Outpatient Quality Reporting Program

Support Contractor

The Question and Answer Show

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Question: The nurse documented on the stroke form that last known well time was 5/2/17 at 2100. The physician documented last known well was 3 days ago (without time, 3 days ago would be 5/1/17). Do I answer "No" to *Last Known Well* because we use physician documentation and because there was no time documented by physician for *Last Known Well* on 5/1/17?

Answer: Documentation on a code stroke form takes precedence over all other forms of documentation. Additionally, you should abstract the medical record at face value if there is a specific time documented. The physician documentation would take precedence if there were no stroke form and if the physician had a specific time documented.

Question: Do we do not take the physician documentation of *Last Known Well* as our priority? The date is one day earlier than the one the nurse documented?

Answer: You may take the medical record at face value and abstract the nurse-documented specific time.

Question: A patient came in with chest pain. The physician listed multiple differential diagnoses and pericarditis was included. Though the final diagnosis was acute chest pain, should we still answer “No” to probable cardiac chest pain?

Answer: Acute chest pain typically matches the inclusion term “chest pain,” however; pericarditis is matched to an inclusion/exclusion term on a case-by-case basis. Since our team does not have a full account of the patient record, please consider the entire context and differential diagnoses and use your best judgment to determine if the chest pain was presumed to be cardiac in origin.

Question: A patient had an ECG (documented as "12-lead ECG" under treatment on EMS record) done by paramedics within 60 minutes of ED arrival, but they are not all snap shots of 12-lead ECGs in the record. Can we still accept this ECG?

Answer: Yes, documentation of a 12-lead ECG within 60 hours of ED arrival is sufficient to abstract “Yes” for data element ECG. A physical printout of the ECG results is not needed.

Question: I had one question regarding EBRT. Is there any chance that the EBRT measure would be reported quarterly in the future?

Answer: At this time, there is no proposal to make the EBRT measure quarterly.

Question: Does the EMS record need to be part of the patient's medical record to use ECG time done in the field, or can the ED nurse document the time the EMS ECG was done?

Answer: The ED nurse may document the time that the EMS ECG was done.

Question: We are a small hospital; 15 minutes away is a large hospital that performs heart catheters. We always send STEMIs to them, not giving fibrinolytics. Is there an answer we should use for why we don't give fibrinolytics?

Answer: If there isn’t documentation of a contraindication or reason for not administering fibrinolytic therapy or if the documented reason is not listed in the data element’s inclusion criteria, you should abstract a value of “3.” We will consider your feedback in the next measure update.

Question: For OP-21, if the physician documents that the patient received pain medications per EMS, but there is no EMS run sheet confirming documentation, is that sufficient?

Answer: There does not need to be documentation of route or exact time the medication was administered, nor an exact medication if described as a pain medication, to use it in your abstraction. Based on the patient’s arrival time to the ED, if you are able to clearly determine that the patient received pain medication in the ambulance or EMS services within 24 hours prior to ED arrival, you may abstract a value of “No.” Otherwise, you should abstract based on pain medication received in the ED.

Question: For OP-4, in the instance of patients being transferred from a hospital, and the need for documentation that aspirin (ASA) was given, not just listed as

a home medication, does an urgent care count as the transfer requirements regarding home medications?

Answer: The Aspirin Received data element intends to capture whether aspirin was received within 24 hours before emergency department arrival or administered in the emergency department prior to transfer. In this instance, if aspirin was received within 24 hours before emergency department arrival, then you may abstract "Yes" for the data element.

Question: A patient came from urgent care to our ED. The home medications listed ASA. Can we select "No" to pain medications or does an urgent care count as a facility where having home medications listed is not sufficient?

Answer: The guidance from the Specifications Manual states "If there is documentation of routine pain medications on the home medication list, it can be assumed these medications were taken within 24 hours prior to arrival." Select "No" to *Pain Medication*. There only needs to be clear evidence that the patient is actively taking the pain medication daily, at home, in order to abstract a value of "No" to the *Pain Medication* data element. A specific schedule or time of last administration is not required; however, if it is not clear that the medication is currently active, you should abstract based on the administration of pain medication in the ED.

Question: For Off the Floor (OTF) time, the Electronic Health Record (EHR) entry states a time of 1248, but a nurse notes that the patient was transferred off the floor at 1233. Do you use the nurse's notes or the entry on the timeline?

Answer: When more than one emergency department departure/discharge time is documented, abstract the latest time. Based on the information provided, you should abstract 1248 for *ED Departure Time* if this is the documented time the patient physically left the ED.

Question: For the stroke measure question for *Time Last Known Well*, if the medical records state that the patient's answer was "2 days ago" but no specific time was documented, should we answer the question as "No/UTD" or estimate the time?

Answer: If the *Time Last Known Well* is clearly greater than 2 hours prior to hospital arrival and no specific time is documented, select "No."

Question: Our facility sends observation admission patients to the patient floor; we do not keep them in an ED hold bed in our emergency department. Should

we use the actual departure from ED time for *ED Departure Time* or should we use the 'admit to observation' time as our *ED Departure Time*?

