Outpatient Quality Reporting Program

Support Contractor

The Abstraction Challenge Show: Real Questions, Real Answers

Questions & Answers

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Question: With respect to slides 38 and 39, does the "routine screening, high risk" have to be included in the recommendation statement for repeat in five years, or can we use it as a medical reason if it's listed anywhere in the Outpatient (OP) Report?

Answer: The medical reason "routine screening, high risk" doesn't have to be included in the recommendation statement for repeat in five years.

Question: For OP-30, if the physician documents in the colonoscopy report, “Indications: High risk colon cancer surveillance. The last colonoscopy 1/1/2017,” which is greater than three years, would this be a denominator exclusion based on this documentation?

Answer: It appears the case would be excluded based on a medical reason.

Question: On the patient's initial GI office visit, the MD wrote, "Per patient, possible history of colon polyps, does not recall when last colonoscopy was." Based on this note, can we answer **Yes** to the question, "Is there documentation of a system reason for needing a follow- up colonoscopy less than 3 years since their last colonoscopy (e.g., unable to locate previous colonoscopy report; previous colonoscopy report was incomplete)?"

Answer: To use a system reason to exclude the case, there must be an interval since the last colonoscopy documented as less than 3 years **and** a system reason documented (e.g., previous colonoscopy report not available, unable to locate last colonoscopy report).

Question: For OP-33, can the guidelines allow for exclusion of case on the basis of a physician having a documented reason for a different treatment fractionation that is not included in the acceptable dosages and number of treatments?

Answer: Unfortunately, there are no other acceptable reasons for not using an American Society for Radiation Oncology (ASTRO)-recommended fractionation scheme. Although various fractionation schemes can provide good rates of palliation, numerous prospective randomized trials have shown that 30gy in 10 fractions, 24gy in 6 fractions, 20gy in 5 fractions, or 8gy in a single fraction can provide excellent pain control and minimal side effects. Additionally, this is a process measure intended to close the gap in the demonstrated treatment variation and ensure the use of an appropriate fractionation schedule, as well as to prevent the overuse of radiation. Finally, these treatment schemes were determined through the study of uncomplicated bone metastases, and the physicians have more options outside of these guidelines for complicated metastases.

Question: On the **s**lides 40-43, a) Why would we abstract 0523 for the *ECG Time* **and** arrival? The ECG was performed 13 minutes ahead of time at 0510, yet the EKG at 0529 was the ECG closest to arrival and within only six minutes of arrival. b) If the EMS ECG completed at 0510 and recorded at 0523 doesn't show a ST-Elevation but the ECG after arrival at 0529 does show a ST-Elevation MI, which ECG would we utilize for "*Initial ECG Interpretation*?"

Answer: To answer your questions, a) You may use 0523 (i.e., *Arrival Time*) because the Specifications Manual notes that "if there are 2 ECGs performed (one within 60 minutes prior to arrival and one after arrival), abstract the ECG performed prior to arrival." b) For the *Initial ECG Interpretation* data element, Version 11.0a of the Specifications Manual states you may "identify the ECG performed closest to arrival, either before or after emergency department arrival, but not more than 1 hour prior to arrival." The manual also states, "if there is no signed tracing, or in the absence of any exclusion on the signed tracing, proceed to other interpretations that clearly refer to the ECG done closest to arrival." Therefore, any documentation clearly referring to findings from the ECG performed closest to ED arrival, which may be either before or after arrival, can be used in your abstraction.

Question: There is no clear ED discharge time or transfer from ED time noted in the record, but the Patient Admit to Inpatient date and time is clearly recorded.

Can we use the Patient Admit to Inpatient time as the ED discharge time, or do we have to select UTD?

Answer: *ED Departure Time* is the documented time the patient physically left the emergency department. Based on the information provided, you may abstract Patient Admit to Inpatient date and time if this is the documented time the patient physically left the ED.

Question: In the scenario on slide 24, what should be abstracted as Last Known Well (LKW)?

Answer: Based on the documentation provided in the presentation, subtract one hour from the arrival time of 2259, and use that time to abstract *Time LKW. Time LKW* would be 2159.

Question: What would be a reason for a physician to document "minimal" in the EKG interpretation?

Answer: While there may be a number of different reasons for which a physician would document "minimal" in an EKG interpretation, if "minimal" is used to describe ST-elevation (ST ↑, STE) in one interpretation, it indicates that there is not conclusive evidence of ST-Elevation sufficient to meet the intent of this data element. Therefore, you should follow the guidance provided in Version 11.0a of the Specifications Manual and abstract **No**.

Question: What should be abstracted as LKW in the following case: On our Code Stroke form, the LKW is documented at 1300. The ED MD documents the LKW at 1400. Neurology documents the LKW at 1330.

Answer: You may use the Code Stroke Form to abstract *Time Last Known Well*. For documentation of *Time Last Known Well*, the Code Stroke Form will take precedence over other forms of documentation.

Question: For OP-30, for a system reason for less than three years since the last colonoscopy, all three must be present: The interval since the last colonoscopy is < 3 years, a medical reason for < 3 years is not documented, and a system reason such as unable to locate the last colonoscopy report. If our MD documents “high risk colon cancer surveillance, father had colon cancer, last colonoscopy date unknown, unable to locate last colonoscopy report,” am I to understand this case will fail because the interval since the last colonoscopy report isn’t documented? Our physicians don't know how to pass this when they can't locate the last colonoscopy report.

