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|  | |  | | **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 |  | |
|  | | catnum | | Pull list category number designates the reason for case selection.  **Computer will auto-fill the category number for which the case was selected.** | **If catnum <> 36 or 61, auto-fill dxexcld as 95, and go to nonvet** |  | |
| [Link to Mnemonics and Questions](https://secure.wvmi.org/QUESTIONS/Specifications/Mnemonics%20and%20Questions/fy2019q4/MnemonicQuestions4q19.xlsx) | | | | | | | |
| **#** | | **Name** | | **Question** | Field Format | Definitions/Decision Rules | |
| 1 | | dxexcld | | Does the patient have one of the following diagnoses:   1. Multiple Sclerosis (MS), without primary problem of paraplegia 2. Amyotrophic Lateral Sclerosis (ALS) 3. Guillain-Barre Syndrome 4. malignant tumor of the spinal cord 5. not applicable 6. patient has none of these diagnoses | 1\*,2,\*3\*,4\*,95,99  If catnum <> 36 or 61 will be auto-filled as 95  **Abstractor cannot enter 95**  \*If 1, 2, 3, or 4, and catnum = 36 or 61, exclude the record.  If 99 and catnum = 61, go to ipadm, else go to nonvet | **Excluded:** ALS (commonly known as Lou Gherig’s disease), Guillain-Barre Syndrome, malignant tumor of the spinal cord, and MS in which patient does not have primary problem of paraplegia.  **Included:** Benign tumors of the spinal cord**,** MS in which patient does have primary problem of paraplegia (paralysis of the legs and lower part of the body) associated with the disease process.  **Abstractor cannot enter 95.**  **Exclusion Statement**: The patient’s diagnosis does not meet inclusion criteria for the spinal cord injury and disorders cohort. | |
| 2 | ipadm | | Did the patient with a diagnosis of spinal cord injury have an inpatient admission at this VA within the past year?  1. Yes  2. No | 1,\*2  \*If 2, go to nonvet | The inpatient admission does not have to be related to the spinal cord injury. If the only admission at this VA in the past year is for the patient’s annual SCI evaluation, answer “1.” | |
| 3 | admdt | | Enter the date of admission to inpatient care. | mm/dd/yyyy  **Can be modified**   |  | | --- | | < = 1 year prior or = stdybeg and < = stdyend | | **May be auto-filled from the pull list; can be modified.**  A patient of a hospital is considered an inpatient upon issuance of written doctor’s orders to that effect. | |
| 4 | dcdate | | Enter the date of discharge. | mm/dd/yyyy   |  | | --- | | >=admdt and warning if > 6 months after admdt | | May be auto-filled from the pull list. If the discharge date is not auto-filled, enter the exact date. | |
| 5 | | nonvet | | Did the record document the patient was a non-Veteran?   1. Yes 2. No | 1\*,2  \*If 1, the record is excluded | In order to answer “1,” there must be documentation that the patient is not a Veteran.  Examples: non-Veteran female patient who is married to a Veteran, active duty military personnel receiving care at this VA  **Exclusion Statement:**  Non-Veteran cases are excluded from outpatient review. | |
| 6 | | seenyr | | Was the **Veteran** seen within the last twelve months by a physician, NP, PA, Psychologist, or Clinical Nurse Specialist in one of the “Nexus clinics”?  Within the last 12 months = twelve months from the first day of the study interval to the end of the study interval  1. Yes  2. No  “Nexus clinics” include primary care and specialty clinics as defined in past years plus mental health clinics added in FY05. The abstractor can scroll through the drop box to view the clinic listing to ensure the patient was seen in a Nexus clinic. | 1,2\*  If 1, go to nexusdt  **\*If 2 and catnum <> 61, the record is excluded**  **If 2 and ipadm = 2, the record is excluded, else if ipadm = 1, go to selectdx**   |  | | --- | | **Warning if 2** | | All the following must be true to answer “yes:”   * the patient was a Veteran * the clinic visit occurred within 12 months from the first day of the study interval to the end of the study interval; * the visit occurred at one of the Nexus clinics; * during the visit, the patient was seen face-to-face (includes televideo encounter) by a physician, NP, PA, Psychologist, or Clinical Nurse Specialist. The qualifying visit may NOT be a telephone call. Subsequent visits during the year may be phone calls.   **If the Veteran is admitted to a VHA Residential Rehabilitation program or Domiciliary, consider applicable Nexus Clinic visits when answering this question.**  **Exclusion Statement:**  **Although the stop code indicated a visit to a Nexus clinic, the Veteran was not seen by a physician, NP, PA, Psychologist, or Clinical Nurse Specialist in an applicable outpatient clinic within the study year.** | |
