Outpatient Quality Reporting Program

Support Contractor

The Abstraction Challenge Show: Real Questions, Real Answers

Presentation Transcript

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Karen VanBourgondien: Hello, and welcome to the Hospital Outpatient Quality Reporting Program webinar. Thank you for joining us today. My name is Karen VanBourgondien, the Education Lead for the Hospital OQR Program.

If you have not yet downloaded today's handouts, you can get them from our website at qualityreportingcenter.com. Just click on the Events Calendar, and you can download and print the handouts from that link. They are also attached to the invitation you received for this webinar.

Today we will go over some scenario-based cases dealing with some of the most commonly asked abstracting questions. Although we will be having some fun, the goal is to present some challenging questions and provide answers that abstractors deal with on a daily basis. We would also like to thank the measure writers for their participation in the creation of this webinar, as well as being available in the chat box to answer any questions that you have today. We always appreciate them lending their expertise, which is invaluable. Also, just to let you know, there is an acronyms list at the end of this presentation should you need it.

The learning objectives for this program are listed on this slide. The program is being recorded. A transcript of today's presentation, including the questions and answers received in the chat box, and the audio portion of today's program will be posted at qualityreportingcenter.com at a later date. During the presentation, if you have a question, please put your question in the chat box located on the left side of your screen, and one of our subject matter experts will respond. Later in the presentation we will give you an opportunity to join in the fun with some interactive questions and answers.

So, without any further ado, let's get started.

Answers McFreely: Welcome to The Abstraction Challenge Show: Real Questions, Real Answers, where we invite you to take a front seat to answer some of our most difficult and troubling abstracting questions. My name is Answers McFreely. And I know what you're thinking folks, and yes, that is a family name. I will be your host today. Also joining me is Hannah Black, my assistant extraordinaire.

So, let's get started with some game rules. The contestants will be asked questions by yours truly. These questions will vary in category and level of difficulty. The more difficult the question, the more points they are worth. The contestants will have three Lifelines. This advantage can be used when they do not know the answer to the question. If the Lifeline used provides them with the correct answer, the contestant will receive the points. The Lifelines available are: Ask the Audience, Phone an Expert, Ask an SME, or Subject Matter Expert. And to our folks in the audience, we invite you to play along and see how well you score.

Our first contestant is Marylou; she works for ABC Hospital and has been abstracting for the OQR program for five years. Her favorite food is pizza, and she loves dogs. Welcome, Marylou.

Marylou: Hello, Answers McFreely. I 'm excited to be here. I am ready to answer anything you can throw at me.

Answers McFreely: Thank you for joining us today, Marylou.

Our second contestant is Spencer. Spencer is with XYZ Hospital and has been abstracting for the OQR program for one year. His favorite food is sushi, and he enjoys skiing.

Welcome, Spencer. Are you ready to play today?

Spencer: Yes Answers, I am ready. I am new to abstracting, but I think I am ready for anything you've got for me.

Answers McFreely: It's great to have you Spencer. Now, let's take a look at our categories. The categories today are: OP-29, ECG Time, Time Last Known Well, Discharge Code, OP-33, Program Questions, Probable Cardiac Chest Pain, OP-30, Arrival Time, Initial ECG Interpretation, ED Discharge Time, and the Bonus Question.

Now, Marylou, you won the coin toss back stage, so you're up first. Please choose your category.

Marylou: Thank you, Answers. To start with, I think I will choose OP-29, please.

Answers McFreely: MaryLou, you have selected OP-29: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients. As you know, this is a colonoscopy measure which is the percentage of patients aged 50-75 years of age receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report. Now, here's your question.

The abstractor states: There is not a documented follow-up interval. The physician documented in the colonoscopy report "Recommendation for a repeat colonoscopy pending pathology results."

The abstractor wants to know: Should this case be a denominator exclusion? MaryLou, for 100 points, what is your answer?

Marylou: Well, Mr. McFreely, I am confused as to why this case is being reported for OP-29; it seems like they had a biopsy. So, I would say yes, this case should be excluded.

Answers McFreely: You are right, MaryLou! This case would be excluded. If the patient had a biopsy or polypectomy, they do not meet the denominator statement criteria. This measure includes all patients aged 50-75 years of age receiving screening colonoscopy without biopsy or polypectomy. This case would not meet the denominator criteria for OP-29. Now, Spencer, you're up. And what is your category?

