National Hospital Inpatient Quality Reporting Measures Specifications Manual

Release Notes Version: 5.0a **Release Notes Completed: May 20, 2015**

Guidelines for Using Release Notes

The Release Notes Version 5.0a provides modifications to the *Specifications Manual for National Hospital Inpatient Quality Measures*. The information in this document is to be used as a reference and is not intended to be used to program abstraction tools. Please refer to the *Specifications Manual for National Hospital Inpatient Quality Measures* for the complete and current technical specifications and abstraction information.

The notes are organized to follow the order of the Table of Contents. The **implementation date is 10-01-2015**, unless otherwise specified. The headings are described below:

- **Impacts** - used to identify the impacted measures and portion(s) of the Manual Section. (i.e., Alphabetical Data Dictionary, Measure Information Form (MIF) and Flowchart (Algorithm)).
- **Description of Changes** - used to identify the section within the document where the change occurs, e.g., Definition, Data Collection Question, Allowable Values, and Denominator Statement - Data Elements.
- **Rationale** - provided for the change being made.

Data elements that cross multiple measures and contain the same changes will be consolidated.

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The content below is organized to follow the Table of Contents in the specifications manual.

SECTION 1 – Data Dictionary

Alphabetical Data Dictionary

Impacts: Index

Rationale: For consistency with existing terminology and flow of patient care, the data element "Hypotension" should be renamed "Persistent Hypotension."

Description of Changes:
Change under 'Element Name' column from:
Hypotension
To
Persistent Hypotension

Impacts:
Hypotension

Rationale: For consistency with existing terminology and flow of patient care, the data element "Hypotension" should be renamed "Persistent Hypotension."

Description of Changes:
Data Element Name
Change to:
Persistent Hypotension

Definition
Change to:
Documentation of the presence of persistent hypotension in septic shock. The criteria for determining that hypotension was persistent are as follows:

In the one hour following administration of crystalloid fluids, one single blood pressure reading of either:

- systolic blood pressure (SBP) < 90, or
- mean arterial pressure (MAP) < 65 or
- a decrease in systolic blood pressure by > 40 mmHg from the last previously recorded SBP considered normal for that specific patient

Suggested Data Collection Question
Change to:
Was persistent hypotension present within one hour of the conclusion of crystalloid fluid administration?

Allowable Values
Change from:

1 (Yes)	Crystalloid fluids were administered at the rate of 30 mL/kg and hypotension was present within one hour of conclusion of fluid administration.
2 (No)	Hypotension was not present within one hour of the conclusion of crystalloid fluid administration at the rate of 30 mL/kg.

3 (No) or UTD	The patient was not assessed for hypotension in the one hour after the conclusion of crystalloid fluid administration at the rate of 30 mL/kg, or Unable to Determine.
4 (Not applicable)	Crystalloid fluids were not administered, or crystalloid fluids were not administered or crystalloid fluids were administered but not at the rate of 30 mL/kg.

To

1 (Yes)	Crystalloid fluids were administered at the rate of 30 mL/kg and persistent hypotension was present within one hour of conclusion of fluid administration.
2 (No)	Persistent hypotension was not present within one hour of the conclusion of crystalloid fluid administration at the rate of 30 mL/kg.
3 (No) or UTD	The patient was not assessed for persistent hypotension in the one hour after the conclusion of crystalloid fluid administration at the rate of 30 mL/kg, or Unable to Determine.
4 (Not applicable)	Crystalloid fluids were not administered, or crystalloid fluids were administered but at a rate less than 30 mL/kg.

Notes for Abstraction

Change first bullet to:

- Begin abstracting at the time that crystalloid fluid administration concludes; abstract for the time period that follows for the next hour only. Choose Value “1” if persistent hypotension was present; choose Value “2” if persistent hypotension was not present.

Change third sentence in fifth bullet to:

- Next, multiply the weight in kilograms times 30; the result is the number of mLs of IV crystalloid fluids that should be specified in the physician/APN/PA order.

Change sixth bullet to:

- If crystalloid fluids were administered but at a rate less than 30 mL/kg, choose Value “4.”

