



# Inpatient Quality Reporting Program

## Support Contractor

### Venous Thromboembolism 2015 Abstraction Guidance

#### Questions and Answers

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**March 23, 2015**

**2 p.m. ET**

**Question 1:** Is it correct—Ambulation counts as a reason for no VTE prophylaxis?

**Answer 1:** Yes, in the data element “Reason for No VTE Prophylaxis,” ambulation must be tied to the wording, “VTE Prophylaxis” or “Reason for No VTE Prophylaxis,” for ambulation to be an acceptable “Reason for no VTE Prophylaxis.”

**Question 2:** If the VTE scoring done by our hospital is high (i.e., 8) and the physician says, “Low risk,” which would you use?

**Answer 2:** You would use the physician documentation “Low Risk.”

**Question 3:** What are acceptable reasons for discontinuing Parenteral Therapy if INR is therapeutic?

**Answer 3:** Well, I did allude, in one of my slides that explicit documentation must be in there. There is no set list of acceptable reasons because we would want to leave that open to physician preference. However, it must be linked with the discontinuation of the Parenteral Therapy.

**Question 4:** If a patient has a CT abdomen and pelvis with IV contrast, and the result was that findings were suspicious for acute PE involving segmental branch of the right lower lobe—

**Answer 4:** In my slide, see, it’s 28 for me which might not be – might be a little different for you since we have different numbers of the slides – If the

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record indicates only a radiology report and that report is questionable regarding whether the patient had the VTE, you would select “No.” So, in the example provided, it sounds like all they have is a CT of contrast, and it’s questionable, so you would select “No.”

**Question 5:** Did you say that an addendum is not acceptable for a reason for discontinuation of Anticoagulation Therapy?

**Answer 5:** No, that is no longer acceptable. Therapeutic INR or an INR of 2.0 to 3.0 requires additional documentation.

**Question 6:** “Reason for DC Parenteral Therapy” is another example of acceptable documentation that the patient is changed to another form of oral therapy, i.e., Xarelto?

**Answer 6:** Xarelto would have to be administered prior to discharge. Xarelto and Eliquis need to be administered. Plan for switching the patient to other anticoagulation therapy is not acceptable.

**Question 7:** If the patient's INR is 3.0 or greater, is that an automatic reason to discontinue Overlap Therapy and not prescribe parenteral TX at discharge?

**Answer 7:** Yes, if an INR is greater than three and is documented by the physician, it is automatically acceptable.

**Question 8:** And up for a follow up, did the INR level change to 3.0? We thought it was 2.0.

**Answer 8:** Well, the ACCP Guideline dictates that 3.0 is the threshold for supratherapeutic INR and so – and has not changed. That follows the ACCP Guideline.

**Question 9:** Can you give an example of an acceptable documentation to DC Parenteral Discontinuation for patients with less than five days, even if MD documented INR 2.5, Pt. therapeutic, DC lovenox

**Answer 9:** Well, as I stated in the slide, if the INR is only 2.5, that patient is still at risk for clotting and still requires protection for the recommended five days by the ACCP Guideline. So, unless the patient’s risk of bleeding outweighs the benefits of anticoagulation, [that] would be the really only acceptable [reason for] discontinuation.

So, I would say an example would be – I put in the slide, intracranial hemorrhage, any kind of rectal bleeding, GI bleeding, those would all be reasons, acceptable reasons why you would discontinue Parental Therapy when you have a therapeutic INR but you don’t have five days of Overlap Therapy yet.

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- Question 10:** Does the refusal of one prophylaxis by a patient or family member cover all prophylaxis?
- Answer 10:** Yes, refusal of one prophylaxis covers all prophylaxes and the data element "Reason for No VTE Prophylaxis."
- Question 11:** Is "Heparin flush given within 24 hour of arrival" acceptable for VTE Prophylaxis?
- Answer 11:** No, Heparin is only given subcutaneously, and that is found in Appendix H Table 2.1.
- Question 12:** When stating "to" the day after admission, does that mean through the end of the day after admission, i.e., midnight of day after admission?
- Answer 12:** That means the day after admission, the calendar day after admission.
- Question 13:** If DVT was diagnosed but age of the clot cannot be defined, how would we answer VTE confirmed?
- Answer 13:** That's a difficult one because, you know, if it's sub-acute or chronic, we don't want to accept it into the measure. We would select "No." So, with age undetermined, I would still say that that's a questionable report. So I would say, going back to, again slide number 28, if it's a questionable report, then you would select "No" and the radiology report is all you have.
- Question 14:** Slide 15 – Overlap is <5 days with no reason for "No Lovenox at D/C." How is this a "Yes?"
- Answer 14:** Because the Xarelto was administered on the day of discharge. So, if Xarelto was administered, you may select "Yes" to automatic reason.
- Question 15:** The example on slide 23 explains the POA of a VTE. That isn't part of Overlap Therapy, right?
- Answer 15:** That's correct. This is the explanation of "VTE Present on Admission," [a] separate data element.
- Question 16:** Is "VTE Prophylaxis not given, patient combative" allowable as "patient refusal"?
- Answer 16:** It has to be documented as "patient refusal."

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- Question 17:** So if the patient refuses “pharmacological,” then that is a reason for “No Prophylaxis?” The physician doesn’t need to then order “mechanical?”
- Answer 17:** That is correct. Any refusal of any of the VTE Prophylaxis medication counts for a “Yes” in the data element, “Reason for No VTE Prophylaxis.”
- Question 18:** Is it acceptable for the physician to state “Low Risk” as a reason for “No Prophylaxis of any kind?”
- Answer 18:** No, you must take physician documentation, provider documentation, physician/APN/PA, pharmacist.
- Question 19:** Can we start inferring the reason the VTE Prophylaxis was not given if the patient is a bilateral amputee?
- Answer 19:** No, that still must be documented.
- Question 20:** Many times you have referred to an "Automatic Reason." Does that mean a link is not required?
- Answer 20:** I’m sorry, yes, that’s what I mean for an automatic reason, meaning that specific explicit documentation does not need to be noted in the chart. An example would have been the Xarelto. If the Xarelto is administered, it’s an automatic reason. The physician does not need to document reason for discontinuation, “Administration of Xarelto.”
- Question 21:** So, to clarify, if [the] nurse documents “Reason for no compressions” as “Below the Knee Amputation (BKA),” then that also excludes pharmacological?
- Answer 21:** No, Pharmacological Prophylaxis must also be considered for “Patient at risk for VTE.”
- Question 22:** Confusion about VTE Prophylaxis: [if a] patient says no to ONE type, [it] cancels all others?
- Answer 22:** Correct. If the patient refuses ANY type of VTE Prophylaxis, the abstracter may select ‘YES” to the data element “Reason for No VTE Prophylaxis.”
- Question 23:** If MD orders Sequential Compression Devices (SCDs) and nurse charts TEDs, does this meet QM for VTE-1?
- Answer 23:** This abstraction would move the record to the numerator. ANY VTE Prophylaxis, or a “Reason for no VTE Prophylaxis” moves the record to the numerator.

