Hospital Outpatient Quality Reporting Program

Support Contractor

OQR 2016 Specifications Manual Update

Questions & Answers

Moderator:
Pam Harris, BSN

Speakers:
Nina Rose, MA
Samantha Berns, MSPH
Bob Dickerson, HSHSA, RRT
Angela Merrill, PhD
Colleen McKiernan, MSPH, CPH

January 20, 2016
10 a.m.

Question: On slide 32, is this for patients that are placed in observation in the ED or for patients that are placed in observation outside of the ED?

Answer: Thank you for your inquiry regarding the *ED Departure Time* data element. Version 9.0a of the Specifications Manual indicates that the intention of *ED Departure Time* is to capture the latest time at which the patient was receiving care in the emergency department, under the care of emergency department services, or awaiting transport to service/care. The Specifications Manual states for patients who are placed into observation services, use the time of the physician/APN/PA order for observation for *ED Departure Time*. Based on the information provided, if the patient was placed into observation services from the ED, then you may abstract the time of the physician/APN/PA order for observation for *ED Departure Time*.

Question: If the ED MD does not enter an order for observation but his disposition note says, "Admit for observation," is that time acceptable?

Answer: Version 9.0a of the Specifications Manual indicates that the intention of *ED Departure Time* is to capture the latest time at which the patient was receiving care in the emergency department, under the care of emergency department services, or awaiting transport to service/care. The Specifications Manual states for patients who are placed into observation services, use the time of the physician/APN/PA order for observation for *ED Departure Time*. Based on the information provided, if the patient was placed into observation services from the ED, then you may abstract the time of the physician/APN/PA order for observation for *ED Departure Time*. However, if the patient was not placed into observation services,

then you should abstract the time the patient physically departed from the ED.

Question: Does Version 9.0 cover January 1, 2016, or 3Q15?

Answer: Specifications Manual version 9.0a covers January 1 through June 30, 2016 only.

Question: Will an ED note with the time stamp "Encounter date and time" for MD count for provider first contact?

Answer: Version 9.0a of the Specifications Manual indicates that the *Provider Contact Date/Time* intends to capture the earliest exact date/time at which the patient had direct contact with the physician/APN/PA or institutionally credentialed provider to initiate the medical screening examination in the emergency department. Based on the information provided, if the ED note with the time stamp "Encounter date and time" is an automatically generated time stamp for provider assignment, that would not be an acceptable source for the *Provider Contact Time* data element unless it is clear that direct contact between the patient and provider occurred at this time, and that this was the first time of contact between the patient and provider. Please also keep in mind that writing a note or an order does not necessarily mean that there was direct contact between the patient and provider at that date/time, so any documentation of *Provider Contact Date/Time* must include clear evidence of direct, face-to-face contact between the patient and the provider at that date/time.

Question: Can you please clarify slide 25, "*Aspirin Received*: Aspirin should be administered in the ED prior to transfer"? Does "prior to transfer" refer to transfer from the ED to another acute care facility **and** also transfer from the ED to observation status within the same facility? So, if aspirin was ordered in the ED but the patient was transferred to observation status prior to aspirin given, we would abstract "No" to *Aspirin Received*, even if the patient received aspirin in the observation unit prior to transfer to another acute care facility, correct?

Answer: The Specifications Manual indicates that the suggested data sources for this data element are the ambulance record and the emergency department records. Thus, you should not use the observation record to abstract for this data element in this case. Based on the information you provided, you should abstract "No" for this data element because aspirin was not received in the emergency department.

Question: Are OP-32 and -33 claims-based or web-based measures?

Answer: OP-32 is a claims-based measure. OP-33 is a chart-abstracted measure answered via the web-based submission tool.

Question: For specifications for OP-26 on QualityNet, it is not listed that cases with modifier 50 should be counted twice. Is this a criteria for 2015 OP-26 data submission?

Answer: Yes, you are calculating the total number of procedures performed; if a modifier is making a note of a double procedure, then the code should be counted twice.

Question: For OP-23, can we use the date/time the CT was completed, or do we need to use the interpretation date/time?

Answer: The manual notes that if there is any documentation in the ED record indicating when the physician first read (i.e., interpreted) the scan, you may use that documentation to abstract this data element. You may abstract the completed time on the MRI or CT report for this data element if this time reflects the MD interpretation time and is known to be an accurate representation of when the scan interpretation occurred.

Question: On slide 25, what is the change? Must ASA be given in the ED, or can it be within 24 hours prior?

Answer: The allowable values for this data element indicate that you can select a "Yes" for this data element if aspirin was received within 24 hours before emergency department arrival or administered prior to transfer.

