Outpatient Quality Reporting Program

Support Contractor

Hitting the Highlights: Changes, Reports, Tools, and FAQs

Questions & Answers

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Question:	When does or did compliance with OP-29 and OP-30 impact financial reimbursement to the hospital? What is the impact?
Answer:	OP-29 and OP-30 were reported for the first time last year on the web-based tool on QualityNet. This affected payment for 2016. The requirements of the program are that information for all the measures are to be reported. If a hospital failed to answer the web-based measures, they risk a two percent reduction in the Medicare payment update.
Question:	For OP-31, if we're **not** collecting that data, can we just leave that blank, despite the incomplete warning?
Answer:	Yes, this will not affect payment.
Question:	For OP-33, should we enter zeros if that measure does not apply to us?
Answer:	Facilities that do not perform EBRT should report "zero" in the numerator and denominator.
Question:	How often does Hospital Compare post – quarterly?
Answer:	Yes, data are posted quarterly. The imaging measures and the web-based measures are updated annually in July.
Question:	If a hospital entered data in 2015 for OP-29 and OP-30, will it receive 100 percent of reimbursement in 2016, regardless of percentage of compliance with the measure in 2015?

Answer: This is not a pay-for-performance program. To meet the program requirements, data must be reported for all measures. If a facility fails to meet the program requirements, they stand to lose up to two percent of their Medicare payment update.

Question: Is OP-33 voluntary?

Answer: No, this is a required measure. It is a chart-abstracted, web-based measure that will be reported annually.

Question: Did I hear correctly that Medicare part B claims should not appear on the Claims Detail Report?

Answer: Yes, you heard correctly that this report only shows Medicare Fee-for Service and/or Medicare part A claims that are in final status.

Question: Is the Provider Participation Report a claims-type of report?

Answer: No, this report summarizes data entered by the facility.

Question: QNet shows validation quarters for CY 2017 to be "quarters included in CY 2017 validation are Second Quarter 2015 (2Q15), Third Quarter 2015 (3Q15), and Fourth Quarter 2015 (4Q15)." Is this correct?

Answer: Yes. For payment determination 2017, there are only three quarters included: Q2, Q3, and Q4 2015.

Question: Was OP-30 removed or not discussed here, as there are no changes?

Answer: OP-30 has not been removed; it is still a required measure. Changes and updates were discussed in the January Specifications Manual update webinar.

Question: For OP-29, if the physician documents a recommendation for a follow-up colonoscopy in 7-10 years due to diverticulitis, will this pass the measure?

Answer: History of diverticulitis can be a medical reason to exclude this patient from your denominator.

Question: Just to clarify – For OP-31 reporting, if we are **not** reporting, then nothing needs to be entered, correct?

Answer: Correct. OP-31 is voluntary. If you are not reporting, then nothing needs to be entered.

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Question: I see patients on the claims report who do not qualify for the OP STK measure. My billing team says they are billed correctly; however, in the chart they appear to be inpatients or observation patients. Why are they showing on the claims report when the number of claims is not supposed to be greater than the number of patients in the measure?

Answer: The Claims Detail Report displays claims submitted by the facility in final status. However, data submitted to the warehouse by your facility are a combination of Medicare and non-Medicare cases. This report is a tool to be used by hospitals in identifying the number of cases to abstract for each measure set and reflects the claims submitted to CMS for payment. If a patient shows up on this report that you cannot find in your outpatient population, their admitting status may have changed. This report gives the providers an idea of the **number** of charts to abstract, not necessarily the exact **patients** to abstract. As we stated, this report will only have Medicare FFS claims.

Question: On OP-29, can we use documentation by the nurse that she or he gave discharge instructions recommending a repeat colonoscopy in 10 years?

Answer: No. For OP-29, the documented follow-up interval must be found in the colonoscopy report.

Question: In earlier webinars we have been told we could use the EMS "arrival time" going in the lines of being able to use the EKG that is done by EMS enroute.

Answer: That scenario is with regard to *ECG Time*, **not** *Arrival Time*. With regard to *ECG Time*, the Specifications Manual states: "In the event the patient had an ECG performed within 60 minutes prior to arrival at the ED, enter the time the patient **arrived** at this ED." *Arrival Time* is the earliest time that the patient arrived in the outpatient or emergency department. The Specifications Manual, with regard to this element, states that documentation outside the Only Acceptable Sources list should not be referenced (e.g., ambulance record). This is in v 9.0a, page 2-10.

