

VHA EXTERNAL PEER REVIEW PROGRAM
ACUTE CORONARY SYNDROME INSTRUMENT
VALIDATION MODULE
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
		Organizational Identifiers		
	VAMC CONTROL QIC BEGDTE REVDTE	Facility ID Control Number Abstractor ID Abstraction Begin Date Abstraction End Date	Auto-fill Auto-fill Auto-fill Auto-fill Auto-fill	
		Patient Identifiers		
	SSN PTNAMEF PTNAMEL BIRTHDT SEX MARISTAT RACE	Patient SSN First Name Last Name Birth Date Sex Marital Status Race	Auto-fill: no change Auto-fill: no change Auto-fill: no change Auto-fill: no change Auto-fill: can change Auto-fill: no change Auto-fill: no change	
		Administrative Data		
1	cardrest	At initial presentation to the hospital was the <u>first cardiac symptom</u> for this patient a cardiac arrest? 1. yes 2. no	1, 2 If 2, auto-fill survive as 95	The question refers to the patient who had no previous cardiac symptoms. The initial symptom is a cardiac arrest. (Example: patient who arrives in the ED with a cardiac arrest) The question does not apply to patients presenting with or receiving any care for cardiac symptoms.
2	survive	Did the patient survive the resuscitation attempt? 1. yes 2. no 95. not applicable	1, 2*, 95 If cardrest = 2, will be auto-filled as 95 *If 2, exclude the record.	Applicable only to cases in which the patient could not be resuscitated and expired during resuscitation efforts or the effort was abandoned. If no resuscitation was attempted, answer "2." Exclusion Statement Cardiac arrest occurring in this case precluded abstraction of the data elements required for the AMI National Hospital Quality Measures.
3	ritecode	Do the diagnostic codes for this episode of care include one of the following AMI ICD-9-CM codes, 410.0 - 410.9, with a fifth digit of 1 or 0? 410 acute myocardial infarction (sudden, severe death of heart	1, 2 If 2, auto-fill amiprin as 95	The fifth digit of 1 = initial episode of care for an AMI. Used to designate the first episode of care (regardless of facility site) for a newly diagnosed myocardial infarction. The fifth digit 1 is assigned regardless of the number of times a patient may be transferred during the initial episode of care.

VHA EXTERNAL PEER REVIEW PROGRAM
ACUTE CORONARY SYNDROME INSTRUMENT
VALIDATION MODULE
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
		<p>muscle due to decreased coronary blood flow; classification is based on the location of the affected tissue, when known)</p> <p>ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction</p> <p>410.01 or 410.00 of anterolateral wall</p> <p>ST elevation myocardial infarction (STEMI) of anterolateral wall</p> <p>410.11 or 410.10 of other anterior wall</p> <p>ST elevation myocardial infarction (STEMI) of other anterior wall</p> <p>410.21 or 410.20 of inferolateral wall</p> <p>ST elevation myocardial infarction (STEMI) of inferolateral wall</p> <p>410.31 or 410.30 of inferoposterior wall</p> <p>ST elevation myocardial infarction (STEMI) of inferoposterior wall</p> <p>410.41 or 410.40 of other inferior wall</p> <p>ST elevation myocardial infarction (STEMI) of other inferior wall</p> <p>410.51 or 410.50 of other lateral wall</p> <p>ST elevation myocardial infarction (STEMI) of other lateral wall</p> <p>410.61 or 410.60 true posterior wall infarction</p> <p>ST elevation myocardial infarction (STEMI) of true posterior wall</p> <p>410.71 or 410.70 subendocardial infarction</p> <p>Non-ST elevation myocardial infarction (NSTEMI)</p> <p>410.81 or 410.80 of other specified sites</p> <p>ST elevation myocardial infarction (STEMI) of other specified sites</p> <p>410.91 or 410.90 unspecified site</p> <p>Myocardial infarction NOS</p>		<p>The fifth digit of 0 = episode of care unspecified</p> <p>The fifth digit of 2 = subsequent episode of care. Used to designate an episode of care following the initial episode when the patient is admitted for further observation, evaluation, or treatment for a myocardial infarction that has received initial treatment but is still less than 8 weeks old.</p> <p>Note: if the AMI code is 410.x2, answer "2." Cases coded with a fifth digit of 2 are not to be reviewed.</p>

VHA EXTERNAL PEER REVIEW PROGRAM
ACUTE CORONARY SYNDROME INSTRUMENT
VALIDATION MODULE
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
4	amiprin	<p>Was AMI the principal diagnosis for this episode of care?</p> <p>1. yes 2. no 95. not applicable</p> <p>The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."</p>	1, 2, 95	<p>The question refers to the principal diagnosis at the facility in which the case is being reviewed. (Example: patient is admitted to first VAMC for surgery, has an AMI after surgery, and is transferred to VAMC #2 for AMI care. AMI is not the principal diagnosis at the first VAMC, but is the principal diagnosis at VAMC #2.)</p> <p>The abstractor should be guided by the principal diagnosis assigned by the VAMC and submitted to the Austin PTF.</p> <p>Catnum 10 AMI records are selected from cases discharged with a diagnosis code of 410.0 - 410.9, with a fifth digit of 1, designated as the principal diagnosis.</p> <p>Catnum 42 records are selected from the same codes, but may be designated as principal or primary diagnosis. In these cases, AMI should be regarded as the principal diagnosis unless the AMI occurred when the veteran was admitted to the hospital for another reason or was already an inpatient when the AMI occurred.</p> <p>Answer "1" to "amiprin" if AMI was correctly assigned as principal or primary diagnosis by the VAMC and enter the code assigned by the VAMC in the question "aprocode."</p> <p>Answer "no" to "amiprin" if AMI was or should have been a secondary diagnosis (example: the veteran was admitted for a strangulated hernia and the AMI occurred following surgery; however, AMI was submitted as the principal diagnosis.) The abstractor must use another code entered by the VAMC as the principal diagnosis and may not assign codes not used by the facility.</p> <p>It is strongly suggested that abstractor use one of the following sources from CPRS to find the facility-assigned codes: under the Reports tab, go to EADT (expanded admission/ discharge transfer) or under the Ad Hoc Menu, look in MAS Discharges.</p>

