s) that should not be included in the denominator, or none.
- **Data Elements:** Those data elements required to determine (or establish) the denominator.

Note: If the measure is reported as a rate (proportion or ratio), the Numerator and Denominator Statements are completed. If a performance measure does not have both a numerator and a denominator, then a Continuous Variable Statement is completed.

Continuous Variable Statement – Describes an aggregate data measure in which the value of each measurement can fall anywhere along a continuous scale.

- **Included Population in Continuous Variable:** Specific information describing the population(s) comprising the performance measure, not contained in the Continuous Variable Statement, or not applicable.
- **Excluded Population in Continuous Variable:** Specific information describing the population(s) that should not be included in the performance measure, or none.
- **Data Elements:** Those data elements required to determine (or establish) the measure for a continuous variable.

Note: If a measure is reported as a central tendency, the Continuous Variable Statement is completed. This item is only completed when the performance measure does not have numerator and denominator statements.

Risk Adjustment – Indicates whether a measure is subject to the statistical process for reducing, removing, or clarifying the influences of confounding factors to allow more useful comparisons.

Data Collection Approach – Recommended timing for when data should be collected for a measure. Data collection approaches include retrospective, concurrent, prospective, or Medicare Claims data collection.

- **Retrospective data collection:** Involves collecting data for events that have already occurred.
- **Concurrent data collection:** The process of gathering data on how a process works or is working while a patient is in active treatment.
- **Prospective data collection:** Data collection in anticipation of an event or occurrence.
- **Medicare Claims data collection:** The use of data that is administratively derived from CMS claims and does not require abstraction.

Data Accuracy – Recommendations to reduce identifiable data errors, to the extent possible.

Measure Analysis Suggestions – Recommendations to assist in the process of interpreting data and drawing valid conclusions.

Sampling – Indicates whether a measure can be sampled. Sampling is a process of selecting a representative part of the population to estimate the hospital's performance without collecting data for its entire population.

Data Reported As – Indicates how data will be reported for a measure.

- Aggregate rate generated from count data reported as a proportion.

- Aggregate rate generated from count data reported as a ratio.
- Aggregate measures of central tendency.
- Claims data reported as condition-specific, hospital-specific, or risk-standardized.
- **Selected References** – Specific literature references that are used to support the importance of the performance measure.

Algorithm Introduction

Each measure set's initial patient population and associated measures are described by a unique algorithm. An algorithm is a predefined set of rules that helps to break down complex processes into simple, repetitive steps.

Initial Patient Population algorithms evaluate and identify which episode of care (EOC) records are in the measure set's population and are eligible to be sampled.

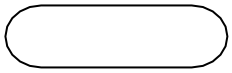
Measure algorithms serve two purposes. First, they evaluate and identify which EOC records contain missing and/or invalid data that will prohibit the ability to properly evaluate the measure. Second, they determine if:

- For rate-based measures, the patient's EOC record belongs in the measure population described by the denominator and if the patient experienced the event described in the numerator.
- For continuous variable measures, the patient's EOC record belongs in the patient population described in the measure's statement and, if so, to define and calculate the measurement value.

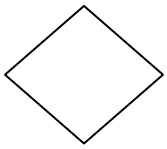
This section contains some standard flowcharting conventions used to develop each algorithm:

- **Flow lines:** Used to guide the reader to different parts of the algorithm, with arrows denoting the direction of movement. Generally, movement is from the top to the bottom of the chart.
- **Symbols:** Used in each algorithm are described later in this section under Flowchart Symbols.
- **Temporary variables:** Within algorithms are noted in the variable key at the top of each page.

Flowchart Symbols

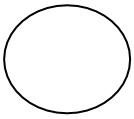


Start/Stop (ovals) denotes the beginning or end of an algorithm.

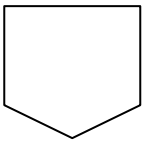


Diamonds represent "If…Then" decision points for logic tests and comparisons. Two or three flow lines exit the decision point to reflect alternative actions based upon an evaluation of the condition(s) stated around the decision point.

Rectangles or process boxes show when computation or manipulation of the data are required, such as a calculation or summarization.

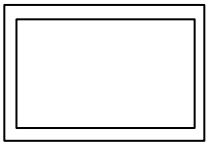


Circle or "On-page" connectors, labeled with a letter, show a link to sections of the algorithm which are continued on the same page.



Five-sided or "Off-page" connectors, labeled with a letter, show a link to sections of the algorithm which are continued on different pages.

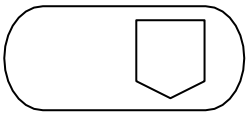
Note: Both circular, "On-page," and five-sided, "Off-page," connectors containing the letters B, D, E, X, or Y lead to measure Outcome Boxes.



Outcome Boxes represent the result of data passed through the algorithm. Connectors extending from outcome boxes lead to the end of the algorithm or to risk adjustment procedures, where applicable. This symbol is also used to identify the strata within a stratified measure.

Symbol to represent comments ("note") that should be considered when programming the flowchart.

The open rectangle symbol is placed alongside the Process box to which they are applicable. Comments are used to expand upon information contained within the process box, such as how to properly calculate age. Comments are never the sole location where processing logic is provided.



Start/Return symbols denote the beginning and end of a sub-routine. Algorithms that use this symbol are called from another algorithm, and the data processing flow returns to the calling algorithm when the "Return" is encountered.

See the Initial Patient Population Algorithms and Transmission Data Processing Flows for an example of the usage of this symbol.

Measure Category Assignments

Measure Category Assignments are calculated measure results for each EOC that is processed through a measure algorithm.

The following are the possible Measure Category Assignments:

B **Not in Measure Population**
- For rate-based and continuous variable measures: Record is not a member of the measure's population.

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

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

E **In Numerator Population**
- For rate-based measures: Record is a member of the measure's population, and there has been an occurrence of the measure.
- For continuous variable measures: Does not apply.

X **Data Are Missing**
- For rate-based and continuous variable measures: Data are missing that are required to calculate the measure. The record will be rejected when transmitted.

Y[1] **Unable to Determine (UTD) (**Allowable Value Does Not Allow Calculation of the Measure)
- For rate-based measures: Does not apply.
- For continuous variable measures: Record contains a Date, Time, or Numeric data element with a value of 'UTD.'

Rural Emergency Hospital Quality Reporting (REHQR) Measures ED-Throughput

Set Measure ID #	Measure Short Name
OP-18	Median Time from ED Arrival to ED Departure for Discharged ED Patients

REHQR ED-Throughput General Data Element List

General Data Element Name	Collected for:
Arrival Time	All Records
Birthdate	All Records
CMS Certification Number ǂ, ‡	All Records
First Name	All Records
Hispanic Ethnicity	All Records
Last Name	All Records
National Provider Identifier ǂ, ‡	Optional for All Records
Outpatient Encounter Date	All Records
Patient Identifier	All Records
Payment Source	All Records
Physician 1	Optional for All Records
Physician 2	Optional for All Records
Postal Code	All Records
Race	All Records
Sex	All Records

ǂ Transmission Data Element
‡ Defined in the Transmission Data Element List within the Rural Emergency Hospital Measure Data Transmission section of this manual.

REHQR ED-Throughput Specific Data Element List

OP ED Data Element Name	Collected for:
Arrival Time	OP-18
Discharge Code	OP-18
E/M Code	OP-18
ED Departure Date	OP-18
ED Departure Time	OP-18
ICD-10-CM Principal Diagnosis Code	OP-18
Outpatient Encounter Date	OP-18

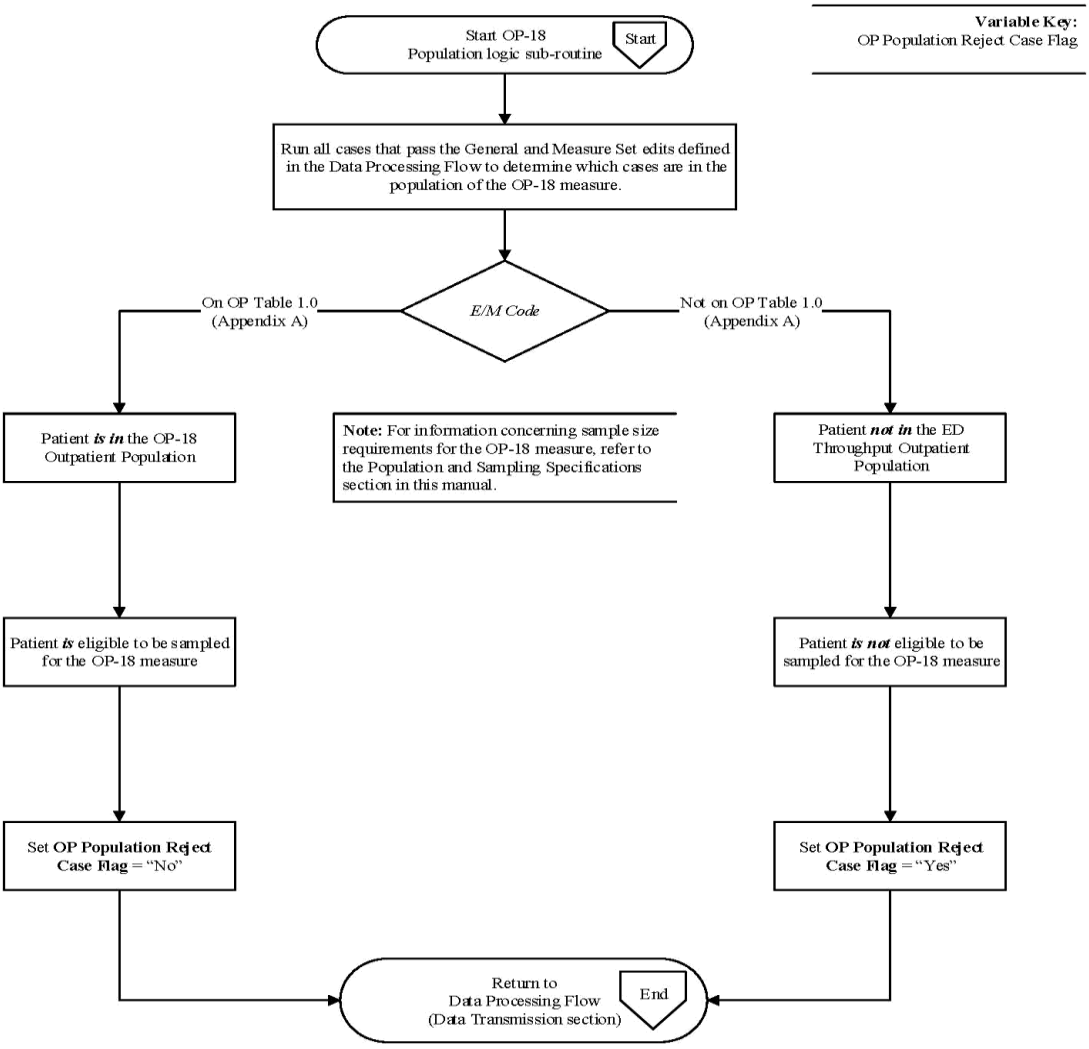
REHQR Emergency Department Throughput Population
ED-Throughput

The population of the OP-18 measure is identified using 1 data element:

- *E/M Code*

Patients seen in a Hospital Emergency Department (E/M Code in Appendix A OP Table 1.0) are included in the OP-18 Hospital Outpatient Population and are eligible to be sampled if they have an *E/M Code* in Appendix A, OP Table 1.0.

ED Throughput Hospital Outpatient Population Algorithm
OP-18



Algorithm Narrative for OP-18:
ED-Throughput Hospital Outpatient Population

Variable Key: OP Population Reject Case Flag

1. Start ED-Throughput Initial Patient Population logic sub-routine. Process all cases that have successfully reached the point in the Transmission Data Processing Flow: Clinical which calls this Initial Patient Population Algorithm. Do not process cases that have been rejected before this point in the Transmission Data Processing Flow.

2. Check *E/M Code*
   a. If the *E/M Code* is not on OP Table 1.0 (Appendix A), the patient is not in the ED Initial Patient Population and is not eligible to be sampled for the ED-Throughput measure set. Set the Initial Patient Population Reject Case Flag to equal Yes. Return to Transmission Data Processing Flow in the Data Transmission section.
   b. If the *E/M Code* is on OP Table 1.0 (Appendix A), the patient is in the ED Initial Patient Population and is eligible to be sampled for the ED-Throughput measure set. Set Initial Patient Population Reject Case Flag to equal No. Return to Transmission Data Processing Flow in the Data Transmission section.

NQF-Endorsed Voluntary Consensus Standards for Hospital Care
Measure Information Form

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

Measure ID #: OP-18

Measure Set: Hospital Outpatient ED-Throughput

Outpatient Setting: Emergency Department

Set Measure ID #	Performance Measure Name
OP-18a	Median Time from ED Arrival to ED Departure for Discharged ED Patients – Overall Rate
OP-18b	Median Time from ED Arrival to ED Departure for Discharged ED Patients – Reporting Measure
OP-18c	Median Time from ED Arrival to ED Departure for Discharged ED Patients – Psychiatric/Mental Health Patients
OP-18d	Median Time from ED Arrival to ED Departure for Discharged ED Patients – Transfer Patients

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

Rationale: Empirical evidence demonstrates that emergency department (ED) throughput is an indicator of hospital quality of care and shows that shorter lengths of stay in the ED lead to improved clinical outcomes. Significant ED overcrowding has numerous downstream effects, including prolonged patient waiting times, increased suffering for those who wait, rushed and unpleasant treatment environments, and potentially poor patient outcomes (Gardner, 2018). Quality improvement efforts aimed at reducing ED overcrowding and length of stay have been associated with an increase in ED patient volume, decrease in number of patients who leave without being seen, reduction in costs, and increase in patient satisfaction (Bucci, 2016; Chang, 2017; Zocchi, 2015).

Recent peer-reviewed studies also demonstrate the need for dedicated emergency mental health services, supplying evidence that the clinical needs for these patients substantively differ from the non-psychiatric population (ACEP, 2017; Lester, 2018).

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*
- *Discharge Code*
- *E/M Code*
- *ED Departure Date*
- *ED Departure Time*
- *ICD-10-CM Principal Diagnosis Code*
- *Outpatient Encounter Date*

Risk Adjustment: No

Data Collection Approach: Retrospective data sources for required data elements include administrative data and medical record documents. Some hospitals may prefer to gather data concurrently by identifying patients in the population of interest. This approach provides opportunities for improvement at the point of care/service. However, complete documentation includes the principal or other ICD-10-CM diagnosis and procedure codes, which require retrospective data entry.

Data Accuracy: There may be variation by provider, facility, and documentation protocol for chart-abstracted data elements.

Measure Analysis Suggestions: None

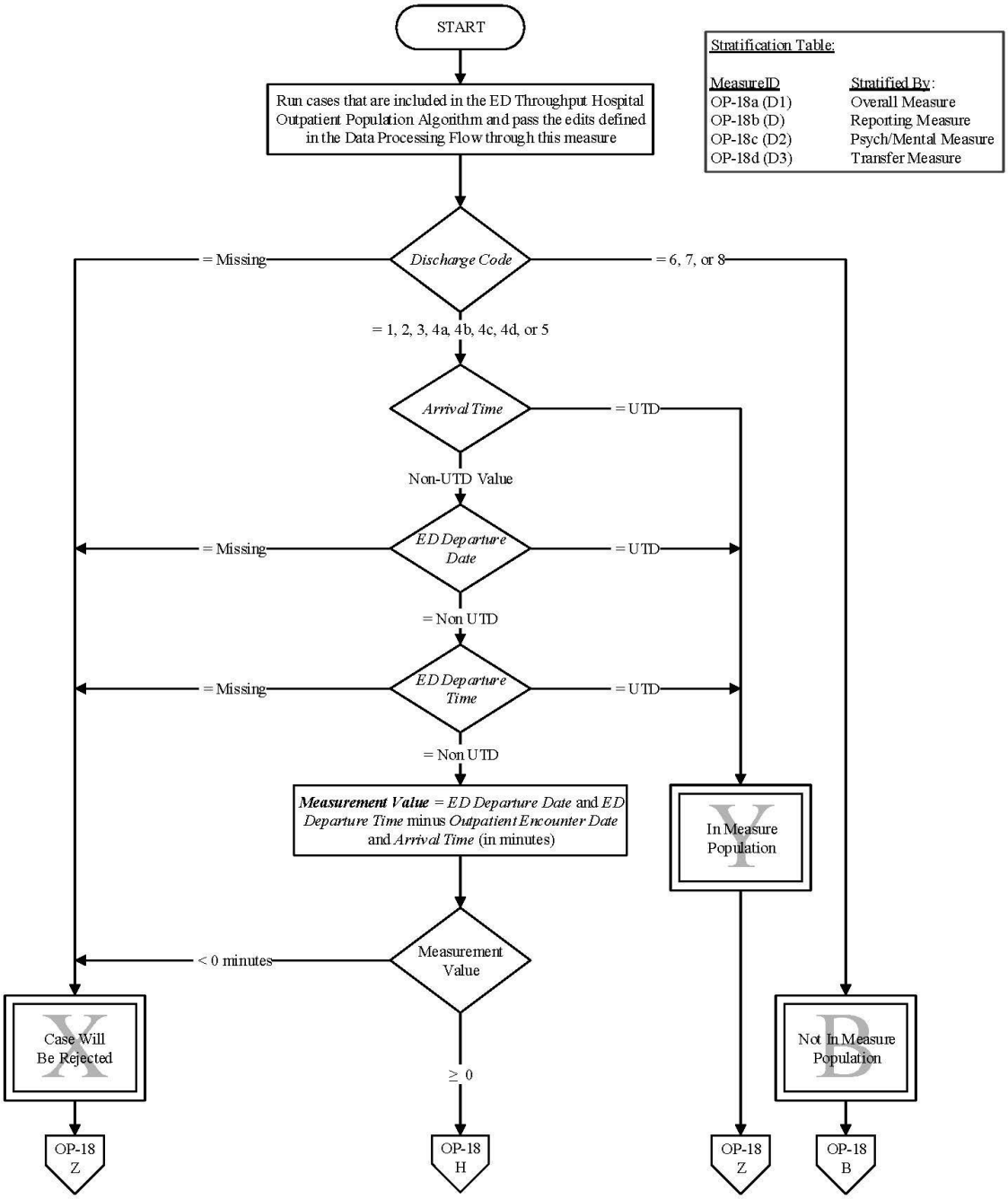
Sampling: Yes; for additional information see the Population and Sampling Specifications section.

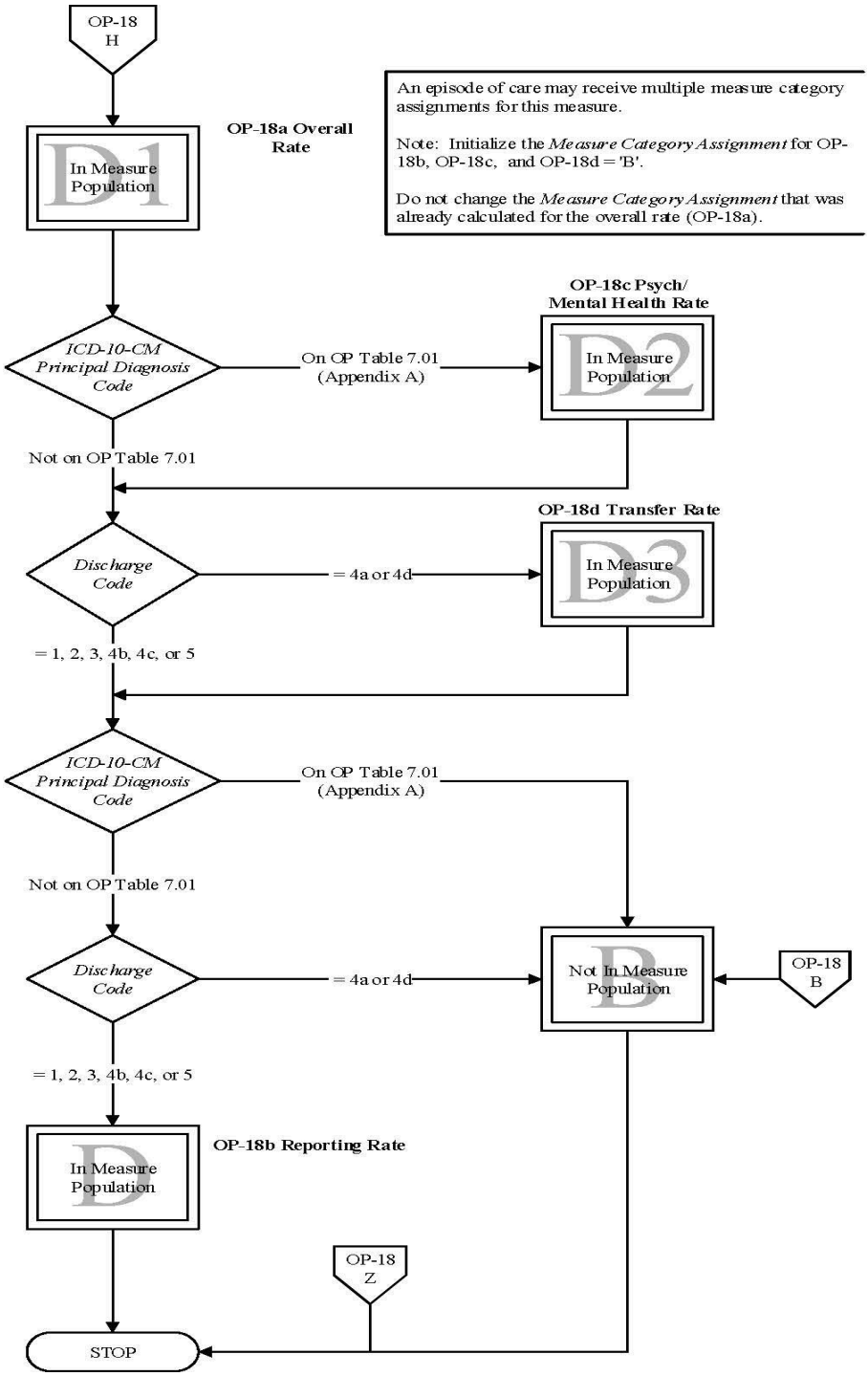
Data Reported As: Aggregate measure of central tendency.

Selected References:

- Bucci, S., A. G. de Belvis, S. Marventano, A. C. De Leva, M. Tanzariello, M. L. Specchia, W. Ricciardi and F. Franceschi. Emergency department crowding and hospital bed shortage: Is Lean a smart answer? A systematic review. Eur Rev Med Pharmacol Sci, 2016, 20(20), 4209-4219.
- Chang, A. M., A. Lin, R. Fu, K. J. McConnell and B. Sun. Associations of Emergency Department Length of Stay With Publicly Reported Quality-of-care Measures. Acad Emerg Med, 2017, 24(2), 246-250.
- Gardner, R. M., N. A. Friedman, M. Carlson, T. S. Bradham and T. W. Barrett. Impact of revised triage to improve throughput in an ED with limited traditional fast track population. Am J Emerg Med., 2017, 36(1), 124-127.
- Lester, N. A., L. R. Thompson, K. Herget, J. A. Stephens, J. V. Campo, E. J. Adkins, T. E. Terndrup and S. Moffatt-Bruce. CALM Interventions: Behavioral Health Crisis Assessment, Linkage, and Management Improve Patient Care. Am J Med Qual., 2017, 33(1), 65-71.
- Zocchi, M. S., M. S. McClelland, and J. M. Pines. Increasing Throughput: Results From A 42-Hospital Collaborative To Improve Emergency Department Flow. The Joint Commission Journal on Quality and Patient Safety, 2015, 41(12):532–542.

OP-18: 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.





Algorithm Narrative for OP-18:
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.

1. Start processing. Run all cases that are included in the ED-Throughput Hospital Outpatient Population Algorithm and pass the edits defined in the Data Processing Flow through this measure. Proceed to *ICD-10-CM Principal Diagnosis Code*.

2. Check *Discharge Code*
   a. If *Discharge Code* is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   b. If *Discharge Code* equals 6, 7, or 8, the case will proceed to a Measure Category Assignment of B. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   c. If *Discharge Code* equals 1, 2, 3, 4a, 4b, 4c, 4d, or 5, the case will proceed to *Arrival Time*.

3. Check *Arrival Time*
   a. If *Arrival Time* equals UTD, the case will proceed to a Measure Category Assignment of Y. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   b. If *Arrival Time* equals Non-UTD Value, the case will proceed to *ED Departure Date*.

4. Check *ED Departure Date*
   a. If *ED Departure Date* is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   b. If *ED Departure Date* equals UTD, the case will proceed to a Measure Category Assignment of Y. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   c. If *ED Departure Date* equals non-UTD, the case will proceed to *ED Departure Time*.

5. Check *ED Departure Time*
   a. If *ED Departure Time* is missing, the case will proceed to a Measure Category Assignment of X and will be rejected. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   b. If *ED Departure Time* equals UTD, the case will proceed to a Measure Category Assignment of Y. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   c. If *ED Departure Time* equals non-UTD, the case will proceed to Measurement Value.

6. Calculate the Measurement Value
   a. Time in minutes is equal to the *ED Departure Date* and *ED Departure Time* (in minutes) minus the *Outpatient Encounter Date* and *Arrival Time* (in minutes).

7. Check Measurement Value
   a. If Measurement Value is less than 0 minutes, the case will proceed to a Measure Category Assignment of X and will be rejected. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
   b. If Measurement Value is greater than or equal to 0 minutes, the case will proceed to a Measure Category Assignment of D1.

8. Initialize the Measure Category Assignment for all cases in D1

9. Proceed to *ICD-10-CM Principal Diagnosis Code*

10. Check *ICD-10-CM Principal Diagnosis Code*
    a. If *ICD-10-CM Principal Diagnosis Code* is in Appendix A, OP Table 7.01, the case will proceed to a Measure Category Assignment of D2. Proceed to *Discharge Code*.
    b. If *ICD-10-CM Principal Diagnosis Code* is not in Appendix A, OP Table 7.01, the case will proceed to *Discharge Code*.

11. Check *Discharge Code*
    a. If *Discharge Code* equals 4a or 4d, the case will proceed to a Measure Category Assignment of D3. Proceed to *ICD-10-CM Principal Diagnosis Code*.
    b. If *Discharge Code* equals 1, 2, 3, 4b, 4c, or 5, the case will proceed to *ICD-10-CM Principal Diagnosis Code*.

12. Check *ICD-10-CM Principal Diagnosis Code*
    a. If *ICD-10-CM Principal Diagnosis Code* is in Appendix A, OP Table 7.01, the case will proceed to a Measure Category Assignment of B. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
    b. If *ICD-10-CM Principal Diagnosis Cod*e is not in Appendix A, OP Table 7.01, the case will proceed to *Discharge Code*.

13. Check *Discharge Code*
    a. If *Discharge Code* equals 4a or 4d, the case will proceed to a Measure Category Assignment of B. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.
    b. If *Discharge Code* equals 1, 2, 3, 4b, 4c, or 5, the case will proceed to a Measure Category Assignment of D. Return to Transmission Data Processing Flow: Clinical in the Data Transmission section.

Measure Information Form

Performance Measure Name: Abdomen Computed Tomography(CT)—Use of Contrast Material

Measure ID #: OP-10

Measure Set: Outpatient Imaging Efficiency (OIE) Measures

Description: This measure calculates the percentage of CT of the abdomen or abdomen and pelvis (referred to as *abdominopelvic CTs*) studies that are performed without and with contrast out of all CT of the abdomen or abdominopelvis studies performed—those without contrast, those with contrast, and those without then with contrast. The measure is calculated based on a one-year window of claims data.

Rationale: OP-10 aims to promote use of high-quality, efficient care; reduce unnecessary exposure to radiation and contrast materials; ensure adherence to evidence-based medicine and clinical practice guidelines; and provide data to consumers and other stakeholders about imaging use at the facility, state, and national level.

Measure Results Interpretation: Lower scores are better. This means that a high-performing facility reports a value near 0 percent, whereas a facility that may be performing too many CTs of the abdomen or abdominopelvis studies without then with contrast scores closer to 100 percent.

Data Source: Medicare fee-for-service (FFS) claims.

Numerator Statement: Among CT studies of the abdomen or abdominopelvis in the denominator, the number of CT abdomen and abdominopelvis studies performed without then with contrast (also referred to as *combined studies*).

- Numerator Codes
  - The following Current Procedural Terminology (CPT®) code category is included in the measure numerator:

Name	Code Type	Object ID
Abdomen CT Without then With Contrast	CPT	2.16.840.1.113883.3.3157.21

Denominator Statement: The number of CT studies of the abdomen or abdominopelvis performed—without contrast, with contrast, or without then with contrast—within a one-year window of Medicare FFS claims data for beneficiaries whose imaging was performed at outpatient hospital facilities reimbursed through the Outpatient Prospective Payment System (OPPS). Medicare FFS beneficiaries can be included in the measure's initial patient population multiple times; each abdomen or abdominopelvis CT (without contrast, with contrast, or both with and without contrast) performed at a facility measured under OPPS is counted once in the measure's denominator.

- Denominator Codes
  - The following International Classification of Disease, Version 10 (ICD-10) and CPT code categories are used to identify the measure denominator population:

Name	Code Type	Object ID
Abdomen CT Without Contrast	ICD-10	2.16.840.1.113883.3.3157.1
Abdomen CT With Contrast	ICD-10	2.16.840.1.113883.3.3157.2
Abdomen CT Without then With Contrast	CPT	2.16.840.1.113883.3.3157.21

Excluded Conditions: The OIE measures are not risk adjusted; instead, Medicare FFS beneficiaries who have a clinical diagnosis of one or more conditions for which imaging is considered appropriate are excluded from the measure. That is, these Medicare FFS beneficiaries are removed from the denominator, as well as from the numerator, since the numerator involves identifying Medicare FFS beneficiaries from the denominator.

For OP-10, Medicare FFS beneficiaries whose abdomen CT had one of the following clinical diagnoses recorded on the claim are excluded from the measure's initial patient population; these conditions include:

- Adrenal mass;
- Diseases of the urinary system;
- Hematuria;
- Infections of kidney;
- Jaundice;
- Liver lesion (mass or neoplasm);
- Malignant neoplasm of bladder;
- Malignant neoplasm of pancreas;
- Non-traumatic aortic disease;
- Pancreatic disorders; and
- Unspecified disorder of kidney or ureter.

For all conditions, clinical evidence exists (within a clinical practice guideline or the peer-reviewed literature) that indicates performing a CT study of the abdomen and/or abdominopelvis may be appropriate care. Consequently, any Medicare FFS beneficiary with one or more of these conditions documented on the CT claim is excluded from the measure.

- Denominator Exclusion Codes
  - The following ICD-10 code categories are excluded from the denominator population:

Name	Code Type	Object ID
Adrenal Mass	ICD-10	2.16.840.1.113883.3.3157.1017
Diseases of the Urinary System	ICD-10	2.16.840.1.113883.3.3157.1019
Hematuria	ICD-10	2.16.840.1.113883.3.3157.1020
Infections of the Kidney	ICD-10	2.16.840.1.113883.3.3157.1021
Jaundice	ICD-10	2.16.840.1.113883.3.3157.1022
Liver Lesion (Mass or Neoplasm)	ICD-10	2.16.840.1.113883.3.3157.1023
Malignant Neoplasm of Bladder	ICD-10	2.16.840.1.113883.3.3157.1024
Malignant Neoplasm of the Pancreas	ICD-10	2.16.840.1.113883.3.3157.1025
Non-Traumatic Aortic Disease	ICD-10	2.16.840.1.113883.3.3157.1026
Pancreatic Diseases	ICD-10	2.16.840.1.113883.3.3157.1027
Unspecified Disorder of the Kidney And Ureter	ICD-10	2.16.840.1.113883.3.3157.1028

Detailed specifications for OP-10 and the other OIE measures, including measure implementation information, can be found via the following link: https://qualitynet.cms.gov/outpatient/measures/imaging-efficiency.

Measure Information Form

Performance Measure Name: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy

Measure ID #: OP-32

Measure Set: CMS Outcome Measures (Claims-Based)

Description: The colonoscopy measure estimates a facility-level rate of risk-standardized, all-cause, unplanned hospital visits within seven days of an outpatient colonoscopy among Medicare FFS patients aged 65 years and older.

Rationale: The colonoscopy measure aims to reduce adverse patient outcomes associated with preparation for colonoscopy, the procedure itself, and follow-up care by capturing and making more visible to providers and patients all unplanned hospital visits following the procedure. The measure score assesses quality and inform quality improvement. CMS uses a comprehensive method for development, testing, and creating final specifications for the measure. For initial measure specifications, CMS assembled a multidisciplinary team of clinicians, health services researchers, and statisticians and convened, through a public process, a national technical expert panel (TEP) consisting of patients, surgeons, methodologists, researchers, and providers. CMS also held a public comment period soliciting stakeholder input on the measure methodology.

Type of Measure: Outcome

Improvement Noted As: A decrease in the facility-level risk-standardized unplanned hospital visit rate. A lower rate indicates better quality.

Numerator Statement:
The colonoscopy measure does not have a traditional numerator and denominator like a core process measure (e.g., percentage of adult patients with diabetes aged 18 to 75 years receiving one or more hemoglobin A1c tests per year); thus, we are using this field to define the outcome. The calculation of the rate is defined below, under the Measure Calculation section.

The outcome for the measure is all-cause, unplanned hospital visits within seven days of an outpatient colonoscopy. The measure defines a hospital visit as any emergency department (ED) visit, observation stay, or unplanned inpatient admission.

Denominator Statement:
The target population for the measure includes low-risk colonoscopies performed in the outpatient setting for Medicare FFS patients aged 65 years and older. For implementation in the Hospital OQR Program, the measure will be calculated among hospital outpatient departments.

Included Populations:
The target population for the measure is Medicare FFS patients aged 65 years and older undergoing an outpatient colonoscopy who have been enrolled in Part A and Part B Medicare for 12 months or more prior to the date of procedure to ensure the availability of administrative data for risk adjustment.

The measure is focused on low-risk colonoscopies. Cohort codes are located in the data dictionary that accompanies the Measure Updates and Specifications Report, on the Colonoscopy Measure Methodology *QualityNet* page: https://qualitynet.cms.gov/outpatient/measures/colonoscopy/methodology.

The measure does not include colonoscopy Current Procedural Terminology (CPT®) procedure codes that reflect fundamentally higher-risk or different procedures. Qualifying colonoscopies billed with a concurrent high-risk colonoscopy procedure code are not included in the measure; the data dictionary that accompanies the most recent Measure Updates and Specifications Report at the link above contains the complete listing of all high-risk procedure codes.

Cohort Exclusions (Excluded Colonoscopies):
See the Measure Updates and Specifications Report available on the Colonoscopy Measure Methodology *QualityNe*t page for detailed measure cohort exclusion criteria with the accompanying data dictionary containing the most current exclusion codes, located here: https://qualitynet.cms.gov/outpatient/measures/colonoscopy/methodology.

Admissions Not Counted in the Outcome ("Planned Admissions"):
Admissions identified as planned by the planned admission algorithm are not counted in the outcome. The "algorithm" is a set of criteria for classifying admissions as planned using Medicare claims. The algorithm identifies admissions that are typically planned and may occur within seven days of an outpatient colonoscopy. CMS based the planned admission algorithm on three principles:

1. A few specific, limited types of care are always considered planned (transplant surgery, maintenance chemotherapy, rehabilitation);
2. Otherwise, a planned admission is defined as a non-acute admission for a scheduled procedure; and
3. Admissions for acute illness or for complications of care are never planned.

The planned admission algorithm uses a flowchart and four tables of procedures and conditions to operationalize these principles and to classify inpatient admissions as planned. ED visits and observation stays are never considered planned. The flowchart and tables are in the Measure Updates and Specifications Report available on the Colonoscopy Measure Methodology *QualityNet* page: https://qualitynet.cms.gov/outpatient/measures/colonoscopy/methodology.

Risk Adjustment:
The measure's approach to risk adjustment is tailored to, and appropriate for, a publicly reported outcome measure as articulated in published scientific guidelines (Krumholz et al., 2006; Normand et al., 2007).

The measure uses a two-level hierarchical logistic regression model to estimate facility-level risk-standardized hospital visit rates. This approach accounts for the clustering of patients within facilities and variation in sample size across facilities. The measure adjusts for differences across facilities in patient demographics, clinical factors, and procedure-related risk. Potential candidate risk factors were identified

from related quality measures and the literature; a preliminary list of risk factors was developed and then revised based on a TEP and expert clinical input.

The risk-adjustment model has 15 patient-level variables (age, concomitant upper gastrointestinal endoscopy, polypectomy during the procedure, and 12 comorbidity variables). The measure defines comorbidity variables using condition categories (CCs), which are clinically meaningful groupings of the many thousands of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes. Certain CCs are considered possible complications of care; therefore, the measure does not risk-adjust for them if they occur only at the time of the procedure.

Therefore, only comorbidities that convey information about the patient at the time of the procedure or in the 12 months prior, and not complications that arose during the colonoscopy procedure are included in the risk adjustment. The Measure Updates and Specifications Report data dictionary contains complete definitions of risk factors and CCs that are considered possible complications of care and are not risk-adjusted for if they occur only at the time of the procedure.

Table 1: Patient-Level Risk-Adjustment Variables

Patient-Level Variables	Risk-Adjusted Variables
Demographics	Age (categorized; 65-69; 70-74; 75-79; 80-84; 85 and greater)
Procedural factors	Endoscopy during Procedure Polypectomy during Procedure
Comorbidities	Congestive Heart Failure Ischemic Heart Disease Stroke/Transient Ischemic Attack Chronic Lung Disease Metastatic Cancer Liver Disease Iron Deficiency Anemia Disorders of Fluid/Electrolyte/Acid-Base Pneumonia Psychiatric Disorders Substance Abuse Arrhythmias Age Categorized x Arrhythmia Interaction

Note: The relationship between age and risk of a hospital visit within seven days was modified by the presence or absence of a cardiac arrhythmia (p-value for interaction <0.001). Therefore, we included an interaction term (age categorized x arrhythmia) in the final model.

Full details of the development of the risk-adjustment model for this measure are available on the Colonoscopy Measure Archived Resources *QualityNet* page: https://qualitynet.cms.gov/outpatient/measures/colonoscopy/resources#tab2.

Data Collection Approach: Medicare administrative claims and enrollment data.

Data Accuracy: The administrative claims data used to calculate the measure are maintained by CMS' Office of Information Services. These data undergo additional quality assurance checks during measure development and maintenance.

Measure Analysis Suggestions: None

Sampling: No

Data Reported As: Facility-level seven-day risk-standardized unplanned hospital visit rate following outpatient colonoscopy.

Measure Calculation:
The measure estimates facility-level seven-day risk-standardized unplanned hospital visit rates using hierarchical logistic regression modeling (a form of hierarchical generalized linear modeling). In brief, the approach simultaneously models two levels (patient and facility) to account for the variance in patient outcomes within and between facilities. At the patient level, the model adjusts the log-odds of a hospital visit within seven days of the procedure for age, procedural factors, and selected clinical covariates. At the facility level, it estimates the facility-specific intercepts as arising from a normal distribution. The facility-specific intercept represents the underlying risk of a hospital visit within seven days after a colonoscopy at that facility while accounting for patient risk. The facility-specific intercepts also account for the clustering (non-independence) of patients within the same facility. If there were no differences among facilities, the facility-specific intercepts would be identical across all facilities after adjusting for patient risk.

The statistical modeling approach is described fully in the original technical report available on the Colonoscopy Measure Archived Resources *QualityNet* page: https://qualitynet.cms.gov/outpatient/measures/colonoscopy/resources#tab2.

Selected References:
Krumholz HM, Brindis RG, Brush JE, et al. Standards for Statistical Models Used for Public Reporting of Health Outcomes: An American Heart Association Scientific Statement from the Quality of Care and Outcomes Research Interdisciplinary Writing Group: Cosponsored by the Council on Epidemiology and Prevention and the Stroke Council Endorsed by the American College of Cardiology Foundation. Circulation. 2006;113(3):456–462.

