Inpatient Psychiatric Facility Quality Reporting Program: Claims-Based Measure Specifications

This document is a resource for the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program for the Centers for Medicare & Medicaid Services (CMS).

June 2022

Notices and Disclaimers

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Section 1: Follow-Up After Hospitalization for Mental Illness (FUH) Measure Specifications—Version 6.0

Description of Measure

This measure assesses the percentage of inpatient psychiatric facility (IPF) hospitalizations for treatment of select mental health disorders that were followed by an outpatient mental health care encounter. Two rates are reported:

- The percentage of discharges for which the patient received follow-up within 7 days of discharge
- The percentage of discharges for which the patient received follow-up within 30 days of discharge

The measurement period used to identify cases in the denominator is typically 12 months, starting in July. For fiscal year (FY) 2023 reporting, the FUH measure will use a measurement period of July 1, 2020, through June 30, 2021, allowing data from the start of the measurement period through 30 days after the close of the measurement period to be used to identify follow-up visits in the numerator.

As this is a claims-based measure, there is no action required by facilities to collect and submit data for this measure. CMS will calculate the measure rates using Part A and Part B claims data that are received by Medicare for payment purposes. CMS will calculate this measure by linking Medicare fee-for-service (FFS) claims submitted by IPFs and subsequent outpatient providers for Medicare FFS IPF discharges. This approach requires no additional data collection or reporting by IPFs. Completion of this measure does not affect an IPF's payment determination.

For a full list of codes used in measure calculation, see the FUH codebook posted on QualityNet at Qualitynet.cms.gov > Inpatient Psychiatric Facilities > Resources > Program Resources/View > Measure Resources.

Numerator Statement

This measure estimates the number of discharges from a psychiatric facility that are followed by an outpatient mental health care encounter within 7 and 30 days after discharge. Outpatient mental health care encounters are defined as outpatient visits, intensive outpatient encounters, or partial hospitalizations provided by a mental health provider. All codes used to identify providers are found in Medicare outpatient/carrier files. Either a Medicare specialty code OR taxonomy code qualifies as a numerator hit. For a full list of codes, refer to the "Numerator practitioner" tab of the FUH codebook.

Outpatient visits, intensive outpatient encounters, and partial hospitalizations are defined by the Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), and Uniform Billing (UB) Revenue codes listed in Table A1. A claim that meets any of the requirements in the table constitutes an outpatient visit.

Table A1. Codes to identify outpatient visits, intensive outpatient encounters, and partial hospitalizations

CPT				Telehealth Modifier
90839-90840, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99393-99397, 99401-99404, 99411, 99412, 99483, 99495, 99496, 99510			with or without	GT
HCPCS				
G0155, G0176, G0177, G0409-G0411, G0463, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485, T1015			with or without	GT
CPT		**Place of Service**		
90832-90834, 90836-90838, 90845, 90847, 90849, 90853, 90870, 90875, 90876, 99324-99328, 99383-99387	with	03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72	with or without	GT
99221-99223, 99231-99233, 99238, 99239, 99251-99255	with	52, 53	with or without	GT
CPT		**Type of Service/Facility Type Classification (TYPSVC/FACTYP)**		
90791, 90792, 90832-90834, 90836-90838, 90845, 90847, 90849, 90853, 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99324-99328, 99383-99387	with	TYPSVC = 2 or 3 if FACTYP = 1–6 or 9 OR FACTYP = 7 or 8	with or without	GT
ICD-10-PCS				
GZB0ZZZ, GZB1ZZZ, GZB2ZZZ, GZB3ZZZ, GZB4ZZZ	with	TYPSVC = 2 or 3 if FACTYP = 1–6 or 9 OR FACTYP = 7 or 8	with or without	GT
UB Revenue				
0513, 0900-0905, 0907, 0911-0917, 0919 – encounter does not have to have NPI taxonomy or Medicare specialty code for a mental health provider				
0510, 0515-0517, 0519-0523, 0526-0529, 0982, 0983 – if encounter does not have NPI taxonomy or Medicare specialty code for a mental health provider, encounter must be for a principal mental illness diagnosis				

Claims with codes for emergency room visits do not count toward the numerator and should be removed. Emergency room visits are defined by the UB revenue, CPT, Place of Service, and Berenson-Eggers type of service (BETOS) codes shown in Table A2.