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- Question 24:** In the example listed on page six, the very first one, I am surprised we can infer the Prophylaxis was not administered. In the past we have had to have specific documentation linking the amputation as the reason for no SCDS.
- Answer 24:** Not able to answer. Slide six is Overlap Therapy.
- Question 25:** If the patient had less than five days of overlap therapy and signed out "Against Medical Advice (AMA)," will we fail the measure?
- Answer 25:** A reason must be documented in the record as to why the Parenteral Therapy was discontinued prematurely
- Question 26:** If a patient is on a high dose Intravenous (IV) Heparin drip, isn't that considered a reason for no VTE Prophylaxis?
- Answer 26:** Yes, if the IV Heparin is continuous. The data element "Reason for No VTE Prophylaxis" indicates: For patients on anticoagulants –For patients on continuous IV heparin therapy the day of or day after hospital admission, select "Yes."
- Question 27:** Aspirin is only acceptable for knee Surgical Care Improvement Project (SCIP) patients. Aspirin is not acceptable. Did this rule change?
- Answer 27:** You are correct. Aspirin is not FDA approved for VTE Prophylaxis in this population.
- Question 28:** Does the refusal for VTE that does not require any other VTE same for Stroke?
- Answer 28:** Correct. The STK measure shares the same data element, "Refusal for one VTE Prophylaxis" counts as a reason for "No VTE Prophylaxis."
- Question 29:** One reason to discontinue Parenteral you stated, no addendum, but why wouldn't that be accepted if it were recorded on the day of the discontinuation?
- Answer 29:** The measure maintenance team felt that an addendum could be used to "game" the measure and that the reason for the discontinuation of the parenteral therapy must be documented prior to discharge.
- Question 30:** [We] have a patient that had a CT scan questionable for Pulmonary Embolism (PE). Two MDs documented she had a PE and treated. However, on discharge day, they did a follow up CT and [the] radiologist said she had no PE, and when comparing to previous one,

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decided it was [an] artifact, so she wasn't sent home on warfarin or lovenox. [The] doctor did document she ultimately had no PE. How do I answer "Reason for no lovenox on discharge?"

**Answer 30:** Documentation must indicate the reason for the discontinuation of the Parenteral Therapy. However, the data element, "VTE Confirmed" should have been a "No," as you have documentation that the PE was indeed not present. This would remove the case from the measure.

**Question 31:** For "VTE at admission," we have previously been told that if the patient had a VTE and was on treatment prior to arrival, that we would select the answer as "No." If a patient is admitted with a known VTE and has been on treatment with warfarin for the past month, how would this be answered?

**Answer 31:** Select "No." The data element is intended to eliminate those VTE that are suspected or diagnosed from arrival to the day after admission. Notes for abstraction indicate: "The time frame for this data element includes any documentation of VTE confirmed or suspected from arrival to the day after admission."

**Question 32:** I find Slide 30 confusing. If you have a positive VTE test and an inconclusive VTE test, do you answer VTE confirmed as "Yes" or "No?"

**Answer 32:** If you have conflicting documentation regarding your VTE diagnostic test, select "No." The data element "VTE Confirmed" notes for abstraction indicate: "If the record indicates ONLY a radiology report, and that report is questionable regarding whether the patient had a VTE, select "No." However, if you have documentation of a positive test in the record, select 'Yes' (slide 31)." For your example, you would select 'Yes'.

**Question 33:** Can Xarelto alone be used for VTE Prophylaxis for a patient that does not have a PE or deep vein thrombosis (DVT), doesn't have a history of knee or hip replacement, and was not on Xarelto prior to admission? If the answer is no, what is the rationale for why not?

**Answer 33:** No, Xarelto is not FDA approved for VTE Prophylaxis unless the patient is post-operative hip or knee, or is being treated for atrial fibrillation or VTE.

**Question 34:** What other oral anticoagulant besides Xarelto [is an] acceptable reason for discontinuation of parenteral therapy?

**Answer 34:** For this version of the Specification Manual, it is Xarelto or Eliquis.

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- Question 35:** If [a] patient [is] admitted with elevated d-dimer and test not done until two days later and DVT is positive, is this a “DVT on admit” or “Acquired while in hospital DVT?”
- Answer 35:** The data element, “VTE Present at Admission” requires documentation of suspected VTE or a VTE Diagnostic Test. A d-dimer is a test used to suspect a VTE. It is just not one of the acceptable VTE tests. This example would be “VTE Present at Admission.”
- Question 36:** Do we abstract “Yes” for “VTE Present at Admission” if any of the following apply: Any acceptable VTE Diagnostic test that was not ordered or performed to rule out VTE; Patients with VTE confirmed greater than 4 days prior to admission and are already on treatment at admission but VTE is not the primary reason for admission?
- Answer 36:** If the VTE Diagnostic Test was not ordered or performed, you would not select ‘YES’ to the data element “VTE Present at Admission” unless documentation of suspicion of VTE is present. For patients who have a “VTE Prior to arrival,” this is [a] history of VTE. The intent of the data element is to collect those VTE that are suspected or diagnosed from arrival to the day after hospital admission.
- Question 37:** What if the patient is an inpatient holding in the ED? Can you take prophylaxis in the ED?
- Answer 37:** VTE Prophylaxis is only abstracted after hospital admission.
- Question 38:** If a patient is discharged at less than five days Overlap Therapy with an INR of 1.8 due to “Patient insistence on discharge with outpatient follow up,” is this a ‘Yes’ or “No” for “Reason for discontinue of overlap therapy?”
- Answer 38:** Yes, if it is explicitly documented as the reason for the discontinuation of the Parenteral Therapy.
- Question 39:** On slide # 36, the wording is "MD risk assessment." My hospital currently has the admission nurse complete the VTE risk assessment. Is this acceptable? Would you recommend daily risk assessments or every shift?
- Answer 39:** Yes, a nurse can complete the risk assessment tool. The notes for abstraction in the data element “Reason for No VTE Prophylaxis” indicate, “Assessment forms may be initiated and completed by a nurse.” The Joint Commission does not endorse any risk assessment forms, nor does it dictate the scheduling of risk assessment.

