Outpatient Quality Program Systems and Stakeholder Support Team

Overview of the Hospital Outpatient Quality Reporting (OQR) Program Data Validation Efforts

Question and Answer Summary Document

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Subject-matter experts researched and answered the following questions during the live webinar. The questions and responses may have been edited for clarification and grammar.

Question 1: **What happens if a hospital fails validation?**

Hospitals that fail validation will not meet program requirements and may request reconsideration. Information on validation reconsiderations can be found on the Annual Payment Update (APU) Validation Reconsiderations page on the QualityNet website.

Question 2: **Was there a change where hospitals no longer highlight portions of the medical record?**

No. The *Outpatient Data Validation Medical Record Submission Do's and Don'ts* document is posted on the Clinical Data Abstraction Center (CDAC) Information page of the QualityNet website. It states, "Do not highlight or otherwise mark any information in the medical record." The CDAC abstractors would not be able to reference any type of letter/memo/explanation as to how and/or why documentation was abstracted a particular way by your hospital's abstractors. CDAC abstractors would disregard written notes that are not part of the original medical record based on this General Abstraction Guideline: "It is not the intent to have documentation added at the time of abstraction to ensure the passing of the measure." The General Abstraction Guidelines also state that the medical record must be abstracted as documented (taken at "face value").

Question 3: **If the CMS CDAC abstractor finds one element of the case abstraction that is a mismatch, does that automatically mean that the case fails, even if all of the other abstraction elements match?**

No. Validation is not scored at the element level; it is scored at the outcome level. If the end result, or the measure outcome, is the same between a CDAC abstractor and what the hospital originally submitted, then it would be considered a match. If the abstractor at your hospital and the CDAC mismatches on one element and that one element doesn't change the outcome of the measure, then that doesn't constitute a mismatch in terms of the validation efforts. Individual elements are not validated in and of themselves; validation occurs at the outcome level.

Question 4: **Are there educational opportunities on how to abstract for new abstractors?**

In Section 6 of the *Hospital OQR Specifications Manual* there are measure-specific Guidelines and Fact Sheets to assist you in abstraction. Additionally, the Hospital OQR Support Team presents abstraction-based educational webinars for the Hospital OQR Program.

Question 5: **What should our facility do if there was an update to the patient's medical records (for example, an updated Date of Birth or Corrected Departure Time) after the CDAC received them, and the case was selected for validation?**

Hospitals **cannot** submit medical records or additional documentation after the CDAC receives the medical record.

Question 6: **What is the timeline for records request and submission?**

Selected hospitals will receive four total medical record requests containing selected cases. The record requests are usually sent within a few weeks after each quarterly data submission deadline. A Validation Estimated Record Request Dates document is available on the Outpatient Data Validation Resources page of the QualityNet website.

Question 7: **Can you share the validation calculation?**

A detailed confidence interval document, which includes the validation calculation, is available on the *Outpatient Data Validation Resources* page of the QualityNet website.

Question 8: **If hospitals are selected for validation, are hospitals notified if it is random or targeted?**

No. The list posted on QualityNet contains both random and targeted selected providers, but it does not publicly indicate which hospitals were selected randomly and which were targeted. If a hospital would like to know how and why they were selected, they may email the Validation Support Contractor at validation@telligen.com, and we can provide that information. Please include your hospital's six-digit CMS Certification Number (CCN) when inquiring.

Question 9: **If the final confidence score is determined to be less than 75 percent, besides being targeted for validation the following year, what are the other consequences?**

Hospitals that fail hospital outpatient validation are at risk of a 2-percentage point reduction to their Outpatient Prospective Payment System APU for the applicable payment year. For example, if the hospital failed validation for calendar year (CY) 2023 reported data, the applicable 2-percentage point reduction would be for the CY 2025 payment determination.

Question 10: **Is allowing a re-submission of a record with an error new? It seems in the past that, once submitted, there was no chance to re-submit.**

There has been no change. Hospitals **cannot** submit medication records or additional documentation after the CDAC receives the medical record.

Question 11: **What is the estimated arrival of the Confidence Interval (CI) Report?**

When validation of all quarters of the year has been completed, and educational review results have been taken into consideration, hospitals will receive an end-of-year CI Report; this report is typically released in August of each year.

Question 12: **When are hospitals selected for validation? Are the random and targeted hospitals selected at the same time?**

For the Hospital OQR Program, the selection and notification of hospitals for data validation efforts usually occurs around mid-August of each year. Unlike the Hospital Inpatient Quality Reporting (IQR) Program, the Hospital OQR Program selects random and targeted hospitals at the same time, once per year.

Question 13: **Regarding slide 29, is there a limit to the number of reconsideration requests a hospital can submit in a year, in a lifetime? If so, are these limits based on program on CCN?**

Hospitals that fail the Hospital OQR Program requirements may submit a reconsideration for each affected payment year determination. One reconsideration request per payment determination year from the hospital is accepted for the Hospital OQR Program.

