Outpatient Quality Reporting Program

Support Contractor

Hospital OQR Program Abstraction Questions and Answers

Presentation

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June 21, 2017

Karen VanBourgondien: Hello and welcome to the Hospital OQR webinar. Thank you for joining us today. My name is Karen VanBourgondien, an Education Coordinator for the Hospital OQR Program. Today we thought we would discuss some commonly asked questions and answers when abstracting things are not always clear cut. We hope this presentation will answer some of your questions and provide some clarity. If you have not down loaded today's handouts, you can get those from our website: www.qualityreportingcenter.com just click on today's events and you should be able to download the slides. They were also attached to the invite you were sent for this presentation.

Our speaker for today is Pam Harris, a Project Coordinator for the OQR Program. Pam has vast clinical knowledge and experience and we look forward to what she will provide today. Before I hand things over to our speaker, I would like to extend our thanks to the measure writers that contributed to this webinar and who are here today to answer your questions directly in the chat box. We do appreciate having the subject matter experts available, their knowledge and expertise is much appreciated.

Also, we have used acronyms within the context of the questions and answers to provide a more realistic approach in dealing with the Q & As so we do have a list of acronyms should you need them. And, they are at the very end of this presentation.

Before we begin today's presentation, let me just mention our upcoming events. Please join us in August; CMS will be presenting the Proposed Rule. It is a great opportunity to see what is new and exciting for the program and

CMS always does a really great job presenting this information. This is also the time to submit your comments regarding the OQR measures to CMS. Each comment is reviewed by CMS, so don't miss that opportunity. Any information regarding program updates or educational opportunities will be sent via ListServe. If you are not signed up for this automatic email service, you can do so on the home page of QualityNet.

The learning objectives for this program are listed here on this slide
This 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 www.qualityreportingcenter.com at a later date.

During the presentation, as stated earlier, if you have a question please put that question in the chat box located on the left side of the screen. One of our subject matter experts will respond. Again, by having live chat we hope to accommodate your questions timely and have some real-time feedback. If your question does NOT get answered, please know that ALL questions and answers will be posted on the qualityreportingcenter.com website at a later date. So now, let me turn things over to our speaker, Pam Harris. Pam?

Pam Harris: Good day to everyone, thank you for joining us. Today we are going over some of the top questions that were submitted to the **QualityNet question and answer tool.**

Now, before we go on, I do want to point out something. When we go over these questions and, when you are submitting questions to the Q&A tool, understand that your question is the only thing that the measure writer is evaluating. If your medical record provides additional or conflicting times or information, then you cannot base your abstraction on the answers given. So, you have to take the answers given as reference knowledge. Okay? The measure writers are not looking at the entire patient's medical record. Also, while we are on the subject of submitting questions, let's talk abbreviations. All Hospitals and EHRs are different, so what a normal abbreviation is to you, may not be for someone outside your facility. So, to keep confusion and misunderstandings from happening, please keep your abbreviations down or at least explain them one time.

So, starting out, we are going to address the questions and answers under the cardiac care measures. We are putting these measures together as they are referred as the AMI and Chest Pain measure set at times. You can see OP-1 through OP-5 are listed on this slide. Within these measure sets are data elements and we are going to begin there.

OP-1: Median Time to Fibrinolysis

OP-2: Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival
OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
OP-4: Aspirin at Arrival
OP-5: Median Time to ECG

With the fibrinolytic measures, one of the most frequent questions, deals with reasons why Fibrinolytic Therapy was NOT Received

Let's look at a situation and see if you have had anything near this. So, our first question would be: Can I use a blood pressure of 178/120 as a reason for no thrombolytic? Now, as abstraction is never this cut and dry, this story starts with the patient in a walk-in clinic. The walk-in clinic documents this 178/120 blood pressure and then transfers the patient to the emergency department with an S T elevated Myocardial Infarction. From this ED, the patient was transferred to a second hospital for the Cardiac Cath intervention.
So, let's see what the measure writers say.

The answer is yes. Documentation of "BP of 178/120" aligns with the contraindication "Severe uncontrolled hypertension on presentation (SBP > 180 mmHg or DBP > 110 mmHg)." So, since the record from the clinic is now a part of the patient medical record, you would abstract a value of "1." The reason for that answer is that the Specifications Manual indicates that if there is documentation of a contraindication, or other reason, by a physician/nurse practitioner, 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."

