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

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Question: Please repeat the date for the upcoming tutorial on the OP-33 measure. The handout says 2/17/16; I believe the initial speaker said it was changed.

Answer: The OP-33 webinar is now scheduled for March 16, 2016. However, any new information released by CMS for this measure will be communicated as it becomes available.

Question: Current specifications for OP-33 require data collection begin Q1 2016. Due to the current issues with CPT code selection, will CMS delay the required reporting period?

Answer: CMS and the measure writers are currently reviewing the concerns brought forward. The changes that occur as a result from this review will be communicated via ListServe notification. At the present time, there is no plan for any delay in the reporting period.

Question: Are any of the current Outpatient core measures for Emergency Department-Throughput, ED Chest Pain, ED Stroke, or Pain Management going away in the near future?

Answer: At this time, CMS has no plans to remove any of the current measures.

Question: Why were the ankle and wrist ICD-10 codes removed from the manual? Does this change affect the Pain Management measure?

Answer: The code list was updated based on a review by expert coders and clinicians, and it was determined that the wrist and ankle bone codes did not appropriately align with the intent of the measure. These changes affect the code list for Table 9.0, Long Bone Fracture ICD-10 Codes.

Question: Can you give some clarification to the statement addressing "variation by provider, facility, and documentation protocol for chart-abstracted data elements"?

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: When you were on slide 24 *Probable Cardiac Chest Pain*, you spoke of something that was not reflected on the slide. Please repeat what you said.

Answer: The Inclusion Guidelines for Abstraction used to list a plus sign qualifier. This option was removed from the inclusion list.

Question: For OP-20 (slide #33), if the physician had contact in the clinic and transferred them up to the ER, can this time in the clinic now be used as the first direct encounter?

Answer: Version 8.0a of the Specifications Manual indicates that the *Provider Contact Time* intends to capture the earliest exact 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, you may not abstract the time the physician had contact in the clinic for *Provider Contact Time* if your facility does not consider the clinic part of the ED. Please review the entire ED record (the only acceptable source listed in the Specifications Manual) and abstract the time of the first, face-to-face contact between the patient and the physician/APN/PA or institutionally credentialed provider that meets the Inclusion Guidelines for Abstraction.

Question: Is a CNP considered a qualified medical professional?

Answer: Yes. Advanced Practice Nurse (APN, APRN) titles may vary between state and clinical specialties. The manual notes that some common titles that represent the APN role are Nurse Practitioner (NP), Certified Registered Nurse Anesthetist (CRNA), Clinical Nurse Specialist (CNS), and Certified Nurse Midwife (CNM).

Question: When is 9.1 expected to be posted?

Answer: Specifications Manual v9.1 is currently posted on QualityNet.

Question: Is it known when the HCPCS codes will be applied to Appendix A? I do not find it to be included in the 9.0a or 9.1 Specifications Manuals.

Answer: The codes for OP-26 will not be updated in the CY 2016 manuals until the end of 2016. The current codes for data submission can be found in Specifications Manual v8.1. This manual was updated to reflect the most current 2015 codes.

Question: Can you elaborate on what OP-17 really means? I always have questions about this each year.

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: Does OP-31 apply to hospitals that do outpatient cataract surgeries and are not an ASC, and is this mandatory?

Answer: OP-31 is a voluntary measure for both the Hospital OQR Program and the ASCQR Program.

Question: For OP-20, are you getting that time from when the doctor goes into the ER room or when he decides to start his note in the EMR?

Answer: The Specifications Manual indicates that the *Provider Contact Time* intends to capture the earliest exact 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, please abstract the time of the first, face-to-face contact between the patient and the physician/APN/PA or institutionally credentialed provider that meets the Inclusion Guidelines for Abstraction. Please 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 and time, so any documentation of *Provider Contact Date and Time* must include clear evidence of direct, face-to-face contact between the patient and the

provider at that date and time.

Question: How do we identify patients admitted to other facilities for OP-32?

Answer: Table 3 of the Facility-Specific Report (FSR) distributed during the dry run in July 2015 provided information on the type of outcome for each case, including the provider ID of the hospital where the inpatient stay, observation stay, or emergency department visit took place. Please see the dry run pages on the QualityNet website at: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228775181947 CMS has not yet determined reporting plans for CY 2018 measure implementation, but will likely provide facilities with a similar table with CY 2016 data.

