Hospital Outpatient Quality Reporting Program

Support Contractor

Understanding Web-Based Measures for the Outpatient Quality Reporting Program (OQR)

Questions & Answers

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Question 1: Hi. I wanted to clarify on the Select Payment Year, did you say 2015 or 2016?

Answer 1: For the upcoming submission that you're going to start on July 1st, you are going to select payment year 2016. That's 6, s-i-x. The payment year drop-down box right now doesn't allow that to occur until the submission period opens, but when you do start your submission, you're going to select 2016.

Question 2: Thank you. I listened to your session this morning and was a little confused, so I listened this afternoon just to clarify. So earlier when you were talking about OP-29 and the 10-year interval, you stated that – something that's directly opposite of what I see in the data collection tools on the flow chart. You stated that if they give a 10-year interval, even if there's a medical reason, that maybe they shouldn't have - maybe they find diverticulitis or something like that - that you should still leave them in the population, which is opposite of the order of how you should abstract the case. You should be looking for the medical reason and then the interval, but it was confusing. And the question that was asked this morning made it sound

like we would need to go back and look at all those cases over again.

Answer 2: Yeah, this is Bob. That does get a little bit confusing, but here's the thing to think about. Is the question that you're answering for that – for OP-29 says "documentation of medical reasons for not recommending at least a 10-year follow-up interval?" That question implies that there is not a 10-year follow-up interval is why you're looking for documentation of medical reasons.

So if there is at least a 10-year follow-up interval, you wouldn't – that reason would not – so for example, if they had documented, let's say, diverticulitis as a finding, and they had a follow-up interval of 10 years, the diverticulitis is a finding. It's not a reason for an interval of less than 10 years because your interval is 10 years.

If they documented diverticulitis and a follow-up interval of five to 10 years, then diverticulitis becomes a medical reason for an interval of less than 10 years because they recommended an interval of less than 10 years. Does that help?

Question 2: I'm afraid that people are confused. I'm a vendor that offers this to our customers, and we've already got customers from this morning's session emailing us saying shouldn't those questions be turned around? Shouldn't we ask if it's a 10-year interval first, and if it is, we should stop there and not look at the medical reason? And I'm looking at the flow chart and all the information I have when we built the measures, and I'm saying no to that. But they're hearing something different when you guys are presenting this. So I just want to make sure that we tell our customers the right thing. I agree with you that the question seems to lead you down the path of, well if I see 10 years then they're in, but that's not the way the question got answered this morning. So I just want to clearly understand that we are doing it correctly by excluding them and then moving to the next question if they are not excluded.

Answer 2: So the correct way to do it would be if they have at least a 10-year interval, they're in the measure, and they meet the measure regardless of what else is documented. If the interval

is less than 10 years, then you would want to see if that documentation would constitute a medical reason.

Question 3: Hi. I have a question about when you were talking about the sampling, that all of patients in the sample must be in the denominator. That's not how any other sampling is done for any of the other measures. We sample, and then when we abstract, it's either in the measure or out of the measure. It's not that we sample until we get somebody that's in the denominator and then we move on. That would entail a whole lot more looking at patients than any other measures that we have worked with.

Answer 3: Right. So this is Marty. And the sampling criteria is different for these measures in that the denominator you want to get to be 63 patients or 96 patients. CMS didn't – has not set up sampling guidelines like they did on the other measures where you would take your total population, you would select one every sixth chart, whichever. Here they're trying to get a sample - a full sample in your denominator.

So if you go through your charts and you find that you had 750 colonoscopies you did, and you go through and you sample for OP-29 and OP-30, and you find that for OP-29 you find that you have 70 cases, and you look at 63 of those cases, and you find that four or five of them don't meet the criteria, then go back to the other seven cases that you have and see if those meet the criteria to stay into the measure, and the same with OP-30. You would try and fulfill your sample requirements.

If you're not able to, then you're going to submit 100 percent of what you have to meet the sampling guidelines.

Question 4: Hi. I'm kind of reeling from the answer that you just gave because I agree with the previous caller. That's not how we do samples. But that was not my question, so that'll be something I need to think about next.

