Appendix A-8: Data Dictionary for MassHealth Chart-Based Measures

RY2024 (CY2024 Performance Period)
Technical Specifications Manual for
Clinical Quality Incentive Program (CQI) Manual v2.0

Effective with Q1-2024 discharges (01/01/24)

Contents

Enhancements to CQI Data Dictionary (v 2.0)

This Appendix contains the full set of clinical and administrative data element definitions to supplement the chart-abstracted measure technical specifications outlined under Section 4 of this manual. It also includes definitions for all patient identifier administrative data elements required in the MassHealth Crosswalk Files to supplement the MassHealth Payer Files for the nationally reported hospital quality measures data.

This version of the data dictionary contains changes to definitions for existing data elements and introduces new data elements effective with Q1-2024 data. These changes are summarized in the table below.

Updates to Data Dictionary (CQI v2.0)

Change to Data Element	**Substance Use** (SUB-2, 3)	**Maternity and Newborn Measures** (MAT-4, NEWB-3)	**Care Coordination Measures** (CCM-1, 2, 3)	**All MassHealth Records**
Existing	N/A	• *Discharge Disposition* • *Term Newborn*	• *Discharge Diagnosis* • *Reconciled Medication List*	N/A
Add New	N/A	N/A	N/A	N/A
Retired	N/A	N/A	N/A	N/A

All updates to existing and/or new data elements are shown in *Emphasis* font style on the table of contents and throughout this data dictionary. The table of contents also shows which data element corresponds to the specific measure it is being collected for and the page number locator.

Data Dictionary Format and Terms

This data dictionary contains detailed information necessary for defining and formatting the collection of all data elements, as well as the allowable values for each data element that uses the following format:

- *Data Element Name*: A short phrase identifying the data element.
- *Collected For*: Identifies the measure(s) requiring that data element to be collected.
- *Definition*: A detailed explanation of the data element.
- *Suggested Data Collection Question*: The wording for a data element question in a data abstraction tool.
- *Format: Length*: The number of characters or digits allowed for the data element.
- *Type*: The type of information the data element contains (e.g., numeric, alphanumeric, date, character, or time).
- *Occurs*: The number of times the data element occurs in a single episode of care record.
- *Allowable Values*: A list of acceptable responses for this data element.
- *Notes for Abstraction*: Notes to assist abstractor in the selection of appropriate value for a data element.
- *Suggested Data Sources*: Source document from which data may be identified such as administrative or medical record. Please note the data sources listed are not intended to reflect a comprehensive list.
- *Guidelines for Abstraction*: Notes to assist abstractors in determining how data element inclusions/exclusions should be answered.

Adherence to data dictionary definitions provided in this EOHHS manual are necessary to ensure that data element abstraction is accurate and reliable. This data dictionary should be used in conjunction with Section 6 (Table 6.1) of this EOHHS manual for a list of the data elements that are subject to data validation scoring.

Data Element Name: Admission Date

Collected For: All MassHealth Records

Definition: The month, day, and year of admission to acute inpatient care.

Suggested Data Collection Question: What is the date the patient was admitted to acute inpatient care?

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:

For patients who are admitted to Observation status and subsequently admitted to acute inpatient care, abstract the date that the determination was made to admit to acute inpatient care and the order was written. Do not abstract the date that the patient was admitted to Observation.

Example: Medical record documentation reflects that the patient was admitted to observation on 04-05-20xx. On 04-06-20xx the physician writes an order to admit to acute inpatient effective 04-05-20xx. The Admission Date would be abstracted as 04-06-20xx; the date the determination was made to admit to acute inpatient care and the order was written.

The admission date should not be abstracted from the earliest admission order without regards to substantiating documentation. If documentation suggests that the earliest admission order does not reflect the date the patient was admitted to inpatient care, this date should not be used.

Example: Preoperative Orders are dated as 04-06-20xx with an order to admit to Inpatient. Postoperative Orders, dated 05-01-20xx, state to admit to acute inpatient. All other documentation supports that the patient presented to the hospital for surgery on 05-01-20xx. The Admission Date would be abstracted 05-01-20xx.

If there are multiple inpatient orders, use the order that most accurately reflects the date that the patient was admitted.

For newborns that are born within this hospital, the Admission Date is the date the baby was born.

Suggested Data Sources:

PRIORITY ORDER FOR THESE SOURCES

- Physician orders
- Face sheet

Note: The physician order is the priority data source for this data element. If there is not a physician order in the medical record, use the other only allowable sources to determine the Admission Date.

Guidelines for Abstraction:

Inclusion	Exclusion
None	Admit to observation Arrival date

Data Element Name:	Advance Care Plan
Collected For:	CCM-2
Definition:	An Advance Care Plan refers to a written statement of patient instructions or wishes regarding future use of life sustaining medical treatment. An Advance Care Plan may include: an advance directive, living will, healthcare proxy or surrogate decision maker, or power of attorney. *(Reference to DNR removed)* Additional information about Massachusetts regulations regarding Advance Care Plans may be found at the following sources: https://www.mass.gov/files/documents/2017/12/18/130cmr450.pdf https://www.mass.gov/info-details/massachusetts-legal-forms-for-subjects-e-h#health-care-proxy-/-living-will-. A transition record that included documentation of the presence of an Advance Care Plan or a documented reason for not providing an advance care plan.
Suggested Data Collection Question:	Does the Transition Record include documentation of the presence of an Advance Care Plan?
Format:	Length: 1 Type: Alphanumeric Occurs: 1
Allowable Values:	Y (Yes) The transition record includes documentation of the presence of an Advance Care Plan or a documented reason for not providing an advance care plan. N (No) The transition record does not include documentation of the presence of an Advance Care Plan or a documented reason for not providing an advance care plan.
Notes for Abstraction:	The presence of an advance care plan must be documented on the transition record for all patients 18 years and over. A checkbox or documentation of the presence of an advance directive, health care proxy, surrogate decision maker, power of attorney, etc. must be documented. *(Reference to DNR or full code status removed)* If there is no advance care plan, a reason must be documented. A documented reason for not providing an advance care plan includes: • The care plan was discussed but the patient did not wish or was not able to name a health care proxy or surrogate decision maker • The patient was not able to provide an advance care plan • Documentation as appropriate that the patient's cultural and/ or spiritual beliefs preclude a discussion of advance care planning as it would be viewed as harmful to the patient's beliefs and thus harmful to the physician patient relationship • The patient was < 18 years of age (calculated from Date of Birth and Admission Date) Patient refusal of advance care plan information or decision for an advance care plan, select Y(Yes)

Documentation in the medical record that there is no advance care plan without a reason does not meet the requirement.

The physician decision not to address the Advance Care Plan topic with the patient does not meet the requirement.

In the event the patient is transferred to another site of care and the advance care plan information is provided to the next site of care, this data element may be documented as Y(Yes). Documentation of Y(Yes) also applies to patients discharged and admitted within the same site.

A copy of an Advance Care Plan document within the medical record does not meet the requirement. The Transition Record must have documentation of the presence of an Advance Care Plan.

Suggested Data Sources: Transition Record
Discharge Instructions

Guidelines for Abstraction:

Inclusion	Exclusion
Advance Directive Power of Attorney Health care proxy Living Will Medical Orders for Life-Sustaining Treatment (MOLST)	Patients < 18 years of age Do Not Resuscitate – DNR, etc Documentation of code status: Full Code

Data Element Name: Alcohol Use Status

Collected For: SUB-2, SUB-3

Definition: Documentation of the adult patient's alcohol use status using a validated screening questionnaire for **unhealthy** alcohol use within the first day of admission (by end of Day 1). A validated screening questionnaire is an instrument that has been psychometrically tested for reliability (the ability of the instrument to produce consistent results), validity (the ability of the instrument to produce true results), and sensitivity (the probability of correctly identifying a patient with the condition). Validated screening questionnaires can be administered by pencil and paper, by computer or verbally. The screening questionnaire should be at a comprehension level or reading level appropriate for the patient population and in the appropriate language for non-English speaking patients.

An example of a validated questionnaire for alcohol screening is the 10 item Alcohol Use Disorder Identification Tests (AUDIT). The first three questions of the AUDIT, the AUDIT-C, ask about alcohol consumption, and can be used reliably and validly to identify unhealthy alcohol use. The four-item CAGE questionnaire is generally inappropriate for screening general populations, as it aims to identify only severely alcohol dependent patients.

Suggested Data Collection Question: What is the patient's alcohol use status?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1. The patient was screened with a validated tool within the first day of admission (by end of Day 1) and the score on the alcohol screen indicates no or low risk of alcohol related problems.

2. The patient was screened with a validated tool within the first day of admission (by end of Day 1) and the score on the alcohol screen indicates unhealthy alcohol use (moderate or high risk) benefiting from brief intervention.

3. The patient was screened with a non-validated tool within the first day of admission (by end of Day 1) and the score on the alcohol screen indicates no or low risk of alcohol related problems.

4. The patient was screened with a non-validated tool within the first day of admission (by end of Day 1) and the score on the alcohol screen indicates unhealthy alcohol use (moderate or high risk) benefiting from brief intervention.

5. The patient refused the screen for alcohol use within the first day of admission (by end of Day 1).

6. The patient was not screened for alcohol use within the first day of admission (by end of Day 1) or unable to determine from medical record documentation.

7. The patient was not screened for alcohol use within the first day of admission (by end of Day 1) because of cognitive impairment.

Notes for Abstraction:

The alcohol use status screening must have occurred within the first day of admission (by end of Day 1). This includes the day of admission which is defined as Day 0 and the day after admission which is defined as Day 1.

EXCEPTION:
If the screening was performed within 3 days prior to admission, i.e., at the transferring facility, in another inpatient hospital unit, emergency department or observation unit, the screening documentation must be present in the current medical record.

If patient has a blood alcohol test with a result of .08 g/dL or greater or the clinician documents the patient was acutely intoxicated per blood alcohol test results, select Value "2."

- The 0.08 limit is a blood alcohol concentration (BAC) reported in g/dL. If results are given in mg/dL, convert to g/dL by moving the decimal point 3 places to the left.
  Examples:
  - A 100 mg/dL serum ethanol level is equivalent to a 0.10 g/dL BAC.
  - An 80 mg/dL serum ethanol level is equivalent to a 0.08 g/dL BAC.

Screening may be done with a "validated" Single Alcohol Screening Question (SASQ) in order to identify those patients with no risk or low risk or who do not drink. Further screening should be done with a validated tool for those patients with a positive result to determine if there is need for a brief intervention.
Examples of SASQs include:

- "On any single occasion during the past 3 months, have you had more than 5 drinks containing alcohol?" ("Yes" response is considered positive.)
- "When was the last time you had more than X drinks in 1 day?" (X = 4 for women and 5 for men) (Within the last 3 months is considered positive.)
- "How many times in the past year have you had X or more drinks in a day?" (X = 5 men and 4 women) (Response of >1 is considered positive.)
- How often have you had 6 or more drinks on one occasion in the past year? (Ever in the past year considered positive.)
- How often do you have X or more drinks on one occasion? (X = 4 for women and 5 for men) (Ever in the past year considered positive.)