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- Question 40:** “Reason for discontinuation of parenteral” – If [a] physician discontinues the parenteral but doesn't write in progress note at the time but comes back later in the same day and writes it in an addendum, is this acceptable?
- Answer 40:** No, no addendums are acceptable to the data element “Reason for Discontinuation of Parenteral Anticoagulation Therapy.” Documentation written after the patient discharge will not be acceptable.
- Question 41:** Is MD/Pharmacist documentation of "increased risk of bleeding" an acceptable reason to discontinue Parenteral Therapy?
- Answer 41:** Yes, if it is explicitly documented with the discontinuation of parenteral anticoagulation therapy. For example, “D/C Lovenox, patient at increased risk of bleeding.”
- Question 42:** Can the nurse document a refusal or does it have to be a physician?
- Answer 42:** In the data element “Reason for No VTE Prophylaxis,” patient refusal may be documented by the nurse. Patient/family refusal may be documented by a nurse but should be documented within the same timeframe as the reason for no VTE Prophylaxis.
- Question 43:** Please clarify – We do need explicit documentation if patient is discharged on Xarelto as long as it is part of the discharge medication?
- Answer 43:** Documentation must indicate that Xarelto was administered in the record.
- Question 44:** Just to clarify, if [a] patient had three days of Overlap Therapy, Lovenox was discontinued day of discharge, and Eliquis was prescribed at discharge but no dose was given prior to discharge, does the physician still need to "link" the reason for stopping Overlap Therapy and prescribing Eliquis or is this [the] explicit reason?
- Answer 44:** Eliquis would only be an acceptable reason if the patient was administered the medication. Otherwise, the provider needs to document explicitly the reason for the discontinuation of the Parenteral Therapy.
- Question 45:** If [a] patient on overlap therapy has Coumadin/Parenteral Therapy discontinued on day of discharge and the plan is to put the patient on Xarelto at home, is that sufficient? (i.e., Does the Xarelto have to be administered in house, or is a prescription for home good enough?)

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- Answer 45:** Xarelto must be administered to be considered a sufficient reason for discontinuation of Parenteral Anticoagulation Therapy.
- Question 46:** I didn't think Aspirin was acceptable for VTE Prophylaxis. Does the order for Aspirin need to state this is ordered for VTE Prophylaxis?
- Answer 46:** Aspirin is not FDA approved for VTE Prophylaxis in this patient population.
- Question 47:** What your are saying is, Ambulation is acceptable for high risk for VTE patients?
- Answer 47:** Ambulation, when documented in the context of VTE, is an acceptable reason for "No VTE Prophylaxis."
- Question 48:** If physician writes an order for No VTE Prophylaxis and the patient is "observation status," does this order need to be re-written when patient is changed to "inpatient status?"
- Answer 48:** No, reasons for no VTE Prophylaxis can be obtained from arrival to the day after hospitalization. Notes for abstraction indicate, "To select "Yes" for this data element, documentation must be dated from arrival to the day after hospital admission or surgery end date."  
Documentation written after arrival but prior to admission is acceptable.
- Question 49:** Can you please clarify, if the MD documents INR is 3.0 or greater, is that acceptable for less than five days Parenteral or do we still need additional documentation?
- Answer 49:** Explicit documentation is needed for the data element "Reason for Discontinuation of Parenteral Anticoagulation Therapy."
- Question 50:** If Lovenox is ordered but the nurse documents refusal, is that sufficient for a reason?
- Answer 50:** For the data element "Reason for No VTE Prophylaxis," if the record indicates patient refusal of ANY VTE Prophylaxis, you may select "Yes." Notes for abstraction indicate, "Patient/family refusal of any form of prophylaxis is acceptable."
- Question 51:** Is "No low risk assessment" [an] acceptable reason for no VTE Prophylaxis?
- Answer 51:** No, the data element indicates that both types of prophylaxis must be considered and a documented reason must be present, unless a risk assessment form is used. If no form is used (in the case above), then documentation must include both types of prophylaxis.

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- Question 52:** What if the MD documented “VTE Drug Prophylaxis ordered” and “Mechanical VTE Prophylaxis not needed,” is that okay?
- Answer 52:** Yes, if the VTE Prophylaxis is administered.
- Question 53:** What if the patient cannot afford Parenteral Therapy?
- Answer 53:** Explicit documentation must indicate the reason for the discontinuation of the Parenteral Therapy.
- Question 54:** Slide 23 – If PE was negative and just arm clot positive, would answer still be “Yes?”
- Answer 54:** It is unknown how old the arm clot is. For the data element “VTE Present at Admission,” ANY VTE present or suspected from arrival to the day after admission is acceptable.
- Question 55:** If patient refuses SCDs day of admission and receives enoxaparin, how do I abstract that?
- Answer 55:** Abstract ALL forms of VTE Prophylaxis, as noted in the data element “VTE Prophylaxis.” Please abstract the VTE Prophylaxis.
- Question 56:** Slide 19 – Assessment “Low Risk” on admission but has positive test for PE three days later – Is “Low Risk” assessment acceptable?
- Answer 56:** For the data element, “Reason for No Administration of VTE Prophylaxis,” no low risk documentation is acceptable.
- Question 57:** Regarding slide #19, “Reason for No administration of VTE Prophylaxis,” did you say that “if it is documented that the patient is ambulating” this IS a reason for NO administration of VTE prophylaxis?
- Answer 57:** Correct. If patient ambulation is documented in the context of VTE Prophylaxis, then it is an acceptable “Reason for No Administration of VTE Prophylaxis.”
- Question 58:** We have a lot of patients who are transferred to our facility with a PE. So often the information in our medical record does not specifically tell us that contrast was used, and we search for this information. In these cases, is the “VTE Present upon Admit” a “No” since the contrast isn’t well documented?
- Answer 58:** The data element “VTE Present at Admission” is intended to eliminate those records where a PE is suspected or confirmed from arrival to the day after admission. If the patient already has the PE, consider this to be history, select “NO.”. If there is documentation in

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the record that the PE is newly diagnosed on arrival and you have the VTE Diagnostic Test, select "YES." The VTE Diagnostic Test must be documented as listed in the data element "VTE Diagnostic Test."

**Question 59:** VTE Prophylaxis Status asks, "Was VTE Prophylaxis administered between the admission date and the VTE Diagnostic Test order date?" Is the timeframe "between the admission date and the VTE Diagnostic Test order date" an inclusive time frame such that a VTE Prophylaxis administered on the same date as the VTE Diagnostic Test order date would be a "Yes?"

**Answer 59:** If the VTE Prophylaxis was administered the same day as admission, select "Yes." Notes for abstraction indicate, "If the VTE Diagnostic Test was ordered the day of or the day after the admission date, select "Yes." If it is ordered the same day as the VTE diagnostic test order date, select "No."