Table A2. Codes to identify emergency room visits

UB Revenue	0450-0459, 0981
CPT	99281, 99282, 99283, 99284, 99285
Place of Service	23

BETOS	M3

Denominator Statement

The denominator includes discharges paid under the IPF prospective payment system (PPS) during the measurement period for Medicare FFS patients with a principal diagnosis of mental illness. Specifically, the measure includes IPF discharges (Table A3) for which the patient was:

- Discharged with a principal diagnosis of mental illness that would necessitate follow-up care with a mental health professional
  - Defined using the ICD-10-CM codes in the "Denominator" tab of the FUH codebook.
- Discharged alive to ensure they are eligible for follow-up care.
  - Defined as any Discharge Status Code other than "20" (expired).
- Enrolled in Medicare Parts A and B during the month of the discharge date and at least one month after the discharge date to ensure data are available to capture the index admission and follow-up visits.
  - Defined as having continuous (no gaps) Medicare Part A and Part B coverage with no Health Maintenance Organization (HMO). Therefore, the Entitlement Buy-in Indicator must be "3" or "C" and the HMO indicator must be "0" for both the month of discharge and the month following the discharge month for the IPF stay to qualify as continuous FFS.
- Six years of age or older on the date of discharge because follow-up with a mental health professional may not always be recommended for younger children.
  - Defined using date of birth from the CMS Enrollment Data Base (EDB) beneficiary table.

Table A3. Codes to identify eligible IPF discharges

Criteria for eligible IPF discharges
Claim Type 60
CMS Certification Number (CCN) meets at least one of the following criteria: • Last 4 digits of the CMS Certification Number (CCN) is 4000–4499 (Psychiatric Hospital excluded from inpatient prospective payment system) • 3rd digit of CCN is 'S' (distinct part Psychiatric Unit in an acute care hospital) • 3rd digit of CCN is 'M' (Psychiatric Unit in a Critical Access Hospital [CAH])

Denominator Exclusions

Medicare files are used to identify all exclusions. The denominator excludes IPF discharges for patients:

- Admitted or transferred to acute and non-acute inpatient facilities within the 30-day follow-up period because admission or transfer to other institutions may prevent an outpatient follow-up visit from taking place.
  - Defined using the claim type and codes in the "Excl – admit, transfer" tab of the FUH codebook. Each facility type must have both a claim type and one of the corresponding CCN, HCPCS, UB, or place of service (POS) codes if the codes are listed in the row for that facility type (Table A4).

- Discharged or transferred to other institutions, including direct transfer to a prison, within the 30-day follow-up period because those patients may not have the opportunity for an outpatient follow-up visit.
    - Defined using the discharge codes in the "Excl – transfer, disch" tabs of the FUH codebook.
- Who died during the 30-day follow-up period because patients who expire may not have the opportunity for an outpatient follow-up visit.
    - Defined using the Medicare Enrollment File.
- Who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began because patients in hospice may require different follow-up services.
    - Defined using the hospice codes listed in the "Excl - hospice" tab of the FUH codebook.

Table A4. Codes to identify admission or transfer to acute and nonacute inpatient facility

Description	File	Claim Type	Codes
Acute care admissions (IPF or acute care hospitals)	Medicare Inpatient	60	CCN: 3rd through 6th digit= 0001-0899 or 4000-4449 or 3rd digit=S, M
SNF, Hospice, Outpatient and HHA	Medicare SNF, Hospice, Outpatient or HHA	10, 20, 30, 40, 50	UB Revenue: 0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659, 019x, 0118, 0128, 0138, 0148, 0158, 0655, 1002, 1001
SNF, Hospice, Outpatient and HHA	Medicare SNF, Hospice, Outpatient or HHA	10, 20, 30, 40, 50	UB Type of Bill: 81x, 82x, 21x, 22x, 28x, 18x
Psychiatric residential treatment center	Medicare Carrier	71	HCPCS: T2048, H0017-H0019
SNF, Hospice, inpatient rehab, respite, intermediate care facility, residential substance abuse and psychiatric treatment facilities	Medicare Carrier	71	Place of Service (POS): 31, 32, 34, 54, 55, 56, 61

Section 2: 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF Readmission) Measure Specifications—Version 5.0

