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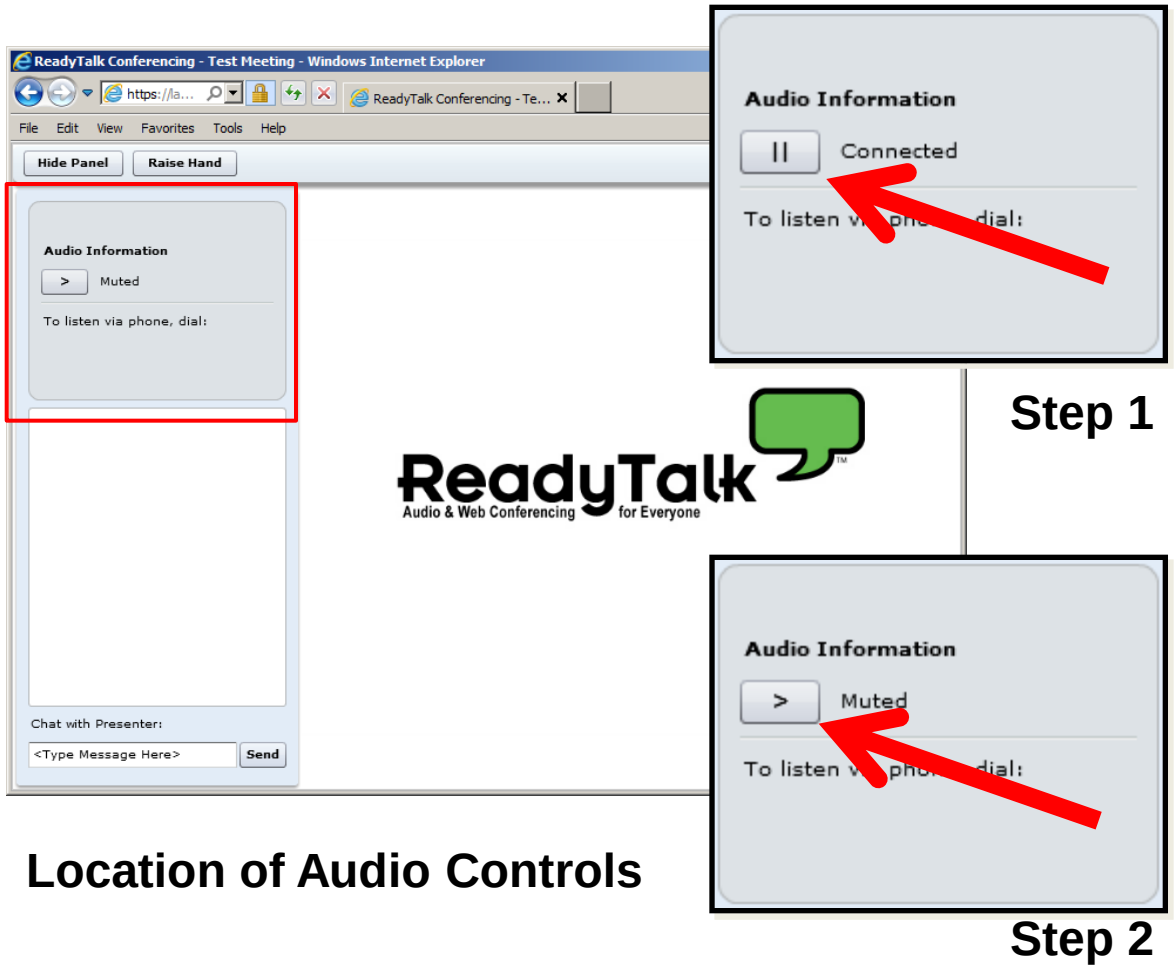

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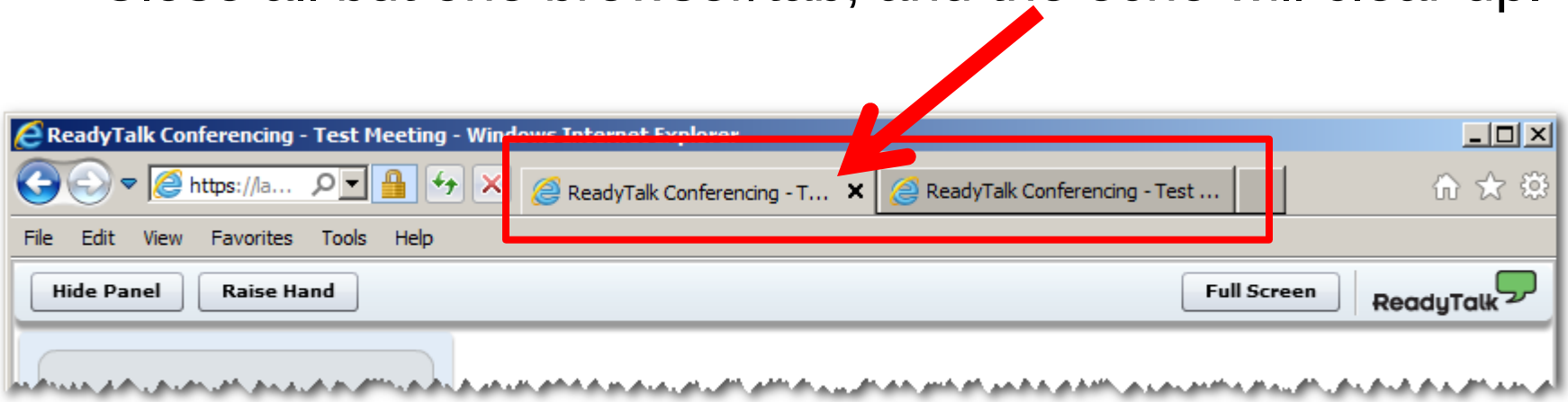