Normand S-LT, Shahian DM. Statistical and Clinical Aspects of Hospital Outcomes Profiling. *Statistical Science*. 2007; 22(2):206–226.

Measure Information Form

Performance Measure Name: Hospital Visits after Hospital Outpatient Surgery

Measure ID #: OP-36

Measure Set: CMS Outcome Measures (Claims-Based)

Description: The surgery measure provides the facility-level, post-surgical risk-standardized hospital visit ratio (RSHVR) of the predicted to expected number of all-cause, unplanned hospital visits within seven days of a same-day surgery at a hospital outpatient department among Medicare Fee-for-Service (FFS) patients aged 65 years and older.

Rationale: The surgery measure can improve transparency, inform patients and providers, and foster quality improvement. Outpatient same-day surgery is exceedingly common in the United States. Unanticipated hospital visits following same-day surgery reflect quality of care. While most outpatient surgery is safe, there are well-described and potentially preventable adverse events that occur after outpatient surgery, which can result in unanticipated hospital visits. Similarly, direct admissions after surgery that are primarily caused by non-clinical patient considerations, such as lack of transport home upon discharge, or facility logistical issues, such as delayed start of surgery, are common causes of unanticipated yet preventable hospital admissions following same-day surgery. CMS uses a comprehensive method for development, testing, and creating final specifications for the measure. For initial measure specifications, CMS assembled a multidisciplinary team of clinicians, health services researchers, and statisticians and convened, through a public process, a national technical expert panel (TEP) consisting of patients, surgeons, methodologists, researchers, and providers. CMS also held a public comment period soliciting stakeholder input on the measure methodology.

Type of Measure: Outcome

Improvement Noted As: A decrease in the ratio of predicted-to-expected unplanned hospital visits. Lower score indicates better quality.

Numerator Statement:
The surgery measure outcome is all-cause unplanned hospital visits, defined as 1) an inpatient admission directly following surgery or 2) an emergency department (ED) visit, observation stay, or unplanned inpatient admission occurring after discharge from the HOPD and within seven days of the outpatient surgery.

Denominator Statement:
Eligible same-day surgeries or cystoscopy procedures with intervention performed at HOPDs for Medicare FFS patients aged 65 years and older, with the exception of eye surgeries and same-day surgeries performed concurrently with high-risk procedures.

Included Populations:

The target population is Medicare FFS patients aged 65 years and older undergoing same-day surgery (those that do not typically require an overnight stay) at HOPDs. The measure is limited to patients who have been enrolled in Medicare Part A and Part B for 12 months or more prior to the date of surgery to ensure the availability of data for identifying comorbidities for risk adjustment.

The measure includes surgeries for which a physician claim identifies a qualifying surgery as having been performed in an outpatient setting and matches to a hospital facility claim to identify the HOPD where the surgery took place. For further information see the Cohort section of the Measure Updates and Specifications report available on the Surgery Measure Methodology *QualityNet* page: https://qualitynet.cms.gov/outpatient/measures/surgery/methodology. Surgeries for which a facility claim is not filed are not included in the measure cohort.

"Same-day surgeries" are substantive surgeries listed on Medicare's list of covered ambulatory surgery center (ASC) procedures. Medicare developed this list to identify surgeries that can be safely performed as same-day surgeries and do not typically require an overnight stay. Surgeries on the Medicare's list of covered ASC procedures do not involve or require major or prolonged invasion of body cavities, extensive blood loss, major blood vessels, or care that is either emergent or life-threatening. Although Medicare developed this list of surgeries for ASCs, this measure uses it for two reasons. First, it aligns with the target cohort of surgeries that have a low to moderate risk profile and are safe to be performed as same day surgeries. By only including surgeries on this list, the measure effectively does not include surgeries performed at hospitals that typically require an overnight stay which are more complex, higher risk surgeries. Second, this list of surgeries is annually reviewed and updated by Medicare and includes a transparent public comment submission and review process for addition and/or removal of procedures codes. The lists are posted at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html (refer to Addendum AA of the respective link).

The measure cohort does not include eye surgeries. Although eye surgery is considered a substantive surgery, its risk profile is more representative of "minor" surgery, in that it is characterized by high volume and a low outcome.

The measure includes cystoscopy procedures with intervention because it is a common procedure, often performed for therapeutic intervention by surgical teams, and the outcome rate and causes of hospital visits post-procedure similar to other surgeries in the measure cohort.

Where multiple procedures occur concurrently, the measure only includes surgeries that are performed concurrently with another low to moderate risk procedure. The measure does not include same-day surgeries performed concurrently with a higher risk procedure such as an inpatient-only surgery.

For further details on the included surgeries and measure cohort, see the Measure Updates and Specifications Report available on the Surgery Measure Methodology *QualityNet* page: https://qualitynet.cms.gov/outpatient/measures/surgery/methodology.

Cohort Exclusions:

See the latest Measure Updates and Specifications Report available on the Surgery Measure Methodology *QualityNet* page for detailed measure cohort exclusion criteria with the accompanying data dictionary containing the most current exclusion codes, located here: https://qualitynet.cms.gov/outpatient/measures/surgery/methodology.

Admissions Not Counted in the Outcome ("Planned Admissions"):

Admissions identified as planned by the planned admission algorithm are not counted in the outcome. The "algorithm" is a set of criteria for classifying admissions as planned using Medicare claims. The algorithm identifies admissions that are typically planned and may occur within seven days of an outpatient surgery. CMS based the planned admission algorithm on three principles:

1. A few specific, limited types of care are always considered planned (transplant surgery, maintenance chemotherapy, rehabilitation);
2. Otherwise, a planned admission is defined as a non-acute admission for a scheduled procedure; and
3. Admissions for acute illness or for complications of care are never planned.

The planned admission algorithm uses a flowchart and four tables of procedures and conditions to operationalize these principles and to classify inpatient admissions as planned. The measure considers admissions occurring on the day of the surgery (Day 0) and Day 1 post-surgery unplanned. For inpatient admissions occurring after Day 1 following surgery, the measure only includes unplanned admissions in the measure outcome.

ED visits and observation stays are never considered planned. The flowchart and tables are available in the latest Measure Updates and Specifications Report, available on the Surgery Measure Methodology *QualityNet* page: https://qualitynet.cms.gov/outpatient/measures/surgery/methodology.

Risk Adjustment:
The measure approach to risk adjustment is tailored to, and appropriate for, a publicly reported outcome measure as articulated in published scientific guidelines.[1,2]

The measure uses a two-level hierarchical logistic regression model to estimate RSHVRs. This approach accounts for the clustering of patients within HOPDs and variation in sample size.

The risk-adjustment model has 27 patient-level variables, including age, clinical comorbidities, and indicators of surgical complexity.

The measure defines comorbidity variables using CMS Condition Categories (CCs), which are clinically meaningful groupings of many thousands of ICD-10-CM diagnosis codes. Certain CCs are considered possible complications of care and are not risk-adjusted for if they only occur at the surgery. See the data dictionary available on the Surgery Measure Methodology *QualityNet* page https://qualitynet.cms.gov/outpatient/measures/surgery/methodology for CCs that are considered possible complications of care and are not risk-adjusted for if they only occur at the surgery.

The measure risk adjusts for surgical procedural complexity using two variables. First, it adjusts for surgical procedural complexity using the Work Relative Value Unit (RVU) of the procedure. Work RVUs are assigned to each Current Procedural Terminology (CPT) code and approximate surgical procedural complexity by incorporating elements of physician time and effort. For patients with multiple concurrent CPT procedure codes, the measure risk adjusts for the CPT code with the highest Work RVU value. Second, it classifies each surgery into an anatomical body system group using the Agency for Healthcare Research and Quality (AHRQ) Clinical Classification System (CCS).[3] The measure uses the body system variable, in addition to the Work RVU of the surgery, to account for organ-specific difference in risk and complications which are not adequately captured by the Work RVU alone. This approach to risk adjustment for surgical procedural complexity is similar to that described in the literature and used for risk adjustment in the American College of Surgeons' National Surgical Quality Improvement Program.[4] The coding list for the body systems is available at: https://www.hcup-us.ahrq.gov/tools_software.jsp.

Table 1: Patient-Level Risk-Adjustment Variables

Patient-Level Variables	Risk-Adjusted Variables
Demographics	Age (years greater than 65)
Comorbidities	Cancer Diabetes and DM complications Disorders of fluid/electrolyte/acid-base Intestinal obstruction perforation Inflammatory bowel disease Bone/joint/muscle infections/necrosis Hematological disorders including coagulation defects and iron deficiency Dementia or senility Psychiatric disorders Hemiplegia, paraplegia, paralysis, functional disability Other significant CNS disease Cardiorespiratory arrest, failure and respiratory dependence Congestive heart failure Ischemic heart disease Hypertension and hypertensive disease Arrhythmias Vascular disease Chronic lung disease UTI and other urinary tract disorders Pelvic inflammatory disease and other specified female genital disorders Chronic ulcers Cellulitis, local skin infection Prior significant fracture Morbid obesity
Procedural Complexity	Work RVU AHRQ surgery body system

For a detailed description of the development and refinement of the risk-adjustment model, see the latest Hospital Visits after Hospital Outpatient Surgery: Measure Updates and Specifications Report, available on the Surgery Measure Methodology *QualityNet* page: https://qualitynet.cms.gov/outpatient/measures/surgery/methodology.

Data Collection Approach: Medicare administrative claims and enrollment data.

Data Accuracy: The administrative claims data used to calculate the measure are maintained by CMS' Office of Information Services. These data undergo additional quality assurance checks during measure development and maintenance.

Measure Analysis Suggestions: None

Sampling: No

Data Reported As: Facility-level seven-day risk-standardized unplanned hospital visit ratio following outpatient surgery.

Measure Calculation:
To calculate a facility-specific, post-surgical RSHVR for outpatient surgery patients, the measure uses hierarchical logistic regression to model the log-odds of the outcome as a function of the patient demographic and clinical characteristics, surgical procedure, and a random facility-specific intercept. This strategy accounts for within-facility correlation of the observed outcome, and it accommodates the assumption that underlying differences in quality across HOPDs lead to systematic difference in outcomes. For fairness, the model adjusts for demographic and clinical characteristics and procedural variables that vary across patient populations, are unrelated to quality, and influence the outcome to help ensure differences in the measure score do not reflect differences in case mix and surgical procedure mix across HOPDs. If there were no differences among facilities, the facility-specific intercepts would be identical across all facilities after adjusting for patient risk. The statistical approach to calculating RSHVR is described in Appendix D of the 2016 Measure Updates and Specifications Report, which can be found on the Archived Resources page of the Surgery Measure *QualityNet* page: https://qualitynet.cms.gov/outpatient/measures/surgery/resources#tab2.

Selected References:
HCUP Clinical Classifications Software for Services and Procedures. Healthcare Cost and Utilization Project (HCUP). 2008. Agency for Healthcare Research and Quality, Rockville, MD http://www.hcup-us.ahrq.gov/toolssoftware/ccs_svcsproc/ccssvcproc.jsp, 2014.

Krumholz HM, Brindis RG, Brush JE, et al. Standards for Statistical Models Used for Public Reporting of Health Outcomes: An American Heart Association Scientific Statement From the Quality of Care and Outcomes Research Interdisciplinary Writing Group: Cosponsored by the Council on Epidemiology and Prevention and the Stroke Council Endorsed by the American College of Cardiology Foundation.a Circulation. 2006; 113 (3): 456-462.

Normand S-LT, Shahian DM. Statistical and Clinical Aspects of Hospital Outcomes Profiling. Statistical Science. 2007; 22 (2): 206-226.

Raval MV, Cohen ME, Ingraham AM, et al. Improving American College of Surgeons National Surgical Quality Improvement Program risk adjustment: incorporation of a novel procedure risk score. Journal of the American College of Surgeons. Dec 2010; 211(6): 715-723.

Measure Information Form

Performance Measure Name: Screening for Social Drivers of Health (SDOH)

Measure ID #: OP-43

Measure Set: Social Drivers of Health

Description: The Screening for SDOH is a process measure that assesses the total number of patients, who were 18 years or older on the date of service, screened for social risk factors (specifically, food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety) during their Rural Emergency Hospital (REH) care.

Rationale: SDOH is an umbrella term that refers to community-level factors that impact health and well-being, while Health-Related Social Needs (HRSNs) are social and economic needs that individuals experience that affect their ability to maintain their health and well-being. Consistent screening of patients for potential HRSNs helps healthcare hospitals identify individuals who have historically been underserved by the healthcare system and could support ongoing quality improvement initiatives at the population level by providing data to stratify patient risk and organizational performance to address SDOH. While widespread interest exists in addressing SDOH at community, state, and national levels and in supporting HRSNs for patients who experience one or more HRSNs, action is inconsistent. Additionally, pilot studies screening for HRSNs have been conducted in the Hospital Outpatient Department (HOPD) and Ambulatory Surgical Center (ASC) settings, with clinicians and staff agreeing that HRSN data are important and relevant to collect in these settings to improve patient care and communication as well as to connect patients with social-related services.

Type of Measure: Process

Improvement Noted As: An increase in the rate of patients screened for all five social risk factors. A higher rate indicates better quality.

Numerator Statement: The numerator consists of the number of patients admitted to a REH, which includes emergency department (ED) visits and observation stays, who are 18 years or older on the date of admission and are screened for all of the following five HRSNs: food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety during their rural emergency hospital care.

Denominator Statement: The denominator consists of the number of patients who are admitted to a REH and who are 18 years or older on the date of admission.

Denominator Exclusions: The following patients can be excluded from the denominator: (1) Patients who opt out of screening; and (2) patients who are themselves unable to complete the

screening and have no legal guardian or caregiver able to do so on the patient's behalf during their REH care.

Clarifying Information: The Screening for Social Drivers of Health measure will be calculated as the number of patients admitted to a REH who are 18 years or older on the date of admission screened for all five HRSNs (food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety) divided by the total number of patients 18 years or older on the date of admission admitted to the REH. REHs would report using their CCN through the Hospital Quality Reporting (HQR) System.

Annual Data Submission Period: See the timeline posted to QualityNet.CMS.gov for this measure; select Rural Emergency Hospitals, then Data Management, then Data Submissions, and then Deadlines tab. Data will be completed through the Hospital Quality Reporting (HQR) system at https://hqr.cms.gov via an online tool available to authorized users.

Data Collection Approach: REHs will use a self-selected screening tool. The Accountable Health Communities (AHC) Model's standard 10-item AHC HRSN Screening Tool, which was used to develop the measure, is one example of a screening tool that could be used; others can be found through evidence-based resources like the Social Interventions Research and Evaluation Network (SIREN) website, which provides comprehensive information about the most widely used HRSN screening tools.

Further information on attestation is available in QualityNet:
https://qualitynet.cms.gov/reh/measures/screening/methodology

Measure Information Form

Performance Measure Name: Screen Positive Rate for Social Drivers of Health (SDOH)

Measure ID #: OP-44

Measure Set: Social Drivers of Health

Description: The Screen Positive Rate for SDOH measure provides information on the percent of patients receiving care at a Rural Emergency Hospital (REH) who are 18 years or older on the date of admission, were screened for a Health-related Social Need (HSRN), and who screen positive for one or more of the following five HRSNs: food insecurity, housing instability, transportation problems, utility difficulties, or interpersonal safety.

Rationale: SDOH is an umbrella term that refers to community-level factors that impact health and well-being, while HRSNs are social and economic needs that individuals experience that affect their ability to maintain their health and well-being. Consistent screening of patients for potential HRSNs helps hospitals identify individuals who have historically been underserved by the healthcare system and could support ongoing quality improvement initiatives at the population level by providing data to stratify patient risk and organizational performance to address SDOH. While widespread interest exists in addressing SDOH at community, state, and national levels and in supporting HRSNs for patients who experience one or more HRSNs, action is inconsistent. Additionally, pilot studies screening for HRSNs have been conducted in the Hospital Outpatient Department (HOPD) and Ambulatory Surgical Center (ASC) settings, with clinicians and staff agreeing that HRSN data are important and relevant to collect in these settings to improve patient care and communication as well as to connect patients with social-related services.

Type of Measure: Process

Numerator Statement: The numerator consists of the number of patients receiving care at a REH who are 18 years or older on the date of admission, which includes emergency department (ED) visits and observation stays, who were screened for all five HSRN, and who screen positive for having a need in one or more of the following five HRSNs (calculated separately): food insecurity, housing instability, transportation needs, utility difficulties or interpersonal safety.

Denominator Statement: The denominator consists of the number of patients receiving care at a REH who are 18 years or older on the date of admission and are screened for all of the following five HSRN (food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety) during their care.

Denominator Exclusions: The following patients can be excluded from the denominator: 1) Patients who opt out of screening; and 2) patients who are themselves unable to complete the

screening and have no legal guardian or caregiver able to do so on the patient's behalf, during their care at a REH.

Measure Calculation: The result of this measure would be calculated as five separate rates. Each rate is derived from the number of patients admitted to a REH and who are 18 years or older on the date of admission, screened for an HRSN, and who screen positive for each of the five HRSNs—food insecurity, housing instability, transportation needs, utility difficulties, or interpersonal safety—divided by the total number of patients 18 years or older on the date of admission screened for all five HRSNs.

Clarifying Information: The result of this measure would be calculated as *five separate rates*. Each rate is derived from the number of patients admitted for outpatient care and who are 18 years or older on the date of admission, screened for an HRSN, and who screen positive for each of the five HRSNs—food insecurity, housing instability, transportation needs, utility difficulties, or interpersonal safety—divided by the total number of patients 18 years or older on the date of admission screened for all five HRSNs.

Annual Data Submission Period: See the timeline posted to QualityNet.CMS.gov for this measure; select Rural Emergency Hospitals, then Data Management, then Data Submissions, and then Deadlines tab. Data will be completed through the Hospital Quality Reporting (HQR) system at https://hqr.cms.gov via an online tool available to authorized users.

Data Collection Approach: REHs will use a self-selected screening tool. The Accountable Health Communities (AHC) Model's standard 10-item AHC HRSN Screening Tool, which was used to develop the measure, is one example of a screening tool that could be used; others can be found through evidence-based resources like the Social Interventions Research and Evaluation Network (SIREN) website, which provides comprehensive information about the most widely used HRSN screening tools.

Further information on attestation is available in QualityNet:
https://qualitynet.cms.gov/reh/measures/screening/methodology

Additional Resources:

For more information about the CMMI Accountable Health Communities Model screening tool and case studies about implementing SDOH screening: https://innovation.cms.gov/innovation-models/ahcm

For a listing of various screening tools, including those that include the five SDOH domains specified in the measure: https://sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison

Measure Information Form

Performance Measure Name: Hospital Commitment to Health Equity Measure

Measure ID #: OP-45

Measure Set: Hospital Commitment to Health Equity

Description: This structural measure assesses hospital commitment to health equity using a suite of equity-focused organizational competencies aimed at achieving health equity for racial and ethnic minority groups, people with disabilities, members of the lesbian, gay, bisexual, transgender, and queer (LGBTQ+) community, individuals with limited English proficiency, rural populations, religious minorities, and people living near or below poverty level. Hospitals will receive one point each for attesting to five different domains of commitment to advancing health equity (equity as a strategic priority, data calculation, data analysis, quality improvement, and leadership engagement) for a total of five points.

Rationale: Strong and committed leadership from healthcare hospital management is essential in shifting organizational culture to reduce health disparities and reach health equity goals. The Agency for Healthcare Research and Quality and The Joint Commission identified that healthcare hospital leadership plays an important role in promoting a culture of quality and safety. The Institute for Healthcare Improvement's research shows that health equity must be a priority championed by leadership teams to improve both patient access to needed healthcare services and outcomes among disadvantaged populations. Based upon these findings, we believe that healthcare hospital leadership is instrumental in setting specific, measurable, attainable, realistic, and time-based (SMART) goals to assess progress towards achieving equity priorities and ensuring high-quality care is equally accessible to all individuals.

Type of Measure: Structure

Improvement Noted As: An increase in the rate of positive attestations. A higher rate indicates better quality.

Numerator Statement: The numerator captures the total number of domains to which the hospital is able to attest affirmatively, up to a maximum of five domains. A hospital only receives a point for a domain if it attested “yes” to all of the elements within that domain. The attestation is not accepted when a hospital attests “yes” to some, but not all, of the elements; in the event a hospital would not be able to attest “yes” to one or more elements within a domain, or the entirety of a domain, they would respond “no.” For example, for Domain 1, if the hospital’s strategic plan meets elements (A) and (B), but not (C) and (D) of Domain 1, then the hospital would not be able to affirmatively attest “yes” and would receive zero points for Domain 1.

Denominator Statement: The denominator for each hospital is 5 which represents the total number of questions. The measure is calculated as the number of complete attestations / total

number of questions. There is no partial credit for any question. Attestation of all elements is required in order to qualify for the measure numerator.

- **Domain 1: Equity is a Strategic Priority**
  Hospital commitment to reducing healthcare disparities is strengthened when equity is a key organizational priority. Please attest that your hospital has a strategic plan for advancing health equity and that it includes all of the following elements. Select all that apply (note: attestation of all elements is required in order to qualify for the measure numerator):

  A. Our hospital strategic plan identifies priority populations who currently experience health disparities.
  B. Our hospital strategic plan identifies health equity goals and discrete action steps to achieving these goals.
  C. Our hospital strategic plan outlines specific resources which have been dedicated to achieving our equity goals.
  D. Our hospital strategic plan describes our approach for engaging key stakeholders, such as community-based organizations.

- **Domain 2: Data Collection**
  Collecting valid and reliable demographic and social determinant of health data on patients served in a hospital is an important step in identifying and eliminating health disparities. Please attest that your hospital engages in the following activities. Select all that apply (note: attestation of all elements is required in order to qualify for the measure numerator):

  A. Our hospital collects demographic information (such as self-reported race, national origin, primary language, and ethnicity data) and/or social determinant of health information on the majority of our patients.
  B. Our hospital has training for staff in culturally sensitive collection of demographic and/or social determinant of health information.
  C. Our hospital inputs demographic and/or social determinant of health information collected from patients into structured, interoperable data elements using a certified EHR technology.

- **Domain 3: Data Analysis**
  Effective data analysis can provide insights into which factors contribute to health disparities and how to respond. Please attest that your hospital engages in the following activities. Select all that apply (note: attestation of all elements is required in order to qualify for the measure numerator):

  A. Our hospital stratifies key performance indicators by demographic and/or social determinants of health variables to identify equity gaps and includes this information on hospital performance dashboards.

- **Domain 4: Quality Improvement**

Health disparities are evidence that high quality care has not been delivered equitably to all patients. Engagement in quality improvement activities can improve quality of care for all patients. Select all that apply (note: attestation of all elements is required in order to qualify for the measure numerator):

A. Our hospital participates in local, regional, or national quality improvement activities focused on reducing health disparities.

- **Domain 5: Leadership Engagement**
  Leaders and staff can improve their capacity to address disparities by demonstrating routine and thorough attention to equity and setting an organizational culture of equity. Please attest that your hospital engages in the following activities. Select all that apply (note: attestation of all elements is required in order to qualify for the measure numerator):

  A. Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews our strategic plan for achieving health equity.
  B. Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews key performance indicators stratified by demographic and/or social factors.

Clarifying Information: The Hospital Commitment to Health Equity measure includes five attestation-based questions, each representing a separate domain of commitment. **For a hospital to affirmatively attest to a domain, and receive credit for that domain, the hospital will evaluate and determine whether it engages in each of the elements that comprise the domain.** Hospitals receive one point for each domain to which they attest "yes," stating they are meeting the required competencies; a hospital's score can be a total of zero to five points **(one per domain)**. For each domain there are between one and four associated yes/no sub-questions for related structures or activities within the hospital. Hospitals will only receive a point for each domain if they attest "yes" to all related sub-questions. There is no "partial credit" for sub-questions. For example, in Domain 1, hospitals must attest "yes" to sub-questions A-D in order to earn the point for that domain. If hospitals participate or complete qualifying activities at any time within the reporting year, they may attest "yes" for that domain.

Annual Data Submission Period: See the timeline posted to QualityNet.CMS.gov for this measure; select Rural Emergency Hospitals, then Data Management, then Data Submission, and then Deadlines tab. Data will be completed through the Hospital Quality Reporting (HQR) system at https://hqr.cms.gov/ via an online tool available to authorized users.

Data Collection Approach: Provider data entry (attestation-based statements)

Definition for Survey: Hospitals will attest to the Hospital Commitment to Health Equity measure via the HQR system available to authorized users. The measure includes five

attestation-based domains of commitment, comprised of several "yes" / "no" sub-questions. Hospitals may attest "yes" for each sub-question where they meet the required competencies.

Further information on attestation is available in QualityNet:

https://qualitynet.cms.gov/reh/measures/hche/methodology

Additional Resources: This measure is supported by evidence and guidance from the following:

- The CMS Meaningful Measures Framework[1] identifies equity as a priority, and the CMS National Quality Strategy[2] promotes the advancement of health equity as a key goal.
- CMS provides a health equity definition and corresponding fact sheet[3] outlining its vision to advance health equity as a strategic pillar and core agency function. CMS also released an updated framework[4] to further advance health equity, expand coverage and improve health outcomes for the more than 170 million individuals supported by CMS programs.
- The CMS Office of Minority Health (OMH) provides information on building an organizational response to health disparities.[5]
- The National Academy of Medicine (NAM) convened health care quality leaders on strategies to address equity.[6]
- The Institute for Healthcare Improvement (IHI) studied 23 health systems to better understand organizational efforts to improve equity and concluded equity must be a strategic priority.[7] IHI also issued a framework for health care organizations on achieving health equity.[8]
- The Joint Commission (TJC) published a roadmap for hospitals to improve communication, cultural competence, and patient- and family-centered care.[9]
- A study published by Health Care Management Review[10] utilized interviews with 19

[1] Meaningful Measures 2.0: Moving from Measure Reduction to Modernization | CMS
[2] CMS National Quality Strategy
[3] Health equity definition and Pillar: Health Equity fact sheet | CMS
[4] CMS Framework for Health Equity 2022-2032
[5] Building an Organizational Response to Health Disparities | CMS OMH
[6] An Equity Agenda for the Field of Health Care Quality Improvement | NAM
[7] Health Equity Must Be a Strategic Priority | NEJM Catalyst
[8] Achieving Health Equity: A Guide for Health Care Organizations | IHI (this content can be accessed on ihi.org via a free account login)
[9] Advancing Effective Communication, Cultural Competence, and Patient-and Family-Centered Care: A Roadmap for Hospitals | TJC
[10] Advancing health equity through organizational change: Perspectives from health care leaders | Health Care

health equity experts and hospital executives to identify approaches for health systems to implement lasting organizational change to advance health equity.

Management Review

Data Dictionary

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

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

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

These data elements include:
- *Arrival Time*
- *Birthdate*
- *CMS Certification Number* ‡, †
- *Hispanic Ethnicity*
- *Outpatient Encounter Date*
- *Patient Identifier*
- *Payment Source*
- *Postal Code*
- *Race*
- *Sex*

‡ Transmission Data Element.

† Defined in the Transmission Data Element List within the Rural emergency hospital Quality Measure Data Transmission section of this manual. ǂ Collected by CMS for patients with a Payment Source of Medicare who have a standard HIC number

Interpretation of Data Dictionary Terms:
Data elements fall into three broad categories in order to support specific measures. They include:
- ***General Data Elements*** – Data elements that must be collected by hospitals for each patient record.
  - Data elements required for each rural emergency hospital encounter record submitted.
  - Data elements used to identify the hospital on each patient record required for each patient-level record submitted.
  - Patient demographic data required for each rural emergency hospital encounter record submitted.
- ***Measure-Specific Data Elements*** – Data elements used by one specific measure or outpatient measure set, such as the ED-Throughput outpatient measure set.
- ***Optional Data Elements*** – Data elements collected to capture information that might be helpful for internal analysis.

Data Dictionary Terms

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

General Abstraction Guidelines

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

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.

Medical Records

The hospital must have one unified medical record service that has administrative responsibility for all medical records, both inpatient and outpatient records. The hospital must create and maintain a medical record for every individual, both inpatient and outpatient evaluated or treated in the hospital. The term "medical records" includes at least written documents, computerized electronic information, radiology film and scans, laboratory reports and pathology slides, videos, audio recordings, and other forms of information regarding the condition of a patient (42CFR482.24). The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services [42CFR428.24(c)].

Medical Record Documentation

The intent of abstraction is to use only documentation that was part of the medical record during the hospitalization (is present upon discharge) and that is present at the time of abstraction. There are instances where an addendum or late entry is added after discharge. This late entry or addendum can be used for abstraction purposes as long as it has been added within 30 days of discharge. Refer to the Medicare Conditions of Participation for Medical Records, 42CFR482.24(c)(4)(viii), unless otherwise specified in the data element. Documents containing amendments, corrections, or delayed entries must employ the following widely accepted recordkeeping principles (CMS "Medicare Program Integrity Manual" Chapter 3, Section 3.3.2.4):

- Clearly and permanently identify any amendments, corrections, or addenda;
- Clearly indicate the date and author of any amendments, corrections, or addenda; and
- Clearly identify all original content.

It is not the intent to have documentation added at the time of abstraction to ensure the passing of a measure.

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

Per the Medicare Conditions of Participation, all documentation in the medical record must be legible and must be timed, dated, and authenticated [42CFR482.24(c) (1)]. However, documentation that is not timed, dated, or authenticated may still be used for abstraction if not required by the specific data element. When abstracting a medical record, if a handwritten document is determined to be not legible, other documentation should be reviewed in an attempt to obtain the answer. If no other source document is able to verify the

handwritten documentation, only then is the abstractor to answer unable to determine from the medical record documentation, unless otherwise specified in the data element. Authentication may include written signatures, initials, computer key, or other codes.

Data element information should be retrieved from the current medical record, covering the encounter date being abstracted. Information ascertainable from previous testing or previous history **and** determined to be part of the current medical record may be used in abstraction. Previous testing or history information used in abstraction should be information that was part of the medical record during the encounter when care was being delivered. As electronic data are available at all times during the hospitalization, it is acceptable to use these data for abstraction purposes. If a hospital uses electronic data for abstraction and is unable to provide a paper or electronic copy of these data, and the record is chosen for validation, there is the potential for a mismatch to occur.

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

Note:

- Hospitals should use abbreviations according to their policy. Frequently flow sheets or other documentation contain a "key" or "legend" that explains the meaning of the abbreviation or symbol, especially if it is unique to that facility. If the record is selected for validation, it is recommended that you include your policy, key, and/or legend if you believe it would have an impact on the validation of the medical record.
- Documentation that is "superscripted" or footnoted is allowable and can be used in abstraction.

Suggested Data Sources

- Suggested Data Sources are listed in alphabetical order, **not** priority order, unless otherwise specified. Suggested Data Sources are designed to provide guidance to the abstractor as to the locations/sources where the information needed to abstract a data element will likely be found. However, the abstractor is not limited to these sources for abstracting the information and is encouraged to review the entire medical record.
- In some instances, a data element may restrict the sources that may be used to gain the information, list a priority in which the sources should be used, or may restrict documentation by only physician/advanced practice nurse/physician assistant. If so, these sources will be identified and labeled as Excluded Data Sources, Only Acceptable Sources, Priority Source, or Physician/APN/PA Documentation Only.
- In the course of abstraction, if conflicting information is found in a source other than the Suggested Data Sources and use of this source is not restricted, consider using this information if it more accurately answers the question, unless otherwise specified.
- If, after due diligence, the abstractor determines that a value is not documented, or the abstractor is not able to determine the answer value, the abstractor must select UTD as the answer.
- Hospitals often label forms and reports with unique names or titles. Suggested Data Sources are listed by commonly used titles; however, information may be abstracted from any source that is equivalent to those listed.

Inclusions/Exclusions

- Inclusions are acceptable terms that should be abstracted as positive findings (e.g., Yes).

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

Physician/Advanced Practice Nurse/Physician Assistant Documentation

- Advanced Practice Nurse (APN, APRN) titles may vary between state and clinical specialties. Some common titles that represent the advanced practice nurse role are:
  - Nurse Practitioner (NP)
  - Certified Registered Nurse Anesthetist (CRNA)
  - Clinical Nurse Specialist (CNS)
  - Certified Nurse Midwife (CNM)
- When a physician/advanced practice nurse/physician assistant (physician/APN/PA) signs a form or report (e.g., ED sheet with triage and nursing information and a physician/APN/PA has signed somewhere on the form), information on that form/report should be considered physician/APN/PA documentation. Rubber-stamped physician/APN/PA signatures are not acceptable on any document within the medical record. Handwritten, electronic signatures, or facsimiles of original written or electronic signatures are acceptable.
- Resident and intern notes should be considered physician documentation. Medical student notes must be co-signed by a physician.
- For purposes of abstraction, telephone or verbal physician/APN/PA orders (TO/VO) in the medical record are considered physician/APN/PA documentation at the time they were written, regardless of whether or not they were authenticated by the physician/APN/PA at the time of abstraction.
- "Scribe" documentation is acceptable as long as the documentation is signed by the treating physician/APN/PA (CMS "Medicare Program Integrity Manual" Chapter 3, Section 3.3.2.4).

Pharmacist Documentation

Pharmacist titles may vary. The following are some common titles that represent the pharmacist role:

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

Medications

- The approved medication tables contained in Appendix C may not be inclusive lists of all available therapeutic agents acceptable for a particular data element. Discrepancies must be reported.
- For electronic health records (EHRs) only accept documentation that reflects the actual administration of the medication in the context of the chart.
- If a medication in the physician orders has been initialed and signed off with a time, do **not** presume that the medication was administered. The documentation **must** indicate that the medication was actually given.

- For an EMT or ambulance record, there is no need for documentation indicating that the medication was actually given.
    - Example: If the EMT or ambulance record reflects "ASA 325mg po 1300" and no other documentation exists indicating that the medication was actually given (e.g., "given" or "administered"), this is acceptable documentation to abstract.

- Hospitals may allow a patient (or his or her caregiver/support person where appropriate) to self-administer both hospital-issued medications and the patient's own medications brought into the hospital. Hospitals must document the administration of each medication, as reported by the patient (or the patient's caregiver/support person where appropriate) in the patient's medical record [42CFR482.23(c)(6)].

Nursing Care Plans, Standing Orders, and Protocols

- Per Medicare Conditions of Participation [42CFR482.23(b)(4)], hospitals have the option of having a stand-alone nursing care plan or a single interdisciplinary care plan that addresses nursing and other disciplines.
- Hospitals may use pre-printed and electronic standing orders, order sets, and protocols for patient orders if such orders and protocols are dated, timed, and authenticated promptly in the patient's medical record by the ordering practitioner responsible for the care of the patient [42CFR482.24(c)(3)].

Abstraction Recommendations for Multiple Same-Day Encounters

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

Alphabetical Data Element List

Data Element Name: ***Arrival Time***

Collected For: All records (used in algorithms for OP-18)

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:

HH = Hour (00–23)

MM = Minutes (0–59)

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 = 0000 Noon = 1200
  - 5:31 a.m. = 0531 5:31 p.m. = 1731
  - 11:59 a.m. = 1159 11:59 p.m. = 2359

Note: 0000 = midnight. If the time is documented as 0000 11-24-20XX, review supporting documentation to determine if the *Outpatient Encounter Date* should remain 11-24-20XX or if it should be converted to 11-25-20XX.

When converting midnight, or 2400, to 0000, do not forget to change the *Outpatient Encounter Date*.
Example:
- Midnight or 2400 on 11-24-20XX = 0000 on 11-25-20XX.

Notes for Abstraction:
- For times that include seconds, remove the seconds and record the time as is.
  Example:
  - 1500:35 would be recorded as 1500

- If the time of the 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 time) **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 CMS Clinical Data Warehouse. Use of UTD for *Arrival Time* allows the case to be accepted into the Warehouse.
- Review the Only Acceptable Sources to determine the earliest time the patient arrived at the ED or observation. The intent is to utilize any documentation which reflects processes that occurred after the arrival at the ED or after arrival to observation.
- Documentation outside of the Only Acceptable Sources list should **not** be referenced (e.g., ambulance record, physician office record, H&P).
  Examples:
  - ED Triage Time 0800. ED rhythm strip 0830. EMS report indicates patient was receiving EMS care from 0805 through 0825. The EMS report is disregarded. Enter 0800 for *Arrival Time*.
  - ED noted arrival time of 0945. Lab report shows blood culture collected at 0830. It is not clear that the blood culture was collected in the ED because the lab report does not specify it was collected in the ED (unable to confirm lab report as an Only Acceptable Source). Enter 0945 for *Arrival Time*.
- *Arrival Time* should **not** be abstracted simply as the earliest time in one of the Only Acceptable Sources, without regard to other substantiating documentation. When looking at the Only Acceptable Sources, if the earliest time documented appears to be an obvious error, this time should not be abstracted.
  Examples:
  - ED arrival time notes as 2300 on 10-28-20xx. ED MAR shows an antibiotic administration time of 0100 on 10-28-20xx. Surrounding documentation on the ED MAR makes clear that the 10-28-20xx date is an obvious error- Date was not changed to 10-29-20xx. The antibiotic administration date/time would be converted to 0100 on 10-29-20xx. (Please see the note under the Allowable Values section of this data element). Enter 2300 for *Arrival Time*.
  - ED face sheet lists arrival time of 1320. ED Registration Time 1325. ED Triage Time 1330. ED Consent to treat form has 1:17 time but "AM" is circled. ED record documentation suggests the 1:17 AM is an obvious error. Enter 1320 for *Arrival Time*.
  - ED ECG timed as 1742. ED Greet Time 2125. ED Triage Time 2130. There is no documentation in the Only Acceptable Sources which suggests the 1742 is an obvious error. Enter 1742 for *Arrival Time*.
  - ED RN documents on the nursing triage note, "Blood culture collected at 0730." ED arrival time is documented as 1030. There is no documentation in the Only Acceptable Sources which suggests the 0730 is an obvious error. Enter 0730 for *Arrival Time*.
- The source "Emergency Department record" includes any documentation from the time period that the patient was an ED patient.
- The source "Procedure notes" refers to procedures such as cardiac caths, endoscopies, and surgical procedures. Procedure notes do not include ECG and x-ray reports.
- The *Arrival Time* may differ from the admission time.

Observation Status:
- If the patient was admitted to observation from an outpatient setting of the hospital, use the time the patient arrived at the ED or 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 arrived at the ED as the *Arrival Time*.

Suggested Data Sources:

Only Acceptable Sources:
- Emergency Department record, which may include:
  - ED face sheet
  - ED consent/Authorization for treatment forms
  - ED/Outpatient registration/Sign-in forms
  - ED ECG reports
  - ED telemetry/rhythm strips
  - ED laboratory reports
  - ED x-ray reports
- Observation record
- Procedure notes
- Vital signs graphic record

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction:
- Addressographs/stamps
- Pre-printed times on a vital sign graphic record

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 (1907–Current Year)

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

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

Data Element Name: ***Discharge Code***

Collected For: OP-18

Definition: The final place or setting to which the patient was discharged from the outpatient setting.

Suggested Data Collection Question: What was the patient's discharge code from the outpatient setting?

Format:
Length: 2
Type: Alphanumeric
Occurs: 1

Allowable Values:
1 Home
2 Hospice – Home
3 Hospice – Health Care Facility
4a Acute Care Facility – General Inpatient Care
4b Acute Care Facility – Critical Access Hospital
4c Acute Care Facility – Cancer Hospital or Children's Hospital
4d Acute Care Facility – Department of Defense or Veteran's Administration
5 Other Health Care Facility
6 Expired
7 Left Against Medical Advice/AMA
8 Not Documented or Unable to Determine (UTD)

Notes for Abstraction:
- Use the latest documentation. However, if there is documentation that further clarifies the level of care, that documentation should be used to determine the correct value to abstract, even if it is not the latest.
  Example:
  - Nursing discharge note documentation reflects that the patient is being discharged to "XYZ" Hospital. The Social Service notes from the day before discharge further clarify that the patient will be transferred to the rehab unit at "XYZ" Hospital; select Value 5.
- If the medical record states only that the patient is being discharged to another hospital and does not reflect the level of care that the patient will be receiving, select Value 4a.
- When determining whether to select Value 7 ("Left Against Medical Advice"):
  - A signed AMA form is not required for this data element, but in the absence of a signed form, the medical record must contain physician or nurse documentation that the patient left against medical advice or AMA.
  - Do not consider AMA documentation and other disposition documentation as "contradictory." If any source states the patient left against medical advice, select Value 7, regardless of whether the AMA documentation was written last (e.g., AMA form signed and discharge instruction sheet states "Discharged home with belongings"—Select Value 7).
  - Physician order written to discharge to home. Nursing notes reflect that the patient left before discharge instructions could be given; select Value 1.