**Question 60:** If no risk assessment is referenced but the physician documents "No mechanical/pharmacological prophylaxis needed – contraindicated," can we select "Yes" as a reason, or does there have to be a specific condition listed?

**Answer 60:** There must be a reason documented as to the reason why the patient was not a candidate for either pharmacological or mechanical prophylaxis. Notes for abstraction indicate, "The two circumstances in which one can select "Yes" to this data element are:

- There is explicit documentation indicating that the patient is at low risk for VTE
- There is explicit documentation of a contraindication to mechanical prophylaxis AND documentation of a contraindication to pharmacological prophylaxis

**Question 61:** Regarding "Reason for Oral Factor Xa Inhibitor," this element does not allow for pharmacist documentation. Is there [a] rationale for this?

**Answer 61:** No rationale for this. [We] will consider adding this to the next manual version.

**Question 62:** You stated that if a patient refused one form of prophylaxis, that [refusal] was universal for all prophylaxis. Are you speaking pharmacological prophylaxis? I am certain it was perceived by some as "she said the patient refusal was overarching for refusal for all prophylaxis."

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- Answer 62:** Correct. Refusal of one form of prophylaxis counts as refusal of all prophylaxis. Notes for abstraction in the data element, "Reason for No VTE Prophylaxis indicates, "Patient/family refusal of any form of prophylaxis is acceptable."
- Question 63:** Hello, I received the slides prior to the presentation. On slide 11 the presenter gave five examples with answers. Can these five examples be provided in a written form, as she went over them kind of fast?
- Answer 63:** There are 6 types of patient scenarios that pass the measure:
1. Overlap Therapy > 5 days D/C Home
  2. Overlap Therapy < 5 days D/C home with Parenteral Therapy
  3. Overlap Therapy < 5 days INR > 3.0 D/C Home
  4. Overlap Therapy < 5 days INR 2.0-3.0 D/C Home with Parenteral Therapy
  5. Overlap Therapy < 5 days INR < 2.0 D/C home with Parenteral Therapy
  6. Overlap Therapy < 5 days INR < 2.0 D/C Home without parenteral therapy but with a reason fir discontinuation
- Two scenarios that fail the measure
1. Overlap Therapy < 5 days INR < 3.0 No parenteral
  2. Overlap Therapy < 5 days INR <3.0 No reason for discontinuation of Parenteral therapy
- Question 64:** What happens when insurance denies Lovenox but will pay for Xarelto, and, due to finding out on discharge that the insurance will not pay for Lovenox and patient received daily dose of Lovenox and not Xarelto, would this be sufficient?
- Answer 64:** This forum cannot respond to questions of the insurance nature. However, if the submitter is asking if Xarelto is an acceptable reason for discontinuation of Parenteral Anticoagulation Therapy, then, yes. Xarelto can be an acceptable reason for discontinuation of Parenteral Anticoagulation Therapy if the medication is administered prior to the patient discharge.
- Question 65:** If the MD documents "No VTE drug prophylaxis" on the VTE assessment due to medical contraindication without specifying bleeding, etc., and on the physician progress notes it says "Hold DVT prophylaxis due to thrombocytopenia," can I use that reason even if it is from the md progress notes?
- Answer 65:** Yes, progress notes can be used as documentation indicating the reason for "No VTE Prophylaxis." Be sure that mechanical prophylaxis is addressed, as well.

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- Question 66:** VTE Confirmed – If dopplers results indicate a DVT in the tibial vein (infrapopliteal DVT) [and the] MD documents only "DVT," would I answer "VTE confirmed" as a "Yes," or would this be a "No" because MD did not document a location?
- Answer 66:** This would be "No" to "VTE Confirmed," as the tibial vein is not included in the data element "VTE Confirmed."
- Question 67:** To only abstract "VTE Prophylaxis after admission," does this mean the admit order for those in the ED?
- Answer 67:** Yes, VTE Prophylaxis can only be abstracted after the order has been written for inpatient acute care.
- Question 68:** Please explain slide 19, especially why "No IV Heparin" is acceptable. Wouldn't the patient who cannot get IV Heparin be able to get SCDs?
- Answer 68:** Correct. IV Heparin is not an automatic reason for "No administration of VTE Prophylaxis" in the patient who acquired a VTE. SCD's could have been applied.
- Question 69:** Referring to slide #18, "No SCDs" documented in ER, is nursing documentation such as "unable to place SCDs due to bilateral burns," would this pass the measure?
- Answer 69:** No, that documentation must come from the provider. Allowable values indicate, "There is physician/APN/PA or pharmacist documentation why VTE Prophylaxis was not administered at hospital admission."
- Question 70:** In the example of "VTE present at admission," if the patient had arrived with the known clot in her arm and Superior Vena Cava (SVC), would that not be "Yes" to "present at admission?"
- Answer 70:** No, the data element "VTE Present at Admission" is intended to exclude those records where a VTE is suspected or confirmed from arrival to the day after hospital admission. If the patient arrives with a known VTE, this might be historical information.
- Question 71:** What is a VKA?
- Answer 71:** Vitamin K Agonist.
- Question 72:** You stated no medications from ED for VTE Prophylaxis. Can you use ED medications when looking at Overlap Therapy?

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- Answer 72:** Yes, the data element “Overlap Therapy Start Date” indicates, “For patients diagnosed with VTE while in the ED that had Overlap Therapy started prior to admission, enter the date that both medications were administered prior to the admission date.”
- Question 73:** Is Pradaxa approved for prophylaxis use?
- Answer 73:** No, however, it is an acceptable reason for “No VTE Prophylaxis,” as it is found in Appendix H table 2.7.
- Question 74:** If there are two different VTE prophylaxes ordered on two different days, do we use the first day the first one is ordered or the second day?
- Answer 74:** The data element, “VTE Prophylaxis” indicates that you abstract ALL VTE Prophylaxis. Abstract ALL VTE Prophylaxis(s) that was administered the day of or the day after hospital admission or the day of or the day after “Surgery End Date” for surgeries that start the day of or the day after hospital admission.
- Question 75:** My question is on the slide “Reason for no Administration of VTE Prophylaxis, Cont.” (3rd slide after “Reason for no administration of VTE Prophylaxis NEW.”) Please clarify the first reason, “No low risk assessment is acceptable.” Please provide an example. Thank you.
- Answer 75:** For the data element “Reason for No Administration of VTE Prophylaxis,” the Technical Advisory Panel felt that if the patient was originally evaluated at low risk and then acquired a clot during the hospital stay, they should be have been re-assessed for VTE – It was at some point that they became a high risk. Therefore, the data element does not allow for documentation regarding low risk.
- Examples for the data element, “Reason for No Administration of VTE Prophylaxis” are indicated in the slide, “No mechanical VTE Prophylaxis bilateral lower extremity burns and no pharmacological VTE Prophylaxis recent rectal bleeding.”
- Question 76:** What are acceptable contraindications for not utilizing mechanical prophylaxis? Also, please explain “History of Warfarin use.”
- Answer 76:** An example of a reason for “No mechanical VTE Prophylaxis” is “bilateral lower extremity burns” documented by the provider.
- “History of Warfarin use” can be: If warfarin is listed as a home or current medication, select “Yes.”
- Question 77:** For Aspirin, do they specifically have to have Aspirin for VTE Prophylaxis, or is it abstracted even if it is part of cardiac treatment?