Change seventh bullet to:

- Determining the presence of persistent hypotension:
  The criteria for determining that persistent hypotension was present are as follows:
  In the one hour following administration of crystalloid fluids, one single blood pressure reading of either:
  - systolic blood pressure < 90, or
  - mean arterial pressure (MAP) < 65 or
  - a decrease in systolic blood pressure by > 40 mmHg

  If crystalloid fluids were given at 30 mL/kg, and if both a MAP reading and systolic blood pressure readings are present, if either the MAP or systolic blood pressure are abnormal, or there was a decrease in systolic blood pressure by > 40 mmHg as outlined above, choose Value “1.” If not, choose Value “2.”

Impacts:
Septic Shock Present

Rationale: The language referring to lactate level and physician/APN/PA documentation as the preferred data source has been revised to reduce confusion and provide clarification.

Description of Changes:
Notes for Abstraction
Change subsection "b" under first bullet to:
b. Tissue hypoperfusion persists in the hour after crystalloid fluid administration, evidenced by either
- systolic blood pressure (SBP) < 90, or
- mean arterial pressure < 65 or
- a decrease in systolic blood pressure by > 40 mmHg from the last previously recorded SBP considered normal for that specific patient

OR
- Lactate level is >= 4 mmol/L

Add new second bullet:
- For evaluation of blood pressure parameters to establish whether or not hypoperfusion persists after crystalloid fluid administration, begin abstracting at the time that crystalloid fluid administration concludes; abstract for the time period that follows for the next hour only. Choose Value "1" if hypotension (systolic blood pressure < 90, or mean arterial pressure < 65 or a decrease in systolic blood pressure by > 40 mmHg) was present in the hour after crystalloid fluid administration.

Impacts:
Septic Shock Presentation Date

Rationale: The language referring to lactate level and physician/APN/PA documentation as the preferred data source has been revised to reduce confusion and provide clarification.

Description of Changes:
Notes for Abstraction
Change subsection "b" under first bullet to:
b. Tissue hypoperfusion persists in the hour after crystalloid fluid administration, evidenced by either
- systolic blood pressure (SBP) < 90, or
- mean arterial pressure < 65 or
- a decrease in systolic blood pressure by > 40 mmHg from the last previously recorded SBP considered normal for that specific patient

OR
- Lactate level is >= 4 mmol/L

Change second bullet to:
- Physician/APN/PA documentation of septic shock or suspected septic shock is acceptable.

Add in fifth bullet:
or physician/APN/PA documentation of septic shock

Impacts:
Septic Shock Presentation Time

Rationale: The language referring to lactate level and physician/APN/PA documentation as the preferred data source has been revised to reduce confusion and provide clarification.

Description of Changes:
Notes for Abstraction
Change subsection "b" under first bullet to:
b. Tissue hypoperfusion persists in the hour after crystalloid fluid administration, evidenced by either
- systolic blood pressure (SBP) < 90, or
- mean arterial pressure < 65 or
- a decrease in systolic blood pressure by > 40 mmHg from the last previously recorded SBP considered normal for that specific patient

OR
- Lactate level is >= 4 mmol/L

Change second bullet to:
- Physician/APN/PA documentation of septic shock or suspected septic shock is acceptable.

Add in fifth bullet:
or physician/APN/PA documentation of septic shock

Impacts:
Severe Sepsis Present

Rationale: The language referring to lactate level and physician/APN/PA documentation as the preferred data source has been revised to reduce confusion and provide clarification.

Description of Changes:
Notes for Abstraction
Remove first, second, and third bullets:
- The preferred data source is physician/APNPA notes or the ED record.
- If signs and criteria below are not met but an inclusion term is documented in physician/APN/PA notes or the ED record, choose Value "1."
- If no inclusion terms are contained in physician/APN/PA documentation, review the record to determine if severe sepsis was present.

Change in fourth bullet, subsection "c" under "i" to:
i. Systolic blood pressure (SBP) < 90, or mean arterial pressure < 65, or a systolic blood pressure decrease of more than 40 mmHg from the last previously recorded SBP considered normal for that specific patient

Add new bullets:
- If criteria for severe sepsis are not met, but there is physician/APN/PA documentation of severe sepsis, choose Value "1."
- If criteria for severe sepsis are not documented and there is not physician/APN/PA documentation of severe sepsis, but there is physician/APN/PA documentation of septic shock, choose Value "1."

Impacts:
Severe Sepsis Presentation Date

Rationale: The language referring to lactate level and physician/APN/PA documentation as the preferred data source has been revised to reduce confusion and provide clarification.

