Outpatient Quality Reporting Program

Support Contractor

Hospital Outpatient Quality Reporting (OQR) Program 2018 Specifications Manual Update

Questions & Answers

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Question: Is there a contact email for the measure writer for Probable Cardiac Chest Pain? I have some questions that may be best addressed in an email or phone call rather than on an open call.

Answer: The measure writers are available today if you would like to ask your question in the chat box. You can also enter your question in the Q&A tool through QualityNet. The measure writers will respond directly to you through that platform.

Question: What time on February 21 will the next OQR webinar be held? I want to put a hold on my calendar.

Answer: The February 21, 2018 OQR webinar will be offered at 10:00 AM and 2:00 PM (ET).

Question: Where can we get a list of possible rejections/alerts that are sent during submissions for Outpatient (OP) conditions? For example, for the pain management administration, past the encounter date.

Answer: We are unclear about what you are asking; please call our helpdesk at 866.800.8756.

Question: For the Hospital OQR Program, is population and sampling optional?

Answer: Yes, population and sampling is still voluntary for the OQR Program.

Question: Is it mandatory for all hospitals to update the NHSN Consent Form?

Answer: Yes, all facilities registered for NHSN are required to sign the Re-consent Form. For any questions, please contact NHSN@cdc.gov.

Question: Once there are release notes, is the actual manual that is on the website updated, or do we have to go to the release note?

Answer: The Release Notes will reflect the changes that have been updated within the manual. You will see these updates in the manual along with the Release Notes.

Question: If a patient has two Outpatient ED visits in the same day, which arrival time and discharge time should be recorded? The visits have the same encounter number.

Answer: 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.

Question: Will we receive an email when the recording is available and where to get it?

Answer: No, we do not send notification when the recording is available. However, generally, the recording is posted within 48 hours of the presentation date and can be found on www.qualityreportingcenter.com under the Archived Events tab for this program.

Question: Is the slide deck available for download or sent to attendees?

Answer: Yes, slides are always sent with your ReadyTalk reminder. They are also posted on our website, www.qualityreportingcenter.com, prior to the event.

Question: I have a question regarding the OP-29 exclusion on slide 40. To be able to use this exclusion, would you have to have the documentation stating "No follow-up needed, patient is 67 years old" or would "No follow-up needed" documented as well as on the chart demographics showing that the patient is 66 years old or older?

Answer: A reason would not have to be documented. Having documentation *no follow up colonoscopy is needed* would be sufficient to exclude the case if the patient was documented as >=66 years old.

Question: I am curious. If a case is coded as "Chest pain, unspecified" but the MD is continuing down a cardiac path, should the "chest pain, unspecified" coding documentation be used as an automatic exclusion?

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 you provided, if there are no other exclusion terms documented and the "chest pain, unspecified" appears to be linked to a cardiac issue, 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 are any exclusions, terms that align with an exclusion, or any additional documentation that clearly suggests the patient's chest pain was not presumed to be cardiac in origin.

Question: Does OP-18a exclude psych patients?

Answer: OP-18a is the overall rate for the Median Time from ED Arrival to ED Departure for Discharged ED Patients. Patients are eligible to be included in the OP-18a population if they have an E/M Code for emergency department encounter.

Question: Is OP-32 still a voluntary measure?

Answer: No, OP-32 is a claims-based outcome measure. This is not a voluntary measure. The only voluntary measure for the OQR Program at this time is OP-31.

Question: To clarify for OP-26, version 10.0a should be used to report 2017 data?

Answer: Correct, you would use the Specifications Manual 10.a for patient encounter dates of 01/01/2017 to 12/31/2018.

Question: For OP-22, if a patient comes to the ED and when the ED physician comes to the bedside, the patient then refuses care, shouldn't that be coded as "refused care"?

Answer: Patients are included in the OP-22 numerator if they left **without** being seen by a physician/APN/PA. Based on the information you provided, if the patient was seen by a physician/APN/PA, then they would not be included in OP-22.

Question: Is OP-31, Cataracts – is this a voluntary measure?

Answer: Yes, OP-31 continues to be a voluntary measure for this program.

Question: When a patient comes in and non-cardiac possibilities are included with cardiac possibilities in the differential but the care remains centered on cardiac etiology, would I continue to answer "yes" to "Probable cardiac CP"?