Suggested Data Sources:

- Discharge instruction sheet
- Nursing discharge notes
- Progress notes
- Emergency Department record
- Physician orders
- Transfer record

Excluded Data Sources:

- UB-04

Inclusion Guidelines for Abstraction:

For Value 1:

- Assisted Living Facilities
- Court/Law Enforcement – includes detention facilities, jails, and prison
- Home – includes board and care, foster or residential care, group or personal care homes, and homeless shelters
- Home with Home Health Services
- Outpatient Services including outpatient procedures at another hospital, Outpatient Chemical Dependency Programs, and Partial Hospitalization

For Value 3:

- Hospice Care – General Inpatient and Respite
- Hospice Care – Residential and Skilled Facilities
- Hospice Care – Other Health Care Facilities (excludes home)

For Value 5:

- Extended or Intermediate Care Facility (ECF/ICF)
- Long Term Acute Care Hospital (LTACH)
- Nursing Home or Facility, including Veteran's Administration Nursing Facility
- Psychiatric Hospital or Psychiatric Unit of a Hospital
- Rehabilitation Facility, including Inpatient Rehabilitation Facility/Hospital or Rehabilitation Unit of a Hospital
- Skilled Nursing Facility (SNF), Sub-Acute Care, or Swing Bed
- Transitional Care Unit (TCU)

Exclusion Guidelines for Abstraction: None

Data Element Name: ***E/M Code***

Collected For: OP-18

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

Suggested Data Collection Question: What was the E/M code documented for this emergency department encounter?

Format:
Length: 5
Type: Alphanumeric
Occurs: 1

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

Suggested Data Sources:
- Outpatient record

Inclusion Guidelines for Abstraction:
- Refer to Appendix A, OP Table 1.0, EM Codes for Emergency Department Encounters.

Exclusion Guidelines for Abstraction: None

Data Element Name: ***ED Departure Date***

Collected For: OP-18

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:
MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)
UTD = Unable to Determine

Notes for Abstraction:

- 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 **and** no other documentation is found that provides this information), the abstractor should select UTD.
  Examples:
  - Documentation indicates the ED departure date was 03-**42**-20xx. No other documentation in the list of Only Acceptable Sources provides a valid date. Since the *ED Departure 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 expired on 02-12-20xx, and all documentation within the Only Acceptable Sources indicates the *ED Departure Date* was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the *ED Departure 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 CMS Clinical Data Warehouse. Use of UTD for *ED Departure Date* allows the case to be accepted into the warehouse.
- If the date the patient departed is unable to be determined from medical record documentation, select 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 date the patient left against medical advice, select UTD.
- For patients who are placed into observation services, use the date of the physician/APN/PA order for observation services as *ED Departure Date*.
- The inclusion and exclusion lists are not to be considered comprehensive lists of inclusions and exclusions.

- If there is a discharge date listed on a disposition sheet, this may be abstracted as *ED Departure Date*.
- **Obstetric ED considerations:**
  - For patients who arrive in the ED and are triaged to Labor and Delivery (L&D) or who receive Emergency care in a L&D Triage unit, and if there is no ED record or if the discharge date is only documented within the L&D record, select UTD for the *ED Departure Date*.

Suggested Data Sources:
Only Acceptable Sources:
- Emergency Department record

Inclusion Guidelines for Abstraction:
- ED departure date
- ED discharge date
- ED leave date

Exclusion Guidelines for Abstraction:
- Disposition date
- Departure or discharge date from an L&D record

Data Element Name: ***ED Departure Time***

Collected For: OP-18

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 (0–59)
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 = 0000 Noon = 1200
  - 5:31 a.m. = 0531 5:31 p.m. = 1731
  - 11:59 a.m. = 1159 11:59 p.m. = 2359

Note: 0000 = midnight. If the time is documented as 0000 11-24-20xx, review supporting documentation to determine if the *ED Departure Date* should remain 11-24-20xx or if it should be converted to 11-25-20xx.

When converting midnight, or 2400, to 0000, do not forget to change the *ED Departure Date*.
Example:
- Midnight or 2400 on 11-24-20xx = 0000 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 service/care.
- For times that include seconds, remove the second and record the time as is.
  Example:
  - 1500:35 would be recorded as 1500.
- 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 ED departure time was 3300. No other documentation in the list of Only Acceptable Sources provides a valid time. Since the *ED Departure 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 CMS Clinical Data Warehouse. Use of UTD for *ED Departure Time* allows the case to be accepted into the warehouse.

- *ED Departure Time* is the documented time the patient physically left the emergency department.
- Do not use the time the discharge order was written because it may not represent the actual time of departure.
- If there is a discharge time listed on the disposition sheet, this may be used for *ED Departure Time*.
- When more than one emergency department departure/discharge time is documented, abstract the latest time.

  Examples:
  - ED nursing notes contain documentation that the patient was transferred to floor at 1800 and transport documentation states that patient left the ED via stretcher at 1815. There are multiple times documented for departure. Use the later time of 1815 as *ED Departure Time*.
  - ED nursing notes contain documentation that the patient departed the ED at 0500. ED record contains documentation of medication administration at 0510 and that the patient departed the ED at 0620. Physician notes contain documentation of an assessment at 0540. As there are multiple departure times documented, enter 0620 for *ED Departure Time*, as it is the latest time documented.
- If the time the patient departed is unable to be determined from medical record documentation, select UTD.

  Example:
  - ED nursing notes documented patient departed from the ED at 1225. Nursing notes document medication administration at 1245. Physician progress notes document assessment at 1310. There is substantial documentation to support that the patient was in the ED after documented departure and no additional documented time of ED departure. Enter UTD for *ED Departure Time*.
- If *ED Departure Time* is documented prior to arrival, abstract as UTD.
- If patient expired in the ED, use the time of death as the departure time.
- The inclusion and exclusion lists are not to be considered comprehensive lists of inclusions and exclusions.

Observation Status:
- For patients who are placed into observation services, use the time of the physician/APN/PA order for observation for *ED Departure Time*.
- If the physician/APN/PA observation order time is after the documented ED departure time, use the documented ED departure time.
- The intent of this guidance is to abstract the time that the patient is no longer under the care of the ED. When a patient is placed into observation, their clinical workflow may vary from patients who are not placed into observation prior to departure from the ED, so the observation order may be used instead of the actual ED departure time.

Obstetric ED considerations:

- For patients who arrive in the ED and are triaged to Labor and Delivery (L&D) or who receive emergency care in a L&D Triage unit, and if there is no ED record or if the discharge time is only

documented within the L&D record, select UTD for the *ED Departure Time*.

- **Suggested Data Sources:**
  Only Acceptable Sources:
  - Emergency Department record

  Inclusion Guidelines for Abstraction:
  - ED leave time
  - ED discharge time
  - ED departure time
  - ED checkout time
  - ED order for observation status
  - Gone time
  - Transfer time
  - The event log, registration sheet, transfer record, etc. (if a discharge time is noted and the document is part of the permanent record)
  - Release Time
  - Out time
  - Transport documented time

  Exclusion Guidelines for Abstraction:
  - Report called time
  - Disposition time
  - Discharge instructions time
  - Coding summary
  - Physician's discharge summary
  - ED record released from holding time
  - Chart closed time
  - Off the tracking board time
  - Departure or discharge time from an L&D record

Data Element Name: ***First Name***

Collected For: All records

Definition: The patient's first name.

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

Format:
Length: 30
Type: Character
Occurs: 1

Allowable Values:
Enter the patient's first name.

Notes for Abstraction: None

Suggested Data Sources:
- Outpatient record
- Emergency Department record

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

Data Element Name: ***Gender Identity***

Collected For: All records (Optional Element) effective July 1, 2024

Definition: A multi-tiered question asking patients to describe their gender identity.
Gender identity is useful as basic demographic information when used with the Sex Assigned at Birth data element.

Suggested Data Collection Question: Which term best describes the patients gender identity?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1 – 6

Allowable Values:
Select all that apply:

1 = Man
2 = Woman
3 = Non-binary
4 = Transgender
5 = None of the Above, Other, or Unable to Determine
6 = Preferred Not to Answer

Notes for Abstraction:
- It is acceptable to select up to six values. If values 5 and/or 6 is selected, it is acceptable to also select values 1, 2, 3, and/or 4.
- If the patient does not describe themselves as non-binary, transgender, and/or describes themself in other terms, select value 5.
- Consider the gender identity to be unable to be determined and select value 5 if the sexual orientation is not documented or not available.

Suggested Data Sources:
- Consultation notes
- Emergency Department record
- Face sheet
- History and Physical
- Nursing admission notes
- Progress notes
- UB-04

Inclusion Guidelines for Abstraction:
Values 3, 4, and 5 includes but are not limited to the following:
- Trans man/Transgender Man/Female to Male (FTM)
- Trans woman/Transgender Woman/Male to Female (MTF)

- Genderqueer
- Genderfluid
- Gender variant
- Questioning or unsure of their gender identity

Exclusion Guidelines for Abstraction: None

Data Element Name: ***Hispanic Ethnicity***

Collected For: All records

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

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

Format:
Length: 1
Type: Character
Occurs: 1

Allowable Values:
Y (Yes) Patient is of Hispanic, Latino, or Spanish ethnicity.

N (No) Patient is not of Hispanic, Latino, or Spanish ethnicity, or unable to determine from medical record documentation.

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

Suggested Data Sources:
- Outpatient record
- Emergency Department record

Inclusion Guidelines for Abstraction:
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
- Colombian
- Ecuadorian
- Dominican
- Guatemalan
- Hispanic
- Latin American
- Latino/Latina
- Mexican-American
- Salvadoran
- Spaniard
- Spanish
- White-Hispanic

Exclusion Guidelines for Abstraction: None

Data Element Name: ***ICD-10-CM Principal Diagnosis Code***

Collected For: OP-18

Definition: The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-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-10-CM code selected as the principal diagnosis for this record?

Format:
Length: 8 (without decimal point or dot)
Type: Alphanumeric
Occurs: 1

Allowable Values:
Any valid diagnosis code as per the CMS ICD-10-CM master code table (Code Descriptions in Tabular Order): https://www.cms.gov/Medicare/Coding/ICD10/index.html

Notes for Abstraction: None

Suggested Data Sources:
- Outpatient record
- Emergency Department record
- UB-04

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

Data Element Name: ***Last Name***

Collected For: All records

Definition: The patient's last name.

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

Format:
Length: 60
Type: Character
Occurs: 1

Allowable Values:
Enter the patient's last name.

Notes for Abstraction: None

Suggested Data Sources:
- Outpatient record
- Emergency Department record

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

Data Element Name: ***Outpatient Encounter Date***

Collected For: All records

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

Suggested Data Collection Question: What was the 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 (20xx)

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

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction:
- Preoperative tests or screening

Data Element Name: ***Patient Identifier***

Collected For: All records

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

A *Patient Identifier* is required.

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

Format:
Length: 40
Type: Character
Occurs: 1

Allowable Values:
Up to 40 letters and/or numbers

Notes for Abstraction: The only characters that will be allowed are spaces, hyphens, dashes and under-scores.

Suggested Data Sources:
- Outpatient record
- Emergency Department record

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

Data Element Name: ***Payment Source***

Collected For: All records

Definition: The source of payment for this outpatient encounter.

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

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

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

Notes for Abstraction:
- If Medicare is listed as the primary, secondary, tertiary, or even lower down on the list of payers, select 1.
- If the patient is an Undocumented Alien or illegal immigrant, select 1.
  Undocumented Alien: Section 1011 of the Medicare Modernization Act of 2003 allows for reimbursement for services rendered to patients who are: Undocumented aliens, aliens paroled into a United States port of entry for the purpose of receiving eligible services, and Mexican citizens permitted to enter the United States for not more than 72 hours under the authority of a laser visa, issued in accordance with the requirements of regulations prescribed under the Immigration and Nationality Act.

Suggested Data Sources:
- Face sheet
- UB-04

Inclusion Guidelines for Abstraction:
Medicare includes, but is not limited to:
- Black Lung
- End Stage Renal Disease (ESRD)
- Medicare Fee-for-Service (includes DRG or PPS)
- Medicare HMO/Medicare Advantage
- Medicare Part A, B, C, D, F, G, K, L, M, and N
- Medicare Secondary Payer
- Railroad Retirement Board (RRB)

Exclusion Guidelines for Abstraction: None

Data Element Name: ***Physician 1***

Collected For: All records (optional element)

Definition: The first physician identifier.

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

Format:
Length: 50
Type: Alphanumeric
Occurs: 1

Allowable Values:
Enter the first physician identifier, as directed. Up to 50 letters, numbers, and/or special characters can be entered.
Note: Only the following special characters will be allowed:
~ ! @ # $ % ^ * ( ) _ + { } | : ? ` - = [ ] \ ; ‘ . , / and space

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

Suggested Data Sources: None

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

Data Element Name: ***Physician 2***

Collected For: All records (optional element)

Definition: A second physician identifier.

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

Format:
Length: 50
Type: Alphanumeric
Occurs: 1

Allowable Values:
Enter the second physician identifiers, as directed. Up to 50 letters, numbers, and/or special characters can be entered.
Note: Only the following special characters will be allowed:
~ ! @ # $ % ^ * ( ) _ + { } | : ? ‘ - = [ ] \ ; . , / and space

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

Suggested Data Sources: None

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

Data Element Name: ***Postal Code***

Collected For: All records

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

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

Format:
Length: 9
Type: Character
Occurs: 1

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

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

Suggested Data Sources:
- Outpatient record
- Emergency Department record
- UB-04

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

Data Element Name: ***Race***

Collected For: All records

Definition: Documentation of the patient's race.

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

Format:
Length: 1
Type: Character
Occurs: 1

Allowable Values:
1 **White:** Patient's race is White, or the patient has origins in Europe, the Middle East, or North Africa.
2 **Black or African American:** Patient's race is Black or African American.
3 **American Indian or Alaska Native:** Patient's race is American Indian/Alaska Native.
4 **Asian or Pacific Islander:** Patient's race is Asian/Pacific Islander.
5 **Retired Value:** effective January 1, 2021, encounters.
7 **UTD:** Unable to determine the patient's race or not stated (e.g., not documented, conflicting documentation, or patient unwilling to provide).

Notes for Abstraction:
- The data element *Hispanic Ethnicity* is required in addition to this data element.
- If documentation indicates the patient has more than one race (e.g., Black-White, Indian-White), select the first listed race.
- Although the terms "Hispanic," "Latino," and "Spanish" are descriptions of the patient's ethnicity, it is not uncommon to find them referenced as race. If the patient's race is documented only as Hispanic, Latino, or Spanish, select "White." If the race is documented as mixed Hispanic/Latino with another race, use whatever race is given (e.g., Black-Hispanic – select "Black"). Other terms for Hispanic, Latino, or Spanish include Chicano, Cuban, H (for Hispanic), Latin American, Latina, Mexican, Mexican-American, Puerto Rican, and South or Central American.

Suggested Data Sources:
- Outpatient record
- Emergency Department record

Inclusion Guidelines for Abstraction:

Black or African American: A person having origins in any of the black racial groups of Africa (e.g., Jamaican, Haitian, Nigerian, Ethiopian, Somali, Negro).

American Indian or Alaska Native: A person having origins in any of the original peoples of North America (including Central America) and who maintains tribal affiliation or community attachment (e.g., any recognized tribal entity in North and Central America, Native American).

Asian or Pacific Islander: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia,

Pakistan, the Philippine Islands, the Pacific Islands, Native Hawaiian, Guam, Samoa, Thailand, and Vietnam.

White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa (e.g., German, Irish, English, Italian, Lebanese, Egyptian).

Exclusion Guidelines for Abstraction: None

Data Element Name: ***Sex Assigned at Birth***

Collected For: All records (effective July 1, 2024)

Definition: The patient's biological sex assigned at birth. Collecting the sex that is assigned at birth is useful as basic demographic information when used with the Gender Identity data element.

Suggested Data Collection Question: What was the patient's reported sex assigned at birth?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 = Female
2 = Male
3 = Intersex
4 = None of the Above, Other, or Unable to Determine
5 = Preferred Not to Answer

Notes for Abstraction:
- Collection of this data element can be self-administered, or interviewer administered.
- Intersex is a general term used to refer to individuals born with, or who develop naturally in puberty, biological sex characteristics that are typically male or female.
- If the patient does not describe themselves as female, male, intersex, describes themself in other terms or if the medical record does not include information about the patient's biological sex assigned at birth, select value 4.
- Consider the sex to be unable to be determined and select value 4 if there is contradictory documentation or if the sex assigned at birth is not documented or not available.

Suggested Data Sources:
- Consultation notes
- Emergency Department record
- Face sheet
- History and Physical
- Nursing admission notes
- Progress notes
- UB-04

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

Data Element Name: ***Sexual Orientation***

Collected For: All records (Optional Element) effective July 1, 2024

Definition: A multi-part question which describes the patient's sexual orientation including:

- Identity: A person's core internal sense of their sexuality.
- Attraction: A multidimensional concept that includes the gender(s) to which a person is attracted and the strength of this attraction, including whether a person feels attraction at all.
- Behavior: A multidimensional concept that includes the gender(s) of sexual partners, specific sexual activities, and frequency of activities.

A person's sexual orientation does not always align with behavior or attraction. This data element is useful as basic demographic information.

Suggested Data Collection Question: Which term best represents how the patient thinks of themselves?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 = Gay
2 = Lesbian
3 = Straight (Not Gay or Lesbian)
4 = Bisexual
5 = None of the Above, Other, or Unable to Determine
6 = Preferred Not to Answer

Notes for Abstraction:

- If the patient does not describe themselves as gay, lesbian, straight, or bisexual and/or describes themself in other terms, select value 5.
- Consider the sexual orientation to be unable to be determined and select value 5 if there is contradictory documentation or if the sexual orientation is not documented or not available.

Suggested Data Sources:

- Consultation notes
- Emergency Department record
- Face sheet
- History and Physical
- Nursing admission notes
- Progress notes
- UB-04

Inclusion Guidelines for Abstraction:
Value 5 includes but is not limited to the following:

- Queer
- Polysexual, omnisexual, sapiosexual, or pansexual
- Asexual
- Two-spirit
- Has not figured out or is in the process of figuring out their sexuality
- Mostly straight, but sometimes attracted to people of their own sex
- Does not think of themselves as having sexuality
- Does not use labels to identify themselves
- Does not know the answer

Exclusion Guidelines for Abstraction: None

Missing and Invalid Data

Introduction

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

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

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

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

- *Birthdate*, *CPT® Code*, *E/M Code*, *ICD-10-CM Principal* and *Outpatient Encounter Date* do not have a UTD allowable value for data transmission. Encounter records containing UTD for any of these data elements are rejected when submitted.
- Date, time, and numeric data elements, other than *Birthdate* and *Outpatient Encounter Date*, have a UTD allowable value option.
  - Rate-based algorithms evaluate records to a Measure Category Assignment = D (failed) when a date, time, or numeric data element containing an allowable value of UTD is evaluated.
  - Continuous variable algorithms evaluate records to a Measure Category Assignment = Y (UTD value exists) when a date, time, or numeric data element containing an allowable value of UTD is evaluated.
  - The method by which data collection software collects UTD information is determined by each software vendor, except the software cannot automatically default to a UTD answer. The decision to enter a UTD for each data element must be made by the abstractor, not the software.
- Yes/No data elements: The allowable value No incorporates UTD into the definition. Refer to the measure algorithms in which each Yes/No data element is used to determine how the record is treated.
- Data elements containing two or more categorical values: The UTD value is either classified as a separate allowable value or included in the same category as "None of the above/Not documented." Refer to the measure algorithms in which each categorical data element is used to determine how the record is treated.

Missing and Invalid Data

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

- The majority of general data elements that are missing data* cause the encounter record to be rejected. Refer to the Data Dictionary Introduction in this manual for the complete list of general data elements.

- In addition, if both the *ICD-10-CM Principal Diagnosis Code* and the CPT® Code data elements are missing data*, the entire record will be rejected.
- Not all patients have *ICD-10-CM Other Diagnosis Codes*. Records will be accepted for missing data for this data element.
- Measure-specific data elements that are missing data* cause the record to be rejected if any measure algorithm results in a Measure Category Assignment = X (missing data). If no measure evaluates to a category assignment of X, the record will be accepted.
- General and measure-specific data elements that contain invalid data cause the record to be rejected.

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

Abstraction Software Skip Logic and Missing Data

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

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

Missing, Invalid, UTD Data Summary

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

Population and Sampling Specifications

Introduction

Population

Defining the population is the first step to estimate a hospital's performance. A population is generally defined as a collection of patients sharing a common set of universally measured characteristics, such as an ICD-10-CM Principal Diagnosis or CPT® Code. The outpatient population and diagnosis/CPT® codes meet this description for the rural emergency hospital quality measures. For the purpose of measuring rural emergency hospital quality measures, the term "outpatient population" is defined below:

- An outpatient population refers to all patients (Medicare and non-Medicare) who share a common set of specified, administratively derived data elements. This may include ICD-10-CM diagnosis codes, CPT® codes, or other population characteristics such as age.
- Population sampling algorithms have been developed for the selected six measures. Each algorithm defines the initial population on the basis of a limited number of criteria such as age, CPT® codes (including Evaluation/Management [E/M] codes), and ICD-10-CM codes. These basic data elements could be easily obtained from electronic files (e.g., from the billing department) and usually allow a computer-based sampling process to be employed.

The measure sets and measure populations are presented in **Table 1** below.

Table 1: Rural Emergency Hospital Measure Sets and Measure Populations

Measure Set:	**ED-Throughput**
Population:	Throughput
Measure(s):	OP-18

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

Sampling

Sampling is a process of selecting a representative part of a population in order to estimate the hospital's performance without collecting data for its entire population. Using a statistically valid sample, a hospital can measure its performance in an effective and efficient manner. Sampling is a particularly useful technique for performance measures that require primary data collection from a source such as the medical record.

Sampling should not be used unless the hospital has a large number of cases in the outpatient population because a fairly large number of sample cases are needed to achieve a representative sample of the population. For the purpose of sampling rural emergency hospital quality measures, the terms "sample," "effective sample," and "case" are defined below:

- The "sample" is the fraction of the population that is selected for further study.
- "Effective sample" refers to the part of the sample that makes it into the denominator of an outpatient measure set. This is defined as the sample for an outpatient measure set minus all the exclusions and contraindications for the outpatient measure set in the sample.
- A "case" refers to a single record (or an encounter) within the population. For example, during the first quarter a hospital may have 600 patients for the OP-18 measure. The hospital's outpatient population

would include 600 cases or 600 outpatient records for this measure during the first quarter. To obtain statistically valid sample data, the sample size should be carefully determined, and the sample cases should be randomly selected in such a way that the individual cases in the population have an equal chance of being selected. Only when the sample data truly represent the whole population can the sample- based performance outpatient measure set data be meaningful and useful. Each hospital is ultimately responsible for adhering to the sampling requirements outlined in this manual.

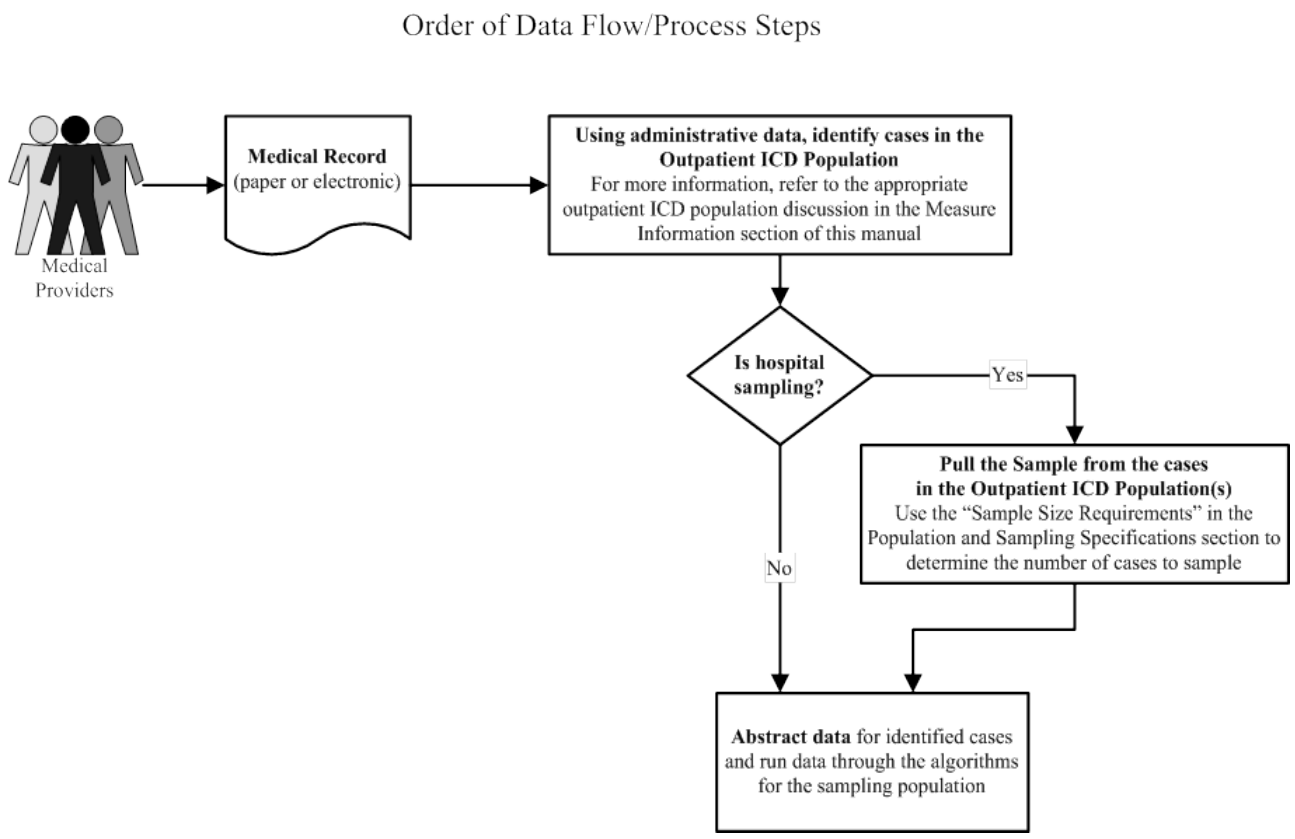
As a general rule/policy of CMS, providers are encouraged to submit as many cases as possible up to the entire population of cases if reasonably feasible. For example, if the raw data can be easily extracted from an existing electronic database or the abstraction burden is manageable, providers should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

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

Order of Data Flow

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

- First, identify the outpatient population for the outpatient measure set. An outpatient population is defined for each outpatient measure set, and the count is collected in the *Outpatient Population Size* data element. This data pull utilizes administrative data such as ICD-10-CM diagnosis codes, CPT® codes, outpatient encounter date, and birthdate.
  - All ICD-10-CM diagnosis codes and CPT® codes included in the appropriate outpatient population definition must be applied. This identification process must be completed prior to application of the data integrity filter, outpatient measure set exclusions, and sampling methodology.
  - For specific outpatient measure set definitions, refer to the appropriate outpatient population discussion in the Measure Information section of this manual.
- Second, if the hospital is sampling, use the outpatient population identified above and pull the sample of medical records for each outpatient measure set using the requirements identified in the Quarterly Sampling Requirements section.
- Third, collect or abstract from the identified medical records the general and outpatient measure set-specific data elements that are needed for the sampling population. The count of the number of cases used in this step is collected in the *Outpatient Sample Size* data elements (If the hospital is not sampling, the *Outpatient Sample Size* will equal the *Outpatient Population Size*).
  - If the hospital is not sampling, use all medical records identified in the outpatient population.
  - If the hospital is sampling, use the medical records from the cases in the identified sample.



Sample Size Requirements

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

- A five percent margin of error is recommended. The margin of error is the extent of error the investigator is willing to tolerate. Lower margins of error (e.g., three percent) would require substantially larger sample sizes and generate more reliable results from the samples, but the burden of abstraction may not be acceptable for most providers. Inversely, higher margins of error would require relatively smaller sample sizes but less reliable results from those samples.
- For OP-18, to reduce the burden of abstraction for smaller hospitals, a 10 percent margin of error was employed to limit the number of cases for the sample size requirements.
- The size of the population, also referred to as the universe population, is the volume of eligible patients from which the sample will be drawn. This number is obviously expected to vary widely among providers. Different sample size estimates are provided for various populations. See Tables 2 for sample size requirements for OP-18.

- Given that the number of cases in the sample could further be reduced during the analysis phase due to missing data in the medical records and additional outpatient measure set-specific exclusion criteria, hospitals are strongly advised to overestimate their sample sizes by 10 to 20 percent, or as much as possible.
- A hospital may choose to use a larger sample size than is required.
- Hospitals whose outpatient population size is less than the minimum number of cases for the sampling population must include all eligible cases in their data.
- As a quality check to ensure that sampling methodology was applied correctly, the provider must run a basic comparative analysis of common demographic variables including age distribution, gender ratio, race/ethnicity distribution, and the proportion of Medicare patients between the sampled set and the population of eligible patients. The relative frequencies or distribution of these common variables should be very close between the two data sets. Any significant discrepancy should trigger a review and a restart of the sampling process.
- As indicated earlier, the adequacy of the sample size will be monitored as the project progresses and revised, as needed. Providers that choose to sample are responsible for the sampling process. However, for each sampled case, providers are required to clearly indicate the sample size (n) to which the case belongs, the population size (N) from which the sample was drawn, and the proportion of Medicare and non-Medicare patients in the sample.

Sampling Requirements

A hospital may choose to use a larger sample size than is required. Hospitals whose population size is less than the minimum number of cases per quarter for the measure set cannot sample. Refer to **Table 2** to determine the minimum number of cases that need to be sampled for each population per quarter per hospital for OP-18.

It is important to point out that if a hospital elects to use the monthly sampling guidelines, the hospital is still required to meet the minimum sampling requirements. Given the potential for substantial variation in monthly sampling population sizes, the monthly sample sizes should be based on the known or anticipated population size. When necessary, appropriate oversampling should be employed to ensure that the hospital meets the minimum sample size requirements.

Table 2: Sample Size Requirements per Quarter per Hospital for OP-18

Population Per Quarter	**0–900**
Quarterly Sample Size	63
Monthly Sample Size	21
Population Per Quarter	**≥ 901**
Quarterly Sample Size	96
Monthly Sample Size	32

Sampling Approaches

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

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

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

Transmission of Outpatient Population and Sample Data Elements

Refer to the *QualityNet* website or the Rural Emergency Hospital (REH) Quality Measure Data Transmission section of this manual for the most current CMS Rural Emergency Hospital Quality Reporting Program submission requirements for transmission of outpatient population and sample count data elements to the CMS Clinical Data Warehouse. Transmission of outpatient population and sample count data elements are used to assist in evaluating completeness of submission in accordance with CMS sampling requirements.

All ICD-10-CM diagnosis codes and CPT® codes included in the appropriate outpatient population definition must be applied. This identification process must be completed prior to the application of a data integrity filter, outpatient measure set exclusions, and sampling methodology. For specific definitions, refer to the appropriate outpatient population in this manual.

The outpatient population and sample data elements are:

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

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

Rural Emergency Hospital Quality Measure Data Transmission

Introduction

This section of the manual is provided to highlight the unique data transmission specifications for hospital outpatient measure data for the Centers for Medicare & Medicaid Services (CMS) and the Hospital Quality Reporting (HQR) system.

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

The Guidelines for Submission of Data section provides the user with the data standards required for submission to HQR. It includes an overview of the data required for submission HQR, as well as the *Rural Emergency Hospital Clinical Data XML file layout* and the *Rural Emergency Hospital Population Data XML File Layout*.

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

The Transmission Data Processing Flow contains information regarding the order in HQR evaluates the hospital outpatient measures.

IMPORTANT SUBMISSION ALERT!!

To submit Rural Emergency Hospital (REH) Quality Reporting Program measures to CMS, files must meet the specifications found only in this CMS manual. Otherwise, the files will be rejected for not meeting CMS quality data submission requirements and providers may not receive the full payment update.

Guidelines for Submission of Data

Data collected for CMS are transmitted to the Hospital Quality Reporting (HQR) Data Submission File. All data submitted are required to meet transmission requirements. The file layout requirements are included in this section.

Submission Threshold

In order to reduce the burden on hospitals that treat a low number of patients but otherwise meet the submission requirements for a particular quality measure, hospitals that have five or fewer cases in a quarter (both Medicare and non-Medicare) for any measure set (i.e., ED Throughput) will **not** be required to submit patient-level data for the entire measure set for that quarter.

Submission of Rural Emergency Hospital Clinical Data

Hospital outpatient clinical data are submitted to the HQR Data Submission File on a quarterly submission schedule. All clinical data submitted to HQR must adhere to the *Rural Emergency Hospital Clinical Data XML File Layout* specifications provided later in the transmission section.

Each case must have a separate XML file. For example, if you have 12 records that you have abstracted, you must have 12 separate XML files. If you have abstracted more than one hospital outpatient measure set for a patient encounter, then a separate XML file must be created for each hospital outpatient measure set. Each hospital outpatient measure can only be abstracted once for the same medical record.

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

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

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

Data Submission Verification
Prior to processing measure outcomes, all data will be verified according to the rules in the Data Transmission section and the edits documents. Cases submitted to HQR that do not meet the requirements outlined in these documents will be rejected.

Requirements for XML Tags and Associated Data
Do not put spaces between XML tags and associated data. Cases with inappropriate spaces will be rejected from HQR.

Export File Character Limitations
Cases exported for submission to HQR may not have greater than 50 characters in the file name.

Missing Data Policy
All cases submitted to HQR must have all data required to calculate the measures. Files submitted, which are missing data required to calculate measures (any case that would result in a Measure Category X assignment), will be rejected from the warehouse. These cases should be reviewed by the provider, corrected, and resubmitted prior to the submission deadline with an allowable value indicated for any data element that was missing. Please refer to the Missing and Invalid Data Section for additional information.

Required Patient Identifiers Based on Payment Source
All cases submitted to HQR are required to include the Patient Identifier. Please refer to the Data Dictionary for the definition of this data element.

Unique Record Key (What fields make a record unique?)
CMS Certification Number, Patient Identifier, Arrival Time, Outpatient Encounter Date, and Outpatient Measure Set.

Principal and Other Diagnosis Codes
Effective March 1, 2007, the National Uniform Billing Committee implemented a Present on Admission (POA) indicator for Principal and other Diagnosis codes. These POA indicators do not apply to outpatient billing and should not be present on outpatient claims. Therefore, data submitted to HQR must have any POA Indicator removed prior to submission. Failure to remove the indicator will result in cases being rejected from HQR.

Hospital Outpatient Clinical Data XML File Layout
The XML file layout is divided into the following sections. Please refer to the Rural Emergency Hospital Clinical Data XML file layout example for details on how the file elements are nested.

Submission – Parent element. This is a **required** element.

The following attributes identify the initiative and file content of this element:

1. **type** – Describes the setting for which the data are being submitted (REH or OUTPATIENT).
2. **data** – Describes the type of data being submitted (CLINICAL).
3. **version** – The version of the file layout (1.0).
4. **action-code** – Describes the intended action of the file being submitted (ADD or DELETE). **Note:** In order to replace or delete an existing case utilizing the action–code ADD or DELETE, the following data element values must match:
   - *CMS Certification Number (provider-id),*
   - *Patient Identifier (patient-id),*
   - *Arrival Time (arrival-time),*
   - *Encounter Date (encounter-date),* and
   - *Measure Set (encounter measure-set).*

file-audit-data – Sub-element of "*submission*" used to identify file characteristics. This sub-element is **not required** for the parent element "*submission"* and has no attributes.

The following identifies the file content on the "*file-audit-data"* sub-element. This file content is **not a required** sub-element of *"file-audit-data"* and has attributes.

1. **create-date –** Sub-element of "*file-audit-data*" identifying the month, day, and year the file was created.
2. **create-time –** Sub-element of "*file-audit-data*" identifying the hour and minutes representing the time the file was created.
3. **create-by –** Sub-element of "*file-audit-data*" identifying the entity creating the file.
4. **version –** Sub-element of "*file-audit-data*" identifying the version of the file being submitted.
5. **create-by-tool –** Sub-element of "*file-audit-data*" identifying the tool used to create the file.

abstraction-audit-data – Sub-element of "*submission*" identifying characteristics of the abstraction. This sub-element is not required for the parent element "*submission*" and has no attributes.

The following identifies the file content of the "*abstraction-audit-data*" sub-element. This file content is **not a required** sub-element of "*abstraction-audit-data*" and has no attributes.

1. **abstraction-date –** Sub-element of "*abstraction-audit-data*" identifying the month, day, and year the abstraction was created.
2. **abstractor-id –** Sub-element of "*abstraction-audit-data*" identifying the abstractor.
3. **total-abstraction-time –** Sub-element of "*abstraction-audit-data*" identifying the total time in seconds required to abstract the information,
4. **comment –** Sub-element of "*abstraction-audit-data*" containing abstractor comments.

provider – Required sub-element of "*submission*" identifying provider, patient, and encounter information. This sub-element and the file content listed below have no attributes.

1. **provider-id – Required** sub-element of "*provider*" identifying the provider's CMS Certification Number (CCN).
2. **npi –** Sub-element of "*provider*" identifying the provider's National Provider Identifier (NPI). This is not a required sub-element of "*provider.*"

patient – Required sub-element of "*provider*" identifying patient demographics. This sub-element has no attributes.

1. **first-name –** Sub-element of "*patient*" providing the patient's first name. This is not a required sub-element of "*patient*" and has no attributes.
2. **last-name –** Sub-element of "*patient*" providing the patient's last name. This is not a required sub-element of "*patient*" and has no attributes.

3. **birthdate –** Sub-element of "*patient*" providing the patient's birthdate. This is a **required** sub-element of "*patient*" and has no attributes.
4. **sex-birth –** Sub-element of "*patient*" identifying the patient's sex assigned at birth. This is a **required** sub-element of "*patient*" and has no attributes.
5. gender-identity – Sub-element of "patient" describing the gender-identity of the patient. This is not a required sub-element of "patient" and has no attributes.
6. sexual-orientation – Sub-element of "patient" describing the patient's sexual orientation. This is not a required sub-element of "patient" and has no attributes.
7. **race –** Sub-element of "*patient*" identifying the patient's race. This is a **required** sub-element of "*patient*" and has no attributes.
8. **ethnic –** Sub-element of "*patient*" identifying the patient's Hispanic ethnicity. This is a **required** sub-element of "*patient*" and has no attributes.
9. **postal-code –** Sub-element of "*patient*" providing the patient's ZIP code. This is a **required** sub-element of "*patient*" and has no attributes.

encounter – Required sub-element of "*patient*" identifying the measure set and the patient's abstracted data. The following attributes identify the initiative and file content of this element:

1. **measure set –** Identifies the measure set for which the data were abstracted. The attribute of "encounter" identifies the measure set.
2. **encounter-date – Required** sub-element of "encounter" identifying the month, day, and year the patient encounter occurred. This sub-element has no attributes.
3. **arrival-time – Required** sub-element of "*encounter*" providing the patient's arrival time. This sub-element has no attributes.
4. **patient-id – Required** sub-element of "*encounter*" identifying the patient associated with the abstracted data. This sub-element has no attributes.

detail – Required sub-element of "*encounter*" identifying the provider-abstracted information. The following attributes of "*detail*" identify the abstracted information.