VHA EXTERNAL PEER REVIEW PROGRAM
ACUTE CORONARY SYNDROME INSTRUMENT
VALIDATION MODULE
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
5	truami	<p>Is there evidence in the medical record that the patient had an acute myocardial infarction?</p> <p>1. yes 2. no</p>	1, 2	<p>Evidence in the medical record the patient had an AMI:</p> <p>1) Review the discharge summary first to determine if there was a diagnosis of AMI (may also be called Non-STEMI, NSTEMI, STEMI, or Acute Coronary Syndrome.)</p> <p>2) If the discharge summary is NOT present, other physician documentation must record a diagnosis of myocardial infarction (or Non-STEMI, NSTEMI, STEMI, or ACS.)</p> <p>EXCEPTION:</p> <p>3) In cases of conflicting documentation when the discharge summary documents AMI as a final diagnosis and the record is coded as an AMI, but a cardiologist documented that an AMI did not occur, <u>accept</u> the discharge summary diagnosis as valid and enter "1." Most likely to occur if the diagnosis is NSTEMI.</p> <p>Any order in which AMI is noted in the listing of discharge diagnoses is acceptable.</p> <p>If the AMI diagnosis documented at the time of discharge is qualified as "probable," "suspected," "likely," "questionable," "possible," "still to be ruled out," or other similar terms indicating uncertainty, coding conventions dictate that this terminology be coded as an AMI and is an acceptable diagnosis of AMI (code the AMI as if it existed or was established).</p> <p>Note: if the AMI code is 410.x2, answer "2." Cases coded with a fifth digit of 2 are not to be reviewed.</p>

VHA EXTERNAL PEER REVIEW PROGRAM
ACUTE CORONARY SYNDROME INSTRUMENT
VALIDATION MODULE
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
6	aprocode	Enter the ICD-9-CM principal diagnosis code. Only enter the principal diagnosis code as documented in the record.	<div> <div> <div>---</div> <div>Hard Edit: If amiprin = 1, aprocode must be 410.x1 or 410.x0 code</div> </div> <div> <div>Cannot enter 000.00, 123.45, or 999.99</div> <div>If aprocode is not on Table 1.1 AND truami = 2, the case is excluded.</div> </div> </div>	<p>Will auto-fill from the PTF with ability to change. The abstractor may change the code if it is incorrect and enter the principal diagnosis code as documented in the medical record. Do not attempt to code the AMI by any code other than that assigned by the facility.</p> <p>If AMI was incorrectly submitted as the principal diagnosis, and AMI is actually the secondary diagnosis, the abstractor may change the principal diagnosis code by entering the correct principal diagnosis from one of the codes submitted by the facility. Do not attempt to code a diagnosis that was not coded by the VAMC. If AMI was submitted as a secondary diagnosis when it is actually the principal diagnosis, the abstractor may enter the AMI code as the principal diagnosis.</p> <p><u>Exclusion Statement</u> Although coding indicated the patient had a diagnosis of Acute Coronary Syndrome, documentation in the medical record does not support an AMI diagnosis.</p>
7	othrdx1 othrdx2 othrdx3 othrdx4 othrdx5 othrdx6 othrdx7 othrdx8 othrdx9 othrdx10 othrdx11 othrdx12	Enter the ICD-9-CM other diagnosis codes selected for this medical record.	<div> <div>---</div> <div>Auto-fill pasthx4, as applicable, from othrdx codes entered</div> </div> <div>Can enter 12 codes</div> <div>Abstractor can enter xxx.xx in code field if no other dx found</div>	<p>Can enter 12 ICD-9-CM other diagnosis codes. Will auto-fill from PTF with ability to change. If the "other diagnoses" codes are incorrect, enter the codes as documented in the medical record.</p> <p>If entered manually, use the codes listed in discharge diagnosis (DD) under the reports tab.</p> <p>If AMI was a secondary diagnosis, enter the AMI code in "othrdx." Includes V codes: V64.1, V64.2, and V64.3. The presence of one of these V codes indicates a surgical or other procedure was not carried out because of a contraindication, patient's decision, or other reason.</p>
8	acutedt	Enter the earliest documented date the patient arrived at this or another VAMC.	<div>mm/dd/yyyy</div> <div>Abstractor may enter 99/99/9999 if arrival date is unable to be determined</div>	<p>Arrival date is the earliest recorded date on which the patient arrived in the hospital's acute care setting where care for ACS could be most appropriately provided. Arrival date may differ from admission date.</p> <p>ONLY ACCEPTABLE SOURCES: Emergency Department record (includes ED Face Sheet, Consent/Authorization for treatment forms, Registration/sign-in forms, vital sign record, triage record, physician orders, ECG reports, telemetry/rhythm strips, laboratory reports, x-ray reports); Nursing admission</p>