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Submitting Questions

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OQR 2016 Specifications Manual Update

January 20, 2016

Announcements

- January 1, 2016: Submission period for web-based measures submitted via QualityNet begins
- February 1, 2016: Deadline for Clinical Data and Population and Sampling submissions from Q3 (July 1–September 30, 2015)
- Please be sure to access the QualityNet Secure Portal every 60 days to keep your password active

Save the Date

- Upcoming Hospital Outpatient Quality Reporting (OQR) Program educational webinars:
  - February 17, 2016: Tutorial on the OP-33 measure
  - March 16, 2016: Analysis of two-year data for the Hospital OQR Program
- Notifications of additional educational webinars will be sent via ListServe

Learning Objectives

At the conclusion of the program, attendees will be able to:

- Identify changes to the data elements in the Specifications Manuals from version 8.1 to 9.0a
- Describe changes in the Measure Information Forms in the Specifications Manual from version 8.1 to 9.0a
- Be able to locate and access the Specifications Manuals for the program

Agenda

- Specifications Manual Changes
  - Appendix A Conversion to ICD-10 codes
  - Version 8.1 Supplemental Document
  - Changes from versions 8.1 to 9.0 and versions 9.0 to 9.0a:
    - Acute Myocardial Infarction (AMI)/Chest Pain
    - ED-Throughput
    - Pain Management
    - Stroke
    - Imaging Efficiency
    - Web-Based Measures
    - Outcome Measures
- Questions and Answers
- Continuing Education Credit

OQR 2016 Specifications Manual Update

Presented by:

- ***Mathematica Policy Research***
- ***The Lewin Group***
- ***Telligen***
- ***Yale Center for Outcomes Research and Evaluation***
- ***HSAG***

APPENDIX A CONVERSION TO ICD-10

Appendix A Conversion to ICD-10

- Methodology
  - Changes to the ICD-10 codes listed in Appendix A were made based on review by expert coders and clinicians. These changes reflect updates to the crosswalk included in previous versions of the manual.
- Next Steps
  - Appendix A will continue to be reviewed and updated to ensure accuracy and to reflect coding updates.

Version 8.1 Supplemental Document 2

- The Version 8.1 Supplemental Document 2 was released in December to cover encounters through 12/31/15. Changes in the Supplemental Document will also be in effect for subsequent versions of the manual.
- Changes made to Appendix A reflect an updated crosswalk between ICD-9 and ICD-10:
  - Table 1.1: Acute Myocardial Infarction (AMI) Diagnosis Codes
  - Table 1.1a: Chest Pain, Angina, Acute Coronary Syndrome Codes
  - Table 8.0: Ischemic and Hemorrhagic Stroke
  - Table 9.0: Long Bone Fracture

Table 1.1: Acute Myocardial Infarction (AMI) Diagnosis Codes

In the Version **8.1 Supplemental Document 2**, the following changes were made:

- Four ICD-10 codes were added to Table 1.1: Acute Myocardial Infarction (AMI) Diagnosis Codes.
- These codes are related to post procedural and intraoperative acute myocardial infarctions.

Table 1.1a: Chest Pain, Angina, Acute Coronary Syndrome Codes

In the Version **8.1 Supplemental Document 2**, the following changes were made:

- Thirty-five ICD-10 codes were added to Table 1.1a: Chest Pain, Angina, Acute Coronary Syndrome Codes.
  - The majority of the codes are related to atherosclerotic heart disease and angina.
- One ICD-10 code related to pleurodynia was removed from Table 1.1a.

Table 8.0: Ischemic and Hemorrhagic Stroke

In the Version **8.1 Supplemental Document 2**, the following change was made:

- One ICD-10 code was de-duplicated so that it is only listed once in Table 8.0: Ischemic and Hemorrhagic Stroke (I63.49: [cerebral infarction] due to embolism of other cerebral artery).