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- Answer 77:** If Aspirin is used in the medical record, do not assume that it was used for VTE Prophylaxis. If Aspirin is abstracted as VTE Prophylaxis, it must accompany ANY other form of VTE Prophylaxis in order to pass. If Aspirin is used alone, the record will move to the data element, "Reason for No VTE Prophylaxis."
- Question 78:** For clarification, if a nurse or doctor documents "patient ambulating," is that acceptable documentation for VTE 1?
- Answer 78:** Ambulation must be documented in the context of VTE Prophylaxis and must be documented by a provider (Physician/APN/PA or pharmacist).
- Question 79:** Why is the reason to discontinue Parenteral Anticoagulation Therapy for patients with less than five days of Overlap Therapy that a patient is discharged on Xarelto and INR is 2.5?
- Answer 79:** Treatment with Xarelto is considered a different type of therapy other than Overlap Therapy. If the patient has started Xarelto, the provider no longer needs to assess the INR.
- Question 80:** Where can the definition of "appropriate" prophylaxis be found? What risk factors are recognized to determine appropriateness?
- Answer 80:** This measure set does not define or measure appropriate prophylaxis. It measures whether or not prophylaxis was provided.
- Question 81:** Do we abstract 81 mg Aspirin that is ordered/patient taking for other reasons, [for] example, for cardiac reasons? Are we to abstract Aspirin ONLY if it is specifically ordered for VTE Prophylaxis?
- Answer 81:** Abstract all VTE Prophylaxis that occurred in the record. Aspirin will move through the measure regardless of the dosage or intent, as long as ANOTHER form of VTE Prophylaxis accompanies it.
- Question 82:** If the MD documents "patient low risk" and orders SCDs but SCDs aren't applied, then is this conflicting information and we should select "No" to "Reason for no VTE Prophylaxis?"
- Answer 82:** Correct. If any VTE Prophylaxis is ordered and not administered, you must select "NO" to the data element "Reason for No VTE Prophylaxis." The notes for abstraction indicate, "For patients with a reason for no pharmacologic or no mechanical prophylaxis and an order for ANY prophylaxis that was NOT administered without a reason, (e.g., patient refusal), select "No."
- Question 83:** VTE related to ambulation must be documented by the Physician, correct?

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- Answer 83:** Correct. The data element “Reason for No VTE Prophylaxis” indicates that “Only Physician/APN/PA or Pharmacist documentation of a reason for not administering VTE Prophylaxis.”
- Question 84:** Clarification of slide 22, “VTE Present on Admission,” – [If a] patient has upper extremity DVT, “YES” would be selected now because it now is stated “This can be found anywhere in the body.”
- Answer 84:** The data element “VTE Present on Admission” does allow for VTE ANYWHERE on the body. However, the age of this documentation is unknown, and the acceptable time period for the data element is documentation of a new VTE written from arrival to the day after hospital admission. This documentation would be historical VTE and you would select “NO” for the data element, “VTE Present at Admission.”
- Question 85:** Is “risk of bleeding” an acceptable reason for discontinuing Anticoagulant Therapy when Overlap Therapy is less than five days?
- Answer 85:** Yes, with explicit documentation indicating the reason and the discontinuation of the Parenteral Anticoagulation Therapy
- Question 86:** Do Inferior Vena Cava (IVC) filters have any bearing on prophylaxis or confirmed VTE measures?
- Answer 86:** For this version of the manual, no. The next version of the manual will address IVC filters.
- Question 87:** If the physician documents a CT with a PE, and the CT is not in the chart, do you accept that for “VTE confirmed,” or do they have [to] indicate contrast was used for the CT in order for it to count?
- Answer 87:** The documentation can come from the physician, but it must indicate that contrast was used.
- Question 88:** If the patient has a confirmed VTE and is started on Xarelto, only then is the five day Dual Therapy needed? Is it only for Coumadin for Dual Therapy?
- Answer 88:** Once the patient is started on Xarelto, Overlap Therapy is no longer needed.
- Question 89:** What would be an example of “Reason to discontinue Parenteral VTE Prophylaxis” if overlap is <5 days and INR is 2-3 range?
- Answer 89:** Examples are indicated in the Specification Manual. One example would be “Discontinue Lovenox, patient has rectal bleeding.”

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- Question 90:** If the physician specifically states, "Stop lovenox, patient will be discharged on Xarelto," [is this] enough documentation if the Xarelto was not actually given?
- Answer 90:** No, Xarelto must be administered for the abstracter to select "Yes" to the data element, "Reason for Discontinuation of Parenteral Anticoagulation Therapy."
- Question 91:** If physician has documented on a VTE Advisor "Low Risk," but it is not LINKED to "No VTE Prophylaxis," will this suffice?
- Answer 91:** If the "Low Risk" is documented on the VTE Advisor, then it is in the context of VTE and will suffice.
- Question 92:** If SCD was applied on day of arrival and Lovenox on day 1 after arrival, I have to abstract all VTEs received, but the day should be on the first date VTE was received?
- Answer 92:** Correct. You should abstract all VTE Prophylaxis that was administered in the acceptable time period of the record. Then you should abstract the date of the earliest VTE Prophylaxis that [was] administered: be sure it was not aspirin.
- Question 93:** Patient was placed on Heparin drip for atrial fibrillation but MD also ordered SCD. No documentation of SCD [is] in [the] record. So can I choose "Yes" for "Reason for no VTE Prophylaxis–hospital admission?"
- Answer 93:** Yes, if you have a Heparin drip that is continuous on the day of or the day after hospital admission, you may select "Yes" to the data element "Reason for no VTE Prophylaxis."
- Question 94:** Can you elaborate on the element on slide number 22, "VTE present on admission," where it states "It must be documented from time of arrival to the day after admission." Is this really present on admission if not identified until the day after admission?
- Answer 94:** The VTE present at admission can be diagnosed or suspected on the day of arrival all the way until the day after hospital admission. This allows time for documentation and a diagnostic test to be ordered and performed.
- Question 95:** Does it matter when Overlap Therapy was started? I do not see anything in COMET asking for the date of diagnostic exam to determine if Overlap was started the day of or after the exam
- Answer 95:** No, Overlap Therapy can be delayed.

