Outpatient Quality Reporting Program

Support Contractor

The Question and Answer Show

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June 21, 2017
10:00 am

Question: Isn't Q2 submission due August 1, 2017?

Answer: August 1, 2017 deadline is for Quarter 1 2017 data. This submission would incorporate encounter dates of January 1-March 31, 2017. For a quick reference, you can access the following link: http://www.qualityreportingcenter.com/hospitaloqr/information/, then scroll down the page to find the heading "Timelines."

Question: I have a question about the answer to the question on slides 43 and 44 where it was noted to use 1800 as the *Time Last Known Well*. The *Time Last Known Well* data element says to take physician documentation before nursing if there are multiple times of last known well documented without a specific time documented on a Code Stroke Form; however, it also notes the following: If both the *Time Last Known Well* and symptom onset are documented, select the *Time Last Known Well* (does not mention this is only physician documentation). If the only time documented is time of symptom onset without mention of when the patient was last known well, use the time of symptom onset for the *Time Last Known Well*.

Answer: Based on the guidance in the manual, physician documentation takes precedence over other forms of documentation. Additionally, the earliest time should be abstracted as it is not possible for the patient to be last known well after symptom onset. For these reasons, 1800 is the appropriate abstraction time.

Question: How do you answer the question of "Were fibrinolytics given?" if your ED doesn't give fibrinolytics?

Answer: 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."

Question: Does it have to be explicitly documented by the physician?

Answer: Version 10.0a 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." Additionally, if there is a contraindication/reason not listed under the Inclusion Guidelines for Abstraction, but there is clearly physician/APN/PA or pharmacist documentation linking this contraindication/reason to the decision to not administer fibrinolytic therapy, you may also abstract a value of "1." If there is no 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."

Question: Could you abstract the ECG completed by EMS upon arrival?

Answer: Yes, if there is no reason to suspect that the ECG was documented in error and if there is documentation that the ECG was a 12-lead, you may abstract the EMS ECG.

Question: On slide 20, would you abstract *Arrival Time* as the earliest arrival time from the free standing ER if billed under same CCN?

Answer: Yes, if the free-standing ED is billing using the main hospital's CCN, then think of these as one ED.

Question: If an EKG tracing is in the chart, do we take the date and time on that EKG tracing? If there is also a narrative with EKG dates and times as follows: ED Timeline states "1811:40 EKG Final Result MD," EKG was ordered on 1/24/17 at 1801 and collected/completed on 1/24/17 at 1533 per the EKG report; which time do we take?

Answer: If there is conflicting documentation, then refer to the EKG tracing time if it is known to be an accurate representation of the EKG. For example, if it is an invalid time (25:00), then continue reviewing the medical record for alternate sources.

Question: Our Emergency Room Form has the terminology 'medically screened,' which is the time our MD/NP sees the patient and assesses urgency. Can I use that as the contact time?

Answer: Based on the information provided, you may use the time the patient was medically screened if this is the time of 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: Doesn't the EKG need to be done within an hour of arrival to the ED? If there is no tracing, how would you know?

Answer: Version 10.0a of the Specifications Manual states: "Identify the ECG performed closest to arrival, either before or after emergency department arrival, but not more than 1 hour prior to arrival." The one hour requirement is only for pre-hospital ECGs; otherwise, abstract the earliest time the ECG was completed in the ED regardless of how late it occurred.

Question: If a patient is admitted to observation services under the ED physician's care, and remains in the ED the entire stay, would the *ED Departure Time* be the time of the order for observation or the time the patient physically left the ED for home?

Answer: Based on the information provided, you should abstract the time of the observation order for *ED Departure Time*.

Question: For slide 25, is this only specific to patients admitted to observation or can we use the admission order for patients admitted as Inpatient acute for a departure time?

Answer: If the patient has an Inpatient order, it would not be eligible for abstraction under the Hospital OQR Program.

Question: If a patient is held in the ED pending transfer to a psych bed in another facility, and remains in the ED causing a prolonged time from arrival to discharge, is there a time that can be used other than the actual time the patient leaves?

Answer: No, this is why this time is separated out from the regular ED population. Currently, psychiatric/Mental Health patients are not included in the reported population.

