Outpatient Quality Reporting Program

Support Contractor

The Escape Room: The Search for Clues in Your Data Abstraction

Questions & Answers

Speakers:

Hospital Outpatient Quality Reporting (OQR) Program
Support Contractor Team

July 10, 2019
10:00 a.m. ET

Question: For the measure OP-29, is "appropriate follow-up advised to patient" appropriate documentation for repeat colonoscopy if there is no specific time frame referenced?

Answer: No. The documentation you provided would not be sufficient for a follow-up interval for the repeat colonoscopy.

Question: What medical reason is noted on slide 8 to exclude the case for OP-29?

Answer: Documentation of significant looping and a tortuous colon can be used as a medical reason for exclusion.

Question: For the OP-29 measure, what if “inadequate prep” and then “colonoscopy at next available appointment” is documented?

Answer: The documentation of “at next available appointment” is not an acceptable follow-up interval for a repeat colonoscopy, as this documentation is not consistent with the examples provided in the measure information form of intervals less than 10 years when a medical reason is documented.

Question: Will we have access to the slide deck?

Answer: Yes, you can access the slides on our website at the following URL: https://www.qualityreportingcenter.com/en/hospital-oqr-program/archived-events/.

Question: On slide 8, was the physician's documentation enough to support recommending repeat colonoscopy of less than 10 years?

Answer: Yes, there was a medical reason documented for the follow-up colonoscopy interval of less than 10 years.

Question: If the physician does not use military time but there is sufficient documentation to support AM or PM, is it acceptable to convert to military time for abstraction?

Answer: Yes, this is acceptable.

Question: For *ED Departure Time*, we are using the time the patient actually left the ED to be admitted/transferred/go home. Our ED physicians say that sometimes the patient being admitted will sit in the ED for a while before they are actually taken to the medical floor. If the doctor has a discharge time in their documentation that is different from the time the patient left the ED, which one do we use?

Answer: Version 12.0a of the Specifications Manual says you should not use the time the discharge order was written because it may not represent the actual time of departure. If the time of discharge order is different from the time the patient left the ER, you should abstract the time the patient physically left the care of the ER.

Question: If the documentation reflects the following: “Checkout time 1940, Ortho Device Applied 1943, wound assessment 1945, wound dressing 1949”; what would *ED Departure Time* be?

Answer: Version 12.0a of the Specifications Manual states that if there is substantial documentation to support that the patient was in the ED after documented departure and no additional documented time of ED departure, please enter unable to determine (UTD) for *ED Departure Time.*

Question: If a patient is discharged from the ED and a time is noted as discharged at 1700 but a medication is charted as given at 1705, wouldn't the ED discharge time be UTD since it's obvious the patient was still in the ED to be able to receive the medication?

Answer: Version 12.0a of the Specifications Manual states that if there is substantial documentation to support that the patient was in the ED after documented departure and no additional documented time of ED departure, please enter UTD for *ED Departure Time*.

Question: For OP-33, there is a problem in that it is required that both treatments have a separate billing number to include, but the Centers for Medicare &

Medicaid Services (CMS) requires both to be billed together. How are we to abstract them?

Answer: OP-33 is a web-based measure. You will report a numerator and a denominator. You will consider all encounters that result from a single treatment plan as one case, with the case being attributed to the first date of administration of External Beam Radiotherapy (EBRT).

Question: On slide 4, if the nurse documents left AMA or a physician documents left before finishing medical care, would that not be a 7- Left Against Medical Advice or AMA?

Answer: Version 12.0a of the Specifications Manual states that "A signed AMA form is not required for this data element, but in the absence of a signed form, the medical record must contain physician or nurse documentation that the patient left against medical advice, or AMA." In the scenario presented, there was neither nurse nor physician documentation of AMA. Additional information on the specifications for the Hospital OQR Program measures can be accessed at: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1196289981244.

Question: Regarding *ED Departure Time*, if there is anything other than medication administration or vital signs charted after the documented departure time from the ED, should the abstractor choose UTD?

Answer: There may be various scenarios when abstracting. If the time the patient departed is unable to be determined from medical record documentation, you would select UTD.

Question: For ED discharge on an outpatient record, can we take the time from the EMS record for the time of patient discharge if there is no clear nursing documentation of the discharge time?

