Outpatient Quality Reporting Program

Support Contractor

OQR 2016 Specifications Manual Update

Presentation

Moderator:
Pam Harris, BSN

Speakers:
Samantha Berns, MSPH
Bob Dickerson, MSHSA
Angela Merrill, PhD
Colleen McKiernan, MSPH, CPH
Nina Rose, MA

January 20, 2016

Pam Harris: Hello, and welcome to the Hospital OQR Program webinar. Thank you for joining us today. My name is Pam Harris, a project coordinator for the Hospital OQR Program. If you have not yet downloaded today's handout, you can get them from our website at qualityreportingcenter.com.

Go to the **Events** banner on the right side of the page. Click on **Today's Event**. Go down to the **Event Resources** tab at the bottom of the page. There will be a link that will allow you to access and print the handouts for today's webinar.

As you can see, we are live streaming in lieu of using only phone lines. However, phone lines are available if needed.

Before we begin today's program, I would like to highlight some important dates and announcements.

January 1st began the submission period for the web-based measures that are submitted through QualityNet. February 1st is the deadline for Clinical Data and Population and Sampling submission for Quarter Three. This will include the encounter dates of July 1st through September 30th, 2015.

We cannot stress enough how important it is not to wait until the last minute for your data submission. The QualityNet website gets very busy and slows down during submission time. We do not want to see anyone not have timely submission due to technical difficulties. CMS provides a lengthy submission period. Please, please take advantage of that.

As a reminder, please keep your QualityNet password active. You don't want to find yourself in the position where you are ready to enter your data but you can't because your password is locked. Please log in to QualityNet consistently to avoid your password being locked. For any password problems, please contact QualityNet directly.

On February 17th, we are going to present a webinar on OP-33. Please be advised that we have recently changed this date. We will present this webinar on the March 16th date. As you may be aware, there are some questions that have come up regarding this measure. CMS is working hard to resolve these issues. We look forward to updating you in March.

Additional webinars and educational opportunities will be forthcoming. Notifications will be sent via ListServe by the support contractor. ListServe notification is our primary mode of communications with regards to this program.

The learning objectives for this program are listed on this slide. This program is being recorded. A transcript of today's presentation, including

the question and answers received in the chat box, and the audio portion of today's program will be posted at www.qualityreportingcenter.com on a later date.

During the presentations, as stated earlier, if you have a question, please put that question in the chat box located at the left side of the screen. One of our subject matter experts will respond. Again, by having a live chat, we hope to accommodate your questions timely and have real time feedback. Some of the questions that are entered during the presentation will be shared at the end of the presentation.

The topics of discussion for today are listed on this agenda slide. This presentation is a collaborative effort among many contractors. We are fortunate today to have the involvement of many speakers from various contractors. The contractors are an integral part of this program and are the subject matter experts for the measures themselves.

For simplicity's sake, I would like to introduce all the speakers now. They will each present different area of topics as we proceed through the presentation.

The first speaker will be Samantha Berns. Samantha received her bachelor's degree in public health studies from Johns Hopkins University and her master's degree in health policy from the Johns Hopkins Bloomberg School of Public Health. Miss Berns joined the Lewin Group in 2013. She has expertise in the development, testing, and maintenance of clinical quality measures, and leads measures maintenance activities for 10 Hospital Outpatient Quality Reporting measures.

The second speaker will be Colleen McKiernan. Miss McKiernan serves as the project manager for the six outpatient imaging efficiency measures at the Lewin Group. Miss McKiernan joined the Lewin Group in June of 2012. She has extensive experience in clinical quality measure development, including the development, testing, implementation, and maintenance of claims-based and EHR measures. Colleen received her bachelor's degree in psychology and public health from the University of Massachusetts and her master's degree in health policy from the Johns Hopkins Bloomberg School of Public Health.

Our third speaker is Bob Dickerson. Bob Dickerson is a lead health informatics solution coordinator for the measure development and maintenance team at Telligen. He is a registered respiratory therapist with a master of science degree in health services administration from the University of Saint Francis in Juliet, Illinois. Most recently, he has been supporting the Centers for Medicare & Medicaid Services, CMS, with the development and maintenance of hospital clinical quality measures. Bob has extensive experience with healthcare process and quality improvements, and in supporting the transition to physician order entry in electronic health records. This includes the development and implementation of interventions, processes, and systems in the hospital setting that support national quality measures and outcome measures that demonstrate improved processes of care and patient care outcomes.

Our fourth speaker is Dr. Angela Merrill. Dr. Merrill holds a PhD in health sciences and policy analysis with a concentration in health economics from the University of California, Berkley. Dr. Merrill has over 20 years of experience in health policy research and is a senior researcher at Mathematica Policy Research. Her experience includes developing, implementing, and evaluating quality measures, and using

these measures to monitor trends in quality of care. Dr. Merrill has worked for over 10 years implementing claims-based, risk-adjusted outcome measures related to mortality, readmissions, admission, patient safety, and complications for the Medicare program to support a variety of CMS pay-for-reporting and pay-for-performance programs. She currently directs a subcontract to the Yale Center for Outcomes Research and Evaluation, or CORE, to develop and implement CMS outcome measures for hospital outpatient departments and ambulatory surgical centers. Dr. Merrill also works on projects supporting the CMS physician value-based modifier and the Physician Quality Reporting System.