Question: If a patient leaves without being seen, wouldn't that case be excluded from the population and not abstracted?

Answer: This depends if the patient was billed with an E/M code. If billed, then the patient will be in the ED-Throughput population and will require a discharge code of UTD. If not given an E/M code, they will be in the OP-22, Left Without Being Seen, population.

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Question: For OP-30, if you are unable to verify the last colonoscopy (not done at your hospital--and not documented in the EMR), how do I exclude this patient without failing the case? UTD fails the case.

Answer: If you do not know when the last colonoscopy was, then you cannot state it was greater than three years. Thus, the patient would be in your denominator but not in your numerator.

Question: On the OP-29 slide, if the physician documents that the patient should follow up in 10 years for their next colonoscopy **and** includes information about diverticulosis or hemorrhoids found on the scope, how would that be abstracted?

Answer: Since the physician documented a recommendation for follow-up in 10 years and if this is documented on the colonoscopy report, the case would be included in your numerator count. For OP-29, the only time a medical reason for exclusion is applicable is when the recommended follow-up interval is less than 10 years.

Question: In regards to the physician's first contact in the ED, does that need to be the provider's documentation, or can we use nursing documentation that the provider is with the patient?

Answer: It is the time the patient first had personal exchange with the physician/APN/PA or institutionally credentialed provider. You can accept nurses' documentation of "physician at bedside" or other documentation indicating direct face-to-face contact with the provider.

Question: Who has to submit OP-33: all hospitals, or just cancer hospitals? I don't see it as an option in QualityNet.

Answer: OP-33 is a required measure for the Hospital OQR Program. Data collection began on January 1, 2016, and will be for the full calendar year. Data submission will be from January 1 – May 15, 2017, along with all other web-based measures.

Question: What version of the Specs Manual are we to use to get the updated codes to calculate volume for each area under OP-26?

Answer: For 2015 patient encounters reported in 2016, use Specifications Manual version 8.1.

Question: We do not have external beam radiation at our facility. How do we address OP-33?

Answer: For facilities that do not perform EBRT, you will enter "zero" for the numerator and denominator.

Question: Is OP-33 due in May 2016 or next year?

Answer: Data collection began on January 1, 2016, and will be for the full calendar year. Data submission will be from January 1 – May 15, 2017, along with all other web-based measures.

Question: For OP-30, if a patient has no previous colonoscopy, then will these be excluded?

Answer: OP-30 requires that the patient have a history of colonic polyps in previous colonoscopy findings. If the patient has not had a prior colonoscopy, they would not be included in OP-30.

Question: I am very confused by the statement that we are submitting 2013 data.

Answer: The last release displayed 2013 data for web-based measures. Web-based measures and imaging measures are updated annually in the July release.

Question: If, during the registration process, the 'arrival time' is documented as 1240 (presuming taken from the EMS run sheet), can it be used?

Answer: You would use the earliest documented time the patient arrived at the emergency department using the Only Acceptable Sources listed for that data element.

Question: We have been told that the EMS run sheet cannot be used for *Arrival Time* to ED.

Answer: That is correct. EMS run sheets cannot be used for *Arrival Time*.

Question: OP-29 and 30 will include all patients, not only outpatients. Is this accurate?

Answer: OP-29 and OP-30 would only include outpatients, as this measure pertains to the Outpatient Quality Reporting Program.

Question: I question the answer of 1253. Obviously, the patient had to have been in the ED longer than 0 minutes before the EKG was done. The actual answer should be what time they were registered, shouldn't it? That time would more closely relate to the ambulance time, I would expect. If we are

trying to calculate amount of time before EKG done, the answer of using that EKG time skews the data.

Answer: I think you are getting two different data elements confused. We are speaking to *Arrival Time*. I believe you are talking about *ECG Time*. With regard to *ECG Time*, the Specifications Manual states: "In the event the patient had an ECG performed within 60 minutes prior to arrival at the ED, enter the time the patient **arrived** at this ED." *Arrival Time* is the earliest time that the patient arrived. The Specifications Manual, with regard to this element, states that documentation outside the Only Acceptable Sources list should not be referenced (e.g., ambulance record). This is in v 9.0a, page 2-10.