Question: For provider contact, the algorithm allows the *Provider Contact Time* and the *Arrival Time* to be the same time. The *Provider Contact Time* cannot be before *Arrival Time,* but we have always noted it could be at the same time as *Arrival Time* since, clinically, that can happen, especially for trauma patients or other patients arriving by squad (AMI or STK). So, on slide 25, when you note the MD documentation seen at arrival cannot be linked to using the arrival time as the provider contact, is that only because it is not a specific time? Is it ok if the *Arrival Time* and the *Provider Contact Time* are both documented as the same specific time?

Answer: There must be a specific time documented for the initial direct encounter between the patient and the provider that is distinct from the patient's arrival in the ED. For example: The physician documents *Provider Contact Time* 1630, and *Arrival Time* is documented as 1630, then you can use 1630 as the *Provider Contact Time* as this is a specific time documented for the initial direct encounter.

Question: For *ED Departure Time*, an ED hold has no impact at all, is that correct?

Answer: Correct, an ED hold will count the complete ED visit time. To use observation time there must be an order for observation.

Question: August 1, 2017 is the deadline for the Q1 data. This would include the encounter dates January 1-March 31, 2017; which Q1 data and where is this supposed to be submitted?

Answer: August 1, 2017 is the last quarter for the 2018 payment determination for your Clinical Data Submission. Hospitals sometimes have vendors that submit this data, but this data can also be submitted via CART.

Question: For OP AMI “transfer for acute coronary intervention," is transfer to another facility for CABG enough to select "yes" to this question?

Answer: Version 10.0a of the Specifications Manual indicates that if there was documentation that the patient was transferred from your facility's emergency department to another facility specifically for acute coronary intervention, a “1” should be abstracted for this data element. If the patient was transferred for an acute CABG, then you may select a value of “1.”

Question: On our physician note in the ED, there is a time at the top of the page which represents the time the chart was opened in the EHR. If the physician does not document on his history and physical(H&P) the time he saw the patient, are we to use the time at the top of the note, or can we use the time in the nurse’s note if the nurse documents "ED physician at

bedside" and has a time for this documented?

Answer: Based on the information provided, you may not use the time the note was opened for *Provider Contact Time*. However, you may abstract the nurse's note that documents "ED physician at bedside" if this is the time of 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 note that writing a note or an order does not necessarily mean that there was contact between the patient and provider at that time, so any documentation of provider contact time must include clear evidence of direct contact between the patient and the provider.

Question: *Last Known Well* (LKW) time of symptoms was documented at a specific time by a nurse but the physician documents the symptoms occurred just prior to arrival. Can we use the nursing time?

Answer: Yes, in this instance you may abstract the medical record at face value if there is a specific time documented for *Time Last Known Well*. You may use a range or estimate if **no** specific time is provided.

Question: In our EHR system, there is a field that states initial provider contact time is 1122 in the ER timeline, but a service note by ER provider states the time as 1109 with physical exam, what time do you use for *Provider Contact Time*?

Answer: Based on the information provided, you may abstract the time of the service note by ER provider of 1109 with physical exam if this is the time of 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 note that writing a note or an order does not necessarily mean that there was contact between the patient and provider at that time, so any documentation of provider contact time must include clear evidence of direct contact between the patient and the provider.

Question: What is the *ED Departure Time* if the discharge time is 1240 and discharge instructions given 1241?

Answer: Based on the information provided, you should abstract 1240 for *ED Departure Time* if this is the time the patient physically departed from the ED. The discharge instruction time of 1241 cannot be used as 'Discharge Instruction Time,' it is an exclusion for this measure.

Question: If the physician documentation of LKW is after the nurse, is the nurse considered a "provider" and can I take her date first and not the physicians?

Answer: If the nurse documented *Time Last Known Well* (TLKW) 1200 and the ED physician documented TLKW is 1215, you may use the physician documented time even though the nursing documentation is earlier.

Question: If the patient has aspirin (ASA) every day as a home medication, do we still assume that the patient took the medication to exclude them?

Answer: There only needs to be clear evidence that the patient is actively taking the pain medication daily at home in order to abstract a value of "No" to the Pain Medication data element. A specific schedule or time of last administration is not required; however, if it is not clear that the medication is currently active, or if the daily medication has not clearly been received within the 24 hours prior to ED arrival, you should abstract based on the administration of pain medication in the ED.

Question: Please clarify; if a patient is to be placed in observation when seen in the ED, do we use the time the order was written for observation as the time the patient left the ED, or do we use the actual time the patient left the ED to go to the floor? What time would be used if the patient was admitted to acute care — would it be the time the order was written or the time the patient actually went to the floor? The slide said for observation it would be the time the order was written.