Refer to the Inclusion Guidelines for examples of commonly used validated screening tools; note that the CAGE, although a validated tool, is not recommended for this measure set.

If there is documentation in the medical record indicating the patient drinks alcohol and conflicting documentation indicating the patient does not drink alcohol, select Value "6" since alcohol use status is unable to be determined.

EXCEPTION:
If there is documentation of a validated questionnaire for alcohol screening

completed within the first day of admission, select the appropriate Value 1 or 2 regardless of conflicting documentation.

When there is conflicting information in the record with regard to risk, for instance, the results from a validated screening tool are documented as both low AND moderate/high risk, select Value “2” indicating the highest risk.

Cognition refers to mental activities associated with thinking, learning, and memory. Cognitive impairment for the purposes of this measure set is related to documentation that the patient cannot be screened for alcohol use due to the impairment (e.g., comatose, obtunded, confused, memory loss) within the first day of admission (by end of Day 1).

If there is documentation within the first day of admission (by end of Day 1) that the patient was psychotic, symptoms of psychosis, e.g., hallucinating, non-communicative, catatonic, etc., must also be documented for the patient to be considered cognitively impaired.

If there is documentation to “rule out” a condition/diagnosis related to cognitive impairment, Value “7” cannot be selected unless there is documentation of symptoms.

Examples:

- Patient actively hallucinating, rule out psychosis. (Select Value “7”).
- Rule out psychosis. (Cannot select Value “7”).

If there is documentation within the first day of admission (by end of Day 1) of any of the examples below, select Value “7” regardless of conflicting documentation.

Examples of cognitive impairment include:

- Altered Level of Consciousness (LOC)
- Altered Mental Status
- Cognitive impairment
- Cognitively impaired
- Cognitive impairment due to acute substance use, overdose, acute intoxication
- Confused
- Dementia
- Intubation and patient is intubated through the end of Day 1
- Memory loss
- Mentally handicapped
- Obtunded
- Psychotic/psychosis with documented symptoms
- Sedation

Documentation of cognitive impairment overrides documentation of an alcohol use screen and therefore would not be considered "conflicting documentation." Even if the family or others tell staff the patient uses alcohol, the patient could not be appropriately screened and subsequently counseled due to cognitive impairment. Select Value “7.”

Suggested Data Sources:

- Consultation notes
- Emergency department record
- History and physical
- Nursing admission assessment
- Nursing Admission Notes
- Physician Progress Notes

Guidelines for Abstraction:

Inclusion	**Exclusion**
Validated Screening Tools for Unhealthy Alcohol Use: This list is not ALL Inclusive • AUDIT • AUDIT-C • ASSIST • CRAFFT • G-MAST • MAST • TWEAK	Any tool which specifically screens for alcohol use disorder, alcohol dependency or alcohol abuse. Examples include, but are not limited to: • CAGE • SASSI • S2BI

Data Element Name: Birth Weight

Collected For: NEWB-3

Definition: The weight (in grams) of a newborn at the time of delivery.

Note:

453.5 grams = 1 pound

28.35 grams = 1 ounce

It is recommended to enter birth weight in either grams or pounds. However, all birth weights must be converted to grams prior to indicator calculation.

Suggested Data Collection Question: What was the weight of the newborn at delivery?

Format:

Length: 4 or UTD

Type: Alphanumeric

Occurs: 1

Allowable Values: 150 through 8165 grams
UTD = Unable to Determine

Note: When converting from pounds and ounces to grams, do not round to the nearest pound before converting the weight to grams. Round to the nearest whole number after the conversion to grams.

Notes for Abstraction: Newborns with birth weights less than 150 grams need to be verified that the baby has live born and for data quality purposes. Birth weights greater than 8165 grams need to be verified for data quality. Abstractors should review all of the suggested data sources to verify the accuracy of the data.

If the birth weight is unable to be determined from medical record documentation, enter "UTD".

The medical record must be abstracted as documented (taken at “face value”). When the value documented is not a valid number/value per the definition of this data element **and** no other documentation is found that provides this information, the abstractor should select “UTD.”
Example:
Documentation indicates the *Birth Weight* was 0 grams. No other documentation in the medical record provides a valid value. Since the *Birth Weight* is not a valid value, the abstractor should select “UTD.”

The NICU admission assessment or notes should be reviewed first for the birth weight. In the absence of admission to the NICU, the delivery record or operating room record should be reviewed next for the birth weight. In cases where there is conflicting data, use the document recording the birth weight closest to the time of delivery.

It is acceptable to use data derived from vital records reports received from state or local departments of public health, delivery logs or clinical information systems if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the suggested data sources listed below.

For newborns received into the hospital as a transfer, the admission birth weight may be used if the original birth weight is not available.

If the birth weight is recorded in pounds and ounces and also in grams, abstract the value for grams.

Suggested Data Sources: In Order of Priority:

- NICU admission assessment or notes
- Delivery record
- Operating room record
- History and physical
- Nursing notes
- Nursery record
- Physician progress notes

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Birthdate

Collected For: All MassHealth Records

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

NOTE: Patient's age (in years) is calculated by *Admission Date* minus *Birthdate.* The algorithm to calculate age must use the month and day portion of admission 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 many 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, for purposes of abstraction, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct birthdate through chart review, she/he should default to the date of birth on the claim information.

Suggested Data Sources:
Emergency department record
Face sheet
Registration form
UB-04

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Brief Intervention

Collected For: SUB-2

Definition: A brief intervention is a single session or multiple sessions conducted by a qualified healthcare professional or trained peer support person, following a positive screen for unhealthy alcohol use. The intervention includes motivational discussion focused on increasing insight and awareness regarding alcohol use and motivation toward behavioral change. Brief interventions can be tailored for variance in population or setting and can be used as a stand-alone treatment for those at risk as well as a vehicle for engaging those in need of more extensive levels of care.

A brief intervention focuses on increasing the patient's understanding of the impact of substance use on his or her health and motivating the patient to change risky behaviors. The components of the intervention include feedback concerning the quantity and frequency of alcohol consumed by the patient in comparison with national norms; a discussion of negative physical, emotional, and occupational consequences; and a discussion of the overall severity of the problem. The qualified health care professional engages the patient in a joint decision-making process regarding alcohol use and plans for follow-up are discussed and agreed to.

Suggested Data Collection Question: Did patients with a positive screening result for unhealthy alcohol use or alcohol use disorder (abuse or dependence) receive a brief intervention prior to discharge?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 The patient received the components of a brief intervention

2 The patient refused/declined the brief intervention

3 Brief counseling was not offered to the patient during the hospital stay or Unable to Determine (UTD) if a brief intervention was provided from medical record documentation

Notes for Abstraction:

A qualified healthcare professional may be defined as a physician, nurse, certified addictions counselor, psychologist, social worker, or health educator with training in brief intervention.

A peer support person who has received specialized training in brief intervention may perform the brief intervention in lieu of a qualified healthcare professional.

If there is no documentation that a brief intervention was given to the patient, select value 3

Select value "3" if the documentation provided is not explicit enough to determine if the intervention provided contained the specific components or if the intervention meets the intent of the measures.

A brief intervention includes, at a minimum, the following three components:

- Concern that the patient is drinking at unhealthy levels known to increase his/her risk of alcohol-related health problems
- Feedback linking alcohol use and health, including:
  - Personalized feedback (i.e., explaining how alcohol use can interact with patient's medical concerns [hypertension, depression/anxiety, insomnia, injury, congestive heart failure (CHF), diabetes mellitus (DM), breast cancer risk, interactions with medications])
    OR
  - General feedback on health risks associated with drinking.
- Advice:
  - To abstain (if there are contraindications to drinking)
    OR
  - To drink below recommended limits (specified for patient).

Suggested Data Sources:

Consultation notes
Nursing notes
Progress notes
Physician Progress Notes

Additional Notes:

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Comfort Measures Only

Collected For: SUB-2, SUB-3

Definition: Comfort Measures Only refers to medical treatment of a dying person where the natural dying process is permitted to occur while assuring maximum comfort. It includes attention to the psychological and spiritual needs of the patient and support for both the dying patient and the patient's family. Comfort Measures Only is commonly referred to as "comfort care" by the general public. It is not equivalent to a physician order to withhold emergency resuscitative measures such as Do Not Resuscitate (DNR).

Suggested Data Collection Question**:** When is the earliest physician/APN/PA documentation of comfort measures only?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 Day 0 or 1: The earliest day the physician/APN/PA documented comfort measures only was the day of arrival (Day 0) or day after arrival (Day 1).

2 Day 2 or after: The earliest day the physician/APN/PA documented comfort measures only was two or more days after arrival day (Day 2+).

3 Timing unclear: There is physician/APN/PA documentation of comfort measures only during this hospital stay, but whether the earliest documentation of comfort measures only was on day 0 or 1 OR after day 1 is unclear.

4 Not Documented/UTD: There is no physician/APN/PA documentation of comfort measures only, or unable to determine from medical record documentation.

Notes for Abstraction: Only accept terms identified in the list of inclusions. No other terminology will be accepted.

Physician/APN/PA documentation of comfort measures only (hospice, comfort care, etc.) mentioned in the following contexts suffices:

- Comfort measures only recommendation
- Order for consultation or evaluation by a hospice care service
- Patient or family request for comfort measures only
- Plan for comfort measures only
- Referral to hospice care service
- Discussion of comfort measures

Determine the earliest day comfort measures only (CMO) was DOCUMENTED by the physician/APN/PA. If any of the inclusion terms are documented by the physician/APN/PA, select value "1," "2," or "3" accordingly.
Examples:
"Discussed comfort care with family on arrival" noted in day 2 progress note -— Select "2.""

State-Authorized Portable Orders (SAPOs).

- SAPOs are specialized forms or identifiers authorized by state law that translate a patient's preferences about specific end-of-life treatment decisions into portable medical orders

Examples:

- DNR-Comfort Care form
- MOLST (Medical Orders for Life-Sustaining Treatment)
- POLST (Physician Orders for Life-Sustaining Treatment)
- Out-of-Hospital DNR (OOH DNR)

- If there is a SAPO in the record that is dated and signed prior to arrival with an option in which an inclusion term is found that is checked, select value "1."
- If a SAPO lists different options for CMO and any CMO option is checked, select value "1," "2,"" or "3" as applicable.
- If one or more dated SAPOs are included in the record (and signed by the physician/APN/PA), use only the most recent one. Disregard undated SAPOs.
- For cases where there is a SAPO in the record with a CMO option selected: If the SAPO is dated prior to arrival and there is documentation on the day of arrival or the day after arrival that the patient does not want CMO, and there is no other documentation regarding CMO found in the record, disregard the SAPO.
  Example:
  Patient has a POLST dated prior to arrival in his chart and ED physician states in current record "Patient is refusing comfort measures, wants to receive full treatment and be a full code."