Now, as abstractors, you run into a lot of scenarios with respect to the ECG, ECG date, ECG time and so forth. So, right now, let's take a look at a situation as it relates to the data element ECG.

The abstractor is asking the question of: If there was a valid time documented of when an ECG was performed, but we are unable to find the actual ECG tracing in the Medical Record, is it acceptable to answer yes to the question "was an ECG performed?" The answer is yes; it is acceptable to abstract "yes" for ECG if there is documentation than an ECG was performed. Now, please note that a physical ECG printout is not required to abstract ECG. And you would abstract the ECG performed closest to arrival.

Now let's look at the ED Throughput and talk about some of the challenges in this measure set.

Measures under ED-throughput are:
OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients

OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional
OP-22: Left Without Being Seen

Now, various data elements are used to answer these measures. So, for simplicity sake, once again, we are going to discuss common questions with regard to some of these measures and data elements for the measures.
So, first we will discuss Arrival Time.

Arrival Time is a data element collected for various measures. Also, in today's world there are a lot of free-standing EDs that are actually part of the Hospital system. In addition, there are multiple locations under the same main hospital entity. There are also a multitude of situations. As such, it would be of benefit to discuss a couple of scenarios regarding this situation.

Now, in this scenario, this question is not an arrival time per say but we've added it here as we get this question so frequently. So, in this scenario, the facility had a patient in their free-standing satellite emergency department transfer to the main campus. And the question is: Would this patient be included in our outpatient measures?

So, let's see what the answer is. The answer is yes. Patients who transfer from a free-standing satellite ED to the facility's main campus would remain in the outpatient population, of course only if they meet all other inclusion criteria. If the free-standing ED is billing using the main hospital's CCN, then think of these as one emergency department.

Let's look at another arrival time. In this situation, a patient fills out a "Reason for Visit" form that includes the date and time of arrival and is a part of the emergency department record. The triage nurse also documents the date and time of arrival on the triage assessment. The abstractor wants to know: If the patient's time of arrival is earlier than the triage nurse's documentation time of arrival, which time would be abstracted? In short, if the "Reason for Visit" form is a permanent part of the medical record, it can be used as a data source.

So, you would abstract the earliest documented time of arrival from review of all the applicable data sources to determine the *Arrival Time*.

Now let's move on to *Provider Contact Time*. This is another area of difficulty for abstractors. Both *Provider Contact Time* and *Discharge Time* have a high degree of mismatches. Now, the purpose of *Provider Contact Time* is to capture the earliest time at which the patient had direct contact with the physician/nurse practitioner or PA or institutionally credentialed provider to initiate the medical screening examination in the emergency department.

So, our first question is: If the physician documents in the ED Summary, "Patient Seen On Arrival", can the arrival time be used as the *Provider Contact Time*? Now that's a great question; let's take a look.

And the answer is: No, you cannot use documentation of "seen on arrival" for your *Provider Contact Time* because 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 time to the emergency department. If there is not exact documentation of the specific time of direct contact between the patient and the provider in the medical record, abstractors should abstract "UTD" or unable to determine for the *Provider Contact Time* data element. The specifications manual also states that *Admission Time* and *Arrival Time* are excluded from abstraction for this data element.

So, now let's look at our next category of *ED Departure Time*. For *ED Departure Time*, we have a few questions in this section and that these can cause problems also for abstractors. Now, I like this question because it really reflects the nature of the emergency department. Just because a patient is admitted, does not mean they are going to be moved to their room quickly. It may be hours after a patient is admitted that they make it out of the ED and onto their admitted or observation room.

So, the question here is if a patient is admitted to observation services but is kept in the ED until a bed is made available, what time is the departure time?

For this scenario, the Specifications Manual indicates that for patients who are placed into observation services, you would abstract the time that the order for observation was written. So, if a patient has an observation order at 8 AM but they are not physically moved until 1 PM, you would use the 8 AM time as your *ED Departure Time*. And you can see the value in that. That eliminates adding the 5 hours it took for this patient to leave the ED for their admission room.

Next question. Well, this is an interesting scenario, the ED nurse documents in multiple places that the patient was transferred at 1237, but there is documentation of: the last vital signs were recorded at 1241. The STEMI data sheet included a line "Time Patient Left ED" with the entry of 1243.
So, the abstractor wants to know what discharge time should be?