Table 9.0: Long Bone Fracture

In the Version **8.1 Supplemental Document 2**, the following changes were made:

- Eighty-nine ICD-10 codes were added to Table 9.0: Long Bone Fracture.
  - The majority of the codes are for long bone fractures related to osteoporosis, pathologic fractures, pathologic fractures in neoplastic disease, and fractures following insertion of orthopedic implant.
- One hundred and fifty ICD-10 codes were removed from Table 9.0: Long Bone Fracture.
  - The majority of the codes are related to fractures of the ankle and wrist.

ACUTE MYOCARDIAL INFARCTION (AMI)/CHEST PAIN MEASURES

OP-1, OP-2, OP-3, OP-4, OP-5 (1 of 2)

- 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

OP-1, OP-2, OP-3, OP-4, OP-5 (2 of 2)

In Version **9.0**, the following changes were made:

- The *Data Accuracy* section of the Measure Information Forms for OP-1, OP-2, OP-3, OP-4, and OP-5 were updated to indicate that there may be variation by provider, facility, and documentation protocol for chart-abstracted data elements.

Initial ECG Interpretation

- Collected for: OP-1, OP-2, OP-3
- In Version **9.0**, the following changes were made:
  - The *Notes for Abstraction* were updated to indicate that any inclusion terms qualified by the term "potential" should be disregarded (neither an Inclusion nor an Exclusion).
  - The *Inclusion and Exclusion Guidelines for Abstraction* were reorganized to facilitate abstraction. No text was deleted.

Reason for Delay in Fibrinolytic Therapy

- Collected for: OP-1, OP-2
- In Version **9.0**, the following change was made:
  - The bullet structure of the *Notes for Abstraction* was reorganized to facilitate abstraction. No text was added or deleted.

Transfer for Acute Coronary Intervention

- Collected for: OP-3
- In Version **9.0**, the following change was made:
  - The *Notes for Abstraction* were updated to clarify that an abstractor may select value “1: There was documentation the patient was transferred from this facility’s emergency department to another facility specifically for acute coronary intervention” if the specifically defined reason for transfer “for cath lab” is listed in the emergency department record.

Probable Cardiac Chest Pain

- Collected for: OP-4, OP-5
- In Version **9.0**, the following change was made:
    - The *Inclusion Guidelines for Abstraction* were updated to include “chest tightness.” No text was deleted.

Aspirin Received

- Collected for: OP-4
- In Version **9.0**, the following change was made:
  - The *Definition* and the *Allowable Values* were updated to clarify that aspirin should be administered in the emergency department prior to transfer.

Reason for No Aspirin on Arrival

- Collected for: OP-4
- In Version **9.0**, the following change was made:
  - The bullet structure of the *Notes for Abstraction* was reorganized to facilitate abstraction. No text was added or deleted.

ECG Time

- Collected for: OP-5
- In Version **9.0**, the following change was made:
  - The *Notes for Abstraction* were updated to provide additional clarification regarding abstraction when multiple ECGs are documented.

ED-THROUGHPUT

OP-18, OP-20, OP-22

- 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: ED–Left Without Being Seen (**no changes**)

OP-18, OP-20

- In Version **9.0**, the following changes were made:
  - The *Data Accuracy* section of the Measure Information Forms for OP-18 and OP-20 were updated to indicate that there may be variation by provider, facility, and documentation protocol for chart-abstracted data elements.

Arrival Time

- Collected for: All Records (used in algorithm for OP-1, OP-2, OP-3, OP-5, OP-18, OP-20, OP-21, OP-23)
- In Version **9.0**, the following change was made:
  - The list of *Only Acceptable Sources* was updated to specify that the Emergency Department Record may include the ED face sheet, ED consent/Authorization for treatment forms, ED/Outpatient Registration/sign-in forms, ED ECG reports, ED telemetry/rhythm strips, ED laboratory reports, and ED x-ray reports.

ED Departure Time

- Collected for: OP-3, OP-18
- In Version **9.0**, the following change was made:
  - The bullet structure of the *Notes for Abstraction* were reorganized to clarify that for patients who are placed into observation services, the time of the physician/APN/PA order for observation should be used for the ED Departure Time data element. No text was added or deleted.

Provider Contact Time (1 of 2)

- Collected for: OP-20
- In Version **9.0**, the following changes were made:
  - The *Notes for Abstraction* were updated to clarify that if there is documentation that a provider had direct, personal contact with a patient during an examination and that this was the first direct encounter between the patient and the provider, then this time may be abstracted even if it is not specifically documented as *Provider Contact Time* in the medical record.

Provider Contact Time (2 of 2)

- In Version **9.0**, the following changes were made (continued):
  - The *Notes for Abstraction* were updated to indicate that documentation of a provider writing an order, beginning the patient note, or making other documentation regarding a patient in the medical record is not sufficient for the *Provider Contact Time* data element because there is no evidence that the provider had direct, personal contact with the patient during these actions.
  - The *Notes for Abstraction* were updated to clarify that documentation of a reexamination is not acceptable for the *Provider Contact Time* data element.