Description of Changes:
Notes for Abstraction
Change third bullet:
- Physician/APN/PA documentation of severe sepsis or suspected severe sepsis is acceptable.

Remove sixth bullet:
- If the presence of severe sepsis is documented in multiple locations and the dates are at variance with one another, choose the earliest date unless one of the documentations is in a physician note; in that case, use the physician documentation date.

Add two new bullets after fifth bullet:
- If there are multiple dates documented on which the last criterion to meet the definition of severe sepsis or physician/APN/PA documentation of severe sepsis is present, and they are at variance with each other, use the earliest date.
- If criteria for severe sepsis are not documented and there is not physician/APN/PA documentation of severe sepsis, but there is physician/APN/PA documentation of septic shock, enter the earliest date septic shock was documented.

Impacts:
Severe Sepsis Presentation Time

Rationale: The language referring to lactate level and physician/APN/PA documentation as the preferred data source has been revised to reduce confusion and provide clarification.

Description of Changes:
Notes for Abstraction
Change third bullet:
- Physician/APN/PA documentation of severe sepsis or suspected severe sepsis is acceptable.

Remove sixth bullet
- If the presence of severe sepsis is documented in multiple locations and the times are at variance with one another, choose the earliest time. If one of the documented times was entered by a physician/APN/PA, use that time.

Add two new bullets:
- If there are multiple times documented when the last criterion to meet the definition of severe sepsis or physician/APN/PA documentation of severe sepsis occurred, and they are at variance with each other, use the earliest time.
- If criteria for severe sepsis are not documented and there is not physician/APN/PA documentation of severe sepsis, but there is physician/APN/PA documentation of septic shock, enter the earliest time septic shock was documented.

SECTION 2 – Measurement Information

Subsection 2.2 – Severe Sepsis and Septic Shock (SEP)

Impacts:
Sepsis Data Element Table

Rationale: For consistency with existing terminology and flow of patient care, the data element "Hypotension" should be renamed "Persistent Hypotension."

Description of Changes:
Remove row under 'Table Name' column:
Hypotension

Add row under 'Table Name' column:
Persistent Hypotension

Impacts:
Monthly Sampling

Rationale: Ranges for average monthly initial patient population size in monthly sample size table are incorrect.

Description of Changes:
Monthly Sample Size – Based on Hospital's Initial Patient Population Size for the Sepsis Measure

Change *Average Monthly Initial Patient Population Size "N"* column in table to:

Average Monthly Initial Patient Population Size "N"
≥ 101
51 - 100
10 - 50
< 10

Impacts:
SEP-1

Rationale: For consistency with existing terminology and flow of patient care, the data element "Hypotension" should be renamed "Persistent Hypotension." The numerator statement is being updated to reflect change in lactate value of >= 4.

Description of Changes:
Numerator Statement
Add between sixth and seventh bullet:
AND ONLY if hypotension persists after fluid administration or initial lactate >= 4 mmol/L, received within six hours of presentation of septic shock:

Data Elements
Remove bullet**:**
- *Hypotension*

Add new bullet:
- *Persistent Hypotension*

Impacts:
SEP-1

Rationale: For consistency with existing terminology and flow of patient care, the data element "Hypotension" should be renamed "Persistent Hypotension."

To stay consistent with NQF documentation, the Numerator's "Section F" should now include the Initial Lactate >= 4 patients.

Description of Changes:
Algorithm
Add after sixth bullet under numerator statement:
AND ONLY if hypotension persists after fluid administration or initial lactate >= 4 mmol/L, received within six hours of presentation of septic shock:

Add to Variable Key**:**
Shock Vasopressor Six Hour Counter

Add statement in initialization box below "SEP-1 H" off-page connector**:**
Initialize Shock Vasopressor Six Hour Counter

Add logic to right and below *Initial Lactate Time* decision point:
less than -360 minutes or greater than 180 minutes, if greater than or equal to -360 minutes and less than or equal to 180 minutes it goes to Add 1 to Sepsis Three Hour Counter.

Change name of *Hypotension* decision point, in all locations, to:
Persistent Hypotension

Add decision box *Initial Lactate Level Result* on the allowable value 2, 3, 4 branch of *Persistent Hypotension*. If Initial Lactate Level Result is equal to 3 then it goes to off-page connector O, if it is equal to 1 or 2 then it goes to off-page connector W.