| 7 | | nexusdt | | Enter the date of the most recent visit to a Nexus clinic during which the patient was seen by a physician, NP, PA, Psychologist, or Clinical Nurse Specialist. | mm/dd/yyyy   |  | | --- | | < = 1 year prior or = stdybeg and < = stdyend | | Most recent visit = the visit in which the patient was seen most immediately prior to the end of the study interval  Enter the exact date of the visit to the Nexus clinic. The use of 01 to indicate missing day or month is not acceptable. | |
| 8 | | wichnxus | | For the most recent NEXUS clinic visit when the patient was seen by a physician, APN, PA, or psychologist, enter the name of the NEXUS clinic.  **(Abstractor will select name from a drop down box of NEXUS Clinics.)** | \_\_\_\_\_  wichnxus | This question asks for the name of the NEXUS clinic for the visit that occurred on the date entered in NEXUSDT. Do not enter a NEXUS clinic name for a visit that occurred after the study end date. | |
| If Mental Health flag = 1, go to othrcare; otherwise, go to nonacadm as applicable | | | | | | | |
| 9 | | othrcare | | Is there evidence in the medical record that within the past two years, the patient refused VHA Primary Care and is receiving ONLY his/her primary care in a non-VHA setting?  1. Yes  2. No  **To answer “1,” both evidence of refusal of VHA Primary Care and documentation of primary care received outside VHA must be present in the record.** | 1,2  **If FEFLAG = 0, go to asesadl in Core Module** | | There must be specific documentation of patient refusal of VHA Primary Care, and the refusal must have occurred within the past two years. (Examples: record documents that patient does not wish to be seen in VHA Primary Care clinics, prefers to seek care elsewhere, or does not wish to receive care at all unless under emergency circumstances. Documentation of patient statements such as “I only signed up for VA for my MH service-connected condition.” or “My private physician does all my primary care” represent refusal of VHA Primary Care.)Receiving primary care ONLY in a non-VHA setting: The patient may be receiving mental health or other specialty care at the VAMC, but his/her primary care during the past two years was received outside VHA.(Examples: patient’s medical care is being provided by a primary care provider who does not practice in the VHA system; patient under care of non-VHA specialist who provides his/her primary care; patient receives care from other sources such as free clinics.) |
| 10 | | nonacadm | | Is there documentation in the medical record the patient had a non-acute inpatient admission during the past year?  1. Yes  2. No | 1,2 | | Examples of non-acute inpatient care include but are not limited to rehabilitation units, skilled nursing facilities, respite care, domiciliary, CLC |
| **Age > = 66 (age at NEXUSDT) go to inltcset; if age < 66, auto-fill inltcset as 95 and go to selectdx** | | | | | | | |
| 11 | | | inltcset | Is there documentation in the medical record the patient lived long-term (greater than 60 consecutive days) in a VHA or community-based institutional setting anytime during the past year? 1. Yes 2. No 95. Not applicable | 1,2,95  If 1, go to selectdx  Will be auto-filled as 95 if age < 66 | | **The intent of this question is to determine if the patient lived long-term (greater than 60 days) in an institutional setting anytime during the past year.**  **Institutional settings may include, but are not limited to nursing homes, community living centers, long term care (LTC) facilities, assisted living facilities.**  **Exclude:** Residential Rehabilitation Treatment Programs (RRTP); Domiciliary facilities (DOM)  **Suggested Data Sources:** Discharge summary, History and physical, other  admin/discharge reports |