Spencer: I think I will go with Marylou and choose OP-29 as well.

Answers McFreely: Okay, Spencer, you have chosen OP-29 for 200 points. And the question is: Can the abstractor take the *Date of Birth* listed on the operative report to indicate the patient is older than 66 years of age and accept that as a medical reason for no follow-up recommendation of at least 10 years, or does the physician have to document no follow-up recommended because the patient is greater than 66 years of age?

Spencer: Oh, wow. I hate to do this right out of the gate, but can I use a Lifeline?

Answers McFreely: Of course, and what Lifeline would you like to use? Again, you can choose from Ask the Audience, Phone an Expert, or Ask an SME.

Spencer: I want to use Ask a Subject Matter Expert.

Answers McFreely: All right, Spencer. You have chosen Ask an SME. If you ever want your measure-specific questions answered, you always have access to the subject matter experts. Being able to communicate directly with the measure writers is a great way to receive a response to your question. These experts helped us in developing all the questions and answers used today. Now let's check out how to contact these experts. Hannah, tell us how to ask a Subject Matter Expert.

Hannah Black: Thank you, Answers McFreely! To communicate with the various subject matter experts, you can access the Questions and Answers tool from the home page of QualityNet. The address is noted here at the top of the slide. You can see that in the second box on the right-hand side of the page, it says "Questions & Answers." Simply click on Hospitals-Outpatient. You will have to sign-up with an email so that the SMEs can respond to your question. It is very simple and easy. The support contractor did a webinar on this Q and A platform earlier; you can access that webinar in the Archived Events tab for this program on qualityreportingcenter.com. Answers? Back to you.

Answers McFreely: Thank you, Hannah. So, Spencer, that is how you can get your measure-specific abstraction questions answered. Now, let's see what they said about your question.

Just to remind the audience, the question is: Can the abstractor take the *Date of Birth* listed on the operative report to indicate the patient is older than 66 years of age and accept that as a medical reason for no follow-up recommendation of at least ten years, or does the physician have to document no follow-up recommended because the patient is greater than 66 years of age?

And the answer is: Yes. The *Date of Birth* can be taken from the operative report indicating the patient is older than 66. If the patient's age is equal to or greater than 66, or life expectancy is less than 10 years and there is documentation for no further colonoscopy needed, it would be acceptable to exclude the case from the denominator.

As a reminder, there was a change in the Specifications Manual version 11.0 regarding the denominator exclusions for OP-29. The denominator exclusion was changed to "documentation indicating no follow-up colonoscopy is needed or recommended is only acceptable if the patient's age is documented as **greater than or equal to 66 years old, or life expectancy is less 10 years.**"

Your lifeline just earned you 200 points, Spencer. Now, Marylou, you're up next, and what is your category?

Marylou: Answers, I think I will go for the Initial ECG Interpretation, please.

Answers McFreely: Marylou, you have selected *Initial ECG Interpretation*: ST-segment elevation based on the documentation of the electrocardiogram performed closest to the emergency department arrival. Now, let's take a look at your question.

Marylou, Initial ECG Interpretation for 200 points. The abstractor wants to know: For the data element *Initial ECG Interpretation*, would the word "minimal" be considered an exclusion criterion?

Marylou: Yes, minimal should be an exclusion.

Answers McFreely: That is correct, Marylou! In version 11.0a of the Specifications Manual, it states, "All ST-elevation in one interpretation described in one or more of the following ways: 'Minimal' should be considered an exclusion for the *Initial ECG Interpretation* data element."
Great job, Marylou; you have earned another 200 points. Spencer, back to you. And what is your category?

Spencer: Answers, I will choose *Time Last Known Well.*

Answers McFreely: All right, Spencer, *Time Last Known Well*: The time prior to hospital arrival at which the patient was last known to be without the signs and symptoms of the current stroke or at his or her baseline state of health.

Your question, for 300 points, is in the following scenario: The arrival time was 2259. The Emergency Department physician documents: "timing/time-course: onset of symptoms was sudden, severity is moderate, duration for approximately one hour prior to arrival."

The abstractor asks: Can I use 2159 as the *Time Last Known Well*? Spencer? And what is your answer?

