



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

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**Hospital Outpatient Quality Reporting  
Program Support Contractor**



# Scenario

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*

*4a: Acute Care Facility – General Inpatient Care*

\* Emergency Department



# Scenario

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?*

# Scenario

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"?*

# Review

## ***Discharge Code***

### Notes for Abstraction

- 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.



# Scenario

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?*



# Review

## **OP-29: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients**

### Denominator Exclusions

- Medical reason(s) are at the discretion of the physician.
- Documentation of a medical condition or finding can be used as a medical reason(s) for denominator exclusion purposes only if the documented recommended follow-up interval is less than 10 years.

# Scenario

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?*

# Review

## *Arrival Time*

### Definition

- The earliest documented time (military time) the patient arrived at the outpatient or emergency department

# Scenario

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?*

# Review

## ***ED Departure Time***

### Notes for Abstraction

- 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.

### Departure Time Guidelines

- Do not use Medication or Vital Signs if they are later than the *ED Departure Time*.





# Scenario

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?*

# OP-33



# Specifications Manual

[www.qualitynet.org](http://www.qualitynet.org)

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# OP-33 Fact Sheet

## OP-33: External Beam Radiotherapy for Bone Metastases Fact Sheet

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

**Numerator:** All patients, regardless of age, with bone metastases and no previous radiation to the same anatomic site who receive EBRT for the treatment of bone metastases with any of the following recommended fractionation schemes: 30Gy/10fxns, 24Gy/6fxns, 20Gy/5fxns, and 8Gy/1fxn.

**Denominator:** All patients with bone metastases and no previous radiation to the same anatomic site who receive EBRT for the treatment of bone metastases. The denominator population for OP-33

**Do** 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 EBRT.

**Do** consider the administration of EBRT to different anatomic sites as separate cases.

**Do** include cases when the treatment plan was initiated but not completed.

**Do** include cases where any portion of the EBRT treatment is billed as part of the outpatient bill.

**Do not** include patients who receive EBRT for a reason other than bone metastases.

**Do not** include patients who are part of a prospective clinical protocol involving the administration of radiation, especially stereotactic radiosurgery (SRS) or stereotactic body radiation therapy (SBRT).





# Review

## **OP-33: External Beam Radiotherapy for Bone Metastases**

### Denominator Exclusions

- Patients who are part of a prospective clinical protocol or registry study involving the administration of radiation therapy, especially stereotactic radiosurgery (SRS) or stereotactic body radiation therapy (SBRT).

# Scenario

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?*

# Review

## **OP-33: External Beam Radiotherapy for Bone Metastases**

### Denominator Exclusions

- Previous radiation treatment to the same anatomic site (i.e., retreatment)

### Additional Instructions

- Consider the administration of EBRT to different anatomic sites as separate cases

# Scenario

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?*

\* Pro re nata (when necessary)

# Scenario

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?*





# Scenario

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?*



# Scenario

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<sup>†</sup> of the head done.

*How should I answer the question "Was a CT\*\* or MRI scan ordered by the physician during the ED visit?"*

\* Magnetic Resonance Imaging †Magnetic Resonance Angiography \*\*Computed Tomography

# Review

## ***Head CT or MRI Scan Order***

### Allowable Values

- Y (Yes): There is documentation a head CT or MRI scan was ordered by the physician/APN/PA during the emergency department visit.
- N (No): There is no documentation a head CT or MRI scan was ordered by the physician/APN/PA during the emergency department visit.

# Scenario

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?*



# Can You Help Betty and Angela?





# Review

## ***Head CT or MRI Scan Interpretation Time***

### Definition

- The time (military time) represented in hours and minutes at which the earliest head CT or MRI scan interpretation was completed or reported

### Notes for Abstraction

- Abstract the result of the earliest head CT or MRI scan interpretation (closest to arrival)

### Exclusion Guidelines for Abstraction

- None

# Scenario

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?*

\* Electrocardiogram

# Review

## *Initial ECG Interpretation*

### Notes for Abstraction

- Notations which describe ST-elevation as old, chronic, age unknown, recent, or previously seen, or which state ST-elevation and “no new changes,” “unchanged,” “no acute changes,” or “no significant changes” when compared to a prior ECG should be disregarded. Other documentation of ST-elevation within the same interpretation or a different interpretation may still count as an Inclusion or Exclusion.







# Scenario

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?*

# Scenario

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"?*

# Review

## ***Reason for Not Administering Fibrinolytic Therapy***

### Allowable Values

1. Documented contraindication/reason: There is a contraindication or other reason documented by a physician/APN/PA or pharmacist for not prescribing fibrinolytic therapy, including patient refusal

# Review (cont.)

## Notes for Abstraction

- If a contraindication/reason listed under the Inclusion Guidelines for Abstraction is clearly documented in the content of the Emergency Department record, then this is sufficient to abstract value 1 for this data element. There does not need to be explicit documentation of a rationale by a provider linking the documented contraindication/reason and the decision to not administer fibrinolytic therapy if the contraindication/reason is listed under the Inclusion Guidelines for Abstraction.