VHA EXTERNAL PEER REVIEW PROGRAM
ACUTE CORONARY SYNDROME INSTRUMENT
VALIDATION MODULE
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
			<div>< = 6 mos prior to or = admdt and < = dcdate</div> <div>Warning if > 3 days prior to admdt</div>	<p>assessment/admitting note; Observation record; Procedure notes (such as cardiac cath, endoscopies, surgical procedures); Vital signs graphic record</p> <ul style="list-style-type: none"> • Review the ONLY ACCEPTABLE SOURCES to determine the earliest date the patient arrived at the ED, nursing floor, observation, or as a direct admit to the cath lab. The intent is to utilize any documentation which reflects processes that occurred after arrival at the ED or after arrival to the nursing floor/observation/cath lab for a direct admit. • If the patient was transferred from your hospital's satellite/free-standing ED or from another hospital within your hospital's system (as an inpatient or ED patient), and there is one medical record for the care provided at both facilities, use the arrival date at the first facility. • Arrival date should NOT be abstracted simply as the earliest date in one of the ONLY ACCEPTABLE SOURCES, without regard to other substantiating documentation. When looking at the ONLY ACCEPTABLE SOURCES, if the earliest date documented appears to be an obvious error, this date should not be abstracted. EXAMPLE: ED MAR has a med documented as 1430 on 11-03-20xx. All other dates in ED record are 12-03-20xx. The 11-03-20xx would not be used because it appears to be an obvious error. • For Observation Status: <ul style="list-style-type: none"> ◦ If the patient was admitted to observation from the ED of the hospital, use the date the patient arrived at the ED. ◦ If the patient was admitted to observation from an outpatient setting of the hospital, use the date the patient arrived at the ED or on the floor for observation care. • If the patient is in an outpatient setting of the hospital (e.g., undergoing dialysis, chemotherapy) or a SNF unit of the hospital, and is subsequently admitted to acute inpatient, use the date the patient presents to the ED or arrives on the floor for acute inpatient care as the arrival date. • For Direct Admits: <ul style="list-style-type: none"> ◦ If the patient is a "Direct Admit" to the cath lab, use the earliest date the patient arrived at the cath lab (or cath lab staging/holding area) as

VHA EXTERNAL PEER REVIEW PROGRAM
ACUTE CORONARY SYNDROME INSTRUMENT
VALIDATION MODULE
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
				<p>the arrival date.</p> <ul style="list-style-type: none"> For "Direct Admits" to acute inpatient or observation, use the earliest date the patient arrived at the nursing floor or in observation (as documented in the ONLY ACCEPTABLE SOURCES) as the arrival date. <p>If unable to determine the date of arrival, enter default 99/99/9999. If the arrival date documented in the record is obviously in error (e.g. 02/42/20XX) and no other documentation is found that provides this information, enter 99/99/9999.</p>
9	acutetm	Enter the earliest documented time the patient arrived at this or another VAMC.	<p style="text-align: center;">____ UMT</p> <p>Abstractor may enter 99:99 if arrival time is unable to be determined</p> <div style="border: 1px solid black; padding: 2px; margin: 5px 0;"> <p>< = 6 mos prior to or = admdt/admtime and < dcdate/dctime</p> </div> <div style="border: 1px solid black; padding: 2px; margin: 5px 0;"> <p>Warning if acutetm > 72 hrs prior to admdt/admtime</p> </div>	<p>Arrival time is the earliest recorded time the patient arrived in the hospital's acute care setting where care for ACS could be most appropriately provided. Arrival time may differ from admission time.</p> <p>ONLY ACCEPTABLE SOURCES: Emergency Department record (includes ED Face Sheet, Consent/Authorization for treatment forms, Registration/sign-in forms, vital sign record, triage record, physician orders, ECG reports, telemetry/rhythm strips, laboratory reports, x-ray reports); Nursing admission assessment/admitting note; Observation record; Procedure notes (such as cardiac cath, endoscopies, surgical procedures); Vital signs graphic record</p> <ul style="list-style-type: none"> Review the ONLY ACCEPTABLE SOURCES to determine the earliest time the patient arrived at the ED, nursing floor, observation, or as a direct admit to the cath lab. The intent is to utilize any documentation which reflects processes that occurred after arrival at the ED or after arrival to the nursing floor/observation/cath lab for a direct admit. If the patient was transferred from your hospital's satellite/free-standing ED or from another hospital within your hospital's system (as an inpatient or ED patient), and there is one medical record for the care provided at both facilities, use the arrival time at the first facility. Arrival time should NOT be abstracted simply as the earliest time in one of the ONLY ACCEPTABLE SOURCES, without regard to other substantiating documentation. When looking at the ONLY ACCEPTABLE

VHA EXTERNAL PEER REVIEW PROGRAM
ACUTE CORONARY SYNDROME INSTRUMENT
VALIDATION MODULE
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
				<p>SOURCES, if the earliest time documented appears to be an obvious error, this time should not be abstracted.</p> <p>EXAMPLE: ED face sheet lists arrival time 1320, ED registration 1325, ED triage 1330. ED consent to treat form has 1:17 with "AM" circled. ED record documentation suggests the 1:17 AM is an obvious error. Enter 1320 for Arrival Time.</p> <ul style="list-style-type: none"> • For Observation Status: <ul style="list-style-type: none"> ◦ If the patient was admitted to observation from the ED of the hospital, use the time the patient arrived at the ED. ◦ If the patient was admitted to observation from an outpatient setting of the hospital, use the time the patient arrived at the ED or on the floor for observation care. • If the patient is in an outpatient setting of the hospital (e.g., undergoing dialysis, chemotherapy) or a SNF unit of the hospital, and is subsequently admitted to acute inpatient, use the time the patient presents to the ED or arrives on the floor for acute inpatient care as the arrival time. <ul style="list-style-type: none"> ◦ If the time the patient arrived on the floor is not documented by the nurse, enter the admission time recorded in EADT. • For Direct Admits: <ul style="list-style-type: none"> ◦ If the patient is a "Direct Admit" to the cath lab, use the earliest time the patient arrived at the cath lab (or cath lab staging/holding area) as the arrival time. ◦ For "Direct Admits" to acute inpatient or observation, use the earliest time the patient arrived at the nursing floor or in observation (as documented in the ONLY ACCEPTABLE SOURCES) as the arrival time. <p>If unable to determine the time of arrival, enter default time 99:99. If the arrival time documented in the record is obviously in error (e.g. 33:00) and no other documentation is found that provides this information, enter 99:99.</p>