Answer: The manual states that for patients placed into observation services to use the time the order was written as the *ED Departure Time.*

Question: On slide 26 or 27, for the time the patient is placed in "observation services," would patients being held under this physician order be considered "departed?"

Answer: Based on the information provided, if the patient entered observation services from the outpatient setting, then you should abstract the observation order 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. When a patient is placed into observation, their clinical workflow may vary from patients who are not placed into observation prior to departure from the ED, so the observation order may be used instead of the actual ED departure time.

Question: For *ED Departure Time*, regarding the patient admitted to observation services and using the time the physician wrote the order to place the patient into observation status, is there a specific time limit on when to use that rule? In other words, should we (a) look for documentation for patient waiting on bed, or (b) use a timeframe of over 2, 3 or greater hours from when the order is written to use the order time rather than documented departure time?

Answer: You will use the time documented when the order for observation is **written** for the *ED Departure Time*.

Question: For pain medication prior to arrival, is the patient's word documentation for time pain medication taken?

Answer: Any clear evidence of pain medication received within 24 hours prior to ED arrival is sufficient to abstract "No" to the Pain Medication data element

Question: What recourse do we have or what recommendations do you have for the following scenario: A patient presents with stroke symptoms but we are unable to complete the first CT scan within 45 minutes because the patient is uncooperative. We sent the patient back to the ED for further evaluation and to settle him down and do the CT scan two hours later. There is no exclusion for this type of situation and it is an outlier or error according to the guidelines.

Answer: At this time, we do not have any exclusions for the scenario you have described. You should abstract the time of the earliest Head CT or MRI scan. We will consider your feedback during our next annual update.

Question: If the patient is placed into observation at 0800; the time the patient departed the ED is 0830. Would I abstract *ED Departure Time* as 0800 or 0830?

Answer: Based on the information provided, you may abstract 0800 for *ED Departure Time* if the order for observation services was written at 0800.

Question: I disagree with the scenario for *ED Departure Time*. Isn't the intent of the measure to document patient flow? If the patient was in the ED for five hours that means there was a problem with patient flow, which is what I thought we were trying to get at with this measure?

Answer: The *ED Departure Time* intends 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 services/care. The intention of this guidance is to abstract the time that the patient is no longer under the care of the ED. When a patient is placed into observation, their clinical workflow may vary from patients who are not placed into observation prior to departure from the ED, so the observation order may be used instead of the actual ED departure time.

Question: Is consulting with a cardiologist a valid reason for delaying the administration of fibrinolytic medications? We are a CAH and have PAs in our ER and if an AMI comes to the ER many times they call a cardiologist.

Answer: Version 10.0a of the Specifications Manual states, "System reasons for delay are not acceptable, regardless of any linkage to the delay in fibrinolysis/reperfusion." One of the examples listed includes, "Consultation with other clinician that is not clearly linked to a patient-centered (non-system) reason for delay." So if the documentation indicates that there was a consultation between clinician that is not "clearly linked" to a patient-centered reason for delay, this would be a system reason and should not be considered an acceptable reason for delay. You should abstract a value of "No" to the data element.

Question: For pain management, is there a plan to add a leading question to ask if pain is present at the time of arrival to help avoid skewing data for patients who have no pain at arrival but develop pain sometime later during their stay?

Answer: We will consider your feedback during our next annual update.

Question: Is the colonoscopy report still the only place follow-up can be documented? Our patients are often given the follow-up information with their discharge instructions.

Answer: Yes, the follow-up interval must be documented in the colonoscopy report.

Question: Patient ED registration discharge time is 2237 and the physician documented "ED Discharge patient 2220," which is the *ED Departure Time*?

Answer: Select the latest time documented that meets the criteria of the patients discharge. If your ED registration states the patient was discharged at XXX, use this time since it is the latest.

Question: I have cases where the patient was discharged to an acute care facility but the medical record has discharged to home because the patient drove to the acute care facility. What would be the correct discharge code?

Answer: Based on the information provided, if the patient was discharged to an acute care facility from the outpatient setting, then you should abstract '4a-Acute Care Facility General Inpatient Care' for the Discharge Code.

Question: I thought oral pain medications do not apply to anyone under the age of 18?