Spencer: I am going to go with yes. The abstractor can use 2159 as the *Time Last Known Well.*

Answers McFreely: Spencer, you are correct! The experts have said: Based on the documentation provided, you may subtract one hour from the arrival time of 2259, and use that time to abstract *Time Last Known Well*. Version 11.0a of the OQR Specifications Manual defines this data element as "the time prior to hospital arrival at which the patient was last known to be without the signs and symptoms of the current stroke or at his or her baseline state of health."

The manual provides the following guidance: “If the *Time Last Known Well* is documented as being a specific number of hours prior to arrival, for example, felt left side go numb two hours ago, rather than a specific time, subtract that number from the time of ED arrival and enter that time as the *Time Last Known Well*.”

Well, Marylou, it’s back to you. And what is your category?

Marylou: Mr. McFreely, I think I will go to the colonoscopy web-based measure OP-30. Spencer is giving me a run here. I think I know the OP-30 measure pretty well.

Answers McFreely: All right, MaryLou. You have chosen OP-30: Colonoscopy Interval for Patients with a History of Adenomatous Polyps–Avoidance of Inappropriate Use. This measure is the percentage of patients aged 18 and older receiving a surveillance colonoscopy, with a history of prior colonic polyps in previous colonoscopy findings, who had a follow-up interval of three or more years since their last colonoscopy.

And your scenario for 200 points is: The physician writes on the History and Physical, "White male presents for colon cancer screening; he had a polyp on exam in 2008." Now the abstractor wants to know: How do I answer documentation that the patient had an interval of three or more years since their last colonoscopy?

Marylou: Well, Answers, it says he had a polyp in 2008, and that is certainly longer than three years, so the abstractor would be able to answer yes; it has been more than three years.

Answers McFreely: All right, Marylou, let’s take a look at the answer. And the experts say: “The documentation provided does not indicate a colonoscopy was performed and would not be used to establish the interval since the last colonoscopy.”

I’m sorry, Marylou. It appears the documentation could not be used. Tough break. All right, Spencer, we are back to you. And what is your category?

Spencer: Well, Answers, I think this time I will choose *Probable Cardiac Chest Pain*.

Answers McFreely: All right, Spencer. You have chosen *Probable Cardiac Chest Pain*: Documentation that a nurse or physician, APN, or PA presumed the patient’s chest pain to be cardiac in origin. And here is your question: For 200 points your scenario is: A response in the QualityNet Q&A tool from 2015 contains this wording: "precordial chest pain would be considered to be clinically synonymous with 'chest-wall pain' which is also an exclusion." Please clarify if the diagnosis

"Precordial Chest Pain" is an exclusion when evaluating *Probable Cardiac Chest Pain*.

Spencer: Oh, wow. This is a tough one. I would say Precordial Chest Pain is an exclusion if the surrounding documentation indicates it is not cardiac in nature. So, the abstractor would say no to *Probable Cardiac Chest Pain*.

Answers McFreely: And the experts say: Precordial chest pain is considered to best match exclusion or inclusion terms on a case-by-case basis. If there is surrounding documentation to indicate that "precordial chest pain" best matches the exclusion term "chest wall pain," then a no may be abstracted for the *Probable Cardiac Chest Pain* data element. However, since the full account of the patient record is not available to the measure writers, please consider the entire context and differential diagnoses and use your best judgment to determine if there is a working diagnosis of acute myocardial infarction or other documentation that clearly suggests the patient's chest pain was presumed to be cardiac in origin. Well, you are correct, Spencer. Nice job!

All right, Marylou, we are back to you. And what is your category?

Marylou: I'm going to go with *Arrival Time*.

Answers McFreely: Marylou, you have chosen *Arrival Time*: The earliest documented time (military time) the patient arrived at the outpatient or emergency department. Your scenario and question for 100 points are: A patient arrives to the ED by ambulance. The ambulance arrived in the parking lot of the hospital at 6:51. The hospital triage note is 6:59. The EMS note states arrival to the ED is 6:45. What is the *Arrival Time*?

Marylou: I don't know. This is a little confusing. I would like to use a Lifeline please, Answers McFreely.

Answers McFreely: All right, Marylou. And what Lifeline would you like to use?

Marylou: I want to use my Ask the Audience Lifeline. I think the audience can help me with this.