| 12 | | | advillns | Is there documentation in the medical record the patient has an active condition/diagnosis considered an advanced illness? 1. Yes 2. No | 1,2 | | ‘Active’ condition/diagnosis = the condition was ever diagnosed and there is no subsequent statement, prior to the most recent outpatient visit, indicating the condition was resolved or is inactive.  **Medical diagnoses must be recorded as the patient’s diagnosis by a physician, NP, PA, or CNS in clinic notes or discharge summary. Diagnoses documented on a problem list must be validated by a clinician diagnosis.**  Because a problem list may not be all-inclusive, it is expected that reviewer will read all progress notes for the Nexus clinics for a year to identify all diagnoses.  Advanced illness may include but is not limited to:   * Malignancies only on Table 5 * Parkinson’s * Alzheimer’s * CKD/ESRD diagnoses only on Table 5 * HF   Any provider (including nurses) can document advanced illness in any setting (including the home). A nurse may only document a medical diagnosis after a physician, APN, or PA has documented the diagnosis.  Refer to Table 5: Advanced Illness for other specific disorders  **Suggested Data Sources:** H&P, nursing assessments, progress notes, problem list, |
| 13 | | | demeds | Is there physician, APN, PA or pharmacist documentation in the medical record the patient has an active prescription for a dementia medication? 1. Yes  2. No | 1,2 | | **An acceptable dementia medication must be documented as an active prescription.**  Acceptable dementia medications include:   * Donepezil * Galantamine * Rivastigmine * Memantine   **Suggested Data Sources: C**linical pharmacy notes, EMLR note, Medication reconciliation notes, Progress notes (clinic notes) |
| 14 | | | frailty | During the past year, is there documentation in the medical record the patient has any condition/diagnosis consistent with frailty? 1. Yes  2. No | 1,2   |  | | --- | | Warning if 2 and case is flagged for frailty | | | Any provider (including nurses) can document frailty in any setting (including the home). A nurse may only document a medical diagnosis after a physician, APN, or PA has documented the diagnosis.  Frailty may include but is not limited to:   * presence of pressure ulcers * abnormalities of gait and mobility * adult Failure To Thrive (FTT) * history of fall(s)   Refer to Table 6 for other specific disorders  **Suggested Data Sources**: H&P, nursing assessments, progress notes, problem list |

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| 15 | **selhtn**  **selmi**  **selpci**  **pcidt**  **selcabg**  **cabgdt** | **Did the patient have one or more of the following active diagnoses?**  **NOTE:** ICD-9-CM codes (prior to 10/01/2015) and ICD-10 codes (on or after 10/01/2015) are used only as examples to guide the abstractor and are not all-inclusive. Diagnoses are determined by clinician documentation, not by the presence or absence of codes.  **Indicate all that apply**:  **1 = Hypertension**  ICD-9 code 401.x (ICD-10 code I10) - excludes elevated blood pressure without diagnosis of hypertension, pulmonary hypertension, that involve vessels of brain and eye  ICD-9 401.0 = malignant hypertension  ICD-9 401.1 = benign hypertension  ICD-9 401.9 = unspecified hypertension  **4 = Old Myocardial Infarction**  ICD-9-CM code 412 (ICD-10 code I252) = old myocardial infarction. The abstractor may determine the patient had a past AMI from clinician documentation, and presence of the code is not an absolute requirement  **5 = PCI in past two years**  **Abstractor must know approximate month and year of px**  ICD-10 02703ZZ, 02704ZZ, 02713ZZ, 02714ZZ, 02723ZZ, 02724ZZ, 02733ZZ, 02734ZZ  **Enter the date of the most recent PCI done anywhere in the past two years.**  **6 = CABG in past two years Abstractor must know approximate month and year of px**  **ICD-10** 0210093, 0210493, 02100A3, 02100J3, 02100K3, 02100Z3, 02104A3, 02104J3, 02104K3, 02104Z3  **ICD-10** 021K0Z8, 021K0Z9, 021K0ZC, 021K0ZW, 021K4Z8, 021K4Z9, 021K4ZC, 021K4ZW, 021L4Z8, 021L4Z9, 021L0ZC, 021L0Z8, 021L0Z9, 021L4ZC  **Enter the date of the most recent CABG done anywhere in the past two years.