Our last speaker will be Nina Rose with HSAG, the support contractor. Ms. Rose received her bachelor of science in family and consumer sciences from Ohio University and her master's degree in gerontology from the University of South Florida. She joined the HSAG team three years ago and has assisted in the development of educational materials for both The Outpatient Quality Reporting Program as well as the Ambulatory Surgical Center Quality Reporting Program. Nina is a project coordinator for both of these programs and the Specifications Manual production lead.

Now, let me turn this over to our first speaker, Samantha Berns with the Lewin Group.

Samantha Berns: Hello everyone. As Pam said, my name is Samantha; I am a research consultant at the Lewin Group. Today, we'll be discussing recent changes made to the Acute Myocardial Infarction, Chest Pain, Emergency Department Throughput, Pain Management, and Stroke measures. First, we will be discussing the conversion from ICD-9 codes to ICD-10 codes in Appendix A.

The changes made to the ICD-10 codes listed in Appendix A were made based on a review performed by expert coders and clinicians. These changes reflect updates to the crosswalk included in previous versions of the Specifications Manual. The preview tables that were included in earlier versions of the Specifications Manual were updated prior to ICD-10 implementation and the use of Version 8.1 of the Specifications Manual on October 1, 2015. Additional updates to the Appendix were made more recently, in the Version 8.1 Supplemental Document 2. The tables included in Appendix A will continue to be reviewed and updated to ensure accuracy and to reflect any coding updates.

Next we will be discussing the Version 8.1 Supplemental Document 2. This document was released on December 17, 2015, and covers encounters from October 1 through December 31, 2015. Changes made in the supplemental document will also be in effect for subsequent versions of the manual. The changes that went into effect with the release of the Version 8.1 Supplemental Document 2 are updates of codes in several tables in Appendix A. The tables that are affected include Table 1.1: Acute Myocardial Infarction Diagnosis Codes; Table 1.1a: Chest Pain, Angina, Acute Coronary Syndrome Codes; Table 8.0: Ischemic and Hemorrhagic Stroke; and Table 9.0: Long Bone Fracture.

In Table 1.1, four ICD-10 Acute Myocardial Infarction Diagnosis Codes were added. These codes, from the I97 code family, were related to post-procedural and intraoperative cardiac disturbances.

In Table 1.1a, 35 ICD-10 codes were added; a majority of these codes come from the I25 code family and are related to atherosclerotic heart disease. Also added were codes related to pain in throat and chest pain, unspecified, from the R07 code family, as well as post infarction angina,

from the I23 code family. Only one code, related to pleurodynia, was removed from this table.

Moving to the next slide, one ICD-10 code was listed twice on earlier versions of Table 8.0. This duplicate code was removed from the current version of Table 8.0, so that it is only listed one time in the table. This is code I63.49, cerebral infarction due to embolism of other cerebral artery.

When viewing Table 9.0, you will notice 89 new ICD-10 codes that were added; many of these new codes are related to osteoporosis, pathologic fractures, pathologic fractures in neoplastic disease, and fractures following insertion of orthopedic implant. The newly added codes all fall under the M80, M84, and M96 code families. Codes from the S82 code family, related to non-displaced fracture of medial malleolus of left and unspecified tibia, were also added. Finally, 150 ICD-10 codes from the S62 code family, primarily related to fractures of the ankle and wrist, were removed.

We will now discuss the changes to the Acute Myocardial Infarction, or AMI, and Chest Pain measures in more detail.

This slide displays all five Acute Myocardial Infarction/Chest Pain measures. OP-1 is Median Time to Fibrinolysis; OP-2 is Fibrinolytic Therapy Received within 30 Minutes of ED Arrival; OP-3 is Median Time to Transfer to Another Facility for Acute Coronary Intervention; OP-4 is Aspirin at Arrival; and OP-5 is Median Time to ECG.

In Version 9.0, the Data Accuracy sections of the Measure Information Forms for all five AMI/Chest Pain measures were updated to indicate that

there may be variation by provider, facility, and documentation protocol for chart-abstracted data elements.

: I will now discuss changes to the data elements that are collected for the AMI/Chest Pain measures. The first data element is *Initial Electrocardiogram, or ECG, Interpretation*, which is collected for OP-1 (Median Time to Fibrinolysis), OP-2 (Fibrinolytic Therapy Received within 30 Minutes of ED Arrival), and OP-3 (Median Time to Transfer to Another Facility for Acute Coronary Intervention). To abstract "Yes" for the *Initial ECG Interpretation* data element, there must be documentation of ST-elevation on the interpretation of the 12-lead ECG performed closest to emergency department arrival. Two changes were made to the Initial ECG Interpretation data element in Version 9.0. For the first change, the Notes for Abstraction were updated to indicate that any inclusion terms described using the word "potential" should be disregarded; cases described with the modifier "potential" would be neither an inclusion nor an exclusion for this data element. The second change reorganized the wording in the Inclusion and Exclusion Guidelines for Abstraction to facilitate easier abstraction. For example, the bullet describing ST, ST abnormality, or ST changes consistent with injury or acute/evolving MI has been broken down into three separate bullets.