Answers McFreely: All right, Marylou. We will ask the audience to take a minute and read this slide again. All right, folks, let's give Marylou some help. Hannah Black, please be so kind as to take this question to the audience.

Answers McFreely: Thank you, everyone. And the answer is 6:59. You will abstract the time the patient physically arrived in the ED for the ED *Arrival Time*.

In this scenario, the time would be 6:59. Please remember that documentation outside of the Only Acceptable Sources list should not be referenced (e.g., ambulance record, physician office record, History and Physical). And that's a great job, everyone.

Spencer, my man, it's your turn. And what is your category?

Spencer: Mr. McFreely, I am also going to go with *Arrival Time*.

Answers McFreely: All right, Spencer. For 200 Points, here is your scenario and question: A patient came to the radiology department at 1417 and had an outpatient ultrasound. During this ultrasound, the patient was found to have an acute DVT and was sent to the ED. The patient arrived at the ED at 1659. Now the abstractor is asking: Which time would I use for the patient *Arrival Time* for OP-18?

Spencer: Well, you are supposed to abstract the earliest time, so I am going to go with the time 1417.

Answers McFreely: All right, Spencer, let's take a look at the answer. And the experts say: You would abstract the time documented of when the patient physically arrived to the ED. In this scenario that time would be 1659. Although the patient arrived at 1417, that arrival time was to the radiology department. The time of 1659 was the arrival time to the ED.

Sorry, Spencer. The answer of 1417 is incorrect.

All right, Marylou, it's back to you. And what category would you like to use?

Marylou: I'd like to go back to OP-29. I had good luck with that the last time.

Answers McFreely: All right, Marylou, OP-29: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients. And here is your question. For 300 points: The reason for exam in the colonoscopy report states "routine screening, high risk" with a discharge recommendation of "repeat in five years." Would this patient be excluded from the denominator due to the medical reason of "high risk?" And Marylou, what is your answer?

Marylou: This case would be excluded. I think that the high-risk documentation would be an exclusion, and we would not include this case to abstract.

Answers McFreely: All right, Marylou, now let's take a look. And you are correct, Marylou! If the physician documents that the patient is high risk as the medical reason for recommending a follow-up interval of less than 10 years, then the patient would be excluded from the denominator. It is at the physician's discretion to determine the medical reason for recommending a repeat procedure in a shorter time interval. Marylou, nicely done; you have gained another 300 points. Folks, it seems our contestants today are evenly matched. Spencer you're up now, and what is your category?

Spencer: Well Answers, I think I will choose *ECG Time*.

Answers McFreely: All right, Spencer. ECG Time: The military time represented in hours and minutes at which the earliest 12-lead Electrocardiogram was performed. For 200 points, here is the scenario. The patient arrived to the Emergency Department by ambulance at 0523. The statement "Patient was hooked up to 12-lead" is documented in the ambulance's narrative documentation with no stated time. There is not a copy of an ECG in the ambulance records. In the ambulance record under Vitals, there is a column with the heading "Rhythm." Under this "Rhythm" column there are two entries of "Regular" at 0454 and 0510. The patient did have a 12-lead ECG at 0529 just after arrival to the hospital. Would the ambulance record documentation be enough to prove that the patient had a 12-lead ECG performed prior to arrival? Would my answer be 0523 or 0529 to the *ECG Time* question based on this questionable ambulance documentation? All right, Spencer. There is a lot going on in this scenario. And what is your answer?

Spencer: Wow, let me think here. It is a little confusing because there were ECGs done by the ambulance, but the documentation seems to be in question. I am going to say *ECG Time* should be 0523. This was the ECG done by EMS.

Answers McFreely: All right, Spencer. Let's take a look at what the experts say. And you are correct, Spencer! You will use 0523, but let's discuss what the experts say in more detail. Based on the documentation, you may use *Arrival Time*, 0523, to abstract *ECG Time* because there is documentation a 12-lead ECG was performed within 60 minutes of arrival. Please note that a physical or scanned copy of the ECG is not required to abstract this data element. In Version 11.0a of the Hospital OQR Specifications Manual, this data element is defined as "the time (military time) represented in hours and minutes at which the earliest 12-lead Electrocardiogram (ECG) was performed."