Description of Measure

This facility-level measure estimates an unplanned, 30-day, risk-standardized readmission rate for adult Medicare FFS patient discharges from an IPF with a principal discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease. The measurement period used to identify cases in the measure population is typically 24 months, starting in July. Due to the impacts of COVID-19 on IPFs, CMS will not count data from January 1, 2020, through June 30, 2020, for performance or payment programs. For FY2023 reporting, the IPF Readmission measure will use a measurement period of July 1, 2019, through December 1, 2019, and July 1, 2020, through June 30, 2021, allowing data from the start of the measurement period through 30 days after the close of the measurement period to be used to identify readmissions.[1] Data from 12 months prior to the start of the measurement period through the measurement period are used to identify risk factors.

For a full list of codes used in measure calculation, see the IPF Readmission codebook posted on QualityNet at Qualitynet.cms.gov > Inpatient Psychiatric Facilities > Resources > Program Resources/View > Measure Resources.

Numerator Statement

The risk-adjusted outcome measure does not have a traditional numerator and denominator. The numerator statement describes the outcome being measured. A readmission is defined as any admission, for any reason, to an IPF or a short-stay acute care hospital (including CAHs) that occurs within 30 days after the discharge date from an eligible index admission to an IPF, except those considered planned. The measure uses the CMS 30-day Hospital-Wide Readmission (HWR) Measure Planned Readmission Algorithm, Version 4.0, to identify planned readmissions.[2] The algorithm follows two principles to identify planned readmissions:

1. Select procedures and diagnoses, such as transplant surgery, maintenance chemotherapy/radiotherapy, or rehabilitation care are considered always planned. For a full list of planned procedures and diagnoses, refer to the "PR1" and "PR2" tabs of the IPF Readmission codebook.
2. Some procedures, such as colorectal resection or aortic resection, are considered either planned or unplanned depending on the accompanying principal discharge diagnosis. For a full list of such procedures, refer to the "PR3" and "PR3b-ICD-10 procedure codes" tabs of the IPF Readmission codebook. Specifically, a procedure is considered planned if it does not coincide with a principal discharge diagnosis of an acute illness or complication. For a full list of such principal discharge diagnoses, refer to the "PR4" and "Pr4DiagnosisICD10" tabs of the IPF Readmission codebook.

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[1] For more information, see CMS's March 27, 2020, memo on exceptions and extensions for quality-reporting requirements for health care entities affected by COVID-19: https://www.cms.gov/files/document/guidance-memo-exceptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf.

[2] For more information, see QualityNet's Readmission Measures Methodology page: https://qualitynet.cms.gov/inpatient/measures/readmission/methodology.

Denominator Statement

The risk-adjusted outcome measure does not have a traditional numerator and denominator. The denominator statement describes the measure population. The measure population consists of eligible index admissions to IPFs. A readmission within 30-days will also be eligible as an index admission, if it meets all other eligibility criteria. Patients may have more than one index admission within the measurement period.

Index admissions are defined as admissions to IPFs for patients with the following characteristics:

- Age 18 or older at admission
- Discharged alive
- Enrolled in Medicare FFS Parts A and B during the 12 months prior to, the month of, and at least one month after the index admission
- Discharged with a psychiatric principal diagnosis included in the "PsychCCS" tab of the IPF Readmission codebook. The list of diagnoses uses the Agency for Healthcare Research and Quality (AHRQ) Clinical Classification Software (CCS) ICD groupings. Information on sorting ICD codes into clinically coherent groups is available on the AHRQ CCS webpage at https://www.hcup-us.ahrq.gov/toolssoftware/ccsr/ccsr_archive.jsp#ccsr.

The measure population excludes admissions for patients with the following characteristics:

- Discharged against medical advice (AMA) because the IPF may have limited opportunity to complete treatment and prepare for discharge.
- Unreliable demographic and vital status data defined as the following:
    - Age greater than 115 years
    - Missing gender
    - Discharge status of "dead" but with subsequent admissions
    - Death date prior to admission date
    - Death date within the admission and discharge dates but the discharge status was not "dead."
- Readmissions on the day of discharge or day following discharge because those readmissions are likely transfers to another inpatient facility. The hospital that discharges the patient to home or a non-acute care setting is accountable for subsequent readmissions.