Documentation of an inclusion term in the following situations should be disregarded. Continue to review the remaining physician/APN/PA documentation for acceptable inclusion terms. If the ONLY documentation found is an inclusion term in the following situations, select value "4.""

- Documentation (other than SAPOs) that is dated prior to arrival or documentation which refers to the pre-arrival time period.
  Examples:
  - Comfort measures only order in previous hospitalization record
  - "Pt. on hospice at home" in MD ED note.
- Inclusion term clearly described as negative or conditional.
  Examples:
  - "No comfort care"
  - "Not appropriate for hospice care"
  - "Comfort care would also be reasonable - defer decision for now"
  - "DNRCCA"" (Do Not Resuscitate -— Comfort Care Arrest)
  - "Family requests comfort measures only should the patient arrest."
- Documentation of "CMO"" should be disregarded if documentation makes clear it is not being used as an acronym for Comfort Measures Only (e.g., "hx dilated CMO" -— Cardiomyopathy context).

If there is physician/APN/PA documentation of an inclusion term in one source that indicates the patient is Comfort Measures Only, AND there is physician/APN/PA documentation of an inclusion term in another source that indicates the patient is NOT CMO, the source that indicates the patient is CMO would be used to select value "1," "2," or "3"" for this data element.
Examples:

- Physician documents in progress note on day 1 "The patient has refused Comfort Measures" AND then on day 2 the physician writes an order for a Hospice referral. Select value "2."

- ED physician documents in a note on day of arrival “Patient states they want to be enrolled in Hospice” AND then on day 2 there is a physician progress note with documentation of “Patient is not a Hospice candidate.” Select value “1.”

Suggested Data Sources: **PHYSICIAN/APN/PA DOCUMENTATION ONLY IN THE FOLLOWING ONLY ACCEPTBLE SOURCES:**

- Consultation notes
- Discharge summary
- DNR/MOLST/POLST forms
- Emergency department record
- History and physical
- Physician orders
- Progress notes

Excluded Data Sources: Restraint order sheet

Guidelines for Abstraction:

Inclusion	Exclusion
Brain dead Brain death Comfort care Comfort focused treatment Comfort measures Comfort measures only (CMO) Comfort only Compassionate extubation DCD DNR-CC Donation after Cardiac Death Donation after Circulatory Death End of life care Hospice Hospice care Organ harvest Terminal care Terminal extubation	None

Data Element Name: Contact Information 24hrs/ 7 days

Collected For: CCM-2

Definition: Contact information 24hrs/ 7 days refers to any phone number that is listed for the patient to call for questions, concerns, or emergencies that is answered 24 hours a day, 7 days a week.

A transition record that included documentation on 24 hr/ 7 day Contact Information for questions, concerns, or emergencies related to the inpatient stay.

Suggested Data Collection Question: Does the Transition Record include 24 hr/ 7 day Contact Information for questions, concerns, or emergencies related to the inpatient stay?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes) The transition record includes 24 hr/ 7 day Contact Information for questions, concerns, or emergencies related to the inpatient stay.

N (No) The transition record does not include 24 hr/ 7 day Contact Information for questions, concerns, or emergencies related to the inpatient stay.

Notes for Abstraction: Any number listed that is answered 24 hours a day, 7 days a week.

Must be clear to the patient that this is the number to call for questions, concerns, or emergencies.
Examples:
- For any questions, please call your PCP at …
- Discharging unit phone number provided on Transition Record
- 24/7 Contact Information: Emergency Department phone number is ____
- Call 911 if chest pain

For the inpatient psychiatric population, contact information for the physician, healthcare team member, or other healthcare personnel who have access to medical records and other information concerning the inpatient stay and who could be contacted regarding emergencies related to the stay is accepted and the abstractor may select Yes.

In the event the patient is transferred to another site of care, this data element may be documented as Y(Yes). Documentation of Y(Yes) also applies to patients discharged and admitted within the same site of care.

Suggested Data Sources: Transition Record
Discharge Instructions

Guidelines for Abstraction:

Inclusion	Exclusion
• Call 911 • Emergency Room Phone Number • Primary Care Physician Phone Number • Specialist Phone Number • Discharging Unit Phone Number • Hospital phone number	None

Data Element Name: Contact Information for Studies Pending at Discharge

Collected For: CCM-2

Definition: Contact information for studies pending refers to the name and/or phone number of a contact person that will provide information on tests when results are pending at discharge.

A transition record that included Contact Information for obtaining results of studies pending at discharge.

Suggested Data Collection Question: Does the Transition Record include Contact Information for obtaining results of studies pending at discharge?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes) The transition record includes Contact Information for Studies Pending at Discharge or documentation that there were no studies pending at discharge.

N (No) The transition record does not include Contact Information for Studies Pending at Discharge or documentation that there were no studies pending at discharge.

Notes for Abstraction: If it is documented on the Transition Record that there were no studies pending at discharge, contact information for studies pending is not required and the abstractor should select Y(Yes).

The physician and/ or phone number to contact for Studies Pending must be clearly stated.
Statements such as: “Contact the Follow-up Physician listed above for any pending test results” will be accepted as long as the physician’s name and/or phone number are documented on the transition record.

- “Dr Jackson will discuss pending test results at your follow up appointment” will be accepted.
- “MD to discuss at next visit” will NOT be accepted.

In the event of a transfer to another site of care, this element may be documented as Y(Yes). Documentation of Y(Yes) also applies to patients discharged and admitted within the same site.

See also data element Studies Pending at Discharge

Suggested Data Sources: Transition Record
Discharge Instructions

Guidelines for Abstraction:

Inclusion	Exclusion
• Primary Care Physician • Name of Next Provider or Site of Care • Specialist Office • Hospital Lab or Radiology Department	None

Data Element Name: Current Medication List

Collected For: CCM-2

Definition: A Current Medication List is a list of all medications (continued and new) to be taken by the patient after discharge.

A transition record that included a Current Medication List given to the patient at the time of inpatient discharge.

Suggested Data Collection Question: Does the Transition Record include a Current Medication List?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes) The Transition Record includes a current medication list at the time of discharge or documentation of no medications.

N (No) The Transition Record does not include a current medication list at the time of discharge or documentation of no medications.

Notes for Abstraction: If there are no current medications at discharge, there must be documentation of "none" or "N/A" in order for the abstractor to select Y(Yes).

A reconciled medication list given to the patient at discharge meets the requirement for Current Medication List.

In the event the patient is transferred to another site of care and a listing of current medications is provided to the next site of care, this data element may be documented as Y(Yes). Documentation of Y(Yes) also applies to patients discharged and admitted within the same site.

Suggested Data Sources:
Transition Record
Discharge Instructions
Discharge Medication Reconciliation Form

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Discharge Date

Collected For: All MassHealth Records

Definition: The month, day, and year the patient was discharged from acute care, left against medical advice (AMA), or expired during this stay.

Suggested Data Collection Question: What is the date the patient was discharged from acute care, left against medical advice (AMA), or expired?

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: Because this data element is critical in determining the population for many measures, the abstractor should NOT assume that the claim information for the discharge date is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct discharge date through chart review, she/he should default to the discharge date on the claim information.

Suggested Data Sources:

- Face sheet
- Progress notes
- Physician orders
- Discharge summary
- Nursing discharge notes
- Transfer note
- UB-04

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Discharge Diagnosis

Collected For: CCM-2

Definition: The discharge diagnosis is defined as the diagnosis determined at discharge, after procedures and tests were administered, to be chiefly responsible for resulting in the patient being admitted for inpatient hospital care.

A transition record that included the Discharge Diagnosis.

Suggested Data Collection Question: Does the Transition Record include the Discharge Diagnosis?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes) The transition record includes the Discharge Diagnosis.

N (No) The transition record does not include the Discharge Diagnosis.

Notes for Abstraction: The discharge diagnosis must be specifically documented as the discharge diagnosis and differentiated from the Reason for Inpatient Admission.

Discharge instructions with a title of the patient's condition does not meet the requirement for documentation of the patient's discharge diagnosis. Examples: Postpartum discharge instructions, Knee Replacement discharge instructions.

A discharge diagnosis of "Postpartum" does not meet the requirement. The delivery type must be specified. For example: vaginal delivery, spontaneous vaginal delivery (SVD), Cesarean section etc.

If the admission and discharge diagnosis are the same, documentation of "Same" for the discharge diagnosis will be accepted. The abstractor should select Y (Yes). For example, a patient's admission diagnosis is pneumonia, and the documented discharge diagnosis is pneumonia.

In the event the patient is transferred to another site of care and the discharge diagnosis is provided to the next site of care, this data element may be documented as Y(Yes). Documentation of Y(Yes) also applies to patients discharged and admitted within the same site.

Suggested Data Sources: Transition Record
Discharge Instructions

Guidelines for Abstraction:

Inclusion	Exclusion
• Discharge diagnosis • Final diagnosis • Primary diagnosis at discharge • Principal diagnosis • Working diagnosis	~~*Post-op diagnosis*~~*(Removed from exclusion)* Secondary diagnosis

Data Element Name: Discharge Disposition

Collected For: All MassHealth Records

Definition: The final place or setting to which the patient was discharged on the day of discharge.

Suggested Data Collection Question: What was the patient's discharge disposition on the day of discharge?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 Home

2 Hospice- Home

3 Hospice- Health Care Facility.

4 Acute Care Facility

5 Other Health Care Facility

6 Expired

7 Left Against Medical Advice / AMA

8 Not Documented or Unable to Determine (UTD)

Notes for Abstraction:

Only use documentation written on the day prior to discharge through 30 days after discharge when abstracting this data element.

Example:

- Documentation in the Discharge Planning notes on 04-01-20xx state that the patient will be discharged back home. On 04-06-20xx the physician orders and nursing discharge notes on the day of discharge reflect that the patient was being transferred to skilled care. The documentation from 04-06-20xx would be used to select value "5" (Other Health Care Facility).

The medical record must be abstracted as documented (taken at "face value"). Inferences should not be made based on internal knowledge.

If there is documentation that further clarifies the level of care that documentation should be used to determine the correct value to abstract. If documentation is contradictory, use the latest documentation.

Examples:

- Discharge summary dictated 2 days after discharge states patient went "home". Physician note on day of discharge further clarifies that the patient will be going home with hospice". Select value "2" ("Hospice - Home").
- Discharge planner note from day before discharge states "XYZ Nursing Home". Discharge order from day of discharge states "Discharge home". Contradictory documentation, use latest. Select value "1" ("Home").
- Physician order on discharge states "Discharge to ALF". Discharge instruction sheet completed after the physician order states patient discharged to "SNF".