1. **question-cd –** Question being asked of the abstractor.
2. **answer-cd –** Answer identification code provided by the abstractor.
3. **row-number –** Sequential number identifying each response to a multiple answer question.

answer-value – Sub-element of "*detail*" providing the answer value text attributable to the answer-cd. This is **not a required** sub-element of "detail" and has no attributes

Example of nested Hospital Outpatient Clinical XML file elements:

- submission (plus attributes type, data, version, and action-code)
  - file-audit-data
    - create-date
    - create-time
    - create-by
    - version
    - create-by-tool
  - abstraction-audit-data
    - abstraction-date
    - abstractor-id
    - total abstraction-time
    - comment
  - provider
    - provider-id

- npi
- patient
  - first-name
  - last-name
  - birthdate
  - sex-birth
  - gender-identity
  - sexual-orientation
  - race
  - ethnic
  - postal-code
  - encounter (plus attribute measure-set)
    - encounter-date
    - arrival-time
    - patient-id
    - detail (plus attributes answer-code, question-cd, row-number)
      - answer-value

To obtain further information about these questions and their possible attribute values, refer to the applicable data element names (as identified in the first column, Question of the Clinical Data Elements worksheet) in Section 2, Data.

Rural Emergency Hospital Population Data XML File Layout
The XML file layout is divided into the following sections. Please refer to the *Rural Emergency Hospital Population Data XML File Layout* example for details on how the file elements are nested.

submission – Parent element. This element **is required.**
The following attributes identify the initiative and file content of this element.

1. **type –** Describes the setting for which the data are being submitted (REH).
2. **data –** Describes the type of data being submitted (POPULATION).
3. **version –** The version of the file layout (1.0).
4. **action-code –** Describes the intended action of the file being submitted (ADD).
   Note: In order to replace an existing case utilizing the action-code ADD, the following data element values must match.
   - *CMS Certification Number* (provider-id),
   - Time period start date (time-period start-date),
   - Time period end date (time-period end-date), and
   - *Measure Set* (encounter measure-set).

file-audit-data – Sub-element of "submission" used to identify file characteristics of the file. This sub-element and the file content listed below **are not required** and have no attributes.
The following identify the file content of the "*file-audit-data*" sub-element:

1. **create-date –** Sub-element of "*file-audit-data*" identifying the month, day, and year the file was created.
2. **create-time –** Sub-element of "*file-audit-data"* identifying the hours and minutes representing the time the file was created.
3. **create-by –** Sub-element of "*file-audit-data"* identifying the entity creating the file.
4. **version –** Sub-element of "*file-audit-data*" identifying the version of the file being submitted.
5. **create-by-tool –** Sub-element of "*file-audit-data*" identifying the tool used to create the file.

provider – **Required** sub-element of "*submission*" identifying encounter period and population data.

There are no attributes for this element.

1. **provider-id –** Sub-element of "*provider*" identifying the provider.
2. **npi –** Sub-element of "*provider"* identifying the provider's National Provider Identifier (NPI). This is not a required sub-element of "provider."

time-period – **Required** sub-element of "*provider*" with attributes of delimiting the encounter period.

1. **start-date –** The starting month, day, and year for the encounters associated with the submitted data.
2. **end-date –** The ending month, day, and year for the encounters associated with the submitted data. **Note:** Dates in these fields should reflect the encounter time period related to the data being submitted. Time period start and end dates must reflect full month increments and not be greater than one month. Files submitted to HQR are required to contain three one-month time-periods comprising the calendar quarter for which data are being submitted.
   Example
   If the Rural Emergency Hospital Population Data file is being submitted for the second quarter of 2025, the file must contain the following time periods and appropriate associated data (including all data elements as the Population Details section that follows):
   April 2025
   May 2025
   June 2025

   Files submitted with time periods that do not meet the above requirements will be rejected from HQR.

encounter – **Required** sub-element of "*time-period*" identifying the measure set and the population. The following attributes identify the file content of this element:

1. **measure set –** Identifies the outpatient measure set for which the case was abstracted.
2. **population size**– **Required** sub-element of "*encounter*" identifying population components. There are no attributes for this element.
   a. **Medicare** – **Required** sub-element of "*population-size*" identifying the numbers of Medicare submissions. There are no attributes for this element.
   b. **non-Medicare** – **Required** sub-element of "*population-size*" identifying the number of non-Medicare submissions. There are no attributes for this element.
3. **sampling frequency** – **Required** sub-element of "*encounter*" identifying if the provider is sampling. This sub-element has no attributes.
4. **sample-size** – **Required** sub-element of "*encounter*" identifying sampled population sizes. This sub-element has no attributes.
   a. **Medicare** – **Required** sub-element of "*sample-size*" identifying the number of Medicare submissions in the sample. There are no attributes for this element.
   b. **non-Medicare** – **Required** sub-element of "*sample-size*" identifying the number of non-Medicare submissions in the sample. There are no attributes for this element.

Example of nested Rural Emergency Hospital Population XML file elements: The XML file elements are nested as follows:

- submission (plus attributes type, data, version, and action-code)
  - file-audit-data
    - create-date
    - create-time
    - create-by
    - version

        - create-by-tool
    - provider
        - provider-id
        - npi
        - time period (plus attributes start-date and end-date)
            - encounter (plus attribute measure-set)
            - population-size
                - Medicare
                - non-Medicare
            - sampling-frequency
            - sample-size
                - Medicare
                - non-Medicare

Please refer to the Transmission Data Element List for further definition of the data elements. Please refer to *Rural Emergency Hospital Population Data XML File Layout* for further information on details of the XML file format. All data elements are based on encounters that occurred during the associated time period.

Transmission Data Element List

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

Element Name	Page #	Collected For:
CMS Certification Number	5-9	All Records
National Provider Number (NPI)	5-10	Optional for All Records
Outpatient Measure Set	5-11	Used in transmission of the Hospital Outpatient Population Data XML file and the Hospital Outpatient Clinical Data XML file
Outpatient Population Size – Medicare Only	5-12	Used in transmission of the Hospital Outpatient Population Data XML file
Outpatient Population Size – Non-Medicare Only	5-13	Used in transmission of the Hospital Outpatient Population Data XML file
Outpatient Sample Size – Medicare Only	5-14	Used in transmission of the Hospital Outpatient Population Data XML file
Outpatient Sample Size – Non-Medicare Only	5-15	Used in transmission of the Hospital Outpatient Population Data XML file
Outpatient Sampling Frequency	5-16	Used in transmission of the Hospital Outpatient Population Data XML file

IMPORTANT SUBMISSION ALERT!!

To submit Rural Emergency Hospital (REH) Quality Reporting Program measures to CMS, files must meet the specifications found only in this CMS manual. Otherwise, the files will be rejected for not meeting CMS quality data submission requirements and providers may not receive the full payment update.

Data Element Name: ***CMS Certification Number***

Collected For: All records

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

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

Format:
Length: 6
Type: Character
Occurs: 1

Allowable Values:
Any valid six-character CMS Certification Number.

The first two digits are the numeric or alphanumeric state code. The third digit of zero represents an acute facility. The third digit of "1" and fourth digit of "3" represents a Critical Access Hospital (CAH).

Notes for Abstraction: None

Suggested Data Sources: None

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

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

Collected For: Optional for all records

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

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

Format:
Length: 10
Type: Character
Occurs: 1

Allowable Values: Any valid 10-digit NPI number.

The 10th digit is a numeric check digit based off the first 9 digits.

Notes for Abstraction: None

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

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

Data Element Name: ***Outpatient Measure Set***

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

Definition: Indicates which Rural Emergency Hospital measure set is being transmitted for the hospital.

Suggested Data Collection Question: Not Applicable.

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

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

Notes for Abstraction: None

Suggested Data Sources: Not Applicable

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

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

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

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

Definition: Indicates the number of encounter records identified for a hospital with Medicare listed as a payment source prior to the application of data integrity filters, measure exclusions, and/or sampling methodology for the specified time period.

The data element is based on the hospital's initial identification of Medicare encounter records for a hospital outpatient measure set. *Outpatient Population Size – Medicare Only* includes all patients that are billed under Medicare or Title 18. Medicare can be listed as a primary, secondary, tertiary, or lower on the list of payment sources for the patient. In addition, patients who are participating as a member of a Medicare HMO/Medicare Advantage are included in the Medicare counts (e.g., Medicare Blue, Humana Gold, Secure Horizons, AARP, Coventry Advantra). This initial data pull utilizes administrative data such as ICD-10-CM diagnosis codes, CPT® codes, outpatient encounter date, and birthdate.

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

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

Suggested Data Collection Question: Not Applicable.

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

Allowable Values: 0 through 999,999

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

Suggested Data Sources: Not Applicable

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

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

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

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

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

The data element is based on the hospital's initial identification of non-Medicare encounter records for a hospital outpatient measure set. This initial data pull utilizes administrative data such as ICD-10-CM diagnosis codes, CPT® codes, outpatient encounter date, and birthdate.

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

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

Suggested Data Collection Question: Not Applicable.

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

Allowable Values: 0 through 999,999

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

Suggested Data Sources: Not Applicable

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

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

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

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

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

Notes:

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

Suggested Data Collection Question: Not Applicable.

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

Allowable Values: 0 through 999,999

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

Suggested Data Sources: Not Applicable

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

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

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

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

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

Notes:

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

Suggested Data Collection Question: Not Applicable.

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

Allowable Values: 0 through 999,999

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

Suggested Data Sources: Not Applicable

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

Data Element Name: ***Outpatient Sampling Frequency***

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

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

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

Suggested Data Collection Question: Not Applicable.

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

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

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

Suggested Data Sources: Not Applicable

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

Transmission Data Processing Flow

Introduction

This section contains information regarding the order in which the Hospital Quality Reporting (HQR) system evaluates the hospital outpatient measures.

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

Data Processing Flow

All data transmitted pass through the following process:

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

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

2. Data are evaluated to ensure the quarter associated to the *Outpatient Encounter Date* is open for data transmission.
   - If the encounter date is missing or not valid per the calendar year, issue the appropriate critical error message, reject the individual XML file, and stop processing.
   - If the encounter date is valid per the calendar year, continue processing.
   - If the Data Collection quarter is closed, issue the appropriate critical error message, reject the individual XML file, and stop processing.
   - If the Data Collection quarter is open, continue processing.
3. Data are evaluated to ensure the *Outpatient Measure Set* is expected from the submitter for the time frame (*Outpatient Encounter Date*) in question. In addition, HQR verifies the data are expected for *CMS Certification Number*.
   - If the data are not expected, missing, or invalid, issue the appropriate critical error message, reject the individual XML file, and stop processing.
   - If the data are expected, continue processing.
4. Check the action-code.
   - If the action-code = ADD, continue with step #5.
   - If the action-code = DELETE, check submission data type.
   - If the submission data type = POPULATION, issue appropriate critical message and reject file(s).
   - If the submission data type = CLINICAL, continue with step # 13.

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

5. The general data elements, as defined in the Data Dictionary section, are evaluated to ensure they exist and contain valid allowable values. These data elements are generally required for all hospital outpatient measures (with the exception of NPI).
   - If any general data element is missing or invalid, issue the appropriate critical error message(s), reject the individual XML file, and stop processing.
   - If all general data elements exist and contain valid allowable values, continue processing.

6. The Outpatient Population Algorithm associated to the *Outpatient Measure Set* is evaluated to ensure that the data are in the population of the set. Refer to the appropriate *Outpatient Measure Set* Data Element List for the algorithm.
   - If the Outpatient Population Algorithm returns an **Outpatient Population Reject Case Flag** = Yes (case is not in the outpatient population), reject the XML file and stop processing.
   - If the Outpatient Population Algorithm returns an **Outpatient Population Reject Case Flag** = No (case is not in the outpatient population), reject the XML file and stop processing.
7. The *Outpatient Measure Set* specific data elements are evaluated to ensure they contain valid allowable values. This step does not evaluate for missing data because that process is performed by the measure algorithms.
   - If any *Outpatient Measure Set* specific data elements are invalid, issue the appropriate critical error message(s), set the Edit Reject Case Flag = Yes, and continue processing with step #8.
   - If all *Outpatient Measure Set* specific data elements contain valid allowable values, continue processing.
8. If appropriate for the *Outpatient Measure Set*, grid data elements are evaluated to ensure each row does not contain missing data. This step does not ensure that the entire grid is empty because that process is performed by the measure algorithms.
   - If any row of the grid is missing data, issue the appropriate critical error message(s), set the Edit Reject Case Flag = Yes, and continue processing with step #9.
   - If all data elements exist in each row, continue processing.
9. Each XML file is evaluated for unexpected data. While a case may be in the population of more than one outpatient measure set, each XML file is associated to only one set.
   - If any data exist that are not expected for the Outpatient Measure Set, issue the appropriate critical error message(s), set the Edit Reject Case Flag = Yes, and continue processing with step #10.

   If no unexpected data for the *Outpatient Measure Set* exist, continue processing.
10. Evaluate the Edit Reject Case Flag.
    - If the Edit Reject Case Flag = Yes, issue the appropriate critical error message(s), reject the individual XML file, and stop processing.
    - If the Edit Reject Case Flag = No, continue with step #11.
11. Execute each measure algorithm associated to the measures the hospital has selected for the *Outpatient Measure Set*. Refer to the appropriate Measure Information Forms for the *Outpatient Measure Set* for the measure algorithms.
    - If any measure evaluates with a Measure Category Assignment = X, reject the XML file and stop processing.
    - If all measures evaluate with Measure Category Assignment = B, D, E, and/or Y, continue processing.
12. The case is accepted into the HQR system.

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

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

Rural Emergency Hospital Clinical Data XML File Layout v2.0a								
Element Name	**XML Attribute/ question-cd**	**Data Type**	**Field Size**	**Occurs**	**Answer Code**	**Answer Value**	**Applicable Measure(s)**	**Programming Notes**
Discharge Code	Suggested Data Collection Question: What was the patient's discharge code from the outpatient setting?							
	DISCHGCODE	Alphanumeric	2	1	1	Home	OP-18	
					2	Hospice - Home		
					3	Hospice - Health Care Facility		
					4a	Acute Care Facility - General Inpatient Care		
					4b	Acute Care Facility - Critical Access Hospital		
					4c	Acute Care Facility - Cancer Hospital or Children's Hospital		
					4d	Acute Care Facility - Department of Defense or Veteran's Administration		
					5	Other Health Care Facility		
					6	Expired		
					7	Left Against Medical Advice /AMA		
					8	Not Documented or Unable to Determine (UTD)		
ED Departure Date	Suggested Data Collection Question: What is the date the patient departed from the emergency department?							
	EDDEPARTDT	Date	10	1	(MM-DD-YYYY) Must be a valid date: MM (01-12) DD (01-31) YYYY (20xx)	User Entered (MM-DD-YYYY)	OP-18	
					UTD	Unable to Determine		
ED Departure Time	Suggested Data Collection Question: What is the time the patient departed from the emergency department?							
	EDDEPARTTM	Time	5	1	(HH:MM)	User Entered (HH:MM) (Military format with or without colon, HH:MM)	OP-18	
					UTD	Unable to Determine		
E/M Code	Suggested Data Collection Question: What was the E/M Code documented for this outpatient encounter?							
	EMCODE	Alphanumeric	5	1	E/M code	E/M code	OP-18	Refer to Appendix A, OP Table 1.0.

Rural Emergency Hospital Clinical Data XML File Layout v2.0a								
Element Name	**XML Attribute/ question-cd**	**Data Type**	**Field Size**	**Occurs**	**Answer Code**	**Answer Value**	**Applicable Measure(s)**	**Programming Notes**
Physician 1	Suggested Data Collection Question: What is the first physician identifier?							
	PHYSICIAN_1	Character	50	1	Up to 50 letters, numbers, and/or special characters can be entered. Only the following special characters will be allowed: ~ ! @ # $ % ^ * ( ) _ + { } | : ? ' - = [ ] \ ; ` . , / and space	User Entered	Optional Data Element	
Physician 2	Suggested Data Collection Question: What is the second physician identifier?							
	PHYSICIAN_2	Character	50	1	Up to 50 letters, numbers, and/or special characters can be entered. Only the following special characters will be allowed: ~ ! @ # $ % ^ * ( ) _ + { } | : ? ' - = [ ] \ ; ` . , / and space	User Entered	Optional Data Element	
Payment Source	Suggested Data Collection Question: What is the patient's source of payment for this outpatient encounter?							
	PMTSRCE	Alphanumeric	1	1	1	Source of payment is Medicare.	All Records	
					2	Source of payment is Non-Medicare.		
ICD-10-CM Principal Diagnosis Code	Suggested Data Collection Question: What was the ICD-10-CM code selected as the principal diagnosis for this record?							
	PRINDX	Alphanumeric	8	1	ICD-10-CM Diagnosis code -without decimal point or dot	Any valid diagnosis code as per the CMS ICD-10-CM master code table (Code Descriptions in Tabular Order): https://www.cms.gov/Medicare/Coding/ICD10/index.html	OP-18	Refer to Appendix A, ICD-10-CM and CPT Code Tables

Modified to include changes effective with 2024 ENCOUNTER DATES							
XML Element	**Attributes**	**Description**	**Data Element**	**Valid Values**	**Data Type**	**Field Size**	**Data Required**
A header is optional at the beginning of each XML file as follows: <?xml version="1.0" encoding="UTF-8" ?>							
<submission>	Opening tag is required.						
	type	Describes the setting for which data is being submitted.	N/A	REH, OUTPATIENT	Character	20	Yes
	data	Describes the type of data being submitted.	N/A	CLINICAL	Character	20	Yes
	version	The version of the file layout.	N/A	1.0	Character	20	Yes
	action-code	Describes the intended action of the file being submitted	N/A	DELETE, ADD	Character	20	Yes
<file-audit-data> Sub-element of the submission data element	Opening tag for file audit data	**Note:** This tag and the entire <file-audit-data> section are optional in the XML document. If submitted, this tag contains no data. Required if sub-elements are included.					
<create-date> Sub-element of the file audit data element	Each element must have a closing tag that is the same as the opening tag but with a forward slash. **Example with data:** **<create-date>**05-10-2007**</create-date>**						
	None	The month, day, and year the file was created	N/A	(MM-DD-YYYY) Must be a valid date: MM (01-12) DD (01-31) YYYY (20xx)	Date	10	No
<create-time> Sub-element of the file audit data element	Each element must have a closing tag that is the same as the opening tag but with a forward slash. Example with data: **<create-time>**23:01**</create-time>**						
	None	The hour and minutes representing the time the file was created.	N/A	HH:MM (Military format with or without colon)	Time	5	No
<create-by> Sub-element of the file audit data element	Each element must have a closing tag that is the same as the opening tag but with a forward slash. **Example with data:** **<create-by>**VendorA**</create-by>**						
	None	The entity who created the file	N/A	Up to 50 letters, numbers, and/or special characters can be entered. Only the following special characters will be allowed: ~ ! @ # $ % ^ * ( ) _ + { } | : ? ` - = [ ] \ ; ‘ . , / and space	Character	50	No
<version> Sub-element of the file audit data element	Each element must have a closing tag that is the same as the opening tag but with a forward slash. **Example with data:** **<version>**1.0**</version>**						
	None	The version of the file being submitted	N/A		Character	20	No
<create-by-tool> Sub-element of the file audit data element	Each element must have a closing tag that is the same as the opening tag but with a forward slash. **Example with data:** **<create-by-tool>**OPPS 1.3**</create-by-tool>**						
	None	Tool used to create the XML file	N/A	Up to 50 letters, numbers, and/or special characters can be entered. Only the following special characters will be allowed: ~ ! @ # $ % ^ * ( ) _ + { } | : ? ` - = [ ] \ ; ‘ . , / and space	Character	50	No
</file-audit-data>	Closing tag for file audit data	**Note:** This tag and the entire <file-audit-data> section are optional in the XML document, but if the opening tag of <file-audit-data> is provided, then this closing tag is required as well.					

Modified to include changes effective with 2024 ENCOUNTER DATES							
XML Element	**Attributes**	**Description**	**Data Element**	**Valid Values**	**Data Type**	**Field Size**	**Data Required**
<abstraction-audit-data> Sub-element of the submission data element	Opening tag for abstraction audit data	**Note:** This tag and the entire <abstraction-audit-data> section are optional in the XML document. If submitted, this tag contains no data. Required if sub-elements are included.					
<abstraction-date> Sub-element of the abstraction audit data element	Each element must have a closing tag that is the same as the opening tag but with a forward slash. **Example with data:** **<abstraction-date>**05-10-2007**</abstraction-date>**						
	None	The month, day, and year the XML file was abstracted	N/A	(MM-DD-YYYY) Must be a valid date: MM (01-12) DD (01-31) YYYY (20xx)	Date	10	No
<abstractor-id> Sub-element of the abstraction audit data element	Each element must have a closing tag that is the same as the opening tag but with a forward slash. Example with data: **<abstractor-id>**JSMITH**</abstractor-id>**						
	None	User id of who abstracted this encounter.	N/A	N/A	Character	20	No
<total-abstraction-time> Sub-element of the abstraction audit data element	Each element must have a closing tag that is the same as the opening tag but with a forward slash. **Example with data:** **<total-abstraction-time>**1125**</total-abstraction-time>**						
	None	Total time it took for the encounter to be abstracted.	N/A	Time in seconds	Number	22	No
<comment> Sub-element of the abstraction audit data element	Each element must have a closing tag that is the same as the opening tag but with a forward slash. **Example with data:** **<comment>**Information about the abstraction**</comment>**						
	None	Comments about the abstraction.	N/A	Text Up to 4000 letters, numbers, and/or special characters can be entered. Only the following special characters will be allowed: ~ ! @ # $ % ^ * ( ) _ + { } | : ? ` - = [ ] \ ; ‘ . , / and space	Character	4000	No
</abstraction-audit-data>	Closing tag for abstraction audit data	**Note:** This tag and the entire <abstraction-audit-data> section are optional in the XML document, but if the opening tag of <abstraction-audit-data> is provided, then this closing tag is required as well.					
<provider> Sub-element of the submission data element	Opening tag for provider	**Note:** This tag is required in the XML document, however, it contains no data.					
<provider-id> Sub-element of the provider element	Each element must have a closing tag that is the same as the opening tag but with a forward slash. **Example with data:** **<provider-id>**125789**</provider-id>**						
	None	Used to identify the provider	CMS Certification Number	Valid 6 character CMS Certification Number	Character	6	Yes
<npi> Sub-element of the provider element	Each element must have a closing tag that is the same as the opening tag but with a forward slash. **Example with data:** **<npi>**1257894658**</npi>**						
	None	National Provider Identifier as assigned by CMS	National Provider Identifier (NPI)	Valid 10 digit NPI Number	Character	10	No

Modified to include changes effective with 2024 ENCOUNTER DATES							
XML Element	**Attributes**	**Description**	**Data Element**	**Valid Values**	**Data Type**	**Field Size**	**Data Required**
<patient> Sub-element of the provider data element	Opening tag for patient	**Note:** This tag is required in the XML document, however, it contains no data.					
<first-name> Sub-element of the patient element	Each element must have a closing tag that is the same as the opening tag but with a forward slash. **Example with data:** **<first-name>**Ann**</first-name>**						
	None	The patient's first name	First Name	Patient's First Name Up to 30 letters, numbers, and/or special characters can be entered. Only the following special characters will be allowed: ~ ! @ # $ % ^ * ( ) _ + { } | : ? ` - = [ ] \ ; ' . , / and space	Character	30	No
<last-name> Sub-element of the patient element	Each element must have a closing tag that is the same as the opening tag but with a forward slash. **Example with data:** **<last-name>**Smith**</last-name>**						
	None	The patient's last name	Last Name	Patient's Last Name Up to 60 letters, numbers, and/or special characters can be entered. Only the following special characters will be allowed: ~ ! @ # $ % ^ * ( ) _ + { } | : ? ` - = [ ] \ ; ' . , / and space	Character	60	No
<birthdate> Sub-element of the patient element	Each element must have a closing tag that is the same as the opening tag but with a forward slash. **Example with data:** **<birthdate>**08-06-1964**</birthdate>**						
	None	The month, day, and year the patient was born	Birthdate	(MM-DD-YYYY) Must be a valid date: MM (01-12) DD (01-31) YYYY	Date	10	Yes
<sex-birth> Sub-element of the patient element	Each element must have a closing tag that is the same as the opening tag but with a forward slash. **Example with data:** **<sex-birth>**1**</sex-birth>**						
	None	The patient's biological sex assigned at birth. Collecting the sex that is assigned at birth is useful as basic demographic information when used with the Gender Identity data element.	Sex Assigned at Birth	1,2,3,4,5	Alphanumeric	1	Yes
<gender-identity> Sub-element of the patient element	Each element must have a closing tag that is the same as the opening tag but with a forward slash. **Example with data:** **<gender-identity>**1**</gender-identity>**						
	None	A multi-tiered question asking patients to describe their gender identity. Gender identity is useful as basic demographic information when used with the Sex Assigned at Birth data element.	Gender Identity	1,2,3,4,5,6	Alphanumeric	1	NO

Modified to include changes effective with 2024 ENCOUNTER DATES							
XML Element	**Attributes**	**Description**	**Data Element**	**Valid Values**	**Data Type**	**Field Size**	**Data Required**
<sexual-orientation> Sub-element of the patient element	Each element must have a closing tag that is the same as the opening tag but with a forward slash. **Example with data:** **<sexual-orientation>1</sexual-orientation>**						
	None	A multi-part question which describes the patient's sexual orientation including: **Identity:** A person's core internal sense of their sexuality. **Attraction:** A multidimensional concept that includes the gender(s) to which a person is attracted and the strength of this attraction, including whether a person feels attraction at all. **Behavior:** A multidimensional concept that includes the gender(s) of sexual partners, specific sexual activities, and frequency of activities. A person's sexual orientation does not always align with behavior or attraction. This data element is useful as basic demographic information.	Sexual Orientation	1,2,3,4,5,6	Alphanumeric	1	NO
<race> Sub-element of the patient element	Each element must have a closing tag that is the same as the opening tag but with a forward slash. **Example with data:** **<race>**2**</race>**						
	None	Documentation of the patient's race.	Race	1,2,3,4,5,7	Character	1	Yes
<ethnic> Sub-element of the patient element	Each element must have a closing tag that is the same as the opening tag but with a forward slash. **Example with data:** **<ethnic>**Y**</ethnic>**						
	None	Documentation that the patient is of Hispanic or Latino ethnicity	Hispanic Ethnicity	Y,N	Character	1	Yes
<postal-code> Sub-element of the patient element	Each element must have a closing tag that is the same as the opening tag but with a forward slash. **Example with data:** **<postal-code>**50266**</postal-code>**						
	None	The postal code of the patient's residence. For the United States zip codes the hyphen is implied. If the patient is determined to not have a permanent residence, then the patient is considered homeless.	Postal Code	(5 or 9 digit without hyphen, "homeless", or "Non-US")	Character	9	Yes
<encounter> Sub-element of the patient element	Opening tag for measure set	**Example with data:** **<encounter measure-set="ED-THROUGHPUT">**					
	measure-set	The code for the measure set submitted.	Measure Set	ED-THROUGHPUT	Character	22	Yes
<encounter-date> Sub-element of the encounter	Each element must have a closing tag that is the same as the opening tag but with a forward slash. **Example:** **<encounter-date>**04-02-2008**</encounter-date>**						
	None	The month, day, and year the patient was seen in the rural emergency hospital.	REH Encounter Date	(MM-DD-YYYY) Must be a valid date: MM (01-12) DD (01-31) YYYY (20xx)	Date	10	Yes

Modified to include changes effective with 2024 ENCOUNTER DATES							
XML Element	**Attributes**	**Description**	**Data Element**	**Valid Values**	**Data Type**	**Field Size**	**Data Required**
<arrival-time> Sub-element of the encounter	Each element must have a closing tag that is the same as the opening tag but with a forward slash. **Example:** **<arrival-time>**15:14**</arrival-time>**						
	None	The earliest documented time (military time) the patient arrived at the outpatient or emergency department.	Arrival Time	HH:MM (Military format with or without colon or can equal UTD)	Time	5	Yes
<patient-id> Sub-element of the encounter	Each element must have a closing tag that is the same as the opening tag but with a forward slash. **Example with data:** **<patient-id>**74185296374185296385**</patient-id>**						
	None	Identifier used to identify the patient at the hospital	Patient Identifier	Up to 40 letters, numbers, and/or characters. NOTE: The only characters that will be allowed are spaces, hyphens, dashes, and under-scores.	Character	Up to 40	Yes
<detail> Sub-element of the encounter	Since this is the opening element, the closing tag for this element will be at the end of the record. Attributes describe the element and are included within the opening and closing <> **Example of multiple choice question (refer to this workbook's Clinical Data Elements tab for valid answer codes):** **<detail** answer-code="4a" row-number="0" question-cd="DISCHGCODE">** **Example of a user-entered code:** **<detail** answer-code="001.9" row-number="0" question-cd="OTHRDX#">**						
	answer-code	ID number of the answer	Not a data element itself; each possible answer has its own unique ID	**Refer to this workbook's Clinical Data Elements tab for valid values.**	Character	See specific element for field size limits	Yes
	question-cd	The field name of the question	Not a data element itself; each data element is a question code	**Refer to this workbook's Clinical Data Elements tab for valid values.**	Character	20	Yes
	row-number	Used to group answers together for multi-row, multi-column answers	Not a data element; used for grouping answers only	0-20 Depending on the number of rows allowed per question. i.e. Surgery Antibiotic Name would have row-number 0 for the first antibiotic, 1 for the second antibiotic, and so on.	Integer	2	Yes Default to 0. For multiple answer options, add 1 to the row number for each additional answer
<answer-value> Sub-element of detail	The answer value **Example**: <answer-value>No</answer-value>	The description of the answer-code	Not a data element itself; each answer has a value	Place the answer text here. Examples: Yes No 04-01-2008 23:00 **Note: All Dates & Times in this field should be formatted as MM-DD-YYYY and military format with or without colon for HH:MM.**	Character	2000	No

Modified to include changes effective with 2024 ENCOUNTER DATES							
XML Element	**Attributes**	**Description**	**Data Element**	**Valid Values**	**Data Type**	**Field Size**	**Data Required**
</detail>	Closing tag for detail	**Note:** This tag is required in the XML document, however, it contains no data.					
</encounter>	Closing tag for encounter	**Note:** This tag is required in the XML document, however, it contains no data.					
</patient>	Closing tag for patient	**Note:** This tag is required in the XML document, however, it contains no data.					
</provider>	Closing tag for provider	**Note:** This tag is required in the XML document, however, it contains no data.					
</submission>	Closing tag for submission	**Note:** This tag is required in the XML document, however, it contains no data.					

Modified to include changes effective with 2025 ENCOUNTER DATES REHQR v2.0a							
XML Element	**Attributes**	**Description**	**Data Element**	**Valid Values**	**Data Type**	**Field Size**	**Data Required**
A header is optional at the beginning of each XML file as follows: <?xml version="1.0" encoding="UTF-8" ?>							
<submission>	Opening tag						
	type	Describes the setting for which data is being submitted.	N/A	REH	Character	20	Yes
	data	Describes the type of data being submitted.	N/A	POPULATION	Character	20	Yes
	version	The version of the file layout.	N/A	1.0	Character	20	Yes
	action-code	Describes the intended action of the file being submitted	N/A	ADD	Character	20	Yes
<file-audit-data> Sub-element of the submission data element	Opening tag for file data	**Note:** This tag and the entire <file-audit-data> section are optional in the XML document. If submitted, this tag contains no data.					
<create-date> Sub-element of the file-audit-data element	Each element must have a closing tag that is the same as the opening tag but with a forward slash. **Example with data:** **<create-date>**04-13-2007**</create-date>**						
	None	The month, day, and year the file was created	N/A	MM-DD-YYYY (Must be a valid date) MM (01-12) DD (01-31) YYYY (20xx)	Date	10	No
<create-time> Sub-element of the file-audit-data element	Each element must have a closing tag that is the same as the opening tag but with a forward slash. **Example with data:** **<create-time>**23:01**</create-time>**						
	None	The hour and minutes representing the time the file was created.	N/A	HH:MM (Military format with or without colon	Time	5	No

Modified to include changes effective with 2025 ENCOUNTER DATES REHQR v2.0a							
XML Element	**Attributes**	**Description**	**Data Element**	**Valid Values**	**Data Type**	**Field Size**	**Data Required**
<create-by> Sub-element of the file-audit-data element	Each element must have a closing tag that is the same as the opening tag but with a forward slash. **Example with data:** **<create-by>**jsmith**</create-by>**						
	None	The entity who created the file	N/A	Up to 50 letters, numbers, and/or special characters can be entered. Only the following special characters will be allowed: ~ ! @ # $ % ^ * ( ) _ + { } 1 : ? ' - = [ ] \ ; ` . , / and space	Character	50	No
<version> Sub-element of the file-audit-data element	Each element must have a closing tag that is the same as the opening tag but with a forward slash. **Example with data:** **<version>**1.0**</version>**						
	None	The version of the file being submitted	N/A		Character	20	No
<create-by-tool> Sub-element of the file-audit-data element	Each element must have a closing tag that is the same as the opening tag but with a forward slash. **Example with data:** **<create-by-tool>**Tool A**</create-by-tool>**						
	None	Tool used to create the file	N/A	Up to 50 letters, numbers, and/or special characters can be entered. Only the following special characters will be allowed: ~ ! @ # $ % ^ * ( ) _ + { } 1 : ? ' - = [ ] \ ; ` . , / and space	Character	50	No
</file-audit-data>	Closing tag for file data	**Note:** This tag and the entire <file-audit-data> section are optional in the XML document, but if the opening tag of <file-audit-data> is provided, then this closing tag is required as well.					

Modified to include changes effective with 2025 ENCOUNTER DATES REHQR v2.0a							
XML Element	**Attributes**	**Description**	**Data Element**	**Valid Values**	**Data Type**	**Field Size**	**Data Required**
<provider> Sub-element of the submission data element	Opening tag for provider	**Note:** This tag is required in the XML document, however, it contains no data.					
<provider-id> Sub-element of the provider element	Each element must have a closing tag that is the same as the opening tag but with a forward slash. **Example with data:** **<provider-id>**125789**</provider-id>**						
	None	Used to identify the provider	CMS Certification Number	Valid 6 character CMS Certification Number	Character	6	Yes
<npi> Sub-element of the provider element	Each element must have a closing tag that is the same as the opening tag but with a forward slash. **Example with data:** **<npi>**1257894658**</npi>**						
	None	National Provider Identifier as assigned by CMS	National Provider Identifier (NPI)	Valid 10 digit NPI Number	Character	10	No
<time-period> Sub-element of the provider data element	**Example with data:** <time-period start date="04-01-2007" end-date="04-30-2007">						
	start-date	The starting month, day, and year for the encounters associated with the submitted data	Not a data element	MM-DD-YYYY (Must be a valid date) Must be start date of month	Date	10	Yes
	end-date	The ending month, day, and year for the encounters associated with the submitted data	Not a data element	MM-DD-YYYY (Must be a valid date) Must be end date of the month corresponding to the start-date	Date	10	Yes

Modified to include changes effective with 2025 ENCOUNTER DATES REHQR v2.0a							
XML Element	**Attributes**	**Description**	**Data Element**	**Valid Values**	**Data Type**	**Field Size**	**Data Required**
<encounter> Sub-element of the time-period element	**Example with data:** **<encounter measure-set ="ED-THROUGHPUT">**						
	measure-set	Used to identify which of the measure sets the case was abstracted for	Measure Set	ED-THROUGHPUT	Character	22	Yes
<population-size> Sub-element of the encounter	Opening tag for population size	**Sampling determination**					
<medicare> Sub-element of the population-size	Each element must have a closing tag that is the same as the opening tag but with a forward slash. **Example with data:** **<medicare>**200**</medicare>**						
	None	Number of medicare submissions	Outpatient Population Size - Medicare only	0-**999999**	Numeric	**6**	Yes
<non-medicare> Sub-element of the population-size	Each element must have a closing tag that is the same as the opening tag but with a forward slash. **Example with data:** **<non-medicare>**175**</non-medicare>**						
	None	Number of non-medicare submissions	Outpatient Population Size - Non-Medicare only	0-**999999**	Numeric	**6**	Yes
</population-size>	Closing tag for population size						
<sampling-frequency> Sub-element of the encounter	Each element must have a closing tag that is the same as the opening tag but with a forward slash. **Example with data:** **<sampling-frequency>**1**</sampling-frequency>**						
	None	Sampling determination	Outpatient Sampling Frequency	1- Sampling 2 - Not Sampling 3 - N/A, submission of patient-level data is not required	Character	1	Yes

Modified to include changes effective with 2025 ENCOUNTER DATES REHQR v2.0a							
XML Element	**Attributes**	**Description**	**Data Element**	**Valid Values**	**Data Type**	**Field Size**	**Data Required**
<sample-size> Sub-element of the encounter	Opening tag for sample size	**Note:** This tag is required in the XML document, however, it contains no data.					
<medicare> Sub-element of the sample-size	Each element must have a closing tag that is the same as the opening tag but with a forward slash. **Example with data:** **<medicare>**175**</medicare>**						
	None	Number of medicare submissions in sample	Outpatient Sample size-Medicare Only	0-**999999**	Numeric	**6**	Yes
<non-medicare> Sub-element of the sample-size	Each element must have a closing tag that is the same as the opening tag but with a forward slash. **Example with data:** **<non-medicare>**150**</non-medicare>**						
	None	Number of non-medicare submissions in sample	Outpatient Sample size-Non-Medicare Only	0-**999999**	Numeric	**6**	Yes
</sample-size>	Closing tag for sample size	**Note:** This tag is required in the XML document, however, it contains no data.					
</encounter>	Closing tag for measure-set	**Note:** This tag is required in the XML document, however, it contains no data.					
</time-period>	Closing tag for time-period	**Note:** This tag is required in the XML document, however, it contains no data.					
</provider>	Closing tag for provider	**Note:** This tag is required in the XML document, however, it contains no data.					
</submission>	Closing tag for submission	**Note:** This tag is required in the XML document, however, it contains no data.					

Alphabetical Tools and Resources List

Arrival Time: Guidelines

The guidelines are to be applied when abstracting all measures included in the REHQR Program (OP-18):

Remember, the definition of *Arrival Time* is ***"the earliest documented time (military time) the patient arrived at the outpatient or emergency department.***"

- If the time of the arrival is unable to be determined from medical record documentation, select "UTD."
- Review the only acceptable sources to determine the earliest time the patient arrived at the ED or observation. Documentation outside of the only acceptable sources list should **not** be referenced (such as ambulance record, physician office record, or H&P).
- "Emergency department record" includes any documentation from the time period that the patient was an ED patient, e.g., ED face sheet, ED consent/authorization for treatment forms, ED/outpatient registration/sign-in forms, triage record, ED physician orders, ECG reports, telemetry rhythm strips, laboratory reports, x-ray reports, etc.
- If the time on the face/registration sheet is not labeled "arrival," "registration," or "admit" time, or is labeled simply "time," then the time can be considered a nondescript time and should **not** be used as *Arrival Time*.
- *Arrival Time* can be the time the patient first sees triage, registration, or the volunteer who puts her/his name on a page with a time. It does **not** have to be a professional who documents the arrival time.
- **Do not** use a time stamp unless it is clear that it is used specifically for patient arrival time.
- **Do not** use pre-printed times on a vital sign graphic record.
- **Do not** use a stamp or label that has a consistent time on every page.

Note the following frequently asked questions:

Question: If the patient enters the ED, is signed in by a volunteer at 1950, and then sits in the waiting room until called by triage at 2012, what is the correct *Arrival Time*?

Answer: The earliest documented time the patient arrived in the ED: 1950.

Question: The patient arrives by ambulance and has an ECG, IV, and O2 that are all recorded as 1300. A nurse note documents 1255. A note in the ambulance run sheet indicates that the patient arrived at 1240. What is the correct *Arrival Time*?

Answer: The earliest documented time the patient arrived in the ED: 1255. You cannot use the ambulance run sheet as a time of arrival; you may only use the run sheet (if you must) to substantiate that the patient was not in the ED at 1240.