Next, we will discuss the data element *Reason for Delay in Fibrinolytic Therapy*. This data element is collected for OP-1 (Median Time to Fibrinolysis) and OP-2 (Fibrinolytic Therapy Received within 30 Minutes of ED Arrival). To abstract "Yes" for this data element, there must be documentation of a reason for a delay in initiating fibrinolytic therapy after hospital arrival by a physician, advanced practice nurse, or physician assistant. System reasons for delay, such as equipment failure or staff issues, are not acceptable. There must be a clinical or patient-centered

reason for a delay in initiating fibrinolytic therapy after hospital arrival. In Version 9.0, the bullet structure of the Notes for Abstraction was reorganized to facilitate abstraction. The text that details the need for clear documentation of a hold or delay AND that the reason was non-systematic in nature has been separated into a new bullet in order to be more easily seen.

The *Transfer for Acute Coronary Intervention* data element is collected for OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention. Patients are included in the OP-3 population if there is documentation that the patient was transferred to another facility specifically for acute coronary intervention. In Version 9.0, the Notes for Abstraction were updated to clarify that an abstractor may select a value of "1" if there was documentation the patient was transferred from this facility's emergency department to another facility specifically for acute coronary intervention, if "transfer for Cath lab" is explicitly listed in the emergency department record.

The *Probable Cardiac Chest Pain* data element is collected for OP-4 (Aspirin at Arrival) and OP-5 (Median Time to ECG). This data element helps to define the measure population. Patients are included in OP-4 if they have an ICD-10 principal diagnosis code for acute myocardial infarction, or if they have an ICD-10 principal diagnosis code for angina, acute coronary syndrome, or chest pain **and** there is also documentation that a nurse, physician, advanced practice nurse, or physician assistant presumed the patient's chest pain to be cardiac in origin. In Version 9.0, the Inclusion Guidelines for Abstraction were updated to include the term "chest tightness." There is one additional change to this data element which is not reflected on the slide. The Inclusion Guidelines for

Abstraction used to list a plus sign qualifier. This option was removed from the inclusion list.

The next data element we will review is *Aspirin Received*, which is collected for OP-4: Aspirin at Arrival. To abstract "Yes" for this data element, it must be documented that aspirin was received in the 24 hours prior to emergency department arrival or administered in the emergency department prior to transfer to another facility or inpatient service. In Version 9.0, the Definition and the Allowable Values were updated to clarify that aspirin should be administered in the emergency department prior to transfer.

The *Reason for No Aspirin on Arrival* data element is also collected for OP-4: Aspirin at Arrival. Patients are not included in the OP-4 population if they have an aspirin allergy; if one or more of the medications listed in the Inclusions List is listed as pre-arrival medication; or if there is documentation of a reason for not administering aspirin from a nurse, physician, advanced practice nurse, or physician assistant. In Version 9.0, the bullet structure of the Notes for Abstraction was reorganized to facilitate abstraction; no text was added or deleted.

The *ECG Time* data element is collected for OP-5: Median Time to ECG. This data element defines the military time, represented in hours and minutes, at which the earliest 12-lead electrocardiogram was performed. In Version 9.0, the Notes for Abstraction were updated to provide additional clarification for abstractors when multiple ECGs are documented. The bullets denoting the order in which to abstract ECGs were made more prominent, so that abstractors know when to abstract the ECG performed prior to arrival.

We will now discuss the Emergency Department-Throughput measures.

This slide displays the three Emergency Department-Throughput measures: OP-18 (Median Time from ED Arrival to ED Departure for Discharged ED Patients), OP-20 (Door to Diagnostic Evaluation by a Qualified Medical Professional), and, OP-22 (Left without Being Seen). There were no changes made to OP-22 in Version 9.0.

For OP-18 (Median Time from ED Arrival to ED Departure for Discharged ED Patients) and OP-20 (Door to Diagnostic Evaluation by a Qualified Medical Professional), the Data Accuracy section of the Measure Information Form was updated to clarify that there may be variation by provider, facility, and documentation protocol for chart-abstracted data elements.

The next four slides highlight changes to the data elements that are collected for the Emergency Department-Throughput measures. The first data element, *Arrival Time*, is used in the algorithms for OP-1, OP-2, OP-3, OP-5, OP-18, OP-20, OP-21, and OP-23. In Version 9.0, the list of Only Acceptable Sources was updated to specify that the emergency department record may include the ED face sheet, ED consent or authorization for treatment forms, ED or outpatient registration or sign-in forms, ED ECG reports, ED telemetry or rhythm strips, ED laboratory reports, and ED X-ray reports.