And the answer: When more than one discharge time is documented, abstract the latest time. In this case, you would abstract 1243.

Discharge Code, in a nutshell: The discharge code is the final place or setting to which the patient was discharged to from the outpatient setting. And, as always with abstracting, things are not always crystal clear.

Our first question is: The physician ordered for the patient to be discharged home, with of course, the discharge instructions, but before the nurse could return to the room and give the discharge instructions, the patient left, which leaves the question, what is my discharge code? You can use a value “8” which is unable to determine; a value “1” of home; or value “7” left against medical advice. Let’s see what the answer is.

Discharge Code “1”; home. The physician had ordered the discharge, so you would select “1” as your discharge code.

Now, there are a lot of different scenarios that come up around AMAs or Against Medical Advice.

In this situation, the medical record progress notes states that the patient requested to be discharged but the discharge was medically contraindicated at that time and an Against Medical Advice (AMA) form was not signed.
The abstractor asked if they should abstract a value of "7," and the answer is yes. A signed AMA form is not required to select value "7 Left Against Medical Advice/AMA.” However, you must have explicit documentation that the patient left AMA.

We will move on to some of the other measures and talk about OP-21 and OP-23 and the data elements for these measures.

Our next topic is Pain Management. There is documentation the patient was administered oral, intranasal, or parenteral pain medication. The following question is relatively common with respect to how to answer “Were they given pain medication?” and this question asks if the patient lists aspirin as a home medication and it is noted as low dose (as in a cardiac dose), should we still answer ‘no’ to “Was there documentation the patient received oral, intranasal, or parenteral pain medication during this emergency department visit?”

In this situation, aspirin, as a daily home medication, would be considered a pain medication given prior to arrival. There has to be clear evidence that the patient received the aspirin or, any other medication with pain relieving factors, within the 24 hours prior to arrival. This documentation would exclude the patient from the measure so the facility would not have data displayed that may show a false delay in medicating the patient in pain.

Stroke or OP-23 measures. There are numerous scenarios with respect to this measure and the data elements, so let’s take a look at a few situations.

In this situation, we are discussing head CT or MRI Scan Interpretation Time. So, if the head CT report states the dictated time was 0941 and then has a signed time of 1020, which time is correct to abstract for interpretation time? Let's look.

You would abstract 0941, as long as this is an accurate time of when the head CT interpretation occurred, this should be the earliest Head CT or MRI scan interpretation time.

So, now let's take a look at the *Last Known Well* data element. And last known time can be slightly confusing. The physician documents sudden and severe headache roughly at 1800. The nurse documents that: "the patient's last known well time was 1853. A headache started really bad at 1900, and then the headache came out of nowhere." Because the physician documented 'roughly' and the nurse wrote an exact time of 1853, should that time be taken or should it even be the 1900, that's when the headache was really bad?

Ok, let's look at the answer. The time is 1800 and the reason that the time 1800 is the correct answer is because the physician's documentation takes precedence over the nurse's documentation. If you look at the OQR Specifications Manual Version 10.0a, it 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 there are multiple times of last know well documented in the absence of the *Time Last Known Well* explicitly documented on a Code Stroke Form, use physician documentation first before other sources (like nursing or EMS). The manual also states: If multiple times last known well are documented by different physicians or the same provider, use the earliest time documented**.** Let's talk about the measures that you input using on on-line submission tool and submit through QualityNet. Now, we will not be discussing all of these today, just a few of the measures.

Now, again, these measures on the slide are not all of the measures submitted using a CMS web-based tool. They are the ones we will be discussing them here today:

OP-26: Hospital Outpatient Volume on Selected Outpatient Surgical Procedures
OP-29: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients
OP-30: Colonoscopy Interval for Patients with a History of Adenomatous Polyps–Avoidance of Inappropriate Use
OP-33: External Beam Radiotherapy for Bone Metastases

So, let's begin with OP-26: Hospital Outpatient Volume on Selected Outpatient Surgical Procedures. We chose this question because it is really asked so commonly. And the question is: Why aren't the surgical procedure codes for OP-26 in the Specification Manual when it is released?

And the answer is: These top 100 surgical procedure codes are posted for the upcoming year. At the end of each calendar year, CMS pulls the top 100 procedures performed for that year. These top 100 surgical procedure codes are then posted for the upcoming year under the OP-26 measure, listed under the associated organ system for that surgical procedure. So, for example, 2017 top 100 surgical procedures will be posted in November of 2017 as an Update to the Specification Manual Version 10.0a. So, you would use these Surgical Procedure Codes to submit your 2017 data for your 2018 reporting.