Contradictory documentation, use latest. Select value “5” (“Other Health Care Facility”).

If documentation is contradictory, and you are unable to determine the latest documentation, select the disposition ranked highest (top to bottom) in the following list. See Inclusion lists for examples.

- Acute Care Facility
- Hospice —- Health Care Facility
- Hospice —- Home
- Other Health Care Facility
- Home

Hospice (values “2” and “3”) includes discharges with hospice referrals and evaluations.

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 “4” (“Acute Care Facility”).

If the patient is being discharged to assisted living care or an assisted living facility (ALF) that is located within a skilled nursing facility, and documentation in the medical record also includes nursing home, intermediate care or skilled nursing facility, select Value “1” (“Home”).

If the medical record states the patient is being discharged to nursing home, intermediate care or skilled nursing facility without mention of assisted living care or assisted living facility (ALF), select Value “5” (“Other Health Care Facility”).

If the medical record identifies the facility the patient is being discharged to by name only (e.g., “Park Meadows”), and does not reflect the type of facility or level of care, select value “5” (“Other Health Care Facility”).

If the medical record states only that the patient is being “discharged” and does not address the place or setting to which the patient was discharged, select value “1” (“Home”).

When determining whether to select value “7” (“Left Against Medical Advice/AMA”):

- Explicit “left against medical advice” documentation is not required. E.g., “Patient is refusing to stay for continued care” —- Select value “7”.
- Documentation suggesting that the patient left before discharge instructions could be given does not count.
- A signed AMA form is not required for the purposes of this data element.
- 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 “7”.

For NEWB-3 only:
Hospitals are encouraged to utilize a data source that reduces unnecessary medical record review e.g., using vital records, delivery logs or clinical information systems as a data source. Mapping from electronic administrative sources to the allowable values is acceptable.

If a newborn is transferred to another acute care facility for purposes other than medical treatment or the need for a higher level of care, and mother and baby remain together, abstract allowable value 8. Examples include transfers:

- *To another facility covered by their health plan*
- *For disaster evacuation*
- *Full census*

Suggested Data Sources:
Consultation notes
Progress notes
Physician orders
Discharge summary
Discharge instruction sheet
Discharge planning notes
Discharge summary
Nursing discharge notes
Social service notes
Transfer record

Excluded Data Source: Any documentation prior to the last two days of hospitalization.
Guidelines for Abstraction:

Inclusion	Exclusion
For Value 1: • Assisted Living Facilities (ALFs)- includes ALFs and assisted living care at nursing home, intermediate care, and skilled nursing facilities • Court/Law Enforcement- includes detention facilities, jails, prison • Home- includes board and care, foster or residential care, group or personal care homes, retirement communities, 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 2: • Hospice in the home (or other “Home” setting as above in Value 1) For Value 3: • Hospice- General Inpatient and Respite • Hospice- Residential and Skilled Facilities • Hospice- Other Health Care Facilities For Value 4: • Acute Short Term General and Critical Access Hospitals • Cancer and Children’s Hospitals • Department of Defense and Veteran’s Administration Hospitals For Value 5: • Extended or Immediate 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 but not limited to: Inpatient Rehabilitation Facility/ Hospital, Rehabilitation Unit of a Hospital, Chemical Dependency/Alcohol Rehabilitation Facility • Skilled Nursing Facility (SNF), Sub-Acute Care or Swing Bed • Transitional Care Unit (TCU) • Veterans Home	None

Data Element Name: Episode of Care

Collected For: All MassHealth Records

Definition: The measure code for the data that is being submitted.

Suggested Data Collection Question: What is the measure code for the data being submitted?

Format:
- Length: 22
- Type: Alphanumeric
- Occurs: 1

Allowable Values:

CCM	Care Coordination (includes CCM-1, CCM-2, & CCM-3)
MAT-4	Cesarean Delivery
NEWB-3	Unexpected Complications in Term Newborns
SUB	Substance Use Treatment (SUB-2, SUB-3)

Notes for Abstraction: None

Suggested Data Sources: Not Applicable

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: First Name

Collected For: All MassHealth Records

Definition: The patient's first name.

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

Format:
Length: 30
Type: Alphanumeric
Occurs: 1

Allowable Values: Enter the patient's first name.

Notes for Abstraction: None

Suggested Data Sources:
Emergency department record
Face sheet
History and physical

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Gestational Age

Collected For: MAT-4

Definition: The weeks of gestation completed at the time of delivery.

Gestational age is defined as the best obstetrical estimate (OE) of the newborn's gestation in completed weeks based on the birth attendant's final estimate of gestation, irrespective of whether the gestation results in a live birth or a fetal death. This estimate of gestation should be determined by all perinatal factors and assessments such as ultrasound, but not the newborn exam. Ultrasound taken early in pregnancy is preferred (source: American College of Obstetricians and Gynecologists reVITALize Initiative).

Suggested Data Collection Question: How many weeks of gestation were completed at the time of delivery?

Format:

Length:	3 or UTD
Type:	Alphanumeric
Occurs:	1

Allowable Values: UTD= Unable to Determine
1-50

Notes for Abstraction: Gestational age should be rounded off to the nearest completed week, not the following week.

- For example, an infant born on the 5th day of the 36th week (35 weeks and 5/7 days) is at a gestational age of 35 weeks, not 36 weeks.

Gestational age should be documented by the clinician as a numeric value between 1-50. Gestational age (written with both weeks and days, eg. 39 weeks and 0 days) is calculated using the best obstetrical Estimated Due Date (EDD) based on the following formula:

- Gestational Age = (280 - (EDD - Reference Date)) / 7 (source: American College of Obstetricians and Gynecologists reVITALize Initiative).

The clinician, not the abstractor, should perform the calculation to determine gestational age.

The delivery or operating room record should be reviewed first for gestational age; documentation of a valid number should be abstracted.

If the gestational age in the delivery or operating room record is missing, obviously incorrect (in error, e.g. 3.6), or there is conflicting data, then continue to review the following data sources, starting with the document completed closest to or at the time of the delivery until a positive finding for gestational age is found:

- History and physical
- Clinician admission progress note
- Prenatal forms

Gestational age documented closest to or at the time of delivery (not including the newborn exam) should be abstracted.

The phrase "estimated gestational age" is an acceptable descriptor for gestational age.

If no gestational age was documented (e.g. the patient has not received prenatal care), select allowable value UTD.

Documentation in the acceptable data sources may be written by the following clinicians:

- Physician
- Certified nurse midwife (CNM)
- Advanced practice nurse/physician assistant (APN/PA)
- Registered nurse (RN)

It is acceptable to use data derived from vital records reports received from state or local departments of public health, delivery logs or clinical information systems if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the acceptable data sources listed below.

The EHR takes precedence over a handwritten entry if different gestational ages are documented in equivalent data sources, e.g., delivery record and delivery summary.

Suggested Data Sources: ONLY ACCEPTABLE SOURCES:

- Delivery or Operating room record, note or summary
- History and physical
- Admission clinician progress notes
- Prenatal forms

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Hispanic Indicator

Collected For: All MassHealth Records

Definition: The patient self-reported as Hispanic, Latino, or Spanish as defined by Massachusetts regulation noted in Section 2 of the RY23 EOHHS manual.

The definition of the "Hispanic" data element in the Massachusetts regulation differs from the CMS National Hospital Inpatient Quality Measures reporting requirement.

Suggested Data Collection Question: Is there documentation that the patient self-reported as Hispanic, Latino, or Spanish?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes) Patient self-reported as Hispanic / Latino / Spanish.

N (No) Patient did not self-report as Hispanic / Latino / Spanish or unable to determine from medical record documentation.

Notes for Abstraction: The Massachusetts regulation valid entry codes and allowable values for the "Hispanic" data element differs from CMS reporting requirement. Hospitals must use the Massachusetts regulation definition and allowable values when preparing all MassHealth data files for submission.

Only collect data that is self-reported by the patient. Do not abstract a clinician's assessment documented in the medical record.

If the medical record contains conflicting documentation on patient self-reported Hispanic Indicator, abstract the most recent dated documentation. If the patient's self-reported Race is Hispanic, abstract "Yes" for Hispanic Indicator.

Suggested Data Sources:
Administrative records
Face sheet (Emergency Department / Inpatient)
Nursing admission assessment
Prenatal initial assessment form

Guidelines for Abstraction:

Inclusion	Exclusion
The term "Hispanic" or "Latino" can be used in addition to "Spanish origin" to include a person of Spanish culture or origin regardless of race.	None

Data Element Name: ICD-10-CM Other Diagnosis Codes

Collected For: All MassHealth Records

Definition: The other or secondary ICD-10-CM codes associated with the diagnosis for this hospitalization.

Suggested Data Collection Question: What were the ICD-10-CM other diagnosis codes selected for this medical record?

Format:
Length: 3-7 (without decimal point or dot)
Type: Character (upper or lower case)
Occurs: 24

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:
Discharge summary
Face sheet
UB-04

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: ICD-10-PCS Other Procedure Codes

Collected For: All MassHealth Records

Definition: The other or secondary ICD-10-PCS codes identifying all significant procedures other than the principal procedure.

Suggested Data Collection Question: What were the ICD-10-PCS code(s) selected as other procedure(s) for this record?

Format:
Length: 3-7 (without decimal point or dot)
Type: Character (upper or lower case)
Occurs: 24

Allowable Values: Any valid procedure code as per the CMS ICD-10-PCS master code table (PCS Long and Abbreviated Titles): https://www.cms.gov/Medicare/Coding/ICD10/index.html

Notes for Abstraction: None

Suggested Data Sources:
Discharge summary
Face sheet
UB-04

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: ICD-10-PCS Other Procedure Dates

Collected For: All MassHealth Records

Definition: The month, day, and year when the associated procedure(s) was (were) performed.

Suggested Data Collection Question: What were the date(s) the other procedure(s) were performed?

Format:
Length: 10 – MM-DD-YYYY (includes dashes) or UTD
Type: Character
Occurs: 24

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

Notes for Abstraction:

If the procedure date for the associated procedure is unable to be determined from the medical record, select "UTD."

The medical record must be abstracted as documented (taken at "face value"). When the date documented is obviously in error (not valid format/range or outside of the parameters of care [after *Discharge Date*]) and no other documentation is found that provides this information, the abstractor should select "UTD."

Examples:

- Documentation indicates the ICD-10-PCS Other Procedure Dates was 02-42-20xx. No other documentation in the medical record provides a valid date. Since the ICD-10-PCS Other Procedure Dates is outside of the range listed in the Allowable Values for "Day", It is not a valid date and the abstractor should select "UTD"
- Patient expires on 02-12-20xx and documentation indicates the ICD-10-PCS Other Procedure Dates was 03-12-20xx. Other documentation in the medical records supports the date of death as being accurate. Since the ICD-10-PCS Other Procedure Dates is after the Discharge Date (death), it is outside of the parameters of care and abstractor should select "UTD"

Suggested Data Sources:
Consultation notes
Diagnostic test reports
Discharge summary
Face sheet
Operative notes
Procedure notes
Progress notes
UB-04

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

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

Collected For: All MassHealth Records

Definition: The ICD-10-CM diagnosis code that is primarily responsible for the admission of the patient to the hospital for care during this hospitalization.