Additionally, the manual provides the following guidance: If there are two ECGs performed (one prior to arrival and one after arrival), abstract the ECG performed prior to arrival. In the event the patient had an ECG performed within 60 minutes prior to arrival at the emergency department, enter the time the patient arrived at the emergency department.

All right, Marylou. It is back to you. And what is your category?

Marylou: Answers, I'm going to go with OP-33 this time.

Answers McFreely: All right, Marylou. OP-33: External Beam Radiotherapy for Bone Metastases. Let's take a look at your question. The abstractor wants to know: For a patient undergoing EBRT, the documentation notes thoracic spine cord compression, and the new site is noted at T7-T12. Based on current guidelines, this patient should be excluded from the EBRT measure for this site. Is that correct? And what is your answer, Marylou?

Marylou: Well, I would say if the patient is having a treatment at T7-T12, then the cord compression would have to be in the same area to be excluded.

Answers McFreely: All right, Marylou. Let's see what the experts say. And that is correct. Cord compression only qualifies a case for exclusion if it has afflicted the same anatomical site that is now receiving EBRT treatment. Does the documented thoracic cord compression overlap with the treatment site (T7-T12)? If so, the patient should be excluded.

Your answer is correct, Marylou. The documentation has to state that the treatment area is the same as the cord compression.

All right, Spencer. We're back to you. And what is your category?

Spencer: Okay, Answers. This time I think I will choose *Time Last Known Well*.

Answers McFreely: All right, Spencer. Let's take a look at the question. Your scenario is: The arrival time is 2229. The physician documentation at 2236 is "An 83-year-old male presents one hour after the sudden onset of right hemiparesis." The abstractor wants to know: For time of symptom onset, do I subtract an hour from the 2236 documentation, so *Time Last Known Well*/symptom onset would be 2136, or from the arrival time, so *Time Last Known Well*/symptom onset would be 2129?

And Spencer, what do you say? Should the abstractor subtract an hour from the 2236 time of the physician documentation or subtract an hour from the arrival time of 2229?

Spencer: Okay, well, this is confusing. I am going to go with the physician documentation of *Time Last Known Well*/symptom onset. This would be subtracting an hour from the physician documentation time of 2236 time, which would be 2136.

Answers McFreely: All right, Spencer. Let's take a look at the experts' response to your scenario. Sorry, Spencer. It looks like that is incorrect. You may subtract one hour from *Arrival Time* and use that time, 2129, to abstract *Time Last Known Well*. Version 11.0a of the Hospital OQR Specifications Manual defines this data element as "the time prior to hospital arrival at which the patient was last known to be without the signs and symptoms of the current stroke or at his or her baseline state of health."

The manual also provides the following guidance: If the *Time Last Known Well* is noted to be a range of time prior to ED arrival (e.g., felt left side go numb two to three hours ago), assume the maximum time from the range (e.g., three hours), and subtract that number of hours from the time of arrival to compute the *Time Last Known Well.*

All right, Marylou, and we are back to you. And what is your category?

Marylou: Well, after Spencer's last question, I think I'll go in a completely different direction. I think I'm going to choose the Program Questions category.

Answers McFreely: All right, Marylou. You have chosen Program Questions. This can be anything related to the Hospital OQR Program, so let's take a look. Marylou, for 100 points, the question is: I know when abstracting the clinical measures if I have low case volumes I do not have to report anything. Is this true? I have heard something about five or fewer. Can you elaborate?

Well, Marylou, what do you say? How would you answer this question?

Marylou: What do I say? Well, I have to say I'm not sure. I know there is something about the five or fewer, but I am not real clear. Mr. McFreely, I would like to use a Lifeline, please.

Answers McFreely: All right, Marylou, and what Lifeline would you like to utilize?

Marylou: I think I will talk to the experts and use Phone an Expert.

Answers McFreely: All right, Marylou, you have chosen Phone an Expert. The Support Contractor help desk will be able to answer all of your program-related questions. Now let's turn it over to Hannah Black, and she will call the help desk number, 866-800-8756. Hannah, take it away.

Hannah Black: Thank you, Answers McFreely. I have the help desk on the line.

Help Desk: Hello, Quality Reporting. How can I assist you today?

Hannah Black: We have a question. Can you please explain the five or fewer rule for quarterly submissions?