The next data element, *ED Departure Time*, is collected for OP-3 (Median Time to Transfer to Another Facility for Acute Coronary Intervention) and OP-18 (Median Time from ED Arrival to ED Departure for Discharged ED Patients). This data element defines the military time at which the patient departed from the emergency department. In Version 9.0, the bullet

structure of the Notes for Abstraction was reorganized to clarify that, for patients who are placed into observation services, the time of the physician, advanced practice nurse, or physician assistant order for observation should be used for the *ED Departure Time* data element. No text was added or deleted.

The *Provider Contact Time* data element is collected for OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional. For the *Provider Contact Time* data element, abstractors should use documentation of the military time for the first direct, personal exchange between an ambulatory patient and a physician or institutionally credentialed provider to initiate the medical screening examination in the emergency department. Three updates were made to the Notes for Abstraction. The first update clarifies that, if there is documentation that a provider had direct, personal contact with a patient during an examination **and** that this was the first direct encounter between the patient and the provider, then this time may be abstracted, even if it is not specifically documented as *Provider Contact Time* in the medical record.

The second clarification indicates that documentation of a provider writing an order, beginning the patient note, or making other documentation in a patient's medical record is not sufficient for the *Provider Contact Time* data element because there is no evidence that the provider had direct, personal contact with the patient during these actions. The final change for this data element notes that documentation of a patient reexamination does not meet requirements for the *Provider Contact Time* data element.

I will now review the emergency department Pain Management measure OP-21: Median Time to Pain Management for Long Bone Fracture. In Version 9.0, the Data Accuracy section of the Measure Information Form

was updated to clarify that there may be variation by provider, facility, and documentation protocol for chart-abstracted data elements.

Finally, I will review updates for the emergency department Stroke measure OP-23: Head CT or MRI Scan Results for Acute Ischemic or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation within 45 minutes of ED Arrival. In Version 9.0, the Data Accuracy section of the Measure Information Form was updated to clarify that there may be variation by provider, facility, and documentation protocol for chart-abstracted data elements.

We will now discuss changes to one data element that is collected for the emergency department Stroke measure. The data element *Head CT or MRI Scan Interpretation Date* is collected for OP-23. This data element captures the month, day, and year at which the earliest head CT or MRI scan interpretation was completed or reported. In Version 9.0, examples were added to the Notes for Abstraction to provide additional clarification for instances when multiple interpretations are documented. *Head CT or MRI Scan Interpretation Time* should not be abstracted as the time the results of the scan were relayed to the ED physician, advanced practice nurse, or physician assistant if an earlier interpretation time is documented. The Notes for Abstraction were also updated to indicate that the date associated with the *Head CT or MRI Scan Interpretation Time* should be abstracted as the *Head CT or MRI Scan Interpretation Date*. This concludes my portion of the presentation; and I will now turn it over to Colleen.

Colleen McKiernan: Thank you, Samantha. As Pam noted earlier, my name is Colleen McKiernan; I am a consultant at the Lewin Group. Today, I will provide an overview of the Outpatient Imaging Efficiency measures. As indicated

in the Outpatient Prospective Payment System rule published November 13, 2015, CMS has removed OP-15 for the calendar year 2017 payment determination and subsequent years. Consequently, the measure information form for OP-15 has been removed from the Version 9.0 of the Specifications Manual. No additional changes were made to the measure information forms for OP-8, OP-9, OP-10, OP-11, OP-13, or OP-14. Additional information about the Outpatient Imaging Efficiency measures will be shared during a future national provider call. This concludes my portion of the presentation; Bob, I will turn it back to you.

Bob Dickerson: Thank you, Colleen. As Pam mentioned previously, my name is Bob Dickerson; I'm the lead health informatics solution coordinator with Telligen.

No changes were made in manual versions 9.0 or 9.0a for OP-12 (the ability of providers to receive lab data electronically), OP-17 (tracking of clinical results between visits), and OP-25 (use of a safe surgery checklist).

For OP-26 (hospital outpatient volume for selected outpatient surgical procedures), there have been and are plans for some changes related to Table 1. Table 1 contains the categories and procedure codes for outpatient surgical procedures for each volume that will be reported for this measure. In version 8.1, Table 1 was updated to reflect the most commonly performed outpatient surgical procedures and the corresponding codes for calendar year 2015.

In version 9.0a of the manual, Table 1 was replaced with the statement, "Please refer to Specifications Manual version 9.1 for updated categories and procedure codes for Outpatient Surgical Procedures." And in the upcoming version 9.1, Table 1 will be reinserted with the most commonly

performed outpatient surgical procedures and the corresponding codes for calendar year 2016.

No changes were made to OP-27, the influenza vaccination coverage among healthcare personnel. Just a couple of reminders that data for this measure is entered via the CDC National Healthcare Safety Network website using your facility's CCN. And the deadline for submission of this data is May 15 of each year.

