Hospital Outpatient Quality Reporting Program

Support Contractor

Hospital Outpatient Quality Reporting (OQR) Program
2017 Specifications Manual Update

Questions and Answers

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Question: When do you anticipate these release notes being posted to QualityNet?

Answer: The release notes for version 10.0 are currently available on the QualityNet website. The updated version of 10.0, which will be 10.0a, will be posted along with the corresponding Release Notes on or before January 1st, 2017.

Question: Where can we find the list of patients used in the claims-based data for OP-11? Our medical staff wants to be able to identify physicians that need to be educated on this measure.

Answer: Please note that patient-level claims data for the OIE measures are only provided to facilities during a one-time dry run reporting period that occurs before the first year that the measures are publicly reported on Hospital Compare. Once public reporting for OIE measures has begun, only facility-level data are made available during the preview period. The dry run for OIE measures OP-8, -9, -10, and -11 reported patient-level claims data from calendar year 2007 and was released to facilities'

QualityNet in-boxes in February 2010. The dry run for OIE measures OP-13 and -14 reported claims from calendar year 2009 and was released to facilities in April 2011. These dry run reports can be accessed by facilities through their QualityNet inboxes. If you are not familiar with how to access your inbox, please contact the QualityNet Help Desk.

Question: Where can we get the drill-down of cases that populated our OIE numerator and denominator that were posted on Hospital Compare?

Answer: Please note that patient-level claims data for the OIE measures are only provided to facilities during a one-time dry run reporting period that occurs before the first year that the measures are publicly reported on Hospital Compare. Once public reporting for OIE measures has begun, only facility-level data are made available during the preview period. The dry run for OIE measures OP-8, -9, -10, and -11 reported patient-level claims data from calendar year 2007 and was released to facilities' QualityNet in-boxes in February 2010. The dry run for OIE measures OP-13 and -14 reported claims from calendar year 2009 and was released to facilities in April 2011. These dry run reports can be accessed by facilities through their QualityNet inboxes. If you are not familiar with how to access your inbox, please contact the QualityNet Help Desk.

Question: Are the measure stewards considering an update for OP-33 since separate sites cannot be entered into vendor tools with the same billing ID?

Answer: The measure writer is aware of this and will continue to incorporate OQR community feedback as they consider revisions to this measure.

Question: Our facility would like a list of cases for OP-13. Is this available, and if so, how can it be accessed?

Answer: Please note that patient-level claims data for the OIE measures are only provided to facilities during a one-time dry run reporting period that occurs before the first year that the measures are publicly reported on Hospital Compare. Once public reporting for OIE measures has begun, only facility-level data are made available during the preview period. The dry run for OIE measures OP-8, -9, -10, and -11 reported patient-level claims data from calendar year 2007 and was released to facilities' QualityNet in-boxes in February 2010. The dry run for OIE measures OP-13 and -14 reported claims from calendar year 2009 and was released to facilities in April 2011. These dry run reports can be accessed by facilities through their QualityNet inboxes. If you are not familiar with how to access your inbox, please contact the QualityNet Help Desk.

Question: If the *Last Known Well* is not documented as unknown, and the physician documents: "Patient awoke with stroke," what is the correct response?

Answer: If there is documentation that the patient woke up with symptoms at a specific time, and it is unclear at what time the patient was *Last Known Well*, you should abstract "No" for *Last Known Well* because the time the patient awoke does not indicate the time of symptom onset, as the symptoms may have begun while the patient was asleep.

Question: For OP-20, if the *Provider Contact Date* is documented outside the patient visit time (provider did not backdate the date that crossed midnight) – if it is a clear error based on review of the chart, do we enter the date as UTD, or can we utilize the correct date that falls within the visit times?

Answer: If the *Provider Contact Date* was obviously documented in error and there is substantiating evidence in the ED record that a different date is the time of the first, direct contact between the patient and the physician/APN/PA or institutionally credentialed provider that meets the Inclusion Guidelines for Abstraction, then you may abstract that date.

Question: For OP-30, if a physician only mentions a history of colon cancer found three years ago, does this count as a past last colonoscopy? Or if in another patient situation, does it count as a colonoscopy that the physician documents: "Colon cancer dx last year and high risk is reason for earlier colonoscopy today"?

Answer: No, the documentation does not indicate that a colonoscopy was performed. The second part of your question does not appear to indicate that a colonoscopy was performed either.

Question: Is OP-31 (Cataracts) still voluntary in 2017?

Answer: Yes. OP 31, Cataracts – Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery, continues to be voluntary for the 2017 reporting year.