Question: The record indicates a non-labeled/non-descript time of 1840 on the registration sheet; the time is not labeled "Admit" or "Registered;" there is a time of 1850 on the triage note; an ECG time of 1845 is noted; and a lab collection time of 0000 is noted. What is the *Arrival Time*?

Answer: The earliest documented time the patient arrived in the ED: 1845. Unless there is other documentation to substantiate that the patient was present at 0000, ignore that time and use the next earliest time: 1845. The 1840 time is not valid to use since it was not labeled "arrival," registration," or "admit."

ED Departure Time: Guidelines

When abstracting *ED Departure Time* for OP-18 (Median Time from ED Arrival to ED Departure for Discharged ED Patients), remember the intent of abstraction *"…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 service/care."*

Source: Alphabetical Data Element List and Data Dictionary, *ED Departure Time* data element, and General Abstraction Guidelines, *Medical Record Documentation*

- **Do use** the later departure time if two departure/discharge times are noted.
- **Do use** the time of the observation order written by the physician/advanced practice nurse (APN)/ physician's assistant (PA) for patients who are placed into observation.
- **Do <u>not</u> use:**
  - Coding Summary
  - Physician's Discharge Summary
  - ED record released from holding time
  - Chart closed time
  - Off the tracking board time
  - Report called time
  - Disposition time
  - Discharge instruction time
- **Do <u>not</u> use** any time that cannot be substantiated in the medical record as direct patient care being provided. For example, if there is a departure time of 2015 and a note from the physician or nurse written at 2200 with no other information available that the patient was still in the facility, the departure time would be 2015.
- **Do <u>not</u> use** note times or late entries for medication administration or vital signs if they are later than the *ED Departure Time*.
- **Do <u>not</u> use** the time the discharge order was written because it may not represent the actual time of departure.
- **Do use:**
  - Discharge time (if it is listed on the disposition sheet)
  - Release time
  - Out time
  - Gone time
  - Checkout time
  - Transport documented time
  - Event log, registration sheet, transfer record, etc. (if a discharge time is noted and the document is part of the permanent medical record)
  - Transfer time
  - Order for observation status time
  - Any other synonym that can easily be understood to mean "Departure" or "Discharge"

Note the following frequently asked questions:

Question: The patient was admitted to "Observation" from the ED. The nurse documents that the patient physically left the ED at 1440. The order for "Observation" was written at 1700. What time should be abstracted for *ED Departure Time*?

Answer: If the order for "Observation" is written after the patient departed the ED, select the time the patient physically left the ED. In this example, abstract 1440 as the *ED Departure Time.*

Question: *ED Discharge Time* is documented on the face sheet at 1400. A nursing note is documented as, "EMS at bedside" at 1422 and medication administration noted at 1428. What would be the appropriate *ED Departure Time*?

Answer: Because there is substantial documentation to support that the patient was in the ED after the documented *Discharge Time* and there is no additional documented time of ED departure, it cannot be determined when the patient physically left the ED. Enter "UTD" for *ED Departure Time.* Medication administration times are not acceptable for establishing the *ED Departure Time*.

Question: A nurse's note indicates when the patient was discharged from the ED. No other care is documented beyond that time. There is also an electronic time entered after the documented *ED Departure Time* that states "patient removed from the system." Which documentation should be used for abstracting the *ED Departure Time*?

Answer: The intent is to capture the latest time the patient was receiving care in the emergency department. In this example, there is a documented discharge time. The documented discharge time from the nurse's note would be used to abstract *ED Departure Time.* Documentation that the patient was removed from system is insufficient for abstracting *ED Departure Time* because it does not provide substantial documentation that the patient physically departed the ED.

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

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

Code	Shortened 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

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

OP Table 7.01: Mental Disorders

Code	Shortened Description
F0150	Vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F01511	Vascular dementia, unspecified severity, with agitation
F01518	Vascular dementia, unspecified severity, with other behavioral disturbance
F0152	Vascular dementia, unspecified severity, with psychotic disturbance
F0153	Vascular dementia, unspecified severity, with mood disturbance
F0154	Vascular dementia, unspecified severity, with anxiety
F01A0	Vascular dementia, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F01A11	Vascular dementia, mild, with agitation
F01A18	Vascular dementia, mild, with other behavioral disturbance
F01A2	Vascular dementia, mild, with psychotic disturbance
F01A3	Vascular dementia, mild, with mood disturbance
F01A4	Vascular dementia, mild, with anxiety
F01B0	Vascular dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F01B11	Vascular dementia, moderate, with agitation
F01B18	Vascular dementia, moderate, with other behavioral disturbance
F01B2	Vascular dementia, moderate, with psychotic disturbance
F01B3	Vascular dementia, moderate, with mood disturbance
F01B4	Vascular dementia, moderate, with anxiety
F01C0	Vascular dementia, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F01C11	Vascular dementia, severe, with agitation
F01C18	Vascular dementia, severe, with other behavioral disturbance
F01C2	Vascular dementia, severe, with psychotic disturbance
F01C3	Vascular dementia, severe, with mood disturbance
F01C4	Vascular dementia, severe, with anxiety
F0280	Dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F02811	Dementia in other diseases classified elsewhere, unspecified severity, with agitation
F02818	Dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance
F0282	Dementia in other diseases classified elsewhere, unspecified severity, with psychotic disturbance
F0283	Dementia in other diseases classified elsewhere, unspecified severity, with mood disturbance
F0284	Dementia in other diseases classified elsewhere, unspecified severity, with anxiety
F02A0	Dementia in other diseases classified elsewhere, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F02A11	Dementia in other diseases classified elsewhere, mild, with agitation
F02A18	Dementia in other diseases classified elsewhere, mild, with other behavioral disturbance
F02A2	Dementia in other diseases classified elsewhere, mild, with psychotic disturbance
F02A3	Dementia in other diseases classified elsewhere, mild, with mood disturbance
F02A4	Dementia in other diseases classified elsewhere, mild, with anxiety
F02B0	Dementia in other diseases classified elsewhere, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F02B11	Dementia in other diseases classified elsewhere, moderate, with agitation
F02B18	Dementia in other diseases classified elsewhere, moderate, with other behavioral disturbance
F02B2	Dementia in other diseases classified elsewhere, moderate, with psychotic disturbance
F02B3	Dementia in other diseases classified elsewhere, moderate, with mood disturbance
F02B4	Dementia in other diseases classified elsewhere, moderate, with anxiety

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
F02C0	Dementia in other diseases classified elsewhere, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F02C11	Dementia in other diseases classified elsewhere, severe, with agitation
F02C18	Dementia in other diseases classified elsewhere, severe, with other behavioral disturbance
F02C2	Dementia in other diseases classified elsewhere, severe, with psychotic disturbance
F02C3	Dementia in other diseases classified elsewhere, severe, with mood disturbance
F02C4	Dementia in other diseases classified elsewhere, severe, with anxiety
F0390	Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F03911	Unspecified dementia, unspecified severity, with agitation
F03918	Unspecified dementia, unspecified severity, with other behavioral disturbance
F0392	Unspecified dementia, unspecified severity, with psychotic disturbance
F0393	Unspecified dementia, unspecified severity, with mood disturbance
F0394	Unspecified dementia, unspecified severity, with anxiety
F03A0	Unspecified dementia, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F03A11	Unspecified dementia, mild, with agitation
F03A18	Unspecified dementia, mild, with other behavioral disturbance
F03A2	Unspecified dementia, mild, with psychotic disturbance
F03A3	Unspecified dementia, mild, with mood disturbance
F03A4	Unspecified dementia, mild, with anxiety
F03B0	Unspecified dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F03B11	Unspecified dementia, moderate, with agitation
F03B18	Unspecified dementia, moderate, with other behavioral disturbance
F03B2	Unspecified dementia, moderate, with psychotic disturbance
F03B3	Unspecified dementia, moderate, with mood disturbance
F03B4	Unspecified dementia, moderate, with anxiety
F03C0	Unspecified dementia, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F03C11	Unspecified dementia, severe, with agitation
F03C18	Unspecified dementia, severe, with other behavioral disturbance
F03C2	Unspecified dementia, severe, with psychotic disturbance
F03C3	Unspecified dementia, severe, with mood disturbance
F03C4	Unspecified dementia, severe, with anxiety
F04	Amnestic disorder due to known physiological condition
F05	Delirium due to known physiological condition
F060	Psychotic disorder with hallucinations due to known physiological condition
F061	Catatonic disorder due to known physiological condition
F062	Psychotic disorder with delusions due to known physiological condition
F0630	Mood disorder due to known physiological condition, unspecified
F0631	Mood disorder due to known physiological condition with depressive features
F0632	Mood disorder due to known physiological condition with major depressive-like episode
F0633	Mood disorder due to known physiological condition with manic features
F0634	Mood disorder due to known physiological condition with mixed features
F064	Anxiety disorder due to known physiological condition
F0670	Mild neurocognitive disorder due to known physiological condition without behavioral disturbance
F0671	Mild neurocognitive disorder due to known physiological condition with behavioral disturbance

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
F068	Other specified mental disorders due to known physiological condition
F070	Personality change due to known physiological condition
F0781	Postconcussional syndrome
F0789	Other personality and behavioral disorders due to known physiological condition
F079	Unspecified personality and behavioral disorder due to known physiological condition
F09	Unspecified mental disorder due to known physiological condition
F1010	Alcohol abuse, uncomplicated
F1011	Alcohol abuse, in remission
F10120	Alcohol abuse with intoxication, uncomplicated
F10121	Alcohol abuse with intoxication delirium
F10129	Alcohol abuse with intoxication, unspecified
F10130	Alcohol abuse with withdrawal, uncomplicated
F10131	Alcohol abuse with withdrawal delirium
F10132	Alcohol abuse with withdrawal with perceptual disturbance
F10139	Alcohol abuse with withdrawal, unspecified
F10930	Alcohol use, unspecified with withdrawal, uncomplicated
F10931	Alcohol use, unspecified with withdrawal delirium
F10932	Alcohol use, unspecified with withdrawal with perceptual disturbance
F10939	Alcohol use, unspecified with withdrawal, unspecified
F1014	Alcohol abuse with alcohol-induced mood disorder
F10150	Alcohol abuse with alcohol-induced psychotic disorder with delusions
F10151	Alcohol abuse with alcohol-induced psychotic disorder with hallucinations
F10159	Alcohol abuse with alcohol-induced psychotic disorder, unspecified
F10180	Alcohol abuse with alcohol-induced anxiety disorder
F10181	Alcohol abuse with alcohol-induced sexual dysfunction
F10182	Alcohol abuse with alcohol-induced sleep disorder
F10188	Alcohol abuse with other alcohol-induced disorder
F1019	Alcohol abuse with unspecified alcohol-induced disorder
F1020	Alcohol dependence, uncomplicated
F1021	Alcohol dependence, in remission
F10220	Alcohol dependence with intoxication, uncomplicated
F10221	Alcohol dependence with intoxication delirium
F10229	Alcohol dependence with intoxication, unspecified
F10230	Alcohol dependence with withdrawal, uncomplicated
F10231	Alcohol dependence with withdrawal delirium
F10232	Alcohol dependence with withdrawal with perceptual disturbance
F10239	Alcohol dependence with withdrawal, unspecified
F1024	Alcohol dependence with alcohol-induced mood disorder
F10250	Alcohol dependence with alcohol-induced psychotic disorder with delusions
F10251	Alcohol dependence with alcohol-induced psychotic disorder with hallucinations
F10259	Alcohol dependence with alcohol-induced psychotic disorder, unspecified
F1026	Alcohol dependence with alcohol-induced persisting amnestic disorder
F1027	Alcohol dependence with alcohol-induced persisting dementia
F10280	Alcohol dependence with alcohol-induced anxiety disorder
F10281	Alcohol dependence with alcohol-induced sexual dysfunction
F10282	Alcohol dependence with alcohol-induced sleep disorder
F10288	Alcohol dependence with other alcohol-induced disorder
F1029	Alcohol dependence with unspecified alcohol-induced disorder

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
F1090	Alcohol use, unspecified, uncomplicated
F1091	Alcohol use, unspecified, in remission
F10920	Alcohol use, unspecified with intoxication, uncomplicated
F10921	Alcohol use, unspecified with intoxication delirium
F10929	Alcohol use, unspecified with intoxication, unspecified
F1094	Alcohol use, unspecified with alcohol-induced mood disorder
F10950	Alcohol use, unspecified with alcohol-induced psychotic disorder with delusions
F10951	Alcohol use, unspecified with alcohol-induced psychotic disorder with hallucinations
F10959	Alcohol use, unspecified with alcohol-induced psychotic disorder, unspecified
F1096	Alcohol use, unspecified with alcohol-induced persisting amnestic disorder
F1097	Alcohol use, unspecified with alcohol-induced persisting dementia
F10980	Alcohol use, unspecified with alcohol-induced anxiety disorder
F10981	Alcohol use, unspecified with alcohol-induced sexual dysfunction
F10982	Alcohol use, unspecified with alcohol-induced sleep disorder
F10988	Alcohol use, unspecified with other alcohol-induced disorder
F1099	Alcohol use, unspecified with unspecified alcohol-induced disorder
F1110	Opioid abuse, uncomplicated
F1111	Opioid abuse, in remission
F11120	Opioid abuse with intoxication, uncomplicated
F11121	Opioid abuse with intoxication delirium
F11122	Opioid abuse with intoxication with perceptual disturbance
F11129	Opioid abuse with intoxication, unspecified
F1113	Opioid abuse with withdrawal
F1114	Opioid abuse with opioid-induced mood disorder
F11150	Opioid abuse with opioid-induced psychotic disorder with delusions
F11151	Opioid abuse with opioid-induced psychotic disorder with hallucinations
F11159	Opioid abuse with opioid-induced psychotic disorder, unspecified
F11181	Opioid abuse with opioid-induced sexual dysfunction
F11182	Opioid abuse with opioid-induced sleep disorder
F11188	Opioid abuse with other opioid-induced disorder
F1119	Opioid abuse with unspecified opioid-induced disorder
F1120	Opioid dependence, uncomplicated
F1121	Opioid dependence, in remission
F11220	Opioid dependence with intoxication, uncomplicated
F11221	Opioid dependence with intoxication delirium
F11222	Opioid dependence with intoxication with perceptual disturbance
F11229	Opioid dependence with intoxication, unspecified
F1123	Opioid dependence with withdrawal
F1124	Opioid dependence with opioid-induced mood disorder
F11250	Opioid dependence with opioid-induced psychotic disorder with delusions
F11251	Opioid dependence with opioid-induced psychotic disorder with hallucinations
F11259	Opioid dependence with opioid-induced psychotic disorder, unspecified
F11281	Opioid dependence with opioid-induced sexual dysfunction
F11282	Opioid dependence with opioid-induced sleep disorder
F11288	Opioid dependence with other opioid-induced disorder
F1129	Opioid dependence with unspecified opioid-induced disorder
F1190	Opioid use, unspecified, uncomplicated
F1191	Opioid use, unspecified, in remission

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
F11920	Opioid use, unspecified with intoxication, uncomplicated
F11921	Opioid use, unspecified with intoxication delirium
F11922	Opioid use, unspecified with intoxication with perceptual disturbance
F11929	Opioid use, unspecified with intoxication, unspecified
F1193	Opioid use, unspecified with withdrawal
F1194	Opioid use, unspecified with opioid-induced mood disorder
F11950	Opioid use, unspecified with opioid-induced psychotic disorder with delusions
F11951	Opioid use, unspecified with opioid-induced psychotic disorder with hallucinations
F11959	Opioid use, unspecified with opioid-induced psychotic disorder, unspecified
F11981	Opioid use, unspecified with opioid-induced sexual dysfunction
F11982	Opioid use, unspecified with opioid-induced sleep disorder
F11988	Opioid use, unspecified with other opioid-induced disorder
F1199	Opioid use, unspecified with unspecified opioid-induced disorder
F1210	Cannabis abuse, uncomplicated
F1211	Cannabis abuse, in remission
F12120	Cannabis abuse with intoxication, uncomplicated
F12121	Cannabis abuse with intoxication delirium
F12122	Cannabis abuse with intoxication with perceptual disturbance
F1213	Cannabis abuse with withdrawal
F12129	Cannabis abuse with intoxication, unspecified
F12150	Cannabis abuse with psychotic disorder with delusions
F12151	Cannabis abuse with psychotic disorder with hallucinations
F12159	Cannabis abuse with psychotic disorder, unspecified
F12180	Cannabis abuse with cannabis-induced anxiety disorder
F12188	Cannabis abuse with other cannabis-induced disorder
F1219	Cannabis abuse with unspecified cannabis-induced disorder
F1220	Cannabis dependence, uncomplicated
F1221	Cannabis dependence, in remission
F12220	Cannabis dependence with intoxication, uncomplicated
F12221	Cannabis dependence with intoxication delirium
F12222	Cannabis dependence with intoxication with perceptual disturbance
F12229	Cannabis dependence with intoxication, unspecified
F1223	Cannabis dependence with withdrawal
F12250	Cannabis dependence with psychotic disorder with delusions
F12251	Cannabis dependence with psychotic disorder with hallucinations
F12259	Cannabis dependence with psychotic disorder, unspecified
F12280	Cannabis dependence with cannabis-induced anxiety disorder
F12288	Cannabis dependence with other cannabis-induced disorder
F1229	Cannabis dependence with unspecified cannabis-induced disorder
F1290	Cannabis use, unspecified, uncomplicated
F1291	Cannabis use, unspecified, in remission
F12920	Cannabis use, unspecified with intoxication, uncomplicated
F12921	Cannabis use, unspecified with intoxication delirium
F12922	Cannabis use, unspecified with intoxication with perceptual disturbance
F12929	Cannabis use, unspecified with intoxication, unspecified
F1293	Cannabis use, unspecified with withdrawal
F12950	Cannabis use, unspecified with psychotic disorder with delusions
F12951	Cannabis use, unspecified with psychotic disorder with hallucinations

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
F12959	Cannabis use, unspecified with psychotic disorder, unspecified
F12980	Cannabis use, unspecified with anxiety disorder
F12988	Cannabis use, unspecified with other cannabis-induced disorder
F1299	Cannabis use, unspecified with unspecified cannabis-induced disorder
F1310	Sedative, hypnotic or anxiolytic abuse, uncomplicated
F1311	Sedative, hypnotic or anxiolytic abuse, in remission
F13120	Sedative, hypnotic or anxiolytic abuse with intoxication, uncomplicated
F13121	Sedative, hypnotic or anxiolytic abuse with intoxication delirium
F13129	Sedative, hypnotic or anxiolytic abuse with intoxication, unspecified
F13130	Sedative, hypnotic or anxiolytic abuse with withdrawal, uncomplicated
F13131	Sedative, hypnotic or anxiolytic abuse with withdrawal delirium
F13132	Sedative, hypnotic or anxiolytic abuse with withdrawal with perceptual disturbance
F13139	Sedative, hypnotic or anxiolytic abuse with withdrawal, unspecified
F1314	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced mood disorder
F13150	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
F13151	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
F13159	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
F13180	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced anxiety disorder
F13181	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced sexual dysfunction
F13182	Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced sleep disorder
F13188	Sedative, hypnotic or anxiolytic abuse with other sedative, hypnotic or anxiolytic-induced disorder
F1319	Sedative, hypnotic or anxiolytic abuse with unspecified sedative, hypnotic or anxiolytic-induced disorder
F1320	Sedative, hypnotic or anxiolytic dependence, uncomplicated
F1321	Sedative, hypnotic or anxiolytic dependence, in remission
F13220	Sedative, hypnotic or anxiolytic dependence with intoxication, uncomplicated
F13221	Sedative, hypnotic or anxiolytic dependence with intoxication delirium
F13229	Sedative, hypnotic or anxiolytic dependence with intoxication, unspecified
F13230	Sedative, hypnotic or anxiolytic dependence with withdrawal, uncomplicated
F13231	Sedative, hypnotic or anxiolytic dependence with withdrawal delirium
F13232	Sedative, hypnotic or anxiolytic dependence with withdrawal with perceptual disturbance
F13239	Sedative, hypnotic or anxiolytic dependence with withdrawal, unspecified
F1324	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced mood disorder
F13250	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
F13251	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
F13259	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
F1326	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting amnestic disorder
F1327	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting dementia
F13280	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced anxiety disorder
F13281	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sexual dysfunction
F13282	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sleep disorder
F13288	Sedative, hypnotic or anxiolytic dependence with other sedative, hypnotic or anxiolytic-induced disorder

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
F1329	Sedative, hypnotic or anxiolytic dependence with unspecified sedative, hypnotic or anxiolytic-induced disorder
F1390	Sedative, hypnotic, or anxiolytic use, unspecified, uncomplicated
F1391	Sedative, hypnotic or anxiolytic use, unspecified, in remission
F13920	Sedative, hypnotic or anxiolytic use, unspecified with intoxication, uncomplicated
F13921	Sedative, hypnotic or anxiolytic use, unspecified with intoxication delirium
F13929	Sedative, hypnotic or anxiolytic use, unspecified with intoxication, unspecified
F13930	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal, uncomplicated
F13931	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal delirium
F13932	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal with perceptual disturbances
F13939	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal, unspecified
F1394	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced mood disorder
F13950	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder with delusions
F13951	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder with hallucinations
F13959	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified
F1396	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced persisting amnestic disorder
F1397	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced persisting dementia
F13980	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced anxiety disorder
F13981	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced sexual dysfunction
F13982	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced sleep disorder
F13988	Sedative, hypnotic or anxiolytic use, unspecified with other sedative, hypnotic or anxiolytic-induced disorder
F1399	Sedative, hypnotic or anxiolytic use, unspecified with unspecified sedative, hypnotic or anxiolytic-induced disorder
F1410	Cocaine abuse, uncomplicated
F1411	Cocaine abuse, in remission
F14120	Cocaine abuse with intoxication, uncomplicated
F14121	Cocaine abuse with intoxication with delirium
F14122	Cocaine abuse with intoxication with perceptual disturbance
F14129	Cocaine abuse with intoxication, unspecified
F1413	Cocaine abuse, unspecified with withdrawal
F1414	Cocaine abuse with cocaine-induced mood disorder
F14150	Cocaine abuse with cocaine-induced psychotic disorder with delusions
F14151	Cocaine abuse with cocaine-induced psychotic disorder with hallucinations
F14159	Cocaine abuse with cocaine-induced psychotic disorder, unspecified
F14180	Cocaine abuse with cocaine-induced anxiety disorder
F14181	Cocaine abuse with cocaine-induced sexual dysfunction
F14182	Cocaine abuse with cocaine-induced sleep disorder
F14188	Cocaine abuse with other cocaine-induced disorder
F1419	Cocaine abuse with unspecified cocaine-induced disorder
F1420	Cocaine dependence, uncomplicated
F1421	Cocaine dependence, in remission
F14220	Cocaine dependence with intoxication, uncomplicated
F14221	Cocaine dependence with intoxication delirium

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
F14222	Cocaine dependence with intoxication with perceptual disturbance
F14229	Cocaine dependence with intoxication, unspecified
F1423	Cocaine dependence with withdrawal
F1424	Cocaine dependence with cocaine-induced mood disorder
F14250	Cocaine dependence with cocaine-induced psychotic disorder with delusions
F14251	Cocaine dependence with cocaine-induced psychotic disorder with hallucinations
F14259	Cocaine dependence with cocaine-induced psychotic disorder, unspecified
F14280	Cocaine dependence with cocaine-induced anxiety disorder
F14281	Cocaine dependence with cocaine-induced sexual dysfunction
F14282	Cocaine dependence with cocaine-induced sleep disorder
F14288	Cocaine dependence with other cocaine-induced disorder
F1429	Cocaine dependence with unspecified cocaine-induced disorder
F1490	Cocaine use, unspecified, uncomplicated
F1491	Cocaine use, unspecified, in remission
F14920	Cocaine use, unspecified with intoxication, uncomplicated
F14921	Cocaine use, unspecified with intoxication delirium
F14922	Cocaine use, unspecified with intoxication with perceptual disturbance
F14929	Cocaine use, unspecified with intoxication, unspecified
F1494	Cocaine use, unspecified with cocaine-induced mood disorder
F14950	Cocaine use, unspecified with cocaine-induced psychotic disorder with delusions
F14951	Cocaine use, unspecified with cocaine-induced psychotic disorder with hallucinations
F14959	Cocaine use, unspecified with cocaine-induced psychotic disorder, unspecified
F14980	Cocaine use, unspecified with cocaine-induced anxiety disorder
F14981	Cocaine use, unspecified with cocaine-induced sexual dysfunction
F14982	Cocaine use, unspecified with cocaine-induced sleep disorder
F14988	Cocaine use, unspecified with other cocaine-induced disorder
F1493	Cocaine use, unspecified with withdrawal
F1499	Cocaine use, unspecified with unspecified cocaine-induced disorder
F1510	Other stimulant abuse, uncomplicated
F1511	Other stimulant abuse, in remission
F1513	Other stimulant abuse with withdrawal
F15120	Other stimulant abuse with intoxication, uncomplicated
F15121	Other stimulant abuse with intoxication delirium
F15122	Other stimulant abuse with intoxication with perceptual disturbance
F15129	Other stimulant abuse with intoxication, unspecified
F1514	Other stimulant abuse with stimulant-induced mood disorder
F15150	Other stimulant abuse with stimulant-induced psychotic disorder with delusions
F15151	Other stimulant abuse with stimulant-induced psychotic disorder with hallucinations
F15159	Other stimulant abuse with stimulant-induced psychotic disorder, unspecified
F15180	Other stimulant abuse with stimulant-induced anxiety disorder
F15181	Other stimulant abuse with stimulant-induced sexual dysfunction
F15182	Other stimulant abuse with stimulant-induced sleep disorder
F15188	Other stimulant abuse with other stimulant-induced disorder
F1519	Other stimulant abuse with unspecified stimulant-induced disorder
F1520	Other stimulant dependence, uncomplicated
F1521	Other stimulant dependence, in remission
F15220	Other stimulant dependence with intoxication, uncomplicated
F15221	Other stimulant dependence with intoxication delirium

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
F15222	Other stimulant dependence with intoxication with perceptual disturbance
F15229	Other stimulant dependence with intoxication, unspecified
F1523	Other stimulant dependence with withdrawal
F1524	Other stimulant dependence with stimulant-induced mood disorder
F15250	Other stimulant dependence with stimulant-induced psychotic disorder with delusions
F15251	Other stimulant dependence with stimulant-induced psychotic disorder with hallucinations
F15259	Other stimulant dependence with stimulant-induced psychotic disorder, unspecified
F15280	Other stimulant dependence with stimulant-induced anxiety disorder
F15281	Other stimulant dependence with stimulant-induced sexual dysfunction
F15282	Other stimulant dependence with stimulant-induced sleep disorder
F15288	Other stimulant dependence with other stimulant-induced disorder
F1529	Other stimulant dependence with unspecified stimulant-induced disorder
F1590	Other stimulant use, unspecified, uncomplicated
F1591	Other stimulant use, unspecified, in remission
F15920	Other stimulant use, unspecified with intoxication, uncomplicated
F15921	Other stimulant use, unspecified with intoxication delirium
F15922	Other stimulant use, unspecified with intoxication with perceptual disturbance
F15929	Other stimulant use, unspecified with intoxication, unspecified
F1593	Other stimulant use, unspecified with withdrawal
F1594	Other stimulant use, unspecified with stimulant-induced mood disorder
F15950	Other stimulant use, unspecified with stimulant-induced psychotic disorder with delusions
F15951	Other stimulant use, unspecified with stimulant-induced psychotic disorder with hallucinations
F15959	Other stimulant use, unspecified with stimulant-induced psychotic disorder, unspecified
F15980	Other stimulant use, unspecified with stimulant-induced anxiety disorder
F15981	Other stimulant use, unspecified with stimulant-induced sexual dysfunction
F15982	Other stimulant use, unspecified with stimulant-induced sleep disorder
F15988	Other stimulant use, unspecified with other stimulant-induced disorder
F1599	Other stimulant use, unspecified with unspecified stimulant-induced disorder
F1610	Hallucinogen abuse, uncomplicated
F1611	Hallucinogen abuse, in remission
F16120	Hallucinogen abuse with intoxication, uncomplicated
F16121	Hallucinogen abuse with intoxication with delirium
F16122	Hallucinogen abuse with intoxication with perceptual disturbance
F16129	Hallucinogen abuse with intoxication, unspecified
F1614	Hallucinogen abuse with hallucinogen-induced mood disorder
F16150	Hallucinogen abuse with hallucinogen-induced psychotic disorder with delusions
F16151	Hallucinogen abuse with hallucinogen-induced psychotic disorder with hallucinations
F16159	Hallucinogen abuse with hallucinogen-induced psychotic disorder, unspecified
F16180	Hallucinogen abuse with hallucinogen-induced anxiety disorder
F16183	Hallucinogen abuse with hallucinogen persisting perception disorder (flashbacks)
F16188	Hallucinogen abuse with other hallucinogen-induced disorder
F1619	Hallucinogen abuse with unspecified hallucinogen-induced disorder
F1620	Hallucinogen dependence, uncomplicated
F1621	Hallucinogen dependence, in remission
F16220	Hallucinogen dependence with intoxication, uncomplicated
F16221	Hallucinogen dependence with intoxication with delirium
F16229	Hallucinogen dependence with intoxication, unspecified
F1624	Hallucinogen dependence with hallucinogen-induced mood disorder

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
F16250	Hallucinogen dependence with hallucinogen-induced psychotic disorder with delusions
F16251	Hallucinogen dependence with hallucinogen-induced psychotic disorder with hallucinations
F16259	Hallucinogen dependence with hallucinogen-induced psychotic disorder, unspecified
F16280	Hallucinogen dependence with hallucinogen-induced anxiety disorder
F16283	Hallucinogen dependence with hallucinogen persisting perception disorder (flashbacks)
F16288	Hallucinogen dependence with other hallucinogen-induced disorder
F1629	Hallucinogen dependence with unspecified hallucinogen-induced disorder
F1690	Hallucinogen use, unspecified, uncomplicated
F1691	Hallucinogen use, unspecified, in remission
F16920	Hallucinogen use, unspecified with intoxication, uncomplicated
F16921	Hallucinogen use, unspecified with intoxication with delirium
F16929	Hallucinogen use, unspecified with intoxication, unspecified
F1694	Hallucinogen use, unspecified with hallucinogen-induced mood disorder
F16950	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder with delusions
F16951	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder with hallucinations
F16959	Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder, unspecified
F16980	Hallucinogen use, unspecified with hallucinogen-induced anxiety disorder
F16983	Hallucinogen use, unspecified with hallucinogen persisting perception disorder (flashbacks)
F16988	Hallucinogen use, unspecified with other hallucinogen-induced disorder
F1699	Hallucinogen use, unspecified with unspecified hallucinogen-induced disorder
F1810	Inhalant abuse, uncomplicated
F1811	Inhalant abuse, in remission
F18120	Inhalant abuse with intoxication, uncomplicated
F18121	Inhalant abuse with intoxication delirium
F18129	Inhalant abuse with intoxication, unspecified
F1814	Inhalant abuse with inhalant-induced mood disorder
F18150	Inhalant abuse with inhalant-induced psychotic disorder with delusions
F18151	Inhalant abuse with inhalant-induced psychotic disorder with hallucinations
F18159	Inhalant abuse with inhalant-induced psychotic disorder, unspecified
F1817	Inhalant abuse with inhalant-induced dementia
F18180	Inhalant abuse with inhalant-induced anxiety disorder
F18188	Inhalant abuse with other inhalant-induced disorder
F1819	Inhalant abuse with unspecified inhalant-induced disorder
F1820	Inhalant dependence, uncomplicated
F1821	Inhalant dependence, in remission
F18220	Inhalant dependence with intoxication, uncomplicated
F18221	Inhalant dependence with intoxication delirium
F18229	Inhalant dependence with intoxication, unspecified
F1824	Inhalant dependence with inhalant-induced mood disorder
F18250	Inhalant dependence with inhalant-induced psychotic disorder with delusions
F18251	Inhalant dependence with inhalant-induced psychotic disorder with hallucinations
F18259	Inhalant dependence with inhalant-induced psychotic disorder, unspecified
F1827	Inhalant dependence with inhalant-induced dementia
F18280	Inhalant dependence with inhalant-induced anxiety disorder
F18288	Inhalant dependence with other inhalant-induced disorder
F1829	Inhalant dependence with unspecified inhalant-induced disorder
F1890	Inhalant use, unspecified, uncomplicated
F1891	Inhalant use, unspecified, in remission

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
F18920	Inhalant use, unspecified with intoxication, uncomplicated
F18921	Inhalant use, unspecified with intoxication with delirium
F18929	Inhalant use, unspecified with intoxication, unspecified
F1894	Inhalant use, unspecified with inhalant-induced mood disorder
F18950	Inhalant use, unspecified with inhalant-induced psychotic disorder with delusions
F18951	Inhalant use, unspecified with inhalant-induced psychotic disorder with hallucinations
F18959	Inhalant use, unspecified with inhalant-induced psychotic disorder, unspecified
F1897	Inhalant use, unspecified with inhalant-induced persisting dementia
F18980	Inhalant use, unspecified with inhalant-induced anxiety disorder
F18988	Inhalant use, unspecified with other inhalant-induced disorder
F1899	Inhalant use, unspecified with unspecified inhalant-induced disorder
F1910	Other psychoactive substance abuse, uncomplicated
F1911	Other psychoactive substance abuse, in remission
F19120	Other psychoactive substance abuse with intoxication, uncomplicated
F19121	Other psychoactive substance abuse with intoxication delirium
F19122	Other psychoactive substance abuse with intoxication with perceptual disturbances
F19129	Other psychoactive substance abuse with intoxication, unspecified
F19130	Other psychoactive substance abuse with withdrawal, uncomplicated
F19131	Other psychoactive substance abuse with withdrawal delirium
F19132	Other psychoactive substance abuse with withdrawal with perceptual disturbance
F19139	Other psychoactive substance abuse with withdrawal, unspecified
F1914	Other psychoactive substance abuse with psychoactive substance-induced mood disorder
F19150	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with delusions
F19151	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder with hallucinations
F19159	Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder, unspecified
F1916	Other psychoactive substance abuse with psychoactive substance-induced persisting amnestic disorder
F1917	Other psychoactive substance abuse with psychoactive substance-induced persisting dementia
F19180	Other psychoactive substance abuse with psychoactive substance-induced anxiety disorder
F19181	Other psychoactive substance abuse with psychoactive substance-induced sexual dysfunction
F19182	Other psychoactive substance abuse with psychoactive substance-induced sleep disorder
F19188	Other psychoactive substance abuse with other psychoactive substance-induced disorder
F1919	Other psychoactive substance abuse with unspecified psychoactive substance-induced disorder
F1920	Other psychoactive substance dependence, uncomplicated
F1921	Other psychoactive substance dependence, in remission
F19220	Other psychoactive substance dependence with intoxication, uncomplicated
F19221	Other psychoactive substance dependence with intoxication delirium
F19222	Other psychoactive substance dependence with intoxication with perceptual disturbance
F19229	Other psychoactive substance dependence with intoxication, unspecified
F19230	Other psychoactive substance dependence with withdrawal, uncomplicated
F19231	Other psychoactive substance dependence with withdrawal delirium
F19232	Other psychoactive substance dependence with withdrawal with perceptual disturbance
F19239	Other psychoactive substance dependence with withdrawal, unspecified
F1924	Other psychoactive substance dependence with psychoactive substance-induced mood disorder
F19250	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with delusions
F19251	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder with hallucinations
F19259	Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder, unspecified

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
F1926	Other psychoactive substance dependence with psychoactive substance-induced persisting amnestic disorder
F1927	Other psychoactive substance dependence with psychoactive substance-induced persisting dementia
F19280	Other psychoactive substance dependence with psychoactive substance-induced anxiety disorder
F19281	Other psychoactive substance dependence with psychoactive substance-induced sexual dysfunction
F19282	Other psychoactive substance dependence with psychoactive substance-induced sleep disorder
F19288	Other psychoactive substance dependence with other psychoactive substance-induced disorder
F1929	Other psychoactive substance dependence with unspecified psychoactive substance-induced disorder
F1990	Other psychoactive substance use, unspecified, uncomplicated
F1991	Other psychoactive substance use, unspecified, in remission
F19920	Other psychoactive substance use, unspecified with intoxication, uncomplicated
F19921	Other psychoactive substance use, unspecified with intoxication with delirium
F19922	Other psychoactive substance use, unspecified with intoxication with perceptual disturbance
F19929	Other psychoactive substance use, unspecified with intoxication, unspecified
F19930	Other psychoactive substance use, unspecified with withdrawal, uncomplicated
F19931	Other psychoactive substance use, unspecified with withdrawal delirium
F19932	Other psychoactive substance use, unspecified with withdrawal with perceptual disturbance
F19939	Other psychoactive substance use, unspecified with withdrawal, unspecified
F1994	Other psychoactive substance use, unspecified with psychoactive substance-induced mood disorder
F19950	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder with delusions
F19951	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder with hallucinations
F19959	Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder, unspecified
F1996	Other psychoactive substance use, unspecified with psychoactive substance-induced persisting amnestic disorder
F1997	Other psychoactive substance use, unspecified with psychoactive substance-induced persisting dementia
F19980	Other psychoactive substance use, unspecified with psychoactive substance-induced anxiety disorder
F19981	Other psychoactive substance use, unspecified with psychoactive substance-induced sexual dysfunction
F19982	Other psychoactive substance use, unspecified with psychoactive substance-induced sleep disorder
F19988	Other psychoactive substance use, unspecified with other psychoactive substance-induced disorder
F1999	Other psychoactive substance use, unspecified with unspecified psychoactive substance-induced disorder
F200	Paranoid schizophrenia
F201	Disorganized schizophrenia
F202	Catatonic schizophrenia
F203	Undifferentiated schizophrenia
F205	Residual schizophrenia
F2081	Schizophreniform disorder
F2089	Other schizophrenia
F209	Schizophrenia, unspecified
F21	Schizotypal disorder
F22	Delusional disorders
F23	Brief psychotic disorder
F24	Shared psychotic disorder
F250	Schizoaffective disorder, bipolar type
F251	Schizoaffective disorder, depressive type
F258	Other schizoaffective disorders
F259	Schizoaffective disorder, unspecified
F28	Other psychotic disorder not due to a substance or known physiological condition

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
F29	Unspecified psychosis not due to a substance or known physiological condition
F3010	Manic episode without psychotic symptoms, unspecified
F3011	Manic episode without psychotic symptoms, mild
F3012	Manic episode without psychotic symptoms, moderate
F3013	Manic episode, severe, without psychotic symptoms
F302	Manic episode, severe with psychotic symptoms
F303	Manic episode in partial remission
F304	Manic episode in full remission
F308	Other manic episodes
F309	Manic episode, unspecified
F310	Bipolar disorder, current episode hypomanic
F3110	Bipolar disorder, current episode manic without psychotic features, unspecified
F3111	Bipolar disorder, current episode manic without psychotic features, mild
F3112	Bipolar disorder, current episode manic without psychotic features, moderate
F3113	Bipolar disorder, current episode manic without psychotic features, severe
F312	Bipolar disorder, current episode manic severe with psychotic features
F3130	Bipolar disorder, current episode depressed, mild or moderate severity, unspecified
F3131	Bipolar disorder, current episode depressed, mild
F3132	Bipolar disorder, current episode depressed, moderate
F314	Bipolar disorder, current episode depressed, severe, without psychotic features
F315	Bipolar disorder, current episode depressed, severe, with psychotic features
F3160	Bipolar disorder, current episode mixed, unspecified
F3161	Bipolar disorder, current episode mixed, mild
F3162	Bipolar disorder, current episode mixed, moderate
F3163	Bipolar disorder, current episode mixed, severe, without psychotic features
F3164	Bipolar disorder, current episode mixed, severe, with psychotic features
F3170	Bipolar disorder, currently in remission, most recent episode unspecified
F3171	Bipolar disorder, in partial remission, most recent episode hypomanic
F3172	Bipolar disorder, in full remission, most recent episode hypomanic
F3173	Bipolar disorder, in partial remission, most recent episode manic
F3174	Bipolar disorder, in full remission, most recent episode manic
F3175	Bipolar disorder, in partial remission, most recent episode depressed
F3176	Bipolar disorder, in full remission, most recent episode depressed
F3177	Bipolar disorder, in partial remission, most recent episode mixed
F3178	Bipolar disorder, in full remission, most recent episode mixed
F3181	Bipolar II disorder
F3189	Other bipolar disorder
F319	Bipolar disorder, unspecified
F32A	Depression, unspecified
F320	Major depressive disorder, single episode, mild
F321	Major depressive disorder, single episode, moderate
F322	Major depressive disorder, single episode, severe without psychotic features
F323	Major depressive disorder, single episode, severe with psychotic features
F324	Major depressive disorder, single episode, in partial remission
F325	Major depressive disorder, single episode, in full remission
F3281	Premenstrual dysphoric disorder
F3289	Other specified depressive episodes
F329	Major depressive disorder, single episode, unspecified