** | 1,4,5,6,7,11,99   |  | | --- | | **If selmi, selpci or selcabg = T, auto-fill vascdis1** | | **pcidt and cabgdt**  **mm/dd/yyyy**  < = 24 months prior or = stdybeg and < = stdyend | | ‘Active’ diagnosis = the condition was ever diagnosed and there is no subsequent statement, prior to the most recent outpatient visit, indicating the condition was resolved or is inactive.  **Medical diagnoses must be recorded as the patient’s diagnosis by a physician, NP, PA, or CNS in clinic notes or discharge summary. Diagnoses documented on a problem list must be validated by a clinician diagnosis.**  Because a problem list may not be all-inclusive, it is expected that reviewer will read all progress notes for the Nexus clinics for a year to identify all diagnoses.  **Hypertension**  A diagnosis recorded as ‘borderline hypertension’ is hypertension if it is coded as hypertension and being treated as hypertension, by recommended weight loss and/or recommended increase in physical activity, and/or prescription for medication such as a diuretic, beta-blocker, ACE, ARB, or calcium channel blocker.  **Old Myocardial Infarction**  The past AMI must have occurred more than eight weeks prior to the date of the most recent NEXUS visit, with treatment at any VHA or community acute care hospital. Do not presume AMI if record states CAD, ASHD, CABG, PTCA, angina, or IHD. Previous MI must be documented by a clinician. Patient self-report is not acceptable.  **PCI or CABG in past two years:** from the first day of the study interval to the first day of the same month two years previously  The abstractor must be able to determine the month and year the procedure was performed for PCI and/or CABG. If month and year cannot be known or extrapolated (e.g., “last fall”, “eighteen months ago”) from documentation, do not select these procedures as applicable to the case under review. |

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|  | **selchf**  **selckd**  **selkidtx**  **kidtxdt** | **7 = CHF (May also be noted as “systolic dysfunction”) See applicable codes in Definitions/Decision rules.**  **11 = Chronic Kidney (Renal) Disease, stage 5 or ESRD (end stage renal disease) or dialysis (hemodialysis or peritoneal dialysis) in past two years**  **ICD-10 codes N185, N186, Z9115, Z992, 3E1M39Z, 5A1D00Z, 5A1D60Z, 5A1D70Z, 5A1D80Z, 5A1D90Z**  **12 - Kidney Transplant**  **ICD-10 codes Z94.0, 0TY00Z0, 0TY00Z1, 0TY00Z2, 0TY10Z0, 0TY10Z1, 0TY10Z2,**  **Enter the date of the most recent kidney transplant done anywhere in the past year.**  **99 = patient did not have any of these diagnoses** | The Core, PI, Shared, and specific disease modules will be enabled if selhtn = T, dmflag = 1, selmi = true, PCI = true, CABG = true, or selchf = true.  If 99, only the Core, PI, and Shared Module (as applicable) will be enabled. | CHF (May also be noted as “systolic dysfunction”)  Codes include both heart failure directly attributable to hypertension and heart failure characterized only as myocardial failure.  CHF must be listed as a patient diagnosis in the outpatient clinic setting, and not merely referring to a one-time acute episode of CHF.  Not acceptable: cardiomyopathy with no reference to CHF  ICD-9-CM and ICD-10-CM codes: (Codes are used only as examples to guide the abstractor and are not all-inclusive. Diagnoses are determined by clinician documentation, not by the presence or absence of codes.)  402.01 (ICD-10 I110) = malignant hypertensive heart disease with congestive heart failure  402.11 (ICD-10 I110) = benign hypertensive heart disease with congestive heart failure  402.91(ICD-10- I110) = unspecified hypertensive heart disease with congestive heart failure  404.01 (ICD-10 I130 )= malignant hypertensive heart and renal disease with congestive heart failure  404.11 (ICD-10 I130) = benign hypertensive heart and renal disease with congestive heart failure  404.91 (ICD-10 I130) = unspecified hypertensive heart and renal disease with congestive heart failure  428.0 (ICD-10 I509) = congestive heart failure  (includes right heart failure, secondary to left heart failure)  428.1(ICD-10 I501) = left heart failure  428.9 (ICD-10 I509) = heart failure, unspecified  **The list of CHF codes should also include 398.91 (ICD-10 I0981), 428.2x (ICD-10 I5020 – I5023), and 428.4x (ICD-10 I5040 – I5043).** |
| **If selhtn = 1, go to htnenc1; else go to vascdisc1** | | | | |