# Scenario

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?*



# Review

## ***Head CT or MRI Scan Order***

### Definition

- 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

### Allowable Values

- Y (Yes): There is documentation a head CT or MRI scan was ordered by the physician/APN/PA during the emergency department visit.
- N (No): There is no documentation a head CT or MRI scan was ordered by the physician/APN/PA during the emergency department visit.

# Scenario

The ED physician documents the last known well time as 30 minutes prior to arrival. The ED nurse's note says the last known well time is 20 minutes prior to arrival.

*Is there a hierarchy rule regarding physician's notes before nurse's notes?*





# Thank You

- Call the Support Contractor at 866.800.8756.
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- Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling
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- Florida Board of Pharmacy
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# CE Credit Process: Survey

☐ No

Please provide any additional comments

**10. What is your overall level of satisfaction with this presentation?**

☐ Very satisfied

☐ Somewhat satisfied

☐ Neutral

☐ Somewhat dissatisfied

☐ Very dissatisfied

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**11. What topics would be of interest to you for future presentations?**

**12. If you have questions or concerns, please feel free to leave your name and phone number or email address and we will contact you.**

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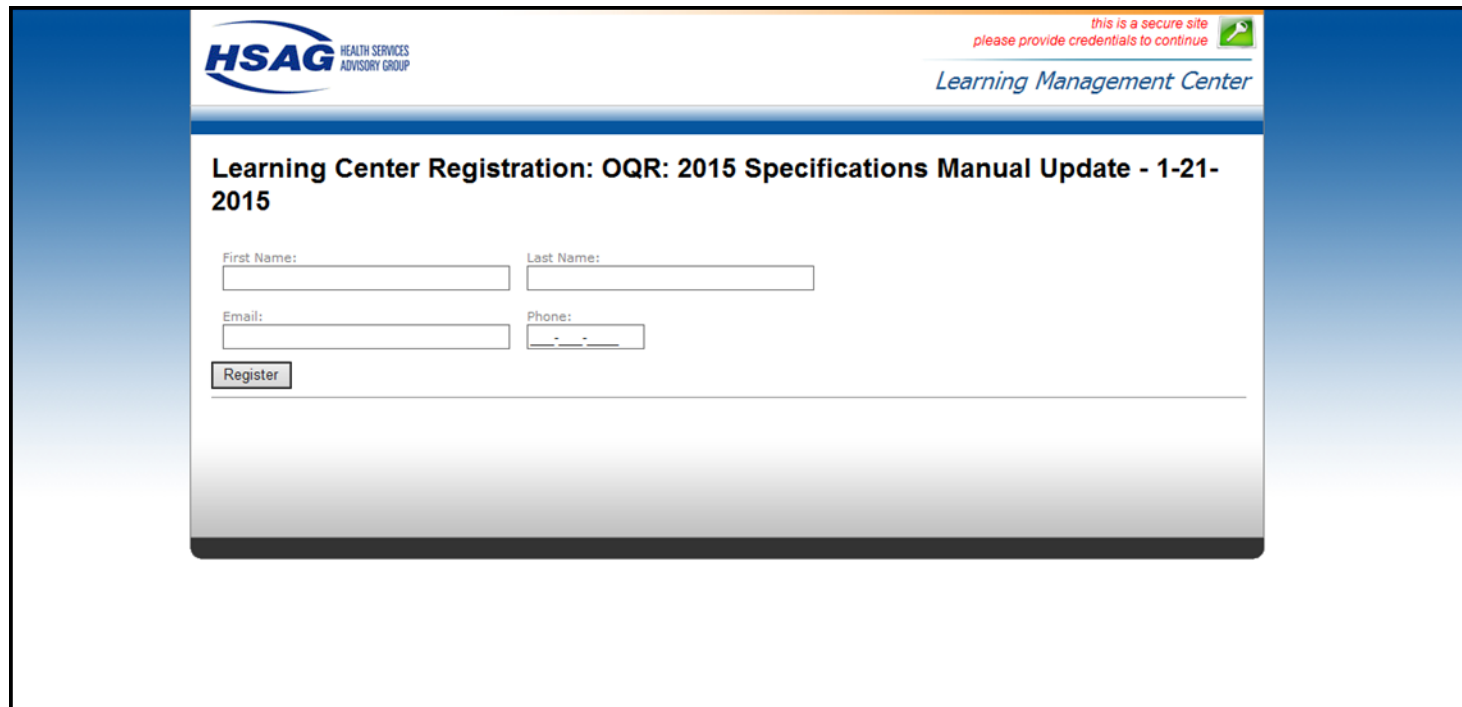
<https://lmc.hshapps.com/test/adduser.aspx?ID=da0a12bc-db39-408f-b429-d6f6b9ccb1ae>