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
F330	Major depressive disorder, recurrent, mild
F331	Major depressive disorder, recurrent, moderate
F332	Major depressive disorder, recurrent severe without psychotic features
F333	Major depressive disorder, recurrent, severe with psychotic symptoms
F3340	Major depressive disorder, recurrent, in remission, unspecified
F3341	Major depressive disorder, recurrent, in partial remission
F3342	Major depressive disorder, recurrent, in full remission
F338	Other recurrent depressive disorders
F339	Major depressive disorder, recurrent, unspecified
F340	Cyclothymic disorder
F341	Dysthymic disorder
F3481	Disruptive mood dysregulation disorder
F3489	Other specified persistent mood disorders
F349	Persistent mood (affective) disorder, unspecified
F39	Unspecified mood (affective) disorder
F4000	Agoraphobia, unspecified
F4001	Agoraphobia with panic disorder
F4002	Agoraphobia without panic disorder
F4010	Social phobia, unspecified
F4011	Social phobia, generalized
F40210	Arachnophobia
F40218	Other animal type phobia
F40220	Fear of thunderstorms
F40228	Other natural environment type phobia
F40230	Fear of blood
F40231	Fear of injections and transfusions
F40232	Fear of other medical care
F40233	Fear of injury
F40240	Claustrophobia
F40241	Acrophobia
F40242	Fear of bridges
F40243	Fear of flying
F40248	Other situational type phobia
F40290	Androphobia
F40291	Gynephobia
F40298	Other specified phobia
F408	Other phobic anxiety disorders
F409	Phobic anxiety disorder, unspecified
F410	Panic disorder (episodic paroxysmal anxiety)
F411	Generalized anxiety disorder
F413	Other mixed anxiety disorders
F418	Other specified anxiety disorders
F419	Anxiety disorder, unspecified
F422	Mixed obsessional thoughts and acts
F423	Hoarding disorder
F424	Excoriation (skin-picking) disorder
F428	Other obsessive-compulsive disorder
F429	Obsessive-compulsive disorder, unspecified

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
F430	Acute stress reaction
F4310	Post-traumatic stress disorder, unspecified
F4311	Post-traumatic stress disorder, acute
F4312	Post-traumatic stress disorder, chronic
F4320	Adjustment disorder, unspecified
F4321	Adjustment disorder with depressed mood
F4322	Adjustment disorder with anxiety
F4323	Adjustment disorder with mixed anxiety and depressed mood
F4324	Adjustment disorder with disturbance of conduct
F4325	Adjustment disorder with mixed disturbance of emotions and conduct
F4329	Adjustment disorder with other symptoms
F4381	Prolonged grief disorder
F4389	Other reactions to severe stress
F439	Reaction to severe stress, unspecified
F440	Dissociative amnesia
F441	Dissociative fugue
F442	Dissociative stupor
F444	Conversion disorder with motor symptom or deficit
F445	Conversion disorder with seizures or convulsions
F446	Conversion disorder with sensory symptom or deficit
F447	Conversion disorder with mixed symptom presentation
F4481	Dissociative identity disorder
F4489	Other dissociative and conversion disorders
F449	Dissociative and conversion disorder, unspecified
F450	Somatization disorder
F451	Undifferentiated somatoform disorder
F4520	Hypochondriacal disorder, unspecified
F4521	Hypochondriasis
F4522	Body dysmorphic disorder
F4529	Other hypochondriacal disorders
F4541	Pain disorder exclusively related to psychological factors
F4542	Pain disorder with related psychological factors
F458	Other somatoform disorders
F459	Somatoform disorder, unspecified
F481	Depersonalization-derealization syndrome
F482	Pseudobulbar affect
F488	Other specified nonpsychotic mental disorders
F489	Nonpsychotic mental disorder, unspecified
F5000	Anorexia nervosa, unspecified
F50010	Anorexia nervosa, restricting type, mild
F50011	Anorexia nervosa, restricting type, moderate
F50012	Anorexia nervosa, restricting type, severe
F50013	Anorexia nervosa, restricting type, extreme
F50014	Anorexia nervosa, restricting type, in remission
F50019	Anorexia nervosa, restricting type, unspecified
F50020	Anorexia nervosa, binge eating/purging type, mild
F50021	Anorexia nervosa, binge eating/purging type, moderate
F50022	Anorexia nervosa, binge eating/purging type, severe

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
F50023	Anorexia nervosa, binge eating/purging type, extreme
F50024	Anorexia nervosa, binge eating/purging type, in remission
F50029	Anorexia nervosa, binge eating/purging type, unspecified
F5020	Bulimia nervosa, unspecified
F5021	Bulimia nervosa, mild
F5022	Bulimia nervosa, moderate
F5023	Bulimia nervosa, severe
F5024	Bulimia nervosa, extreme
F5025	Bulimia nervosa, in remission
F50810	Binge eating disorder, mild
F50811	Binge eating disorder, moderate
F50812	Binge eating disorder, severe
F50813	Binge eating disorder,extreme
F50814	Binge eating disorder, in remission
F50819	Binge eating disorder, unspecified
F5082	Avoidant/restrictive food intake disorder
F5083	Pica in adults
F5084	Rumination disorder in adults
F5089	Other specified eating disorder
F509	Eating disorder, unspecified
F5101	Primary insomnia
F5102	Adjustment insomnia
F5103	Paradoxical insomnia
F5104	Psychophysiologic insomnia
F5105	Insomnia due to other mental disorder
F5109	Other insomnia not due to a substance or known physiological condition
F5111	Primary hypersomnia
F5112	Insufficient sleep syndrome
F5113	Hypersomnia due to other mental disorder
F5119	Other hypersomnia not due to a substance or known physiological condition
F513	Sleepwalking (somnambulism)
F514	Sleep terrors (night terrors)
F515	Nightmare disorder
F518	Other sleep disorders not due to a substance or known physiological condition
F519	Sleep disorder not due to a substance or known physiological condition, unspecified
F520	Hypoactive sexual desire disorder
F521	Sexual aversion disorder
F5221	Male erectile disorder
F5222	Female sexual arousal disorder
F5231	Female orgasmic disorder
F5232	Male orgasmic disorder
F524	Premature ejaculation
F525	Vaginismus not due to a substance or known physiological condition
F526	Dyspareunia not due to a substance or known physiological condition
F528	Other sexual dysfunction not due to a substance or known physiological condition
F529	Unspecified sexual dysfunction not due to a substance or known physiological condition
F530	Postpartum depression
F531	Puerperal psychosis

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
F550	Abuse of antacids
F551	Abuse of herbal or folk remedies
F552	Abuse of laxatives
F553	Abuse of steroids or hormones
F554	Abuse of vitamins
F558	Abuse of other non-psychoactive substances
F59	Unspecified behavioral syndromes associated with physiological disturbances and physical factors
F600	Paranoid personality disorder
F601	Schizoid personality disorder
F602	Antisocial personality disorder
F603	Borderline personality disorder
F604	Histrionic personality disorder
F605	Obsessive-compulsive personality disorder
F606	Avoidant personality disorder
F607	Dependent personality disorder
F6081	Narcissistic personality disorder
F6089	Other specific personality disorders
F609	Personality disorder, unspecified
F630	Pathological gambling
F631	Pyromania
F632	Kleptomania
F633	Trichotillomania
F6381	Intermittent explosive disorder
F6389	Other impulse disorders
F639	Impulse disorder, unspecified
F640	Transsexualism
F641	Dual role transvestism
F642	Gender identity disorder of childhood
F648	Other gender identity disorders
F649	Gender identity disorder, unspecified
F650	Fetishism
F651	Transvestic fetishism
F652	Exhibitionism
F653	Voyeurism
F654	Pedophilia
F6550	Sadomasochism, unspecified
F6551	Sexual masochism
F6552	Sexual sadism
F6581	Frotteurism
F6589	Other paraphilias
F659	Paraphilia, unspecified
F66	Other sexual disorders
F68A	Factitious disorder imposed on another
F6810	Factitious disorder imposed on self, unspecified
F6811	Factitious disorder imposed on self, with predominantly psychological signs and symptoms
F6812	Factitious disorder imposed on self, with predominantly physical signs and symptoms
F6813	Factitious disorder imposed on self, with combined psychological and physical signs and symptoms
F688	Other specified disorders of adult personality and behavior

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
F69	Unspecified disorder of adult personality and behavior
F70	Mild intellectual disabilities
F71	Moderate intellectual disabilities
F72	Severe intellectual disabilities
F73	Profound intellectual disabilities
F78A1	SYNGAP1-related intellectual disability
F78A9	Other genetic related intellectual disability
F79	Unspecified intellectual disabilities
F800	Phonological disorder
F801	Expressive language disorder
F802	Mixed receptive-expressive language disorder
F804	Speech and language development delay due to hearing loss
F8081	Childhood onset fluency disorder
F8082	Social pragmatic communication disorder
F8089	Other developmental disorders of speech and language
F809	Developmental disorder of speech and language, unspecified
F810	Specific reading disorder
F812	Mathematics disorder
F8181	Disorder of written expression
F8189	Other developmental disorders of scholastic skills
F819	Developmental disorder of scholastic skills, unspecified
F82	Specific developmental disorder of motor function
F840	Autistic disorder
F842	Rett's syndrome
F843	Other childhood disintegrative disorder
F845	Asperger's syndrome
F848	Other pervasive developmental disorders
F849	Pervasive developmental disorder, unspecified
F88	Other disorders of psychological development
F89	Unspecified disorder of psychological development
F900	Attention-deficit hyperactivity disorder, predominantly inattentive type
F901	Attention-deficit hyperactivity disorder, predominantly hyperactive type
F902	Attention-deficit hyperactivity disorder, combined type
F908	Attention-deficit hyperactivity disorder, other type
F909	Attention-deficit hyperactivity disorder, unspecified type
F910	Conduct disorder confined to family context
F911	Conduct disorder, childhood-onset type
F912	Conduct disorder, adolescent-onset type
F913	Oppositional defiant disorder
F918	Other conduct disorders
F919	Conduct disorder, unspecified
F930	Separation anxiety disorder of childhood
F938	Other childhood emotional disorders
F939	Childhood emotional disorder, unspecified
F940	Selective mutism
F941	Reactive attachment disorder of childhood
F942	Disinhibited attachment disorder of childhood
F948	Other childhood disorders of social functioning

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
F949	Childhood disorder of social functioning, unspecified
F950	Transient tic disorder
F951	Chronic motor or vocal tic disorder
F952	Tourette's disorder
F958	Other tic disorders
F959	Tic disorder, unspecified
F980	Enuresis not due to a substance or known physiological condition
F981	Encopresis not due to a substance or known physiological condition
F9821	Rumination disorder of infancy and childhood
F9829	Other feeding disorders of infancy and early childhood
F983	Pica of infancy and childhood
F984	Stereotyped movement disorders
F985	Adult onset fluency disorder
F988	Other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence
F989	Unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence
F99	Mental disorder, not otherwise specified
G2561	Drug induced tics
R401	Stupor
R404	Transient alteration of awareness
R410	Disorientation, unspecified
R411	Anterograde amnesia
R412	Retrograde amnesia
R413	Other amnesia
R4182	Altered mental status, unspecified
R4185	Anosognosia
R4189	Other symptoms and signs involving cognitive functions and awareness
R440	Auditory hallucinations
R441	Visual hallucinations
R442	Other hallucinations
R443	Hallucinations, unspecified
R448	Other symptoms and signs involving general sensations and perceptions
R450	Nervousness
R451	Restlessness and agitation
R452	Unhappiness
R453	Demoralization and apathy
R454	Irritability and anger
R455	Hostility
R456	Violent behavior
R457	State of emotional shock and stress, unspecified
R4581	Low self-esteem
R4582	Worries
R4583	Excessive crying of child, adolescent or adult
R4584	Anhedonia
R4588	Nonsuicidal self-harm
R45850	Homicidal ideations
R45851	Suicidal ideations
R4586	Emotional lability
R4587	Impulsiveness

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
R4589	Other symptoms and signs involving emotional state
R461	Bizarre personal appearance
R462	Strange and inexplicable behavior
R463	Overactivity
R465	Suspiciousness and marked evasiveness
R466	Undue concern and preoccupation with stressful events
R467	Verbosity and circumstantial detail obscuring reason for contact
R4681	Obsessive-compulsive behavior
R4689	Other symptoms and signs involving appearance and behavior
T1491XA	Suicide attempt, initial encounter
T1491XD	Suicide attempt, subsequent encounter
T1491XS	Suicide attempt, sequela
T360X2A	Poisoning by penicillins, intentional self-harm, initial encounter
T360X2D	Poisoning by penicillins, intentional self-harm, subsequent encounter
T360X2S	Poisoning by penicillins, intentional self-harm, sequela
T361X2A	Poisoning by cephalosporins and other beta-lactam antibiotics, intentional self-harm, initial encounter
T361X2D	Poisoning by cephalosporins and other beta-lactam antibiotics, intentional self-harm, subsequent encounter
T361X2S	Poisoning by cephalosporins and other beta-lactam antibiotics, intentional self-harm, sequela
T362X2A	Poisoning by chloramphenicol group, intentional self-harm, initial encounter
T362X2D	Poisoning by chloramphenicol group, intentional self-harm, subsequent encounter
T362X2S	Poisoning by chloramphenicol group, intentional self-harm, sequela
T363X2A	Poisoning by macrolides, intentional self-harm, initial encounter
T363X2D	Poisoning by macrolides, intentional self-harm, subsequent encounter
T363X2S	Poisoning by macrolides, intentional self-harm, sequela
T364X2A	Poisoning by tetracyclines, intentional self-harm, initial encounter
T364X2D	Poisoning by tetracyclines, intentional self-harm, subsequent encounter
T364X2S	Poisoning by tetracyclines, intentional self-harm, sequela
T365X2A	Poisoning by aminoglycosides, intentional self-harm, initial encounter
T365X2D	Poisoning by aminoglycosides, intentional self-harm, subsequent encounter
T365X2S	Poisoning by aminoglycosides, intentional self-harm, sequela
T366X2A	Poisoning by rifampicins, intentional self-harm, initial encounter
T366X2D	Poisoning by rifampicins, intentional self-harm, subsequent encounter
T366X2S	Poisoning by rifampicins, intentional self-harm, sequela
T367X2A	Poisoning by antifungal antibiotics, systemically used, intentional self-harm, initial encounter
T367X2D	Poisoning by antifungal antibiotics, systemically used, intentional self-harm, subsequent encounter
T367X2S	Poisoning by antifungal antibiotics, systemically used, intentional self-harm, sequela
T368X2A	Poisoning by other systemic antibiotics, intentional self-harm, initial encounter
T368X2D	Poisoning by other systemic antibiotics, intentional self-harm, subsequent encounter
T368X2S	Poisoning by other systemic antibiotics, intentional self-harm, sequela
T3692XA	Poisoning by unspecified systemic antibiotic, intentional self-harm, initial encounter
T3692XD	Poisoning by unspecified systemic antibiotic, intentional self-harm, subsequent encounter
T3692XS	Poisoning by unspecified systemic antibiotic, intentional self-harm, sequela
T370X2A	Poisoning by sulfonamides, intentional self-harm, initial encounter
T370X2D	Poisoning by sulfonamides, intentional self-harm, subsequent encounter
T370X2S	Poisoning by sulfonamides, intentional self-harm, sequela
T371X2A	Poisoning by antimycobacterial drugs, intentional self-harm, initial encounter
T371X2D	Poisoning by antimycobacterial drugs, intentional self-harm, subsequent encounter
T371X2S	Poisoning by antimycobacterial drugs, intentional self-harm, sequela

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
T372X2A	Poisoning by antimalarials and drugs acting on other blood protozoa, intentional self-harm, initial encounter
T372X2D	Poisoning by antimalarials and drugs acting on other blood protozoa, intentional self-harm, subsequent encounter
T372X2S	Poisoning by antimalarials and drugs acting on other blood protozoa, intentional self-harm, sequela
T373X2A	Poisoning by other antiprotozoal drugs, intentional self-harm, initial encounter
T373X2D	Poisoning by other antiprotozoal drugs, intentional self-harm, subsequent encounter
T373X2S	Poisoning by other antiprotozoal drugs, intentional self-harm, sequela
T374X2A	Poisoning by anthelminthics, intentional self-harm, initial encounter
T374X2D	Poisoning by anthelminthics, intentional self-harm, subsequent encounter
T374X2S	Poisoning by anthelminthics, intentional self-harm, sequela
T375X2A	Poisoning by antiviral drugs, intentional self-harm, initial encounter
T375X2D	Poisoning by antiviral drugs, intentional self-harm, subsequent encounter
T375X2S	Poisoning by antiviral drugs, intentional self-harm, sequela
T378X2A	Poisoning by other specified systemic anti-infectives and antiparasitics, intentional self-harm, initial encounter
T378X2D	Poisoning by other specified systemic anti-infectives and antiparasitics, intentional self-harm, subsequent encounter
T378X2S	Poisoning by other specified systemic anti-infectives and antiparasitics, intentional self-harm, sequela
T3792XA	Poisoning by unspecified systemic anti-infective and antiparasitics, intentional self-harm, initial encounter
T3792XD	Poisoning by unspecified systemic anti-infective and antiparasitics, intentional self-harm, subsequent encounter
T3792XS	Poisoning by unspecified systemic anti-infective and antiparasitics, intentional self-harm, sequela
T380X2A	Poisoning by glucocorticoids and synthetic analogues, intentional self-harm, initial encounter
T380X2D	Poisoning by glucocorticoids and synthetic analogues, intentional self-harm, subsequent encounter
T380X2S	Poisoning by glucocorticoids and synthetic analogues, intentional self-harm, sequela
T381X2A	Poisoning by thyroid hormones and substitutes, intentional self-harm, initial encounter
T381X2D	Poisoning by thyroid hormones and substitutes, intentional self-harm, subsequent encounter
T381X2S	Poisoning by thyroid hormones and substitutes, intentional self-harm, sequela
T382X2A	Poisoning by antithyroid drugs, intentional self-harm, initial encounter
T382X2D	Poisoning by antithyroid drugs, intentional self-harm, subsequent encounter
T382X2S	Poisoning by antithyroid drugs, intentional self-harm, sequela
T383X2A	Poisoning by insulin and oral hypoglycemic [antidiabetic] drugs, intentional self-harm, initial encounter
T383X2D	Poisoning by insulin and oral hypoglycemic [antidiabetic] drugs, intentional self-harm, subsequent encounter
T383X2S	Poisoning by insulin and oral hypoglycemic [antidiabetic] drugs, intentional self-harm, sequela
T384X2A	Poisoning by oral contraceptives, intentional self-harm, initial encounter
T384X2D	Poisoning by oral contraceptives, intentional self-harm, subsequent encounter
T384X2S	Poisoning by oral contraceptives, intentional self-harm, sequela
T385X2A	Poisoning by other estrogens and progestogens, intentional self-harm, initial encounter
T385X2D	Poisoning by other estrogens and progestogens, intentional self-harm, subsequent encounter
T385X2S	Poisoning by other estrogens and progestogens, intentional self-harm, sequela
T386X2A	Poisoning by antigonadotrophins, antiestrogens, antiandrogens, not elsewhere classified, intentional self-harm, initial encounter
T386X2D	Poisoning by antigonadotrophins, antiestrogens, antiandrogens, not elsewhere classified, intentional self-harm, subsequent encounter
T386X2S	Poisoning by antigonadotrophins, antiestrogens, antiandrogens, not elsewhere classified, intentional self-harm, sequela
T387X2A	Poisoning by androgens and anabolic congeners, intentional self-harm, initial encounter
T387X2D	Poisoning by androgens and anabolic congeners, intentional self-harm, subsequent encounter
T387X2S	Poisoning by androgens and anabolic congeners, intentional self-harm, sequela
T38802A	Poisoning by unspecified hormones and synthetic substitutes, intentional self-harm, initial encounter

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
T38802D	Poisoning by unspecified hormones and synthetic substitutes, intentional self-harm, subsequent encounter
T38802S	Poisoning by unspecified hormones and synthetic substitutes, intentional self-harm, sequela
T38812A	Poisoning by anterior pituitary [adenohypophyseal] hormones, intentional self-harm, initial encounter
T38812D	Poisoning by anterior pituitary [adenohypophyseal] hormones, intentional self-harm, subsequent encounter
T38812S	Poisoning by anterior pituitary [adenohypophyseal] hormones, intentional self-harm, sequela
T38892A	Poisoning by other hormones and synthetic substitutes, intentional self-harm, initial encounter
T38892D	Poisoning by other hormones and synthetic substitutes, intentional self-harm, subsequent encounter
T38892S	Poisoning by other hormones and synthetic substitutes, intentional self-harm, sequela
T38902A	Poisoning by unspecified hormone antagonists, intentional self-harm, initial encounter
T38902D	Poisoning by unspecified hormone antagonists, intentional self-harm, subsequent encounter
T38902S	Poisoning by unspecified hormone antagonists, intentional self-harm, sequela
T38992A	Poisoning by other hormone antagonists, intentional self-harm, initial encounter
T38992D	Poisoning by other hormone antagonists, intentional self-harm, subsequent encounter
T38992S	Poisoning by other hormone antagonists, intentional self-harm, sequela
T39012A	Poisoning by aspirin, intentional self-harm, initial encounter
T39012D	Poisoning by aspirin, intentional self-harm, subsequent encounter
T39012S	Poisoning by aspirin, intentional self-harm, sequela
T39092A	Poisoning by salicylates, intentional self-harm, initial encounter
T39092D	Poisoning by salicylates, intentional self-harm, subsequent encounter
T39092S	Poisoning by salicylates, intentional self-harm, sequela
T391X2A	Poisoning by 4-Aminophenol derivatives, intentional self-harm, initial encounter
T391X2D	Poisoning by 4-Aminophenol derivatives, intentional self-harm, subsequent encounter
T391X2S	Poisoning by 4-Aminophenol derivatives, intentional self-harm, sequela
T392X2A	Poisoning by pyrazolone derivatives, intentional self-harm, initial encounter
T392X2D	Poisoning by pyrazolone derivatives, intentional self-harm, subsequent encounter
T392X2S	Poisoning by pyrazolone derivatives, intentional self-harm, sequela
T39312A	Poisoning by propionic acid derivatives, intentional self-harm, initial encounter
T39312D	Poisoning by propionic acid derivatives, intentional self-harm, subsequent encounter
T39312S	Poisoning by propionic acid derivatives, intentional self-harm, sequela
T39392A	Poisoning by other nonsteroidal anti-inflammatory drugs [NSAID], intentional self-harm, initial encounter
T39392D	Poisoning by other nonsteroidal anti-inflammatory drugs [NSAID], intentional self-harm, subsequent encounter
T39392S	Poisoning by other nonsteroidal anti-inflammatory drugs [NSAID], intentional self-harm, sequela
T394X2A	Poisoning by antirheumatics, not elsewhere classified, intentional self-harm, initial encounter
T394X2D	Poisoning by antirheumatics, not elsewhere classified, intentional self-harm, subsequent encounter
T394X2S	Poisoning by antirheumatics, not elsewhere classified, intentional self-harm, sequela
T398X2A	Poisoning by other nonopioid analgesics and antipyretics, not elsewhere classified, intentional self-harm, initial encounter
T398X2D	Poisoning by other nonopioid analgesics and antipyretics, not elsewhere classified, intentional self-harm, subsequent encounter
T398X2S	Poisoning by other nonopioid analgesics and antipyretics, not elsewhere classified, intentional self-harm, sequela
T3992XA	Poisoning by unspecified nonopioid analgesic, antipyretic and antirheumatic, intentional self-harm, initial encounter
T3992XD	Poisoning by unspecified nonopioid analgesic, antipyretic and antirheumatic, intentional self-harm, subsequent encounter
T3992XS	Poisoning by unspecified nonopioid analgesic, antipyretic and antirheumatic, intentional self-harm, sequela
T400X2A	Poisoning by opium, intentional self-harm, initial encounter
T400X2D	Poisoning by opium, intentional self-harm, subsequent encounter
T400X2S	Poisoning by opium, intentional self-harm, sequela

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
T401X2A	Poisoning by heroin, intentional self-harm, initial encounter
T401X2D	Poisoning by heroin, intentional self-harm, subsequent encounter
T401X2S	Poisoning by heroin, intentional self-harm, sequela
T402X2A	Poisoning by other opioids, intentional self-harm, initial encounter
T402X2D	Poisoning by other opioids, intentional self-harm, subsequent encounter
T402X2S	Poisoning by other opioids, intentional self-harm, sequela
T403X2A	Poisoning by methadone, intentional self-harm, initial encounter
T403X2D	Poisoning by methadone, intentional self-harm, subsequent encounter
T403X2S	Poisoning by methadone, intentional self-harm, sequela
T40412A	Poisoning by fentanyl or fentanyl analogs, intentional self-harm, initial encounter
T40412D	Poisoning by fentanyl or fentanyl analogs, intentional self-harm, subsequent encounter
T40412S	Poisoning by fentanyl or fentanyl analogs, intentional self-harm, sequela
T40422A	Poisoning by tramadol, intentional self-harm, initial encounter
T40422D	Poisoning by tramadol, intentional self-harm, subsequent encounter
T40422S	Poisoning by tramadol, intentional self-harm, sequela
T40492A	Poisoning by other synthetic narcotics, intentional self-harm, initial encounter
T40492D	Poisoning by other synthetic narcotics, intentional self-harm, subsequent encounter
T40492S	Poisoning by other synthetic narcotics, intentional self-harm, sequela
T405X2A	Poisoning by cocaine, intentional self-harm, initial encounter
T405X2D	Poisoning by cocaine, intentional self-harm, subsequent encounter
T405X2S	Poisoning by cocaine, intentional self-harm, sequela
T40602A	Poisoning by unspecified narcotics, intentional self-harm, initial encounter
T40602D	Poisoning by unspecified narcotics, intentional self-harm, subsequent encounter
T40602S	Poisoning by unspecified narcotics, intentional self-harm, sequela
T40692A	Poisoning by other narcotics, intentional self-harm, initial encounter
T40692D	Poisoning by other narcotics, intentional self-harm, subsequent encounter
T40692S	Poisoning by other narcotics, intentional self-harm, sequela
T40712A	Poisoning by cannabis, intentional self-harm, initial encounter
T40712D	Poisoning by cannabis, intentional self-harm, subsequent encounter
T40712S	Poisoning by cannabis, intentional self-harm, sequela
T408X2A	Poisoning by lysergide [LSD], intentional self-harm, initial encounter
T408X2D	Poisoning by lysergide [LSD], intentional self-harm, subsequent encounter
T408X2S	Poisoning by lysergide [LSD], intentional self-harm, sequela
T40902A	Poisoning by unspecified psychodysleptics [hallucinogens], intentional self-harm, initial encounter
T40902D	Poisoning by unspecified psychodysleptics [hallucinogens], intentional self-harm, subsequent encounter
T40902S	Poisoning by unspecified psychodysleptics [hallucinogens], intentional self-harm, sequela
T40992A	Poisoning by other psychodysleptics [hallucinogens], intentional self-harm, initial encounter
T40992D	Poisoning by other psychodysleptics [hallucinogens], intentional self-harm, subsequent encounter
T40992S	Poisoning by other psychodysleptics [hallucinogens], intentional self-harm, sequela
T410X2A	Poisoning by inhaled anesthetics, intentional self-harm, initial encounter
T410X2D	Poisoning by inhaled anesthetics, intentional self-harm, subsequent encounter
T410X2S	Poisoning by inhaled anesthetics, intentional self-harm, sequela
T411X2A	Poisoning by intravenous anesthetics, intentional self-harm, initial encounter
T411X2D	Poisoning by intravenous anesthetics, intentional self-harm, subsequent encounter
T411X2S	Poisoning by intravenous anesthetics, intentional self-harm, sequela
T41202A	Poisoning by unspecified general anesthetics, intentional self-harm, initial encounter
T41202D	Poisoning by unspecified general anesthetics, intentional self-harm, subsequent encounter
T41202S	Poisoning by unspecified general anesthetics, intentional self-harm, sequela

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
T41292A	Poisoning by other general anesthetics, intentional self-harm, initial encounter
T41292D	Poisoning by other general anesthetics, intentional self-harm, subsequent encounter
T41292S	Poisoning by other general anesthetics, intentional self-harm, sequela
T413X2A	Poisoning by local anesthetics, intentional self-harm, initial encounter
T413X2D	Poisoning by local anesthetics, intentional self-harm, subsequent encounter
T413X2S	Poisoning by local anesthetics, intentional self-harm, sequela
T4142XA	Poisoning by unspecified anesthetic, intentional self-harm, initial encounter
T4142XD	Poisoning by unspecified anesthetic, intentional self-harm, subsequent encounter
T4142XS	Poisoning by unspecified anesthetic, intentional self-harm, sequela
T415X2A	Poisoning by therapeutic gases, intentional self-harm, initial encounter
T415X2D	Poisoning by therapeutic gases, intentional self-harm, subsequent encounter
T415X2S	Poisoning by therapeutic gases, intentional self-harm, sequela
T420X2A	Poisoning by hydantoin derivatives, intentional self-harm, initial encounter
T420X2D	Poisoning by hydantoin derivatives, intentional self-harm, subsequent encounter
T420X2S	Poisoning by hydantoin derivatives, intentional self-harm, sequela
T421X2A	Poisoning by iminostilbenes, intentional self-harm, initial encounter
T421X2D	Poisoning by iminostilbenes, intentional self-harm, subsequent encounter
T421X2S	Poisoning by iminostilbenes, intentional self-harm, sequela
T422X2A	Poisoning by succinimides and oxazolidinediones, intentional self-harm, initial encounter
T422X2D	Poisoning by succinimides and oxazolidinediones, intentional self-harm, subsequent encounter
T422X2S	Poisoning by succinimides and oxazolidinediones, intentional self-harm, sequela
T423X2A	Poisoning by barbiturates, intentional self-harm, initial encounter
T423X2D	Poisoning by barbiturates, intentional self-harm, subsequent encounter
T423X2S	Poisoning by barbiturates, intentional self-harm, sequela
T424X2A	Poisoning by benzodiazepines, intentional self-harm, initial encounter
T424X2D	Poisoning by benzodiazepines, intentional self-harm, subsequent encounter
T424X2S	Poisoning by benzodiazepines, intentional self-harm, sequela
T425X2A	Poisoning by mixed antiepileptics, intentional self-harm, initial encounter
T425X2D	Poisoning by mixed antiepileptics, intentional self-harm, subsequent encounter
T425X2S	Poisoning by mixed antiepileptics, intentional self-harm, sequela
T426X2A	Poisoning by other antiepileptic and sedative-hypnotic drugs, intentional self-harm, initial encounter
T426X2D	Poisoning by other antiepileptic and sedative-hypnotic drugs, intentional self-harm, subsequent encounter
T426X2S	Poisoning by other antiepileptic and sedative-hypnotic drugs, intentional self-harm, sequela
T4272XA	Poisoning by unspecified antiepileptic and sedative-hypnotic drugs, intentional self-harm, initial encounter
T4272XD	Poisoning by unspecified antiepileptic and sedative-hypnotic drugs, intentional self-harm, subsequent encounter
T4272XS	Poisoning by unspecified antiepileptic and sedative-hypnotic drugs, intentional self-harm, sequela
T428X2A	Poisoning by antiparkinsonism drugs and other central muscle-tone depressants, intentional self-harm, initial encounter
T428X2D	Poisoning by antiparkinsonism drugs and other central muscle-tone depressants, intentional self-harm, subsequent encounter
T428X2S	Poisoning by antiparkinsonism drugs and other central muscle-tone depressants, intentional self-harm, sequela
T43012A	Poisoning by tricyclic antidepressants, intentional self-harm, initial encounter
T43012D	Poisoning by tricyclic antidepressants, intentional self-harm, subsequent encounter
T43012S	Poisoning by tricyclic antidepressants, intentional self-harm, sequela
T43022A	Poisoning by tetracyclic antidepressants, intentional self-harm, initial encounter
T43022D	Poisoning by tetracyclic antidepressants, intentional self-harm, subsequent encounter
T43022S	Poisoning by tetracyclic antidepressants, intentional self-harm, sequela
T431X2A	Poisoning by monoamine-oxidase-inhibitor antidepressants, intentional self-harm, initial encounter

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
T431X2D	Poisoning by monoamine-oxidase-inhibitor antidepressants, intentional self-harm, subsequent encounter
T431X2S	Poisoning by monoamine-oxidase-inhibitor antidepressants, intentional self-harm, sequela
T43202A	Poisoning by unspecified antidepressants, intentional self-harm, initial encounter
T43202D	Poisoning by unspecified antidepressants, intentional self-harm, subsequent encounter
T43202S	Poisoning by unspecified antidepressants, intentional self-harm, sequela
T43212A	Poisoning by selective serotonin and norepinephrine reuptake inhibitors, intentional self-harm, initial encounter
T43212D	Poisoning by selective serotonin and norepinephrine reuptake inhibitors, intentional self-harm, subsequent encounter
T43212S	Poisoning by selective serotonin and norepinephrine reuptake inhibitors, intentional self-harm, sequela
T43222A	Poisoning by selective serotonin reuptake inhibitors, intentional self-harm, initial encounter
T43222D	Poisoning by selective serotonin reuptake inhibitors, intentional self-harm, subsequent encounter
T43222S	Poisoning by selective serotonin reuptake inhibitors, intentional self-harm, sequela
T43292A	Poisoning by other antidepressants, intentional self-harm, initial encounter
T43292D	Poisoning by other antidepressants, intentional self-harm, subsequent encounter
T43292S	Poisoning by other antidepressants, intentional self-harm, sequela
T433X2A	Poisoning by phenothiazine antipsychotics and neuroleptics, intentional self-harm, initial encounter
T433X2D	Poisoning by phenothiazine antipsychotics and neuroleptics, intentional self-harm, subsequent encounter
T433X2S	Poisoning by phenothiazine antipsychotics and neuroleptics, intentional self-harm, sequela
T434X2A	Poisoning by butyrophenone and thiothixene neuroleptics, intentional self-harm, initial encounter
T434X2D	Poisoning by butyrophenone and thiothixene neuroleptics, intentional self-harm, subsequent encounter
T434X2S	Poisoning by butyrophenone and thiothixene neuroleptics, intentional self-harm, sequela
T43502A	Poisoning by unspecified antipsychotics and neuroleptics, intentional self-harm, initial encounter
T43502D	Poisoning by unspecified antipsychotics and neuroleptics, intentional self-harm, subsequent encounter
T43502S	Poisoning by unspecified antipsychotics and neuroleptics, intentional self-harm, sequela
T43592A	Poisoning by other antipsychotics and neuroleptics, intentional self-harm, initial encounter
T43592D	Poisoning by other antipsychotics and neuroleptics, intentional self-harm, subsequent encounter
T43592S	Poisoning by other antipsychotics and neuroleptics, intentional self-harm, sequela
T43602A	Poisoning by unspecified psychostimulants, intentional self-harm, initial encounter
T43602D	Poisoning by unspecified psychostimulants, intentional self-harm, subsequent encounter
T43602S	Poisoning by unspecified psychostimulants, intentional self-harm, sequela
T43612A	Poisoning by caffeine, intentional self-harm, initial encounter
T43612D	Poisoning by caffeine, intentional self-harm, subsequent encounter
T43612S	Poisoning by caffeine, intentional self-harm, sequela
T43622A	Poisoning by amphetamines, intentional self-harm, initial encounter
T43622D	Poisoning by amphetamines, intentional self-harm, subsequent encounter
T43622S	Poisoning by amphetamines, intentional self-harm, sequela
T43632A	Poisoning by methylphenidate, intentional self-harm, initial encounter
T43632D	Poisoning by methylphenidate, intentional self-harm, subsequent encounter
T43632S	Poisoning by methylphenidate, intentional self-harm, sequela
T43652A	Poisoning by methamphetamines intentional self-harm, initial encounter
T43652D	Poisoning by methamphetamines intentional self-harm, subsequent encounter
T43652S	Poisoning by methamphetamines intentional self-harm, sequela
T440X2A	Poisoning by anticholinesterase agents, intentional self-harm, initial encounter
T440X2D	Poisoning by anticholinesterase agents, intentional self-harm, subsequent encounter
T440X2S	Poisoning by anticholinesterase agents, intentional self-harm, sequela
T441X2A	Poisoning by other parasympathomimetics [cholinergics], intentional self-harm, initial encounter
T441X2D	Poisoning by other parasympathomimetics [cholinergics], intentional self-harm, subsequent encounter
T441X2S	Poisoning by other parasympathomimetics [cholinergics], intentional self-harm, sequela

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
T442X2A	Poisoning by ganglionic blocking drugs, intentional self-harm, initial encounter
T442X2D	Poisoning by ganglionic blocking drugs, intentional self-harm, subsequent encounter
T442X2S	Poisoning by ganglionic blocking drugs, intentional self-harm, sequela
T443X2A	Poisoning by other parasympatholytics [anticholinergics and antimuscarinics] and spasmolytics, intentional self-harm, initial encounter
T443X2D	Poisoning by other parasympatholytics [anticholinergics and antimuscarinics] and spasmolytics, intentional self-harm, subsequent encounter
T443X2S	Poisoning by other parasympatholytics [anticholinergics and antimuscarinics] and spasmolytics, intentional self-harm, sequela
T444X2A	Poisoning by predominantly alpha-adrenoreceptor agonists, intentional self-harm, initial encounter
T444X2D	Poisoning by predominantly alpha-adrenoreceptor agonists, intentional self-harm, subsequent encounter
T444X2S	Poisoning by predominantly alpha-adrenoreceptor agonists, intentional self-harm, sequela
T445X2A	Poisoning by predominantly beta-adrenoreceptor agonists, intentional self-harm, initial encounter
T445X2D	Poisoning by predominantly beta-adrenoreceptor agonists, intentional self-harm, subsequent encounter
T445X2S	Poisoning by predominantly beta-adrenoreceptor agonists, intentional self-harm, sequela
T446X2A	Poisoning by alpha-adrenoreceptor antagonists, intentional self-harm, initial encounter
T446X2D	Poisoning by alpha-adrenoreceptor antagonists, intentional self-harm, subsequent encounter
T446X2S	Poisoning by alpha-adrenoreceptor antagonists, intentional self-harm, sequela
T447X2A	Poisoning by beta-adrenoreceptor antagonists, intentional self-harm, initial encounter
T447X2D	Poisoning by beta-adrenoreceptor antagonists, intentional self-harm, subsequent encounter
T447X2S	Poisoning by beta-adrenoreceptor antagonists, intentional self-harm, sequela
T448X2A	Poisoning by centrally-acting and adrenergic-neuron-blocking agents, intentional self-harm, initial encounter
T448X2D	Poisoning by centrally-acting and adrenergic-neuron-blocking agents, intentional self-harm, subsequent encounter
T448X2S	Poisoning by centrally-acting and adrenergic-neuron-blocking agents, intentional self-harm, sequela
T44902A	Poisoning by unspecified drugs primarily affecting the autonomic nervous system, intentional self-harm, initial encounter
T44902D	Poisoning by unspecified drugs primarily affecting the autonomic nervous system, intentional self-harm, subsequent encounter
T44902S	Poisoning by unspecified drugs primarily affecting the autonomic nervous system, intentional self-harm, sequela
T44992A	Poisoning by other drug primarily affecting the autonomic nervous system, intentional self-harm, initial encounter
T44992D	Poisoning by other drug primarily affecting the autonomic nervous system, intentional self-harm, subsequent encounter
T44992S	Poisoning by other drug primarily affecting the autonomic nervous system, intentional self-harm, sequela
T450X2A	Poisoning by antiallergic and antiemetic drugs, intentional self-harm, initial encounter
T450X2D	Poisoning by antiallergic and antiemetic drugs, intentional self-harm, subsequent encounter
T450X2S	Poisoning by antiallergic and antiemetic drugs, intentional self-harm, sequela
T451X2A	Poisoning by antineoplastic and immunosuppressive drugs, intentional self-harm, initial encounter
T451X2D	Poisoning by antineoplastic and immunosuppressive drugs, intentional self-harm, subsequent encounter
T451X2S	Poisoning by antineoplastic and immunosuppressive drugs, intentional self-harm, sequela
T452X2A	Poisoning by vitamins, intentional self-harm, initial encounter
T452X2D	Poisoning by vitamins, intentional self-harm, subsequent encounter
T452X2S	Poisoning by vitamins, intentional self-harm, sequela
T453X2A	Poisoning by enzymes, intentional self-harm, initial encounter
T453X2D	Poisoning by enzymes, intentional self-harm, subsequent encounter
T453X2S	Poisoning by enzymes, intentional self-harm, sequela
T454X2A	Poisoning by iron and its compounds, intentional self-harm, initial encounter