Answer: You are correct, during the time of the measure's development, there was mixed evidence on the efficacy of oral pain medication for patients aged 18 years or older for the management of pain associated with long bone fractures. Oral medications for patients aged 18 and older are not acceptable ED pain medications for the purposes of abstracting this measure.

Question: For LKW, why doesn't the question just ask if LKW is within 120 minutes since it will be excluded if over that?

Answer: The measure algorithms are designed to collect specific levels of information. The *Time Last Known Well* and *Arrival Time* must be abstracted separately for data collection purposes.

Question: For *Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients*, if there are multiple different dates found in medical record of the last colonoscopy, which date do you take?

Answer: When establishing the interval since the last colonoscopy, use the most recent documentation of the previous colonoscopy.

Question: On slide 29, regarding *ED Departure Time*, you said to abstract the latest time. However, in the previous example, on slide 28, you said to use the time of the observation order. One was a transfer and one was going to observation status. Is that reason the difference or something else? Please clarify if it's the time of order or latest documented time.

Answer: It is dependent upon the scenario. The intention of the *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 services/care. When a patient is placed into observation, their clinical workflow may vary from patients who are not

placed into observation prior to departure from the ED, so the observation order may be used instead of the actual ED departure time.

Question: In our EHR, we have a 'history of present illness' section completed by nursing. We consider this our 'code stroke form.' Is this appropriate that we consider this our code form and, therefore, use this time over other LKW times even those documented by the physician?

Answer: If the form is an electronic template used to document the acute stroke care process, you may consider that a priority source.

Question: Regarding slide 39, is the patient report of having taken a chronic pain medication within the last 24 hours sufficient to say that pain medication was received in the 24 hours prior? Do we have to have a specific time of that pain medication or does this require physician/nurse documentation of time medication last taken?

Answer: The guidance from the Specifications Manual states, "If there is documentation of routine pain medications on the home medication list, it can be assumed these medications were taken within 24 hours prior to arrival. Select 'No' to Pain Medication." There only needs to be clear evidence that the patient is actively taking the pain medication daily at home in order to abstract a value of "No" to the Pain Medication data element. A specific schedule or time of last administration is not required; however, if it is not clear that the medication is currently active, you should abstract based on the administration of pain medication in the ED.

Question: If the medication aspirin (ASA) is only mentioned as part of the patient's home medication, do you say "Yes" for pain medication, or must they say the patient took the ASA.

Answer: There only needs to be clear evidence that the patient is actively taking the pain medication daily, at home, in order to abstract a value of "No" to the Pain Medication data element. A specific schedule or time of last administration is not required; however, if it is not clear that the medication is currently active, or if the aspirin medication has not clearly been received within the 24 hours prior to ED arrival, you should abstract based on the administration of pain medication in the ED.

Question: If the patient leaves after triage but before the physician can see them, we cannot put Left Against Medical Advice/AMA as the physician never saw to advise the patient against leaving. Also, no AMA form was signed. Nursing alone advising not to leave won't count. Do we have to put Discharge Code as "1- home?"

Answer: To select "Value 7- Left Against Medical Advice/AMA," there must be explicit documentation that the patient left against medical advice. Based on the information provided, you should abstract "Value 8: Not Documented or Unable to Determine (UTD)" if the final place or setting is unable to be determined from the medical record.

Question: If the physician documents and orders lidocaine for a hematoma block could this be used as pain management medication?

Answer: We recognize that hematoma blocks and other forms of local anesthesia are commonly used for the reduction of long bone fractures; however, this form of administration of a medication, even with anesthetic or pain-relieving factors, does not meet the intent of the measure. We recognize that at times this may or may not be the only time during the ED visit that medication with pain-relieving factors is administered, which makes abstraction complicated as the Specifications Manual does not provide explicit guidance as to what to abstract in this situation. The intent of the measure is to manage the pain associated with a fracture, so local anesthetics, as well as anesthetics administered to aid with procedures performed to repair the fractures, would not be deemed acceptable. Please consider the administration of pain medication in each case to determine whether it refers to regional analgesia or anesthesia intended to treat the pain associated with the long bone fracture. If so, then please abstract "Yes" for this data element. Otherwise, please abstract "No." Additionally, we recognize that certain medications used for these procedures, such as lidocaine, may be used in other types of pain management; however the inclusion of the term "lidocaine block" on the list of medications in the pain medication data element may be confusing. At this time, please understand that this term refers to lidocaine used for regional anesthesia/analgesia to treat the pain associated with the long bone fracture only.

