# Inpatient Quality Reporting Program

## Support Contractor

## 2015 Updates to Perinatal Care (PC) Core Measure: PC-01 Elective Delivery and Structural Measures and Data Accuracy and Completeness Acknowledgement (DACA)

## Questions & Answers

**Moderator:**
Candace Jackson, RN
IQR Support Contractor Team Lead, HSAG

**Speaker(s):**
Celeste Milton, MPH, BSN, RN
Associate Project Director, Division of Healthcare Quality Evaluation, Company

Candace Jackson, RN
IQR Support Contractor Team Lead, HSAG

**February 23, 2015**

**2 p.m. ET**

**Question 1:** What is UTD?

**Answer 1:** UTD = Unable to Determine.

**Question 2:** Sorry I missed [the] start of [the] program. If we are already reporting IQR structural measures via web, we should be all set and don't need to do a DACA, etc., as it should be on file. Is that correct?

**Answer 2:** The DACA must be completed annually. For [Fiscal Year] FY 2016 ([Calendar Year] CY 2014), the timeframe to complete both the structural measures and DACA will be April 1, 2015–May 15, 2015.

**Question 3:** If your hospital has less than 250 births per year, are you required to report PC-core measures, or is it optional?

**Answer 3:** For Joint Commission purposes, it's optional. We're looking at a minimum of 1,100 births annually, and that's based on your two previous years of delivery to come up – or of births - to come up with that number, whether you're at that baseline. So, if you have 250 births annually, it's not required. But, you certainly can use that

to meet your requirement for Joint Commission purposes. You could report that fact. That could be one that you couldn't select. However, for CMS, you are required to report the PC_01 data, regardless of how many births you have in a year. If you do not have an OB unit or treat OB patients, then you are required to submit zero for all of the data fields.

**Question 5:** What is IQR?

**Answer 5:** Inpatient Quality Reporting.

**Question 6:** Will CMS be collecting and reporting data on any other PC measures in addition to PC-01

**Answer 6:** For the Inpatient Quality Reporting Program, currently only PC-01 is required.

**Question 7:** If our small rural hospital is not accredited by [The] Joint Commission, what are our current reporting requirements?

**Answer 7:** If you are an Acute Care Hospital for the Inpatient Quality Reporting Program, you need to submit just the PC-01 measure.

**Question 8:** How can I determine if we are participating in that reporting program?

**Answer 8:** You can log into *QualityNet* and go to the "My Tasks Page" and you can check to see if you have submitted an Inpatient Pledge under "Manage Notice of Participation."

**Question 9:** When will the ICD-10 codes for these be available?

**Answer 9:** We think they're going to be available the 1st of October. Actually, if you go to the current manual right now, in Appendix P as in Paul of the manual, there is a previous section that shows you what we envision the ICD-10 codes to be. We also have another section that shows [the] crosswalk from ICD-9 and ICD-10. That's actually been up there for quite some time. We put it up last year.

So this will give you an idea, but unless the government changes its mind, and they pass another law, we expect that it's going to take place the 1st of October. And therefore, the manual that we're

currently working on, which will be available around the 1st of May, will show you then what those ICD-10 codes are.

Just to give kind of give you a preview, right now you have four code tables that identify pregnancies that resulted in the delivery. The new ICD-10 codes don't have any codes that relate to whether they had a delivery or not. So we're actually going to a new table – procedure code – that will take a look at the types of delivery to identify patients. So in other words, the patient had a vaginal delivery, had a cesarean birth, vacuum, et cetera, et cetera; those will all be coded. And if you've got a code for that during in-hospitalization, that tells us there was a delivery. So that makes the patient eligible.

So, there are going to be some changes, and we expect that that will be in the next manual.

**Question 10:** I don't understand what is meant by "hard-stop" policy

**Answer 10:** A “hard-stop” policy mean[s] basically–would be … Let's say that you have a clinician that says, I'm on a schedule on induction that you actually have a policy in place that says if they're calling to schedule in induction or any of these conditions present. And you go to the American Congress of Obstetricians and Gynecologists (ACOG) guidelines on labor induction. They're very clear about what types of cases do merit an early-term elective induction, where you could say that the patient has this condition, that condition, or the other condition, and so forth. I'm not going to get into all the different conditions. But basically, if it's not on your list, then the schedule will or would say that this needs to go to a higher level of review. And that's exactly what it would do, whether it would be a committee review or a chairman of the department – that someone else would be looking at this to say that even though it doesn't have – meet the criteria that we'd set forth, it does meet criteria as I alluded to when I was saying how come we couldn’t capture all of the reasons.