PAIN MANAGEMENT

OP-21

- OP-21: Median Time to Pain Management for Long Bone Fracture
- In Version **9.0**, the following changes were made:
  - The *Data Accuracy* section of the Measure Information Form for OP-21 was updated to indicate that there may be variation by provider, facility, and documentation protocol for chart-abstracted data elements.

STROKE

OP-23

- OP-23: Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival
- In Version **9.0**, the following changes were made:
  - The *Data Accuracy* section of the Measure Information Form for OP-23 was updated to indicate that there may be variation by provider, facility, and documentation protocol for chart-abstracted data elements.

Head CT or MRI Scan Interpretation Date

- Collected for: OP-23
- In Version **9.0**, the following changes were made:
  - Examples were added to the *Notes for Abstraction* to provide additional clarification regarding abstraction when multiple interpretations are documented.
  - The *Notes for Abstraction* were updated to clarify that the date associated with the *Head CT or MRI Scan Interpretation Time* should be abstracted as the *Head CT or MRI Scan Interpretation Date*.

IMAGING EFFICIENCY

Imaging Efficiency Measures

- OP-8: MRI Lumbar Spine for Low Back Pain
- OP-9: Mammography Follow-Up Rates
- OP-10: Abdomen CT–Use of Contrast Material
- OP-11: Thorax CT–Use of Contrast Material
- OP-13: Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery
- OP-14: Simultaneous Use of Brain CT and Sinus CT
- OP-15: Use of Brain CT in the Emergency Department for Atraumatic Headache (**measure removed**)

WEB-BASED MEASURES

OP-12, OP-17, OP-25

No changes were made to these measures in Version **9.0** and Version **9.0a**.

- OP-12: The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their ONC-Certified EHR System as Discrete Searchable Data
- OP-17: Tracking Clinical Results between Visits
- OP-25: Safe Surgery Checklist Use

OP-26

OP-26: Hospital Outpatient Volume on Selected Outpatient Surgical Procedures

- In Version **8.1**, Table 1 was updated to reflect the outpatient surgical procedures most frequently performed in calendar year (CY) 2015.
- In Version **9.0a**, Table 1 was replaced with the following language: "Please refer to Specifications Manual v9.1 for the updated categories and HCPCS for Outpatient Surgical Procedures."
- In Version **9.1**, Table 1 will be updated in late 2016 to reflect the outpatient surgical procedures most frequently performed in CY 2016.

OP-27

- OP-27: Influenza Vaccination Coverage among Healthcare Personnel
  - Data must be entered via the National Healthcare Safety Network (NHSN) website using the facility's CMS Certification Number (CCN).
  - The data submission deadline is May 15 annually.
- No changes for this measure.

OP-29 (1 of 2)

- OP-29: Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients
- Changes made in Version **9.0a**:
  - Measure Description
    - "50 years and older" was changed to "50 to 75 years of age"
  - Denominator
    - "50 years and older" was changed to "50 to 75 years of age"
  - Denominator Criteria (Eligible Cases)
    - Added "and ≤ 75"

OP-29 (2 of 2)

- Added examples to Denominator Exclusions:
  - Diverticulitis documented in the medical record and a follow-up interval of 5 years in the colonoscopy report
  - Family history of colon cancer and a follow-up interval of 3 years documented in the colonoscopy report
  - Less than adequate prep documented in the medical record with a repeat colonoscopy in 3 years in the colonoscopy report
- Additional instructions
  - Added “A range that includes ‘10 years’ (e.g.: 7 to 10 years) is not acceptable.”

OP-30 (1 of 3)

- OP-30: Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps–Avoidance of Inappropriate Use
- Changes made in Version **9.0a**:
  - Denominator Criteria (Eligible Cases)
    - The following CPT codes have been inactivated and were removed:
      - 44393
      - 45355
      - 45383

OP-30 (2 of 3)

Denominator Exclusions

- "Documentation of medical reason(s) for an interval of less than 3 years since the last colonoscopy (e.g., patients with high risk for colon cancer, last colonoscopy incomplete, last colonoscopy inadequate prep, piecemeal removal of adenomas, or last colonoscopy found greater than 10 adenomas)"

changed to

- "Documentation of medical reason(s) for an interval of less than 3 years since the last colonoscopy (e.g., patients with high risk for colon cancer, last colonoscopy incomplete, last colonoscopy inadequate prep, piecemeal removal of adenomas/polyps, or last colonoscopy found greater than 10 adenomas/polyps)"

OP-30 (3 of 3)

Added to Denominator Exclusions:

- "For a system reason all of the following must be present in the medical record:
  - The interval since the last colonoscopy is less than 3 years; **and**
  - A medical reason for an interval of less than 3 years is not documented; **and**
  - A "system reason" is documented (e.g., previous colonoscopy report not available, unable to locate last colonoscopy report)."