Question: In cases of multiple discharge times, can we use the ED registration face sheet which has the latest discharge time for the *ED Departure Time*?

Answer: Based on the information provided, if there are multiple discharge times, then please abstract the latest time for *ED Departure Time*. You may use the ED registration face sheet if this is included within the ED record.

Question: For *EKG Time*, if the EKG tracing time is 1300, and the physician EKG narrative states "EKG collected/completed 1301," which time we take?

Answer: You may use the EKG tracing time as it is the earliest documented time.

Question: Can Versed and Ketamine be accepted as pain medication if given as pre-procedural sedation?

Answer: Please note that there are several medications that are used for procedural sedation that are not acceptable for purposes of abstraction of this measure, as they do not have analgesic properties. Without specific analgesic properties, a medication may not appropriately manage the pain experienced by a patient with a long bone fracture. For example: Propofol, Midazolam (Versed), and Etomidate are all examples of medications used for procedural sedation during the reduction of a fracture. However, these medications do not have significant analgesic properties and thus do not treat the pain associated with the long bone fracture.

Question: When a patient has documentation in the procedure record "colonoscopy follow-up in 10 years," which is part of the permanent record, doesn't that count?

Answer: It is acceptable to have a 10-year follow-up interval documented in the colonoscopy report.

Question: On slide 25, it is indicated that we use the admission order as the departure time to be used in the abstraction.

Answer: The Specifications Manual states that patients that are placed into observation services use the time of the order for observation for *ED Departure Time.*

Question: I know if a patient receives pain medication prior to arrival, either at home or by EMS, we are supposed to select "No" for pain medication. But what if they also received pain medication in the ED?

Answer: If there is evidence of any medication with pain-relieving properties received prior to arrival, this excludes the patient from the measure, even if they received pain medication in the ED, so as not to penalize the facility if pain medication administration in the hospital was in any way delayed due to the patient having taken or received a pain medication prior to arrival. You should abstract a value of "No" to the Pain Medication data element in this case.

Question: On slide 28, regarding departure time with observation patients, would this apply to inpatient admissions as well?

Answer: If a patient is admitted as an Inpatient, the case would not be eligible for abstraction under the Hospital OQR Program. For questions regarding Inpatient measures specifically, please call 844.472.4477.

Question: Regarding slide 43, if the physician documents that the patient was last known well at 2200 and went to sleep but woke up with cerebral vascular accident (CVA) symptoms at 0500, is it correct to document UTD last known well?

Answer: You should abstract the medical record at face value and abstract 2200 as the time last known well.

Question: With regard to fibrinolytic therapy, our hospital is a small hospital and does not do interventions; we transfer patients to larger facilities and never give thrombolytics. How is the best way to abstract "reason for not giving?"

Answer: 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." We will consider your feedback in the next measure update.

Question: For OP-29, on slide 54, concerning age for the medical reason for not documenting a 10-year interval, is this for below age 50 and above age 75 as well?

Answer: The Denominator Statement indicates only patients 50 to 75 years old are included.

Question: With regards to OP-2, on slide 42, would the dictation time and the time next to that need to depict that the dictation time came from a doctor/provider or have a doctor's name next to it in order to be valid? I ask because often a dictation specialist's initials are the only thing next to the dictation time. So, in this instance, we disregard it for abstraction.

Answer: The interpretation itself must be completed by a qualified professional, even if the dictation was completed by a dictation specialist.

Question: On slide 19, if a patient at the free-standing satellite ED had a different account number than the encounter at the main campus ED, are they treated as one encounter/case for abstraction or two separate?

Answer: The Specifications Manual states "If two ED visits on the same day are rolled into one claim, abstract the first chronological encounter that meets

the inclusion criteria for the population. If two ED visits on the same encounter date meet the inclusion criteria and are billed as two separate claims, both cases may be eligible for abstraction according to sampling requirements."

Question: If a patient is to be placed in observation when seen in the ED, do we use the time the order was written for observation as the time the patient left the ED, or do we use the actual time the patient left the ED to go to the floor? What time would be used if the patient was admitted to acute care? Would it be the time the order was written or the time the patient actually went to the floor? The slide said that for observation it would be the time the order was written.

Answer: The manual states that for patients placed into observation services use the time the order was written as *ED Departure Time*.

