GUIDELINES FOR HOSPITAL OQR MEASURES SUBMITTED VIA A WEB-BASED TOOL FOR THE CY 2017 AND SUBSEQUENT PAYMENT DETERMINATIONS

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For detailed information on each measure, click on the topic above.
GUIDELINES FOR SUBMISSION

- In order for a hospital to submit data, the hospital must authorize a QualityNet Security Administrator (SA), a prerequisite necessary for accessing the QualityNet Secure Portal. The QualityNet SA must enter measure data via the QualityNet Secure Portal.

- The Hospital OQR Program requires only one SA for each facility; however, it is highly recommended that facilities have two – a primary and an alternate.

- If a facility does not perform a particular measure, enter zero on the web-based tool on QualityNet at submission time.

- In order to submit data to the National Healthcare Safety Network (NHSN) website for OP-27, the hospital must complete the enrollment process at www.cdc.gov/nhsn/enrollment/index.html.

TIMELINES FOR SUBMISSION

Payment Year 2017

- Data for OP-12, OP-17, OP-22, OP-25, OP-26, OP-29, and OP-30 are reported during the submission period that begins on January 1, 2016, and extends through May 15, 2016, for the reference period of January 1, 2015 to December 31, 2015.

- For OP-27, the data will be collected during the flu season of October 1, 2015 (or when the vaccine becomes available) through March 31, 2016, and be reported during the submission period of October 1, 2015 through May 15, 2016.

- OP-31 continues as a voluntary measure in the calendar year (CY) 2016 OPPS/ASC final rule. While reporting of data is not required for this measure, all data submitted will be publicly reported.

Payment Year 2018

- In addition to the measures listed above for payment year 2017, measure data for OP-33: External Beam Radiotherapy for Bone Metastases will be collected for the reference period of January 1, 2016 through December 31, 2016.

- Data for OP-33 will be reported during the submission period of January 1, 2017 through May 15, 2017.
OP-12: THE ABILITY FOR PROVIDERS WITH HIT TO RECEIVE LABORATORY DATA DIRECTLY INTO THEIR ONC-CERTIFIED EHR SYSTEM AS DISCRETE SEARCHABLE DATA

- **Measure Question:** Does/did your facility have the ability to receive laboratory data electronically directly into your ONC-certified electronic health record (EHR) system as discrete searchable data? Yes/No

- **Measure Question:** Did your facility use this feature during the performance period? Yes/No
  
  Note: This question would be answered only if the previous question was answered “Yes.”

- **Laboratory Data:** Incorporation of laboratory test results into the EHR as structured data includes the following:
  - Electronically receiving clinical laboratory test results in a structured format and displaying such results in a human-readable format,
  - Displaying test report information, and
  - Incorporating results by electronically attributing, associating, or linking a laboratory test result to a laboratory order or patient record.

- **ONC-Certified EHR System:** An ONC-certified EHR system is defined as an EHR system that has been certified according to the Office of the National Coordinator for Health Information Technology (ONC) criteria. Please visit the Department of Health and Human Services website at https://www.healthit.gov/policy-researchers-implementers/certified-health-it-product-list-chpl for additional information.

  **Q:** If the hospital scans laboratory results into the patient’s EHR, is the answer to the measure “Yes” or “No”?

  **A:** Yes. In this case, the hospital receives laboratory values into its EHR directly from the lab via electronic interchange.

  **Q:** If the hospital’s EHR is capable of receiving data electronically but the facility did not use the feature consistently throughout the reference period, how is this measure answered?

  **A:** Answer “Yes” if the hospital used this feature of its EHR system at any time during the reference period.

OP-17: TRACKING CLINICAL RESULTS BETWEEN VISITS

- **Measure Questions:**
  - Does/did your facility have the ability to track pending laboratory tests, diagnostic studies (including common preventive screenings), or patient referrals through the ONC-certified EHR system? Yes/No
  - Did your facility use the ONC-certified EHR to track pending laboratory tests, diagnostic studies (including common preventive screenings), or patient referrals during the performance period? Yes/No
    
    Note: This question would be answered only if the previous question was answered “Yes.”

  **Q:** If the hospital uses its EHR to track lab results, but does not use it to track referrals, how is the measure answered?

  **A:** The measure is answered “Yes.” Demonstrating that the EHR is capable of reminding clinicians to take certain actions, regardless of whether all reminders are activated, allows the hospital to answer “yes” to the measure.
Q: What is the difference between a reminder and an alert in the electronic medical record?
A: A reminder prompts the user to take an impending or follow-up action. An alert typically requires immediate action or warns that an action is contraindicated.

