Outpatient Quality Reporting Program

Support Contractor

The Abstraction Challenge Show: Real Questions, Real Answers

Questions & Answers

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Question: Are OP-29 charts chosen by codes? Meaning, if the patient showed up on our abstraction list but actually had a biopsy, does that mean it was coded wrong?

Answer: To be in the OP-29 measure, the denominator criteria must be met. If the denominator criteria are met but there is documentation that a biopsy was performed, the case would be excluded.

Question: Can you please clarify that if the Last Known Well (LKW) and the symptom onset have different times that the LKW takes precedence?

Answer: In general, if Time Last Known Well and symptom onset are both documented, the Time Last Known Well will take precedence over symptom onset.

Question: For OP-29, what if the age is not in the procedure note but is only in the Electronic Medical Record (EMR)?

Answer: The age in the EMR could be used to determine if the patient is 66 years old.

Question: Can you please clarify what other documentation would be acceptable in the precordial chest pain scenario?

Answer: Precordial chest pain is considered to best match exclusion or inclusion terms on a case-by-case basis. If there is surrounding documentation to indicate that “precordial chest pain” best matches the exclusion term “chest wall pain,” then a **No** may be abstracted for the *Probable Cardiac Chest Pain* data element. However, 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 there is a working/differential diagnosis of acute myocardial infarction or any additional documentation that clearly suggests the patient's chest pain was presumed to be cardiac in origin.

Question: In regards to ED arrival time, at times there is documentation in the ED patient timeline prior to ED arrival/triage time that may include IV information, lab results, etc. Would these be considered the earliest arrival time since it is documented in the ED patient timeline and there is no supporting documentation that it was done outside the ED?

Answer: *Arrival Time* is "the earliest documented time (military time) the patient arrived at the outpatient or emergency department." If the emergency department record includes any documentation from the time period that the patient was an ED patient, e.g., ED face sheet, ED consent/authorization for treatment forms, ED/outpatient registration/sign-in forms, triage record, ED physician orders, ECG reports, telemetry rhythm strips, laboratory reports, x-ray reports, etc., that time may be used.

Question: Our trauma notes state the patient arrival time, which we take this as the arrival time. We also have a Greet Time, which is usually earlier. Greet Time is the call-in time. The trauma team is always there to greet the patient. Is it the actual physical arrival time?

Answer: *Arrival Time* is "the earliest documented time (military time) the patient arrived at the outpatient or emergency department." Arrival Time should not be abstracted simply as the earliest time in one of the Only Acceptable Sources without regard to other substantiating documentation. Based on the information provided, you may abstract the Greet Time if this is the time the patient physically arrived to the outpatient setting.

Question: Can you go over the question regarding OP-29 and age? You stated the date of birth (DOB) on an endoscopy report could be used to exclude a case if the age is greater than or equal to 66 years old. Doesn't there also have to be documentation in the endoscopy report that "no follow-up colonoscopy is recommended"?

Answer: The DOB can be taken from the operative report to determine the patient is 66 years old. There would also have to be documentation that no further colonoscopy is needed to be able to exclude the case from the denominator.

Question: How can the femoral axis cortical involvement for External Beam Radiotherapy (EBRT) be determined from the chart by the abstractor? There is no scale or information other than of the radiation treatment profile. Abstractors are not supposed to measure or assume. Would the physician be responsible to include this documentation (greater than 3cm in length) if there was EBRT to a femur?

Answer: Yes, in cases where the length of the cortical involvement is not indicated in the patient documentation, the abstractor should follow up with the physician for more information.

Question: May Critical Access Hospitals (CAHs) participating in MBQIP use the phone an expert service?

Answer: The helpdesk can answer program-related questions for anyone that calls. These would be questions that are related to the Hospital OQR Program.

Question: For OP-29, in the procedure note the physician documented “repeat endoscopy in 10 years.” Is this okay to establish there is a 10-year follow-up interval?

Answer: No. The documentation of “repeat endoscopy in 10 years” does not clearly indicate a 10-year follow-up interval for a repeat colonoscopy.

Question: So, the answer to Acute Chest Pain with the use of the code R07.9 is **No**?

Answer: Typically, "Chest Pain, Unspecified" matches the data element exclusion term "Non-Specific Chest Pain" unless surrounding documentation suggests that the "Chest Pain, Unspecified" is clearly linked to a cardiac issue. Please consider the entire context and differential diagnoses and use your best judgment to determine if there is a working/differential diagnosis of acute myocardial infarction or any additional documentation that clearly suggests the patient's chest pain was presumed to be cardiac in origin.

