# The Escape Room: The Search for Clues in Your Data Abstraction
# Scenarios and Solutions

1. The record indicates the patient is a private vehicle transfer to an acute care hospital. He left the transferring ED with his father who was driving him to the acute care hospital. Which of these two is the correct discharge code: 1: Home or 4a: Acute Care Facility – General Inpatient Care?

   Answer: If the patient was discharged to an Acute Care Facility, regardless of mode of transportation, select discharge code 4a: Acute Care Facility-General Inpatient Care.

2. The patient did not discuss leaving with the physician who had performed an evaluation; he just left before there was a discharge order written by the physician. What discharge code should be used?

   Answer: With the scenario provided, abstract value 8: Not Documented or Unable to Determine (UTD). Since there is no discharge order, you cannot select value 1 for Home, and as you stated, there is no documentation to support AMA.

3. The ED patient was discharged from the unit to home after documentation of multiple attempts to get the patient to be admitted to the hospital or to be transferred to another facility. In the ED record it states: “patient refused admission.” The physician dictation states: “I did as well as I could to convince him he needs to be admitted...explained the risks...at this point, my hands are tied. I cannot get him to be admitted.” There is no AMA form or no word-for-word exact verbiage stating “against medical advice.” Can the abstractor imply that the verbiage stated both in the dictation and in the chart are the medical advice from the physician that the patient would not accept and, therefore, left "AMA"?

   Answer: When determining whether to select value 7 (“Left Against Medical Advice”), 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.

4. The physician documented in the procedure note: “The colonoscopy was technically difficult and complex due to significant looping and a tortuous colon. Successful completion of the procedure was aided by applying abdominal pressure.” The recommendation states: “Repeat colonoscopy in 5 years for screening purposes.” Would this be enough documentation of a medical reason for not recommending at least a 10-year follow-up interval?

   Answer: It appears there is a medical reason for an interval of less than 10 years.

5. The medical record shows RN documentation on 10/01/18 at 0001:
   - Door Time: 2359
   - Start Triage: 0001

   The ED Event Log has on 10/01/18 at 0000: “Patient arrived in ED.” What would be the earliest arrival time?

   Answer: The chart should be abstracted at face value unless there is substantial documentation to indicate the patient was not physically in the ED at the documented 2359.

With the information provided, you would abstract 2359 for the *ED Arrival Time* data element.

6. The medical record shows:
    - 0838 Report given, ambulance at bedside for transport
    - 0840 Patient discharged
    - 0855 Medication administration documented
    - 0858 Vital signs recorded

    What time should the abstractor use for *ED Departure Time*?

    Answer: With the information provided, you would abstract the latest time documented that would indicate the patient was in the ED. In this case that would be 0841 for *ED Departure Time*. The intention is to capture the latest time at which the patient was receiving care in the emergency department, under the care of emergency department services, or awaiting transport to service/care.

7. Stereotactic body radiation therapy (SBRT) is no longer listed as an exclusion for this measure but may be given as a curative treatment as opposed to palliative. Would SBRT be included in the population for OP-33?

    Answer: Since SBRT is considered radiation therapy, any anatomic site that has previously been treated with SBRT (or any other radiation therapy) should be excluded from the denominator.

8. A patient is receiving external beam radiation to two separate bony areas. One area is a retreatment of radiation to the same site. Do I answer the question "Is there a history of previous radiation to the same anatomic site?" with repeated therapy, and it falls out of the measure; or do I answer it for the therapy to the non-repeated site, and it stays in the measure?

    Answer: In cases such as these, you would abstract each site separately and apply the exclusion criteria to each site independently. In this case, only one site would be excluded due to previous radiation.

9. The patient's age is 66 years old. The physician documents in the colonoscopy report "Repeat colonoscopy PRN for screening purposes." Is this acceptable documentation to exclude the case?

    Answer: Documentation indicating no follow-up colonoscopy is needed or recommended is only acceptable if the patient's age is documented as ≥66 years old or life expectancy is <10 years. The documentation provided appears to be consistent with the information above in the Measure Information Form and would be a medical reason to exclude the case.

10. The patient was admitted to inpatient on 7/9 at 2255, and then a change was made on 7/9 at 2305 to hospital observation status. The patient was in the ED until 0132 on 7/10. Should the

abstractor take the order for observation at 2305 as *ED Departure Time*, or should the initial order for inpatient time of 2255 be used?

Answer: We do not abstract orders for Inpatient for abstracting *ED Departure Time* in the OQR Program. You can abstract the time for an Observation Order if the patient was physically in the ED when the order was written. If the patient departed the ED prior to the Observation Order, abstract the time the patient physically departed the ED for your *ED Departure Time*.

11. There is an After Visit Summary (AVS) report under discharge instructions with the recommendation for a 10-year follow-up. I saw in a fact sheet that if your facility utilizes another report that is equivalent or contains the OR report, it can be used. The AVS report does not contain the OR report. For the recommended follow-up interval of 10 years, does it only have to be on the OR report?

    Answer: The follow-up interval must be documented in the colonoscopy report. Based on the information provided, it appears that the interval in the After Visit Summary would not be sufficient.