Readmissions two days following discharge because readmissions to the same IPF within two days of discharge are combined into the same claim as the index admission and do not appear as readmissions due to the interrupted stay billing policy. Therefore, complete data on readmissions within two days of discharge are not available.

Statistical Risk Model and Variables

Hierarchical logistic regression is used to estimate a risk standardized readmission rate.

Risk-Factor Variables

Four types of risk factors are included in the risk-adjustment model:

1. Demographics (Table B1)
    - Gender and age

2. Principal discharge diagnosis of the IPF index admission. Discharge diagnoses are summarized into 13 distinct principal discharge risk factors using a modified version of the AHRQ CCS groupings. For a full list of codes, please refer to the "Principal_DxICD10_CCS" tab of the IPF Readmission codebook.
3. Comorbidity risk variables
   - Comorbidities are summarized into distinct psychiatric and non-psychiatric risk factors using a modified version of CMS's Hierarchical Condition Categories (HCC). For a full list of codes, refer to the "ModifiedCCIcd10" tab of the IPF Readmission codebook. The comorbidity risk factors are derived from three sources:
     - Secondary diagnoses of the index admission when not considered a potential complication of care.
     - Principal or secondary diagnoses of inpatient encounters during the 12 months prior to the index admission.
     - Primary or secondary diagnoses of outpatient encounters that had evaluation and management (E&M) procedure codes indicating services were provided by physicians or qualified health professionals. To eliminate diagnoses that may have been assigned during diagnostic work up without later confirmation, a minimum of two outpatient claims with a diagnosis in the same HCC are required during the 12 months prior to the index admission for inclusion as a risk variable for a given patient.
4. Other risk factor variables among psychiatric patients (Table B2)
   - Other risk factors were summarized into three distinct risk factor descriptions using Medicare FFS claims. For a full list of codes to identify suicide attempt/self-harm and aggression, refer to the "SuicideICD10" and "AggressionICD10" tabs of the IPF Readmission codebook.

Table B1. Demographic risk factors

Risk Factor Name/Description
Gender: male or female
Age: 18–34, 35–44, 45–54, 55–64, 65–74, 75–84, or 85+

Table B2. Other risk factors

Risk Factor Name/Description	
Suicide attempt/self-harm	• At least 1 claim with a diagnosis in the 12 months prior to the index admission • Secondary diagnosis during the index admission
Aggression	• Diagnosis during inpatient admission in the 12 months prior to the index admission • At least 2 outpatient claims in the 12 months prior to the index admission • Secondary diagnosis during the index admission
Discharge disposition	• Discharged against medical advice (AMA) in prior 12 months • Not discharged AMA in prior 12 months • No admissions to determine AMA discharge

Section 3: Medication Continuation Following Inpatient Psychiatric Discharge (MedCont) Measure Specifications—Version 3.0

Description of Measure

This measure assesses whether psychiatric patients admitted to an inpatient psychiatric facility (IPF) for major depressive disorder (MDD), schizophrenia, or bipolar disorder filled a prescription for evidence-based medication within 2 days prior to discharge and 30 days post-discharge. The performance period for the measure is typically two years, starting in July. Due to the impacts of COVID-19 on IPFs, CMS will not count data from January 1, 2020, through June 30, 2020, for performance or payment programs. For FY2023 reporting, the MedCont measure will use a measurement period of July 1, 2019, through December 1, 2019, and July 3, 2020, through June 30, 2021, allowing data from the start of the measurement period through 30 days after the close of the measurement period to be used to identify medications 30 days post-discharge.[3]

As this is a claims-based measure, there is no action required by facilities to collect and submit data for this measure. CMS will calculate the measure rates using Part A and Part B claims data that are received by Medicare for payment purposes. CMS will calculate this measure by linking Medicare fee-for-service (FFS) claims submitted by IPFs and subsequent outpatient providers for Medicare FFS IPF discharges. This approach requires no additional data collection or reporting by IPFs. Completion of this measure does not affect an IPF's payment determination.

For a full list of codes used in measure calculation, see the MedCont codebook posted on QualityNet at Qualitynet.cms.gov > Inpatient Psychiatric Facilities > Resources > Program Resources/View > Measure Resources.