Question: Is OP-31 still a voluntary measure?

Answer: Yes, OP-31 is still a voluntary measure.

Question: When I look at QualityNet, the reporting period for the structural (web-based) measures is January–December 2015, to be reported by February 1. Did I misread this?

Answer: The data submission for all web-based measures is due by May 15, 2016. The deadline of February 1, 2016 is for the core measures for Q3 2015 (AMI, CP, Pain Management, Stroke, ED-Throughput).

Question: For the data submission period beginning January 1, 2016, for web-based measures, which manual version should be used for the OP-26 measure?

Answer: Please utilize Specifications Manual 8.1.

Question: What is the full time frame for submitting our web-based measures – 1/1/16 to when?

Answer: The data submission time frame for all web-based measures is January 1, 2016–May 15, 2016.

Question: What is the significance of the data variation statement?

Answer: In general, the guidance for chart-abstracted measures is to interpret the medical record at "face value." However, we recognize that facilities may vary in the way they document or interpret records (e.g., inconsistencies in chart abstraction or assignment of ICD-10 codes).

Question: For OP 29, do we only submit patients ages 50-75?

Answer: Effective with 1/1/2016 encounters, your initial patient population for OP-29 should be limited to patients aged ≥ 50 years and ≤ 75 years.

Question: For OP-30, is monitoring for colonoscopies every 3 years - is it by calendar year or exact dates? (I have some that are days short of 3 years.)

Answer: Determining the previous colonoscopy interval is based on the information available. If only the year of the previous colonoscopy is available, you determine the interval based on that. If the exact date of the previous colonoscopy is available, you base the interval on that.

Question: Is OP-33 voluntary?

Answer: No, OP-33 is a required web-based measure.

Question: Is OP-33 a claims-based measure?

Answer: No, OP-33 is a web-based, chart-abstracted measure.

Question: For the submission period January 1 through May 15, 2016, for outpatient web-based measures, are we using Specs Manual 8.1 or 9.0a for the list of procedures?

Answer: You will utilize Specifications Manual v.8.1 for data submission.

Question: Will the questions and answers be documented and made available for future reference?

Answer: A transcript of the presentation and all of the questions entered into the chat box will be posted to www.qualityreportingcenter.com and www.qualitynet.org.

Question: For the OP-13 imaging measure, we often perform diagnostic imaging studies and bronchoscopies as part of a several-day outpatient evaluation. The imaging study is unrelated to the bronchoscopy. Is there any way to add a comment about our apparent high use of CT for a low risk procedure?

Answer: Because OP-13 relies on claims data, there is no way to provide comments or feedback on performance scores for this measure. Consequently, we expect to see some variation in facility performance for imaging procedures that are appropriately performed but fall into the measure because this context/rationale cannot be provided.

Question: Is OP-23 a claims based measure?

Answer: No, it's a chart-abstracted measure.

Question: I was unable to attend most of the meeting. How do I find out more about the OP-33 measure?

Answer: The Specifications Manual has the information on this measure and is posted on QualityNet. There are updates to this measure being conducted. These updates will be communicated via ListServe as soon as they are available.

Question: When do we need to start abstracting OP-33?

Answer: The encounter period for OP-33 began on January 1, 2016, and will continue until December 31, 2016. Data submission for that encounter period will be from January 1, 2017–May 15, 2017.

Question: Is OP-31 now required for 2016?

Answer: OP-31 continues to be a voluntary measure.

Question: My understanding is that the indicators are CPT codes or professional fees and not outpatient hospital fees. The codes for this measure [OP-33] are the professional component and can only be billed by the practitioner on their 1500 claim. Therefore, the hospital charge description master (CDM) does not bill for this service, and thus these codes are not on the administrative data that is available through the hospital's billing data. Is this something CMS is reviewing, and will it be addressed?

Answer: CMS and the measure writers are currently reviewing the concerns brought forward. The changes that occur as a result will be communicated via ListServe notification.

Question: What table will be used for OP-26 for CY 2016 for the 2017 submission?

Answer: You will be utilizing Specifications Manual 9.1; however, this manual will not be updated with the codes until the end of CY 2016.

Question: Our vendor does not have any information on OP-33. How are we to collect this data?

Answer: The Specifications Manual is your resource for all measure information. OP-33 was added to version 9.0a. CMS and the measure writers are currently reviewing the concerns brought forward regarding this measure. The changes that occur as a result of this review will be communicated via ListServe notification.

Question: Is OP-33 a voluntary measure, or do we have to submit data for this measure if we are not a CAH?

Answer: No, OP-33 is not a voluntary measure. It is a required measure for the Hospital OQR Program and will be submitted via the QualityNet Secure Portal.