| 16 | htnenc1 | Within the past year is there documentation the patient had an outpatient encounter with a documented diagnosis of hypertension?  1. Yes  2. No | 1,2  If 2, autofill htnencdt1 as 99/99/9999 and go to vascdis   |  | | --- | | Warning if 2 and selhtn = 1 | | **The intent of these questions (htnenc1 and htnenc2) is to determine if the patient had at least two outpatient encounters on different dates of service with a diagnosis of hypertension during the previous year or the year prior**.   * Visit type need not be the same for the two visits. Only one of the two visits may be a telephone visit, an online assessment or a telehealth visit.   **Review notes during the past year to determine if there was an outpatient encounter. An outpatient encounter includes any of the following:**   * Face to face visit - includes any face to face encounter with a provider, e.g., clinic, PCP, specialty provider, etc. * Telephone visit - must be an actual communication with the patient, not an attempt or voice mail. * Telehealth visit - refers to real-time clinic based video encounter between patient and provider. * Online assessment - a medical evaluation done online   **Hypertension diagnoses must be recorded as the patient’s diagnosis by a physician, APN, PA, or CNS in the encounter note.**  **Hypertension**  A diagnosis recorded as ‘borderline hypertension’ is hypertension if it is coded as hypertension and being treated as hypertension, by recommended weight loss and/or recommended increase in physical activity, and/or prescription for medication such as a diuretic, beta-blocker, ACE, ARB, or calcium channel blocker. |
| 17 | htnencdt1 | Enter the date of the most recent outpatient encounter with documented diagnosis of hypertension in the past year. | mm/dd/yyyy   |  | | --- | | < = 1 year prior or = stdybeg and < = stdyend | | Enter the exact date of the outpatient visit. The use of 01 to indicate missing day or month is not acceptable. |
| 18 | htnenc2 | During the timeframe from (computer to display 2 years prior to stdybeg) to (computer to display htnencdt1-1 day) is there documentation the patient had an outpatient encounter with a documented diagnosis of hypertension?  1. Yes  2. No | 1,2  If 2, autofill htnencdt2 as 99/99/9999 | **Review notes during the specified timeframe to determine if there was an outpatient encounter. An outpatient encounter includes any of the following:**   * Face to face visit - includes any face to face encounter with a provider, e.g., clinic, PCP, specialty provider, etc. * Telephone visit - must be an actual communication with the patient, not an attempt or voice mail. * Telehealth visit - refers to real-time clinic based video encounter between patient and provider. * Online assessment - a medical evaluation done online   **Hypertension diagnoses must be recorded as the patient’s diagnosis by a physician, APN, PA, or CNS in the encounter note.**  **Hypertension**  A diagnosis recorded as ‘borderline hypertension’ is hypertension if it is coded as hypertension and being treated as hypertension, by recommended weight loss and/or recommended increase in physical activity, and/or prescription for medication such as a diuretic, beta-blocker, ACE, ARB, or calcium channel blocker. |
| 19 | htnencdt2 | Enter the date of the outpatient encounter with documented diagnosis of hypertension during the timeframe from (computer to display 2 years prior to stdybeg) to (computer to display htnencdt1- 1 day). | mm/dd/yyyy   |  | | --- | | < = 2 yrs prior to stdybeg and < htnencdt1 | | Enter the exact date of the outpatient visit. The use of 01 to indicate missing day or month is not acceptable. |
| 20 | vascdis1  vascdis2  vascdis3  vascdis4  vascdis5  vascdis6  vascdis7  vascdis8  vascdis99 | Within the past two years, at any inpatient or outpatient encounter, did the patient have an active diagnosis of any of the following?  **Indicate all that apply:**  1. Coronary artery disease  2. Angina  3. Lower extremity arterial disease/peripheral artery disease  4. Transient cerebral ischemia  5. Stroke  6. Atheroembolism  7. Abdominal aortic aneurysm  8. Renal artery atherosclerosis  99. No ischemic vascular disease diagnosis | 1,2,3,4,5,6,7,8,99   |  | | --- | | If 1 or 2 warning if selmi = F and selpci = F, and selcabg = F  Will be auto-filled as 1 if selmi, selpci, or selcabg = T | | **Within the past two years: from the first day of the study interval to the first day of the same month two years previously. Please see table on the following pages for list of ICD-10-CM diagnosis codes.