Suggested Data Collection Question: What was the ICD-10-CM code selected as the principal diagnosis for this record?

Format:
Length: 3-7 (without decimal point or dot)
Type: Character (upper or lower case)
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:
Discharge summary
Face sheet
UB-04

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: ICD-10-PCS Principal Procedure Code

Collected For: All MassHealth Records

Definition: The principal procedure is the procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or which is necessary to take care of a complication.

Suggested Data Collection Question: What was the ICD-10-PCS code selected as the principal procedure for this record?

Format:
Length: 3-7 (without decimal point or dot)
Type: Character (upper or lower case)
Occurs: 1

Allowable Values: Any valid procedure code as per the CMS ICD-10-PCS master code table (PCS Long and Abbreviated Titles):
https://www.cms.gov/Medicare/Coding/ICD10/index.html

Notes for Abstraction: None

Suggested Data Sources:
Discharge summary
Face sheet
UB-04

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: ICD-10-PCS Principal Procedure Date

Collected For: All MassHealth Records

Definition: The month, day, and year when the principal procedure was performed.

Suggested Data Collection Question: What was the date the principal procedure was performed?

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 (2001-Current Year)
UTD = Unable to Determine

Notes for Abstraction: If the principal procedure date is unable to be determined from medical record documentation, select "UTD."

The medical record must be abstracted as documented (taken at "face value"). When the date documented is obviously in error (not valid date/format or is outside of the parameters of care [after Discharge Date]) and no other documentation is found that provides this information, the abstractor should select "UTD."

Examples:

- Documentation indicates the ICD-10-PCS Principal Procedure Date was 02-42-20xx. No other documentation in the medical record provides a valid date. Since the ICD-10-PCS Principal Procedure Date is outside of the range listed in the Allowable Values for "Day", it is not a valid date and the abstractor should select "UTD"
- Patient expires on 02-12-20xx and documentation indicates the ICD-10-PCS Principal Procedure Date was 03-12-20xx. Other documentation in the medical record supports the date of death as being accurate. Since the ICD-10-PCS Principal Procedure Date is after the Discharge Date (death), it is outside of the parameter of care and the abstractor should select "UTD".

Suggested Data Sources:
Consultation notes
Diagnostic test reports
Discharge summary
Face sheet
Operative notes
Procedure notes
Progress notes
UB-04

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Last Name

Collected For: All MassHealth Records

Definition: The patient's last name.

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

Format:
Length: 60
Type: Alphanumeric
Occurs: 1

Allowable Values: Enter the patient's last name.

Notes for Abstraction: None

Suggested Data Sources:
Emergency department record
Face sheet
History and physical

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: MassHealth Member ID

Collected For: All MassHealth Records

Definition: The patient's MassHealth Member ID.

Suggested Data Collection Question: What is the patient's MassHealth Member ID?

Format:
Length: 20
Type: Alphanumeric
Occurs: 1

Allowable Values:
Any valid MassHealth Member ID number
Alpha characters must be upper case
No embedded dashes or spaces or special characters

Notes for Abstraction:
The Provider Regulations define a valid MassHealth Member ID as a twelve (12) digit number that contains numeric characters only. This 12 digit member ID number applies to members enrolled within various Medicaid managed care or fee-for-service insurance programs.

However, some MassHealth managed care insurance plans may issue different MassHealth member ID numbers that use alphanumeric type and exceed the 12 digit numeric requirement. For the purposes of measures reporting the "format length" was expanded to 20 fields within the portal environment only. This portal edit allows data files that may exceed the12 characters to not be rejected by the portal. The change in the portal environment **does not** constitute a change to existing MassHealth Provider Regulation definitions of member ID number.

Once a member is assigned a MassHealth ID number it will not change through the duration of their enrollment or if they change managed care plans (e.g.: coverage changed from fee-for-service to an MCO plan). Member ID numbers can be verified using the on-line Eligibility Verification System (EVS) at:

https://www.mass.gov/how-to/eligibility-verification-for-providers. EVS provides historical data on a member for any given point in time that can be reviewed by entering a particular date of service.

The abstractor should NOT assume that their hospital's claim information for the patient's MassHealth Member ID number is correct. If the abstractor determines through chart review that the MassHealth Member ID number is incorrect, for purposes of abstraction, she/he should correct and override the downloaded value.

Suggested Data Sources:
Emergency department record
Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	Medical Procedures and Tests & Summary of Results
Collected For:	CCM-2
Definition:	Medical procedures and tests performed refer to procedures and tests performed during the acute inpatient hospitalization to help establish the diagnosis at discharge and course of treatment. Summary of results refers to the results of the medical procedures and tests performed. A transition record includes the Medical Procedures and Tests that were significant and relevant to the care of the patient performed during inpatient stay and a Summary of Results.
Suggested Data Collection Question:	Does the Transition Record include the Medical Procedure(s) and Test(s) and a Summary of Results?
Format:	Length: 1 Type: Alphanumeric Occurs: 1
Allowable Values:	Y (Yes) The transition record includes the Medical Procedure(s) and Test(s) and a Summary of Results or documentation of No Procedures and Tests. N (No) The transition record does not include the Medical Procedure(s) and Test(s) and a Summary of Results or documentation of No Procedures and Tests.
Notes for Abstraction:	Hospitals determine which procedures or tests are relevant to the care of the specific patient. Not all procedures and tests should be documented. Some examples of procedures and tests are: o Procedures: Cesarean section, vaginal delivery, appendectomy, heart catheterization with stent, knee replacement o Tests: Urine cultures, blood cultures, Imaging Studies (x-rays, CT scan) Surgical procedures documented do not require a summary of the results. o Example: Appendectomy would not require a summary of the result. Examples of documentation for Summary of Results: “Results discussed with physician,” “Within normal limits,” “Contact your physician with any questions regarding your results,” should accompany the specific medical procedure or tests listed. Documentation of actual test results such as: “CT negative for pulmonary emboli” or “Echocardiogram shows your heart is enlarged” also meet the requirement. If there is documentation of “No procedures or tests/ None/ N/A”, the abstractor should select Y (Yes).

In the event of a transfer to another site of care, if a summary or listing of medical procedures and tests performed during inpatient stay is provided with the patient to the receiving site, this element may be documented as Y(Yes). Documentation of Y(Yes) also applies to patients discharged and admitted within the same site.

Suggested Data Sources: Transition Record
Discharge Instructions

Guidelines for Abstraction:

Inclusion	Exclusion
Normal/ Abnormal Within normal limits Results to be discussed with physician	None

Data Element Name: National Provider ID

Collected For: All MassHealth Records

Definition: The provider's ten digit national provider identifier.

Suggested Data Collection Question: What is the provider's ten digit national provider identifier?

Format:
Length: 10
Type: Alphanumeric
Occurs: 1

Allowable Values: Any valid ten digit national provider ID.

Notes for Abstraction: Hospitals must submit either their valid Medicare or Medicaid Provider ID or their National Provider ID for all MassHealth measure files.

Suggested Data Sources: Administrative record

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Patient Identifier

Collected For: All MassHealth Records

Definition: The identification number used by the Hospital to identify this patient.

Suggested Data Collection Question: What is the patient's hospital patient identification number?

Format:
Length: 40
Type: Alphanumeric
Occurs: 1

Allowable Values: Up to 40 letters and / or numbers

Notes for Abstraction: When abstracting this data element for a clinical measure file, the data in this field must match the hospital patient ID number submitted in the corresponding crosswalk file.

Suggested Data Sources: Administrative record
Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Patient Instructions

Collected For: CCM-2

Definition: Patient Instructions refers to information that is associated with the diagnosis, treatment, and plan of care specific to the patient's inpatient stay that should be followed by the patient after discharge from inpatient care.

A transition record that included patient instructions (discharge instructions) related to the inpatient stay.

Suggested Data Collection Question: Does the Transition Record include Patient Instructions?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes) The transition record includes Patient Instructions.

N (No) The transition record does not include Patient Instructions.

Notes for Abstraction: Patient instructions include post-discharge patient self-management instructions.

If the patient instructions given to the patient are on a separate page from the transition record and not retained in the permanent medical record, there must be a reference listing the patient instructions given to the patient.

Patient instructions should be transmitted to the next provider of care with the Transition Record.

In the event the patient is transferred to another site where the patient instructions will be determined at the time of discharge from that site of care, this data element may be documented as Y(Yes). Documentation of Y(Yes) also applies to patients discharged and admitted within the same site of care.

Suggested Data Sources: Transition Record
Patient Instructions (may be pre-printed forms)
Discharge Instructions

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Patient Refusal of Transmission

Collected For: CCM-3

Definition: Documentation in the medical record of the patient's or caregiver's refusal of transmission of the patient's healthcare information to include the Transition Record to the next site of care, physician, or other health care professional designated for follow-up care

Suggested Data Collection Question: Is there documentation in the medical record of patient refusal of transmission to the next site of care, physician, or other health care professional designated for follow-up care?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:
Y (Yes) The medical record includes documentation of patient refusal of transmission to the next site of care, physician, or other health care pay professional designated for follow-up care.

N (No) The medical record does not include documentation of patient refusal of transmission to the next site of care, physician, or other health care professional designated for follow-up care.

Notes for Abstraction:
Patient refusal of transmission of the transition record may occur at any point during the inpatient stay.

Documentation requirements may be met by the following:

- patient signature indicating refusal of transfer of medical record information
- nursing note stating patient refusal
- other health care provider documentation of refusal

TRANSFER- In the event the patient is transferred to another site of care where the plan for follow-up care will be determined at the time of discharge from that site, patient refusal is abstracted as No. The discharge date should be used as the Transmission Date. Documentation of the discharge date also applies to patients discharged and admitted within the same site.

Suggested Data Sources:
Admission Consent Forms
Nursing notes

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Payer Source

Collected For: All MassHealth Records

Definition: The definition of Medicaid payer source as defined by the Massachusetts regulations noted in Section 2 of the RY23 EOHHS manual.

The definition of the Medicaid payer source data element differs from the CMS National Hospital Inpatient Quality Measures reporting requirement.

Suggested Data Collection Question: What is the patient's primary source of Medicaid payment for care provided?