If a hospital fails in the Hospital OQR Program and Hospital IQR Program (for example), the hospital may follow the guidelines specific to each program and file a reconsideration to each program. More information on the reconsideration process specific to the Hospital OQR Program can be found on the QualityNet website.

Question 14: **What does Adjudication Completed mean on the case detail report**?

Adjudication Completed indicates that the CDAC has completed its adjudication efforts (formal judgment/validation).

Question 15: **In addition to the Chief Executive Officer and quality improvement contacts, will the QualityNet Administrator [now referred to as the Hospital Quality Reporting (HQR) system security official] be notified of the validation request?**

The Validation Support Contractor sends a supplemental email notification to the Medical Records contact type when the CDAC sends a medical records request packet.

Question 16: **The Managed File Transfer (MFT) application changed the way we upload the records. This did not work for Q1 for our hospital, and we were told to upload the previous way. Does the MFT change currently work for Q2 uploads?**

The Validation Support Contractor did not hear of many hospitals having issues with the new CDAC Providers Form. We're sorry to hear of any inconvenience you experienced. Please do attempt to submit via the new CDAC Providers Form again for Q2 and reach out to the CDAC Help Desk if you experience issues again. Their contact information can be found on the CDAC Information page of the QualityNet website.

Question 17: **Does the August list of hospitals selected for validation for the Hospital OQR Program include random and targeted hospitals?**

Yes, all hospitals selected for validation will be published on the QualityNet website as a downloadable PDF.

Question 18: **How soon do hospitals receive validation results?**

It typically takes 3-4 months after each quarter's medical record request deadline to receive Case Detail Report results via the Hospital Quality Reporting system.

Question 19: **If validation is at the outcome level, where is the outcome in date and time for the OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients measure?**

In the case of a timing measure, the original and validated "outcome" must match (e.g., 203 minutes).

Question 20: **If the emergency department (ED) has holds for Behavioral Health beds, has no order for Observation, and discharges the patient home five days later, is the discharge date the five days later date documented in the ED Discharge Notes? For example, an order is written for Behavioral Health, and five days later the patient is still held in the ED due to no Behavioral Health beds available.**

In the scenario where patients are held in the ED awaiting bed placement, and no order for observation placed, you will abstract the date and time they physically departed the ED.

Question 21: **Can we use the time the discharge instructions were given to patients as the *ED Departure Time* data element? It is the last thing we do before a patient goes home.**

No. Per the *Hospital OQR Specifications Manual*, discharge instruction time is an exclusion for abstracting *ED Departure Time*. The time discharge instructions are provided does not indicate the time the patient physically departed the ED.

Question 22: **Slide 38 states, "The patient is no longer under the care of the ED." Where can I locate this information?**

This guidance is provided in the *Hospital OQR Specifications Manual* under Observation Status for the *ED Departure Time* data element. It states, "The intent of this guidance is to abstract the time that the patient is no longer under the care of the ED. When a patient is placed into observation, their clinical workflow may vary from patients who are not placed into observation prior to departure from the ED, so the observation order may be used instead of the actual ED departure time."

Question 23: **If an order is written for an Inpatient Admission (not Observation), and there is no other order, would we abstract Unable To Determine (UTD)?**

No. If an order was written for an Inpatient Admission, the case would not be eligible for abstraction for the Hospital OQR Program.

Question 24: **Do we need to enter the actual departure date and time from the ED since the order to admit an inpatient does not count as the ED discharge date and time? Can we only use an order to admit for Observation to abstract the ED discharge date and time?**

Yes. The only acceptable order type that can be used in abstracting the ED Departure Date and Time data elements are orders for Observation. If an order for Observation (not inpatient) was placed while the patient is still

physically in the ED, you would abstract the date and time of the order. If the order was placed after the patient departed the ED, then abstract the date and time the patient physically departed the ED.

Question 25: **If the patient arrived in the ED but has no logged arrival time, and the medical record shows the patient was triaged at 1500, is 1500 the arrival time?**

Yes. You would abstract that time if 1500 is the earliest documented time the patient arrived at the outpatient or emergency department.

Question 26: **Regarding the ED-Throughput measures, can we only use the ED medical record for abstraction? If a patient has an Observation Order, can only the ED medical record be used to determine ED departure time (when the patient was made Observation), not physician orders elsewhere in the record?**

The intent for abstraction is to use only documentation that is part of the outpatient encounter medical record. Regarding observation order entry, you can only abstract that order time for the *ED Departure Time* data element if the order is placed while the patient is still physically in the ED. If the patient departs the ED to the medical floor, for example, and an order for observation is placed after they left the ED, disregard the Observation Order, and abstract the time the patient physically departed the ED, for the *ED Departure Time* data element.

Question 27: **Is the ED medical record the only source document that can be used for the time of the Observation Order?**

Yes. As specified in the Hospital OQR Specifications Manual, for the *ED Departure Time* data element, the ED record is the only Acceptable Source listed under Suggested Data Sources.