Numerator Statement

The numerator for this measure includes:

1. Discharges with a principal diagnosis of MDD in the denominator population for which patients were dispensed evidence-based outpatient medication within 2 days prior to discharge through 30 days post-discharge
2. Discharges with a principal diagnosis of schizophrenia in the denominator population for which patients were dispensed evidence-based outpatient medication within 2 days prior to discharge through 30 days post-discharge
3. Discharges with a principal diagnosis of bipolar disorder in the denominator population for which patients were dispensed evidence-based outpatient medication within 2 days prior to discharge through 30 days post-discharge

The following are the evidence-based medications for treating MDD (Table C1), schizophrenia (Table C2), and bipolar disorder (Table C3), by class. The route of administration includes all oral formulations and the long-acting (depot) injectable of the medications listed in this section, except where noted. Active ingredients for the oral medications listed are limited to oral, buccal, sublingual,

[3] For more information, see CMS's March 27, 2020, memo on exceptions and extensions for quality-reporting requirements for health care entities affected by COVID-19: https://www.cms.gov/files/document/guidance-memo-exceptions-and-extensions-quality-reporting-and-value-based-purchasing-programs.pdf.

and translingual formulations only. Obsolete drug products are excluded from National Drug Codes (NDCs) with an inactive date more than three years before the beginning of the measurement period.

Table C1. Medications for treatment of MDD

Type	Medication
Monoamine Oxidase Inhibitors	-isocarboxazid -phenelzine -selegiline (transdermal patch) -tranylcypromine
Selective Serotonin Reuptake Inhibitors (SSRI)	-citalopram -escitalopram -fluoxetine -fluvoxamine -paroxetine -sertraline
Serotonin Modulators	-nefazodone -trazodone -vilazodone -vortioxetine
Serotonin Norepinephrine Reuptake Inhibitors (SNRI)	-desvenlafaxine -duloxetine -levomilnacipran -venlafaxine
Tricyclic and Tetracyclic Antidepressants	-amitriptyline -amoxapine -clomipramine -desipramine -doxepin -imipramine -maprotiline -nortriptyline -protriptyline -trimipramine
Other Antidepressants	-bupropion -mirtazapine
Psychotherapeutic Combinations	-amitriptyline-chlordiazepoxide -amitriptyline-perphenazine -fluoxetine-olanzapine

Table C2. Medications for treatment of schizophrenia

Type	Medication
First-generation Antipsychotics	-chlorpromazine -fluphenazine -haloperidol -haloperidol lactate -loxapine succinate -molindone -perphenazine -pimozide -prochlorperazine -thioridazine -thiothixene -trifluoperazine
Second-generation (Atypical) Antipsychotics	-aripiprazole -asenapine -brexpiprazole -cariprazine -clozapine -iloperidone -lurasidone -olanzapine -paliperidone -quetiapine -risperidone -ziprasidone -lumateperone
Psychotherapeutic Combinations	-amitriptyline-perphenazine -fluoxetine-olanzapine
Long-Acting (Depot) Injectable Antipsychotics	-fluphenazine decanoate -haloperidol decanoate -aripiprazole -aripiprazole lauroxil -olanzapine pamoate -paliperidone palmitate (1-month extended-release injection) -risperidone -risperidone microspheres

Table C3. Medications for treatment of bipolar disorder

Type	Medication
Anticonvulsants	-carbamazepine -divalproex sodium -lamotrigine -valproic acid
First-generation Antipsychotics	-chlorpromazine -haloperidol -haloperidol lactate -loxapine succinate
Second-generation (Atypical) Antipsychotics	-aripiprazole -asenapine -cariprazine -clozapine -lurasidone -olanzapine -quetiapine -risperidone -ziprasidone -lumateperone
Lithium Salts	-lithium -lithium carbonate -lithium citrate
Psychotherapeutic Combinations	-fluoxetine-olanzapine
Long-acting (depot) Injectable Antipsychotics	-haloperidol decanoate -aripiprazole -aripiprazole lauroxil -olanzapine pamoate -risperidone -risperidone microspheres

Denominator Statement

The target population for this measure is Medicare FFS beneficiaries with Part D coverage aged 18 years and older discharged from an IPF with a principal diagnosis of MDD, schizophrenia, or bipolar disorder.

