## Questions and Answers – Expert to Expert Webinar Annual Updates STK and VTE eCQMs for 2026 RY

*Broadcast March 5, 2026*

| Category/Theme | Question | Answer |
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| Benchmarks | Where is the eCQM national benchmark data located? | Hospital datasets containing national averages for eCQMs are located at https://data.cms.gov/. You can select 'Explore Data' to review the specific datasets you are interested in. |
| Benchmarks | Is it better to report self-selected measures that are higher than the national average or >95%. For example, STK-2 national average is 95.9% and EH score is 95% verse STK-3 national average 73.3% and EH score is 90%. Is it better to report STK-3 at 90%? | In the context of quality reporting, benchmarking against national averages allows stakeholders to see if their hospital performs lower, better than, or no different than the average peer. Scores below the national average might be interpreted as no different than, whereas scores above the national average are a strong indicator of high quality and improvement compared to peers. Each individual organization should determine which self-selected measures to report. |
| Comfort Measures | A patient was admitted on 11/12/2025 with a POLST form stating DNR/DNI and comfort measures only. The comfort care measures was ordered on 11/12/2025. However, on 11/13, the patient's family decided to keep DNR/DNI, but overturn and continue full treatment. Code status updated from comfort care to DNR/DNI with full treatment noted in the discharge summary on 11/21/2025. Question - does this patient case meet the exclusion criteria "Inpatient hospitalizations for patients who have comfort care measures ordered or provided during the encounter."? | Yes, an order for Comfort Measures Only is acceptable to meet the exclusion criteria. Each measure does have its own timing criteria for when Comfort Measures Only should be documented. For STK-5, VTE-1 and VTE-2 documentation that occurs on the day of or after arrival meets the exclusion criteria. For STK-2 and STK-3 Comfort Measures Only documented any time during the encounter meets exclusion criteria. |
| Comfort measures | Will the case meet criteria for exclusion from STK 2 (CMO) Comfort Measure Only if CMO is documented any day during the encounter or does it need to be documented on day 1 or 2? | Inpatient hospitalizations for patients with comfort measures documented at any time during the encounter will meet denominator exclusion criteria for STK-2. |
| Comfort Measures | We have implemented the order for comfort care measure for exclusions, but CMS/TISTA during chart validation is not considering the order for Comfort Care Measure. Requesting additional guidance and context in which the comfort care order is used. Lot of the patients with Full Code are also ordered comfort care. Thank you. | An order for comfort measures is acceptable for both STK and VTE eCQMS and is captured by ["Intervention, Order": "Comfort Measures"] in the measure logic. Each measure will have its own timing criteria of when it is authored to be accepted for that exclusion criteria. Please refer to the specific measure specification logic and work with your Electronic Health Record (EHR) vendor to ensure the proper criteria is implemented. |

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| Palliative Care | Does an order for palliative care count? | No, palliative care is not an inclusion term accepted for Comfort Measures Only. Palliative care may involve any stage of a serious illness including curative treatment and is not limited to end of life care. |
| Medications - Heparin | For STK-5, SQ heparin for VTE prophylaxis was previously captured in the numerator in our system for reporting year 2025. Is SQ heparin for prophylaxis considered acceptable for the numerator in the 2026 specifications? | No, subcutaneous heparin for VTE Prophylaxis is not acceptable for STK-5. The measure rationale states, "Anticoagulants at doses to prevent VTE are insufficient antithrombotic therapy to prevent recurrent ischemic stroke or TIA".<br>The exclusion criteria of the value set for Antithrombotic Therapy for Ischemic Stroke states "Excludes concepts that represent enoxaparin and heparin generally given for VTE prophylaxis". |
| Medications - Apixaban | For VTE-1, if a patient is currently taking Eliquis at home, prior to the encounter, without a history of A-fib, A-flutter, or hip/knee surgery and a physician orders Eliquis for DVT prophylaxis is this acceptable to pass the measure? | No. For VTE-1, apixaban (Eliquis) meets VTE Prophylaxis for patients who were administered this medication during the qualifying time frame AND with a history of atrial fibrillation, a diagnosis of atrial fibrillation, history of VTE, or an encounter with prior or present procedure of hip or knee replacement surgery. |
| Medications - Aspirin | STK-5 - is 48 hours within 2 calendar days? For example if patient arrives at 23:50 on March 1, would the Aspirin have to be administered by March 2 23:59 or March 3 23:49? | STK-5 is time-sensitive and antithrombotic therapy administered must be documented the day of, or day after, hospital arrival. In your example, the Aspirin medication should be administered by end of day on March 2. |
| Medications - Aspirin | I believe AHA's Get with the Guideline's does not count Aspirin on discharge to meet the d/c on Antithrombotic therapy. Does CMS count ASA on d/c to meet this measure? | For the discharge measures, STK-2 Discharged on Antithrombotic Therapy, Aspirin does qualify while for STK-3 Anticoagulation therapy for Atrial fibrillation/flutter, Aspirin does not qualify. For detailed information about the acceptable medications included in the value set, please visit the Value Set Authority Center at https://vsac.nlm.nih.gov/. For STK-2 and STK-5 measures, refer to value set Antithrombotic Therapy for Ischemic Stroke (OID: 2.16.840.1.113762.1.4.1110.62), and for STK-3, refer to the value set Anticoagulant Therapy (OID: 2.16.840.1.113883.3.117.1.7.1.200). |
| Medications - Tenecteplase | STK5: Why is Tenecteplase 25mg vial not included in the as thrombolytic therapy during hospitalization. This is the recommended dose for ischemic stroke patients? The 25mg vial was introduced specifically to improve patient safety by reducing dosing errors associated with larger volume vials. | Tenecteplase 25mg was not an available medication RXNORM term type during the last annual update. We have reviewed the code with our subject matter experts and plan to add this code to the value set during our next annual update process. |