VHA EXTERNAL PEER REVIEW PROGRAM
ACUTE CORONARY SYNDROME INSTRUMENT
VALIDATION MODULE
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
10	admdt	Enter the date the patient was formally admitted to inpatient status at this VAMC.	mm/dd/yyyy Computer will auto-fill <div>> = acutedt and < = dcdte</div> <div>Warning window if admdt > 6 mos prior to dcdte</div>	<p>Auto-filled; can be modified if abstractor determines that the date is incorrect.</p> <ul style="list-style-type: none"> Admission date is the date the patient was actually admitted to acute inpatient care. 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. If there are multiple inpatient orders, use the order that most accurately reflects the date that the patient was admitted. 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. <p>Exclusion: Admit to observation; Arrival date ONLY ALLOWABLE SOURCES: Physician orders (priority data source), Face Sheet</p>
11	admtime	Enter the time the patient was formally admitted to inpatient status at this VAMC.	_____ UMT Computer will auto-fill <div>> = acutetm and < = dcdte</div>	<p>Auto-filled; can be modified Abstractor to verify admission time is correct. Admission time = time when the patient was formally admitted to inpatient status. Exclusion: Admit to observation time, Arrival time If correction is necessary, enter time in Universal Military Time</p>
12	dcdte	Enter the date of discharge.	mm/dd/yyyy Auto-filled: cannot be modified > = admdt	<p>Auto-filled. Cannot be modified. The computer auto-fills the discharge date from the OABI pull list. This date cannot be modified in order to ensure the selected episode of care is reviewed.</p>

VHA EXTERNAL PEER REVIEW PROGRAM
ACUTE CORONARY SYNDROME INSTRUMENT
VALIDATION MODULE
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
13	dctime	Enter the time of discharge.	<div> <div>UMT</div> <div>> admdt/admtime</div> </div>	<p>Does not auto-fill. Discharge time must be entered.</p> <p>Includes the time the patient was discharged from acute care, left against medical advice (AMA), or expired during this stay.</p> <p>If the patient expired, use the time of death as the discharge time.</p> <p>Suggested sources for patient who expire: Death record, resuscitation record, physician progress notes, physician orders, nurses notes</p> <p>For other patients: If the time of discharge is NOT documented in the nurses notes, discharge/transfer form, or progress notes, enter the discharge time documented in EADT under the "Reports Tab."</p> <p>Enter time in Universal Military Time: a 24-hour period from midnight to midnight using a 4-digit number of which the first two digits indicate the hour and the last two digits indicate the minute.</p> <p>Converting time to military time: If time is in the a.m., no conversion is required. If time is the p.m., add 12 to the clock hour time.</p>
14	dcdispo	<p>What was the patient's discharge disposition on the day of discharge?</p> <p>1. Home</p> <ul style="list-style-type: none"> Assisted Living Facilities (ALFs) - includes assisted living care at nursing home facility Court/Law Enforcement - includes detention facilities, jails, and prison Home - includes board and care, domiciliary, 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 	1, 2, 3, 4, 5, 6, 7, 99	<p>Discharge disposition: The final place or setting to which the patient was discharged on the day of discharge.</p> <ul style="list-style-type: none"> Only use documentation written on the day prior to discharge or the day of discharge when abstracting this data element. For example: Discharge planning notes on 04-01-20xx document the patient will be discharged back home. On 04-06-20xx, the nursing discharge notes on the day of discharge indicate the patient was being transferred to skilled care. Enter "5". Discharge disposition documentation in the discharge summary, post-discharge addendum, or a late entry, may be considered if written within 30 days after discharge date and prior to pull list date. 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.

VHA EXTERNAL PEER REVIEW PROGRAM
ACUTE CORONARY SYNDROME INSTRUMENT
VALIDATION MODULE
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
		<p>2. Hospice - Home (or other home setting as listed in #1 above)</p> <p>3. Hospice - Health Care Facility</p> <ul style="list-style-type: none"> General Inpatient and Respite, Residential and Skilled Facilities, and Other Health Care Facilities <p>4. Acute Care Facility</p> <ul style="list-style-type: none"> Acute Short Term General and Critical Access Hospitals Cancer and Children's Hospitals Department of Defense and Veteran's Administration Hospitals <p>5. Other Health Care Facility</p> <ul style="list-style-type: none"> 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 Inpatient Rehabilitation Facility/Hospital or Rehabilitation Unit of a Hospital Skilled Nursing Facility (SNF), Sub-Acute Care or Swing Bed Transitional Care Unit (TCU) Veteran's Home <p>6. Expired</p> <p>7. Left Against Medical Advice/AMA</p> <p>99. Not documented or unable to determine</p>		<p>For example: Discharge planner note from day before discharge states "XYZ" Nursing Home". Nursing discharge note on day of discharge states "Discharged: Home." Select "1"</p> <ul style="list-style-type: none"> 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. <ul style="list-style-type: none"> Acute Care Facility Hospice - Health Care Facility Hospice - Home Other Health Care Facility Home Values "2" and "3" hospice 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 "4". 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 "5". 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 "1". Selection of option "7" (left AMA) <ul style="list-style-type: none"> Explicit "left against medical advice" documentation is not required. (e.g., "Patient is refusing to stay for continued care"- select "7"). For the purposes of this data element, a signed AMA form is not required. If any source states the patient left against medical advice, select value "7", regardless of whether the AMA documentation was written last. Documentation suggesting that the patient left before discharge instructions could be given without "left AMA" documentation does not count.