Question: Regarding the OP-30 measure, if there is not a previous colonoscopy available, we are unable to find it, and we do not have the date of the prior colonoscopy, how is the question of "interval of 3 or more years since last colonoscopy" to be answered: "Yes" or "No"?

Answer: You will need to answer "No." Because there is no documentation supporting it was three or more years, selecting "Yes" is not appropriate.

Question: If we have no patients that qualify for OP-33, do we do anything in QualityNet?

Answer: Facilities that do not perform EBRT should report "zero" in the numerator and denominator

Question: Is OP-32 voluntary?

Answer: OP-32 is not voluntary; it is a claims-based measure. Therefore, data is automatically abstracted from submitted claims.

Question: On slide 24 there was information added verbally which was not clear. Could that be repeated?

Answer: A plus sign was removed from the list of inclusion guidelines for abstraction.

Question: For OP-30, does it mean that the date or year of last colonoscopy has to be documented in order to use the System Reason as denominator exclusion? But if a previous colonoscopy report is not available or cannot be located and that is documented well, can a doctor document "unable to determine last colonoscopy; unable to locate prior colonoscopy report"?

Answer: Yes, the interval since the last colonoscopy must be known to use a system reason. While ideal, determining the interval does not require documentation of the exact date of the previous colonoscopy. It can be determined based on the year or documentation of when the patient reports they had their last colonoscopy.

Question: For OP-33, when will the manual be updated, or where can we find the codes/information that will need to be submitted to QualityNet?

Answer: The Specifications Manual is your resource for all measure information. OP-33 was added to version 9.0a. CMS and the measure writers are currently reviewing the concerns brought forward. The changes that occur as a result of this review will be communicated via ListServe notification.

Question: When will we be able to abstract outpatient data into CART for the 4th quarter?

Answer: CMS will provide updates as they are available. It is advisable that you have your CART paper tools available if needed.

Question: Can you please explain OP-17?

Answer: OP-17 seeks to answer the extent a provider uses an Office of the National Coordinator for Health Information Technology (ONC) certified electronic health record (EHR) system to track pending laboratory tests, diagnostic studies, or patient referrals. The measure establishes if your facility has the ability to which you will answer "Yes" or "No," and did your facility use this ability during the performance period, to which you will answer "Yes" or "No."

Question: If a hospital cannot locate their Medicare Claims Detail Report needed for the Quarter 3 OQR submission, who would they contact?

Answer: This report is updated monthly. You can run this report on the secure side of QualityNet. If you need detailed instructions on how to run this report and interpret it, you may wish to view the short tutorial video available on our website using this link;
http://www.qualityreportingcenter.com/hospitaloqr/tools/

Question: If Median Time to Fibrinolysis was dropped for Inpatient, why was it not also dropped for Outpatient?

Answer: We cannot speak to the Inpatient Quality Reporting Program. However, at this time CMS has no plans to drop OP-2 from the OQR Program.

Question: In regards to *Initial ECG Interpretation*, "any inclusion terms qualified by the term 'potential' and 'possible' should be disregarded." Would you please address the qualifier "probable"? Should this be disregarded also?

Answer: Thank you for your inquiry regarding the *Initial ECG Interpretation* data element. As Version 8.1 of the Specifications Manual does not provide specific guidance on the modifier "probable," please use the following guidance: "Disregard any description of an MI or ST-segment that is not on either the Inclusion list or the Exclusion list." You should then abstract based on the remainder of the patient record. Please note that CMS contractors do not have access to the full patient record and thus can only provide general guidance in the interpretation of the specifications. Please use your best judgement in each case to determine how best to abstract the *Initial ECG Interpretation* data element.

Question: The OP-33 measure lists CPT codes 77261, 77262, and 77263 as part of the initial patient population. However, these CPT codes are not recognized by Medicare (not paid under OPPS) and as such are not always

included on patient billing data. How are we to identify the patients if the CPT codes used in the IPP are not billed?

Answer: CMS and the measures writers are currently reviewing the concerns brought forward. Any changes that occur as a result will be communicated via ListServe notification.

Question: Are the changes for OP-29 & OP-30 for cases in CY 2015?

Answer: The changes are effective for encounters starting January 1, 2016.

Question: On slide 31, regarding the list of only acceptable sources, do Nursing Flowsheets that are documented by ED nurses and describe care given in the ED still considered for *Arrival Time*? They are part of the ED legal record and are often seen as the earliest times descriptive of care to the patient.

Answer: Yes. *Arrival Time* is the earliest documented time the patient arrived at the outpatient or ED.