**   * **‘Active’ diagnosis = the condition was ever diagnosed and there is no subsequent statement, prior to the most recent outpatient visit, indicating the condition was resolved or is inactive.** * Include diagnoses noted in clinic notes or progress notes. Diagnoses documented on a problem list must be validated by a clinician diagnosis within the past 2 years. * Diagnoses may be taken from the inpatient or outpatient setting. The abstractor is not limited to the codes provided and may take diagnoses from clinician documentation even though an applicable code is not present.   Do not include diagnoses that occurred greater than two years in the past or are not active diagnoses**.** |

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| |  |  | | --- | --- | | **ICD-10-CM Code** | **ICD-10 Description** | | I241 | Dressler's syndrome | | I200 | Unstable angina | | I240 | Acute coronary thrombosis not resulting in myocardial infrc | | I248 | Other forms of acute ischemic heart disease | | I208 | Other forms of angina pectoris | | I201 | Angina pectoris with documented spasm | | I208 | Other forms of angina pectoris | | I209 | Angina pectoris, unspecified | | I2510 | Athscl heart disease of native coronary artery w/o ang pctrs | | | I25810 | Atherosclerosis of CABG w/o angina pectoris | | | | | I25811 | Athscl native cor art of transplanted heart w/o ang pctrs | | I25812 | Athscl bypass of cor art of transplanted heart w/o ang pctrs | | I2582 | Chronic total occlusion of coronary artery | | I255 | Ischemic cardiomyopathy | | I2589 | Other forms of chronic ischemic heart disease | | I259 | Chronic ischemic heart disease, unspecified | | I2510 | Athscl heart disease of native coronary artery w/o ang pctrs | | I651 | Occlusion and stenosis of basilar artery | | I6322 | Cerebral infrc due to unsp occls or stenosis of basilar art | | I6529 | Occlusion and stenosis of unspecified carotid artery | | I63139 | Cerebral infarction due to embolism of unsp carotid artery | | I63239 | Cereb infrc due to unsp occls or stenos of unsp carotid art | | | | | |
| |  |  | | --- | --- | | **ICD-10-CM Code** | **ICD-10 Description** | | I6509 | Occlusion and stenosis of unspecified vertebral artery | | I63019 | Cerebral infarction due to thombos unsp vertebral artery | | I63119 | Cerebral infarction due to embolism of unsp vertebral artery | | I63219 | Cereb infrc due to unsp occls or stenosis of unsp verteb art | | I658 | Occlusion and stenosis of other precerebral arteries | | I6359 | Cereb infrc due to unsp occls or stenosis of cerebral artery | | I658 | Occlusion and stenosis of other precerebral arteries | | I6359 | Cereb infrc due to unsp occls or stenosis of cerebral artery | | I659 | Occlusion and stenosis of unspecified precerebral artery | | I6320 | Cereb infrc due to unsp occls or stenos of unsp precerb art | | I6609 | Occlusion and stenosis of unspecified middle cerebral artery | | I6619 | Occlusion and stenosis of unsp anterior cerebral artery | | I6629 | Occlusion and stenosis of unsp posterior cerebral artery | | I6330 | Cerebral infarction due to thombos unsp cerebral artery | | I6609 | Occlusion and stenosis of unspecified middle cerebral artery | | I6619 | Occlusion and stenosis of unsp anterior cerebral artery | | I6629 | Occlusion and stenosis of unsp posterior cerebral artery | | I669 | Occlusion and stenosis of unspecified cerebral artery | | I6340 | Cerebral infarction due to embolism of unsp cerebral artery | | I669 | Occlusion and stenosis of unspecified cerebral artery | | I6350 | Cereb infrc due to unsp occls or stenos of unsp cereb artery | | G450 | Vertebro-basilar artery syndrome | | G450 | Vertebro-basilar artery syndrome | | G458 | Oth transient cerebral ischemic attacks and related synd | | G450 | Vertebro-basilar artery syndrome | | G451 | Carotid artery syndrome (hemispheric) | | G458 | Oth transient cerebral ischemic attacks and related synd | | | | | |