Question: Does diverticulosis equate to diverticulitis? I see MD/NP/PA documentation of diverticulosis more often than diverticulitis; is this acceptable?

Answer: No, for OP-32 diverticulosis does not equate to diverticulitis. Only diagnoses of diverticulitis (as defined in the manual) are excluded.

Question: I viewed Appendix v8.1, and it does not display HCPCS codes.

Answer: You will not find the OP-26 codes located in the Appendix. The table is in the measure information form. All you will need to do is download the OP-26 MIF in the v8.1 manual, and you will have the table.

Question: Is OP-26 mandatory for hospitals that do outpatient surgeries but are not an ASC?

Answer: Yes. OP-26 is a web-based measure that must be reported to meet OQR Program requirements.

Question: For OP-30, how do you calculate three years?

Answer: Determining the interval since the last colonoscopy is based on the information you have available. There needs to be some reference in the medical record of when the last colonoscopy was performed. The interval is determined based on the detail of information available. If the day/month/year are available, you will determine the interval based on that compared to the current procedure date. If only a month and year is available, base the interval compared to the current month and year. If only a year is available, base the interval on the year. You can also use

information reported by the patient. For example, if the patient reports the last colonoscopy they had was about five years ago, that is sufficient to say it was more than three years.

Question: How often is the EBRT measure reported?

Answer: OP-33 is a web-based measure and will be reported once a year via the QualityNet Secure Portal.

Question: We had several errors on our dry run of OP-32 and submitted feedback to the measure originator/stewards. Mostly our errors were planned readmissions or patients who were admitted as inpatients during the first visit and the colonoscopy was an "emergency colonoscopy" for a GI bleed (i.e., not a routine screening). Was this addressed in changes?

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: If the ED physician is waiting on a cardiologist to call, can this be used as a *Reason for Delay in Fibrinolytic Therapy*? We do not have 24-hour cardiology coverage at our hospital.

Answer: As long as there is clear documentation 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, then any clinical or patient-centered reason for delay is acceptable to abstract a value of "Yes" to this data element. An example of acceptable documentation would be, "Hold fibrinolytics. Need to consult with cardiology."

Question: Is OP-33 mandatory, and is it claims-based?

Answer: OP-33 is a required measure for the OQR Program. It is a chart-abstracted, web-based measure.

Question: Do you know if core measure vendors will support OP-33?

Answer: This is a question for your vendor. A hospital's relationship with its vendor is independent from the Hospital Outpatient Quality Reporting Program.

Question: Are OP-31 & 32 required measures, or are they still voluntary?

Answer: OP-31 is a voluntary measure under the Hospital OQR Program. OP-32 is a claims-based measure, and data are captured from submitted claims.

Question: Is OP-31 still voluntary reporting?

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

Question: Which version of the manual do we use for OP-26 for 2015 encounters – v8.0a or v8.1?

Answer: You will utilize Specifications Manual v8.1 for data submission of OP-26.

Question: To confirm, if a patient is placed in ED observation status, do I abstract the time of the ED observation order, or the time they physically left their ED observation?

Answer: The Specifications Manual states that if the patient is placed in observation services while in the ED, you should abstract the time the observation order was placed for *ED Departure Time*.

Question: Can you clarify the effective date for OP-33?

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

Question: In OP-30, as per the explanation in this webinar, a denominator exclusion for a system reason must indicate an interval of less than three years since the last colonoscopy. What if it is unknown when the last colonoscopy was performed due to the previous report not being available, unable to locate the last report, or patient transferring from another practice and the report is not available?

Answer: If the interval since the last colonoscopy is unknown, you will need to respond "No" to the questions: "Documentation of < 3 years due to a medical reason" and "Documentation of < 3 years due to a medical reason." The reason is that both of these questions require knowledge that the interval is < 3 years. You will also need to respond "No" to "Documentation the patient had an interval >= 3 years:" because, again, the interval is not known.

Question: For OP-1, if the chart reflects that the patient is being transferred for acute coronary intervention, does this meet the exclusion criteria for a reason for not administering fibrinolysis?

Answer: Thank you for your inquiry. The *Reason for Not Administering Fibrinolytic Therapy* is an OP-3 data element. Version 9.0a of the Specifications Manual indicates that if there is documentation of a contraindication or other reason by a physician/APN/PA or pharmacist that is explicitly listed in the data element as a contraindication for administering fibrinolytic therapy, then you should abstract a value of "1." If there is not documentation of a contraindication or reason for not administering fibrinolytic therapy, or if the documented reason is not listed in the data element's inclusion criteria, you should abstract a value of "3."