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| Medications - Tenecteplase | Regarding the Tenecteplase 25 mg vial, if it was used in 2026 - will this be a fallout as the rxnorm will not be added until the next annual update (2027?) | Tenecteplase 25mg was not an available medication RXNORM term type during the last annual update and therefore will not qualify for the numerator. We have reviewed the code with our subject matter experts and plan to add this code to the value set during our next annual update process. |
| Medications - Clopidogrel | What about a patient on clopidogrel that does have AFIB? My quality measures continue to say incomplete for VTE with these patients. | Clopidorgel is commonly prescribed as long-term antithrombotic therapy for ischemic stroke patients without atrial fibrillation, (i.e., noncardioembolic source). Anticoagulation therapy is recommended for ischemic stroke patients with atrial fibrillation rather than antiplatelets, such as, clopidogrel. Clopidogrel is also used for secondary prevention after a heart attack or unstable angina. Indications do not include VTE prophylaxis. |
| Atrial Fibrillation | Could you clarify the STK-3 measure regarding a history of atrial fibrillation (Afib) that was treated in the past but is not mentioned during the current encounter? If Afib was documented years ago from another facility or the same facility, does it still count for STK-3, or must Afib be documented during the present encounter only? | The denominator includes current or history of atrial fibrillation (AFIB). Documentation of a diagnosis of AFIB in the medical record will still count for STK-3 even if the documentation is from a previous encounter. |
| Hemorrhagic Stroke Code | Can a secondary code of hemorrhagic STK (primary code ischemic STK) exclude/be an autocontraindication to anticoagulation medications? | A principal diagnosis of ischemic stroke is required for a case to be included in the initial population. Patients with a principal diagnosis of hemorrhagic stroke are not included in the initial population. Please visit the Value Set Authority Center (VSAC) at https://vsac.nlm.nih.gov/ to review the diagnosis codes included in the value set "Ischemic Stroke" (OID 2.16.840.1.113883.3.117.1.7.1.247) that meet the initial population. Patients with a secondary diagnosis of hemorrhagic stroke will be excluded from the STK eCQMs, unless a principal diagnosis of ischemic stroke was assigned at discharge. If the principal diagnosis is ischemic stroke and the hemorrhage is recent, a documented medical reason for not prescribing anticoagulation therapy at discharge could qualify for the case for denominator exception criteria. |
| Value Sets | How do I access the value set? | The human readable file (HTML) provides a list of value sets under the Terminology section of the HTML that includes value set names and object identifiers (OIDs). For detailed information about value sets and to access specific codes for each OID, please go to the Value Set Authority Center (VSAC) website (https://vsac.nlm.nih.gov/welcome) and by search by value set name or OID. |