Answer: To use a system reason to exclude the case, there must be an interval since the last colonoscopy documented as less than three years **and** a system reason documented (e.g., previous colonoscopy report not available, unable to locate last colonoscopy report). Documentation of a month/year, year, or even a statement from the patient or documentation in the medical record indicating the last colonoscopy was, for example, "about 2 years ago" or "over 5 years ago" are all sufficient for establishing the interval.

Question: For arrival time, we go by Time of Greet, which is when the patient arrived at the check-in window of the ED. Is that incorrect? Should we be waiting until the triage nurse sees the patient?

Answer: *Arrival Time* is the earliest documented time (military time) the patient arrived at the outpatient or emergency department. Based on the information provided, you should abstract the Time of Greet, if this is the time the patient physically arrived to the ED.

Question: For OP-30, can we use our Electronic Medical Record (EMR) to search for the patient's previous colonoscopy if the MD does not include it in the History and Physical? If yes, how do we know that the patient did not go elsewhere for a recent colonoscopy?

Answer: Yes, the EMR could be used to establish the interval since the last colonoscopy.

Question: OP-30 – MD documents he has brought patient back within one year for treatment with Argon Plasma Coagulator status post cecal tubular adenoma. Is this sufficient for a medical reason?

Answer: Medical reason(s) are at the discretion of the physician. The documentation appears to be a sufficient medical reason.

Question: Just logged into my OP-33 for the May sample and realized they have gone back to January, and I have to re-enter patients that I have already entered. What happened and why do we have to re-enter them?

Answer: I recommend you reach out to the vendor for the abstraction tool. It is not clear why you would have to re-enter cases that were previously entered. If the vendor is unable to help, please submit an inquiry through the OP-33 mailbox for further assistance.

Question: For Chest Pain, if the ED physician note says "may also be due to a NSTEMI" with exclusion criteria also in that same note, do we answer **Yes** or **No** to *Probable Cardiac Chest Pain*?

Answer: Based on the information you provided, there is documentation of "may also be due to a NSTEMI," which indicates a differential/working diagnosis of Acute Myocardial Infarction. As a result, you should abstract a **Yes** for this data element.

Question: This information does not state that a 12-lead was performed, just that the patient was hooked up by the ambulance crew. Regular rhythm could be determined by a single lead. Please clarify.

Answer: Based on the documentation in the presentation, the patient was hooked up to a 12-lead ECG by EMS. From the manual: "The medical record must be abstracted as documented (taken at face value). When the time documented is obviously in error (not a valid time) and no other documentation is found that provides this information, the abstractor should select UTD." Though this does not explicitly state that a 12-lead ECG was performed, the documentation supports that the patient received a 12-lead ECG via EMS.

Question: For cord compression with EBRT, do we need to have one of the listed ICD-10 codes, or is a note acceptable stating that the patient has cord compression for exclusion?

Answer: A physician note or radiology report with a clear diagnosis of cord compression is sufficient to exclude the patient due to cord compression. If there is any ambiguity in the note as to whether the patient has cord compression, please follow up with the physician.

Question: If that is the case, then why were we graded down for answering that way on our Validation Survey?

Answer: For any validation questions, please contact the validation contractor directly at validation@hcqis.org.

Question: Is there an actual phone number that abstractors can call in with a question instead of having to wait sometimes weeks for an email reply?

Answer: As there are numerous measure writers/contractors accessing the Q&A tool on QualityNet, the platform will send your question to the appropriate contractor for a direct response to your question.

Question: Some of these are time-sensitive, so there is no number we can call?

Answer: The measure writers do not have an outreach phone number. You can always call the support contractor helpdesk at 866.800.8756; we will be glad to assist you if at all possible.

Question: A facility reports their cases on a measure such as OP-23. On Hospital Compare it states, "too few to report" for the quarter. Does too few to report also mean five or fewer cases?

Answer: Hospitals whose outpatient population size is less than the minimum number of cases for the sampling population must include all eligible cases in their data. Please refer to Table 2 (p. 4-212) in the manual for measure-specific requirements.

Question: On slide 59, if the ED patient is transferred to another ED in our system then discharged home, what *Discharge Code* do we use for the initial encounter?

Answer: The *Discharge Code* intends to capture the final place or setting to which the patient was discharged from the outpatient setting. Based on the information provided, you should abstract value “1-Home” if the patient was discharged home from the outpatient setting.

Question: Why would you use UTD rather than an eloped code for the *Discharge Code* question?

Answer: There is not a *Discharge Code* or an Allowable Value for elopement. Without explicit documentation that the patient left Against Medical Advice (AMA) you cannot select this option (7-Left Against Medical Advice/AMA) as the *Discharge Code*. Therefore, the appropriate *Discharge Code* would be value 8-Not Documented or Unable to Determine (UTD).

Question: If the patient was not seen in the ED, wouldn't she be considered to not be an ED patient and be excluded on that reason?

Answer: The patient should be included in the population if they have an E/M code for emergency department encounter as defined in Appendix A, OP Table 1.0 for ED-Throughput measures.

Question: We submitted our data for validation 3Q17. Even though we passed validation, there were questions we had submitted prior to help determine the correct answer. When our validation returned, several of the answers were marked wrong even though we used the exact Question and Answer submitted. Do you have any suggestions?

Answer: For any validation questions, please contact the validation contractor at this email: validation@hcqis.org.

Question: Can you get approval for CPHQ credits? This would be really helpful for those of us in Quality who are Certified Professional Health Care Quality, as these credits are really hard to find. Many hospital budgets don't allow us to travel to conferences anymore, so this would really be helpful!

Answer: We will certainly pass that along to the appropriate individuals.