VHA EXTERNAL PEER REVIEW PROGRAM
ACUTE CORONARY SYNDROME INSTRUMENT
VALIDATION MODULE
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES				
				<p>Excluded Data Sources: Any documentation prior to the last two days of hospitalization coding documents.</p> <p>Suggested Data Sources: Discharge instruction sheet, discharge planning notes, discharge summary, nursing discharge notes, physician orders, progress notes, social service notes, transfer record</p>				
15	pxcode	<p>Enter the ICD-9-CM principal procedure code and date the procedure was performed.</p> <table><tr><td>Code</td><td>Date</td></tr><tr><td>____. ____</td><td>__/__/____</td></tr></table> <div>Determine whether the patient had a PCI before attempting to enter any procedure code.</div> <div>Only enter the principal procedure code as documented in the record.</div>	Code	Date	____. ____	__/__/____	<p>____. ____</p> <p>If there is no principal procedure, the abstractor can enter xx.xx in code field and 99/99/9999 in the date field</p> <div>Cannot enter 00.00</div> <p>mm/dd/yyyy</p> <p>Abstractor can enter 99/99/9999</p> <p>If there is no principal procedure, auto-fill othrpdx and othrpdxdt with xx.xx and 99/99/9999</p> <div>> = acutedt and < = dcdte</div>	<p>Principal procedure= that procedure performed for definitive treatment, rather than for diagnostic or exploratory reasons, or was necessary to treat a complication. The principal procedure is related to the principal diagnosis and needs to be accurately identified.</p> <ul style="list-style-type: none">VA records do not identify the principal procedure; use the above definition of principal procedure to determine the correct code to enter if there are multiple procedures during the episode of care. Ask for assistance from your RM or WVMI if you are uncertain. <p>Codes 36.06 and 36.07 contain instructions that PCI code 00.66 should also be used. If a PCI was performed, but the 00.66 PCI code is not documented in the medical record, enter xx.xx in the code field.</p> <p>Codes for stent placement (36.06) or drug-eluting stent (36.07) may be entered in either enter PXCODE or OTHRPXS if the procedure is applicable</p> <p>If no procedure was performed during the episode of care, fill ICD-9-CM code field with default code xx.xx. Do not enter 99.99 or 00.00 to indicate no procedure was performed.</p> <p>Date of the principal procedure is to be filled with 99/99/9999 if no procedure was performed.</p> <p>If the principal procedure date is unable to be determined from the medical record documentation, or if the procedure date documented in the record is obviously in error (e.g. 02/42/20XX) and no other documentation is found that provides this information, enter 99/99/9999.</p>
Code	Date							
____. ____	__/__/____							

VHA EXTERNAL PEER REVIEW PROGRAM
ACUTE CORONARY SYNDROME INSTRUMENT
VALIDATION MODULE
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES				
16	prinpxdt	<div>Enter the ICD-9-CM principal procedure code and date the procedure was performed.</div> <table><tr><td>Code</td><td>Date</td></tr><tr><td>____. ____</td><td>__/__/____</td></tr></table> <div>Determine whether the patient had a PCI before attempting to enter any procedure code.</div> <div>Only enter the principal procedure code as documented in the record.</div>	Code	Date	____. ____	__/__/____	<div>____. ____</div> <div>If there is no principal procedure, the abstractor can enter xx.xx in code field and 99/99/9999 in the date field</div> <div>Cannot enter 00.00</div> <div>mm/dd/yyyy</div> <div>Abstractor can enter 99/99/9999</div> <div>If there is no principal procedure, auto-fill othrpdx and othrpdxdt with xx.xx and 99/99/9999</div> <div>> = acutedt and < = dcdte</div>	<div>Principal procedure= that procedure performed for definitive treatment, rather than for diagnostic or exploratory reasons, or was necessary to treat a complication. The principal procedure is related to the principal diagnosis and needs to be accurately identified.</div> <div><ul style="list-style-type: none">VA records do not identify the principal procedure; use the above definition of principal procedure to determine the correct code to enter if there are multiple procedures during the episode of care. Ask for assistance from your RM or WVMI if you are uncertain.</div> <div>Codes 36.06 and 36.07 contain instructions that PCI code 00.66 should also be used. If a PCI was performed, but the 00.66 PCI code is not documented in the medical record, enter xx.xx in the code field.</div> <div>Codes for stent placement (36.06) or drug-eluting stent (36.07) may be entered in either enter PXCOD or OTHRPXS if the procedure is applicable</div> <div>If no procedure was performed during the episode of care, fill ICD-9-CM code field with default code xx.xx. Do not enter 99.99 or 00.00 to indicate no procedure was performed.</div> <div>Date of the principal procedure is to be filled with 99/99/9999 if no procedure was performed.</div> <div>If the principal procedure date is unable to be determined from the medical record documentation, or if the procedure date documented in the record is obviously in error (e.g. 02/42/20XX) and no other documentation is found that provides this information, enter 99/99/9999.</div>
Code	Date							
____. ____	__/__/____							