For OP-29 (appropriate follow-up interval for normal colonoscopy in the average risk patient), an age cap was applied to the denominator population criteria for version 9.0a. This entails changing the measure description and denominator statements from "50 years and older" to "50 to 75 years of age" **and** adding to the denominator criteria immediately after "greater than or equal to 50 years" "less than or equal to 75." This change is to better synchronize the OP-29 measure with the U.S. Preventive Services Task Force age-based recommendations regarding follow-up colonoscopy. This will result in patients older than 75 years being removed from the initial patient population instead of them being removed during medical record abstraction, as currently occurs based upon physician documentation of the age being the reason for not recommending an interval of at least 10 years. In addition to better synchronizing the measure with the guidelines, this change will simplify abstraction because cases where patients are older than 75 years at the time of the colonoscopy will no longer need to be abstracted.

You may recall this was initially a change in version 8.1 of the manual that was rather quickly changed back. The short story behind this is there are three versions of this measure; one is for the Hospital Outpatient Program, which is OP-29, the measure which we are reviewing now. There is also a version for the Ambulatory Surgery Center Program, and one for the Physician Quality Reporting Program. The PQRS measure is

on a different update and release schedule, which was not fully realized until version 8.1 was released. While the measure stewards fully support this change, they wanted the timing of this change to occur at the same time for all three versions of this measure. So we ended up having to pull it back in version 8.1, and now you see it put back in it in version 9.0a of the manual.

Additional changes to OP-29 are the addition of some examples to the Denominator Exclusions section that are intended to better illustrate what constitutes exclusions based on a medical reason. We continue to receive questions regarding whether or not a follow-up interval being expressed as a range that is less than 10 years and inclusive of 10 years is acceptable; for example, an interval of 7 to 10 years. This is not acceptable, and we have added a statement about this to the Additional Instructions section.

For OP-30, colonoscopy interval for patients with a history of polyps, three CPT codes 44393, 45355, and 45383 have been inactivated. As a result, they've been removed from the Denominator Criteria. Now for those folks familiar with CPT codes, there are replacement codes; however, the measure stewards have indicated to not add the replacement codes at this time.

Also for OP-30, the word "polyps" has been added behind adenomas in the Denominator Exclusions section so this is consistent with the measure name and definition which uses the terms somewhat interchangeably.

In OP-30 the documentation of a system reason for an interval of less than three years since the last colonoscopy continues to generate a number of questions. While the exclusion statement implies there must be an interval of less than three years to use a system reason, it is not explicitly clear. The purpose of the system reason exclusion is to allow for exclusion of cases where the interval is less than three years and a medical reason

cannot be found. To help provide clarity regarding the system reason, we have added some specifics of what must be present to constitute a system reason. First, there needs to be documentation reflecting it has been less than three years since the last colonoscopy. In most cases, there is also a medical reason documented why the interval is less than three years. The system reason is available for situations where it is known the interval is less than three years but there is no medical reason documented. So the second requirement for a system reason is a medical reason is not documented. The last requirement is there is documentation present reflecting the previous colonoscopy report was not available or could not be located.

So at this point, I am going to turn the presentation over to Angela Merrill for a review of the remainder of the changes to data elements.

Angela Merrill: Thank you Bob. This is Angela Merrill; I am a senior researcher at Mathematica Policy Research. The next two slides discuss the manual revisions to the OP-31 measure, Cataracts–Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery.

The changes that we made reflect the alignment of the measure specifications across Outpatient Quality Reporting (OQR) and Ambulatory Surgical Center Quality Reporting (ASCQR) manuals, as well as the alignment with the measure steward specifications. The first update was to the Data Collection Approach section where we added the following statement: "Include procedures performed from the beginning of the reporting year through 90 days prior to the end of the reporting period. This will allow the postoperative period to occur."

We also made two updates to the Additional Instructions section, Definition for Survey. First, we updated the language so that the

instructions now state: "The same data collection instrument used pre-operatively must be used post-operatively," and we added the following point: ""For each of the Visual Function tools, Visual Function VF-14 or VF-8R, all questions have equal weight, only non-missing questions are included, and the total weight is 100." Please note that the discussed changes were made in version 9.0 of the OQR Specifications Manual. There were no changes to this measure information form between the 9.0 and 9.0a version.

I will now discuss the one claims-based outcome measure used in this program. The next five slides describe changes for OP-32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy measure.

Please note that OP-32 is a claims-based measure. Facilities do not need to submit data for this measure other than normal billing data. The first change to the Specifications Manual was to expand the full measure title to "Centers for Medicare & Medicaid Services (CMS) Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy" measure. In addition, several minor edits were made throughout the Specifications Manual for clarity and will not be reviewed here. The substantive edits on the next four slides reflect changes to update cohort codes and exclusion criteria made prior to and following the July 2015 national dry run for the measure. We note that the measure is still undergoing reevaluation based on facility feedback from the July 2015 dry run. Additional updates may be made to the measure in the upcoming year, and manual amendments would be issued.

The first change reflects that the CPT/HCPCS codes that define the patient cohort have been updated to reflect two new codes introduced in 2015.

The two new codes, as described on the slide, are 45388 and G6024. We note that CPT 45388 replaced CPT 45383 in 2015. However, HCPCS G6024 was used in 2015 CMS billing, and 45388 will be used in 2016 forward.