Question: Is OP-32 a claims-based measure?

Answer: Yes, CMS uses paid claims to calculate OP-32.

Question: If a provider states a specific time of *Last Known Well* and that's different than the Stroke Code Flow record, does that also take precedence (as in the "unknown/uncertain/unclear" change)?

Answer: If there is a specific time documented by a physician and a specific time listed on a Code Stroke Form, the time on the Code Stroke Form will take precedence. Please refer to the release notes for version 10.0 for more detailed guidance on the interpretation of unknown/uncertain/unclear symptom onset or *Time Last Known Well*.

Question: Can you explain, under EKG OP-5, why you would accept an EKG performed in the ED that wasn't specified as a 12-lead?

Answer: Based on feedback from clinical experts, it is standard practice for emergency departments to administer 12-lead ECGs for suspected AMI.

Question: For OP-23, if documentation notes: "Woke up normal at 7 a.m. and symptoms started at 8 a.m.," which time would be used for *Last Known Well?*

Answer: If both the time *Last Known Well* and symptom onset time are documented, the time *Last Known Well* will take precedence because it is the earliest documented time that the patient was known to be without signs or symptoms of the current stroke. You may abstract 0700 since it is the time at which the patient was known to be without the signs and symptoms of stroke.

Question: Please clarify – for OP-30, is the dx code Z85.038 (Personal history of malignant neoplasm of large intestine) being removed from the denominator criteria? Or is this a typo and dx code Z86.010 (personal history of colonic polyps) is being removed from the denominator criteria?

Answer: It is the diagnosis code Z85.038 (Personal history of malignant neoplasm of large intestine) that is being removed from the denominator criteria. The slide is indicating the section of the denominator criteria in which the code is being removed.

Question: If there is documentation of a *Last Known Well*, but there is also physician documentation that patient awoke with stroke symptoms, should we abstract the time *Last Known Well*, or answer No to *Last Known Well*?

Answer: It depends on the specific documentation. For example, if there is documentation that the patient was last known well last night at 22:00, and also documentation that the patient awoke at 09:00 today with symptoms, you would abstract Yes for *Last Known Well* and 22:00 for *Time Last Known Well*. However, if there is no specific time documented (e.g., "Patient last known well last night; awoke at 09:00 with symptoms," you would abstract No for *Last Known Well*. The medical record should be taken at face value, so do not make any inferences if there is no supporting documentation.

Question: For OP-33, is the patient excluded from the measure if he has had SRS or SBRT to another anatomical area separate from the area being treated with EBRT?

Answer: No, each site is viewed independent of any others. So in this case, the site being treated with the EBRT would be included, as long as this was the first radiation treatment to that site.

Question: We use a Rapid Triage in our electronic medical record that the nurse fills out with the *Last Known Well* date and time. Can we still use that as our stroke code time?

Answer: If the Rapid Triage section is considered to be part of the nurse's documentation, then follow the hierarchy listed in the Specifications Manual (Code Stroke Form, physicians, and then other providers). If, however, the Rapid Triage is a separate, electronic-based form, then you may consider it to be a Code Stroke Form.

Question: For OP-33, if the patient's radiation starts while they are an inpatient, should they be included in the measure?

Answer: Yes, as long as any part of the treatment occurred as an outpatient, you may include them in the population.

Question: If a colonoscopy interval of less than three years can be determined from a prior colonoscopy report and a physician documents a medical reason for performing a colonoscopy (i.e., rectal bleeding) that could exclude the case but the physician does not reference the interval, is this still acceptable for denominator exclusion purposes?

Answer: If the interval can be determined as less than three years, it would be acceptable to exclude the case based on a medical reason. The interval does not have to be documented by the physician if the interval can be determined.

Question: In the Final Rule, CMS finalized that only a 90-day period would be required for submission of electronic measures and objectives in 2016 and 2017. Can you confirm that this does not include eCQM reporting, which is required for 12 full months in 2017?

Answer: We are unable to answer questions as they relate to Inpatient Reporting. You may submit your question into the Question and Answer tool on QualityNet or call their Help Desk directly at 844.472.4477.

Question: Is there a time frame associated in the following statement in the *Pain Medication* element?

Answer: Though there does not need to be documentation of the exact time the medication was administered, you should abstract based on the pain medication administered in the ED unless there is clear evidence that the home medication was received within 24 hours of ED arrival. For

example, if arrival is at 22:00 and there is documentation stating: “Patient received medication this morning,” you can infer that it was administered within 24 hours.