VHA EXTERNAL PEER REVIEW PROGRAM
ACUTE CORONARY SYNDROME INSTRUMENT
VALIDATION MODULE
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES						
17	othrpxs1 othrpxs2 othrpxs3 othrpxs4 othrdts5 othrdts1 othrdts2 othrdts3 othrdts4 othrpxs5	Enter the ICD-9-CM other procedure codes and dates the procedures were performed <table><tr><th>Code</th><th>Date</th></tr><tr><td>____. ____</td><td>__/__/____</td></tr><tr><td>____. ____</td><td>__/__/____</td></tr></table>	Code	Date	____. ____	__/__/____	____. ____	__/__/____	____. ____ If no other procedure was performed, the abstractor can enter xx.xx in code field mm/dd/yyyy Abstractor can enter 99/99/9999 <div>> = acutedt and < = dcdte</div> Can enter 5 codes and dates	Can enter 5 procedure codes, other than the principal procedure code. Enter the ICD-9-CM codes and dates corresponding to each of the procedures performed, beginning with the procedure performed most immediately following the admission. Other procedures =may be PCI, if not designated as the principal procedure, cardiac cath, CABG, or other unrelated procedure. Procedure must be performed at this VAMC or at an affiliated hospital and the patient returned to this facility within 12 hours If no other procedures were performed, enter default code xx.xx in the code field and default date 99/99/9999 in the date field. If no other procedure was performed, it is only necessary to complete the xx.xx and 99/99/9999 default entries for the first code and date. It is not necessary to complete the default entry five times. If the date of a procedure is unable to be determined from the medical record documentation, or if the procedure date documented in the record is obviously in error (e.g. 02/42/20XX) and no other documentation is found that provides this information, enter 99/99/9999.
Code	Date									
____. ____	__/__/____									
____. ____	__/__/____									
18	transin3	Was the patient received as a transfer from an inpatient, outpatient or emergency/observation department of an <u>outside</u> hospital or from an ambulatory surgery center? 1. Yes 2. No	1, 2 <div>If 2, auto-fill tranvaed as 95 and go to comm1tx</div>	If a patient is transferred in from any emergency department (ED) or observation unit <u>OUTSIDE</u> of your hospital, select "1". This applies even if the emergency department or observation unit is part of your hospital's system (e.g., your hospital's free-standing or satellite emergency department), has a shared medical record or provider number, or is in close proximity. If the patient is transferred to your hospital from an outside hospital where he was an inpatient or outpatient, select "1". This applies even if the two hospitals are close in proximity, part of the same hospital system, have the same provider number, and/or there is one medical record. Select "Yes" in the following types of transfers: <ul style="list-style-type: none">• Long term acute care (LTAC): Any LTAC hospital or unit (outside or inside your hospital)• Acute rehabilitation: Rehab unit in outside hospital, free-standing rehab hospital/facility/pavilion outside your hospital, OR rehab hospital inside your hospital• Psychiatric: Psych unit in outside hospital, free-standing psych						

VHA EXTERNAL PEER REVIEW PROGRAM
ACUTE CORONARY SYNDROME INSTRUMENT
VALIDATION MODULE
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
				<p>hospital/facility/pavilion outside your hospital, OR psych hospital inside your hospital</p> <ul style="list-style-type: none"> • Cath lab, same day surgery, or other outpatient department of an outside hospital • Disaster Medical Assistance Team (DMAT): Provides emergency medical assistance following catastrophic disaster or other major emergency <p>Select "No" in the following types of transfers:</p> <ul style="list-style-type: none"> • Urgent care center • Psych or rehab unit inside your hospital • Dialysis center (unless documented as an outpatient department of an outside hospital) • Same Day Surgery or other outpatient department inside your hospital • Clinic (outside or inside your hospital) • Hospice facility (outside or inside your hospital) • Skilled nursing facility (SNF) care: Any facility or unit (outside or inside your hospital) providing SNF level of care to patient <p>If there is conflicting documentation in the record, and you are unable to determine whether or not the patient was received as a transfer from an inpatient, outpatient, or emergency/observation department of an outside hospital or from an ambulatory surgery center, select "No" UNLESS there is supporting documentation for one setting over the other. Examples:</p> <p>One source reports patient was transferred from an outside hospital's ED, another source reports patient was transferred in from an urgent care center. No additional documentation. Select "No".</p> <p>One source states patient came from physician office, another source reports patient was transferred from an outside hospital's ED, and transfer records from the outside hospital's ED are included in the record. Select "Yes".</p> <p>If, in cases other than conflicting documentation, you are unable to determine whether or not the patient was received as a transfer from an inpatient, outpatient, or emergency/observation department of an outside hospital or from an ambulatory surgery center, select "No". (E.g., "Transferred from Park Meadows" documented</p>