We have a patient that has a stage four tumor that needs to have the cesarean so they can start the patient on the chemotherapy. Well, that's not going to be on your list of criteria for scheduling an elective induction. It's just [a] non-common thing, thank goodness – if this not a common thing where it’s happening all the time. So it

will go to another level of review, and they would say, "Yes, this is the reason that you should be doing this." They would concur with that. And you'll find that you have fewer of these cases where it's a little muddy, like there's impending macrosomia. That's a favorite one.

Well, impending macrosomia means that it might be a high birth weight. Well, if you look at table 11.07, there are no codes at all for macrosomia on there because it's very subjective. So there is going to be times where they might want to schedule something that doesn't have a really true reason. And that's where it would go to another level of review.

There is an article that came out in the O.B. Green Journal, like I said last year. Dr. Clark was one of the principal authors on this. If you do a query on it, he basically talks about – that they've looked at The Joint Commission measures, and that we've got the majority of the reasons on our table. So I'm going to kind of refer you back, you know, to looking at the evidence that's out there.

**Question 11:** If MD documents "prior classical concerns" AND/OR "prior T-incision on uterus," would this is an inclusion for prior uterine surgery?

**Answer 11:** Yes, T-incision would be that there's a vertical incision in the upper part. And then, the bottom of the T would be where the traverse – low transverse section took place. So, since it has extended up into the upper uterus, then that would be the same as just – as it was just a vertical incision. So that would be counted. That's a yes.

**Question 12:** On slide 37 for gestational age it says to take documentation closest to time of delivery. Vital records reports, delivery logs, or clinical information systems. The dictionary says something slightly different. What priority should I go with?

**Answer 12:** Okay, when you look at the data in [the] dictionary and you look at the data elements form for this, it's, once again, the use of the vital record reports for the delivery log or the clinical information systems are to identify those cases that are 37 and 38 weeks of gestation because that's what you reported on the birth certificate, which should be accurate. [The] hospital should also be monitoring to make sure that [the] reports they get back or that they find are as

accurate as what they look at in the medical record. But you know, once you confirmed that, then you would look at this document closer to the time of delivery that would be how they got this information for the birth certificate data.

So, the reason for the vital record reports and the delivery logs and the clinical information systems is to identify all of your cases which you don't have to sample. You still have to open up the record and look at it because there's going to be certain things that you want to – you just want to validate; that yes, the gestational age is 37, just as the report told me, because that's – what's in the medical record is what happened. And again, if you got discrepancies, then you should findi out why you're reporting something different to your state, or putting something different in your delivery log. So that's what that direction is about in the data element form.

**Question 13:** Will TJC PC certification be done through electronic measures or chart-abstracted measures?

**Answer 13:** Well, currently we do have two of our PC measures available in eMeasure specification. This happens to be one of them. The other one is PC-05, our breast feeding measure, which is – you can use for voluntary EHR reporting under the – your Inpatient Prospective Payment System (IPPS) program.

We are in the process of – we have done some specifications on PC-02, and those have not been used by CMS to date, but those will have been completed. They're not out there for [the] public yet. We have not begun re-specifying three or four yet. That'll come eventually, but that's in the immediate queue for re-specifying. We're working on a number of our paper-based measures, and a number of our course set. But that will happen eventually.

The requirements for ORYX, when you look at the reporting changed this year, you could do all paper-based, a hybrid of paper-based and eMeasures, or all eMeasures. But once again, not all sets are completely specified; in this case, the P.C. set.

So to answer your question for the certification program, at this point in time, we would just be looking at the paper-based obstructed measures. And if you're doing it with a vendor now, we're working on a way so that that measure information can

seamlessly go over into the database for the certification programs. We, basically, are collecting and reporting at once, and it'll be used for two purposes: for accreditation and for certification.

**Question 14:** Why do you discourage sampling?

**Answer 14:** Okay, well, I think I just alluded to that for this measure. For PC-01 and actually for PC-02, you would basically – if you have vital record report, you would query all of your cases that are for measure one, that are 37 or 38 weeks of gestation. So even if you're a really large hospital, we've done an analysis of gestational ages and measures that were reported from the entire set. That comprises about 20 percent of all deliveries.