Answer: No. The only acceptable source for abstraction is the ED medical record for *ED Departure Time*.

Question: For OP-29, if a patient is 66 or greater and there is no follow-up documented at all, is this acceptable?

Answer: The age of 66 or greater alone would not exclude the case.

Question: On slide 23, what if the patient is in observation in the ED, in other words, the patient doesn't leave the ED?

Answer: Since the patient was located in the ED when the change was made from inpatient to observation status, you would use the time of the order for observation for *ED Departure Time*. For slide 23, this was 7/9 at 2305.

Question: On slide 22, does the age have to be recorded specifically as 66, or can we assume that from the date of birth and recommendation for PRN (as needed) by nurse or doctor?

Answer: The date of birth in the medical record can be used to determine the patient's age. This can be documented by the physician.

Question: I thought the *ED Departure Time* was changed and we were not to use the order time but the time the patient physically left the ED. This is about boarding in the ED. The patient may still be in the ED (Boarded) awaiting a bed in the hospital.

Answer: If an order for observation is entered prior to the patient departing the ED, you may use the time of the observation order for *ED Departure Time*. If there is no order for observation, abstract the time the patient physically departed the ED for *ED Departure Time.* Version 12.0a of the Specifications Manual states that "for patients who are placed into observation services, use the time of the physician/APN/PA order for observation for *ED Departure Time*. 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: On slide 23, what does the admission order time, inpatient or observation, have to do with when the patient departing the ED? Wouldn't the time that the patient left the ED be the *ED Departure Time*?

Answer: No. Version 12.0a of the Specifications Manual states that "for patients who are placed into observation services, use the time of the physician/APN/PA order for observation for *ED Departure Time*. 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."

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Question: A magnetic resonance angiography (MRA) is a specialized magnetic resonance imaging (MRI), so I don't understand why that would not be considered as the MRI for documentation.

Answer: Please note that, based on feedback from our technical experts, a computed tomography angiography (CTA)/MRA is not acceptable for abstraction for the *Head CT or MRI Scan Order* data element. If you are unable to determine if a result time refers to the CTA/MRA or the non-contrast CT/MRI, then you should abstract "No" for *Head CT or MRI Scan Order*, as we are aware a CTA/MRA may take longer to perform than a CT/MRI. Additional information on the specifications for the Hospital OQR Program measures can be accessed at: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1196289981244.

Question: On slide 23, what is the correct time for *ED Departure Time*?

Answer: The correct time is 2305. For patients placed into observation services, you will use the time of the order for observation for *ED Departure Time*, as long as the patient was in the ED when this order was written.

Question: Is a CTA considered the same as an MRA, therefore, not considered a CT of head?

Answer: Please note that, based on feedback from our technical experts, a CTA/MRA is not acceptable for abstraction for the *Head CT or MRI Scan Order* data element. If you are unable to determine if a result time refers to the CTA/MRA or the non-contrast CT/MRI, then you should abstract "No" for *Head CT or MRI Scan Order*, as we are aware a CTA/MRA may take longer to perform than a CT/MRI. Additional information on the specifications for the Hospital OQR Program measures can be accessed at: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1196289981244.

Question: To clarify one of the OP-29 questions, if the patient is within the age time frame and there is no follow-up indicated, is this acceptable, and will it be excluded? Or, do they need to write no follow-up within 10 years due to age?

Answer: For a patient that is 66 years old or older, there must be documentation indicating that no follow-up colonoscopy is needed or recommended to exclude the case.

Question: For the National Institutes of Health (NIH) score, the patient presented with seizure, unable to get NIH score due to this; does this have to be a failure?

Answer: NIH score is not part of the measure criteria.

Question: What if a head/cervical CT is ordered for outpatient stroke; do you answer Yes to CT order?

Answer: Yes, if the order includes head CT.

Question: Will this webinar be recorded so others who were not able to attend now will be able to listen later?

Answer: Yes, this presentation recording will be posted on our website within 24 hours. You can find this by accessing the Archived Events tab on qualityreportingcenter.com. The direct link is https://www.qualityreportingcenter.com/en/hospital-oqr-program/archived-events/.