Switching gears to OP-29, Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients. Let's take a look at a couple of questions for this one.

In this first question, the physician performs a biopsy during the colonoscopy and is awaiting the result. Does the physician still need to document a recommendation for a 10-year follow-up, or would the documentation of "Awaiting biopsy results; will follow-up in the office" be sufficient documentation to be excluded from this measure?
And the measure writers say: If the patient had a biopsy, then the case is excluded from the OP-29 measure. To meet the criteria for the denominator, the patient should be 50 – 75 years of age, receiving screening colonoscopy ***without*** biopsy or polypectomy. Now, this case has a documented biopsy which would exclude the case from the measure.

Now we are going to talk about a scenario that involves the issue of the age of the patient. The abstractor wants to know, for OP-29, if the documentation states "no follow up due to age," is that enough documentation?
The answer is: Yes, if there is documentation that a follow-up colonoscopy is not recommended or needed and it is due to age, then the case would be excluded from the measure.

Let's move on to OP-30 and talk about some of the questions coming in regarding this measure. Our first question on OP-30 is: If a colonoscopy interval of less than three years can be determined from a prior colonoscopy report and the physician documents a medical reason for performing the colonoscopy (i.e., rectal bleeding), is this still acceptable for denominator exclusion purposes?

And the answer is: if the interval can be determined as less than three years, then you can exclude the case based on a medical reason. If the interval can be

determined as less than three years, it would be acceptable to exclude the case based on a medical reason. The interval does not have to be documented by the physician if the interval can be determined. So, let's say for example the nurse documents that the patient states their last colonoscopy was 2 years ago. Then, this would be acceptable documentation for the interval.

Now, moving on to our next question, and that is: If a physician mentions a history of colon cancer found three years ago, can you count this documentation as a past last colonoscopy? That's a great question, and the answer is: No, the documentation of a history of colon cancer found three years ago does not indicate that a colonoscopy was performed.

Okay, OP-33(or EBRT): The External Beam Radiotherapy for Bone Metastases is a newer measure and this has gathered a lot of questions so let's jump in on a couple there. And the question is: A patient received EBRT, but physician's documentation on the initial treatment plan noted this was a "re-treatment," should this case be excluded?

Our answer is: Yes, it should be excluded. When the documentation states the EBRT was prescribed as "re-treatment" or "re-irradiation," this is an indication that the patient has previously received radiation to the same anatomic site.

The next question is: Would pelvic fractures be considered cord compression with regards to OP-33?

And that answer is: Pelvic fractures, in the context of this measure, should NOT be considered spinal cord compression, unless there is explicit clinical documentation linking the two. For example, "fracture has led to spinal cord compression." Thus, this case should not be excluded from the denominator on the basis of spinal cord compression only.

This question relates to the situation involving two anatomic sites. The question states: A patient had two treatments to two different anatomic sites but they were captured in a single encounter (billing number). Should this be abstracted as a single case or as two cases?

And the answer is: this should be abstracted as two cases. All encounters to separate anatomic sites should be abstracted individually even if they are within the same encounter. Please note that vendors have been instructed to create tools where abstraction of multiple treatments within the same encounter can be done.

Well, we have talked about a few questions and answers today; we cannot talk about every scenario and every question everyone could possible think of, but hopefully we've covered some question and answers that are useful to you.

We have listed some resources here. Please do not ever hesitate to call our helpline. We are always more than happy to try to assist you in any way we can. If you have any questions about any measure or a program question, you can also submit your question using the QA tool on QualityNet, the direct link is seen here on this slide. When you ask your question, a subject matter expert will respond directly to you through your email.

Well that's going to do it for me today. I hope this webinar gave everyone something. Let me hand things back over to Karen, thank you.

Thank you, Pam, that was very informative!

We would like to, again, thank the measure writers that have graciously contributed to this presentation and have made themselves available to answer your questions here today in the chat box. As a reminder, all questions and answers are posted on our website at qualityreportingcenter.com at a later date. It is very helpful to go back and read what other folks have asked and the answers to those.

So, that's all the time we have today. We do appreciate you joining us today, and I'm going to turn things back over to our host to go over the CE process. Thank you everyone, have a great day!