So if you look at sampling, you're roughly right on that same range. But the difference is you're looking at every single record that was 37 and 38, and you're not opening up one that was 40 or one that was 36 and closing it. And you can't count it. It's not a part of your initial patient population that's going to, you know, basically be excluded from that measure. So it decreases your denominator's size if you're sampling.

Sampling is basically – is a statistical estimate that's trying to say, "Well, if I look at this number of record, it'll probably be the same as if I look at all of them.

But what we have found, especially in hospitals that have a smaller number of discharges, if you're not looking at all of them, and you're counting on occasional fallout for those very reasons that I discussed as far as not being able to take them out with a specific ICD-9 code. You reviewed them, and yes, it really was a reason to do it, then you're getting a higher rate than what you would anticipate. And I field these questions literally, every single week and almost every day, from hospitals that don't understand that.

That's why we're encouraging you not to sample. If you can find all of those cases, do not sample. Look at all of them that are 37 and 38. I think you'll be far more satisfied if you have [an] occasional case that ends up in the numerator even if it had a valid reason or not, as far as giving you a more accurate reflection of what your true rate is.

**Question 15:** While every conceivable exclusion for the measure are included, but the value based purchasing benchmark is to have 0% fallouts. In other words, we will not have any dollars/points for value-based purchasing with any fallouts, though it is known that there are many ACOG-approved medical indications that would still be a PC-01 fallout.

**Answer 15:** The PC-01 is a reverse measure, meaning that lower values/rates indicate better quality. The goal of this measure is to have a rate of 0% and the benchmark for the Hospital Value-Based Purchasing (VBP) Program [which] was finalized as 0.000000 or 0% in the FY 2015 IPPS Final Rule. A hospital may still receive achievement points for the measure within the program if their measure rate is better than or equal to the achievement threshold of 0.031250 or 3.125%.

**Question 16:** Is there a consideration to include all inductions referred by Maternal Fetal Medicine for medical necessity as an "approved" less than 39 weeks gestation?

**Answer 16:** No. As previously stated, the purpose of this measure is to enable hospitals to establish a baseline for their performance, which in turn serves as a determinant of whether improvement efforts are effective over time. In order to exclude medical conditions that do not have a specific ICD-9-CM diagnosis code, e.g., uncontrolled seizures, or those that have no ICD-9-CM diagnosis codes, e.g., maternal fetal medicine recommendation to deliver, non-specific abdominal pain, etc., a data element would need to be created and every chart would need to be manually reviewed to determine if this was present in the medical record. The issue with regard to additional exclusions from the denominator for this measure really has to do with the burden of data collection versus the frequency with which these conditions occur. We are always very mindful of the amount of resources required to collect data for our measures, and it was felt by our Technical Advisory Panel that the value of including every conceivable justification for an elective delivery (even if they could all be identified, which seems unlikely) would be far outweighed by the additional time required to identify those cases via medical record review. This is especially true in the case of conditions for which there is no existing ICD-9-CM diagnosis code. The ICD-9-CM diagnosis codes on Table 11.07 were recently compared to other valid medical indications that did not have

specific ICD-9-CM diagnosis codes in a large health care system. They concluded [that] approximately 98% of the total number of medical indications are currently included on Table 11.07.

**Question 17:** What if a patient did not receive prenatal care, but a gestational age is documented?

**Answer 17:** The documented gestational age should be used. UTD should only be selected if there is no gestational age documented.

**Question 18:** What if you have an elective delivery but coding does not code it as such? Can it be abstracted as an elective delivery?

**Answer 18:** There is no procedure code for an elective delivery. We are not sure what you are asking.

**Question 19:** If you document Spontaneous Rupture of Membranes (SROM) and deliver, but don't' say in LABOR is that OK?

**Answer 19:** If you are referring to the data element *Labor*, there must be documentation that the patient was in "labor," which should be taken at face value. SROM may occur immediately before onset of labor, during labor OR without commencement of labor. SROM and labor are not equivalent.

**Question 20:** Would you be able to provide a one page summary to support education with coders? Our coders have told us that they are only allowed to pay attention to the provider documentation, not nursing documentation.

**Answer 20:** The Joint Commission cannot provide specific guidance on coding requirements. The information "shared" from "lessons learned" came directly from hospitals participating in the Hospital Engagement Network.