| |  |  | | --- | --- | | **ICD-10-CM Code** | **ICD-10 Description** | | G459 | Transient cerebral ischemic attack, unspecified | | I67848 | Other cerebrovascular vasospasm and vasoconstriction | | I701 | Atherosclerosis of renal artery | | I7092 | Chronic total occlusion of artery of the extremities | | I7100 | Dissection of unspecified site of aorta | | I7101 | Dissection of thoracic aorta | | I7102 | Dissection of abdominal aorta | | I7103 | Dissection of thoracoabdominal aorta | | I711 | Thoracic aortic aneurysm, ruptured | | I712 | Thoracic aortic aneurysm, without rupture | | I713 | Abdominal aortic aneurysm, ruptured | | I714 | Abdominal aortic aneurysm, without rupture | | I718 | Aortic aneurysm of unspecified site, ruptured | | I715 | Thoracoabdominal aortic aneurysm, ruptured | | I716 | Thoracoabdominal aortic aneurysm, without rupture | | I719 | Aortic aneurysm of unspecified site, without rupture | | I7401 | Saddle embolus of abdominal aorta | | I7409 | Other arterial embolism and thrombosis of abdominal aorta | | I7411 | Embolism and thrombosis of thoracic aorta | | I742 | Embolism and thrombosis of arteries of the upper extremities | | I743 | Embolism and thrombosis of arteries of the lower extremities | | I745 | Embolism and thrombosis of iliac artery | | I748 | Embolism and thrombosis of other arteries | | I749 | Embolism and thrombosis of unspecified artery | | I75019 | Atheroembolism of unspecified upper extremity | | I75029 | Atheroembolism of unspecified lower extremity | | I7581 | Atheroembolism of kidney | | I7589 | Atheroembolism of other site | | | | | |
| 21 | famhx | Does the record document any one of the following:   1. patient has a family history of coronary events occurring prior to age 45 2. patient’s father or other male first-degree relative had a definite MI or sudden death before age 55 3. patient’s mother or other female first-degree relative had a definite MI or sudden death before age 65   99. none of these factors documented | 1,2,3,99 | **Definition of “family history” is the same as that for “first-degree relative,” i.e., father, mother, brother, or sister.**  **First-degree relative** = a natural (not adoptive) parent or sibling with whom an individual shares one-half of his/her genetic material, i.e., father, mother, brother, or sister  **Coronary events occurring before age 45** = acute myocardial infarction and unstable angina, conditions associated with stenosis within the coronary artery  **Sudden death before age 55** = death from cardiovascular disease, not as the result of an accident or other disease |
| **If (dmflag = 1) OR (selmi = 1) OR (selcabg = 1) OR (selpci =1) OR (vascdis <> 99), go to cirrhosis; if (dmflag <> 1), (selmi <> = 1), (selcabg <>1), (selpci <>1), and (vascdis = 99) and  (sex = 2 and age < 51 years), go to ivfpreg; else go to end** | | | | |
| 22 | cirrhosis | Does the record document a diagnosis of cirrhosis during the past two years?   1. Yes 2. No | 1,2 | * Include diagnosis noted in clinic notes or progress notes. Diagnosis may be taken from the inpatient or outpatient setting. * Diagnoses documented on a problem list must be validated by a clinician diagnosis within the past 2 years. |
| 23 | muscledx | Does the record document a diagnosis of myalgia, myositis, myopathy, or rhabdomyolysis during the past year?   1. Yes 2. No | 1,2  If sex = 2 and age < 51 years, go to ivfpreg; else go to end | * Include documentation of myalgia (muscle pain), myositis, myopathy, or rhabdomyolysis noted in clinic notes or progress notes during the past year. Documentation may be taken from the inpatient or outpatient setting. * Diagnoses documented on a problem list must be validated by a clinician diagnosis within the past year. * Documentation of myalgia, myositis, myopathy, or rhabdomyolysis may also be accepted from the allergy/adverse reaction drug reaction package. The date of allergy/adverse drug reaction documentation may be greater than the past year. * If there is documentation of an allergy/adverse drug reaction to more than one statin medication, select value 1.   **Myalgia** means muscle pain or aching.  **Myositis** means muscle inflammation.  Myopathy is a muscular disease in which the muscle fibers do not function for any one of many reasons, resulting in muscular weakness.  Rhabdomyolysis is the breakdown of muscle tissue that leads to the release of muscle fiber contents into the blood. These substances are harmful to the kidney and often cause kidney damage.  **NOTE: For the purposes of this question, fibromyalgia and cardiomyopathy are not acceptable to answer “yes”.**  **Suggested data sources:** Progress notes, problem list, allergy/adverse drug reaction package |