OP-31 (1 of 2)

- OP-31: Cataracts – Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery
- *Data Collection Approach* section added:
  - "Include procedures performed from the beginning of the reporting year through 90 days prior to the end of the reporting period. This will allow the postoperative period to occur."

OP-31 (2 of 2)

- *Definition for Survey* language updated to:
  - "The same data collection instrument used pre-operatively **must** be used post-operatively."
- The following last sentence added to the *Definition for Survey* section:
  - "For each of the VF tools (VF-14 or VF-8R), all questions have equal weight; only non-missing questions are included, and the total weight is 100."

OUTCOME MEASURE

OP-32 (1 of 5)

- OP-32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy
- *Title* was expanded to full measure title:
  - "Centers for Medicare & Medicaid Services (CMS) Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy Measure"
- Several minor edits were made throughout the Specifications Manual for clarity and will not be reviewed here.
- The substantive edits reflect changes to update cohort codes and exclusion criteria made prior to and following the July 2015 national dry run for the measure.

OP-32 (2 of 5)

CPT/HCPCS codes that define the *patient cohort* have two codes added:

- 45388 – Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
- G6024 – Colonoscopy, flexible; proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare

OP-32 (3 of 5)

Exclusion refined:

- Colonoscopies for patients who lack continuous enrollment in Medicare FFS Parts A and B in the 1 month after the procedure.

changed to

- Colonoscopies for patients who lack continuous enrollment in Medicare FFS Parts A and B in the 7 days after the procedure.

OP-32 (4 of 5)

- Exclusions expanded with underlined text*:*
  - Colonoscopies for patients with a history of inflammatory bowel disease (IBD) or diagnosis of IBD at time of index colonoscopy.
  - Colonoscopies for patients with a history of diverticulitis or diagnosis of diverticulitis (DVT) at time of index colonoscopy.
- Exclusions table added with diagnosis codes (ICD-9 and ICD-10) for IBD and diverticulitis exclusions above.

OP-32 (5 of 5)

Exclusions added:

- Colonoscopies that occur on the same hospital outpatient claim as an ED visit.
- Colonoscopies that occur on the same hospital outpatient claim as an observation stay.
- Colonoscopies followed by a subsequent outpatient colonoscopy procedure within 7 days.

New Measure

OP-33 EBRT

OP-33 (1 of 3)

- OP-33: External Beam Radiotherapy for Bone Metastases (EBRT)
- Percentage of patients, regardless of age, with a diagnosis of painful bone metastases and no history of previous radiation who receive EBRT with an acceptable fractionation scheme.

OP-33 (2 of 3)

- Numerator:
  - All patients, regardless of age, with painful bone metastases and no previous radiation to the same anatomic site who receive EBRT with any of the following recommended fractionation schemes: 30Gy/10fxns, 24Gy/6fxns, 20Gy/5fxns, and 8Gy/1fxns. The data for the numerator may be found in the consultation and office visit notes, outpatient treatment center record, and problem/diagnosis list.
- Denominator:
  - All patients with painful bone metastases and no previous radiation to the same anatomic site who receive EBRT. The data for the denominator may be found in the consultation and office visit notes, outpatient treatment center record, and other-treatment summaries.

OP-33 (3 of 3)

Sampling Size Requirements per hospital for EBRT:

Population Per Year	Sampling Requirements
≤ 39	Include all cases
40–200	40
201–500	20% of cases
≥ 501	100

Don’t Forget

- Always check the updated release notes
- Look for updates
- Make sure you are signed up for the Hospital OQR ListServe
  - Sign up on the home page of QualityNet
- You can find the Specifications Manuals on the QualityNet website at www.qualitynet.org

Questions

CONTINUING EDUCATION CREDIT PROCESS

CE Approval

- This program has been approved for 1.0 continuing education unit for the following professional boards:
  - Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling
  - Florida Board of Nursing Home Administrators
  - Florida Council of Dietetics
  - Florida Board of Pharmacy
  - Board of Registered Nursing (Provider #16578)
- It is your responsibility to submit this form to your accrediting body for credit.
- Nationally accepted by all state Boards of Nursing

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- Please go back to the **New User** link and register your personal email account.
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  - A one-time registration process is required.