**Question 21:** From the ultrasound report, does the term "uterine window" need to be present, or is "thinning" or "weak wall" adequate documentation?

**Answer 21:** The clinician should be documenting uterine wall, thinning of the uterine wall, or defect of the uterine wall based on ultrasound findings as the reason for performing an early term elective cesarean birth.

**Question 22:** What if there is conflicting documentation regarding labor...e.g., one progress note states early labor and another note states labor. Which is used for abstraction of the data element for labor? Sorry, one note states early labor and the other note states prodromal labor.

**Answer 22:** This is conflicting documentation based on inclusion and exclusion descriptors for "labor," so the answer should be "no" to labor, as you are unable to determine which description is correct.

**Question 23:** Will there be more exclusion with the new ICD-10 codes?

**Answer 23:** The proposed PC ICD-10 tables are available for preview in Appendix P of the manual at: https://manual.jointcommission.org/releases/TJC2015A1/AppendixPTJC.html.

**Question 24:** If you chose a combination of both electronic measures and paper based measures for TJC and sent PC via electronic Clinical Quality Measures (eCQMs), would you still have to submit the missing PC measures that are only available in paper-based records, e.g., PC-04, etc.?

**Answer 24:** This is beyond the scope of the presentation. This question should be directed to the Wiki Q & A platform at: http://manual.jointcommission.org. Select the category*: Health Care Organization - General ORYX Question, Other.*

**Question 25:** Condition present on admission is not considered if an early elective induction results in abnormal fetal heart rate, the case falls out of the EED measure. Is anyone considering this issue?

**Answer 25:** All of the core measures using ICD-9-CM diagnosis codes, in order to determine exclusions, are based on the discharge diagnoses assigned to the appropriate codes. There is no way to incorporate the use of admission diagnoses in an automated fashion, as the discharge diagnoses may be different. As previously stated, the purpose of this measure is to enable hospitals to establish a baseline for their performance, which in turn serves as a determinant of whether improvement efforts are effective over time.

In order to exclude medical conditions that do not have a specific ICD-9-CM diagnosis code, e.g., uncontrolled seizures, or those that have no ICD-9-CM diagnosis codes, e.g., maternal fetal medicine recommendation to deliver, non-specific abdominal pain, etc., a data element would need to be created and every chart would need to be manually reviewed to determine if this was present in the medical record. The issue with regard to additional exclusions from the denominator for this measure really has to do with the burden of data collection versus the frequency with which these conditions occur. We are always very mindful of the amount of resources required to collect data for our measures, and it was felt by our Technical Advisory Panel that the value of including every conceivable justification for an elective delivery (even if they could all be identified, which seems unlikely) would be far outweighed by the additional time required to identify those cases via medical record review. This is especially true in the case of conditions for which there is no existing ICD-9-CM diagnosis code. The ICD-9-CM diagnosis codes on Table 11.07 were recently compared to other valid medical indications that did not have specific ICD-9-CM diagnosis codes in a large health care system. They concluded approximately 98% of the total number of medical indications are currently included on Table 11.07.

**Question 26:** Exclusion criteria is still not robust enough to exclude at risk mothers

**Answer 26:** As previously stated, the purpose of this measure is to enable hospitals to establish a baseline for their performance, which in turn serves as a determinant of whether improvement efforts are effective over time. In order to exclude medical conditions that do not have a specific ICD-9-CM diagnosis code, e.g., uncontrolled seizures or those that have no ICD-9-CM diagnosis codes, e.g., maternal fetal medicine recommendation to deliver, non-specific abdominal pain, etc., a data element would need to be created and every chart would need to be manually reviewed to determine if this was present in the medical record. The issue with regard to additional exclusions from the denominator for this measure really has to do with the burden of data collection versus the frequency with which these conditions occur. We are always very mindful of the amount of resources required to collect data for our measures, and it was felt by our Technical Advisory Panel that the value of including every conceivable justification for an elective delivery

(even if they could all be identified, which seems unlikely) would be far outweighed by the additional time required to identify those cases via medical record review. This is especially true in the case of conditions for which there is no existing ICD-9-CM diagnosis code. The ICD-9-CM diagnosis codes on Table 11.07 were recently compared to other valid medical indications that did not have specific ICD-9-CM diagnosis codes in a large health care system. They concluded approximately 98% of the total number of medical indications are currently included on Table 11.07.