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- Question 96:** Comet states that “if the report is intermediate probability for PE, select “No” for PE.” But now the physician can say the patient has a PE and treats the PE – we have to say “Yes?”
- Answer 96:** Correct. If you have physician/provider documentation that confirms the VTE, you may select “Yes” to the data element “VTE Confirmed.”
- Question 97:** Heparin subcutaneous is acceptable, but Heparin IV infusion is not?
- Answer 97:** Heparin subcutaneous is an acceptable form of VTE Prophylaxis. Heparin IV continuous infusion is an acceptable reason for “No VTE Prophylaxis” in the data element, “Reason for No VTE Prophylaxis,” not in the data element, “Reason for No Administration of VTE Prophylaxis.”
- Question 98:** Must a provider document “Patient ambulatory – No VTE Prophylaxis needed,” or is documentation that “Patient is ambulatory” enough?
- Answer 98:** The ambulation must be in the context of VTE Prophylaxis. Notes for abstraction in the data element, “Reason for No VTE Prophylaxis” indicates, “Documentation that the patient is ambulating without mention of VTE Prophylaxis is insufficient.” Do not infer that VTE Prophylaxis is not needed unless explicitly documented.
- Question 99:** Does the physician have to address mechanical and pharmacological VTE-Prophylaxis for all patients?
- Answer 99:** Yes, for all patients at-risk for VTE. According to the ACCP 9<sup>th</sup> Edition Guideline, that is “all hospitalized patients, unless assessment reveals they are low risk.”
- Question 100:** When you say “after hospital admission,” does this mean the date and time of the admission order?
- Answer 100:** Correct.
- Question 101:** How do you define hospital admission, when patient is moved from ED to the nursing unit, or when the inpatient order is written?
- Answer 101:** The data element, “Admission Date” indicates, “What is the date the patient was admitted to acute inpatient care?” Notes for abstraction indicate, “Abstract the date the order was written.”
- Question 102:** Can you provide a link to the American College of Chest Physicians (ACCP) guidelines?
- Answer 102:** <http://journal.publications.chestnet.org/article.aspx?articleID=1159399>

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- Question 103:** If the patient does not receive any Warfarin (i.e., only receives Lovenox and is sent home on Lovenox), does there have to be documentation of a “Reason for No Overlap Therapy?”
- Answer 103:** If the patient does not receive any Warfarin, they are excluded from the measure, moved to category B.
- Question 104:** Does this begin with 1/1/2015 discharges? If so, why wasn't this call provided prior to the abstraction period?
- Answer 104:** The material provided was for discharges beginning with 01/01/2015. There are many hospitals that are already abstracting records for first quarter 2015 and asking for abstraction guidance. That is why this information was provided now.
- Question 105:** Can the MD document “Discontinue Heparin, patient is therapeutic?”
- Answer 105:** For patients with less than five days of Overlap Therapy, a reason must be documented to indicate the premature discontinuation of Parenteral Therapy.
- Question 106:** If patient is listed as an outpatient and SCDs are ordered and documented, and [then] the [patient is] placed as an inpatient three days later, which date would you use for the documentation for the SCDs, the first day as an outpatient or the first date as an inpatient?
- Answer 106:** Please abstract VTE Prophylaxis that was administered after hospital admission. The data element, “VTE Prophylaxis Date” indicates, “What date was the VTE Prophylaxis administered after hospital admission?”
- Question 107:** “Reason for discontinuation of Parenteral Anticoagulation Therapy” – if the Lovenox is discontinued on the day of discharge, can the physician dictate the reason in the discharge summary the day of?
- Answer 107:** No, if the discharge summary is dated/timed after discharge, it is not acceptable.
- Question 108:** If a patient is very sensitive to Coumadin and his INR goes above 3 and the physician stops Coumadin and does not restart for a couple of days and the patient is back down below 2, does the physician have to reorder both Lovenox and Coumadin?
- Answer 108:** This question and answer forum does not provide prescribing information.
- Question 109:** The Specifications Manual states that if our providers “document their reason for discontinuation of the Parenteral on the same day or the

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day before the order for discontinuation of the Parenteral Anticoagulation, and it is explicitly linked to the order for discontinuation, ANY reason should be accepted since there are other acceptable reasons. Since the bullets are not all inclusive, as long as they are documented with the link to the discontinuation of parenteral therapy, and are explicitly clear why the discontinuation is to take place, they will be accepted.” So if a reason is explicitly linked to the order for discontinuation of Parenteral Therapy and charted within the appropriate time frame, documentation that clearly reflects that the medication "x" was discontinued due to "y" should be accepted, including “Use of oral anticoagulants other than Warfarin” (such as switching to Xarelto for treatment of VTE, even if a dose was not provided while inpatient), correct?

**Answer 109:** No, the administration of Xarelto must take place for the abstractor to select “YES” to the data element, “Reason for Discontinuation of Parenteral Anticoagulation Therapy.”

**Question 110:** If patient has PE/DVT diagnosed at another facility but [that] is not the reason for transfer, how would this be abstracted?

**Answer 110:** If the record indicates the confirmation of the PE or the location and confirmation of the DVT, the acceptable test, by an acceptable provider, then the abstractor can select “Yes” to the data element, “VTE Confirmed.”

**Question 111:** If the prophylaxis is given after [the patient is] admitted in the ED, this would be abstracted?

**Answer 111:** The location of the patient is not significant, as long as it is after hospital admission.

**Question 112:** What does “No IV Heparin is acceptable” mean? This slide is confusing. (19)

**Answer 112:** IV Heparin is not an acceptable automatic reason for the data element, “Reason for No Administration of VTE Prophylaxis” for the measure VTE 6.

**Question 113:** Why don't refusals work as a “Reason for no prophylaxis?” You went over that section quickly.

**Answer 113:** “Patient/Family refusal” of ANY VTE Prophylaxis is an acceptable reason for no VTE Prophylaxis. The data element “Reason for No VTE Prophylaxis” indicates, “Patient/family refusal of any form of prophylaxis is acceptable.”