But my question was in reference to the documentation of reasons. So like, for instance, in your fictitious number two patient for OP-30 where you say the patient had documented abdominal pain and sluggish digestion, does it have to be documented that this is the reason for an interval that's less

than three years, or can they infer that if you see the documentation of the condition in the record and you see an interval for less than three years, that those two are linked? Or does the phrase from the physician have to say it's less than three years because of this?

Answer 4: That's a question that we get frequently, and it does not have to be stated within the same sentence. So if they have – if they have documentation that the reasons they're doing this colonoscopy is, for example in the situation Karen gave you, like abdominal pain, sluggish digestion. As long as that is in the medical record, that could be used as a reason for excluding the case if the interval is less than three years from the last one. So it doesn't have to be documented within the same statement, or they don't have to specifically say "reason for colonoscopy earlier than three years is because of XYZ." As long as that information is in there and you can link it or infer it, it's acceptable.

Question 5: Thank you. The problem we have in our facility is that we do not, for OP-30, have documentation of when is the last colonoscopy. So if we have no date of the last colonoscopy but we do have a medical reason, like high risk for colon cancer, can we exclude the patient from the denominator?

Answer 5: That would not allow you to exclude the patient from the denominator because you have to have information indicating that the last colonoscopy was less than three years prior in order to exclude them from the denominator.

Now there are some things you can look for. And I know from an abstraction perspective it doesn't help you really right now at this point, but some things that people can think about when they're getting that documentation in there is, as Karen said, you don't have to have the exact date, time, and year. In fact there's some situations where the patient may not remember the exact date, time, and year, but they remember it was four years ago that I had my colonoscopy. That would be as acceptable as saying it was greater than three years ago.

Are you working with an electronic health record?

Question 5:	Yes, we are.
Answer 5:	Okay. So one of the things, and this is a little known paragraph that is contained within the Outpatient Manual. It's not with the Measure Information Forms themselves, but if you are working from an electronic health record, you can look at information from previous visits that would contain – that might contain when that last colonoscopy was. And the rationale for that is stated in the, I think it's the, Introduction of the Data Dictionary, is for electronic health records, if that previous information – if information from previous visits is in the electronic health record, it's readily and easily available at any time. So if their last colonoscopy report was in there in their electronic health record, you could look back and identify how long ago it was and then determine what the interval was. And Marty had a little caveat to that this morning that I probably won't do it justice, if you recall what you said…
Answer 5:	Yeah. That's that the measure right now is not being validated, but if in the future this was to be a validated measure and you had to chart – send in a chart to have it reviewed by the CDAC, then you would need to send in that page from that previous electronic medical record to the CDAC to validate when that previous colonoscopy was. So in a sense, it's like OP-29 asks you to have the date in the colonoscopy report, this would be for OP-30, you would have to show when the previous colonoscopy was in your paperwork that you submitted to the CDAC for validation. But as I say, right now it's not being validated, so when you look back and you obtain that information from your electronic health records, that's fine to look at that date.
Question 6:	Okay. My question has to do with the documentation of that 10-year interval. Can you give me, please, the rationale as to why it has to be in the colonoscopy report? A lot of our physicians will put it in their discharge progress note, in the discharge instructions, I mean, and it clearly says follow-up in 10 years. So why does it have to be in the body of the colonoscopy report?

Answer 6: I honestly am not clear on what the rationale for it specifically being in the colonoscopy report, other than as I'm aware, as you are, that that's how the measure is specified. Marty or Karen, do you have any insights into that?

Answer 6: I think what the specifications of the measure – when they said to put it in the colonoscopy report, they were looking for a one-page report that's going to cover everything. So they're looking for the colonoscopy results, the colonoscopy follow-up, at least that's my understanding.

Question 7: Hi. Going back to the date of the last colonoscopy, if the physician has dictated the symptoms and stuff like that but doesn't give a date, but in that encounter - that electronic record for that encounter - the patient gives us a date, can we use that?

Answer 7: Yes. The date of the last colonoscopy for OP-30 can come from the patient. It just needs to be documented in the medical record, and as we discussed that, if it's an electronic record, you can use from the previous report.

Question 8: Thank you. My question regarding OP-29 is that if the physician recommends a follow-up interval per screening protocol, does that exclude the chart from the denominator?