VHA EXTERNAL PEER REVIEW PROGRAM
ACUTE CORONARY SYNDROME INSTRUMENT
VALIDATION MODULE
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
				- Documentation is not clear whether Park Meadows is a hospital or not.) Suggested data sources: Ambulance record, emergency department record, history and physical, nursing admission assessment, progress notes, transfer sheet
19	tranvaed	Was the patient received from the emergency department of another VAMC? 1. Yes 2. No 95. Not applicable	1, 2, 95 Will be auto-filled as 95 if transin3 = 2	Note: the emergency department of another VAMC includes both emergency room AND observation bed/unit stays at that hospital.
20	comm1tx	Did the patient present initially to a community hospital where he/she received all or part of the first 24 hours of care for ACS? 1. Yes 2. No	1, 2 If 1, auto-fill inptacs as 95 <div>If 1, transin3 must = 1</div>	To answer "1," the patient must have been treated at the community hospital for ACS symptoms. If the patient was transferred to a VAMC from a community hospital but was treated initially for another medical problem not related to ACS, answer "2." If the patient was transferred from the community hospital to a VAMC, then subsequently transferred to another VAMC, and the case is being reviewed at the second VAMC, the initial presentation and ACS care at a community hospital applies, and the abstractor should answer "1."
21	comm1npt	Was the patient a transfer from a community hospital where he/she was an inpatient for ACS care? 1. Yes 2. No	1, 2 If 1, auto-fill inptacs as 95 <div>If 1, transin3 must = 1</div>	The question is not limited to initial presentation, but is intended to address situations in which the patient was transferred from the VAMC to a community hospital and returned to the VAMC after a stay of 24 hours or more. Patient may be transferred to a community hospital for a cardiac cath, PCI or other service not available at the VAMC, then returned to the VAMC for further recuperation.
22	inptacs	Was the veteran already a VAMC inpatient when ACS occurred? 1. Yes 2. No 95. Not applicable	1, 2, 95 <div>If comm1tx = 1, inptacs cannot = 1</div>	Already an inpatient = the veteran had already been formally admitted to this VAMC, either for an unrelated problem or for related symptoms such as unstable angina. In either event, to answer "1," documentation in the record must clearly indicate ACS occurred after the patient had been formally admitted to a VAMC as an inpatient.
23	comfort	When is the earliest physician, APN, or PA documentation of comfort measures only? 1. Day of arrival (day 0) or day after arrival (day 1) 2. Two or more days after arrival (day 2 or greater) 3. Comfort measures only documented during hospital stay, but	1, 2, 3, 99 <div>Warning if comfort = 2</div> If 3 or 99, auto-fill plcaredt as 99/99/9999	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

VHA EXTERNAL PEER REVIEW PROGRAM
ACUTE CORONARY SYNDROME INSTRUMENT
VALIDATION MODULE
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES														
		timing unclear 99. Comfort measures only was not documented by the physician/APN/PA or unable to determine		<p>to a physician order to withhold emergency resuscitative measures such as Do Not Resuscitate (DNR).</p> <p>ONLY accept terms identified in the list of inclusions. No other terminology will be accepted. Day of arrival is day 0.</p> <table><tr><th colspan="2">Inclusion (Only acceptable terms)</th></tr><tr><td>Brain death/dead</td><td>End of life care</td></tr><tr><td>Comfort care</td><td>Hospice</td></tr><tr><td>Comfort measures</td><td>Hospice care</td></tr><tr><td>Comfort measures only (CMO)</td><td>Organ harvest</td></tr><tr><td>Comfort only</td><td>Terminal care</td></tr><tr><td>DNR-CC</td><td></td></tr></table> <ul style="list-style-type: none">• Determine the <u>earliest</u> day the physician/APN/PA DOCUMENTED comfort measures only in the ONLY ACCEPTABLE SOURCES. Do not factor in when comfort measures only was actually instituted. Example: "Discussed <u>comfort care</u> with family on arrival" noted in day 2 progress note - Select "2."• Physician/APN/PA documentation of comfort measures only mentioned in the following context is acceptable:<ul style="list-style-type: none">◦ Comfort measures only recommendation◦ Order for consultation/evaluation by hospice care◦ Patient/family request for comfort measures only◦ Plan for comfort measures only◦ Referral to hospice care service• If any of the inclusions are documented in the ONLY ACCEPTABLE SOURCES, select option "1," "2," or "3" accordingly, unless otherwise specified.• 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).• Disregard documentation of an Inclusion term in the following	Inclusion (Only acceptable terms)		Brain death/dead	End of life care	Comfort care	Hospice	Comfort measures	Hospice care	Comfort measures only (CMO)	Organ harvest	Comfort only	Terminal care	DNR-CC	
Inclusion (Only acceptable terms)																		
Brain death/dead	End of life care																	
Comfort care	Hospice																	
Comfort measures	Hospice care																	
Comfort measures only (CMO)	Organ harvest																	
Comfort only	Terminal care																	
DNR-CC																		

VHA EXTERNAL PEER REVIEW PROGRAM
ACUTE CORONARY SYNDROME INSTRUMENT
VALIDATION MODULE
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
				<p>situations:</p> <ul style="list-style-type: none"> ◦ Inclusion term clearly described as negative (Examples: "No comfort care," "Not appropriate for hospice care," "Declines hospice care"). NOTE: If an Inclusion term is clearly described as negative in one source and NOT described as negative in another source, the second source would count for comfort measures only. (e.g., On Day 0, the physician documents, "The patient is not a hospice candidate." On Day 3, the physician orders a hospice consult. Select "2.") ◦ Comfort measures made conditional upon whether or not the patient arrests. (Examples: "DNRCCA" (Do Not Resuscitate-Comfort Care Arrest; "Comfort Care Protocol will be implemented in the event of a cardiac or respiratory arrest"; "Family requests comfort measures only should the patient arrest.") ◦ Documentation that is dated prior to arrival or documentation which refers to the pre-arrival time period (e.g., comfort measures only order in previous hospitalization record, "Pt. on hospice at home" in physician ED note). EXCEPTION: State-authorized portable orders (SAPOs). SAPOs are specialized forms, Out-of-Hospital DNR (OOH DNR) or Do Not Attempt Resuscitation (DNAR) orders, 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) ◦ Pre-printed order forms signed by physician/APN/PA: Disregard an Inclusion term in a statement that is not part of the order or that is not clearly selected (on a form that offers options to select from). Examples: <ul style="list-style-type: none"> ▪ Inclusion term used only in the title of the form (e.g., DNR-Comfort Care order form - option "Comfort Care" is not checked. ▪ Inclusion term used only in the pre-printed instruction for