Question: I am using VF-8R for OP-31 to obtain the V-8 score. Should I include the "No" and "N/A" checked boxes, or should I count only the "Yes" boxes?

Answer: You should score "No" and "Yes" boxes according to the instructions for administering the survey. Responses of "No" correspond to a certain point. Each "Yes" option within a question has a different point. You should include scores on all activities that the person performed or did not perform because of vision. If a question is answered "N/A," it is not included in the scoring; it implies that the person does not do the activity for some reason other than their vision.

Question: Can you give an example of the change to the *Provider Contact* element? I'm not clear on what that initial change means. What is considered acceptable if it doesn't include provider initial contact?

Answer: Under "Notes for Abstraction," the time may be abstracted even if it is not specifically documented as *Provider Contact Time* in the medical record.

Question: The instruction for V-8 asked for the total checked boxes. Should the checked boxes for "Yes" answers – for example, the answer to "Yes" was "a little" – should I count "Yes" and "a little" separately (to obtain the total number of checked boxes), or is it 8 (the number of questions) as my total number of checked boxes?

Answer: The count is not based on the total boxes checked. Each "Yes" and "No" answer corresponds to a point in the VF-8R questionnaire. You should assign the relevant point to each answer in the instrument. Following, the score is calculated on a scale of 0-100. The difference between the pre-

operative and post-operative scores on the VF-8R indicates a change in functional activities.

Question: Will the dry run data be updated with the many measure revisions so that hospitals will know where they stand in the new definition?

Answer: The planned admission algorithm is still undergoing annual updates evaluation based on facility feedback during the dry run. Any changes to that algorithm will be published in subsequent manual amendments.

Question: The measure [OP-33] was started January 1st, but I understand that CMS is not giving our vendors the detailed specs until February. Is this true?

Answer: The Specifications Manual was posted publicly on the QualityNet website on December 30, 2015. Version 9.0a includes information and the MIF for OP-33. Any additional updates and/or changes will be communicated via ListServe.

Question: In the description it specifies "painful bone metastases." Does this exclude painless bone metastases?

Answer: Determination of painful bone metastasis is within the scope of both specialty and primary care medical practice. The purpose of this measure is to reduce the rate of EBRT services overuse.

Question: We have always been told not to enter zero for voluntary measure OP-31. Zero indicates participation. That is different than the new OP-33 measure, which is not voluntary, and hospitals must enter zero. Please clarify.

Answer: Regarding the OP-31 measure, the reporting of this measure is voluntary. If you open the window and do not enter any data, the system understands it as incomplete. The only way you can have this display as 'complete status' is to enter zeros. The recommendation is to just enter zeros for OP-31. If your facility does not perform EBRT, you should report "zero" in the numerator and denominator, as OP-33 is not a voluntary measure.

Question: When will QualityNet start providing timely answers to abstraction questions?

Answer: The questions are answered by various subject matter experts from different contractors. Therefore, the response times do vary.

Question: Are changes highlighted in the updated version of the manual? It makes it so much easier on the user end if they are.

Answer: Yes, changes are highlighted.

Question: For OP-33, is that for facilities that provide the EBRT service in-house.

Answer: OP-33 will apply to any facility that performs EBRT.

Question: For OP-18, if a nurse documents "MD is at bedside," can we take this as *Provider Contact Time*?

Answer: Yes.

Question: If our hospital contracts with the facility that performs the EBRT, do we need to abstract this measure? We would not have access to those records.

Answer: OP-33 will apply to any outpatient facility that performs EBRT. If the other facility bills for the services under your hospital's CCN, then your hospital would be responsible for reporting the measure. If the other facility bills under their own CCN, and is paid under the OPPS , then they would need to report for this measure

Question: So with the data variation statement, can facilities decide what they will count for abstraction?

Answer: No. Variation may exist in the assignment of ICD-10-CM codes. Therefore, coding practices may require evaluation to ensure consistency. There may be additional variation by provider, facility, and documentation protocol for chart-abstracted data elements.

Question: I have been looking for the OQR calendar that indicates the reporting period for the web-based OP measures. I do see that it is January 1 to May 15, 2016. Is there a calendar on Quality Reporting Center that includes this deadline for my team?

Answer: All documents are currently being updated to reflect current changes.

Question: For OP-33, please clarify how this can be both web-based and chart-abstracted. Does this mean the data is entered on the QualityNet site vs. submitted via a vendor, as other core measures?

Answer: OP-33 is a chart-abstracted web-based measure that is reported annually, just as OP-29 and OP-30 are chart-abstracted web-based measures. As such, this data will be entered via the online submission tool in QualityNet.