Answer: Based on the information provided, if the patient was placed into observation services from the outpatient setting, then you should abstract the observation order for *ED Departure Time*. The intention of this guidance is to abstract the time that the patient is no longer under the care of the ED. When a patient is placed into observation, their clinical workflow may vary from patients who are not placed into observation prior to departure from the ED, so the observation order may be used instead of the actual ED departure time.

Question: In the example you have for reason for not giving fibrinolytics, the clinic record shows a blood pressure (BP) of 178/120. The measure states that if there is documentation or other reasons documented by a physician/APN/PA, we can use it. How is the clinic documentation of a BP 178/120 documented by a physician?

Answer: The data element's contraindication "severe uncontrolled hypertension on presentation (SBP > 180 mm Hg or DBP > 110 mm Hg)" refers to the first blood pressure taken during the visit. If physician/APN/PA or pharmacist documentation in the ED record supports the patient has uncontrolled hypertension on presentation, then you should abstract a "1" for this data element.

Question: For *ED Departure Time*, must the time be listed in the ED Record? Our registration discharge time is viewed at the header of our EHR System but this is not found in the electronic clinical record. We document a departure time in the ED record. The registration time is the time that the patient was taken off the tracking board; this time is also included in our printed medical record in the header only for the CDAC audits. The CDAC auditor stated we had to use the discharge time from the header. We are just looking for clarification.

Answer: The only acceptable source for the *ED Departure Time* data element is the emergency department record. Based on the information provided, you should abstract the documented time in the ED record that the patient physically left the ED. Since this question seems specific to your facility workflows, we recommend that you review these guidelines internally in your facility and determine the most accurate abstraction for *ED Departure Time*. Following these guidelines will also allow you to establish accuracy and consistency of data abstraction for this measure for the included populations moving forward.

Question: I understand that if a patient is admitted to observation, we are to use the 'admitted to observation' order time for *ED Departure Time*. We use a status event to document times as well. If we have a status event that states "decision to admit to observation," can we use this for *ED Departure Time*, or do we need to use the actual order time to admit to observation?

Answer: The Specifications Manual states, for patients placed into observation services, to use the time of the physician/APN/PA order for observation for *ED Departure Time*. The intention of this guidance is to abstract the time that the patient is no longer under the care of the ED. Based on the information you provided, you must use the actual order time to admit observation.

Question: We have a triage in our ED where 12-lead EKGs are done by paramedics and RNs, would these EKG's be acceptable for CP/AMI abstraction?

Answer: Yes, these would be acceptable.

Question: We have documentation in the dictated ED report that notes "EKG showed ST-elevation in the inferior leads as well as T-wave inversions and ST-depressions in leads 1, aVL, V2, and V3 consistent with acute MI." The signed EKG notes "inferior injury probable early acute infarct." There was only one EKG done in the ED. Based on this information, how should the initial EKG interpretation question be abstracted?

Answer: Version 10.0a of the Specifications Manual states, "Disregard any description of an MI or ST-segment that is not on either the Inclusion list or the Exclusion list." As it is on neither the inclusion or exclusion list, "probable" should be disregarded in your abstraction. Therefore, it is not treated in the same way that the list of negative qualifiers and/or modifiers are.

Question: Regarding OP-21, why is the timing of oral pain medications excluded in adults for this measure? This results in median times that are more representative of pediatric patient analgesia timing.

Answer: During the time of the measure's development, there was mixed evidence on the efficacy of oral pain medication for patients aged 18 years or older for the management of pain associated with long bone fractures. The appropriateness of other routes of administration for pain medication in adults is currently being evaluated.

Question: If the nurse documents a different provider contact time from what the doctor charts, which one should be used? Also, if the doctor logs in and

uses a patient contact check button, to "check in with patient," is this an acceptable provider contact time?

Answer: Based on the information provided, you should abstract the earliest exact time at which the patient had direct contact with the physician/APN/PA or institutionally credentialed provider to initiate the medical screening examination in the emergency department.

Question: For a post-operative follow up, the physician documents in his colonoscopy report that the patient "does not need to return to see me in my office unless there is a problem or concern." There is no mention of a recommended follow up colonoscopy, just the above follow up instructions. How would I answer to the follow-up interval?

Answer: If the follow-up interval is not documented in the colonoscopy report, the case will remain in the denominator.

Question: The data element on our tool for ED patients states, “If a patient is transferred in from any emergency department (ED) or observation unit of your hospital, our tool states to select ‘No.’” This applies even if the emergency department or observation unit is part of your hospital’s system (e.g., your hospital’s free-standing or satellite emergency department). This seems to conflict with slide 20.

Answer: The Specifications Manual states if two ED visits on the same day are rolled into one claim, abstract the first chronological encounter that meets the inclusion criteria for the population. If two ED visits on the same encounter date meet the inclusion criteria and are billed as two separate claims, both cases may be eligible for abstraction according to sampling requirements. Because the data element *Arrival Time* is used to differentiate between two cases that occur on the same encounter date, if both cases are submitted with UTD for *Arrival Time*, the case submitted last will override the previous case.