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# CE Credit Process: New User



The screenshot displays the registration interface for the HSAG Learning Management Center. At the top left is the HSAG logo with the text 'HEALTH SERVICES ADVISORY GROUP'. To the right, a security notice states 'this is a secure site please provide credentials to continue' next to a lock icon. Below this is the title 'Learning Management Center'. The main heading for the registration is 'Learning Center Registration: OQR: 2015 Specifications Manual Update - 1-21-2015'. The form includes input fields for 'First Name:', 'Last Name:', 'Email:', and 'Phone:'. The 'Phone:' field has a format guide '( ) - - -'. A 'Register' button is located below the email field. The entire form is set against a blue gradient background.

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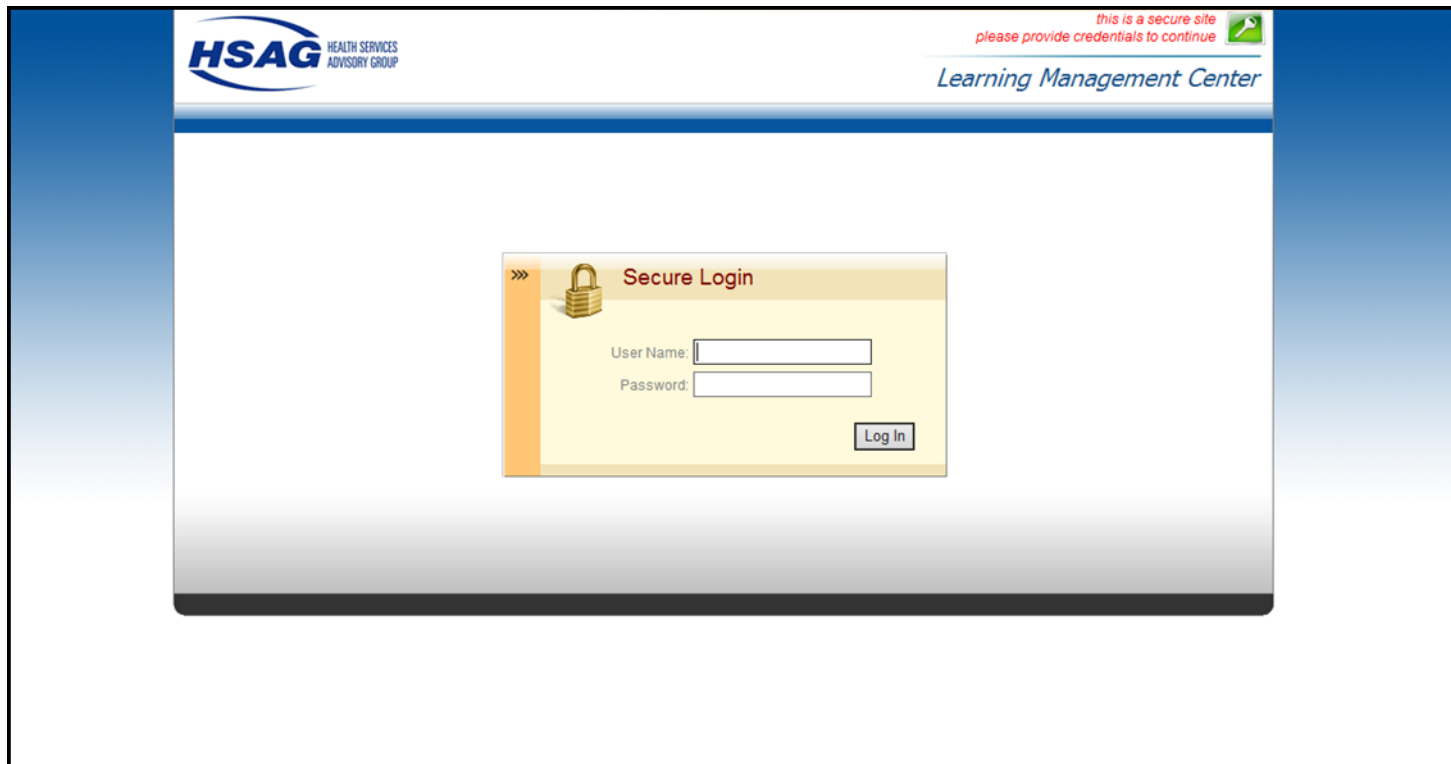
*Learning Management Center*

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Learning Management Center

Secure Login

User Name:

Password:

Log In

# References

- Slides 17, 18: [www.qualitynet.org](http://www.qualitynet.org). Accessed on: April 3, 2019.

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