Question: Why would the time of 7/9 2305 be used on slide 23, instead of 7/10 0132?

Answer: For this scenario, you would abstract the time the order for admission was written. The Specifications Manual's guidance is **"**For patients who are placed into observation services, use the time of the physician/APN/PA order for observation for *ED Departure Time*." (Specifications Manual 12.0a, page 2-115)

Question: With regard to slides 31 and 32, wouldn't "age indeterminate" be the same as "age unknown"? Would being "age unknown" mean you disregard anterior infarct also as not being new or undetermined?

Answer: You would disregard only "age indeterminate," as that is the part that is neither an Inclusion nor Exclusion term. But the rest of the term can be considered in abstraction.

Question: For the data element *ED Departure Time*, what is the rationale for choosing the time the observation order is written? I have sent questions into OQR before where the patient had an inpatient order written in the ED but the patient never leaves the ED due to bed capacity issues, and the patient eventually is discharged from the ED. The stay is billed as outpatient. I have been told to treat these cases as outpatient and to

disregard the inpatient order time when considering *ED Departure Time*. Why count observation order and not inpatient orders for ED departure?

Answer: CMS looks at how the order was billed to determine the program through which the measure is reported. So, an observation stay that occurs on an inpatient floor but is billed to the patient's outpatient coverage would be processed through the Outpatient Prospective Payment System and included in the Hospital OQR Program measures. If the patient was billed as an inpatient, it would not meet the measure criteria for the Hospital OQR Program.

Question: Is this presentation being recorded? I recently joined the webinar. I would like to share this webinar at a later date.

Answer: Yes, you will be able to access this recording and all of the questions and answers on our website, qualityreportingcenter.com, under the Archived Events tab. The direct link is https://www.qualityreportingcenter.com/en/hospital-oqr-program/archived-events/.

Question: For slide 34 regarding radicular pain for OP-33, would we exclude or include the patient?

Answer: You would not be able to use this documentation to say Yes to radicular pain. In this case, the documentation is not definitive in the diagnosis of radicular pain and should not be excluded on this basis.

Question: For slide 38, Head CT in ED, what if the patient was in a virtual bed in the ED and registered as OP?

Answer: CMS looks at how the order was billed to determine the program through which the measure is reported. CMS has not yet provided guidance on how to manage virtual care; we will review the appropriate approach for how these cases will be captured through the Outpatient Prospective Payment System and with our expert panel, providing guidance in a future version of the Manual.

Question: For OP-23, Date and Time *Last Known Well*, if symptoms have completely resolved on arrival but there is available documentation in the record of *Last Known Well*, can we abstract No?

Answer: Based on the documentation that you provided, you may abstract the most recent (last) episode prior to arrival, regardless if all symptoms had resolved prior to arrival.

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Question: On slide 23, if the patient's inpatient order was changed to observation after the patient left the ED, would you then abstract the time the patient physically departed the ED instead?

Answer: Yes, if the order for observation is after the patient physically departed the ED, abstract the time the patient physically departed for the *ED Departure Time* data element.

Question: The physician ordered a brain CT during the ED visit. Is this acceptable since the Specifications Manual states CT of the head?

Answer: Based on the documentation that you provided, you may abstract the CT of the brain for the *Head CT or MRI Scan Order* data element.

Question: If the decision to admit is at 1004, the admission order (for observation) is written at 1029, the nurse documents "patient moved to admit at this time," then the patient physically leaves at 1803, and departure is 1803; what time do we use?

Answer: For this scenario, you would abstract the time the order for admission to observation was written, which was 1029. The Specifications Manual's guidance is **"**For patients who are placed into observation services, use the time of the physician/APN/PA order for observation for *ED Departure Time*." (Specifications Manual 12.0a, page 2-115)

Question: For OP-Stroke, can you infer the last known well time if you suspect it was a dictation error? For example, the RN documents symptom onset at 2230, arrived in ED at 2359. The physician documents last known well is 1000 AM, and symptom onset was 1030 AM. More than likely, that should have been PM. Can I use 10:00 PM as *Last Known Well*?

Answer: Based on the documentation you provided, when the time documented is obviously in error (not a valid time) and no other documentation is found that provides this information, the abstractor should select UTD.