Question: I thought *Last Known Well* (1853) took precedence over onset of symptoms (1800) if a time was not documented on a stroke code form. Can you explain?

Answer: The time *Last Known Well* cannot be earlier than the symptom onset time. The manual advises: If multiple times for *Last Known Well* are documented by different physicians or the same provider, use the earliest time documented.

Question: If you have ASA listed as a home medication without any dose, time, or frequency listed, do we still infer that ASA was taken within 24 hours prior to arrival and answer "No" for OP-21?

Answer: The guidance from the Specifications Manual states "If there is documentation of routine pain medications on the home medication list, it can be assumed these medications were taken within 24 hours prior to arrival. Select 'No' to Pain Medication." There only needs to be clear evidence that the patient is actively taking the pain medication daily at home in order to abstract a value of "No" to the Pain Medication data element. A specific schedule or time of last administration is not required; however, if it is not clear that the medication is currently active, or if it has been received within 24 hours prior to ED arrival, you should abstract based on the administration of pain medication in the ED.

Question: If "seen by MD" time is not specifically written, is the time of a physical exam still the only other acceptable time of "seen by MD?"

Answer: 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 the time of the exam may be abstracted for the *Provider Contact Time* data element, even if it is not specifically documented as "provider contact time" in the medical record. Based on the information provided, you may use other times if there is documentation to support that this is the first, direct contact with a patient during an examination.

Question: I have a question regarding AMI. A patient had an ECG completed by the paramedics prior to hospital arrival but the interpretation was not signed by a provider. The first signed ECG was completed after arrival to the ED. When completing the AMI abstraction, I would use the ECG performed in the ambulance for the first ECG (using the arrival time), but should I use the first signed ECG to answer ECG Interpretation? I want to clarify that I can use the first initial ECG (ECG Time) and that the one used for interpretation does not necessarily need to be the same one. Is this correct?

Answer: Abstraction of OP-5 requires abstraction of *ECG Date* and *ECG Time*, for which specific information about the time and date of the ECG performed is required, but no abstraction of the interpretation of the ECG is necessary. For abstraction of OP-1, OP-2, and OP-3, you are required to abstract the Initial ECG Interpretation based on documentation that is clearly from the ECG performed closest to ED arrival; no specific date and time of ECG is necessary. Therefore, the following guidance regarding

ECG Time applies to abstraction of OP-5, while guidance regarding the Initial ECG Interpretation data element applies to the abstraction of OP-1, OP-2, and OP-3.

Question: Could you explain how to use the OP-26 procedure codes posted in November?

Answer: OP-26 Surgical Procedure Codes for the 2018 reporting year, (using 2017 data) will be posted in the Specification Manual in November of 2017. You would only use those Surgical Procedure Codes listed for this current reporting period. If you continue to have questions, please call our help desk at 866.800.8756.

Question: On slides 38 and 39, please clarify further what is meant by "if there is clear evidence of any medication with pain-relieving properties received within the 24 hours prior to arrival...?" It seems that the example on slide 38 does not give clear evidence that the patient took aspirin prior to arrival.

Answer: While the Specifications Manual does not explicitly define what constitutes "clear evidence," it gives guidance regarding pain medications administered prior to arrival which states that there should be documentation in the medical record the patient received pain medication (e.g., self-administration, physician's office or ambulance) prior to arrival, or documentation of routine pain medications on the home medication list. Overall, there must be some sort of evidence that clearly demonstrates that the patient either: a) received the medication within the 24 hour window prior to their arrival in the ED, or b) the patient is currently prescribed/is actively taking a daily pain medication or medication with pain-relieving factors at home.

Question: OP-33 is for "PAINFUL" metastasis to bone. If the physician states patient doesn't have pain but is still getting EBRT, would I abstract this as a "YES?"

Answer: Yes, if the ICD-CM codes for bone metastasis are present, this would still be included in the measure denominator, even if the physician did not denote the bone metastases as "painful" in the visit note.

Question: Why are the rules around "time of ED departure" different for the Inpatient ED throughput measure different from the Outpatient ED throughput measure?

Answer: The ED Departure Time data element intends to capture the time represented in hours and minutes at which the patient departed from the emergency department. We can only answer questions related to the Hospital Outpatient Quality Reporting (HOQR) Program measures. For specific questions regarding Inpatient measures, please call 844.472.4477.

Question: Our documentation of colonoscopy follow-up is not on the colonoscopy report but in a different summary report, which is part of the medical record, would follow the patient in the future and be available for other facilities if medical records were requested. Is this separate summary report acceptable to abstract 10-year follow-up recommended?

Answer: The follow-up interval must be documented in the colonoscopy report. If your facility utilizes another report that is equivalent to or contains the final colonoscopy report, utilize this report for abstraction.