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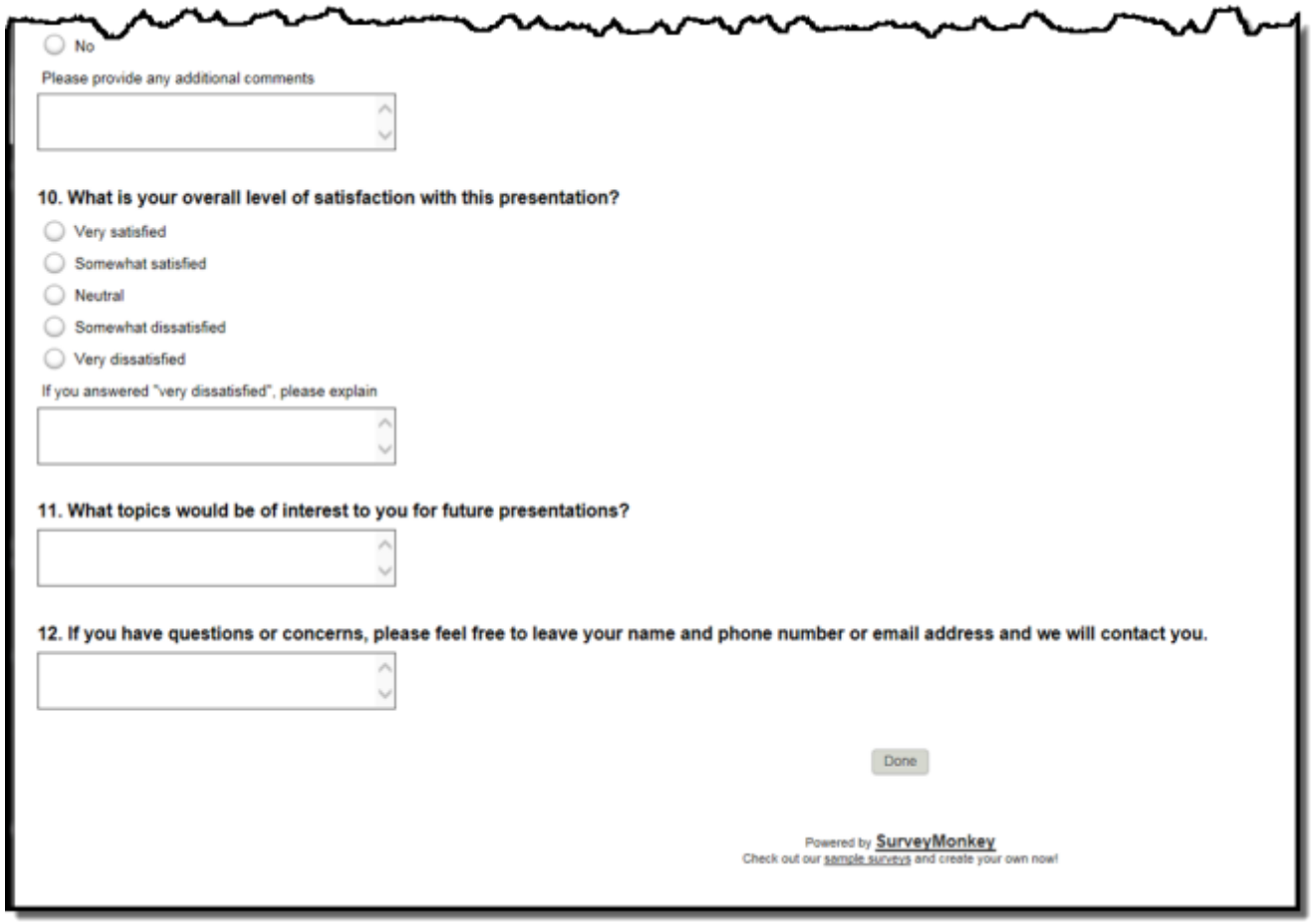

No

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- Somewhat satisfied
- Neutral
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11. What topics would be of interest to you for future presentations?