Answer 8: That would not exclude the chart from the denominator. What it does is it's not a specific interval. So essentially, it would fall into the category of not recommending at least a 10-year interval.

Question 9: Thank you. I had a question about if there were conflicting dates for a last procedure. For example, if the nurses started documenting per what the patient reported and if then there ended up in the record something from the physician that there was a conflict, which one – how would that work?

Answer 9: That's a great question. Typically, on the measures when you have that conflicting type of information, unless it is otherwise specified in the Measure Information Form, you typically will take the information that would result in, I guess, a positive finding. So if the patient was thinking the interval was, for like

OP-30, two years, but the physician documents it was three years and three months or whatever, you would go with what – with the physician documentation because that would result in the case meeting the measure.

Karen or Marty, are you aware that it's any different for these specific measures?

Answer 9: No, we've looked at it the same way.

Answer 9: Yeah, we agree with that.

Question 10: Hi. So a problem we have here at our facility is the issue of implied language, and we know we've sort of touched on that earlier. But the issue that I'm running into is that the physician will document or will imply that the colon was tortuous and then recommend a less than 10-year interval. So in that case, I'm not clinical, so I don't know what the clinical background and the clinical – what the implied language is behind the less than 10-year interval.

So what we're having providers do is we're encouraging them to document five years, a less than 10-year interval due to poor prep or due to so-and-so, and we're asking them to be very explicit. But if I come in – if I run into a case where poor prep or something with a tortuous colon is implied in the colonoscopy report and they – the provider recommends a less than 10-year interval without explicitly stating so, would that be numerator compliant?

Answer 10: That would be acceptable. Obviously, I think it's great that you're making efforts to have your physicians document more explicitly because that is always more helpful, and I think really is a good goal to shoot for. In the case where they don't document it explicitly but they have documentation in the colonoscopy report that says colon was tortuous and then in their follow-up interval they're saying recommend five to 10 years, you can imply that that was the reason why it was five to 10 years.

Answer 10: And let me just add to that - is when we were evaluating these measures, we understood that the abstractors often might not have a medical background, and that's where kind of the basis of it's at the physician's discretion, and basically, any medical reason can eliminate the measure from the required 10-year follow-up if there's a medical reason. So even though you don't have a medical background, when you do see that something, like a tortuous colon, then that's allowable.

Question 11: Thank you. So my question has to do with the OP-30 measure and the date of the last colonoscopy. Oftentimes, the physician, when they're dictating their note right off the bat or very early in their note, they'll say it's been three years since their last colonoscopy or four years since they had their colonoscopy with polyp removed, and I had a comment from one of the questions on the Q&A tool before where they said that I am not allowed to take any documentation from the op procedure note for the last colonoscopy, and I found that hard to believe. And that's mainly why I'm calling just to get a second opinion on that - that are we allowed to take documentation on the procedure note of the last colonoscopy?

Answer 11: So for OP-30, you can take documentation from anywhere in the current medical record. So if that is part of that medical record for that episode or, as we discussed, if you have an electronic health record, you can make reference to other information in the EHR. That would be acceptable. It does not have to be, for OP-30, it does not have to be specifically located in the colonoscopy report. Does that answer your question, or does that help?

Question 11: Yeah. The person who answered the question said if it's in the colonoscopy report you can't take it, and that didn't make sense to me whatsoever, so that's why I'm asking.

Answer 11: Oh, yeah, if it's in the colonoscopy report, you can take that as well, as long as it's part of the medical record.

Question 12: Thank you, but my question was already answered.

Question 13: Hi. On OP-30, so if you cannot find anywhere in the medical record when the last colonoscopy was done, does the doctor

have to specifically say that he doesn't know when it was done in order for you to select a system reason, or can you just select a system reason because you cannot find the date anywhere?

Answer 13: The system reason - this is something that gets really confusing. The system reason is similar to the medical reason in that, in order to make use of it, you have – the physician has to have documented – or you have to have documentation in the medical record that there is an interval of less than three years. If there is no interval stated, the case will not meet the measure, regardless of what else is documented. Right, now I need to back up a moment. Well, yeah, that's right.