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
T454X2D	Poisoning by iron and its compounds, intentional self-harm, subsequent encounter
T454X2S	Poisoning by iron and its compounds, intentional self-harm, sequela
T45512A	Poisoning by anticoagulants, intentional self-harm, initial encounter
T45512D	Poisoning by anticoagulants, intentional self-harm, subsequent encounter
T45512S	Poisoning by anticoagulants, intentional self-harm, sequela
T45522A	Poisoning by antithrombotic drugs, intentional self-harm, initial encounter
T45522D	Poisoning by antithrombotic drugs, intentional self-harm, subsequent encounter
T45522S	Poisoning by antithrombotic drugs, intentional self-harm, sequela
T45602A	Poisoning by unspecified fibrinolysis-affecting drugs, intentional self-harm, initial encounter
T45602D	Poisoning by unspecified fibrinolysis-affecting drugs, intentional self-harm, subsequent encounter
T45602S	Poisoning by unspecified fibrinolysis-affecting drugs, intentional self-harm, sequela
T45612A	Poisoning by thrombolytic drug, intentional self-harm, initial encounter
T45612D	Poisoning by thrombolytic drug, intentional self-harm, subsequent encounter
T45612S	Poisoning by thrombolytic drug, intentional self-harm, sequela
T45622A	Poisoning by hemostatic drug, intentional self-harm, initial encounter
T45622D	Poisoning by hemostatic drug, intentional self-harm, subsequent encounter
T45622S	Poisoning by hemostatic drug, intentional self-harm, sequela
T45692A	Poisoning by other fibrinolysis-affecting drugs, intentional self-harm, initial encounter
T45692D	Poisoning by other fibrinolysis-affecting drugs, intentional self-harm, subsequent encounter
T45692S	Poisoning by other fibrinolysis-affecting drugs, intentional self-harm, sequela
T457X2A	Poisoning by anticoagulant antagonists, vitamin K and other coagulants, intentional self-harm, initial encounter
T457X2D	Poisoning by anticoagulant antagonists, vitamin K and other coagulants, intentional self-harm, subsequent encounter
T457X2S	Poisoning by anticoagulant antagonists, vitamin K and other coagulants, intentional self-harm, sequela
T458X2A	Poisoning by other primarily systemic and hematological agents, intentional self-harm, initial encounter
T458X2D	Poisoning by other primarily systemic and hematological agents, intentional self-harm, subsequent encounter
T458X2S	Poisoning by other primarily systemic and hematological agents, intentional self-harm, sequela
T4592XA	Poisoning by unspecified primarily systemic and hematological agent, intentional self-harm, initial encounter
T4592XD	Poisoning by unspecified primarily systemic and hematological agent, intentional self-harm, subsequent encounter
T4592XS	Poisoning by unspecified primarily systemic and hematological agent, intentional self-harm, sequela
T45AX2A	Poisoning by immune checkpoint inhibitors and immunostimulant drugs, intentional self-harm, initial encounter
T45AX2D	Poisoning by immune checkpoint inhibitors and immunostimulant drugs, intentional self-harm, subsequent encounter
T45AX2S	Poisoning by immune checkpoint inhibitors and immunostimulant drugs, intentional self-harm, sequela
T460X2A	Poisoning by cardiac-stimulant glycosides and drugs of similar action, intentional self-harm, initial encounter
T460X2D	Poisoning by cardiac-stimulant glycosides and drugs of similar action, intentional self-harm, subsequent encounter
T460X2S	Poisoning by cardiac-stimulant glycosides and drugs of similar action, intentional self-harm, sequela
T461X2A	Poisoning by calcium-channel blockers, intentional self-harm, initial encounter
T461X2D	Poisoning by calcium-channel blockers, intentional self-harm, subsequent encounter
T461X2S	Poisoning by calcium-channel blockers, intentional self-harm, sequela
T462X2A	Poisoning by other antidysrhythmic drugs, intentional self-harm, initial encounter
T462X2D	Poisoning by other antidysrhythmic drugs, intentional self-harm, subsequent encounter
T462X2S	Poisoning by other antidysrhythmic drugs, intentional self-harm, sequela
T463X2A	Poisoning by coronary vasodilators, intentional self-harm, initial encounter
T463X2D	Poisoning by coronary vasodilators, intentional self-harm, subsequent encounter
T463X2S	Poisoning by coronary vasodilators, intentional self-harm, sequela
T464X2A	Poisoning by angiotensin-converting-enzyme inhibitors, intentional self-harm, initial encounter

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
T464X2D	Poisoning by angiotensin-converting-enzyme inhibitors, intentional self-harm, subsequent encounter
T464X2S	Poisoning by angiotensin-converting-enzyme inhibitors, intentional self-harm, sequela
T465X2A	Poisoning by other antihypertensive drugs, intentional self-harm, initial encounter
T465X2D	Poisoning by other antihypertensive drugs, intentional self-harm, subsequent encounter
T465X2S	Poisoning by other antihypertensive drugs, intentional self-harm, sequela
T466X2A	Poisoning by antihyperlipidemic and antiarteriosclerotic drugs, intentional self-harm, initial encounter
T466X2D	Poisoning by antihyperlipidemic and antiarteriosclerotic drugs, intentional self-harm, subsequent encounter
T466X2S	Poisoning by antihyperlipidemic and antiarteriosclerotic drugs, intentional self-harm, sequela
T467X2A	Poisoning by peripheral vasodilators, intentional self-harm, initial encounter
T467X2D	Poisoning by peripheral vasodilators, intentional self-harm, subsequent encounter
T467X2S	Poisoning by peripheral vasodilators, intentional self-harm, sequela
T468X2A	Poisoning by antivaricose drugs, including sclerosing agents, intentional self-harm, initial encounter
T468X2D	Poisoning by antivaricose drugs, including sclerosing agents, intentional self-harm, subsequent encounter
T468X2S	Poisoning by antivaricose drugs, including sclerosing agents, intentional self-harm, sequela
T46902A	Poisoning by unspecified agents primarily affecting the cardiovascular system, intentional self-harm, initial encounter
T46902D	Poisoning by unspecified agents primarily affecting the cardiovascular system, intentional self-harm, subsequent encounter
T46902S	Poisoning by unspecified agents primarily affecting the cardiovascular system, intentional self-harm, sequela
T46992A	Poisoning by other agents primarily affecting the cardiovascular system, intentional self-harm, initial encounter
T46992D	Poisoning by other agents primarily affecting the cardiovascular system, intentional self-harm, subsequent encounter
T46992S	Poisoning by other agents primarily affecting the cardiovascular system, intentional self-harm, sequela
T470X2A	Poisoning by histamine H2-receptor blockers, intentional self-harm, initial encounter
T470X2D	Poisoning by histamine H2-receptor blockers, intentional self-harm, subsequent encounter
T470X2S	Poisoning by histamine H2-receptor blockers, intentional self-harm, sequela
T471X2A	Poisoning by other antacids and anti-gastric-secretion drugs, intentional self-harm, initial encounter
T471X2D	Poisoning by other antacids and anti-gastric-secretion drugs, intentional self-harm, subsequent encounter
T471X2S	Poisoning by other antacids and anti-gastric-secretion drugs, intentional self-harm, sequela
T472X2A	Poisoning by stimulant laxatives, intentional self-harm, initial encounter
T472X2D	Poisoning by stimulant laxatives, intentional self-harm, subsequent encounter
T472X2S	Poisoning by stimulant laxatives, intentional self-harm, sequela
T473X2A	Poisoning by saline and osmotic laxatives, intentional self-harm, initial encounter
T473X2D	Poisoning by saline and osmotic laxatives, intentional self-harm, subsequent encounter
T473X2S	Poisoning by saline and osmotic laxatives, intentional self-harm, sequela
T474X2A	Poisoning by other laxatives, intentional self-harm, initial encounter
T474X2D	Poisoning by other laxatives, intentional self-harm, subsequent encounter
T474X2S	Poisoning by other laxatives, intentional self-harm, sequela
T475X2A	Poisoning by digestants, intentional self-harm, initial encounter
T475X2D	Poisoning by digestants, intentional self-harm, subsequent encounter
T475X2S	Poisoning by digestants, intentional self-harm, sequela
T476X2A	Poisoning by antidiarrheal drugs, intentional self-harm, initial encounter
T476X2D	Poisoning by antidiarrheal drugs, intentional self-harm, subsequent encounter
T476X2S	Poisoning by antidiarrheal drugs, intentional self-harm, sequela
T477X2A	Poisoning by emetics, intentional self-harm, initial encounter
T477X2D	Poisoning by emetics, intentional self-harm, subsequent encounter
T477X2S	Poisoning by emetics, intentional self-harm, sequela
T478X2A	Poisoning by other agents primarily affecting gastrointestinal system, intentional self-harm, initial encounter

Code	Shortened Description
T478X2D	Poisoning by other agents primarily affecting gastrointestinal system, intentional self-harm, subsequent encounter
T478X2S	Poisoning by other agents primarily affecting gastrointestinal system, intentional self-harm, sequela
T4792XA	Poisoning by unspecified agents primarily affecting the gastrointestinal system, intentional self-harm, initial encounter
T4792XD	Poisoning by unspecified agents primarily affecting the gastrointestinal system, intentional self-harm, subsequent encounter
T4792XS	Poisoning by unspecified agents primarily affecting the gastrointestinal system, intentional self-harm, sequela
T480X2A	Poisoning by oxytocic drugs, intentional self-harm, initial encounter
T480X2D	Poisoning by oxytocic drugs, intentional self-harm, subsequent encounter
T480X2S	Poisoning by oxytocic drugs, intentional self-harm, sequela
T481X2A	Poisoning by skeletal muscle relaxants [neuromuscular blocking agents], intentional self-harm, initial encounter
T481X2D	Poisoning by skeletal muscle relaxants [neuromuscular blocking agents], intentional self-harm, subsequent encounter
T481X2S	Poisoning by skeletal muscle relaxants [neuromuscular blocking agents], intentional self-harm, sequela
T48202A	Poisoning by unspecified drugs acting on muscles, intentional self-harm, initial encounter
T48202D	Poisoning by unspecified drugs acting on muscles, intentional self-harm, subsequent encounter
T48202S	Poisoning by unspecified drugs acting on muscles, intentional self-harm, sequela
T48292A	Poisoning by other drugs acting on muscles, intentional self-harm, initial encounter
T48292D	Poisoning by other drugs acting on muscles, intentional self-harm, subsequent encounter
T48292S	Poisoning by other drugs acting on muscles, intentional self-harm, sequela
T483X2A	Poisoning by antitussives, intentional self-harm, initial encounter
T483X2D	Poisoning by antitussives, intentional self-harm, subsequent encounter
T483X2S	Poisoning by antitussives, intentional self-harm, sequela
T484X2A	Poisoning by expectorants, intentional self-harm, initial encounter
T484X2D	Poisoning by expectorants, intentional self-harm, subsequent encounter
T484X2S	Poisoning by expectorants, intentional self-harm, sequela
T485X2A	Poisoning by other anti-common-cold drugs, intentional self-harm, initial encounter
T485X2D	Poisoning by other anti-common-cold drugs, intentional self-harm, subsequent encounter
T485X2S	Poisoning by other anti-common-cold drugs, intentional self-harm, sequela
T486X2A	Poisoning by antiasthmatics, intentional self-harm, initial encounter
T486X2D	Poisoning by antiasthmatics, intentional self-harm, subsequent encounter
T486X2S	Poisoning by antiasthmatics, intentional self-harm, sequela
T48902A	Poisoning by unspecified agents primarily acting on the respiratory system, intentional self-harm, initial encounter
T48902D	Poisoning by unspecified agents primarily acting on the respiratory system, intentional self-harm, subsequent encounter
T48902S	Poisoning by unspecified agents primarily acting on the respiratory system, intentional self-harm, sequela
T48992A	Poisoning by other agents primarily acting on the respiratory system, intentional self-harm, initial encounter
T48992D	Poisoning by other agents primarily acting on the respiratory system, intentional self-harm, subsequent encounter
T48992S	Poisoning by other agents primarily acting on the respiratory system, intentional self-harm, sequela
T490X2A	Poisoning by local antifungal, anti-infective and anti-inflammatory drugs, intentional self-harm, initial encounter
T490X2D	Poisoning by local antifungal, anti-infective and anti-inflammatory drugs, intentional self-harm, subsequent encounter
T490X2S	Poisoning by local antifungal, anti-infective and anti-inflammatory drugs, intentional self-harm, sequela
T491X2A	Poisoning by antipruritics, intentional self-harm, initial encounter
T491X2D	Poisoning by antipruritics, intentional self-harm, subsequent encounter
T491X2S	Poisoning by antipruritics, intentional self-harm, sequela
T492X2A	Poisoning by local astringents and local detergents, intentional self-harm, initial encounter

Code	Shortened Description
T492X2D	Poisoning by local astringents and local detergents, intentional self-harm, subsequent encounter
T492X2S	Poisoning by local astringents and local detergents, intentional self-harm, sequela
T493X2A	Poisoning by emollients, demulcents and protectants, intentional self-harm, initial encounter
T493X2D	Poisoning by emollients, demulcents and protectants, intentional self-harm, subsequent encounter
T493X2S	Poisoning by emollients, demulcents and protectants, intentional self-harm, sequela
T494X2A	Poisoning by keratolytics, keratoplastics, and other hair treatment drugs and preparations, intentional self-harm, initial encounter
T494X2D	Poisoning by keratolytics, keratoplastics, and other hair treatment drugs and preparations, intentional self-harm, subsequent encounter
T494X2S	Poisoning by keratolytics, keratoplastics, and other hair treatment drugs and preparations, intentional self-harm, sequela
T495X2A	Poisoning by ophthalmological drugs and preparations, intentional self-harm, initial encounter
T495X2D	Poisoning by ophthalmological drugs and preparations, intentional self-harm, subsequent encounter
T495X2S	Poisoning by ophthalmological drugs and preparations, intentional self-harm, sequela
T496X2A	Poisoning by otorhinolaryngological drugs and preparations, intentional self-harm, initial encounter
T496X2D	Poisoning by otorhinolaryngological drugs and preparations, intentional self-harm, subsequent encounter
T496X2S	Poisoning by otorhinolaryngological drugs and preparations, intentional self-harm, sequela
T497X2A	Poisoning by dental drugs, topically applied, intentional self-harm, initial encounter
T497X2D	Poisoning by dental drugs, topically applied, intentional self-harm, subsequent encounter
T497X2S	Poisoning by dental drugs, topically applied, intentional self-harm, sequela
T498X2A	Poisoning by other topical agents, intentional self-harm, initial encounter
T498X2D	Poisoning by other topical agents, intentional self-harm, subsequent encounter
T498X2S	Poisoning by other topical agents, intentional self-harm, sequela
T4992XA	Poisoning by unspecified topical agent, intentional self-harm, initial encounter
T4992XD	Poisoning by unspecified topical agent, intentional self-harm, subsequent encounter
T4992XS	Poisoning by unspecified topical agent, intentional self-harm, sequela
T500X2A	Poisoning by mineralocorticoids and their antagonists, intentional self-harm, initial encounter
T500X2D	Poisoning by mineralocorticoids and their antagonists, intentional self-harm, subsequent encounter
T500X2S	Poisoning by mineralocorticoids and their antagonists, intentional self-harm, sequela
T501X2A	Poisoning by loop [high-ceiling] diuretics, intentional self-harm, initial encounter
T501X2D	Poisoning by loop [high-ceiling] diuretics, intentional self-harm, subsequent encounter
T501X2S	Poisoning by loop [high-ceiling] diuretics, intentional self-harm, sequela
T502X2A	Poisoning by carbonic-anhydrase inhibitors, benzothiadiazides and other diuretics, intentional self-harm, initial encounter
T502X2D	Poisoning by carbonic-anhydrase inhibitors, benzothiadiazides and other diuretics, intentional self-harm, subsequent encounter
T502X2S	Poisoning by carbonic-anhydrase inhibitors, benzothiadiazides and other diuretics, intentional self-harm, sequela
T503X2A	Poisoning by electrolytic, caloric and water-balance agents, intentional self-harm, initial encounter
T503X2D	Poisoning by electrolytic, caloric and water-balance agents, intentional self-harm, subsequent encounter
T503X2S	Poisoning by electrolytic, caloric and water-balance agents, intentional self-harm, sequela
T504X2A	Poisoning by drugs affecting uric acid metabolism, intentional self-harm, initial encounter
T504X2D	Poisoning by drugs affecting uric acid metabolism, intentional self-harm, subsequent encounter
T504X2S	Poisoning by drugs affecting uric acid metabolism, intentional self-harm, sequela
T505X2A	Poisoning by appetite depressants, intentional self-harm, initial encounter
T505X2D	Poisoning by appetite depressants, intentional self-harm, subsequent encounter
T505X2S	Poisoning by appetite depressants, intentional self-harm, sequela
T506X2A	Poisoning by antidotes and chelating agents, intentional self-harm, initial encounter
T506X2D	Poisoning by antidotes and chelating agents, intentional self-harm, subsequent encounter

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
T506X2S	Poisoning by antidotes and chelating agents, intentional self-harm, sequela
T507X2A	Poisoning by analeptics and opioid receptor antagonists, intentional self-harm, initial encounter
T507X2D	Poisoning by analeptics and opioid receptor antagonists, intentional self-harm, subsequent encounter
T507X2S	Poisoning by analeptics and opioid receptor antagonists, intentional self-harm, sequela
T508X2A	Poisoning by diagnostic agents, intentional self-harm, initial encounter
T508X2D	Poisoning by diagnostic agents, intentional self-harm, subsequent encounter
T508X2S	Poisoning by diagnostic agents, intentional self-harm, sequela
T50902A	Poisoning by unspecified drugs, medicaments and biological substances, intentional self-harm, initial encounter
T50902D	Poisoning by unspecified drugs, medicaments and biological substances, intentional self-harm, subsequent encounter
T50902S	Poisoning by unspecified drugs, medicaments and biological substances, intentional self-harm, sequela
T50912A	Poisoning by multiple unspecified drugs, medicaments and biological substances, intentional self-harm, initial encounter
T50912D	Poisoning by multiple unspecified drugs, medicaments and biological substances, intentional self-harm, subsequent encounter
T50912S	Poisoning by multiple unspecified drugs, medicaments and biological substances, intentional self-harm, sequela
T50992A	Poisoning by other drugs, medicaments and biological substances, intentional self-harm, initial encounter
T50992D	Poisoning by other drugs, medicaments and biological substances, intentional self-harm, subsequent encounter
T50992S	Poisoning by other drugs, medicaments and biological substances, intentional self-harm, sequela
T50A12A	Poisoning by pertussis vaccine, including combinations with a pertussis component, intentional self-harm, initial encounter
T50A12D	Poisoning by pertussis vaccine, including combinations with a pertussis component, intentional self-harm, subsequent encounter
T50A12S	Poisoning by pertussis vaccine, including combinations with a pertussis component, intentional self-harm, sequela
T50A22A	Poisoning by mixed bacterial vaccines without a pertussis component, intentional self-harm, initial encounter
T50A22D	Poisoning by mixed bacterial vaccines without a pertussis component, intentional self-harm, subsequent encounter
T50A22S	Poisoning by mixed bacterial vaccines without a pertussis component, intentional self-harm, sequela
T50A92A	Poisoning by other bacterial vaccines, intentional self-harm, initial encounter
T50A92D	Poisoning by other bacterial vaccines, intentional self-harm, subsequent encounter
T50A92S	Poisoning by other bacterial vaccines, intentional self-harm, sequela
T50B12A	Poisoning by smallpox vaccines, intentional self-harm, initial encounter
T50B12D	Poisoning by smallpox vaccines, intentional self-harm, subsequent encounter
T50B12S	Poisoning by smallpox vaccines, intentional self-harm, sequela
T50B92A	Poisoning by other viral vaccines, intentional self-harm, initial encounter
T50B92D	Poisoning by other viral vaccines, intentional self-harm, subsequent encounter
T50B92S	Poisoning by other viral vaccines, intentional self-harm, sequela
T50Z12A	Poisoning by immunoglobulin, intentional self-harm, initial encounter
T50Z12D	Poisoning by immunoglobulin, intentional self-harm, subsequent encounter
T50Z12S	Poisoning by immunoglobulin, intentional self-harm, sequela
T50Z92A	Poisoning by other vaccines and biological substances, intentional self-harm, initial encounter
T50Z92D	Poisoning by other vaccines and biological substances, intentional self-harm, subsequent encounter
T50Z92S	Poisoning by other vaccines and biological substances, intentional self-harm, sequela
T510X2A	Toxic effect of ethanol, intentional self-harm, initial encounter
T510X2D	Toxic effect of ethanol, intentional self-harm, subsequent encounter
T510X2S	Toxic effect of ethanol, intentional self-harm, sequela
T511X2A	Toxic effect of methanol, intentional self-harm, initial encounter

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
T511X2D	Toxic effect of methanol, intentional self-harm, subsequent encounter
T511X2S	Toxic effect of methanol, intentional self-harm, sequela
T512X2A	Toxic effect of 2-Propanol, intentional self-harm, initial encounter
T512X2D	Toxic effect of 2-Propanol, intentional self-harm, subsequent encounter
T512X2S	Toxic effect of 2-Propanol, intentional self-harm, sequela
T513X2A	Toxic effect of fusel oil, intentional self-harm, initial encounter
T513X2D	Toxic effect of fusel oil, intentional self-harm, subsequent encounter
T513X2S	Toxic effect of fusel oil, intentional self-harm, sequela
T518X2A	Toxic effect of other alcohols, intentional self-harm, initial encounter
T518X2D	Toxic effect of other alcohols, intentional self-harm, subsequent encounter
T518X2S	Toxic effect of other alcohols, intentional self-harm, sequela
T5192XA	Toxic effect of unspecified alcohol, intentional self-harm, initial encounter
T5192XD	Toxic effect of unspecified alcohol, intentional self-harm, subsequent encounter
T5192XS	Toxic effect of unspecified alcohol, intentional self-harm, sequela
T520X2A	Toxic effect of petroleum products, intentional self-harm, initial encounter
T520X2D	Toxic effect of petroleum products, intentional self-harm, subsequent encounter
T520X2S	Toxic effect of petroleum products, intentional self-harm, sequela
T521X2A	Toxic effect of benzene, intentional self-harm, initial encounter
T521X2D	Toxic effect of benzene, intentional self-harm, subsequent encounter
T521X2S	Toxic effect of benzene, intentional self-harm, sequela
T522X2A	Toxic effect of homologues of benzene, intentional self-harm, initial encounter
T522X2D	Toxic effect of homologues of benzene, intentional self-harm, subsequent encounter
T522X2S	Toxic effect of homologues of benzene, intentional self-harm, sequela
T523X2A	Toxic effect of glycols, intentional self-harm, initial encounter
T523X2D	Toxic effect of glycols, intentional self-harm, subsequent encounter
T523X2S	Toxic effect of glycols, intentional self-harm, sequela
T524X2A	Toxic effect of ketones, intentional self-harm, initial encounter
T524X2D	Toxic effect of ketones, intentional self-harm, subsequent encounter
T524X2S	Toxic effect of ketones, intentional self-harm, sequela
T528X2A	Toxic effect of other organic solvents, intentional self-harm, initial encounter
T528X2D	Toxic effect of other organic solvents, intentional self-harm, subsequent encounter
T528X2S	Toxic effect of other organic solvents, intentional self-harm, sequela
T550X2A	Toxic effect of soaps, intentional self-harm, initial encounter
T550X2D	Toxic effect of soaps, intentional self-harm, subsequent encounter
T550X2S	Toxic effect of soaps, intentional self-harm, sequela
T551X2A	Toxic effect of detergents, intentional self-harm, initial encounter
T551X2D	Toxic effect of detergents, intentional self-harm, subsequent encounter
T551X2S	Toxic effect of detergents, intentional self-harm, sequela
T560X2A	Toxic effect of lead and its compounds, intentional self-harm, initial encounter
T560X2D	Toxic effect of lead and its compounds, intentional self-harm, subsequent encounter
T560X2S	Toxic effect of lead and its compounds, intentional self-harm, sequela
T561X2A	Toxic effect of mercury and its compounds, intentional self-harm, initial encounter
T561X2D	Toxic effect of mercury and its compounds, intentional self-harm, subsequent encounter
T561X2S	Toxic effect of mercury and its compounds, intentional self-harm, sequela
T562X2A	Toxic effect of chromium and its compounds, intentional self-harm, initial encounter
T562X2D	Toxic effect of chromium and its compounds, intentional self-harm, subsequent encounter
T562X2S	Toxic effect of chromium and its compounds, intentional self-harm, sequela
T563X2A	Toxic effect of cadmium and its compounds, intentional self-harm, initial encounter

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
T563X2D	Toxic effect of cadmium and its compounds, intentional self-harm, subsequent encounter
T563X2S	Toxic effect of cadmium and its compounds, intentional self-harm, sequela
T564X2A	Toxic effect of copper and its compounds, intentional self-harm, initial encounter
T564X2D	Toxic effect of copper and its compounds, intentional self-harm, subsequent encounter
T564X2S	Toxic effect of copper and its compounds, intentional self-harm, sequela
T565X2A	Toxic effect of zinc and its compounds, intentional self-harm, initial encounter
T565X2D	Toxic effect of zinc and its compounds, intentional self-harm, subsequent encounter
T565X2S	Toxic effect of zinc and its compounds, intentional self-harm, sequela
T566X2A	Toxic effect of tin and its compounds, intentional self-harm, initial encounter
T566X2D	Toxic effect of tin and its compounds, intentional self-harm, subsequent encounter
T566X2S	Toxic effect of tin and its compounds, intentional self-harm, sequela
T567X2A	Toxic effect of beryllium and its compounds, intentional self-harm, initial encounter
T567X2D	Toxic effect of beryllium and its compounds, intentional self-harm, subsequent encounter
T567X2S	Toxic effect of beryllium and its compounds, intentional self-harm, sequela
T56812A	Toxic effect of thallium, intentional self-harm, initial encounter
T56812D	Toxic effect of thallium, intentional self-harm, subsequent encounter
T56812S	Toxic effect of thallium, intentional self-harm, sequela
T56822D	Toxic effect of gadolinium, intentional self-harm, subsequent encounter
T56822S	Toxic effect of gadolinium, intentional self-harm, sequela
T56823A	Toxic effect of gadolinium, assault, initial encounter
T56823D	Toxic effect of gadolinium, assault, subsequent encounter
T56823S	Toxic effect of gadolinium, assault, sequela
T56824A	Toxic effect of gadolinium, undetermined, initial encounter
T56824D	Toxic effect of gadolinium, undetermined, subsequent encounter
T56824S	Toxic effect of gadolinium, undetermined, sequela
T56892A	Toxic effect of other metals, intentional self-harm, initial encounter
T56892D	Toxic effect of other metals, intentional self-harm, subsequent encounter
T56892S	Toxic effect of other metals, intentional self-harm, sequela
T5692XA	Toxic effect of unspecified metal, intentional self-harm, initial encounter
T5692XD	Toxic effect of unspecified metal, intentional self-harm, subsequent encounter
T5692XS	Toxic effect of unspecified metal, intentional self-harm, sequela
T570X2A	Toxic effect of arsenic and its compounds, intentional self-harm, initial encounter
T570X2D	Toxic effect of arsenic and its compounds, intentional self-harm, subsequent encounter
T570X2S	Toxic effect of arsenic and its compounds, intentional self-harm, sequela
T571X2A	Toxic effect of phosphorus and its compounds, intentional self-harm, initial encounter
T571X2D	Toxic effect of phosphorus and its compounds, intentional self-harm, subsequent encounter
T571X2S	Toxic effect of phosphorus and its compounds, intentional self-harm, sequela
T572X2A	Toxic effect of manganese and its compounds, intentional self-harm, initial encounter
T572X2D	Toxic effect of manganese and its compounds, intentional self-harm, subsequent encounter
T572X2S	Toxic effect of manganese and its compounds, intentional self-harm, sequela
T573X2A	Toxic effect of hydrogen cyanide, intentional self-harm, initial encounter
T573X2D	Toxic effect of hydrogen cyanide, intentional self-harm, subsequent encounter
T573X2S	Toxic effect of hydrogen cyanide, intentional self-harm, sequela
T578X2A	Toxic effect of other specified inorganic substances, intentional self-harm, initial encounter
T578X2D	Toxic effect of other specified inorganic substances, intentional self-harm, subsequent encounter
T578X2S	Toxic effect of other specified inorganic substances, intentional self-harm, sequela
T5792XA	Toxic effect of unspecified inorganic substance, intentional self-harm, initial encounter
T5792XD	Toxic effect of unspecified inorganic substance, intentional self-harm, subsequent encounter

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
T5792XS	Toxic effect of unspecified inorganic substance, intentional self-harm, sequela
T5802XA	Toxic effect of carbon monoxide from motor vehicle exhaust, intentional self-harm, initial encounter
T5802XD	Toxic effect of carbon monoxide from motor vehicle exhaust, intentional self-harm, subsequent encounter
T5802XS	Toxic effect of carbon monoxide from motor vehicle exhaust, intentional self-harm, sequela
T5812XA	Toxic effect of carbon monoxide from utility gas, intentional self-harm, initial encounter
T5812XD	Toxic effect of carbon monoxide from utility gas, intentional self-harm, subsequent encounter
T5812XS	Toxic effect of carbon monoxide from utility gas, intentional self-harm, sequela
T582X2A	Toxic effect of carbon monoxide from incomplete combustion of other domestic fuels, intentional self-harm, initial encounter
T582X2D	Toxic effect of carbon monoxide from incomplete combustion of other domestic fuels, intentional self-harm, subsequent encounter
T582X2S	Toxic effect of carbon monoxide from incomplete combustion of other domestic fuels, intentional self-harm, sequela
T588X2A	Toxic effect of carbon monoxide from other source, intentional self-harm, initial encounter
T588X2D	Toxic effect of carbon monoxide from other source, intentional self-harm, subsequent encounter
T588X2S	Toxic effect of carbon monoxide from other source, intentional self-harm, sequela
T5892XA	Toxic effect of carbon monoxide from unspecified source, intentional self-harm, initial encounter
T5892XD	Toxic effect of carbon monoxide from unspecified source, intentional self-harm, subsequent encounter
T5892XS	Toxic effect of carbon monoxide from unspecified source, intentional self-harm, sequela
T590X2A	Toxic effect of nitrogen oxides, intentional self-harm, initial encounter
T590X2D	Toxic effect of nitrogen oxides, intentional self-harm, subsequent encounter
T590X2S	Toxic effect of nitrogen oxides, intentional self-harm, sequela
T591X2A	Toxic effect of sulfur dioxide, intentional self-harm, initial encounter
T591X2D	Toxic effect of sulfur dioxide, intentional self-harm, subsequent encounter
T591X2S	Toxic effect of sulfur dioxide, intentional self-harm, sequela
T592X2A	Toxic effect of formaldehyde, intentional self-harm, initial encounter
T592X2D	Toxic effect of formaldehyde, intentional self-harm, subsequent encounter
T592X2S	Toxic effect of formaldehyde, intentional self-harm, sequela
T593X2A	Toxic effect of lacrimogenic gas, intentional self-harm, initial encounter
T593X2D	Toxic effect of lacrimogenic gas, intentional self-harm, subsequent encounter
T593X2S	Toxic effect of lacrimogenic gas, intentional self-harm, sequela
T594X2A	Toxic effect of chlorine gas, intentional self-harm, initial encounter
T594X2D	Toxic effect of chlorine gas, intentional self-harm, subsequent encounter
T594X2S	Toxic effect of chlorine gas, intentional self-harm, sequela
T595X2A	Toxic effect of fluorine gas and hydrogen fluoride, intentional self-harm, initial encounter
T595X2D	Toxic effect of fluorine gas and hydrogen fluoride, intentional self-harm, subsequent encounter
T595X2S	Toxic effect of fluorine gas and hydrogen fluoride, intentional self-harm, sequela
T600X2A	Toxic effect of organophosphate and carbamate insecticides, intentional self-harm, initial encounter
T600X2D	Toxic effect of organophosphate and carbamate insecticides, intentional self-harm, subsequent encounter
T600X2S	Toxic effect of organophosphate and carbamate insecticides, intentional self-harm, sequela
T601X2A	Toxic effect of halogenated insecticides, intentional self-harm, initial encounter
T601X2D	Toxic effect of halogenated insecticides, intentional self-harm, subsequent encounter
T601X2S	Toxic effect of halogenated insecticides, intentional self-harm, sequela
T602X2A	Toxic effect of other insecticides, intentional self-harm, initial encounter
T602X2D	Toxic effect of other insecticides, intentional self-harm, subsequent encounter
T602X2S	Toxic effect of other insecticides, intentional self-harm, sequela
T603X2A	Toxic effect of herbicides and fungicides, intentional self-harm, initial encounter
T603X2D	Toxic effect of herbicides and fungicides, intentional self-harm, subsequent encounter

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
T603X2S	Toxic effect of herbicides and fungicides, intentional self-harm, sequela
T604X2A	Toxic effect of rodenticides, intentional self-harm, initial encounter
T604X2D	Toxic effect of rodenticides, intentional self-harm, subsequent encounter
T604X2S	Toxic effect of rodenticides, intentional self-harm, sequela
T608X2A	Toxic effect of other pesticides, intentional self-harm, initial encounter
T608X2D	Toxic effect of other pesticides, intentional self-harm, subsequent encounter
T608X2S	Toxic effect of other pesticides, intentional self-harm, sequela
T6092XA	Toxic effect of unspecified pesticide, intentional self-harm, initial encounter
T6092XD	Toxic effect of unspecified pesticide, intentional self-harm, subsequent encounter
T6092XS	Toxic effect of unspecified pesticide, intentional self-harm, sequela
T6102XA	Ciguatera fish poisoning, intentional self-harm, initial encounter
T6102XD	Ciguatera fish poisoning, intentional self-harm, subsequent encounter
T6102XS	Ciguatera fish poisoning, intentional self-harm, sequela
T6112XA	Scombroid fish poisoning, intentional self-harm, initial encounter
T6112XD	Scombroid fish poisoning, intentional self-harm, subsequent encounter
T6112XS	Scombroid fish poisoning, intentional self-harm, sequela
T61772A	Other fish poisoning, intentional self-harm, initial encounter
T61772D	Other fish poisoning, intentional self-harm, subsequent encounter
T61772S	Other fish poisoning, intentional self-harm, sequela
T61782A	Other shellfish poisoning, intentional self-harm, initial encounter
T61782D	Other shellfish poisoning, intentional self-harm, subsequent encounter
T61782S	Other shellfish poisoning, intentional self-harm, sequela
T618X2A	Toxic effect of other seafood, intentional self-harm, initial encounter
T618X2D	Toxic effect of other seafood, intentional self-harm, subsequent encounter
T618X2S	Toxic effect of other seafood, intentional self-harm, sequela
T6192XA	Toxic effect of unspecified seafood, intentional self-harm, initial encounter
T6192XD	Toxic effect of unspecified seafood, intentional self-harm, subsequent encounter
T6192XS	Toxic effect of unspecified seafood, intentional self-harm, sequela
T620X2A	Toxic effect of ingested mushrooms, intentional self-harm, initial encounter
T620X2D	Toxic effect of ingested mushrooms, intentional self-harm, subsequent encounter
T620X2S	Toxic effect of ingested mushrooms, intentional self-harm, sequela
T621X2A	Toxic effect of ingested berries, intentional self-harm, initial encounter
T621X2D	Toxic effect of ingested berries, intentional self-harm, subsequent encounter
T621X2S	Toxic effect of ingested berries, intentional self-harm, sequela
T622X2A	Toxic effect of other ingested (parts of) plant(s), intentional self-harm, initial encounter
T622X2D	Toxic effect of other ingested (parts of) plant(s), intentional self-harm, subsequent encounter
T622X2S	Toxic effect of other ingested (parts of) plant(s), intentional self-harm, sequela
T628X2A	Toxic effect of other specified noxious substances eaten as food, intentional self-harm, initial encounter
T628X2D	Toxic effect of other specified noxious substances eaten as food, intentional self-harm, subsequent encounter
T628X2S	Toxic effect of other specified noxious substances eaten as food, intentional self-harm, sequela
T6292XA	Toxic effect of unspecified noxious substance eaten as food, intentional self-harm, initial encounter
T6292XD	Toxic effect of unspecified noxious substance eaten as food, intentional self-harm, subsequent encounter
T6292XS	Toxic effect of unspecified noxious substance eaten as food, intentional self-harm, sequela
T63002A	Toxic effect of unspecified snake venom, intentional self-harm, initial encounter
T63002D	Toxic effect of unspecified snake venom, intentional self-harm, subsequent encounter
T63002S	Toxic effect of unspecified snake venom, intentional self-harm, sequela
T63012A	Toxic effect of rattlesnake venom, intentional self-harm, initial encounter
T63012D	Toxic effect of rattlesnake venom, intentional self-harm, subsequent encounter