Change counter after *Vasopressor Time* calculation to:
Add 1 to Shock Vasopressor Six Hour Counter.

Change:
Branches now go directly to the Measure Category of D from *Vasopressor Administration* when allowable value is equal to 2, *Vasopressor Administration Date* is Unable to Determine, *Vasopressor Administration Time* is Unable to Determine and Vasopressor Time is greater than 360 minutes.

Add on the last page when *Persistent Hypotension* is equal to 2:
New decision box for *Initial Lactate Level Result* where allowable values of 1 or 2 go to Measure Category Assignment of E and allowable value of 3 goes to Shock Six Hour Counter.

Add on the last page when *Persistent Hypotension* is equal to 1:
New decision box for Shock Vasopressor Six Hour Counter where allowable value of less than 1 goes to Measure Category Assignment of D and allowable value of 1 goes to Shock Six Hour Counter.

Change Shock Six Hour Counter branches on the last page to:
Allowable value equal to 1 goes to Measure Category Assignment of E and allowable value less than 1 goes to Measure Category Assignment of D

SECTION 9 – Data Transmission

Hospital Clinical Data XML File Layout

Impacts:
Hypotension

Rationale: For consistency with existing terminology and flow of patient care, the data element "Hypotension" should be renamed "Persistent Hypotension."

Description of Changes:
Detail Elements Info
Change under Question Hypotension to Persistent Hypotension

Change Suggested Data Collection to:
Was persistent hypotension present within one hour of the conclusion of crystalloid fluid administration?

APPENDICES

Appendix A – ICD-10 Code Tables

Impacts:
Table 5.11: Cardiac Surgery (Excel)

Rationale: Leading zeros were added to the Appendix A Excel file in Table 5.11. This change is to correct an error in the prior version of the manual.

Description of Changes:
Change the following codes from:

210093 Bypass Coronary Artery, One Site from Coronary Artery with Autologous Venous Tissue, Open Approach

210098 Bypass Coronary Artery, One Site from Right Internal Mammary with Autologous Venous Tissue, Open Approach

210099 Bypass Coronary Artery, One Site from Left Internal Mammary with Autologous Venous Tissue, Open Approach

211093 Bypass Coronary Artery, Two Sites from Coronary Artery with Autologous Venous Tissue, Open Approach

211098 Bypass Coronary Artery, Two Sites from Right Internal Mammary with Autologous Venous Tissue, Open Approach

211099 Bypass Coronary Artery, Two Sites from Left Internal Mammary with Autologous Venous Tissue, Open Approach

212093 Bypass Coronary Artery, Three Sites from Coronary Artery with Autologous Venous Tissue, Open Approach

212098 Bypass Coronary Artery, Three Sites from Right Internal Mammary with Autologous Venous Tissue, Open Approach

212099 Bypass Coronary Artery, Three Sites from Left Internal Mammary with Autologous Venous Tissue, Open Approach

213093 Bypass Coronary Artery, Four or More Sites from Coronary Artery with Autologous Venous Tissue, Open Approach

213098 Bypass Coronary Artery, Four or More Sites from Right Internal Mammary with Autologous Venous Tissue, Open Approach

213099 Bypass Coronary Artery, Four or More Sites from Left Internal Mammary with Autologous Venous Tissue, Open Approach

270046 Dilation of Coronary Artery, One Site, Bifurcation, with Drug-eluting Intraluminal Device, Open Approach

271046 Dilation of Coronary Artery, Two Sites, Bifurcation, with Drug-eluting Intraluminal Device, Open Approach

272046 Dilation of Coronary Artery, Three Sites, Bifurcation, with Drug-eluting Intraluminal Device, Open Approach

273046 Dilation of Coronary Artery, Four or More Sites, Bifurcation, with Drug-eluting Intraluminal Device, Open Approach

To:

0210093 Bypass Coronary Artery, One Site from Coronary Artery with Autologous Venous Tissue, Open Approach

0210098 Bypass Coronary Artery, One Site from Right Internal Mammary with Autologous Venous Tissue, Open Approach

0210099 Bypass Coronary Artery, One Site from Left Internal Mammary with Autologous Venous Tissue, Open Approach

0211093 Bypass Coronary Artery, Two Sites from Coronary Artery with Autologous Venous Tissue, Open Approach

0211098 Bypass Coronary Artery, Two Sites from Right Internal Mammary with Autologous Venous Tissue, Open Approach

0211099 Bypass Coronary Artery, Two Sites from Left Internal Mammary with Autologous Venous Tissue, Open Approach

0212093 Bypass Coronary Artery, Three Sites from Coronary Artery with Autologous Venous Tissue, Open Approach

0212098 Bypass Coronary Artery, Three Sites from Right Internal Mammary with Autologous Venous Tissue, Open Approach

0212099 Bypass Coronary Artery, Three Sites from Left Internal Mammary with Autologous Venous Tissue, Open Approach

0213093 Bypass Coronary Artery, Four or More Sites from Coronary Artery with Autologous Venous Tissue, Open Approach

0213098 Bypass Coronary Artery, Four or More Sites from Right Internal Mammary with Autologous Venous Tissue, Open Approach

0213099 Bypass Coronary Artery, Four or More Sites from Left Internal Mammary with Autologous Venous Tissue, Open Approach

0270046 Dilation of Coronary Artery, One Site, Bifurcation, with Drug-eluting Intraluminal Device, Open Approach

0271046 Dilation of Coronary Artery, Two Sites, Bifurcation, with Drug-eluting Intraluminal Device, Open Approach

0272046	Dilation of Coronary Artery, Three Sites, Bifurcation, with Drug-eluting Intraluminal Device, Open Approach
0273046	Dilation of Coronary Artery, Four or More Sites, Bifurcation, with Drug-eluting Intraluminal Device, Open Approach

Impacts:
Table 5.17: Intracranial Neurosurgery (Word and Excel)

Rationale: This change is to align with the Electronic Clinical Quality Model version of the manual.

Description of Changes:
Add:

00D10ZZ	Extraction of Cerebral Meninges, Open Approach
00D20ZZ	Extraction of Dura Mater, Open Approach
00H002Z	Insertion of Monitoring Device into Brain, Open Approach
00H003Z	Insertion of Infusion Device into Brain, Open Approach
00H602Z	Insertion of Monitoring Device into Cerebral Ventricle, Open Approach
00H603Z	Insertion of Infusion Device into Cerebral Ventricle, Open Approach
00J00ZZ	Inspection of Brain, Open Approach
00N90ZZ	Release Thalamus, Open Approach
00NA0ZZ	Release Hypothalamus, Open Approach
00P000Z	Removal of Drainage Device from Brain, Open Approach
00P002Z	Removal of Monitoring Device from Brain, Open Approach
00P003Z	Removal of Infusion Device from Brain, Open Approach
00P007Z	Removal of Autologous Tissue Substitute from Brain, Open Approach
00P00JZ	Removal of Synthetic Substitute from Brain, Open Approach
00P00KZ	Removal of Nonautologous Tissue Substitute from Brain, Open Approach
00P600Z	Removal of Drainage Device from Cerebral Ventricle, Open Approach
00P602Z	Removal of Monitoring Device from Cerebral Ventricle, Open Approach
00P603Z	Removal of Infusion Device from Cerebral Ventricle, Open Approach
00P6X2Z	Removal of Monitoring Device from Cerebral Ventricle, External Approach
00Q90ZZ	Repair Thalamus, Open Approach
00QA0ZZ	Repair Hypothalamus, Open Approach
00T70ZZ	Resection of Cerebral Hemisphere, Open Approach
00W000Z	Revision of Drainage Device in Brain, Open Approach
00W002Z	Revision of Monitoring Device in Brain, Open Approach
00W003Z	Revision of Infusion Device in Brain, Open Approach
00W007Z	Revision of Autologous Tissue Substitute in Brain, Open Approach
00W00JZ	Revision of Synthetic Substitute in Brain, Open Approach
00W00KZ	Revision of Nonautologous Tissue Substitute in Brain, Open Approach
00W00MZ	Revision of Neurostimulator Lead in Brain, Open Approach
00W600Z	Revision of Drainage Device in Cerebral Ventricle, Open Approach