Format:
Length: 3
Type: Alphanumeric
Occurs: 1

Allowable Values: Payment source code values assigned by Massachusetts regulations include:

103	MassHealth FFS Network, MassHealth Limited Plans
103	Primary Care Clinician Management (PCCM) Plan
118	Medicaid Managed Care: Massachusetts Behavioral Health Partnership
103	Medicaid Managed Care: Other (not listed elsewhere)
288	Medicaid Managed Care: WellSense Health Plan
7	Medicaid Managed Care: Tufts Health Plan
311	Medicaid Other ACO
4	Fallon Health-Atrius Health Care Collaborative
4	Berkshire Fallon Health Collaborative
4	Fallon 365 Care
24	Be Healthy Partnership with Health New England
288	East Boston Neighborhood Health WellSense Alliance
288	WellSense Beth Israel Lahey Health (BILH) Performance Network ACO
288	WellSense Boston Children's ACO
288	WellSense Care Alliance
288	WellSense Community Alliance
288	WellSense Mercy Alliance
288	WellSense Signature Alliance
288	WellSense Southcoast Alliance
320	Community Care Cooperative
322	Mass General Brigham Health Plan with Mass General Brigham ACO
323	Steward Health Choice (ACO)
7	Tufts Health Together with UMass Memorial Health
7	Tufts Health Together with Cambridge Health Alliance
328	Tufts Medicine (ACO)

Notes for Abstraction: As noted in Section 2.B.1 (Table 2.1) in the RY23 EOHHS manual is a revised list of included and excluded Medicaid payer codes resulting from Affordable Care Act requirements apply. The Massachusetts regulations outline the payer data reporting definitions and codes for Medicaid payment sources required when preparing MassHealth data files for submission.

Primary source of payment is a MassHealth insurance program:

- If Medicaid is the only payer listed (see payer codes above);
- If Medicaid is primary and another secondary insurance is listed.

Primary source of payment is NOT a MassHealth insurance program:

- If Medicare is the only payer listed;
- If Medicare is primary and lists Medicaid as secondary (ex: dual eligible)
- If HMO/Commercial Plan is primary and lists Medicaid as secondary (TPL)

Suggested Data Sources: Face sheet (Emergency Department / Inpatient)
UB-04, file location, 50A, B, C
MassHealth Eligibility Verification System (EVS)
http://www.mass.gov/eohhs/provider/insurance/masshealth/claims/eligibility-verification/

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	Plan for Follow-up Care
Collected For:	CCM-2
Definition:	Plan for Follow-up Care refers to a document that describes further action to be taken after the patient is discharged that is shared with patient/family caregiver. The purpose of a plan for follow-up care is to track and monitor progress toward patient goals. A transition record that included a Plan for Follow-up Care related to the inpatient stay or documentation by a physician of no follow-up care required.
Suggested Data Collection Question:	Does the Transition Record include a Plan for Follow-up Care related to the inpatient stay OR documentation by a physician of no follow-up care required OR patient is a transfer to another site of care?
Format:	Length: 1 Type: Alphanumeric Occurs: 1
Allowable Values:	Y (Yes) The transition record includes a Plan for Follow-up Care OR documentation by a physician of no follow-up care required OR patient is a transfer to another site of care. N (No) The transition record does not include a Plan for Follow-up Care.
Notes for Abstraction:	The Plan for follow-up care may include: • Any post discharge therapy needed (ex. physical, occupational, home health visits, VNA) • Any durable medical equipment needed • Family psychosocial resources available for patient support, self-care instructions (e.g. counseling) • Follow up appointments • Follow-up for medical issues, social work and benefits follow-up, pending legal issues, and peer support (e.g. Alcoholics Anonymous, Narcotics Anonymous, and/or home-based services) A scheduled appointment or specific instructions for the patient to call within a certain timeframe to make an appointment with a physician/ health care professional will be accepted. Example: o Call Dr Jackson for appointment in 1 week o Primary Care Physician to call patient with appointment date/time o Follow up with Dr Jackson as needed o Call OB for appointment in 1 week o Appointment scheduled with Cardiology in 2 days If the patient does not have a primary care physician, then the patient can be referred to a healthcare clinic for follow up**.** If it is documented that the patient has declined any plan for follow-up care OR a primary care provider or clinic cannot be identified, then the

patient can be referred to the Emergency Department for emergent care.

In the event the patient is transferred to another site of care where the plan for follow-up care will be determined at the time of discharge from that site, this data element may be documented as Y(Yes). Documentation of Y(Yes) also applies to patients discharged and admitted within the same site.

If it is determined and documented by the physician that the patient requires no follow-up care, documentation of this on the transition record will be acceptable and Y(Yes) should be selected.

Suggested Data Sources: Transition Record
Discharge Instructions

Guidelines for Abstraction:

Inclusion	Exclusion
• Instruction for patient to call physician / health care professional or site of care such as a clinic to schedule appointment within a specific time frame • OB/Pediatric follow-up appointments • A scheduled appointment • Oxygen therapy • Physical therapy • Occupational therapy • DME • VNA • Social work and benefits follow-up • References for pending legal issues • Peer support (e.g. Alcoholics Anonymous, Narcotics Anonymous, and/or home-based services	None

Data Element Name:	Prescription for Alcohol or Drug Disorder Medication
Collected For:	SUB-3
Definition:	Documentation that an FDA-approved medication for alcohol or drug disorder was prescribed at hospital discharge.
Suggested Data Collection Question:	Was one of the FDA approved medications for alcohol or drug disorder prescribed at discharge?
Format:	Length: 1 Type: Alphanumeric Occurs: 1
Allowable Values**:**	1. A prescription for an FDA-approved medication for alcohol or drug disorder was given to the patient at discharge 2. A prescription for an FDA-approved medication for alcohol or drug disorder was offered at discharge and the patient refused 3. The patient: - is being discharged to a residence outside the USA - is released to a court hearing and does not return - is being discharged to jail/law enforcement 4. A prescription for an FDA-approved medication for alcohol or drug disorder was not offered at discharge; or unable to determine from medical record documentation.
Notes for Abstraction:	In determining whether a medication for alcohol or drug disorder was prescribed at discharge, it is not uncommon to see conflicting documentation among different medical record sources. For example, the discharge summary may list Disulfiram but this is not included in any of the other discharge medications sources, e.g., discharge orders. All discharge medication documentation available in the chart should be reviewed and taken into account by the abstractor. In cases where there is a medication for alcohol or drug disorder in one source and it is not mentioned on other sources, it should be interpreted as a discharge medication, select value "1" unless documentation elsewhere in the medical record suggests that it was not prescribed at discharge. If documentation is contradictory (physician noted “d/c Antabuse” or “hold Antabuse” in the discharge orders, but Antabuse is listed in the discharge summary's discharge medication list), or after careful examination of circumstances, context, timing, etc, documentation raises enough questions, the case should be deemed unable to determine, select value "4" If the patient does not have a residence in the USA, Value “3” must be selected.
Suggested Data Sources:	Discharge summary Transfer sheet

Discharge Instruction Sheet
Medication Reconciliation Form
Nursing Discharge notes
Physician Order Sheets

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendix C, Table 9.2 for a comprehensive list of FDA-approved medications for alcohol and drug dependence	None

Data Element Name:	Previous Births
Collected For:	MAT-4
Definition:	Documentation that the patient experienced a birth >= 20 weeks gestation regardless of the outcome (i.e. parity > 0) prior to the current hospitalization.
Suggested Data Collection Question:	Did the patient experience a birth prior to current hospitalization?
Format:	Length: 1 Type: Alphanumeric Occurs: 1
Allowable Values:	Y (Yes) There is documentation that the patient experienced one or more births prior to the current hospitalization. N (No) There is no documentation that the patient experienced one or more births prior to the current hospitalization OR unable to determine from medical record documentation.
Notes for Abstraction:	The delivery or operating room record should be reviewed first for documentation of parity greater than zero. If documentation of parity greater than zero is not present or is conflicting in the delivery or operating room record, then continue to review the acceptable data sources in the following order: history and physical, clinician admission progress note, prenatal forms, and discharge summary until a positive finding for parity greater than zero is found. If there is conflicting documentation throughout the acceptable sources and it cannot be determined from the medical record if there were previous births, select No. Documentation in the acceptable data sources may be written by the following clinicians: physician, certified nurse midwife (CNM), advanced practice nurse/physician assistant (APN/PA) or registered nurse (RN). It is acceptable to use data derived from vital records reports received from state or local departments of public health, delivery logs or clinical information systems if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the Only Acceptable Sources listed below. In the absence of parity, documentation that the patient experienced a previous birth > = 20 weeks gestation regardless of the outcome may be used. If the number for parity documented is "one" and includes the delivery for the current hospitalization, do not include the current delivery to determine previous births. A string of three or more numbers without the alpha designation of "p" preceding the second number cannot be used to determine parity. Example: 321 When GTPAL terminology is documented, G= Gravida, T= Term, P= Preterm, A= Abortions, L= Living, P does not equal parity.
Suggested Data Sources:	**ONLY ACCEPTABLE SOURCES IN ORDER OF PREFERENCE**

- Delivery or Operating room record, note or summary
- History and physical
- Admission clinician progress note
- Prenatal forms
- Discharge summary

Guidelines for Abstraction:

Inclusion	Exclusion
Select Yes: • Number of previous births is greater than 0 • Parity is greater than 0 • Term is greater than 0 • Preterm is greater than 0 • Living is greater than 0 • Documentation of multiparous	Select No: • Number of previous births equals 0 • Parity equals 0 • Gravidity equals 1 • Documentation of primigravida or nulliparous • Preterm and term births equals 0

Data Element Name:	Primary Physician or Other Health Care Professional for Follow-up Care
Collected For:	CCM-2
Definition:	Primary Physician refers to the physician responsible for overseeing the continued care of the patient immediately after discharge/ post-discharge (ex: Internist, Pediatrician, or Psychiatrist). Other Health Care Professional refers to any other medical specialist that may be involved in the continued care process (ex: surgeon, cardiologist, nurse practitioner etc). A transition record that included the name of the Primary Physician or other Health Care Professional or site designated for follow-up care.
Suggested Data Collection Question:	Does the Transition Record include the name of the Primary Physician or other Health Care Professional or site designated for follow-up care?
Format:	Length: 1 Type: Alphanumeric Occurs: 1
Allowable Values:	Y (Yes) The transition record includes the name of the Primary Physician or other Health Care Professional or site designated for follow-up care. N (No) The transition record does not include the name of the Primary Physician or other Health Care Professional or site designated for follow-up care.
Notes for Abstraction:	The primary physician or other health care provider's name must be specified. The exception is for a site of care such as a nursing home when the physician name may not be known. In this case the site name must be documented. The VNA or home health agency is not acceptable as a Primary Care Physician or other Health Care Professional designated for follow-up care. If the patient is transferred to the next site of care and the physician designated for follow-up is unknown, "site physician" or site of care name will be accepted, and this element may be documented as Y (Yes). If a follow-up appointment is made with a clinic where the physician / other health care professional is not known at the time of the appointment, this element may be documented as Y (Yes). Example. Follow up appointment made at GI Clinic in one week In the case of a patient declining assignment of a PCP or clinic, the patient may be referred to the Emergency Room for follow up care. If it is determined and documented by the physician that the patient requires no follow-up care, the name of the patient's primary physician or other health care professional or site designated for care must be documented.
Suggested Data Sources:	Transition Record Discharge Instructions
Guidelines for Abstraction:	

Inclusion	Exclusion
• Specific physician name • Specific health care professional • Clinic or site name • Transferred • Emergency Room	• “PCP” “Primary Care Physician” • VNA

Data Element Name: Provider ID

Collected For: All MassHealth Records

Definition: The provider's ten-digit acute care Medicaid or six-digit Medicare provider.