The denominator for this measure includes patients discharged from an IPF:

- With a principal diagnosis of MDD, schizophrenia, or bipolar disorder. For a full list of codes, please refer to the "Diagnosis Codes" tab of the MedCont codebook.
- 18 years of age or older at admission.
- Enrolled in Medicare FFS Part A and Part B during the index admission and Parts A, B, and D at least 30 days post-discharge.
- Alive at discharge and alive during the follow-up period.
- With a discharge status code indicating that they were discharged to home or home health care.

Denominator Exclusions

The denominator for this measure excludes discharged patients who:

- Received electroconvulsive therapy (ECT) during the inpatient stay or follow-up period.

- Received transcranial magnetic stimulation (TMS) during the inpatient stay or follow-up period.
- Were pregnant at discharge.
- Had a secondary diagnosis of delirium at discharge.
- Had a principal diagnosis of schizophrenia with a secondary diagnosis of dementia at discharge.

For a full list of codes, please see the “Exclusions” tab of the MedCont codebook.

Appendix A. Updates to Follow-Up After Hospitalization for Mental Illness Measure

Version 6.0—Fiscal Year 2023 Public Reporting

1. Removed one retired taxonomy code from the "Numerator practitioner" tab of the FUH codebook to identify mental health practitioners in Medicare.

Taxonomy Code	Taxonomy Description
103G00000X	Behavioral Health & Social Service Providers/Neuropsychologist, Clinical

2. Added nine new ICD-10-CM codes to the "Denominator" tab of the FUH codebook to identify the principal mental illness diagnosis and inpatient acute care.

Principal Diagnosis	ICD-10-CM Code	Description
Intentional Self-harm	T40412A	Poisoning by fentanyl or fentanyl analogs, intentional self-harm, initial encounter
Intentional Self-harm	T40422A	Poisoning by tramadol, intentional self-harm, initial encounter
Intentional Self-harm	T40492A	Poisoning by other synthetic narcotics, intentional self-harm, initial encounter
Intentional Self-harm	T40412D	Poisoning by fentanyl or fentanyl analogs, intentional self-harm, subsequent encounter
Intentional Self-harm	T40422D	Poisoning by tramadol, intentional self-harm, subsequent encounter
Intentional Self-harm	T40492D	Poisoning by other synthetic narcotics, intentional self-harm, subsequent encounter
Intentional Self-harm	T40412S	Poisoning by fentanyl or fentanyl analogs, intentional self-harm, sequela
Intentional Self-harm	T40422S	Poisoning by tramadol, intentional self-harm, sequela
Intentional Self-harm	T40492S	Poisoning by other synthetic narcotics, intentional self-harm, sequela

Appendix B. Updates to 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an IPF Measure

Version 5.0—Fiscal Year 2023 Public Reporting

Owing to the high number of codes, the measure's codebook has a column to indicate if a code was added.

1. Incorporated updates from CMS's 30-day Hospital-Wide Readmission (HWR) Measure's 2021 Planned Readmission Algorithm, Version 4.0.
2. Added 39 new ICD-10 codes to the "Principal_DxICD10_CCS" tab of the IPF Readmission codebook.
3. Added 281 new ICD-10 codes to the "ModifiedCCIcd10" tab of the codebook.
4. Added 9 new ICD-10 codes to the "SuicideICD10" tab of the codebook.
5. Added 496 ICD-10-CM codes to the "ICD10CCS_ISRreadmitdx" tab of the codebook.
6. Removed 5,304 unused ICD-10 codes from the "ModifiedCCIcd10" tab of the codebook.

Appendix C. Updates to Medication Continuation Following Inpatient Psychiatric Discharge Measure

Version 3.0—Fiscal Year 2023 Public Reporting

Owing to the high number of codes, the measure's codebook has a column to indicate whether a code was added.

1. Removed 1,309 NDC codes from the "Numerator – NDCs" tab of the MedCont codebook.
2. Added 2,534 NDC codes to the "Numerator – NDCs" tab of the MedCont codebook.
3. Added the medication Lumateperone to Medication Tables C2 and C3. In December 2019, the U.S. Food and Drug Administration (FDA) approved Lumateperone to treat schizophrenia. In December 2021, the FDA approved Lumateperone to treat bipolar disorder.
4. Added Risperidone injection to Medication Tables C2 and C3 for schizophrenia and bipolar disorder, respectively. This medication was already included in the measure and in the measure codebook, but it was erroneously left out of this measure specifications manual.