Question: With regard to OP-33, I asked a question several months ago in the QualityNet Question and Answer tool that if a patient fell and had a hip fracture resulting in surgical stabilization and is now getting EBRT to that same area, can I exclude the case. I was told no because the surgical stabilization was due to a fall and not bone metastasis. On slide 63, it seems you answer yes regardless of the reason. Is this correct?

Answer: I will revisit your question and the answer given in the OP-33 mailbox. In the meantime, the answer provided in this presentation is accurate. You

would exclude the patient due to surgical stabilization, even if the stabilization was not required due to bone metastasis.

Question: If the patient is admitted on preset cardiac orders, even though the code is R07.9, will the answer still be **No**?

Answer: Typically "Chest Pain, Unspecified" matches the data element exclusion term "Non-Specific Chest Pain" unless surrounding documentation suggests that the “Chest Pain, Unspecified” is clearly linked to a cardiac issue. Based on the information provided, there is documentation of “preset cardiac set of orders," which best matches the inclusion term “Cardiac Chest Pain.” As a result, you should abstract a **Yes** for this data element. However, 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 there is a working/differential diagnosis of other exclusion terms or any additional documentation that clearly suggests the patient’s chest pain was not presumed to be cardiac in origin.

Question: With regard to the first slide, what do we do if the case is listed in our OP-29 list? Do we need to change the coding, or is there some way to answer it?

Answer: To be in the OP-29 measure, the denominator criteria must be met. If the denominator criteria are met but there is documentation that a biopsy was performed, the case would be excluded.

Question: I am a little confused on OP-33 and the prosthesis. Would this only be for hips which would be in the pelvic area? What about total shoulders, total knees? What area does this exclude? For instance, the total hip is for the pelvis area. What area is for total knee or total shoulder? Does this also include past surgeries with pins – for example, Open Reduction Internal Fixation (ORIF) – does this affect anatomy of where pins are?

Answer: While a note clearly indicating that a surgical stabilization procedure has occurred is the best way to identify this exclusion, if you review the procedure note and see evidence of any stabilization (cement, rods, screws, metal plates, pins, etc.), regardless of the location, then the surgical stabilization exclusion would apply.

Question: A patient comes in via ambulance for Chest Pain. They had a 12-lead done in the ambulance and another done in the ED. It showed STEMI, but the provider did not reference which ECG showed the STEMI. Would I indicate **Yes** for *ECG* done, as well as the date and time of arrival for

when the ECG was done? However, if I do not have a provider referencing the specific ECG, do I put **No** for ECG Interpretation?

Answer: Please note that OP-5 requires abstraction of the *ECG Date* and *ECG Time* data elements, for which specific information about the time and date the ECG was performed is required. 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* data element 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, -2, and -3.

With regard to *ECG Time*: Please note that the abstraction guidelines for this data element in Version 11.0a in the Hospital Outpatient Quality Reporting (OQR) Specifications Manual defines *ECG Time* as the time (military time) represented in hours and minutes at which the earliest 12-lead Electrocardiogram (ECG) was performed. Suggested data sources for this data element include the ED record. Additionally, the manual notes the following: "In the event the patient had an ECG performed within 60 minutes prior to arrival at the emergency department, enter the time the patient arrived at this emergency department."

With regard to *Initial ECG Interpretation*: For the abstraction of the *Initial ECG Interpretation* data element for OP-1, -2, and -3, you should use the ECG performed closest to arrival. Version 11.0a of the Specifications Manual states, "Identify the ECG performed closest to arrival, either before or after emergency department arrival, but not more than 1 hour prior to arrival. If unable to determine which ECG was performed closest to arrival, select **No**." Additionally, please note that the manual also states, "Only those terms specifically identified or referred to by the physician/APN/PA as ECG findings and where documentation is clear it is from the ECG performed closest to arrival should be considered in abstraction." Therefore, you should only use documentation that is clearly associated with the ECG performed closest to arrival. A specific time does not need to be abstracted for this data element, as long as it is clear which ECG was performed closest to arrival. In other words, if the physician documentation (e.g., note, impression, diagnosis) is listed without any reference to the appropriate ECG, it may not be used in your abstraction of this data element.