The next slide describes a refinement made to a measure exclusion prior to the 2015 dry run. The exclusion, "colonoscopies for patients who lack continuous enrollment in Medicare-Fee-For-Service parts A and B in the one month after the procedure" was changed to "colonoscopies for patients who lack continuous enrollments in Medicare-Fee-For-Service parts A and B in the seven days after the procedure." This exclusion was refined to only seven days since the outcome period for this measure is seven days.

Slide 57 describes exclusions that were refined after the 2015 national dry run to exclude patients receiving a diagnosis of inflammatory bowel disease or diverticulitis at the time of the index colonoscopy procedure. Specifically, the exclusions were expanded with the underlying text on the slide. The measure will now exclude colonoscopy for patients with a history of inflammatory bowel disease or diagnosis of IBD at the time of index colonoscopy and colonoscopies for patients with a history of diverticulitis or diagnosis of diverticulitis at the time of the index colonoscopy. These exclusions were refined because admissions for acutely ill inflammatory bowel disease or diverticulitis patients who are evaluated with an outpatient colonoscopy and are subsequently admitted for medical treatments of an IBD flare or diverticulitis do not reflect the quality of the colonoscopy. The manual was also updated to add a crosswalk table to the ICD-10 code for these two conditions.

Slide 58 reflects three new exclusions. The first new exclusion, colonoscopies that occur on the same outpatient claim of an emergency department visit, was added to the measure prior to the 2015 dry run. It was added because the sequence of events in these cases is not clear. It is not possible to use claims data to determine whether the colonoscopy was the cause of, subsequent to, or during the ED visits. This exclusion applies to OPD facilities only.

The second new exclusion, colonoscopies that occur on the same outpatient claim as an observation stay, was added to the measure after the 2015 dry run based on feedback from facilities. Similar to the first exclusion, the sequence of events in these cases is not clear, and it is not possible to determine whether the colonoscopy was the cause of the observation stay or if the patient was placed into observation to complete the prep for the procedure or due to an acute event such as G.I. bleed for which the colonoscopy was performed. This exclusion also applies to OPD facilities only.

The third exclusion, colonoscopies followed by a subsequent outpatient colonoscopy procedure within seven days, was added prior to the 2015 dry run. For cases in which a colonoscopy is followed by another colonoscopy within seven days, the measure will use the subsequent colonoscopy as the index colonoscopy. The two colonoscopies are considered part of a single episode of care for which the subsequent colonoscopy is considered the index procedure.

This concludes the summary of the manual updates for the OP-32 measure. I will now hand the presentation over to Nina Rose.

Nina Rose: Thank you, Angela. Hi everyone; my name is Nina Rose, and I am the Specifications Manual lead for the support contractor. As you are aware, there was an implementation of a new OP-33 measure, which the collection period started on January 1st. Let's talk about this measure and see what was in the Specifications Manual.

OP-33: External Beam Radiotherapy for Bone Metastases, or the EBRT measure. The description for this measure is seen on the slide here. Essentially, this measure is assessing a percentage of patients with a diagnosis of painful bone metastases and no history of radiation that received EBRT with an acceptable fractionation scheme.

The measure information form, or MIF, in the Specifications Manual gives details on this measure. On this slide, the numerator and denominator are displayed as they are seen in the manual. The acceptable fractionation schemes, as we stated on the last slide, are seen here. The MIF will also list a denominator criteria, denominator exclusions, data source, and collection information.

The sampling requirements for this measure are also listed in the Specifications Manual. The table you see here on the slide is what is in the Specifications Manual. You will notice that this sampling criteria is very different from other measures in the program.

For those of you that are looking for more information regarding this measure, the support contractor will be doing a webinar in the future, so please stay tuned. You don't want to miss out on the more in-depth explanations for this measure.

Before we go on to some of your questions, let me remind you of a few things as it relates to the Specifications Manual. First, you always want to check the updated release notes. Next, make sure you're signed up for the ListServe through QualityNet. This is the easiest way to stay informed on everything going on with the quality program. The Specs Manual is a vital tool in the success of this program. You can find the Specifications Manual on the QualityNet.org website. You can access the various versions of the Specifications Manual and the release notes. You can download either the individual document or the entire manual as well. That's going to do it for the Specifications Manual.

I'd like to thank all of the contractors and speakers today for their valuable information. We appreciate all the subject matter experts and their input. I think we now have some time to go over some questions and answers regarding what's come into the chat box.

Here's a good one. "During the OP-32 dry run, a lot of the hospital visits following colonoscopies at our facilities were unrelated reasons. Why is my facility being held responsible?" Angela, I think that's a question for you.

Angela Merrill: Thank you for the question. You are correct, Nina. This was a common question during the dry run. The answer is that, although the measure removed planned hospital admissions from the outcome, it measures all-cause hospital visits to encourage facilities to minimize all types of risks that may lead to the need for a hospital visit after a colonoscopy.