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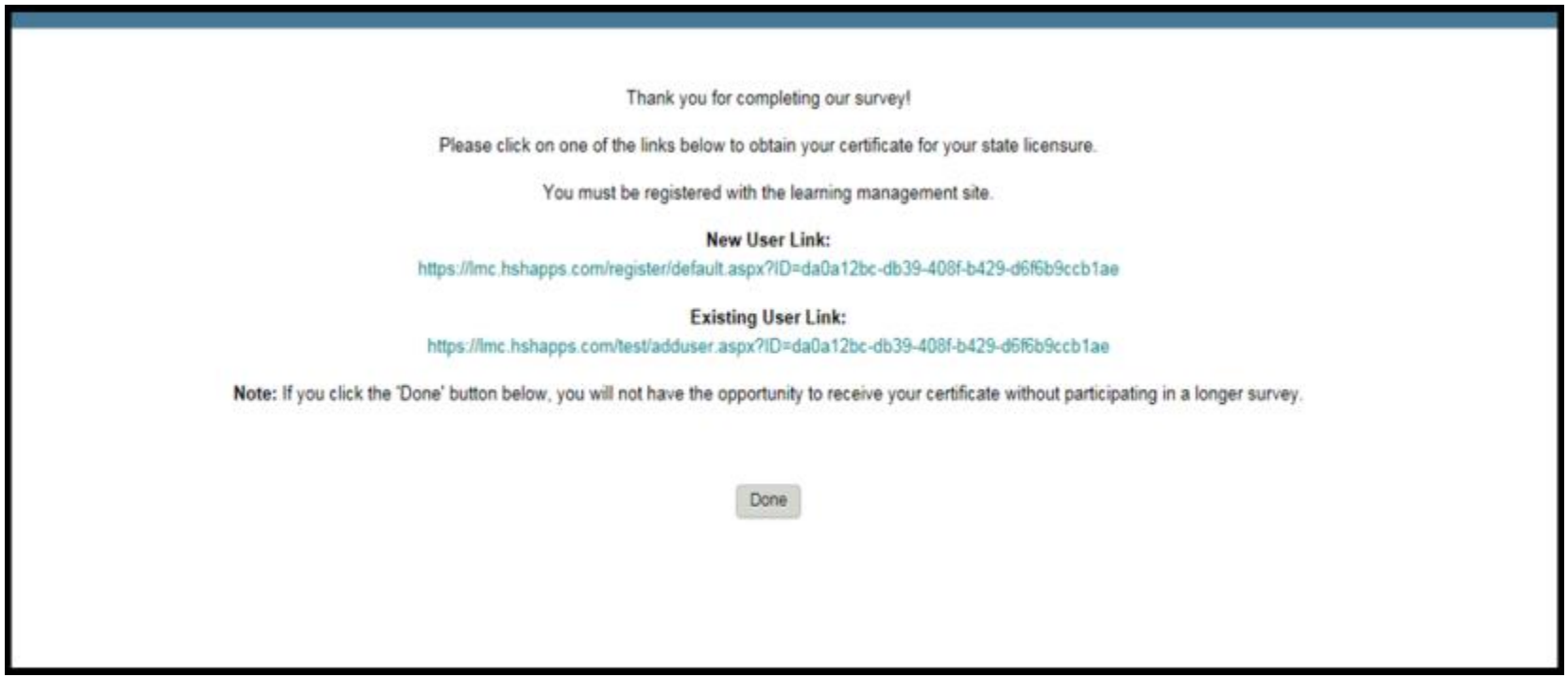
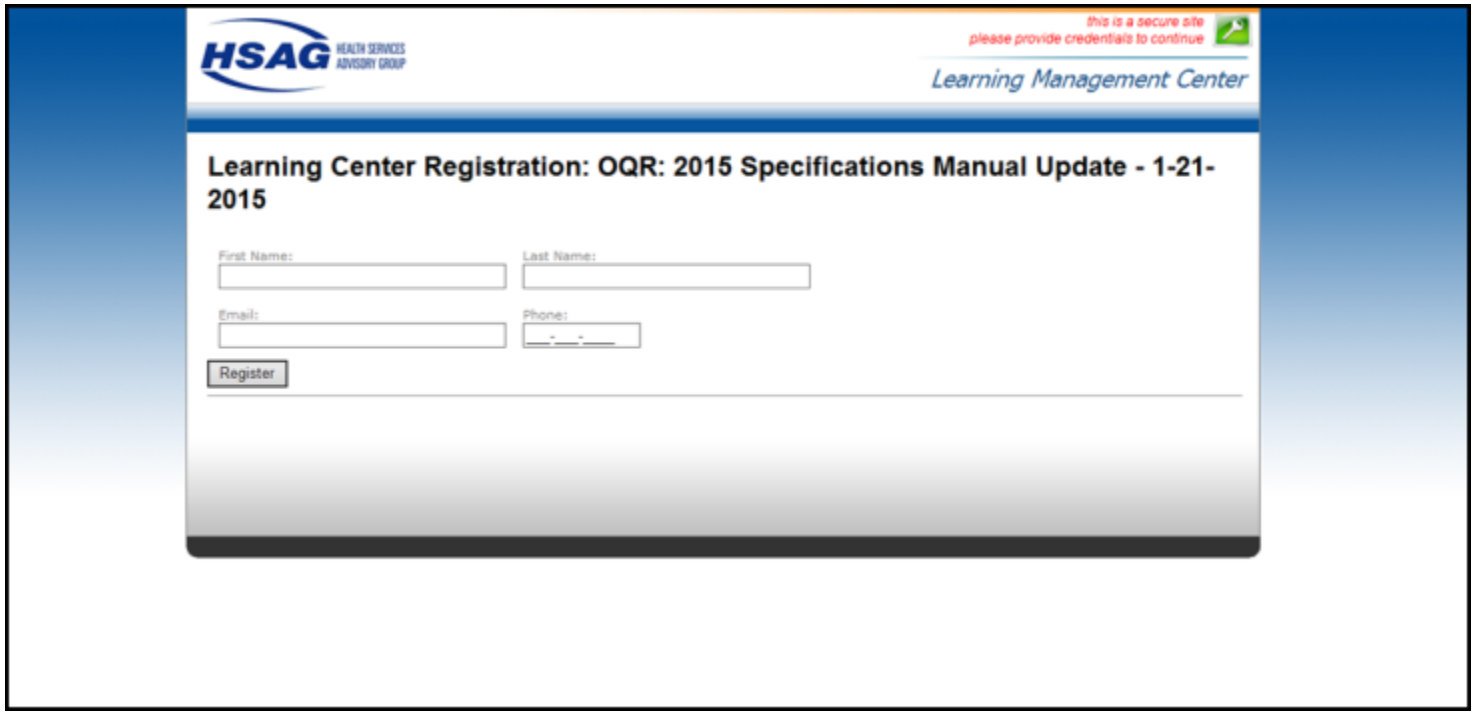
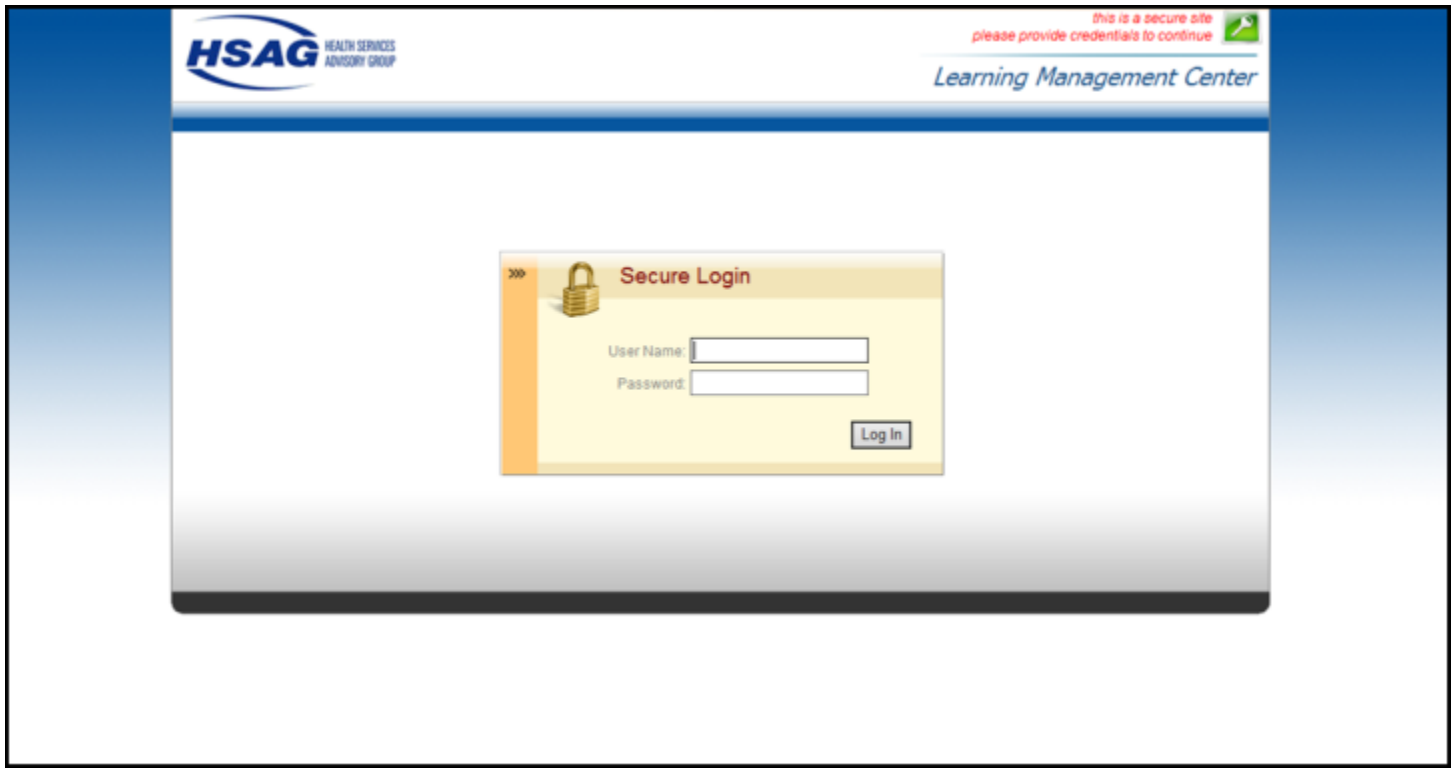


CE Credit Process: New User



CE Credit Process: Existing User



Thank You for Participating!

Please contact the Hospital OQR Support Contractor if you have any questions:

- Submit questions online through the QualityNet Question & Answer Tool at www.qualitynet.org

Or

- Call the Hospital OQR Support Contractor at 866.800.8756.