Suggested Data Collection Question: What is the provider's ten-digit acute care Medicaid or six-digit Medicare ID?

Format:
Length: 10
Type: Alphanumeric
Occurs: 1

Allowable Values: Any valid ten-digit Medicaid or six-digit Medicare provider ID.

Notes for Abstraction: Hospitals must submit either their valid Medicare or Medicaid Provider ID for all MassHealth measure files or crosswalk files.

Suggested Data Sources: Administrative record

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Provider Name

Collected For: All MassHealth Records

Definition: The name of the provider of acute care inpatient services.

Suggested Data Collection Question: What is the name of the provider of acute care inpatient services?

Format:
Length: 60
Type: Alphanumeric
Occurs: 1

Allowable Values: Provider name

Notes for Abstraction: The provider name is the name of the hospital.

Suggested Data Sources: Face sheet

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: Race

Collected For: All MassHealth Records

Definition: The patient's self-reported race as defined by the Massachusetts regulation noted in Section 2 of RY22 EOHHS manual.

The definition of "Race" data element categories in the Massachusetts regulation differ from the CMS National Hospital Inpatient Quality Measures reporting requirement.

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

Format:
Length: 6
Type: Alphanumeric
Occurs: 1

Allowable Values: Select one:

Code	Race
R1	American Indian or Alaska Native
R2	Asian
R3	Black / African American
R4	Native Hawaiian or other Pacific Islander
R5	White
R9	Other Race
UNKNOW	Unknown / not specified

Notes for Abstraction: The Massachusetts regulation codes and allowable values for the "Race" data element differ from CMS reporting requirement. Hospitals must use the Massachusetts regulation race codes and allowable values when preparing all MassHealth data files for submission.

Only collect race data that is self-reported by the patient. Do not abstract a clinician's assessment documented in the medical record.

If the medical record contains conflicting documentation on patient self-reported race, abstract the most recent dated documentation. If the medical record contains multiple patient self-reported races on one document, abstract the first self-reported race listed (e.g. – Black/Asian, select Black).

If the patient self-reports as Hispanic, the Race selected is "Other Race".

If codes and allowable values, other than those listed above, are documented in the medical record, a crosswalk that links the hospitals' codes/values to the Massachusetts regulation requirements must be provided for chart validation.

Suggested Data Sources: Administrative records

Face sheet (Emergency Department / Inpatient)
Nursing admission assessment
Prenatal initial assessment form

Guidelines for Abstraction:

Inclusions	Exclusion
(OMB definitions) • American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliations or community attachment, e.g. any recognized tribal entity in North and South America (including Central America), Native American. • Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. • Black / African American: A person having origins in any of the black racial groups of Africa. Terms such as “Haitian” or “Negro”, can be used in addition to “Black or African American”. • Native Hawaiian or Other Pacific Islander: A person having origins in any of the other original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. • White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa, e.g., Caucasian, Iranian, White. • Other Race: A person having an origin other than what has been listed above. • Unknown: Unable to determine the patient’s race or not stated (e.g., not documented, conflicting documentation or patient unwilling to provide).	None

Data Element Name: Reason for Inpatient Admission

Collected For: CCM-2

Definition: The reason for inpatient admission describes the patient's chief complaint, reason for admission, or diagnosis at time of admission.

A transition record that included the Reason for Inpatient Admission.

Suggested Data Collection Question: Does the Transition Record include the Reason for Inpatient Admission?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes) The transition record includes the Reason for Inpatient Admission.

N (No) The transition record does not include the Reason for Inpatient Admission.

Notes for Abstraction: The reason for admission may be a short synopsis or listing of the triggering or precipitating event prior to the patient's admission to the hospital.

Documentation of a diagnosis, symptoms, or procedure is acceptable for Reason for Admission. The Reason for Inpatient Admission must be documented and differentiated from the Discharge Diagnosis on the Transition Record.

For the inpatient psychiatric population, it is recommended to document the events the patient experienced prior to this hospitalization; the reason for hospitalization as a short synopsis describing or listing the triggering or precipitating event.

In the event the patient is transferred to another site of care and the reason for admission is provided to the next site of care, this data element may be documented as Y(Yes). Documentation of Y(Yes) also applies to patients discharged and admitted within the same site.

Suggested Data Sources: Transition Record
Discharge Instructions

Guidelines for Abstraction:

Inclusion	Exclusion
This list is not all-inclusive • Reason for Admission • Admission diagnosis • Primary diagnosis • Chief complaint	None

Data Element Name: Reconciled Medication List

Collected For: CCM-1

Definition: A Reconciled Medication List is the result of the formal process of identifying all medications to create the most complete and accurate list and comparing the list to those in the patient's record or medication orders at the time of discharge.

The Transition Record included the reconciled list received by the patient/caregiver(s) including new, continued, and discontinued medications as applicable to the patient at the time of discharge.

Suggested Data Collection Question: Did the patient/ caregiver(s) receive a copy of the reconciled medication list at the time of discharge?

Format:

Length:	1
Type:	Alphanumeric
Occurs:	1

Allowable Values: Y (Yes) The patient/caregiver(s) received a reconciled medication list at the time of discharge.

N (No) The patient/caregiver(s) did not receive a reconciled medication list that the time of discharge.

Notes for Abstraction: The reconciled list should address medications taken prior to inpatient stay (to be continued or active), started during inpatient stay or upon discharge (new) and medications to discontinue at discharge. If the patient has no home medications and is discharged with no medications, the abstractor should select "Yes".

Discontinued – Medications that should be discontinued or held after discharge, AND
Continued – Medications (including any prescribed before inpatient stay and any started during inpatient stay) that patient should continue to take after discharge, AND
New – Newly prescribed medications that patient should begin taking after discharge.

In the case of electronic health records, when determining that the New, Continued, and Discontinued sections of the medication reconciliation form are present, if one or more of the sections is missing, and it is determined that there are no medications ordered that would be included in those sections, you may answer "YES" to this element.

Example: If there are no medications to be discontinued at discharge, and there is no discontinued section in the electronic health record due to this fact, then this would be acceptable.

All 3 categories of continued, new, and discontinued must be addressed for the patient but do not need to be labeled separately. For instance, a medication reconciliation form with the category title "medications to take" is acceptable documentation for the continued and new categories.

A reconciled medication form that does not list discontinued medications must state clearly to the patient that "medications not listed should be discontinued" or "only medications listed should be taken."

In the event the medication reconciliation form is present in the medical record and there is no documentation which clearly suggests that a copy was given, the inference should be made that it was given IF the patient's name or the medical record number appears on the material AND hospital staff or the patient/caregiver has signed the material.

The following must be included for each continued and new medication listed:

- *prescribed or recommended dosage,*
- *special instructions/considerations, and*
- *intended duration.*

Documentation of duration is not required for pro re nata (PRN) and over-the-counter (OTC) medications to meet this element.

A generalized statement regarding intended duration, such as a blanket statement indicating that the patient should continue the medications until told to stop, would be acceptable for routine medications.

In the event the patient is transferred to another site of care where the medication reconciliation will be determined at the time of discharge from that site, this data element may be documented as Y(Yes). Documentation of Y(Yes) also applies to patients discharged and admitted within the same site.

If discharge medications are noted using only references such as "continue home meds", "resume other meds", or "same medications," rather than list the names of the discharge medications, the abstractor should select N (No).

Oxygen should not be considered a medication.

Medication which the patient will not be taking at home (and/or the caregiver will not be giving at home) are NOT required in the medication list included in the written discharge instructions (e.g., monthly B12 injections, intermittent IV Dobutamine, Natrecor infusions, dialysis meds, chemotherapy)

If the patient refused written discharge instructions/ material which addressed discharge medications, select Y(Yes).

If the patient was given written discharge medication instructions only in the form of written prescriptions, select N(No).

Suggested Data Sources: Medication Reconciliation Form provided to the patient at discharge.

Guidelines for Abstraction:

Inclusion	Exclusion
None	Prenatal Vitamins

Data Element Name:	Referral for Addictions Treatment
Collected For:	SUB-3
Definition:	Documentation that a referral was made at discharge for addictions treatment by a physician or non-physician (such as nurse, psychologist, or counselor). A referral is defined as an appointment made by the provider either through telephone contact, fax or e-mail. The referral may be to an addictions treatment program, to a mental health program or mental health specialist for follow-up for substance use or addiction treatment, or to a medical or health professional for follow-up for substance use or addiction.
Suggested Data Collection Question:	Was a referral for addictions treatment made for the patient prior to discharge?
Format:	**Length:** 1 **Type:** Alphanumeric **Occurs:** 1
Allowable Values:	1. The referral to addictions treatment was made by the healthcare provider or health care organization at any time prior to discharge. 2. Referral information was given to the patient at discharge, but the appointment was not made by the provider or health care organization prior to discharge. 3. The patient refused the referral for addictions treatment and the referral was not made. 4. The patient: - is being discharged to a residence outside the USA - is released to a court hearing and does not return - is being discharged to jail/law enforcement 5. A referral for addictions treatment was not offered anytime prior to discharge or Unable to Determine (UTD) from the medical record documentation
Notes for Abstraction:	If a patient is referred to an addictions treatment provider that does not schedule appointments and the patient was given a specific date and time to present for addictions treatment, select Value “1.” Value "4" should be selected if the patient: o is being discharged to a residence outside the USA o is released to a court hearing and does not return o is being discharged to jail/law enforcement A referral to Alcoholics Anonymous (AA) or similar mutual support groups does not meet the intent of the measure. Select Value “5.” Select Value “5” if: o it cannot be determined that a referral for addictions treatment was made or; o it is unclear that the absence of the referral was due to a patient refusal or because the referral was not offered.

Suggested Data Sources: Discharge summary

Transfer sheet
Instruction Sheet
Discharge Nursing Discharge Notes
Physician Order Sheet

Guidelines for Abstraction:

Inclusion	Exclusion
Group counseling Individual counseling o Addictions counselor o Personal physician o Psychiatrist o Psychologist	Self help interventions in the form of printed/electronic/digital media Support groups that are not considered treatment such as Alcoholics Anonymous (AA)

Data Element Name: Sex

Collected For: All MassHealth Records

Definition: The patient's documented sexual orientation and/or gender identity.