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
T63012S	Toxic effect of rattlesnake venom, intentional self-harm, sequela
T63022A	Toxic effect of coral snake venom, intentional self-harm, initial encounter
T63022D	Toxic effect of coral snake venom, intentional self-harm, subsequent encounter
T63022S	Toxic effect of coral snake venom, intentional self-harm, sequela
T63032A	Toxic effect of taipan venom, intentional self-harm, initial encounter
T63032D	Toxic effect of taipan venom, intentional self-harm, subsequent encounter
T63032S	Toxic effect of taipan venom, intentional self-harm, sequela
T63042A	Toxic effect of cobra venom, intentional self-harm, initial encounter
T63042D	Toxic effect of cobra venom, intentional self-harm, subsequent encounter
T63042S	Toxic effect of cobra venom, intentional self-harm, sequela
T63062A	Toxic effect of venom of other North and South American snake, intentional self-harm, initial encounter
T63062D	Toxic effect of venom of other North and South American snake, intentional self-harm, subsequent encounter
T63062S	Toxic effect of venom of other North and South American snake, intentional self-harm, sequela
T63072A	Toxic effect of venom of other Australian snake, intentional self-harm, initial encounter
T63072D	Toxic effect of venom of other Australian snake, intentional self-harm, subsequent encounter
T63072S	Toxic effect of venom of other Australian snake, intentional self-harm, sequela
T63082A	Toxic effect of venom of other African and Asian snake, intentional self-harm, initial encounter
T63082D	Toxic effect of venom of other African and Asian snake, intentional self-harm, subsequent encounter
T63082S	Toxic effect of venom of other African and Asian snake, intentional self-harm, sequela
T63092A	Toxic effect of venom of other snake, intentional self-harm, initial encounter
T63092D	Toxic effect of venom of other snake, intentional self-harm, subsequent encounter
T63092S	Toxic effect of venom of other snake, intentional self-harm, sequela
T63112A	Toxic effect of venom of gila monster, intentional self-harm, initial encounter
T63112D	Toxic effect of venom of gila monster, intentional self-harm, subsequent encounter
T63112S	Toxic effect of venom of gila monster, intentional self-harm, sequela
T63122A	Toxic effect of venom of other venomous lizard, intentional self-harm, initial encounter
T63122D	Toxic effect of venom of other venomous lizard, intentional self-harm, subsequent encounter
T63122S	Toxic effect of venom of other venomous lizard, intentional self-harm, sequela
T63192A	Toxic effect of venom of other reptiles, intentional self-harm, initial encounter
T63192D	Toxic effect of venom of other reptiles, intentional self-harm, subsequent encounter
T63192S	Toxic effect of venom of other reptiles, intentional self-harm, sequela
T632X2A	Toxic effect of venom of scorpion, intentional self-harm, initial encounter
T632X2D	Toxic effect of venom of scorpion, intentional self-harm, subsequent encounter
T632X2S	Toxic effect of venom of scorpion, intentional self-harm, sequela
T63302A	Toxic effect of unspecified spider venom, intentional self-harm, initial encounter
T63302D	Toxic effect of unspecified spider venom, intentional self-harm, subsequent encounter
T63302S	Toxic effect of unspecified spider venom, intentional self-harm, sequela
T63312A	Toxic effect of venom of black widow spider, intentional self-harm, initial encounter
T63312D	Toxic effect of venom of black widow spider, intentional self-harm, subsequent encounter
T63312S	Toxic effect of venom of black widow spider, intentional self-harm, sequela
T63322A	Toxic effect of venom of tarantula, intentional self-harm, initial encounter
T63322D	Toxic effect of venom of tarantula, intentional self-harm, subsequent encounter
T63322S	Toxic effect of venom of tarantula, intentional self-harm, sequela
T63332A	Toxic effect of venom of brown recluse spider, intentional self-harm, initial encounter
T63332D	Toxic effect of venom of brown recluse spider, intentional self-harm, subsequent encounter
T63332S	Toxic effect of venom of brown recluse spider, intentional self-harm, sequela
T63392A	Toxic effect of venom of other spider, intentional self-harm, initial encounter
T63392D	Toxic effect of venom of other spider, intentional self-harm, subsequent encounter

Code	Shortened Description
T63392S	Toxic effect of venom of other spider, intentional self-harm, sequela
T63412A	Toxic effect of venom of centipedes and venomous millipedes, intentional self-harm, initial encounter
T63412D	Toxic effect of venom of centipedes and venomous millipedes, intentional self-harm, subsequent encounter
T63412S	Toxic effect of venom of centipedes and venomous millipedes, intentional self-harm, sequela
T63422A	Toxic effect of venom of ants, intentional self-harm, initial encounter
T63422D	Toxic effect of venom of ants, intentional self-harm, subsequent encounter
T63422S	Toxic effect of venom of ants, intentional self-harm, sequela
T63432A	Toxic effect of venom of caterpillars, intentional self-harm, initial encounter
T63432D	Toxic effect of venom of caterpillars, intentional self-harm, subsequent encounter
T63432S	Toxic effect of venom of caterpillars, intentional self-harm, sequela
T63442A	Toxic effect of venom of bees, intentional self-harm, initial encounter
T63442D	Toxic effect of venom of bees, intentional self-harm, subsequent encounter
T63442S	Toxic effect of venom of bees, intentional self-harm, sequela
T63452A	Toxic effect of venom of hornets, intentional self-harm, initial encounter
T63452D	Toxic effect of venom of hornets, intentional self-harm, subsequent encounter
T63452S	Toxic effect of venom of hornets, intentional self-harm, sequela
T63462A	Toxic effect of venom of wasps, intentional self-harm, initial encounter
T63462D	Toxic effect of venom of wasps, intentional self-harm, subsequent encounter
T63462S	Toxic effect of venom of wasps, intentional self-harm, sequela
T63482A	Toxic effect of venom of other arthropod, intentional self-harm, initial encounter
T63482D	Toxic effect of venom of other arthropod, intentional self-harm, subsequent encounter
T63482S	Toxic effect of venom of other arthropod, intentional self-harm, sequela
T63512A	Toxic effect of contact with stingray, intentional self-harm, initial encounter
T63512D	Toxic effect of contact with stingray, intentional self-harm, subsequent encounter
T63512S	Toxic effect of contact with stingray, intentional self-harm, sequela
T63592A	Toxic effect of contact with other venomous fish, intentional self-harm, initial encounter
T63592D	Toxic effect of contact with other venomous fish, intentional self-harm, subsequent encounter
T63592S	Toxic effect of contact with other venomous fish, intentional self-harm, sequela
T63612A	Toxic effect of contact with Portugese Man-o-war, intentional self-harm, initial encounter
T63612D	Toxic effect of contact with Portugese Man-o-war, intentional self-harm, subsequent encounter
T63612S	Toxic effect of contact with Portugese Man-o-war, intentional self-harm, sequela
T63622A	Toxic effect of contact with other jellyfish, intentional self-harm, initial encounter
T63622D	Toxic effect of contact with other jellyfish, intentional self-harm, subsequent encounter
T63622S	Toxic effect of contact with other jellyfish, intentional self-harm, sequela
T63632A	Toxic effect of contact with sea anemone, intentional self-harm, initial encounter
T63632D	Toxic effect of contact with sea anemone, intentional self-harm, subsequent encounter
T63632S	Toxic effect of contact with sea anemone, intentional self-harm, sequela
T63692A	Toxic effect of contact with other venomous marine animals, intentional self-harm, initial encounter
T63692D	Toxic effect of contact with other venomous marine animals, intentional self-harm, subsequent encounter
T63692S	Toxic effect of contact with other venomous marine animals, intentional self-harm, sequela
T63712A	Toxic effect of contact with venomous marine plant, intentional self-harm, initial encounter
T63712D	Toxic effect of contact with venomous marine plant, intentional self-harm, subsequent encounter
T63712S	Toxic effect of contact with venomous marine plant, intentional self-harm, sequela
T63792A	Toxic effect of contact with other venomous plant, intentional self-harm, initial encounter
T63792D	Toxic effect of contact with other venomous plant, intentional self-harm, subsequent encounter
T63792S	Toxic effect of contact with other venomous plant, intentional self-harm, sequela
T63812A	Toxic effect of contact with venomous frog, intentional self-harm, initial encounter
T63812D	Toxic effect of contact with venomous frog, intentional self-harm, subsequent encounter

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
T63812S	Toxic effect of contact with venomous frog, intentional self-harm, sequela
T63822A	Toxic effect of contact with venomous toad, intentional self-harm, initial encounter
T63822D	Toxic effect of contact with venomous toad, intentional self-harm, subsequent encounter
T63822S	Toxic effect of contact with venomous toad, intentional self-harm, sequela
T63832A	Toxic effect of contact with other venomous amphibian, intentional self-harm, initial encounter
T63832D	Toxic effect of contact with other venomous amphibian, intentional self-harm, subsequent encounter
T63832S	Toxic effect of contact with other venomous amphibian, intentional self-harm, sequela
T63892A	Toxic effect of contact with other venomous animals, intentional self-harm, initial encounter
T63892D	Toxic effect of contact with other venomous animals, intentional self-harm, subsequent encounter
T63892S	Toxic effect of contact with other venomous animals, intentional self-harm, sequela
T6392XA	Toxic effect of contact with unspecified venomous animal, intentional self-harm, initial encounter
T6392XD	Toxic effect of contact with unspecified venomous animal, intentional self-harm, subsequent encounter
T6392XS	Toxic effect of contact with unspecified venomous animal, intentional self-harm, sequela
T6402XA	Toxic effect of aflatoxin, intentional self-harm, initial encounter
T6402XD	Toxic effect of aflatoxin, intentional self-harm, subsequent encounter
T6402XS	Toxic effect of aflatoxin, intentional self-harm, sequela
T6482XA	Toxic effect of other mycotoxin food contaminants, intentional self-harm, initial encounter
T6482XD	Toxic effect of other mycotoxin food contaminants, intentional self-harm, subsequent encounter
T6482XS	Toxic effect of other mycotoxin food contaminants, intentional self-harm, sequela
T650X2A	Toxic effect of cyanides, intentional self-harm, initial encounter
T650X2D	Toxic effect of cyanides, intentional self-harm, subsequent encounter
T650X2S	Toxic effect of cyanides, intentional self-harm, sequela
T651X2A	Toxic effect of strychnine and its salts, intentional self-harm, initial encounter
T651X2D	Toxic effect of strychnine and its salts, intentional self-harm, subsequent encounter
T651X2S	Toxic effect of strychnine and its salts, intentional self-harm, sequela
T65212A	Toxic effect of chewing tobacco, intentional self-harm, initial encounter
T65212D	Toxic effect of chewing tobacco, intentional self-harm, subsequent encounter
T65212S	Toxic effect of chewing tobacco, intentional self-harm, sequela
T65222A	Toxic effect of tobacco cigarettes, intentional self-harm, initial encounter
T65222D	Toxic effect of tobacco cigarettes, intentional self-harm, subsequent encounter
T65222S	Toxic effect of tobacco cigarettes, intentional self-harm, sequela
T65292A	Toxic effect of other tobacco and nicotine, intentional self-harm, initial encounter
T65292D	Toxic effect of other tobacco and nicotine, intentional self-harm, subsequent encounter
T65292S	Toxic effect of other tobacco and nicotine, intentional self-harm, sequela
T653X2A	Toxic effect of nitroderivatives and aminoderivatives of benzene and its homologues, intentional self-harm, initial encounter
T653X2D	Toxic effect of nitroderivatives and aminoderivatives of benzene and its homologues, intentional self-harm, subsequent encounter
T653X2S	Toxic effect of nitroderivatives and aminoderivatives of benzene and its homologues, intentional self-harm, sequela
T654X2A	Toxic effect of carbon disulfide, intentional self-harm, initial encounter
T654X2D	Toxic effect of carbon disulfide, intentional self-harm, subsequent encounter
T654X2S	Toxic effect of carbon disulfide, intentional self-harm, sequela
T655X2A	Toxic effect of nitroglycerin and other nitric acids and esters, intentional self-harm, initial encounter
T655X2D	Toxic effect of nitroglycerin and other nitric acids and esters, intentional self-harm, subsequent encounter
T655X2S	Toxic effect of nitroglycerin and other nitric acids and esters, intentional self-harm, sequela
T656X2A	Toxic effect of paints and dyes, not elsewhere classified, intentional self-harm, initial encounter
T656X2D	Toxic effect of paints and dyes, not elsewhere classified, intentional self-harm, subsequent encounter

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
T656X2S	Toxic effect of paints and dyes, not elsewhere classified, intentional self-harm, sequela
T65812A	Toxic effect of latex, intentional self-harm, initial encounter
T65812D	Toxic effect of latex, intentional self-harm, subsequent encounter
T65812S	Toxic effect of latex, intentional self-harm, sequela
T65822A	Toxic effect of harmful algae and algae toxins, intentional self-harm, initial encounter
T65822D	Toxic effect of harmful algae and algae toxins, intentional self-harm, subsequent encounter
T65822S	Toxic effect of harmful algae and algae toxins, intentional self-harm, sequela
T65832A	Toxic effect of fiberglass, intentional self-harm, initial encounter
T65832D	Toxic effect of fiberglass, intentional self-harm, subsequent encounter
T65832S	Toxic effect of fiberglass, intentional self-harm, sequela
T65892A	Toxic effect of other specified substances, intentional self-harm, initial encounter
T65892D	Toxic effect of other specified substances, intentional self-harm, subsequent encounter
T65892S	Toxic effect of other specified substances, intentional self-harm, sequela
T6592XA	Toxic effect of unspecified substance, intentional self-harm, initial encounter
T6592XD	Toxic effect of unspecified substance, intentional self-harm, subsequent encounter
T6592XS	Toxic effect of unspecified substance, intentional self-harm, sequela
X710XXA	Intentional self-harm by drowning and submersion while in bathtub, initial encounter
X710XXD	Intentional self-harm by drowning and submersion while in bathtub, subsequent encounter
X710XXS	Intentional self-harm by drowning and submersion while in bathtub, sequela
X711XXA	Intentional self-harm by drowning and submersion while in swimming pool, initial encounter
X711XXD	Intentional self-harm by drowning and submersion while in swimming pool, subsequent encounter
X711XXS	Intentional self-harm by drowning and submersion while in swimming pool, sequela
X712XXA	Intentional self-harm by drowning and submersion after jump into swimming pool, initial encounter
X712XXD	Intentional self-harm by drowning and submersion after jump into swimming pool, subsequent encounter
X712XXS	Intentional self-harm by drowning and submersion after jump into swimming pool, sequela
X713XXA	Intentional self-harm by drowning and submersion in natural water, initial encounter
X713XXD	Intentional self-harm by drowning and submersion in natural water, subsequent encounter
X713XXS	Intentional self-harm by drowning and submersion in natural water, sequela
X718XXA	Other intentional self-harm by drowning and submersion, initial encounter
X718XXD	Other intentional self-harm by drowning and submersion, subsequent encounter
X718XXS	Other intentional self-harm by drowning and submersion, sequela
X719XXA	Intentional self-harm by drowning and submersion, unspecified, initial encounter
X719XXD	Intentional self-harm by drowning and submersion, unspecified, subsequent encounter
X719XXS	Intentional self-harm by drowning and submersion, unspecified, sequela
X72XXXA	Intentional self-harm by handgun discharge, initial encounter
X72XXXD	Intentional self-harm by handgun discharge, subsequent encounter
X72XXXS	Intentional self-harm by handgun discharge, sequela
X730XXA	Intentional self-harm by shotgun discharge, initial encounter
X730XXD	Intentional self-harm by shotgun discharge, subsequent encounter
X730XXS	Intentional self-harm by shotgun discharge, sequela
X731XXA	Intentional self-harm by hunting rifle discharge, initial encounter
X731XXD	Intentional self-harm by hunting rifle discharge, subsequent encounter
X731XXS	Intentional self-harm by hunting rifle discharge, sequela
X732XXA	Intentional self-harm by machine gun discharge, initial encounter
X732XXD	Intentional self-harm by machine gun discharge, subsequent encounter
X732XXS	Intentional self-harm by machine gun discharge, sequela
X738XXA	Intentional self-harm by other larger firearm discharge, initial encounter
X738XXD	Intentional self-harm by other larger firearm discharge, subsequent encounter

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
X738XXS	Intentional self-harm by other larger firearm discharge, sequela
X739XXA	Intentional self-harm by unspecified larger firearm discharge, initial encounter
X739XXD	Intentional self-harm by unspecified larger firearm discharge, subsequent encounter
X739XXS	Intentional self-harm by unspecified larger firearm discharge, sequela
X7401XA	Intentional self-harm by airgun, initial encounter
X7401XD	Intentional self-harm by airgun, subsequent encounter
X7401XS	Intentional self-harm by airgun, sequela
X7402XA	Intentional self-harm by paintball gun, initial encounter
X7402XD	Intentional self-harm by paintball gun, subsequent encounter
X7402XS	Intentional self-harm by paintball gun, sequela
X7409XA	Intentional self-harm by other gas, air or spring-operated gun, initial encounter
X7409XD	Intentional self-harm by other gas, air or spring-operated gun, subsequent encounter
X7409XS	Intentional self-harm by other gas, air or spring-operated gun, sequela
X748XXA	Intentional self-harm by other firearm discharge, initial encounter
X748XXD	Intentional self-harm by other firearm discharge, subsequent encounter
X748XXS	Intentional self-harm by other firearm discharge, sequela
X749XXA	Intentional self-harm by unspecified firearm discharge, initial encounter
X749XXD	Intentional self-harm by unspecified firearm discharge, subsequent encounter
X749XXS	Intentional self-harm by unspecified firearm discharge, sequela
X75XXXA	Intentional self-harm by explosive material, initial encounter
X75XXXD	Intentional self-harm by explosive material, subsequent encounter
X75XXXS	Intentional self-harm by explosive material, sequela
X76XXXA	Intentional self-harm by smoke, fire and flames, initial encounter
X76XXXD	Intentional self-harm by smoke, fire and flames, subsequent encounter
X76XXXS	Intentional self-harm by smoke, fire and flames, sequela
X770XXA	Intentional self-harm by steam or hot vapors, initial encounter
X770XXD	Intentional self-harm by steam or hot vapors, subsequent encounter
X770XXS	Intentional self-harm by steam or hot vapors, sequela
X771XXA	Intentional self-harm by hot tap water, initial encounter
X771XXD	Intentional self-harm by hot tap water, subsequent encounter
X771XXS	Intentional self-harm by hot tap water, sequela
X772XXA	Intentional self-harm by other hot fluids, initial encounter
X772XXD	Intentional self-harm by other hot fluids, subsequent encounter
X772XXS	Intentional self-harm by other hot fluids, sequela
X773XXA	Intentional self-harm by hot household appliances, initial encounter
X773XXD	Intentional self-harm by hot household appliances, subsequent encounter
X773XXS	Intentional self-harm by hot household appliances, sequela
X778XXA	Intentional self-harm by other hot objects, initial encounter
X778XXD	Intentional self-harm by other hot objects, subsequent encounter
X778XXS	Intentional self-harm by other hot objects, sequela
X779XXA	Intentional self-harm by unspecified hot objects, initial encounter
X779XXD	Intentional self-harm by unspecified hot objects, subsequent encounter
X779XXS	Intentional self-harm by unspecified hot objects, sequela
X780XXA	Intentional self-harm by sharp glass, initial encounter
X780XXD	Intentional self-harm by sharp glass, subsequent encounter
X780XXS	Intentional self-harm by sharp glass, sequela
X781XXA	Intentional self-harm by knife, initial encounter
X781XXD	Intentional self-harm by knife, subsequent encounter

Code	Shortened Description
X781XXS	Intentional self-harm by knife, sequela
X782XXA	Intentional self-harm by sword or dagger, initial encounter
X782XXD	Intentional self-harm by sword or dagger, subsequent encounter
X782XXS	Intentional self-harm by sword or dagger, sequela
X788XXA	Intentional self-harm by other sharp object, initial encounter
X788XXD	Intentional self-harm by other sharp object, subsequent encounter
X788XXS	Intentional self-harm by other sharp object, sequela
X789XXA	Intentional self-harm by unspecified sharp object, initial encounter
X789XXD	Intentional self-harm by unspecified sharp object, subsequent encounter
X789XXS	Intentional self-harm by unspecified sharp object, sequela
X79XXXA	Intentional self-harm by blunt object, initial encounter
X79XXXD	Intentional self-harm by blunt object, subsequent encounter
X79XXXS	Intentional self-harm by blunt object, sequela
X80XXXA	Intentional self-harm by jumping from a high place, initial encounter
X80XXXD	Intentional self-harm by jumping from a high place, subsequent encounter
X80XXXS	Intentional self-harm by jumping from a high place, sequela
X810XXA	Intentional self-harm by jumping or lying in front of motor vehicle, initial encounter
X810XXD	Intentional self-harm by jumping or lying in front of motor vehicle, subsequent encounter
X810XXS	Intentional self-harm by jumping or lying in front of motor vehicle, sequela
X811XXA	Intentional self-harm by jumping or lying in front of (subway) train, initial encounter
X811XXD	Intentional self-harm by jumping or lying in front of (subway) train, subsequent encounter
X811XXS	Intentional self-harm by jumping or lying in front of (subway) train, sequela
X818XXA	Intentional self-harm by jumping or lying in front of other moving object, initial encounter
X818XXD	Intentional self-harm by jumping or lying in front of other moving object, subsequent encounter
X818XXS	Intentional self-harm by jumping or lying in front of other moving object, sequela
X820XXA	Intentional collision of motor vehicle with other motor vehicle, initial encounter
X820XXD	Intentional collision of motor vehicle with other motor vehicle, subsequent encounter
X820XXS	Intentional collision of motor vehicle with other motor vehicle, sequela
X821XXA	Intentional collision of motor vehicle with train, initial encounter
X821XXD	Intentional collision of motor vehicle with train, subsequent encounter
X821XXS	Intentional collision of motor vehicle with train, sequela
X822XXA	Intentional collision of motor vehicle with tree, initial encounter
X822XXD	Intentional collision of motor vehicle with tree, subsequent encounter
X822XXS	Intentional collision of motor vehicle with tree, sequela
X828XXA	Other intentional self-harm by crashing of motor vehicle, initial encounter
X828XXD	Other intentional self-harm by crashing of motor vehicle, subsequent encounter
X828XXS	Other intentional self-harm by crashing of motor vehicle, sequela
X830XXA	Intentional self-harm by crashing of aircraft, initial encounter
X830XXD	Intentional self-harm by crashing of aircraft, subsequent encounter
X830XXS	Intentional self-harm by crashing of aircraft, sequela
X831XXA	Intentional self-harm by electrocution, initial encounter
X831XXD	Intentional self-harm by electrocution, subsequent encounter
X831XXS	Intentional self-harm by electrocution, sequela
X832XXA	Intentional self-harm by exposure to extremes of cold, initial encounter
X832XXD	Intentional self-harm by exposure to extremes of cold, subsequent encounter
X832XXS	Intentional self-harm by exposure to extremes of cold, sequela
X838XXA	Intentional self-harm by other specified means, initial encounter
X838XXD	Intentional self-harm by other specified means, subsequent encounter

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
X838XXS	Intentional self-harm by other specified means, sequela
Z554	Educational maladjustement and discord with teachers and classmates
Z563	Stressful work schedule
Z564	Discord with boss and workmates
Z5681	Sexual harassment on the job
Z592	Discord with neighbors, lodgers and landlord
Z600	Problems of adjustment to life-cycle transitions
Z603	Acculturation difficulty
Z604	Social exclusion and rejection
Z605	Target of (perceived) adverse discrimination and persecution
Z620	Inadequate parental supervision and control
Z621	Parental overprotection
Z6222	Institutional upbringing
Z6229	Other upbringing away from parents
Z623	Hostility towards and scapegoating of child
Z626	Inappropriate (excessive) parental pressure
Z62810	Personal history of physical and sexual abuse in childhood
Z62811	Personal history or psychological abuse in childhood
Z62812	Personal history of neglect in childhood
Z62813	Personal history of forced labor or sexual exploitation in childhood
Z62819	Personal history of unspecified abuse in childhood
Z62820	Parent-biological child conflict
Z62821	Parent-adopted child conflict
Z62822	Parent-foster child conflict
Z62823	Parent-step child conflict
Z62831	Non-parental relative-child conflict
Z62832	Non-relative guardian-child conflict
Z62833	Group home staff-child conflict
Z62890	Parent-child estrangement NEC
Z62891	Sibling rivalry
Z62892	Runaway [from current living environment]
Z62898	Other specified problems related to upbringing
Z629	Problem related to upbringing, unspecified
Z630	Problems in relationship with spouse or partner
Z631	Problems in relationship with in-laws
Z634	Disappearance and death of family member
Z635	Disruption of family by separation and divorce
Z6371	Stress on family due to return of family member from military deployment
Z6372	Alcoholism and drug addiction in family
Z6379	Other stressful life events affecting family and household
Z638	Other specified problems related to primary support group
Z644	Discord with counselors
Z658	Other specified problems related to psychosocial circumstances
Z69010	Encounter for mental health services for victim of parental child abuse
Z69011	Encounter for mental health services for perpetrator of parental child abuse
Z69020	Encounter for mental health services for victim of non-parental child abuse
Z69021	Encounter for mental health services for perpetrator of non-parental child abuse
Z6911	Encounter for mental health services for victim of spousal or partner abuse

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
Z6912	Encounter for mental health services for perpetrator of spousal or partner abuse
Z6981	Encounter for mental health services for victim of other abuse
Z6982	Encounter for mental health services for perpetrator of other abuse
Z700	Counseling related to sexual attitude
Z701	Counseling related to patient's sexual behavior and orientation
Z702	Counseling related to sexual behavior and orientation of third party
Z703	Counseling related to combined concerns regarding sexual attitude, behavior and orientation
Z708	Other sex counseling
Z709	Sex counseling, unspecified
Z7141	Alcohol abuse counseling and surveillance of alcoholic
Z7142	Counseling for family member of alcoholic
Z7151	Drug abuse counseling and surveillance of drug abuser
Z7152	Counseling for family member of drug abuser
Z7189	Other specified counseling
Z7251	High risk heterosexual behavior
Z7252	High risk homosexual behavior
Z7253	High risk bisexual behavior
Z726	Gambling and betting
Z72810	Child and adolescent antisocial behavior
Z72811	Adult antisocial behavior
Z72820	Sleep deprivation
Z7289	Other problems related to lifestyle
Z730	Burn-out
Z731	Type A behavior pattern
Z733	Stress, not elsewhere classified
Z734	Inadequate social skills, not elsewhere classified
Z735	Social role conflict, not elsewhere classified
Z73810	Behavioral insomnia of childhood, sleep-onset association type
Z73811	Behavioral insomnia of childhood, limit setting type
Z73812	Behavioral insomnia of childhood, combined type
Z73819	Behavioral insomnia of childhood, unspecified type
Z7389	Other problems related to life management difficulty
Z8651	Personal history of combat and operational stress reaction
Z8659	Personal history of other mental and behavioral disorders
Z87820	Personal history of traumatic brain injury
Z91410	Personal history of adult physical and sexual abuse
Z91411	Personal history of adult psychological abuse
Z91412	Personal history of adult neglect
Z91419	Personal history of unspecified adult abuse
Z9142	Personal history of forced labor or sexual exploitation
Z9149	Other personal history of psychological trauma, not elsewhere classified
Z9151	Personal history of suicidal behavior
Z9152	Personal history of nonsuicidal self-harm

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

OP Table 8.0: Ischemic Hemorrhagic Stroke

Code	Shortened Description
I6000	Nontraumatic subarachnoid hemorrhage from unspecified carotid siphon and bifurcation
I6001	Nontraumatic subarachnoid hemorrhage from right carotid siphon and bifurcation
I6002	Nontraumatic subarachnoid hemorrhage from left carotid siphon and bifurcation
I6010	Nontraumatic subarachnoid hemorrhage from unspecified middle cerebral artery
I6011	Nontraumatic subarachnoid hemorrhage from right middle cerebral artery
I6012	Nontraumatic subarachnoid hemorrhage from left middle cerebral artery
I602	Nontraumatic subarachnoid hemorrhage from anterior communicating artery
I6030	Nontraumatic subarachnoid hemorrhage from unspecified posterior communicating artery
I6031	Nontraumatic subarachnoid hemorrhage from right posterior communicating artery
I6032	Nontraumatic subarachnoid hemorrhage from left posterior communicating artery
I604	Nontraumatic subarachnoid hemorrhage from basilar artery
I6050	Nontraumatic subarachnoid hemorrhage from unspecified vertebral artery
I6051	Nontraumatic subarachnoid hemorrhage from right vertebral artery
I6052	Nontraumatic subarachnoid hemorrhage from left vertebral artery
I606	Nontraumatic subarachnoid hemorrhage from other intracranial arteries
I607	Nontraumatic subarachnoid hemorrhage from unspecified intracranial artery
I608	Other nontraumatic subarachnoid hemorrhage
I609	Nontraumatic subarachnoid hemorrhage, unspecified
I610	Nontraumatic intracerebral hemorrhage in hemisphere, subcortical
I611	Nontraumatic intracerebral hemorrhage in hemisphere, cortical
I612	Nontraumatic intracerebral hemorrhage in hemisphere, unspecified
I613	Nontraumatic intracerebral hemorrhage in brain stem
I614	Nontraumatic intracerebral hemorrhage in cerebellum
I615	Nontraumatic intracerebral hemorrhage, intraventricular
I616	Nontraumatic intracerebral hemorrhage, multiple localized
I618	Other nontraumatic intracerebral hemorrhage
I619	Nontraumatic intracerebral hemorrhage, unspecified
I629	Nontraumatic intracranial hemorrhage, unspecified
I6300	Cerebral infarction due to thrombosis of unspecified precerebral artery
I63011	Cerebral infarction due to thrombosis of right vertebral artery
I63012	Cerebral infarction due to thrombosis of left vertebral artery
I63013	Cerebral infarction due to thrombosis of bilateral vertebral arteries
I63019	Cerebral infarction due to thrombosis of unspecified vertebral artery
I6302	Cerebral infarction due to thrombosis of basilar artery
I63031	Cerebral infarction due to thrombosis of right carotid artery
I63032	Cerebral infarction due to thrombosis of left carotid artery
I63033	Cerebral infarction due to thrombosis of bilateral carotid arteries
I63039	Cerebral infarction due to thrombosis of unspecified carotid artery
I6309	Cerebral infarction due to thrombosis of other precerebral artery
I6310	Cerebral infarction due to embolism of unspecified precerebral artery
I63111	Cerebral infarction due to embolism of right vertebral artery
I63112	Cerebral infarction due to embolism of left vertebral artery
I63113	Cerebral infarction due to embolism of bilateral vertebral arteries
I63119	Cerebral infarction due to embolism of unspecified vertebral artery
I6312	Cerebral infarction due to embolism of basilar artery
I63131	Cerebral infarction due to embolism of right carotid artery

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
I63132	Cerebral infarction due to embolism of left carotid artery
I63133	Cerebral infarction due to embolism of bilateral carotid arteries
I63139	Cerebral infarction due to embolism of unspecified carotid artery
I6319	Cerebral infarction due to embolism of other precerebral artery
I6320	Cerebral infarction due to unspecified occlusion or stenosis of unspecified precerebral arteries
I63211	Cerebral infarction due to unspecified occlusion or stenosis of right vertebral artery
I63212	Cerebral infarction due to unspecified occlusion or stenosis of left vertebral artery
I63213	Cerebral infarction due to unspecified occlusion or stenosis of bilateral vertebral arteries
I63219	Cerebral infarction due to unspecified occlusion or stenosis of unspecified vertebral artery
I6322	Cerebral infarction due to unspecified occlusion or stenosis of basilar artery
I63231	Cerebral infarction due to unspecified occlusion or stenosis of right carotid arteries
I63232	Cerebral infarction due to unspecified occlusion or stenosis of left carotid arteries
I63233	Cerebral infarction due to unspecified occlusion or stenosis of bilateral carotid arteries
I63239	Cerebral infarction due to unspecified occlusion or stenosis of unspecified carotid artery
I6329	Cerebral infarction due to unspecified occlusion or stenosis of other precerebral arteries
I6330	Cerebral infarction due to thrombosis of unspecified cerebral artery
I63311	Cerebral infarction due to thrombosis of right middle cerebral artery
I63312	Cerebral infarction due to thrombosis of left middle cerebral artery
I63313	Cerebral infarction due to thrombosis of bilateral middle cerebral arteries
I63319	Cerebral infarction due to thrombosis of unspecified middle cerebral artery
I63321	Cerebral infarction due to thrombosis of right anterior cerebral artery
I63322	Cerebral infarction due to thrombosis of left anterior cerebral artery
I63323	Cerebral infarction due to thrombosis of bilateral anterior cerebral arteries
I63329	Cerebral infarction due to thrombosis of unspecified anterior cerebral artery
I63331	Cerebral infarction due to thrombosis of right posterior cerebral artery
I63332	Cerebral infarction due to thrombosis of left posterior cerebral artery
I63333	Cerebral infarction due to thrombosis of bilateral posterior cerebral arteries
I63339	Cerebral infarction due to thrombosis of unspecified posterior cerebral artery
I63341	Cerebral infarction due to thrombosis of right cerebellar artery
I63342	Cerebral infarction due to thrombosis of left cerebellar artery
I63343	Cerebral infarction due to thrombosis of bilateral cerebellar arteries
I63349	Cerebral infarction due to thrombosis of unspecified cerebellar artery
I6339	Cerebral infarction due to thrombosis of other cerebral artery
I6340	Cerebral infarction due to embolism of unspecified cerebral artery
I63411	Cerebral infarction due to embolism of right middle cerebral artery
I63412	Cerebral infarction due to embolism of left middle cerebral artery
I63413	Cerebral infarction due to embolism of bilateral middle cerebral arteries
I63419	Cerebral infarction due to embolism of unspecified middle cerebral artery
I63421	Cerebral infarction due to embolism of right anterior cerebral artery
I63422	Cerebral infarction due to embolism of left anterior cerebral artery
I63423	Cerebral infarction due to embolism of bilateral anterior cerebral arteries
I63429	Cerebral infarction due to embolism of unspecified anterior cerebral artery
I63431	Cerebral infarction due to embolism of right posterior cerebral artery
I63432	Cerebral infarction due to embolism of left posterior cerebral artery
I63433	Cerebral infarction due to embolism of bilateral posterior cerebral arteries
I63439	Cerebral infarction due to embolism of unspecified posterior cerebral artery
I63441	Cerebral infarction due to embolism of right cerebellar artery

Appendix A
ICD-10-CM Diagnosis and CPT® Code Tables

Code	Shortened Description
I63442	Cerebral infarction due to embolism of left cerebellar artery
I63443	Cerebral infarction due to embolism of bilateral cerebellar arteries
I63449	Cerebral infarction due to embolism of unspecified cerebellar artery
I6349	Cerebral infarction due to embolism of other cerebral artery
I6350	Cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery
I63511	Cerebral infarction due to unspecified occlusion or stenosis of right middle cerebral artery
I63512	Cerebral infarction due to unspecified occlusion or stenosis of left middle cerebral artery
I63513	Cerebral infarction due to unspecified occlusion or stenosis of bilateral middle cerebral arteries
I63519	Cerebral infarction due to unspecified occlusion or stenosis of unspecified middle cerebral artery
I63521	Cerebral infarction due to unspecified occlusion or stenosis of right anterior cerebral artery
I63522	Cerebral infarction due to unspecified occlusion or stenosis of left anterior cerebral artery
I63523	Cerebral infarction due to unspecified occlusion or stenosis of bilateral anterior cerebral arteries
I63529	Cerebral infarction due to unspecified occlusion or stenosis of unspecified anterior cerebral artery
I63531	Cerebral infarction due to unspecified occlusion or stenosis of right posterior cerebral artery
I63532	Cerebral infarction due to unspecified occlusion or stenosis of left posterior cerebral artery
I63533	Cerebral infarction due to unspecified occlusion or stenosis of bilateral posterior cerebral arteries
I63539	Cerebral infarction due to unspecified occlusion or stenosis of unspecified posterior cerebral artery
I63541	Cerebral infarction due to unspecified occlusion or stenosis of right cerebellar artery
I63542	Cerebral infarction due to unspecified occlusion or stenosis of left cerebellar artery
I63543	Cerebral infarction due to unspecified occlusion or stenosis of bilateral cerebellar arteries
I63549	Cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebellar artery
I6359	Cerebral infarction due to unspecified occlusion or stenosis of other cerebral artery
I636	Cerebral infarction due to cerebral venous thrombosis, nonpyogenic
I6381	Other cerebral infarction due to occlusion or stenosis of small artery
I6389	Other cerebral infarction
I639	Cerebral infarction, unspecified

Appendix B
Glossary of Terms

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

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

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

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

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

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

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

clinical measures Measures designed to evaluate the processes or outcomes of care associated with the delivery of clinical services; allow for intra- and inter-organizational comparisons to be used to continuously improve patient health outcomes; may focus on the appropriateness of clinical decision-making and implementation of these decisions; must be condition-specific, procedure-specific, or address important functions of patient care.

continuous variable An aggregate data measure in which the value of each measurement can fall anywhere along a continuous scale.

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

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

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

critical access hospital (CAH) Hospitals that offer limited services to include round-the-clock emergency care services and are, by definition, located more than 35 miles from a hospital or another critical access hospital, or are certified by the state as being a necessary provider of healthcare services to residents in the area. They maintain no more than 25 beds for acute (hospital-level) inpatient care and are subject to a 96-hour

average length of stay for acute care patients. For CAHs with swing bed agreements, any of its beds may be used to furnish either inpatient acute care or swing bed services. Hospitals certified by the Secretary of the Department of Health and Human Services (HHS) as critical access hospitals are eligible for cost-based reimbursement from Medicare if they meet a specific set of federal Conditions of Participation (COPs).

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

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

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

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

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

data point The representation of a value for a set of observations or measurements at a specific time interval (e.g., perioperative mortality rate for the month of June 2024).

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

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

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

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

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

discrete variable See rate-based measure.

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

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

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

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

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

excluded populations Detailed information describing the populations that should not be included in the indicator. For example, specific age groups, ICD-10-CM procedure or diagnostic codes, or certain time periods could be excluded from the general population drawn upon by the indicator.

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

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

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

hospital An institution primarily engaged in providing, by or under the supervision of physicians, inpatient diagnostic and therapeutic services or rehabilitation services.

hospitalist A doctor who primarily takes care of patients when they are in the hospital. This doctor will take over your care from your primary doctor when you are in the hospital, keep your primary doctor informed about your progress, and will return you to the care of your primary doctor when you leave the hospital.

ICD-10-CM codes A two-part classification system in current use for coding patient medical information used in abstracting systems and for classifying patients into diagnosis-related groups (DRGs). The first part is a comprehensive list of diseases with corresponding codes compatible with the World Health Organization's list of disease codes. The second part contains procedure codes independent of the disease codes.

included populations Detailed information describing the population(s) that the indicator intends to measure. Details could include such information as specific age groups, diagnoses, ICD-10-CM diagnostic and procedure codes, CPT® codes, enrollment periods, insurance and health plan groups, etc.

Inpatient Prospective Payment System (IPPS) Rule Section 1886(d) of the Social Security Act (the Act) sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates. This payment system is referred to as the inpatient prospective payment system (IPPS). Under the IPPS, each case is categorized into a diagnosis-related group (DRG). Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG.

invalid data The data element value falls outside of the range of defined allowable values. Refer to the Missing and Invalid Data section for further information.

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

measure information form Tool to provide specific clinical and technical information on a measure. The information contained includes performance measure name, description, rationale,

numerator/denominator/continuous variable statements, included populations, excluded populations, data elements, risk adjustment, sampling, data accuracy, and selected references.

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

measure-specific data elements Data elements used by one specific measure or several measures in one specific measure set.

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

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

mode The most frequently occurring response for that data element.

module A set of measures under a common group/topic area.

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

multivariate analysis The analysis of the simultaneous relationships among variables.

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

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

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

numerator data elements The upper portion of a fraction used to calculate a rate, proportion, or ratio. For the Hospital Outpatient Quality Reporting (OQR) Program, it represents the portion of the denominator that satisfies the conditions of the performance measure.

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

Outpatient Prospective Payment System (OPPS) Rule A prospective payment system (PPS) under Medicare for hospital outpatient services, certain Part B services furnished to hospital inpatients that have no Part A coverage, and partial hospitalization services furnished by community mental health centers. All services paid under the PPS are classified into groups called Ambulatory Payment Classifications or APCs.

A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC for an encounter.

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

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

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

- **complications** Conditions arising after the beginning of healthcare observation and treatment that modifies the course of the patient's health or illness and the intervention/care required.
- **co-morbidities** Pre-existing diseases or conditions.
- **severity of illness classifications** Seriousness or stage of illness at the time of the beginning of healthcare observation or treatment (for example, AJCC staging for oncology patients, NYHA class for cardiovascular patients).
- **functional status** Factors related to health status including physical functioning, role disability due to physical-health problems, bodily pain, general health perceptions, vitality, social functioning, role disability due to emotional problems, and general mental health.
- **patient demographics** Age, ethnicity, gender, location, etc.

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

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

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

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

performance measure-related feedback See measure-related feedback.

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

process A measure used to assess a goal directed, interrelated series of actions, events, mechanisms, or steps, such as measure of performance that describes what is done to, for, or by patients, as in performance of a procedure.

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

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

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

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

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

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

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

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

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

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

risk-adjusted rate A rate that considers differences in case mix to allow for more valid comparisons between groups.

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

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

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

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

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

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

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

strata See stratified measure.

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

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

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

stratum See stratified measure.

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

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

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

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

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

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

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

variance Equal to the square of the standard deviation.

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

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