**Question 27:** There needs to be a broader exclusion for medical conditions affecting the mother, including epilepsy, recent neuro surgery, [and/or] psychological issues affecting mother.

**Answer 27:** As previously stated, the purpose of this measure is to enable hospitals to establish a baseline for their performance, which in turn serves as a determinant of whether improvement efforts are effective over time. In order to exclude medical conditions that do not have a specific ICD-9-CM diagnosis code, e.g., uncontrolled seizures or those that have no ICD-9-CM diagnosis codes, e.g., maternal fetal medicine recommendation to deliver, non-specific abdominal pain, etc., a data element would need to be created and every chart would need to be manually reviewed to determine if this was present in the medical record. The issue with regard to additional exclusions from the denominator for this measure really has to do with the burden of data collection versus the frequency with which these conditions occur. We are always very mindful of the amount of resources required to collect data for our measures, and it was felt by our Technical Advisory Panel that the value of including every conceivable justification for an elective delivery (even if they could all be identified, which seems unlikely) would be far outweighed by the additional time required to identify those cases via medical record review. This is especially true in the case of conditions for which there is no existing ICD-9-CM diagnosis code. The ICD-9-CM diagnosis codes on Table 11.07 were recently compared to other valid medical indications that did not have specific ICD-9-CM diagnosis codes in a large health care system. They concluded approximately 98% of the total number of medical indications are currently included on Table 11.07.

**Question 28:** Just need a broader exclusion statement from physician as with reasons for “no VTE prophylaxis.”

**Answer 28:** This presentation did not address VTE prophylaxis. All questions about VTE measures should be directed to your performance measurement systems vendor who has been educated on the measure specifications.

**Question 29:** When submitting the PC-01 into the web-based measures, the question regarding prior uterine surgery has been removed. Where are we supposed to be excluding those patients?

**Answer 29:** Please refer to the measure algorithm. Prior Uterine Surgery is now evaluated at the numerator level and is no longer an exclusion.

**Question 30:** What type of documentation is required by a provider that may help pass the elective measure when a pregnant patient presents at 38 weeks of gestational age with acute surgical condition (e.g., acute appendicitis) and the determination is made to perform an appendectomy and a C-section?

**Answer 30:** As previously stated, the purpose of this measure is to enable hospitals to establish a baseline for their performance, which in turn serves as a determinant of whether improvement efforts are effective over time. In order to exclude medical conditions that do not have a specific ICD-9-CM diagnosis code, e.g., uncontrolled seizures or those that have no ICD-9-CM diagnosis codes, e.g., maternal fetal medicine recommendation to deliver, non-specific abdominal pain, etc., a data element would need to be created and every chart would need to be manually reviewed to determine if this was present in the medical record. The issue with regard to additional exclusions from the denominator for this measure really has to do with the burden of data collection versus the frequency with which these conditions occur. We are always very mindful of the amount of resources required to collect data for our measures, and it was felt by our Technical Advisory Panel that the value of including every conceivable justification for an elective delivery (even if they could all be identified, which seems unlikely) would be far outweighed by the additional time required to identify those cases via medical record review. This is especially true in the case of conditions for which there is no existing ICD-9-CM diagnosis code. The ICD-9-CM diagnosis codes on Table 11.07 were recently compared to other valid medical indications that did not have specific ICD-9-CM diagnosis codes in a large health care system.

They concluded approximately 98% of the total number of medical indications are currently included on Table 11.07.

**Question 31:** If a patient does not receive prenatal care but has a gestational age documented in the chart, do I still select UTD for gestational age?

**Answer 31:** The documented gestational age should be used. UTD should only be selected if there is no gestational age documented.

**Question 32:** Understanding that not every conceivable exclusion for the measure is included in Table 11.07, are there any resources that may help with educating the providers in clear and concise documentation that would justify the elective delivery?

**Answer 32:** The clear and concise documentation is necessary to aid the coders in applying the appropriate ICD-9 codes. Your coders and clinicians should meet to discuss shared expectations on documentation requirements.