**OP-22: ED-LEFT WITHOUT BEING SEEN**
- **Measure Question:** What was the total number of patients who left without being evaluated by a physician/APN/PA? __________ (Numerator)
- **Measure Question:** What was the total number of patients who presented to the ED? __________ (Denominator)
- **Patient Population:** All patients who sign in to be evaluated for emergency services are included in the denominator, including Medicare patients.
- **Provider:** Patients seen by an institutionally credentialed provider (e.g., an obstetric nurse providing an assessment of an OB patient) acting under the direct supervision of a physician are considered as having been seen by a physician/APN/PA.

Q: If a patient is triaged then leaves the ED, is the patient included in the measure?
A: Yes. All patients who sign in to be evaluated for emergency services are to be counted for inclusion in the measure.

Q: What is the difference between left without being seen and left against medical advice?
A: Patients who leave without being seen are not evaluated by a physician/APN/PA. Patients who leave against medical advice do so after examination by a provider. Once a patient is evaluated by a provider, the patient is no longer considered for this measure.

Q: If a patient leaves before being seen by a provider, would the patient have a discharge code?
A: If the patient is assigned an E/M code and there is no documentation of when the patient left the ED, the discharge code would be UTD (#8). However, if the patient was not assigned an E/M code, they would not have a discharge code and would only be included in OP-22, not in the ED-Throughput measures.

**OP-25: SAFE SURGERY CHECKLIST USE**
- **Measure Question:** Does/did your facility use a safe surgery checklist based on accepted standards of practice? Yes/No
- **Payers:** The response for OP-25 is for all payers, including Medicare.
- **Safe Surgery Checklist:** There is no one standard or recommended safe surgery checklist for use in the hospital setting. The definition from the Centers for Medicare & Medicaid (CMS) on the use of a safe surgery checklist for surgical procedures includes safe surgery practices during each of the three critical perioperative periods:
  1. The period prior to the administration of anesthesia,
  2. The period prior to skin incision, and
  3. The period of closure of incision and prior to patient leaving the operating room.

- **Sample Safe Surgery Checklist:** To obtain a copy of the World Health Organization’s Surgical Safety Checklist, visit [http://www.who.int/patientsafety/safesurgery/en/](http://www.who.int/patientsafety/safesurgery/en/).
Q: Does the safe surgery checklist need to be documented in the medical record?
A: No. The safe surgery checklist does not need to be in the medical record. However, the checklist must address the specified time frames listed above.

Q: Should the facility have used a safe surgery checklist during any part of 2015 or for the entire year of 2015 to answer “Yes” to OP-25?
A: For the measure’s first year, 2012, it was required only that a checklist was used for part of the reported year to answer “Yes.” For 2013 and subsequent years, the checklist must be used for the full reference period to answer “Yes.”

OP-26: HOSPITAL OUTPATIENT VOLUME ON SELECTED OUTPATIENT SURGICAL PROCEDURES

- **Measure Question:** What was the aggregate count of selected outpatient surgical procedures per category?

- **Procedure Categories:** An updated listing of the groups and corresponding Healthcare Common Procedure Coding System (HCPCS) codes will be posted in an addendum to the Specifications Manual available at [www.qualitynet.org](http://www.qualitynet.org). Program participants will be notified of the posting via ListServe. Data entry is required only for those categories included on the web-based tool.

- **Number of Procedures:** Count the total number of procedures for all HCPCS codes within each group performed in your hospital during the performance period. If a patient has multiple procedures during one encounter, count each procedure performed in Table 1 separately.

Q: Does the surgical procedure code (HCPCS) need to be the primary code, or can it be either the primary or secondary code?
A: Count any HCPCS code that is billed, whether it is primary or secondary. If two procedures with the same code are performed, include both in the total.

Q: Does the hospital include procedures billed to all payers, or just those billed to Medicare?
A: All procedures, regardless of whether they are billed to Medicare or to another insurer, are included in the count.

Q: If a procedure has a modifier code of 50 (the procedure was performed bilaterally during the same operative session by the same provider), is it counted twice for this measure?
A: Yes. Procedures done bilaterally are treated as two separate procedures and counted twice.

OP-27: INFLUENZA VACCINATION COVERAGE AMONG HEALTHCARE PERSONNEL

- **Description:** Percentage of healthcare personnel (HCP) who receive the influenza vaccination.

- **Denominator:** Number of HCP who are working in the healthcare facility for at least one working day between October 1, 2015 and March 31, 2016, regardless of clinical responsibility or patient contact. Denominators are to be calculated separately for employees, licensed independent practitioners, students, trainees, and volunteers.

- **Numerator:** HCP in the denominator population who:
  - Received an influenza vaccination
  - Have a medical condition of allergic reaction or history of Guillain-Barre Syndrome within six weeks after a previous flu vaccination
  - Declined influenza vaccination
• Are persons with unknown vaccination status or who do not otherwise meet any of the definitions above

Data for OP-27 will be submitted to the National Healthcare Safety Network (NHSN) website at www.cdc.gov/nhsn.