Question: Does a specific time take precedence in the 'physician over nursing' rule?

Answer: Both the source and specificity of the documentation should be considered. If both physician and nurse have specific times, then you should use specific time regardless. If the nurse has a specific time for *Time Last Known Well* and physician has an estimate, you may use the specific time.

Question: What if the nurse states roughly 1800 and the provider documents 1853, which would you use?

Answer: Use the specific time 1853 over the estimated time.

Question: For slide 29, what would be acceptable as "clear evidence" that the medication was taken by the patient?

Answer: While the Specifications Manual does not list any specific requirements in regards to defining "clear evidence," there must be documentation in the medical record that the patient received pain medication (e.g., self-administration, physician's office or ambulance) prior to arrival; documentation of routine pain medications on the home medication list or any other medically documented evidence that shows the patient either: a) Received the medication within the 24-hour window prior to their arrival in the ED, or b) The patient is currently prescribed/is actively taking a daily pain medication or a medication with pain-relieving factors at home.

Question: Does slide 28 include an order for admission as observation regardless of where they are being admitted? For example, admitted to an inpatient unit but as an observation patient?

Answer: The manual states for patients placed **into observation services**, use the time of the physician/APN/PA order for observation for ED Departure Time regardless of the admission unit. The intention of this guidance is to abstract the time that the patient is no longer under the care of the ED. When a patient is placed into observation, their clinical workflow may vary from patients who are not placed into observation prior to departure from the ED, so the observation order may be used instead of the actual ED departure time.

Question: For OP-30, if the doctor does not specify exactly when the last colonoscopy was, and we cannot find that information in the chart, but the doctor does document bringing in that patient for symptoms of constipation/bleeding/and pain/weight loss. Can these reasons count as an exclusion for medical reason without him explicitly stating that?

Answer: Without knowing whether or not the time interval since the patient's last colonoscopy was less than 3 years **or** 3 years or more, you cannot establish there was a medical reason for an interval of less than 3 years. You will not be able to exclude this case from the denominator based on a medical reason.

Question: Regarding EBRT, I reviewed the slides and they state that if a patient has two distinct anatomic sites on one encounter, it should be treated as a separate encounter. Our facility is required to submit 100 records annually; would a second anatomic site be counted separately? An example is Quarter 1, 2017, 25 records were sampled, 6 of the records had two or more anatomic sites. If I make these second and third sites, I will have 32 records for Q1, 2017.

Answer: Yes, these sites would be abstracted separately and would each count as a separate encounter in your facility's sample.

Question: What is the definition of "initial encounter" under the OP-33 measure?

Answer: An initial encounter is the first time a patient receives EBRT to a specific anatomic site and should generally be captured as the date on which treatment began.

Question: Relative to OP-29 and OP-30, our day surgery face sheets all have 0600 as arrival time. Our health record report has an admit date and time, as well

as discharge date and time and the correct arrival time. Which time should be used?

Answer: Arrival time is not an OP-29 or OP-30 requirement.

Question: Will the questions and answers in the chat box be available to us? I am trying to listen to the speaker, but I am interested in the conversations in the chat box that answer questions that we always have as abstractors. As a result, I am missing some of the presentation content.

Answer: Yes, all Questions and Answers will be posted on our website; www.qualityreportingcentercom, under the 'Archived Events' section.

Question: Regarding slide 66, when you have a patient who has two separate anatomical sites but the same billing number, how do you enter the cases? I receive a message that the case has already been entered because it has the same billing number.

Answer: Your error message may come from your collection tool. The information that is required by the OP-33 measure is just the total number of EBRT treatments for the treatment of bone metastases meeting the Denominator Statement and the total number of EBRT treatments meeting the Numerator Statement.

Question: In your presentation, you stated that if the satellite hospital bills under the main hospital's CCN, to think of it as one ED. How does this affect the pain management measure? Our cases are sampled for both facilities together so we may have the case for Hospital A and then also have it selected for Hospital B. If the pain medication was given at Hospital A, but we are sampling the case for Hospital B, is it excluded for Hospital B because the medication was given at Hospital A?

Answer: For the pain management measure, if both ED visits on the same encounter date meet the inclusion criteria and are billed as two separate claims, both cases may be eligible for abstraction according to sampling requirements. However, please note that Hospital A would exclude the patient from being included for Hospital B because pain medication was administered within 24 hours prior to Hospital B ED arrival.