**Question 33:** Some of the codes on Table 11.07 seem to be postpartum codes. We had a case where a patient was thought to have had an abruption and had an emergency CS, however she was not found to have an abruption during the surgery. The coders would not use the TJC accepted code since the abruption was not substantiated during the surgery. This was a fallout, even though the provider acted appropriately

**Answer 33:** All of the core measures using ICD-9-CM diagnosis codes in order to determine exclusions are based on the discharge diagnoses assigned to the appropriate codes. Table 11.07 is comprised of discharge diagnosis codes only. There is no way to incorporate the use of admission diagnoses in an automated fashion, as the discharge diagnoses may be different. As previously stated, the purpose of this measure is to enable hospitals to establish a baseline for their performance, which in turn serves as a determinant of whether improvement efforts are effective over time. In order to exclude medical conditions that do not have a specific ICD-9-CM diagnosis code, e.g., uncontrolled seizures or those that have no ICD-9-CM diagnosis codes, .e.g., maternal fetal medicine recommendation to deliver, non-specific abdominal pain, etc., a data element would need to be created and every chart would need to be manually reviewed to determine if this was present in the

medical record. The issue with regard to additional exclusions from the denominator for this measure really has to do with the burden of data collection versus the frequency with which these conditions occur. We are always very mindful of the amount of resources required to collect data for our measures, and it was felt by our Technical Advisory Panel that the value of including every conceivable justification for an elective delivery (even if they could all be identified, which seems unlikely) would be far outweighed by the additional time required to identify those cases via medical record review. This is especially true in the case of conditions for which there is no existing ICD-9-CM diagnosis code. The ICD-9-CM diagnosis codes on Table 11.07 were recently compared to other valid medical indications that did not have specific ICD-9-CM diagnosis codes in a large health care system. They concluded approximately 98% of the total number of medical indications are currently included on Table 11.07.

**Question 34:** Could TJC consider adding antepartum codes, as well, for some of these scenarios?

**Answer 34:** Table 11.07 is comprised of discharge diagnosis codes. These codes also indicate a delivery took place during the hospitalization based on assignment of the 5$^{th}$ digit. Antepartum codes alone would not capture that level of specificity required for use in the PC measure set.

**Question 35:** Can we change from sampling to doing 100% review after a quarter of abstraction?

**Answer 35:** Yes, you will need to work with your performance measurement systems vendor to accomplish this. Sampling has always been optional.

**Question 36:** Is it incorrect to report gestational age in the week/day format, e.g. 38.5, or are we to report only the completed week and not the week and day? Thank you.

**Answer 36:** A single numeric value for completed weeks of gestational age should be used for reporting purposes. Gestational age should be rounded off to the nearest completed week, not the following week. For example, an infant born on the 5th day of the 36th week (35

weeks and 5/7 days) is at a gestational age of 35 weeks, not 36 weeks.

**Question 37:** Should I enter UTD on any patient presenting with no prenatal care documented even when the physician documents an estimated gestational age?

**Answer 37:** The documented estimated gestational age should be used. UTD should only be selected if there is no gestational age documented.

**Question 38:** You've identified differences in the way each hospital is collecting the data. How can you ensure that benchmarking with other organizations is truly comparing apples to apples?

**Answer 38:** The PC measures are based on standardized specifications which appear in in the Specifications Manual for Joint Commission National Quality Measures (v2015A1) at: https://manual.jointcommission.org/releases/TJC2015A1/index.html. All hospitals should be adhering to the specifications provided in this manual in order to ensure apples to apples comparisons of the data reported.

**Question 39:** The CMS Coding Clinic Guidelines do not match the definitions for PC-01.

**Answer 39:** This is a non-specific question which we cannot address.

**Question 40:** [A] 37 week gestation is not considered premature in the coding clinic rules.

**Answer 40:** This is a non-specific question which we cannot address. 37 to 38 weeks gestation is considered early term gestation.

**Question 41:** [I am] concerned that you are advising to use RN documentation when coding guidelines direct coders to code from physician documentation. Your guidance is not consistent with guidelines.

**Answer 41:** The information "shared" from "lessons learned" came directly from hospitals participating in the Hospital Engagement Network.

**Question 42:** Does TJC have webinars similar to this for the other four PC core measures?

**Answer 42:** The Joint Commission does presentations on the PC measures based on request. Please submit your request online to our Speaker's Bureau at: www.jointcommission.org/about_us/speakers_bureau.aspx

**Question 43:** Is SROM in the exclusion codes now?

**Answer 43:** SROM was removed because it is redundant. There are currently two ICD-9-CM diagnosis codes on Table 11.07 which should be used for SROM: 658.11 and 658.21. The coders should be applying these codes when there is appropriate documentation that SROM occurred without commencement of labor. As a result, the case would be excluded from the measure.