So if – this is why it gets confusing. If there is no interval stated, the case is not going to meet the measure, regardless what's documented. If the interval is stated as less than three years, however that's done, if you've got dates in there or they specifically say it was less than three years or however you come to that conclusion and you do not have a medical reason documented, then if you can't find the last colonoscopy report, if that is stated in the documentation, it counts as a system reason. It's another way to allow you to exclude a class if you don't have documentation of specific medical reasons.

An example might be a patient had a colonoscopy, and at that point it was recommended that they come back in within six months, for example. And now they're back for their appointment, you know it was less than three years, but nobody can find that last colonoscopy report so that they know medically why they came in in less than three years. Documentation of not being able to find that medical report allows for a system reason so that lack of – not being able to find that report does not count against the facility.

I know this is a really confusing issue. Does that help at all?

Question 13: Maybe a little bit. So if you know that it was greater than three years ago but you can't find the date, then you could say that there was a system reason?

Answer 13: If you don't know the interval, the case is going to fail the measure regardless.

Answer 13: Let me see if we can say it another way.

Answer 13: In your example you said if you know the case was more than three years ago, then you don't need to look for a system reason or a medical reason because if it was more than three years ago, then the patient is going to be in the denominator.

Now in Bob's example where it was six months ago so you know it's less than three years ago, and you don't have a medical reason documented, then that patient is going to be in the denominator but not in the numerator. If you have a medical reason documented, then it'll be something that could exclude it, or if you have documentation that you're unable to find the colonoscopy report because of a system reason, then that will exclude the measure – or exclude the case from the measure.

Answer 13: Because remember - to use the system reason, you have to have documentation that the interval is less than three years plus a system reason. So in your example, let's say, the patient says I had a colonoscopy two years ago, but nobody can find the report, then the physician needs to document "patient had a colonoscopy two years ago, unable to locate report." So he has documented that the interval is less than three years plus the system reason.

Conversely, if you have the patient that says I have no idea when I had a colonoscopy done, you can't use that as a system reason because you don't know if the interval was less than three years. Does that clarify it a little bit?

Question 13: It does, but I just don't think that it should have to count against us if we don't know that it was or was not. I mean it could have been greater than three years, but you're saying it will still count against us because we don't know.

Answer 13: And the reason that counts against you is that you want your physicians knowing when the last colonoscopy was so that you're not having over-utilization of the procedure, and that's the whole basis of the measure is that if you have a patient the

physician says will come back in two years and we're going to repeat the colonoscopy, but you don't know why because the reason hasn't been given, then that would be a possible overuse of the procedure, documentation – wise, because we don't know exactly if the physician – obviously he had a reason, but he didn't document it. So you'd have to look at that as a failure of the measure due to poor documentation.

Question 14: Thank you. My question has to do with the use of the physician's office notes to determine the date of the last colonoscopy. If those office notes are scanned into the current medical record, can we use them then to determine the date?

Answer 14: Yes, ma'am, you can. Remember we said that you have to have the office notes within the context of that current episode of care. So if you are scanning that into the present or current episode of care, you can use that documentation.

Answer 14: And that would be acceptable in that situation.

Question 14: One other question. A lot of times I'll see documentation where the physician will say something like “patient has a history of colon polyp removal in 2012” but they don't actually use the term “colonoscopy.” Can that type of documentation be used, or no?

Answer 14: Bob, we'll see if you agree with this, but what we've – how we've looked at that is there's – the majority of the time, if a polyp is removed, it's removed through colonoscopy. So you could have an open procedure where they could remove a polyp, but it would be fairly unlikely. So we've looked at that as we can assume that that was a colonoscopy.

Answer 14: I would concur.

Marty Ball: Okay. Well this concludes our program for today, and I'd like to thank Karen and Bob for the valuable information that they shared with us today. We hope you've heard useful information, and that it will help in your Hospital Outpatient Quality Reporting Program chart abstractions.

Please remember that you will not receive your WebEx survey for your CE certificate today, but it will be sent from WebEx in your email within 48 hours.

If you didn't get a chance to have your question answered, please use the question-and-answer tool located on www.qualitynet.org for the Hospital Outpatient Program. The subject matter expert will send you a response.

Thanks again and enjoy the rest of your day.

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