| 24 | ivfpreg | Does the record document any one of the following during the past two years:   1. Pregnancy 2. In vitro fertilization (IVF) 3. Both in vitro fertilization and pregnancy   99. None of the above | 1,2,3,99  If 99, go to clomiphen; else go to end  If 1 or 3, go to pregdt | **The question intent is to determine if there is medical record documentation the patient was pregnant or received in vitro fertilization during the past two years.**  **Evidence of pregnancy includes but is not limited to documentation of:**   * Positive pregnancy test * In vitro fertilization procedure * Intrauterine pregnancy * Abdominal, ectopic, molar, ovarian or tubal pregnancy * Missed, spontaneous or threatened abortion * Induced termination of pregnancy |
| 25 | pregdt | Enter the most recent date there is evidence of pregnancy documented in the medical record. | mm/dd/yyyy   |  | | --- | | <=stdyend and <= 2 years prior to stdybeg |   **Go to end** | Enter the most recent date there is evidence of pregnancy documented in the medical record. |
| 26 | clomiphen | Does the record document the patient was prescribed clomiphene during the past two years?   1. Yes 2. No | 1,2 | Clomiphene is a non-steroidal fertility medicine. It causes the pituitary gland to release hormones needed to stimulate ovulation (the release of an egg from the ovary). |

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|  | **Nexus Clinics** |  |
|  | |  |  |  |  | | --- | --- | --- | --- | | **Code** | **Clinic Description** | **Code** | **Clinic Description** | | **303** | Cardiology | **548** | Intensive SUD Individual | | **305** | Endocrinology/Metabolism | **550** | MH Clinic Group | | **306** | Diabetes | **552** | MHICM Individual | | **309** | Hypertension | **560** | Substance Use Disorder Group | | **312** | Pulmonary/Chest | **562** | PTSD Individual | | **322** | Womens Clinic | **565** | MH Intervention Biomed Group (examples: chronic pain, essential hypertension, LBP, migraine HA, obesity…) | | **323** | Primary Care | **567** | MHICM Group | | **348** | Primary Care Shared Appointment | **576** | Psychogeriatric Clinic Individual | | **350** | GeriPACT | **577** | Psychogeriatric Clinic Group | | **502** | Mental Health Clinic Individual | **582** | Psychosocial Rehabilitation and Recovery Center (PRRC) Individual | | **513** | Substance Use Disorder Individual | **583** | PRRC Group | | **516** | Post Traumatic Stress Disorder (PTSD) Group |  |  | | **523** | Opioid Substitution |  | **Clinics ONLY applicable to SCI patients** | | **525** | Women’s Stress Disorder Treatment Team | **210** | SCI | | **533** | MH Intervention Biomed Care Individual (for use by MH clinicians who provde individual…primary diagnosis is med rather than psych…examples: chronic pain, essential hypertension, LBP, migraine HA, obesity…) | **215** | SCI Home Care Program | | **534** | MH Integrated Care Individual | **315** | Neurology | | **539** | MH Integrated Care Group | **414** | Urology | | **547** | Intensive SUD Group | **201** | Rehabilitation | | **In determining whether the patient was seen in a Nexus clinic, the abstractor should be guided by whether the clinic is a Mental Health clinic or a Primary Care clinic (or Cardiology, Endocrinology, etc.)**  If unable to make a definitive decision, consult with the facility Liaison for help in determining the clinic Stop Code.  Stop codes can be found in VistA in the Patient Care Encounter (PCE) program.  **Do not include:**   |  |  | | --- | --- | | **Code** | **Clinic Description** | | **117** | Nurse Only Visit | | **160** | Pharmacy Consult | | **450** | Compensation & Pension Exam | | **529** | Health Care for Homeless Vet | | **573** | MH Incentive Therapy Group | | **574** | MH Compensated Work Tx Group | | **575** | MH Vocational Group | | **591** | Incarcerated Veterans Re-entry | | **656** | DoD Non-VA care | | **710** | Flu clinics | | **717** | PPD only | |