**Question 44:** When the updated benchmarks for 2014 are released, how will this information be distributed?

**Answer 44:** If you are referring to The Joint Commission's 2015 Annual Report on Quality and Safety which will contain the PC composite rates for 2014, this will be available in the fall of 2015 at: www.jointcommission.org/annualreport.aspx.

**Question 45:** We are a small rural hospital. Because we have patients from geographically isolated communities where natural weather events can have a significant impact, is there any documentation of a justification that can be accepted? We do review all "fallouts" and we see that the provider thoughtfully arrived at his/her decision to proceed, but we are worried about being penalized for VBP.

**Answer 45:** We encourage you to review the case studies in the *March of Dimes (MOD)/California Maternal Quality Care Collaborative (CMQCC) <39wk Toolkit* available at: marchofdimes.com or CMQCC.org. Intermountain Health serves a primarily rural population, and they developed successful strategies to decrease early term elective deliveries based on geographic considerations.

**Question 46:** Where can we find those definitions?

**Answer 46:** The PC measure specifications are available in the Specifications Manual for Joint Commission National Quality Measures (v2015A1) at: https://manual.jointcommission.org/releases/TJC2015A1/index.html

**Question 47:** Would you encourage non-sampling for all the PC measures or only PC 1?

**Answer 47:** If you have access to Vital Records reports, delivery logs, or other clinical information systems which provides you with gestational age and the number of previous live deliveries, it is encouraged that you review all cases identified via these external data sources with the gestational age range under evaluation for each of the maternal measures:PC-01, PC-02, and PC-03. PC-04 does not allow sampling. You may still sample for PC-05 which is a newborn measure and has a different initial patient population from the maternal measures.

**Question 48:** SROM: unless this is coded, the case will not fall out, correct? What documentation does the LCP need to make for this code?

**Answer 48:** Yes, that is correct. Documentation of spontaneous rupture of membranes without onset of labor should be taken at face value according to ACOG. The 2013 ACOG definition of Premature Rupture of Membranes (PROM) is rupture of membranes before the onset of labor period. Membrane rupture that occurs before 37 weeks of gestation is referred to as preterm PROM. Membrane rupture that occurs at 37 weeks of gestation or later is referred to as term PROM. In 2014, ACOG re-named premature rupture of membranes to pre-labor rupture of membranes in order to further clarify the meaning of PROM. We consider ACOG an authoritative source. Based on the ACOG definition, code 658.11 applies to all cases with SROM regardless of gestational age, and only the absence of labor should be required to use this code. If the ruptured membranes are >24 hours, then code 658.21 applies.

**Question 49:** Did the 11.07 codes change for 2015? Any added, etc.?

**Answer 49:** Please refer to the Release Notes found on the Table of Contents page for all revisions to the PC measures posted in the Specifications Manual for Joint Commission National Quality Measures (v2015A1) at: https://manual.jointcommission.org/releases/TJC2015A1/

**Question 50:** What is the top decile for the individual PC measures?

**Answer 50:** For 3Q14, the top decile (90th percentile) is a follows:

- PC-01: 0.11111
- PC-02: 0.4
- PC-03: 1
- PC-04: 0.0625
- PC-05: 0.75205
- PC-05a: 0.93333

**Question 51:** Can you provide a clarification on the structural measure for surgery database? Does National Health Safety Network (NHSN) count or are you looking for more of a National Surgical Quality Improvement Program (NSQIP)?

**Answer 51:** As a provider, you will need to make the determination if NHSN meets the definition of a registry. A systemic clinical database registry is a collection of clinical data for purposes of assessing clinical performance, quality of care and opportunities for quality improvement. When answering structural measures questions you will also want to keep in mind the definitions of "participation" and "qualified." "Participation" is defined as, "submitting standardized data elements applicable to at least two National Quality Forum-(NQF-) endorsed measures related to the topic measured by the registry and reporting on all patients eligible for the measures. And "qualified" is defined as receiving data from more than five hospitals, and providing calculated measures, results, benchmarks, and quality improvement information to the participant (and to designated third parties).

**Question 52:** Clarification please: SROM excludes the patient from the numerator for PC-01, making it 'okay' to induce or C-section prior to 39 weeks, but it stays in the denominator?