VHA EXTERNAL PEER REVIEW PROGRAM
ACUTE CORONARY SYNDROME INSTRUMENT
VALIDATION MODULE
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
				<p>completing the form (e.g., "Copy of form to hospice", "Instructions" section of the form further defines the option "Comfort care")</p> <p>ONLY ACCEPTABLE SOURCES: Discharge summary, DNR/MOLST/POLST forms, Emergency Department record, Physician orders, Progress notes</p> <p>Excluded Data Source: Restraint order sheet</p> <p>Exclusion Statement: Clinician documentation of "comfort measures only" excludes the case from Joint Commission designated AMI Hospital Quality measures. Abstraction of required data elements for VHA measures remains applicable</p>
24	plcaredt	Enter the date of documentation of comfort measures only.	<p>mm/dd/yyyy</p> <p>If comfort = 3 or 99, will be auto-filled as 99/99/9999</p> <p>If comfort = 1, auto-fill donotx as 95, notx1dt as 99/99/9999, notx1tm as 99:99, and go to clntrial</p> <div style="border: 1px solid black; padding: 2px; width: fit-content; margin: 0 auto;"> <p>> = acutedt and < = dcdte</p> </div>	<p>Sources: Admitting physician orders, Consultation notes, ED record, H&P, Physician admitting note, Physician orders, Progress notes.</p> <p>Enter the exact date. The use of 01 to indicate missing day or month is not acceptable.</p>

VHA EXTERNAL PEER REVIEW PROGRAM
ACUTE CORONARY SYNDROME INSTRUMENT
VALIDATION MODULE
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
25	donotx	Is there explicit documentation of the decision not to treat during this episode of care? 1. Yes 2. No 95. Not applicable	1, 2, 95 Will be auto-filled as 95 if comfort = 1 If 2, auto-fill notx1dt as 99/99/9999 and notx1tm as 99:99, and go to clintrial	Decision not to treat = the record clearly documents that the patient, patient's family, or legal representative wishes comfort measures only, and/or there is agreement that the patient's cardiac condition and co-morbid conditions preclude further treatment. Include: physician documentation that care is limited to comfort only at family's request or due to patient's age or chronic illness; supportive care only The question does not mean that there is a decision not to treat aggressively or to treat only with medical management due to classification of AMI or unstable angina as low risk. Exclude: Documentation of DNR or living will <u>without</u> documentation that the patient's cardiac condition and co-morbid conditions preclude further treatment.
26	notx1dt	Enter the date the decision not to treat was documented in the record.	mm/dd/yyyy Will be auto-filled as 99/99/9999 if comfort = 1 or donotx = 2 <div>> = acutedt and < = dcdte</div>	Enter the exact date. The use of 01 to indicate missing day or month is not acceptable.
27	notx1tm	Enter the time the decision not to treat was documented in the record.	UMT Will be auto-filled as 99:99 if comfort = 1 or donotx = 2 <div>> = acutedt/acute tm and < = dcdte/dctime</div>	

VHA EXTERNAL PEER REVIEW PROGRAM
ACUTE CORONARY SYNDROME INSTRUMENT
VALIDATION MODULE
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
28	clntrial	<p>During this hospital stay, was the patient enrolled in a clinical trial in which patients with acute myocardial infarction (AMI) were being studied? (Includes AMI, STEMI, NSTEMI, or heart attack)</p> <p>1. yes 2. no</p>	<p>*1, 2</p> <p>*If 1, the record is excluded.</p>	<p>In order to answer "Yes", BOTH of the following must be documented:</p> <p>1. There must be a signed consent form for the clinical trial. For the purposes of abstraction, a clinical trial is defined as an experimental study in which research subjects are recruited and assigned a treatment/intervention and their outcomes are measured based on the intervention received; AND</p> <p>2. There must be documentation on the signed consent form that during this hospital stay the patient was enrolled in a clinical trial in which patients with AMI were being studied (e.g., enrollment of the patient with AMI in a clinical trial studying stents). Patients may be newly enrolled in a clinical trial during the hospital stay or enrolled in a clinical trial prior to arrival and continued active participation in that clinical trial during this hospital stay.</p> <p>In the following situations, select "No":</p> <p>1. There is a signed patient consent form for an observational study only. Observational studies are non-experimental and involve no intervention (e.g., registries).</p> <p>2. It is not clear whether the study described in the signed patient consent form is experimental or observational.</p> <p>3. It is not clear which study population the clinical trial is enrolling. Assumptions should not be made if it is not specified.</p> <p>ONLY ACCEPTABLE SOURCE: Signed consent form for clinical trial</p> <p>Exclusion Statement: Enrollment of the patient in a clinical trial during this hospital stay relevant to AMI excludes the case from the JC AMI Hospital Quality Measures.</p>

VHA EXTERNAL PEER REVIEW PROGRAM
ACUTE CORONARY SYNDROME INSTRUMENT
VALIDATION MODULE
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
		<p>If COMMITX, COMMINT, AND INPTACS = 2, go to History & Assessment Module.</p> <p>If COMMITX, COMMINT, OR INPTACS = 1 and (DCDISPO = 1,5, or 99), go to LDLARRV in History & Assessment Module.</p> <p>If COMMITX, COMMINT, OR INPTACS = 1 and (DCDISPO = 4), go to LVFDOC2 in Continuing Care & Assessment Module.</p> <p>If COMMITX, COMMINT, OR INPTACS = 1 and (DCDISPO = 2,3,6, or 7), GO TO END (Partial abstraction only - enable common modules as applicable).</p>		<p>Exclusion Statement: Cases in which the patient:</p> <p>a) presented initially to a community hospital where he/she received all or part of the first 24 hours of care for ACS;</p> <p>OR</p> <p>b) was transferred from a community hospital where he/she was an inpatient for ACS care;</p> <p>OR</p> <p>c) was already a VAMC inpatient when ACS occurred</p> <p>are excluded from TJC designated AMI Hospital Inpatient Quality Measures.</p>