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| Value Sets | Is history of DVT not included in CMS190v12 value set 2.16.840.1.113883.3.117.1.7.1.279? If not why? | In CMS190v12, ICD-10CM and SNOMED-CT diagnosis codes are included in the Venous Thromboembolism value set (2.16.840.1.113883.3.117.1.7.1.279). Personal history codes, such as Z codes (i.e., Z86.718, Z79.01), are situational status codes that are not diagnostic codes and therefore not included. |
| Brand Name Medications | The Value Sets only have generic RxNorms. Can brand names be used? Our cases are dropping out of the measure if our providers prescribe Eliquis instead of Apixaban | The medication value sets contain Semantic Clinical Drugs (SCD) RxNorm codes that are generic, and prescribable. SCD RxNorm codes are generalizable drug concepts, providing information about ingredient, strength, and dose form. Brand name medication codes can be mapped to the SCD RxNorm codes found in the value set. Please consult with your EHR vendor and clinical partners for more information about mapping. If mapping is conducted, you should maintain documentation in case of a CMS audit. |
| Patient Inclusion | Can a patient be in both for VTE-1 and VTE-2 measures? | Yes, a patient could be in both VTE-1 and VTE-2 depending on when admission to the hospital and transfer to the Intensive Care Unit (ICU) happens. Only patient's admitted to the hospital and transferred to the ICU on the day of or the day after the hospital admission and with VTE prophylaxis given during those 2 days will be in both measures. |
| Length of Stay (LOS) | Does the encounter LOS for VTE-2 count the entire hospital duration or the inpatient LOS? | For VTE-2 Denominator Exclusion, the measure checks the hospital length of stay (LOS) for the entire inpatient encounter less than 2 days.<br>For VTE-2 Denominator Exception, the measure evaluates whether the intensive care unit LOS less than 1 day. |
| ICU Location vs. ICU Order | For VTE-2, is the measure identifying patients based on their physical location in the ICU, or based on an order indicating an ICU level of care (LOC)? We have noticed that some patients had an ICU LOC order but were never physically transferred to the ICU, yet they were still captured in the VTE-2 population. | For VTE-2, the measure is looking for the patient who directly admits to the Intensive Care Unit (ICU) or is transferred to ICU, based on the patient's physical location. |

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| Assessment Tool | Similar to the Caprini VTE Risk Assessment, would the VTE Advisor function the same way? | This measure does not require the use of a specific risk assessment model or tool (e.g., Caprini, Padua, and IMPROVE) to determine VTE risk. Using the Caprini Risk Score Assessment does not count as a documented "Reason for No VTE Prophylaxis." Checking these boxes on the scoring tool adds 1 to 3 points to the total Caprini Score and indicates that the patient is at risk for developing VTE. Such patients should receive VTE prophylaxis on the day of or day after admission or surgery end date, unless there is a reason for no pharmacological AND a reason for no mechanical prophylaxis documented within the same time frame. |
| Mental Disorders | For VTE, please elaborate why patients with a mental health diagnosis are excluded? | Patients with a principal diagnosis code for mental health are usually ambulatory and therefore low risk for developing VTE. If the patient with a mental health principal diagnosis is transferred to the intensive care unit, then they will be captured in VTE-2. |
| Documentation | Does nursing documentation of patient refusal throughout the hospital stay qualify as a denominator exclusion for VTE measures, or is provider documentation also required? | Nursing documentation in the measurement timeframe may be used for patient refusal. This is an exception since all other reasons must be documented by the physician/APN/PA or pharmacist. |
| Documentation | Where should providers document a contraindication to antithrombotic therapy for STK-2 and STK-5 so that it is appropriately captured? Additionally, if the contraindication for STK-2 or STK-3 is documented only in the discharge summary and cannot be submitted electronically as an eCQM, but can be manually abstracted, does it still count as a valid exclusion? | For eCQMs, documentation should be in a structured field so the qualifying data elements can be pulled into the Quality Reporting Document Architecture (QRDA) file. Consult with your EHR vendor and clinical partners to understand which structured fields are captured for these measures. |
| Timing | If a patient has a Watchman in place, how do you document the need for AC/AP for stroke. The majority of patients do not get placed on AC/AP as they are past the initial time frame where it is needed. Thanks | If anticoagulation therapy is not indicated, then it would need to be documented as a medical reason to meet the denominator exception criteria. |
| Timing | STK-5 Reason for no Antithrombotic Therapy- often this documentation is present in the record during the encounter but not documented by end of hospital day 2. Is there any thought to expanding the reason for no antithrombotic therapy documentation to expand to the entire encounter when the physician specifically states, "Reason for not administering antithrombotic therapy by end of day 2" with radial button selected for "Medical reason"? | STK-5 is time-sensitive and must be documented the day of, or day after, hospital arrival. There are no plans to expand the timeframe, as it is taken directly from clinical practice guideline recommendations for early antithrombotic administration. The clinical practice guidelines are included in the list of references in the header of the measure. |