12. A patient presented to the ED on 7/2. The ED record notes: "Pt had an outpatient MRI on 6/30. Dr. called patient today after MRI on 6/30/18 showed a possible acute ischemic infarct left cerebellum and told him to come to the ER for evaluation." During this ED visit on 7/2, the patient had an MRA of the head done. How should I answer the question "Was a CT or MRI scan ordered by the physician during the ED visit?"

    Answer: Version 11.0b of the Hospital Outpatient Quality Reporting (OQR) Specifications Manual defines this data element as "documentation in the medical record that a Computerized Tomography (CT) or Magnetic Resonance Imaging (MRI) scan of the head was ordered during an emergency department visit." The manual provides the following guidance: "If there is documentation a head CT or MRI scan was ordered by the physician/APN/PA during the emergency department visit, select 'Yes.'"

    Based on the documentation you have provided, you may abstract "No" for the data element *Head CT or MRI Scan Order* if there is no documentation of a head CT or MRI scan ordered during the emergency department visit. 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.

13. The patient had a last known well time 30 minutes before arrival but needed to be stabilized before going to CT. He needed to be intubated and sedated before going to CT; therefore, his time from arrival to CT read is over the 45 minutes for the measure. Is there a way to exclude the patient due to need to stabilize on arrival?

Answer: Version 11.0a of the Hospital Outpatient Quality Reporting (OQR) Specifications Manual defines this data element as "the time (military time) represented in hours and minutes at which the earliest head CT or MRI scan interpretation was completed or reported." The manual provides the following guidance:

- Abstract the result of the earliest head CT or MRI scan interpretation (closest to arrival).
- The medical record must be abstracted as documented (taken at "face value"). 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.

Based on the documentation you have provided, you may abstract the interpretation time closest to arrival for *Head CT or MRI Scan Interpretation Time*. Please note that, currently, there are no exclusions for the situation you have described, although we will consider it during our next annual update.

14. The first and only printed ECG signed by the cardiologist has anterior infarct: "Age Indeterminate." We do not see this as either an inclusion or exclusion term. How do we treat this phrase? Do we ignore it and just utilize anterior infarct?

    Answer: Version 11.0b of the Specifications Manual states, "only those terms specifically identified or referred to by the physician/APN/PA as ECG findings AND where documentation is clear it is from the ECG performed closest to arrival should be considered in abstraction." Because the term "Age Indeterminate" is not included in either the Inclusion Guidelines or Exclusion Guidelines lists, you should consider it neither an Inclusion term nor Exclusion term. Therefore, the only Inclusion or Exclusion term is "Anterior MI," so you should abstract a value of "Yes" for this data element.

15. The medical record has the following documented: "Pain is in the lumbar spine with radiation to the legs." Would this documentation be able to be used to say Yes to radicular pain?

    Answer: In order to meet the exclusion for radicular pain, the documentation must reflect a clear and explicit diagnosis of radicular pain. In this case, the documentation is not definitive in the diagnosis of radicular pain and should not be excluded on this basis.

16. The documentation by the provider states: "cardiologist does not want fibrinolytics at this time, transfer to cardiac cath." Is this sufficient to choose "documented reason for not administering fibrinolytics"?

    Answer: Version 11.0a of the Specifications Manual indicates that if there is documentation of a contraindication or other reason by a physician/APN/PA or pharmacist that is explicitly listed in the data element as a contraindication for administering fibrinolytic therapy, then you should abstract a value of "1"; additionally, if there is a contraindication/reason not listed under the Inclusion Guidelines for Abstraction, but there is clearly physician/APN/PA or

pharmacist documentation linking this contraindication/reason to the decision to not administer fibrinolytic therapy, you may also abstract a value of "1." If there is not documentation of a contraindication or reason for not administering fibrinolytic therapy or if the documented reason is not listed in the data element's inclusion criteria, you should abstract a value of "3."

Based on the information provided, documentation of "cardiologist does not want fibrinolytics at this time," is sufficient to abstract a "1" for this data element, as this is a clearly documented reason for not administered fibrinolytics.

17. The patient arrived at 1518, was admitted to Observation, and departed the ED at 1846. A CT was ordered after the patient left the ED but during the Outpatient encounter. Is it acceptable to use the CT from outside the ED?

    Answer: Version 11.0b of the Hospital Outpatient Quality Reporting (OQR) Specifications Manual defines this data element as "documentation in the medical record that a Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) scan of the head was ordered during an emergency department visit." The manual provides the following guidance: "Select 'Yes' if there is documentation a head CT or MRI scan was ordered by the physician/APN/PA during the emergency department visit.

    Based on the documentation you have provided, you may abstract "No" for *Head CT or MRI Scan Order*. Although a CT was ordered during the outpatient encounter, because it was not ordered while the patient was in the emergency department, you may abstract "No."

**Table of Acronyms**

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| AMA | Against Medical Advice |
| APN | Advanced Practice Nurse |
| AVS | After Visit Summary |
| CT | Computed Tomography |
| CTA | Computed Tomography Angiography |
| ECG | Electrocardiogram |
| ED | Emergency Department |
| MI | Myocardial Infarction |
| MRA | Magnetic Resonance Angiography |
| MRI | Magnetic Resonance Imaging |
| PA | Physician's Assistant |
| PRN | Pro re nata (when necessary) |
| SBRT | Stereotactic Body Radiation Therapy |
| UTD | Unable to Determine |