Q: Does the hospital report this information to the QualityNet Secure Portal?
A: No. Information should be entered via the Centers for Disease Control and Prevention’s NHSN website at www.cdc.gov/nhsn.

Q: When information is reported to the NHSN throughout the reporting period, can hospitals enter the data as they are collected (more than once)? If so, is the previous data deleted?
A: Yes. Previous entries will be replaced with the current information; therefore, data must be submitted as a cumulative total each time during the submission period of October 1, 2015 through May 15, 2016.

Q: Should all the HCP categories be entered separately, or can they be entered as the total number of employees?
A: Each category, e.g., employees, licensed independent practitioners, students, etc., should be entered separately on the tool provided by the NHSN.

OP-29: ENDOSCOPY/POLYP SURVEILLANCE: APPROPRIATE FOLLOW-UP INTERVAL FOR NORMAL COLONOSCOPY IN AVERAGE RISK PATIENTS

• Description: Percentage of patients aged 50 to 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

• Denominator: All patients aged 50 to 75 years of age receiving screening colonoscopy without biopsy or polypectomy

• Numerator: Patients who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report

Q: When a patient comes in for a scheduled screening colonoscopy but has a biopsy performed, would this patient be included in the denominator for this measure?
A: No. If the patient has a biopsy performed, they should not be included because the patient would be expected to have a follow-up colonoscopy prior to 10 years from the date of the exam.

Q: Does the follow-up interval have to be documented in the colonoscopy report?
A: Yes. The physician must document the recommended follow-up time (e.g., 10 years) after the exam is performed in the colonoscopy report.

OP-30: ENDOSCOPY/POLYP SURVEILLANCE: COLONOSCOPY INTERVAL FOR PATIENTS WITH A HISTORY OF ADENOMATOUS POLYPS – AVOIDANCE OF INAPPROPRIATE USE

• Description: Percentage of patients aged 18 years and older receiving a surveillance colonoscopy, with a history of a prior colonic polyp(s) in previous colonoscopy findings, who had a follow-up interval of three or more years since their last colonoscopy

• Denominator: All patients aged 18 years and older receiving a surveillance colonoscopy, with a history of a prior colonic polyp(s) in previous colonoscopy findings
• **Numerator:** Patients who had an interval of three or more years since their last colonoscopy

  Q: If the physician documents a medical reason for performing a colonoscopy in less than three years but does not document the interval, is this acceptable for the measure?
  
  A: No. Documentation of a medical condition or finding can be used as a medical reason(s) for denominator exclusion purposes only if the previous colonoscopy was documented to be less than three years prior.

  Q: If the reason for performing the colonoscopy is charted in the patient’s history and physical but not in the colonoscopy report, would this patient be included in the population?
  
  A: Information regarding the performance interval can be obtained from medical record documentation.

  Q: Can the physician document any reason to support an interval of less than three years since the last colonoscopy?
  
  A: Yes. Documentation of medical reason(s) for an interval of less than three years since the last colonoscopy (e.g., patients with high risk for colon cancer, last colonoscopy incomplete, last colonoscopy had inadequate prep, piecemeal removal of adenomas/polyps, or last colonoscopy found greater than 10 adenomas/polyps) are at the discretion of the physician.

  Q: Must documentation of a system reason for measure exclusion also include documentation of the interval of the previous colonoscopy?
  
  A: Yes. An interval of less than three years must be documented to exclude the measure, including a documented system reason (e.g., previous colonoscopy report not available, unable to locate last colonoscopy report).

**OP-31: Cataracts — Improvement in Patient’s Visual Function within 90 Days Following Cataract Surgery** *This measure is voluntary. All data reported for OP-31 will be publicly reported.*

• **Description:** Percentage of patients aged 18 years and older who had cataract surgery and had improvement in visual function achieved within 90 days following the cataract surgery

• **Denominator:** All patients aged 18 years and older who had cataract surgery and completed both a pre-operative and post-operative visual function instrument

• **Numerator:** Patients who had improvement in visual function achieved within 90 days following cataract surgery, based on completing both a pre-operative and post-operative visual function instrument

• The encounter dates for OP-31 are January 1 through December 31, 2015. This data will be entered via the QualityNet Secure Portal as a web-based measure during the submission period of January 1, 2016 through May 15, 2016.

**OP-33: External Beam Radiotherapy for Bone Metastases** *Data collection begins with CY 2016 encounters for the CY 2018 payment determination.*

• **Description:** Percentage of patients, regardless of age, with a diagnosis of painful bone metastases and no history of previous radiation who receive external beam radiation therapy (EBRT) with an acceptable fractionation scheme
- **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.

- **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/1fxn. The data for the numerator may be found in the consultation and office visit notes, outpatient treatment center record, and problem/diagnosis list.