Answer: Version 11.0a of the Specifications Manual indicates that if there is documentation of an inclusion criterion and no exclusions are present, you should select “Yes” for the Probable Cardiac Chest Pain data element. However, if there is documentation of an exclusion term, select “No.” That being said, if there is documentation of a differential/working diagnosis of acute myocardial infarction, select “Yes,” even if an exclusion term is documented. The intent of this data element is to determine if the patient’s chest pain was cardiac in origin.

Question: Do we manually submit for OP-35 and OP-36, or is that data automatically pulled?

Answer: There is no manual abstraction on behalf of the facility for OP-35 and OP-36.

Question: OP-32 is not clear to me; would you please re-explain?

Answer: More information about OP-32 can be found on QualityNet at: www.qualitynet.org/dcs/ContentServer?cid=1228775181947&pagename=QnetPublic%2FPage%2FQnetTier3&%20c=Page. If you have further questions about the measure, please send them to the Outpatient and ASC Question and Answer tool: https://cms-ocsq.custhelp.com/.

Question: Would you repeat what we need to reference for the codes?

Answer: Please use Specifications Manual v10.0a for the surgical procedure codes for the OP-26 measure.

Question: If an OP measure is no longer collected starting January 2018, will a facility have to choose another measure to be abstracted to take its place?

Answer: No. All measures required to meet program requirements for the Hospital OQR Program are provided in the Final Rule.

Question: If an ED nurse is a certified emergency department nurse, would that be considered a clinical nurse specialist?

Answer: Although a registered nurse would not be considered an advanced practice nurse, a RN may qualify for the Provider Contact Time data element if they are considered an institutionally credentialed provider by your facility. 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 definition of an institutionally credentialed provider for the Provider Contact Time data element. 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: Regarding OP-35 (and other claims-based measures), how often can we expect QNet to provide us with reports? The Dry Run report had old data; can we expect the rest of 2016 and 2017 data any time soon?

Answer: CMS will provide facilities in the OQR program with annual Facility-Specific Reports prior to the public reporting on Hospital Compare on or after December 1, 2019. Each report will be based on data from the previous calendar year to assess facility performance (e.g., reports received in 2019 will be based on calendar year 2018 data).

Question: Same as above questions – are OP-32, OP-35, and OP-36 measures automatically inputted from the UB billing?

Answer: OP-32, OP-35, and OP-36 are all claims-based measures; therefore, data to calculate the measures is pulled from Medicare Part A and Part B claims, and no action is required on the part of facilities to abstract the data.

Question: Is there a CEU available for this session?

Answer: Yes, this webinar is approved for 1 CEU for the boards listed on slide 68. At the end of the presentation, we will go over the CE process.

Question: In reading the above Q&A for OP-29, the "no follow-up needed" documented on the demographics as sufficient. I thought documentation on follow-up had to be in the colonoscopy report?

Answer: If the patient is >=66 years old and there is documentation of "no follow up colonoscopy is needed," then that would be sufficient to exclude the case.

Question: Are the Outpatient Imaging Efficiency (OIE) measures required for CAHs?

Answer: Critical Access Hospitals do not fall under the category of subsection (d) hospitals, which are required to report on the Outpatient Imaging Efficiency (OIE) measures and other measures in the Hospital Outpatient Quality Reporting (HOQR) Program. As a result, Critical Access Hospitals must "opt in" to public reporting under the HOQR Program to have their claims data reported for the OIE measures. To opt in to public reporting through the HOQR Program, please visit QualityNet.

Question: Is a social worker or case manager acceptable as the source for the "against medical advice" discharge disposition documentation?

Answer: Yes, documentation by a social worker is an acceptable source for abstracting that the patient left AMA, as long as this documentation is in the patient's medical record.

Question: If the patient is not seen by a physician/APN/PA, do we have to answer UTD?

Answer: Correct. If it cannot be determined whether the patient had direct contact with a physician/APN/PA or institutionally credentialed provider, select UTD.

Question: How do I know if someone here has received the NHSN form?

Answer: You can contact the NHSN directly via email at NHSN@cdc.gov.

Question: Where do you get the ECG Time if a copy of the ECG is not in the record?

Answer: Please note that a copy of the ECG strip or readout is not required to abstract ECG Time. You may refer to documentation in the ED record to abstract ECG Time. If it is unable to be determined, then you should select UTD.

Question: Can a copy of the Q&As be sent to attendees after the presentation?

Answer: A transcript of the presentation, as well as all questions and answers in the chat box, are posted on our website, www.qualityreportingcenter.com. These are usually posted within three weeks of the presentation.

Question: How do I know whether to use 11.0 or 11.0a?