**Answer 52:** No. SROM, which does not result in commencement of labor, excludes the case from the denominator based on the assignment of either code 658.11 or 658.21, which appear on Table 11.07. Once the case is excluded from the denominator, the case will not be eligible for the numerator.

**Question 53:** Why does CMS collect data regarding registry participation?

**Answer 53:** CMS believes requesting structural measure information will encourage facilities to increase the use of tools, ultimately improving the quality of care provided to the Medicare beneficiaries.

**Question 54:** Are there national benchmarks for PC-01 yet?

**Answer 54:** National benchmarks are available on Hospital Compare.

**Question 55:** Less than or equal to 39? Isn't [it] less than 39?

**Answer 55:** If you are referring to the gestational age range for the denominator population, it is "Patients delivering newborns with >= 37 and < 39 weeks of gestation completed."

**Question 56:** With multiple sites being acceptable to use for gestational age, which should be used as the source of truth?

**Answer 56:** **The ONLY ACCEPTABLE SOURCES, IN ORDER OF PREFERENCE are:**

- Delivery Record
- Operating room record
- History and physical
- Prenatal forms
- Admission clinician progress notes
- Discharge Summary

**Question 57:** Please review ... should SROM be coded as "prolonged" or "premature" rupture of membranes?

**Answer 57:** Based on the ACOG definition, code 658.11 applies to all cases with SROM regardless of gestational age, and only the absence of labor should be required to use this code. If the ruptured membranes are >24 hours, then code 658.21 applies.

**Question 58:** Just to clarify, our coders had been using PROM only for <37 weeks gestation, but they should be instructed that ACOG considers PROM to also be SROM without onset of labor between 37 and 39 weeks?

**Answer 58:** Yes. Documentation of spontaneous rupture of membranes without onset of labor should be taken at face value according to ACOG. The 2013 ACOG definition of premature rupture of membranes

(PROM) is rupture of membranes before the onset of labor. Membrane rupture that occurs before 37 weeks of gestation is referred to as preterm PROM. Membrane rupture that occurs at 37 weeks of gestation or later is referred to as term PROM. In 2014, ACOG re-named premature rupture of membranes to pre-labor rupture of membranes in order to further clarify the meaning of PROM. We consider ACOG an authoritative source. Based on the ACOG definition, code 658.11 applies to all cases with SROM regardless of gestational age, and only the absence of labor should be required to use this code. If the ruptured membranes are >24 hours, then code 658.21 applies.

**Question 59:** Just to clarify, we can use our full data rather than sampling if we have it?

**Answer 59:** Yes, sampling has always been optional.

**Question 60:** For PC-05, in 2015 it states that the mother can change her feeding plan, but there are not clear guidelines for the documentation requirements. Can the nurse complete the conversation and have the provider confirm it later (like with the initial conversation)? I'm thinking about if it happens after hours, when there is not an approved provider available.

**Answer 60:** This presentation covered PC-01 measure specifications only. PC-05 is not a part of the Hospital Inpatient Quality Reporting (HIQR) program. All questions about PC-05 should be directed to your performance measurement systems vendor who has been educated on the measure specifications.

**Question 61:** Is the RN triage form acceptable to use to obtain gestational age if L&D and H&P do not specify?

**Answer 61:** Yes, a triage form would be equivalent to an admission clinician's progress notes.

**Question 62:** Since removing Rupture of Membrane (ROM), this will reduce the number of in the denominator ID, the patient was in labor, which may increase the rate [to more] than what it was in the previous year, correct?

**Answer 62:** Yes, it could potentially. The case would ONLY be removed at the denominator level via ICD-9-CM diagnosis codes on Table 11.07 if the patient was NOT in labor. If the patient was in labor, this question is still asked prior to the cesarean section question, and the case would remain in the denominator if the answer is “yes” to labor.

**Question 63:** Can you expand on the clinical trial question?

**Answer 63:** Clinical trial relates to the condition being studied in relationship to the measure under evaluation. For PC-01, the clinical trial must be directly related to pregnancy prior to delivery.

**Question 64:** Must the word "cornual" be present to refer to ectopic pregnancy?

**Answer 64:** Yes, since “cornual” means the pregnancy occurred in a sac attached to the outside wall of the uterus. This type of “ectopic” pregnancy compromises the uterus putting the patient at risk for rupture if the patient goes into labor.

This material was prepared by the Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. HHSM-500-2013-13007I, FL-IQR-Ch8-03042015-06