Measuring only hospital visits that are potentially related to a colonoscopy, such as gastrointestinal bleeding, would limit the measure's impact on quality improvement efforts. Measuring all-cause patient

outcomes encourages facilities to minimize the risk of a broad range of outcomes, including the risk of dehydration, pain, dizziness, and urinary retention. These are common problems that may be related or unrelated to a recent colonoscopy.

We have structured the measure so that the facilities that most effectively minimize patient risk of these outcomes will perform better on the measure. We do not expect the rate of hospital visits to be zero since some patients will have visits for reasons completely unrelated to the colonoscopy. The measure is risk-adjusted so facilities that are more likely to experience unrelated visits because they have a generally higher risk patient mix are not disadvantaged in the measure.

Nina Rose: Thank you, Angela. Colleen, I think I found the question for you. "Will the imaging measures for CT scans include patients who come into the emergency department, have a CT scan, and then are discharged?"

Colleen McKiernan: Thanks for the question. So, the answer is yes. Measures involving these CT studies, such as OP-10 which is Abdomen CT–Use of Contrast Material, OP-11 or Thorax CT–Use of Contrast Material, and OP-14 or Simultaneous Use of Brain CT and Sinus CT, do include utilization from emergency departments as they are classified as outpatient facilities and paid under the Outpatient Prospective Payment System.

Nina Rose: Thank you Colleen. Bob, I'm seeing one for you. "With the change to OP-29, if a patient is not 75 but will be older than 75 in 10 years, does the physician need to document age as the reason for not recommending a follow-up colonoscopy?"

Bob Dickerson: Thank you, Nina. That's a great question, and that is correct. The change only excludes cases from the measure population that are older than 75 on the date of the encounter. So, if the patient is 75 or less on the date of the colonoscopy and they will be older than 75 in 10 years, the physician will need to include in the colonoscopy report for the current encounter that age is the reason they're not recommending a follow-up colonoscopy.

Nina Rose: Thank you so much, Bob. I'm seeing an OP-31 question. And this is, "Can patients be excluded from the denominator population due to a co-morbid ocular condition? If co-morbidities exist, there may not be improvement in all the visual activities."

Angela Merrill: Thanks. This is Angela. I'll take that question. The measure population does include both groups of patients, those with and without ocular co-morbidities. An improvement in visual function after cataract surgery would be expected in both groups. However, the magnitude of the difference would vary by group.

Please note how the numerator for the measure is defined. It is patients who had improvement in visual function achieved within 90 days following cataract surgery, based on completing both the pre-operative and post-operative visual function instrument. The numerator does not track the degree of improvement and function of that.

Nina Rose: Thank you so much, Angela. I'm seeing an OP-9 question. And it's: "Specifically, how are mammography follow-up rates for OP-9 captured?"

Colleen McKiernan: So, this is Colleen. I'll take that one. Thanks, Nina. For OP-9, Medicare claims data are used to check if mammography screening studies are followed by a diagnostic mammography, ultrasound, or a magnetic

resonance imaging study of the breasts in an outpatient or office setting within 45 days. The time window of 45 days is inclusive of the same day that the screening was performed. That is, the numerator would include diagnostic mammography, ultrasound or MRI of the breast on the same day as the screening mammogram.

Nina Rose: Thank you, Colleen. I have an OP-33 question here, and I'm going to take that. "So, does OP-33 affect critical access hospitals? We are a CAH and have an oncology and radiation center." And honestly, the answer is that the participation of critical access hospitals is completely voluntary for the OQR Program. Of course, critical access hospitals are encouraged to participate. However, there is no penalty if a CAH does not report.

Another question, this is specifically about the reasons for delay in fibrinolytic therapy. "The E.D. physician documented that there was a delay in fibrinolytic therapy due to waiting for results of the CT scan. The patient had an abdominal CT yesterday and had been complaining of right lower quadrant and lower back pain. Is this sufficient to answer a 'Yes' to the question, 'Is there a physician documentation of a reason for delay in administering fibrinolytic therapy?'"

Samantha Berns: Hi Nina, this is Samantha. I can take that one. Yes, the reason for delay must be patient-centered and clinical in nature in order to abstract a "Yes" for these data elements. In addition, there must be a clear documentation in the medical record that a hold, delay, deferral, or wait in initiating fibrinolysis actually occurred, and that the underlying reason for that delay was not system-related.

Nina Rose: Thank you so much, Samantha. I'm seeing an OP-32 question again. "What are the codes that must be billed for this measure, and when does the facility need to start billing for these codes?"

Angela Merrill: Thanks. This is Angela. I can take that one. The OP-32 measure is calculated from routine billing claims data from hospitals. Facilities do not need to report specific codes on their claims for the purposes of this measure.

For the calendar year 2018 payment determination, the performance period is anticipated to be based on calendar year 2016 claims data. If you want more information on the measure, you can refer to the most recent Specifications Manual, version 9.0, or there is also a detailed methodology report on this measure posted on QualityNet. The address for that information is QualityNet.org, **Hospitals-Outpatient**, pull down, then choose **Measures**, and then choose the **Colonoscopy Measure Dry Run**. https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228775181947

Nina Rose: Thank you so much. This is a popular question. "The OP-30 measure information form states that history of colonic polyps is not an acceptable reason to exclude cases from the denominator. If there is documentation indicating a large polyp was removed one year ago in a follow-up or multiple polyps were removed during the last colonoscopy a year ago, how do I abstract these cases?"