Help Desk: Absolutely! In order to reduce the burden on hospitals that treat a low number of patients, hospitals that have five or fewer cases in a quarter for any measure set will not be required to submit patient-level data for that measure set for the given quarter. Let me mention that the AMI and Chest Pain measure sets are combined, so if a hospital has five or fewer cases for these measure sets together, they will not be required to submit patient-level data for that quarter. Now, having said that, if hospitals fall into that five or fewer category, they can still submit that data voluntarily if they choose to do so.

Hannah Black: Is there somewhere people can find this information?

Help Desk: Yes. You can find this information under the Data Transmission section of the Specifications Manual.

Hannah Black: Okay, great. Thank you.

Help Desk: It's my pleasure; you have a wonderful day.

Hannah Black: Answers—back to you!

Answers McFreely: Thank you, Hannah. Now, let's recap what the help desk just said.

To reduce the burden on hospitals that treat a low number of patients but otherwise meet the submission requirements for a particular quality measure, hospitals that have five or fewer cases in a quarter, both Medicare and non-Medicare, for any measure set will not be required to submit patient-level data for the entire measure set for that quarter.

For the purpose of calculating submission thresholds, the AMI and CP measure sets are combined; therefore, hospitals with five or fewer cases in a quarter, both Medicare and non-Medicare, will not be required to submit patient-level data for that quarter. Even if hospitals are not required to submit patient-level data because they have five or fewer cases, they may still voluntarily do so.

You can find more information regarding this submission threshold in the Specifications Manual in Section 5, Hospital Outpatient Quality Measure Data Transmission.

All right, Spencer, it's your turn. And what is your category?

Spencer: I am going to choose Initial ECG Interpretation Mr. McFreely.

Answers McFreely: For 100 points, here is the scenario: I have a medical record with the following documentation, "EKG interpretation: Sinus tachycardia, probable anterior infarct, acute borderline T abnormalities, inferior leads." Are "T abnormalities" synonymous with "ST abnormalities?"

And Spencer, what is your answer?

Spencer: My answer is no. T abnormalities are not the same as ST abnormalities.

Answers McFreely: And that is correct, Spencer! No. The Specifications Manual states that "ST-elevation described using one of the negative modifiers or qualifiers listed under the Exclusion Guidelines for Abstraction" should be considered an exclusion." However, "T abnormalities" are not synonymous with "ST abnormalities," and you should not consider "borderline T abnormalities" to be an exclusion in this case.

Great job! You have earned another 100 points. Now, Marylou it is back to you. And what is your category?

Marylou: Okay, I'm going to go with *Probable Cardiac Chest Pain*.

Answers McFreely: For 300 points, here is your scenario and question: The ED physician documented the impression as "acute chest pain" but did not document that this was related to a cardiac issue. The case was coded as R07.9 chest pain, unspecified. The manual indicates that this code typically best matches the exclusion term "non-specific chest pain." Does this mean that even if an inclusion term is used, such as acute chest pain, but with no documentation that this is related to a cardiac issue, then it would be abstracted as "no" to Probable Cardiac Chest Pain?

Well, Marylou, what do you think?

Marylou: Well, R07.9, chest pain, unspecified is the same as saying non-specific chest pain. So, I guess the pain should be considered non-cardiac in nature. So, the abstractor would choose "no" to *Probable Cardiac Chest Pain*.

Answers McFreely: All right, Marylou. Let's see what the experts say. "R07.9 Chest Pain, unspecified" matches the data element exclusion term "non-specific chest pain" unless surrounding documentation suggests that the "chest pain, unspecified" is clearly linked to a cardiac issue.

Version 11.0a of the Specifications Manual indicates that if there is documentation of any inclusion criteria and no exclusions are present, you should select "yes" for the *Probable Cardiac Chest Pain* data element. However, if there is documentation of an exclusion term, select "no." That being said, if there is documentation of a differential or working diagnosis of acute myocardial infarction, select "yes," even if an exclusion term is documented. The intent of this data element is to determine if the patient's chest pain was cardiac in origin.

That was tricky, Marylou, but good job. And Spencer, we are back to you. And what is your category?

Spencer: Well, while we are talking cardiac, I am going to go with something different altogether. How about *Discharge Code*?