00W602Z Revision of Monitoring Device in Cerebral Ventricle, Open Approach
00W603Z Revision of Infusion Device in Cerebral Ventricle, Open Approach
00W60MZ Revision of Neurostimulator Lead in Cerebral Ventricle, Open Approach
0W9100Z Drainage of Cranial Cavity with Drainage Device, Open Approach
0W910ZZ Drainage of Cranial Cavity, Open Approach
0WC10ZZ Extirpation of Matter from Cranial Cavity, Open Approach
0WH10YZ Insertion of Other Device into Cranial Cavity, Open Approach
0WJ10ZZ Inspection of Cranial Cavity, Open Approach
0WP100Z Removal of Drainage Device from Cranial Cavity, Open Approach
0WP101Z Removal of Radioactive Element from Cranial Cavity, Open Approach
0WP10JZ Removal of Synthetic Substitute from Cranial Cavity, Open Approach
0WP10YZ Removal of Other Device from Cranial Cavity, Open Approach
0WW100Z Revision of Drainage Device in Cranial Cavity, Open Approach
0WW101Z Revision of Radioactive Element in Cranial Cavity, Open Approach
0WW103Z Revision of Infusion Device in Cranial Cavity, Open Approach
0WW10JZ Revision of Synthetic Substitute in Cranial Cavity, Open Approach
0WW10YZ Revision of Other Device in Cranial Cavity, Open Approach

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Impacts:
Table 5.19: General Surgery (Word and Excel)

Rationale: This change is to align with the Electronic Clinical Quality Model version of the manual.

Description of Changes:
Add:
06L20ZZ Occlusion of Gastric Vein, Open Approach
0DB68ZZ Excision of Stomach, Via Natural or Artificial Opening Endoscopic
0DS6XZZ Reposition Stomach, External Approach
0HQ4XZZ Repair Neck Skin, External Approach
0HQ5XZZ Repair Chest Skin, External Approach
0TRB07Z Replacement of Bladder with Autologous Tissue Substitute, Open Approach

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Impacts:
Table 5.21: Urological Surgery (Word and Excel)

Rationale: This change is to align with the Electronic Clinical Quality Model version of the manual.

Description of Changes:
Add:
0TQ60ZZ Repair Right Ureter, Open Approach
0TQ67ZZ Repair Right Ureter, Via Natural or Artificial Opening

0TQ68ZZ	Repair Right Ureter, Via Natural or Artificial Opening Endoscopic
0TQ70ZZ	Repair Left Ureter, Open Approach
0TQ77ZZ	Repair Left Ureter, Via Natural or Artificial Opening
0TQ78ZZ	Repair Left Ureter, Via Natural or Artificial Opening Endoscopic
0TTD0ZZ	Resection of Urethra, Open Approach
0TTD7ZZ	Resection of Urethra, Via Natural or Artificial Opening
0TTD8ZZ	Resection of Urethra, Via Natural or Artificial Opening Endoscopic
0VT07ZZ	Resection of Prostate, Via Natural or Artificial Opening
0VT08ZZ	Resection of Prostate, Via Natural or Artificial Opening Endoscopic
0VT30ZZ	Resection of Bilateral Seminal Vesicles, Open Approach
0WQF0ZZ	Repair Abdominal Wall, Open Approach
0WQFXZ2	Repair Abdominal Wall, Stoma, External Approach
0WQFXZZ	Repair Abdominal Wall, External Approach

Impacts:
Table 7.01: Mental Disorders (Word and Excel)

Rationale: This change is being made to align the table 7.01 in the IQR manual with 7.01 in the OQR manual.

Description of Changes:
Change table to remove and add codes. Refer to Appendix A for table updates.

Impacts:
Table 7.02: Obstetrics (Word and Excel)

Rationale: Duplicate codes are not allowed in individual code tables. This change is to remove duplicate codes in Table 7.02.

Description of Changes:
Change table to remove duplicate codes. Refer to Appendix A for updated table.

Impacts:
Table 7.03: Venous Thromboembolism (VTE) (Word and Excel)

Rationale: This change is to align with the Electronic Clinical Quality Model version of the manual.

Description of Changes:
Remove:
I26.01 Septic pulmonary embolism with acute cor pulmonale
I26.90 Septic pulmonary embolism without acute cor pulmonale

Add:
I82.220 Acute embolism and thrombosis of inferior vena cava

Impacts:
Table 7.04: Obstetrics - VTE (Word and Excel)

Rationale: This change is to align with the Electronic Clinical Quality Model version of the manual.

Description of Changes:
Remove:
O87.0 Superficial thrombophlebitis in the puerperium
O87.3 Cerebral venous thrombosis in the puerperium