Bob Dickerson: Thanks. This is another great question. And it is correct that a history of colonic polyps cannot be used to exclude a case for a medical reason because that is one of the denominator inclusion criteria. So, the thing to look for is the specificity that is within the documentation. In this case,

the physician is specifically referencing a large polyp found in the last colonoscopy one year ago or multiple polyps removed in the last colonoscopy one year ago. They're not referencing a general history of colon polyps. So these cases are very similar to the example of the

medical reason that is given in the OP-30 measure information form that says, "last colonoscopy found greater than 10 adenomatous polyps."

If you know the last colonoscopy was less than three years ago and something like this is documented in the medical record, it can be used as a medical reason for an interval of less than three years.

Nina Rose: Thanks, Bob. This is an OP-31 question. "In the new manual, a new guideline states, 'Include procedures from the beginning of the reporting year through 90 days prior to the end of the reporting year. This will allow the post-operative period to occur.' Is it the expectation that only procedures performed January 1, 2015 through October 2, 2015 – 90 days before the end of calendar year 2015 – will qualify for the OP-31 measure?"

Angela, do you want to take that?

Angela Merrill: Sure. And yes, this is correct. We clarified this data collection approach in the measure specifications in version 9.0. The measure identified patients 18 years and older who had cataract surgery and had improvement in visual function achieved within 90 days following the cataract surgery. Therefore, for the denominator population facilities should include procedures performed from the beginning of the reporting year through 90 days prior to the end of the reporting period.

For the numerator, since facilities need to assess improvement in the visual function achieved within 90 days following cataract surgery, this data collection approach allows for the post-operative period of 90 days to occur. Thus, the numerator covers the entire reporting year.

Nina Rose: Awesome. Thank you. Here's another OP-33 question. It is: "Is OP-33 a web-based measure or claims-based measure?"

OP-33 is actually a chart-abstracted, web-based measure, and it will be reported annually. The encounter period began on January 1st of this year and will extend through December 31st of this year. You will then enter the data via the online QualityNet Secure Portal beginning with a January 1, 2017, submission through the deadline of May 15, 2017.

I'm seeing another question. "I have a question regarding OP-3 in the *Probable Cardiac Chest Pain* data element. If there is a working diagnosis of chest tightness documented and then the final diagnosis is atypical chest pain, would you select 'Yes' for the *Probable Cardiac Chest Pain* data element?"

Samantha Berns: That's a great question. The short answer to your question is that you would select "No." Let's consider your example. There's documentation of chest tightness which is an inclusion term. There's also a documentation of atypical chest pain which is an exclusion term. And there's no documentation of a differential or working diagnosis of acute myocardial infarction. Thus, since there's documentation of an exclusion term and there's no diagnosis of AMI, you should select "No" for the *Probable Cardiac Chest Pain* data element.

Nina Rose: All right. I'm seeing another question for OP-32. "There were a lot of issues identified in the dry run data. How are those issues being resolved?"

Angela Merrill: Thanks. This is Angela. So, we thank facilities very much for all of the feedback they provided during the dry run. And we – the OP-32 measure

is currently undergoing annual re-evaluation, during which CMS is evaluating all of the issues noted by facilities.

We would refer people to the QualityNet website for the most recent Specifications Manual, version 9.0. This update reflects some measure refinements, what I talked about earlier, that address dry run feedback. We know that these specifications may be further revised in 2016 as the annual re-evaluation is completed.

Nina Rose: Thank you. All right guys, I think we only have one – time for one more question and it's – I'm seeing as OP-29. So Bob, this will be for you, okay? "If there is documentation of a medical reason for a repeat colonoscopy in less than 10 years, such as diverticulitis or history of colon cancer, but it is not specifically stated as a reason for repeating the colonoscopy in less than 10 years, can it be used as documentation of a medical reason?"

Bob Dickerson: Thanks, Nina. That's another great question. The reason for a follow-up in less than 10 years does not need to be explicitly stated in the same statement as the actual follow-up interval. So, if there's documentation of the medical reason, like in the examples in the question, that's in the patient's history and the follow-up interval documented in the colonoscopy report is less than 10 years, you can take that as documentation of the medical reason for not recommending at least a 10-year follow-up interval.

Nina Rose: Thank you so much, Bob.

All right guys, that's all the time we have for today. Once again, I'd like to thank all of our speakers. A special thanks to all the contractors that

support the measures for this program, and the contractors today are the Lewin Group, Telligen, Mathematica Policy Research, and Yale Center for Outcomes Research and Evaluation.

Pam, back to you.

Pam Harris: Thank you, Nina.

This concludes our program today. We hope that you've heard useful information that will help you in the OQR Program. Thank you, and enjoy the rest of your day.

END