Answers McFreely: All right, Spencer. Here we go. Spencer, you have chosen *Discharge Code*: The final place or setting to which the patient was discharged from the outpatient setting. For 200 points, here is your scenario: The ED Disposition is listed as "eloped" in the medical record. There is no specific mention of the patient leaving AMA or being discharged home. The nurse documented "Patient walked out of ED. Writer was in another room. Pt will be called by writer per MD request."

The physician documented "The CT results were discussed with the patient who appeared very comfortable during his ED stay. He was agreeable to follow-up with his neurologist, and if we can initiate contact with him, an outpatient MRI scan will be arranged and follow-up with the neurologist will be scheduled as well." The abstractor wants to know: Can the documented ED Disposition of "eloped" be interpreted as the patient leaving AMA without specific documentation of the patient leaving against medical advice? If not, do I select UTD for the *Discharge Code* in this situation? All right, this is quite the scenario, Spencer. And what do you think?

Spencer: Well, the abstractor said that the patient eloped, so they left against medical advice. I think that is the *Discharge Code* that should be used. The abstractor should choose 7-Left Against Medical Advice.

Answers McFreely: All right, Spencer. Now, let's take a look at what the experts say. Although a signed AMA form is not required for the data element *Discharge Code*, the medical record must contain physician or nurse documentation that the patient left against medical advice. Since there was no documentation of the patient leaving the ED as AMA in the medical record, you would abstract the ED discharge code as UTD.

I'm sorry Spencer. It is not AMA. The abstractor would use the *Discharge Code* 8-Not Documented or Unable to Determine (UTD). Tough break.

Marylou, you're up now. And what is your category?

Marylou: I think I'll choose OP-33.

Answers McFreely: Marylou, for 400 points, here is your scenario: A patient is to have EBRT treatment to the left SI Pelvis area with the CT simulation worksheet saying the body area is the pelvis, and the superior border is L1, and the inferior border is mid-thigh. There is documentation on the PET scan of a metallic left hip prosthesis. Would this documentation be enough to say "yes" to surgical stabilization with the prosthesis being in the treatment area?

Well, Marylou, what do you think? Should the abstractor say "yes?"

Marylou: Let me just think a minute. Okay, yes, I think the abstractor should say "yes" to surgical stabilization.

Answers McFreely: All right, Marylou. Let's take a look. Yes, given the hip replacement, exclude the patient from the measure as the previous surgery and insertion of prosthetic changes the anatomy of the area and, therefore, the physical considerations. Nicely done, Marylou!

Now folks, our contestants have a done an amazing job today. And to reward one of you, we have a Bonus Question worth 500 points that will tip the scale for one of our contestants.

For 500 points: A patient did not enter the hospital through the ED; she went directly to Labor and Delivery. Do I select UTD for arrival time as she did not arrive to the ED, or do I add the arrival time to Labor and Delivery?

Spencer? What do you think?

Spencer: Well, they were not in the ED, so I guess you would select Unable to Determine, or UTD.

Answers McFreely: All right. And Marylou, for all the marbles, what is your answer?

Marylou: Well, I guess it depends on if the patient had an E/M code. If they do, then you would use the time the patient arrived to Labor and Delivery.

Answers McFreely: Okay, and for the last 500 points, here we go. Let's find out the answer. The Specifications Manual states that this data element intends to capture the earliest documented time (military time) the patient arrived at the outpatient or emergency department. In this scenario, you should abstract the earliest documented time (military time) the patient arrived to Labor and Delivery if the patient has an E/M code for emergency department encounter as defined in Appendix A, OP Table 1.0 for ED Throughput measures.

Well, Marylou, you did it! Great job! What a great game! And thank you to our contestants! Spencer, for only abstracting for a year, you really gave Marylou a run for her money.

I would like to thank our audience today on behalf of the contestants; you did a great job as well. And as your host, Answers McFreely, I am signing off for the Abstraction Challenge Show.

Karen VanBourgondien: Thank you again for joining us today. We hope this was helpful to help you in dealing with the abstraction challenges you encounter. We would also like to thank the various measure writers involved in both the questions and answers presented here today as well as being available in the chat box to respond to your questions.

As a reminder, a recording of today's event, as well as the transcripts of the presentation and all the questions and answers in the chat box, will be posted on our website at qualityreportingcenter.com. Thanks everyone, have a great day!