**Question 114:** Can an addendum to the discharge summary be used?

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- Answer 114:** Unsure which data element this refers to.
- Question 115:** Did you just state that you do not have to have the VTE diagnostic test confirm the VTE in all cases???
- Answer 115:** The data element, "VTE Confirmed" indicates that you must have both the confirmation of the VTE (by the provider, confirmed as acute, in one of the defined locations) and the VTE Diagnostic Test. Notes for abstraction indicate, "This data element includes patients who had an acceptable VTE Diagnostic Test and are confirmed to have an acute VTE by a physician/APN/PA within four days prior to arrival or anytime during the hospitalization." Refer to the data element, "VTE Diagnostic Test" for a list of acceptable tests.
- Question 116:** If a VTE Risk Assessment form is completed by a nurse, but that form only explicitly states patients "At Risk," can that result be used to answer the "Reason for No VTE Prophylaxis" question for low risk patients? (i.e., the form does NOT say anything like "At low risk for VTE or No VTE Prophylaxis needed.)
- Answer 116:** No, only risk assessment forms that indicate patient is at low risk can be used as acceptable documentation to the data element, "Reason for No VTE Prophylaxis."
- Question 117:** What if the patient gets Lovenox in cath lab before admission to the inpatient floor but on the same calendar day; does this count as VTE Prophylaxis?
- Answer 117:** No, the VTE Prophylaxis must occur after hospital admission. The data element, "VTE Prophylaxis Date" indicates, "Suggested Data Collection Question: What date was the VTE Prophylaxis administered after hospital admission?"
- Question 118:** I noticed there are still not automatic exclusions for Mechanical Prophylaxis in patients with BKA, arterial/crush lower extremity injury, post-op peripheral vascular disease (PVD) symptoms, etc. for Pharmacologic Prophylaxis. There are still not any automatic exclusions for acute hemorrhagic shock/bleeding documented as present on admission (including ICH, etc.), documented coagulopathies, etc. Are you able to comment why?
- Answer 118:** No, the Advisory panel wants the providers to consider and document the reason for "No VTE Prophylaxis."
- Question 119:** You said an addendum cannot be used. If the addendum is done before the patient is discharged, can it be used?

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- Answer 119:** Only documentation done prior to the discharge of the patient can be used in the data element, "Reason for Discontinuation of Parenteral Anticoagulation Therapy."
- Question 120:** If there are multiple MD documentations with varying VTE Prophylaxis use assessments, what will I use? If the first MD says "Yes" to SCD and the next MD says "Not needed due to edema" but it was ordered, what will I use?
- Answer 120:** If no VTE Prophylaxis is administered/applied, despite conflicting orders, you must select "No" to the data element, "Reason for No VTE Prophylaxis." The notes for abstraction indicate, "For patients with a reason for no pharmacologic or no mechanical prophylaxis and an order for ANY prophylaxis that was NOT administered without a reason (e.g., patient refusal), select 'No.'"
- Question 121:** Why can't a prescription for Xarelto as discharge medication be enough for reason for discontinuation of Parenteral Anticoag Therapy? Why must a case have to have at least one dose given of Xarelto in the hospital before discharge to pass the measure? Please provide rationale based on clinical practice guidelines
- Answer 121:** The VTE sub-group wanted the patient to have at least one dose of Oral Factor Xa Inhibitors and not just a plan to switch therapies. They wanted to see that the patient was protected from further VTE, which is the premise of Overlap Therapy.
- Question 122:** Can we still use nurse protocol with low risk assessment and statement of "No VTE Prophylaxis required" done by end of day one?
- Answer 122:** Yes, if the documentation indicates a risk assessment was performed by a nurse and this risk assessment indicated "Low Risk," the abstractor may select "Yes" to the data element, "Reason for No VTE Prophylaxis."
- Question 123:** If there is an order written by the physician, "No VTE Prophylaxis," is that an acceptable reason for both mechanical and pharmacologic forms?
- Answer 123:** Yes, the data element, "Reason for No VTE Prophylaxis" indicates, "For ONLY those patients determined to be AT LOW RISK for VTE:
- If documentation of "No VTE Prophylaxis needed" is written, then it will be inferred that both mechanical and pharmacological options were not indicated for the patient, select "Yes."
  - Example:
    - Low Risk, No VTE Prophylaxis, select "Yes."

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- Question 124:** Rationale for slide #36 please; it's conflicting.
- Answer 124:** The slide is an example of inadequate documentation for the data element, "*Reason for No VTE Prophylaxis.*" With the bullet, "For patients with a reason for no pharmacologic or mechanical prophylaxis" and an order for ANY prophylaxis that was NOT administered without a reason (e.g., patient refusal), select 'NO'."
- Question 125:** If the physician orders SCDs and the nurse documents that the patient refused, do I answer "Yes" or "No?"
- Answer 125:** Please select "Yes" to the data element, "Reason for No VTE Prophylaxis." Based on the notes for abstraction, "Patient/family refusal of any form of prophylaxis is acceptable."
- Question 126:** Can you give an example of an acceptable order or documentation to be able to use ambulation as VTE Prophylaxis?
- Answer 126:** No VTE Prophylaxis, patient ambulating
- Question 127:** If your record is dated from observation, can I use the Intermittent Compression Device (ICD) placed in observation?
- Answer 127:** No, you must use the VTE Prophylaxis that was administered after hospital arrival. The data element, "VTE Prophylaxis Date" indicates, "What date was the VTE Prophylaxis administered after hospital admission?"
- Question 128:** Can you clarify "Reason for no administration of VTE Prophylaxis?" Heparin IV IS accepted?
- Answer 128:** IV Continuous Heparin is not accepted as an automatic "Reason for no Administration of VTE Prophylaxis" because those patients should already have their anticoagulants managed and should not have acquired a VTE.
- Question 129:** If the patient is on Lovenox and Coumadin and five days is not met nor is the INR of 2.0 met and the patient is discharged on Lovenox only, is this acceptable?
- Answer 129:** Yes, The data element, "Parenteral Anticoagulant Prescribed at Discharge" would be answered as a "Yes" and the record would move to the numerator.
- Question 130:** If SCDs are day one and Lovenox is day two, do we abstract both?
- Answer 130:** Yes, please select All VTE Prophylaxis(s) that was administered the day of or the day after hospital admission or the day of or the day

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after "Surgery End Date" for surgeries that start the day of or the day after hospital admission.

**Question 131:** What do you mean by "linked" to discontinuation of parenteral therapy? If at the beginning of the progress note the physician documents INR of 3.2 and continues on with his note, and then, for the plan, the first item is "Stop IV Heparin," would this be "linked?"

**Answer 131:** Yes.

**Question 132:** If patient on three days of Overlap Therapy with doctor documentation of INR 2.8, "therefore no need for continued 5 days of Overlap Therapy," this is NOT acceptable, right?