Answer: Version 11.0a is the most updated version. This will be the version you will find posted on QualityNet for 2018 encounter dates.

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Question: Do you have a website or number to contact NHSN?

Answer: You may contact NHSN directly via email at NHSN@cdc.gov.

Question: If a patient is not seen by a physician, NP, etc., do we have to answer UTD?

Answer: Patients are included in the OP-22 numerator if they left **without** being seen by a physician/APN/PA.

Question: For the data element ECG Interpretation, would the word “minimal” be considered an exclusion criterion?

Answer: Yes, version 11.0a of the Specifications Manual states, "All ST-elevation (ST, STE) in one interpretation described in one or more of the following ways: "Minimal" should be considered an exclusion for the Initial ECG Interpretation data element.”

Question: Do we stop collecting the Health Insurance Claim number (HIC#) on 1/1/2018 or 4/1/2018?

Answer: You would stop collecting the HIC number on patient encounters by January 1, 2018. The data element HIC Number has been removed from the Hospital OQR Program.

Question: Can you please list under the Q&As a list of chart-abstracted measures that will be discontinued?

Answer: Data for OP-1, -4, -20, and -21 will be collected in Q1 of 2018 (encounter dates of January 1 through March 31), as that quarter is part of the CY 2019 Payment Determination. You will no longer collect data on these measures after that Q1 submission. For the web-based measures OP-25 and OP-26, you will report your 2017 data. However, you will no longer collect data beginning January 1, 2018 on these two web-based measures.

Question: Are the measures on slide 31 claims-based measures?

Answer: Yes, all OIE measures, OP-8, OP-9, OP-10, OP-11, OP-13 and OP-14, are claims-based measures.

Question: The Measure Information Form (MIF) for OP-29 states follow-up interval documented in their colonoscopy report; was there a change for 2018?

Answer: The follow-up interval needs to be documented in the colonoscopy report.

Question: How will the updated NHSN form be sent to us, or how will we be notified?

Answer: The Facility Administrator and Primary Contact at your hospital will receive an email alerting them to the form's availability.

Question: For colonoscopy OP-29, can we exclude if age is within parameters, or does the physician have to document this?

Answer: If the patient is >=66 years old and there is documentation of "no follow up colonoscopy is needed," that would be sufficient to exclude the case.

Question: For OP-21, while Propofol and Ketamine are not listed in the appendix table 9.1, they are used as part of procedural sedation, would they then be an inclusion guideline for abstraction?

Answer: We recognize that certain medications and methods of administration used for these procedures—such as procedural sedation—may be used in other types of pain management. Without specific analgesic properties, a medication may not appropriately alleviate long bone fracture pain. In each case, it should be determined whether the medication used for a procedure, such as a nerve block, has analgesic properties in addition to anesthetic properties. Although Ketamine is not currently included on Table 9.1, it has analgesic properties and may be considered an acceptable pain medication. There are several other medications that are used during the reduction of a long bone fracture that are not acceptable for purposes of abstraction of this measure, as they are not intended to treat the pain experienced by the patient as a result of the long bone fracture but instead as part of the procedure. These include Propofol, Midazolam (Versed), and Etomidate.

Question: Can you explain the Probable Cardiac Chest Pain more in depth?

Answer: Version 11.0a of the Specifications Manual indicates that if there is documentation of an inclusion criterion and no exclusions are present, you should select “Yes” for the Probable Cardiac Chest Pain data element. However, if there is documentation of an exclusion term, select "No." That being said, if there is documentation of a differential/working diagnosis of acute myocardial infarction, select "Yes," even if an exclusion term is documented. The intent of this data element is to determine if the patient's chest pain was cardiac in origin.

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that the "chest pain, unspecified" is clearly linked to a cardiac issue. Based on the information you provided, if there are no other exclusion terms documented and the "chest pain, unspecified" appears to be linked to a cardiac issue, 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 are any exclusions, terms that align with an exclusion, or any additional documentation that clearly suggests the patient's chest pain was not presumed to be cardiac in origin.

Question: According to the guidelines I have, for OP-29 must have the follow-up documented in the only allowable source of the colonoscopy report. My question is then, does the physician document no follow-up necessary in the colonoscopy operative?

Answer: If the patient is >=66 years old and there is documentation of "no follow up needed," that would be sufficient to exclude the case.

Question: What about nitrous oxide for adult use as pain medication inclusion?

Answer: Nitrous oxide is administered via inhalation which is not currently considered an acceptable pain medication administration route.