Question: Should the denominator include all cases that had cataract surgery with pre- and post-surveys? What about those that scored zero in pre-survey and in post-survey? Are they in the denominator and not in the numerator?

Answer: Yes. Even if the preoperative score was zero, the case should be included in the denominator, providing that the patient is 18 years of age or older and had the same survey administered pre- and post-operatively. If there is no difference in the pre-operative and post-operative score, then the case should not be included in the numerator.

Question: For OP-33, we do not do external beam radiation at our facility. Are we excluded from reporting this measure?

Answer: Facilities that do not perform EBRT should report "zero" in the numerator and denominator.

Question: Please explain which patients are included in the denominator for OP-33.

Answer: Please consult the Specifications Manual v9.0a, as it describes the denominator criteria.

Question: When will CART be released to abstract these elements?

Answer: CMS will provide updates as soon as they are available. It is recommended that you have your CART paper tools available should they be needed.

Question: If your facility does not participate in OP-31, do we answer "Not sampled" or "N/A, Submission not required" under the hospital's sampling frequency?

Answer: If you open the window and do not enter any data, the system understands it as incomplete. The only way you can have this display as 'complete status' in QualityNet is to enter zeros. The recommendation is to just enter zeros. As this is a voluntary measure, there will be no effect on payment whether the measure is answered or not.

Question: Is the new measure, OP-33, payment-based, pay-for-performance?

Answer: The OQR Program is not pay-for-performance program. OP-33 is a required measure for the OQR Program. As such, facilities must meet the program requirements to qualify for their full payment update.

Question: For OP-1, the patient arrived to the ED with STEMI, and the plan was to transfer them to a center with an interventional cath lab. The air flight was set up, and we were notified 15 minutes later that, due to weather, the flight could not occur. We then did fibrinolytic therapy and transferred the patient by ground; however, the drug was administered outside of the 30 minutes of arrival window. Does this fall out if the weather issue was documented by physician?

Answer: The Specifications Manual states, "Documentation must be made clear somewhere in the medical record that (1) a "hold," "delay," deferral," or "wait" in initiating fibrinolysis/reperfusion actually occurred, **and** (2) that the underlying reason for that delay was non-system in nature." As weather cannot be considered a clinical or patient-centered reason for delay, and there was no documentation of a "hold," "delay," or "wait" in the documentation you provided, this would not be considered an

acceptable reason for delay, and you should abstract a value of "No" to this data element.

Question: Would the following be a sufficient reason to answer "Yes" for *Reason for Delay in Fibrinolytic Therapy*? The ED MD noted the delay due to needing to confer with the interventional cardiologist regarding also administering heparin along with Activase.

Answer: The Specifications Manual lists as an unacceptable reason for delay "Consultation with other clinician that is not clearly linked to a patient-centered (non-system) reason for delay." Therefore, if the documented consultation is patient-centered in nature, you should abstract "Yes." Otherwise, abstract "No."

Question: From the QualityNet Hospital Outpatient Quality Reporting Specifications Manual, v9.0a, Performance Measure Name: External Beam Radiotherapy for Bone Metastases Measure ID #: OP-33, Additional instructions: "This measure is applicable to any hospital that conducts radiation oncology, including Critical Care Hospitals." I do believe you said that OP-33 is voluntary for any hospitals other than Cancer Hospitals – can you please clarify your statement?

Answer: The new measure applies to all Outpatient Quality Reporting hospitals and is not a voluntary measure. However, Outpatient Quality Reporting is voluntary for Critical Access Hospitals. CMS encourages you to participate, especially in reporting web-based measures which include OP-33. PPS refers to the Prospective Payment System which applies to outpatient, also. **All** PPS-paid hospitals are required to participate in the OQR Program.

Question: For OP-30, if there is no documentation of any previous colonoscopy in the medical record, how do I answer the question?

Answer: If there is no documentation of a previous colonoscopy in the medical record, you will need to answer "No" to "Documentation patient had an interval of ≥ 3 years since the last colonoscopy" because there is no documentation to establish the interval. For this same reason you will also need to answer "No" for "Documentation of < 3 year interval since last colonoscopy due to a medical reason" and "Documentation of < 3 year interval since last colonoscopy due to a system reason." All of these questions require the interval be known. In this situation, the case will remain in the denominator and will not be in the numerator.

Question: For OP-30, once you do not have an interval date, you answer "No" (based on a previous question). If you have a medical reason, do you answer Medical Reason as "No" because you do not have an interval?

Answer: That is correct. The exclusion for a medical reason and for a system reason requires the interval be known. The interval must be < 3 years to answer "Yes." Without an interval, you need to select "No."