**Answer 132:** Correct, there must be a reason documented for the premature discontinuation of the Parenteral Therapy. The date element, "Reason for Discontinuation of Parenteral therapy" indicates, "For documentation of therapeutic INR or an INR with a value equal to 2.0–3.0 (target range of 2.5), additional documentation is needed to support the reason to select 'Yes.'"

**Question 133:** In the scenario you gave of the INR 3, is this an automatic reason for "Reason for Parenteral Therapy discontinuation?"

**Answer 133:** Physician/APN/PA or pharmacist documentation of the INR of 3.0 or greater is an automatic reason for discontinuation of Parenteral Therapy. Notes for abstraction indicate, "Documentation of reasons synonymous with a high or suprathreshold INR or an INR >3.0 is acceptable for discontinuation of Parenteral Anticoagulation Therapy when documented by a physician/APN/PA or pharmacist."

- Examples:
  - o D/C enoxaparin, INR 6.0, select "Yes."
  - o D/C heparin, INR suprathreshold, select "Yes."

**Question 134:** Patient comes in with DVT and was on Coumadin at home. Initial INR sub-therapeutic ordered on Lovenox only. Lovenox D/C'd after four days with an INR of 2.07. Coumadin at home resumed at discharge. Would this patient pull into the measure, and if so, how would the VTE questions be answered?

**Answer 134:** No, there must [be] administration of Warfarin for the record to be kept in the VTE 3 Measure. If Warfarin was administered prior to discharge, the record would stay in the measure and a reason for discontinuation of Parenteral Therapy would need to be noted if Overlap Therapy only took place one day

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**Question 135:** Per lab results, the INR is 2.0 after five days of Bridge Therapy. Can I use this as a reason for not being discharged home on a Parenteral Anticoagulation?

**Answer 135:** If the record indicates five days of Overlap Therapy, the record moves to the data element, "INR Value." If the INR is 2.0 or greater, the record moves to the numerator.

**Question 136:** "Low Risk for DVT" is not an allowable reason for not prescribing Pharmacological or Non Pharmacological DVT Prophylaxis?

**Answer 136:** For the data element, "Reason for no VTE Prophylaxis," notes for abstraction indicate, "For ONLY those patients determined to be AT LOW RISK for VTE:

- If documentation of "No VTE Prophylaxis needed" is written, then it will be inferred that both mechanical and pharmacological options were not indicated for the patient, select "Yes."
- Example:
  - Low Risk, No VTE Prophylaxis, select "Yes."

For the data element, "Reason for No Administration of VTE Prophylaxis," low risk is not acceptable documentation.

**Question 137:** I Apologize. Would we answer "No" for "VTE Diagnostic Test" if the use of contrast is missing?

**Answer 137:** Correct, the use of contrast must be present for a CT to be counted in the data element, "VTE Diagnostic Test."

**Question 138:** Does the VTE assessment have to be done by MD?

**Answer 138:** Yes, Only a VTE Risk Assessment can be completed by a nurse.

**Question 139:** The physicians are frustrated with this measure in instances where there is obvious documentation of bleeding that might not have the "dots" connected to "so I am going to discontinue the anticoagulant." Can you explain why the MDs are required to explain that, i.e., why an order to discontinue the med alone does not count?

**Answer 139:** The data element, "Reason for Discontinuation of Parenteral Therapy" was developed during testing of the measure. This data element was developed to ensure that physicians had the opportunity to document such events as bleeding in those rare instances when the risk of bleeding outweighs the benefits of anticoagulation, and they discontinued the anticoagulation.

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- Question 140:** On the flow sheet, SCDs were documented as off ambulating and there is no other documentation, would we put “Yes” as a “Reason for no prophylaxis?”
- Answer 140:** No, ambulation must be documented in the context of VTE, for example, “No VTE Prophylaxis, patient ambulating.”
- Question 141:** If heparin is ordered, but on day 1 the patient refuses and on day 2 it is held for a thoracentesis, can i abstract a reason for not bte prophylaxis or does there need to be a reason that venodynes were not ordered?
- Answer 141:** I would abstract ‘YES” to the data element *Reason for No VTE Prophylaxis* based on patient refusal.
- Question 142:** Did the INR level change to 3.0? We thought it was 2.0.
- Answer 142:** The threshold for “INR value” after five days of Overlap Therapy is 2.0. The data element, “Reason for Discontinuation of Parenteral therapy” never had a defined threshold until this manual. It is always Physician/APN/PA or Pharmacist documentation.
- Question 143:** Slide titled “Reason for No Administration of VTE Phrophylaxis cont.” states, \* No Low Risk Assessment is acceptable.
- Answer 143:** Correct, documentation of “Low Risk” is not acceptable in the data element, “Reason for No Administration of VTE Prophylaxis.”
- Question 144:** So if the admission order is placed and the ED physician orders giving Lovenox prior to transfer to unit, we do not count it as VTE Prophylaxis given during admission?
- Answer 144:** This appears to be an example of inpatient documentation. The patient is already admitted, so I would abstract the Lovenox.
- Question 145:** If Chemical Prophylaxis is administered in ED and then the patient is admitted, the patient would not be a candidate for additional dose of Chemical Prophylaxis on that day. Is the patient considered a fallout since you are stating that the ED administration is not considered meeting the criteria?
- Answer 145:** The patient could receive Mechanical Prophylaxis, or receive a second dose of prophylaxis on the day after hospital admission.
- Question 146:** For patients admitted to observation and given VTE Prophylaxis but converted to inpatient status [in the] next day or so and therefore possibly in the measure, why can't we use initial prophylaxis date? It is sometimes discontinued and not given after converted and

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therefore date shows error if [we] try to enter [it] and fails due to “no VTE Prophylaxis” when [the patient] did have some this admit.

**Answer 146:** That is why the data element, “VTE Prophylaxis” allows for both the day of and the day after hospital admission. There is still time to prophylax after hospital admission if they received prophylaxis in observation.

**Question 147:** What is the start date for these rules? Does it start with January 2015 Abstraction?

**Answer 147:** Yes, the Specification Manual begins Jan 2015 to Sept 30, 2015.

**Question 148:** What is the rationale for not allowing a timely addendum to clarify why Parenteral Therapy is being D/C'd?

**Answer 148:** The VTE Sub-group felt that the documentation regarding the reason for the discontinuation of Parenteral Therapy must be documented in the acceptable timeframe the day of or the day before the order for the discontinuation of the Parenteral Anticoagulation Therapy.

This material was prepared by the Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. HHSM-500-2013-13007I, FL-IQR-Ch8-04062015-01