The Specifications Manual lists *Transfer for Acute Coronary Intervention* as an exclusion guideline for abstraction, so you cannot abstract a "1" for this data element. As a result, you should abstract a "3" for the *Reason for Not Administering Fibrinolytic Therapy* data element.

Please use the above guidance in version 9.0a of the Specifications Manual to abstract *Reason for Not Administering Fibrinolytic Therapy* in this case. Please note that CMS' contractors do not have access to hospitals' medical records and cannot make judgments based on excerpts. The Specifications Manual continues to remain the definitive source for guidance on measure specifications and reporting. Please make a final determination regarding appropriate case abstraction based on your best judgment.

Additional information on the specifications for the Hospital OQR Program measures can be accessed at: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1196289981244.

Question: For OP-30, the colonoscopy was on 11-12-2012; the repeat colonoscopy was on 12-20-2015. Is this a three-year interval? How do you calculate three years?

Answer: Yes. The interval must be less than three years to answer "Yes." Without an interval, you need to select "No." The interval is determined based on the detail of information available. If the day/month/year are available, you will determine the interval based on that compared to the current procedure date. If only a month and year are available, base the interval compared to the current month and year. If only a year is available, base the interval on the year.

Question: Does OP-33 apply to free-standing outpatient cancer treatment centers?

Answer: OP-33 will apply to any outpatient offsite facility that bills under the main hospital's CCN. If your offsite facility bills under your hospital's CCN, then you will need to report for OP-33. Also, if radiation therapy is performed in the hospital and billed as outpatient, then this too would be applicable to the measure. It is the billing as an outpatient, not the setting, that includes this to the outpatient measure.

Question: For OP-30, if the provider does not mention timing of a prior colonoscopy, can we use the electronic medical record to find the date of a prior colonoscopy?

Answer: Use of information documented in an electronic health record is acceptable because it is available at the time of the procedure.

Question: Is there an algorithm for OP-33?

Answer: Not at this time. [Editor's note: a flowchart was developed and is available at qualityreportingcenter.com.]

Question: For OP-30 (Slide 50), if the last colonoscopy cannot be found or is not available in the chart, can we say "Yes" to the question "Is there documentation of a system reason for needing a follow-up colonoscopy less than three years since their last colonoscopy (e.g., unable to locate previous colonoscopy report; previous colonoscopy report was incomplete)?"

Answer: You will need to select "No" to this question because the question requires the interval since the last colonoscopy to be less than three years. If the interval is unknown, you cannot say it was less than years, or less than or equal to three years.

Question: For OP-33, if we do not do radiation at the hospital, where do we put that information to show we have no patients?

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

Question: What is a non-missing question on slide 52?

Answer: The response assumes this is a question on the OP-31 measure.
A non-missing question is one which has been answered both in the pre-operative and in the post-operative surveys.

Question: Can we use previous records to determine prior colonoscopy dates?

Answer: The General Abstraction Guidelines of the Data Dictionary Introduction indicate that previous testing or history information used in abstraction should be information that was part of the medical record during the encounter when care was being delivered. As electronic data are available at all times during the hospitalization, it is acceptable to use these data for abstraction purposes. Therefore, if the prior colonoscopy and current colonoscopy are both contained in the same electronic medical record, you can refer to the prior colonoscopy to help determine the interval since the last colonoscopy. If the previous records you refer to are not in the electronic medical record, they cannot be used.

Question: For OP-23, has there been any consideration to excluding cases if there is a documented reason for delay, such as emergent CPR or intubation required on arrival? We submitted that during the open comments period.

Answer: Currently, there are no exclusions for the clinical situation you described. We appreciate your feedback and will take it into consideration during our next annual update, in conjunction with feedback from our clinical experts, to determine whether certain clinical situations should be considered as exclusions for this measure.

Question: Can you clarify OP-18 on slide 32? I don't understand how the time the order was written for OBV can be counted as the time the patient left the ED.

Answer: The Specifications Manual indicates the intention of *ED Departure Time* is to capture the latest time at which the patient was receiving care in the ED, under the care of ED services, or awaiting transport to services/care. The Specifications Manual dictates that for patients who are placed into observation services, use the time of the physician/APN/PA order for observation for *ED Departure Time*. The intention of this guidance is to abstract the time that the patient is no longer under the care of the ED.