Suggested Data Collection Question: What was the patient's sexual orientation and/or gender identity?

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

Allowable Values:
Select all that apply:
1 Male
2 Assigned/Designated Male at Birth
3 Female
4 Assigned/Designated Female at Birth
5 LGBTQ
6 Unknown

Notes for Abstraction: Select any of the values that are applicable. The data element and values encompass both the patient's current gender identity and one assigned at birth.

Consider the sex to be unable to determine and select "Unknown" if the patient refuses to provide their sexual orientation and/or gender identity. If "Unknown" is selected, then no other value should be selected.

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

Guidelines for Abstraction:

Inclusion	Exclusion
LGBTQ (Value 5) • LGBTQIA, LGBTQ+, LGBTQIA2 • Lesbian, gay, or bisexual • MSM (men who have sex with men) • Queer, Genderqueer • Pansexual • Asexual • Transgender • Gender non-conforming • Two-spirit • Non-binary • Gender diverse • People/person with intersex traits	None

Data Element Name: Studies Pending at Discharge

Collected For: CCM-2

Definition: Studies pending at discharge refers to any medical tests performed during hospitalization, but whose final results were unavailable at the time the patient was discharged, and therefore could not be reviewed by clinicians prior to hospital discharge.

A transition record that included the Studies Pending at Discharge or documentation that no studies are pending.

Suggested Data Collection Question: Does the Transition Record include documentation of Studies Pending at Discharge or that no studies were pending?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes) The transition record includes documentation of studies pending at discharge or documentation that no studies were pending.

N (No) The transition record does not include documentation of studies pending at discharge or documentation that no studies were pending.

Notes for Abstraction: The definition requires documentation of Studies Pending at Discharge or documentation of none. If there is documentation of No studies pending/ None/ N/A, the abstractor should select Y (Yes).

Any studies pending must be listed, not just documented as “Yes” on the transition record.

Studies pending do not include tests scheduled to be performed after discharge from inpatient care.

In the event of a transfer to another site of care, if documentation of tests or procedures with pending results was provided with the patient to the receiving site, this element may be documented as Y (Yes). Documentation of Y(Yes) also applies to patients discharged and admitted within the same site.

Suggested Data Sources: Transition Record
Discharge Instructions

Guidelines for Abstraction:

Inclusion	Exclusion
• No studies pending, None, NA • Tissue Pathology Studies • Radiology Studies • Biopsy Reports • CT Scan results • X-ray results • Lab results	None

Data Element Name:	Term Newborn
Collected For:	NEWB-3
Definition:	Documentation that the newborn was at term or >= 37 completed weeks of gestation at the time of birth.
Suggested Data Collection Question:	Is there documentation that the newborn was at term or >= 37 completed weeks of gestation at the time of birth?
Format:	Length: 1 Type: Alphanumeric Occurs: 1
Allowable Values:	1. Y (Yes) There is documentation that the newborn was at term or >= 37 completed weeks of gestation at the time of birth. 2. N (No) *No, there is documentation that the newborn was not* at term or >= 37 completed weeks of gestation at the time of birth. 3. UTD, unable to determine from medical record documentation.
Notes for Abstraction:	Gestational age should be rounded off to the nearest completed week, not the following week. For example, an infant born on the 5th day of the 36th week (35 weeks and 5/7 days) is at a gestational age of 35 weeks, not 36 weeks. Estimated gestational age (EGA) may be used to determine gestational age, including a range of numbers that are 37 weeks or greater, e.g.,37-38 weeks gestation. It is acceptable to use data derived from vital records reports received from state or local departments of public health, delivery logs or clinical information systems if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the acceptable data sources listed below. The mother's medical record ALONE cannot be used to determine the newborn's gestational age. This documentation must appear in the newborn's medical record without using the mother's medical record to perform the abstraction even if there is a link between the mother and newborn medical records in the EHR. In cases when there is conflicting documentation, e.g., both term and a gestational age of 36 weeks are documented, the gestational age takes precedence. In cases where there are two different values documented for gestational age and one is determined by examination and the other is determined by the best obstetrical estimate (OE) based on dates, abstract the value determined by dates.
Suggested Data Sources:	History and physical Nursing notes Nursing admission assessment Progress notes

Physician's notes
Discharge summary

Guidelines for Abstraction:

Inclusion	Exclusion
• Gestational age of 37 weeks or more • Early term • Full term • Late term • Post term • Term	• Gestational age of 36 weeks or less • Preterm • Early preterm • Late preterm

Data Element Name: Transition Record

Collected For: CCM-2

Definition: A transition record refers to a document (or set of documents), as defined by the hospital, that must contain the minimum core set of information relevant to the patient's diagnosis, treatment, and plan of care. The core set of required information data elements are as follows.

Core set of Required Elements (11):

- Advance Care Plan
- Contact Information 24 hrs/7 days
- Contact Information for Studies Pending
- Current Medication List
- Medical Procedures & Tests
- Patient Instructions
- Plan for Follow-up Care
- Primary Physician/ Health Care Professional for Follow-up Care
- Discharge Diagnosis
- Reason for Inpatient Admission
- Studies Pending at Discharge

Suggested Data Collection Question: Did the patient/ caregiver(s) or the next site of care for a transfer receive a transition record at the time of discharge?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes) The patient/caregiver(s) or the next site of care for a transfer received a transition record at the time of discharge.

N (No) The patient/caregiver(s) or the next site of care for a transfer did not receive a transition record at the time of discharge.

Notes for Abstraction: For a transition record that included any or all of the required elements received by the patient/ family caregiver at the time of hospital inpatient discharge, select Y(Yes).

If the Transition Record is offered to the patient at discharge and the patient/caregiver refuses, select Y(Yes) if there is documentation in the medical record of patient/caregiver refusal.

The required data elements in a Transition Record may be found on a single source document or multiple sources but these sources must be provided to the patient/ caregiver or the next site of care in the case of a transfer.

Documents used for the Transition Record may include, but are not limited to:

- Transition Record
- Discharge Instructions
- Transfer Forms
- Any document given to the patient/ family caregiver that includes ANY or ALL of the required data elements
- Any document given to the next site of care for a patient transfer that includes ANY or ALL of the required data elements
- Physician Discharge Summary ONLY if given to the patient/ family caregiver or the next site of care in the case of a transfer.

In the event the patient is transferred to another site of care and the transition record, that included any or all of the required elements, is given to the next

site of care, the Transition Record may be documented as Y(Yes). Documentation of Y(Yes) also applies to patients discharged and admitted within the same site of care.

PATIENT PORTAL- Notification to the patient of the availability of a patient portal which gives access to ANY or ALL of the required data elements does not meet the requirement for Transition Record. There must be documentation in the medical record that the patient has elected to access the patient portal for the post discharge Transition Record information. Abstractors may then select Y(Yes) for data elements available to the patient within the portal. Documentation of the required data elements located in the patient portal must be provided for records selected for validation.

Documentation of evidence the patient/ family caregiver received the Transition Record includes:

- Patient/ family caregiver signature on Transition Record
- Nursing documentation of patient receipt of Transition Record
- Physician/ Nurse signature on Transition Record

The caregiver is defined as the patient's family or any other person over age 18 who will assume responsibility for managing the care of the patient after discharge. The caregiver term is differentiated from other health care professional entities that may assist in the care of the patient.

Suggested Data Sources:

Transition Record
Discharge Instructions
Transfer Forms

Guidelines for Abstraction:

Inclusion	Exclusion
None	Physician Discharge Summary: Do not abstract information from the physician discharge summary for CCM-2 (unless a copy of the physician discharge summary is given to the patient/caregiver or the patient is a transfer)

Data Element Name: Transmission Date (of Transition Record)

Collected For: CCM-3

Definition: The Transmission Date refers to the month, day, and year the Transition Record data elements were transmitted to the next site of care, physician, or other health care professional designated for follow-up care.

Transmission methods may occur via fax, secure email, mail, via mutual access of an electronic medical record (EMR), or by CEHRT transmission. The transmission date may be the day of discharge or within the following two days.

Suggested Data Collection Question: What was the date documented in the medical record that the Transition Record was transmitted?

Format:

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

Allowable Values:

MM	=	Month (01-12)
DD	=	Day (01-31)
YYYY	=	Year (2000 – 9999)
UTD	=	Unable to determine/ No transmission date

Notes for Abstraction: There must be a Transmission of the Transition Record data elements to the next provider or site of care. A physician or site of care listed as “cc” on the discharge summary or transition record is not enough to meet the measure.

Documentation of the date of Transmission must be provided for validation.

EMR -In the case of Electronic Medical Records (EMR), there must be documentation in the medical record or on the transition record by discharging staff of the date the information has been transmitted to the next provider of care. This includes transmission by CEHRT (certified electronic health record technology).

MUTUAL ACCESS- In the case of mutual access, there must be documentation in the medical record or on the transition record of the date of notification to the provider that the patient has been discharged and the transition record elements are ready for review. The next provider of care having access to the EMR without documentation of notification is not enough to pass this measure.

NEXT PROVIDER NOT IDENTIFIED- If the Emergency Room of the hospital is documented as the referral for follow-up care, EMR mutual access is the assumed answer and the date of discharge may be documented for the Transmission Date.

If there is documentation of “Unknown MD/PCP” on the transmission documentation or no MD/PCP/next site of care is identified on the Transition Record and the Emergency Room is NOT designated for follow up, UTD must be selected for transmission date.

TRANSFER- In the event the patient is transferred to another site of care where the plan for follow-up care will be determined at the time of discharge

from that site, the discharge date should be used as the Transmission Date. Documentation of the discharge date also applies to patients discharged and admitted within the same site.

FAX- In the case of a fax transmission, there must be documentation in the medical record or on the transition record of the date the fax was sent to the next provider.

MAIL- If the transition record is sent by mail, the date of the mailing may be documented in the medical record or on the transition record as the Transmission Date.

HAND DELIVERY- A transition record given to the patient to hand carry to a physician is not acceptable.

If the discharging physician is also the physician designated for follow up care, transmission of the Transition Record to the provider or provider practice is still required.

Any documentation used to complete the Transition Record must be transmitted with the Transition Record (ex. Medication Reconciliation Form, Discharge Instructions).

The transition record should be transmitted to the next provider even if there is no follow-up care required.

Suggested Data Sources:

Transition Record
Discharge Instructions
Physician Discharge Summary
Administrative Records or Screen Shots
Information Systems Reports
Health Information Management (HIM) Reports

Guidelines for Abstraction:

Inclusion	Exclusion
• Faxed • Secure Email • Mail • Electronic Medical Record (EMR) or Electronic Health Record (EHR) with proper documentation of notification to next provider of care • CEHRT Transmission	• Hand carried by patient • Transmission to the VNA