Outpatient Quality Reporting Program

Support Contractor

Abstraction Tricks and Tips

Questions & Answers

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Question 1: Last year there was confusion regarding which Manual we use for OP-26. For encounter submission 2014, which manual shall we use?

Answer 1: For OP-26, you should utilize Specifications Manual v8.0a. This manual includes the top 100 procedure codes billed in 2014.

Question 2: What is the date that the comment period closes for the proposed rule?

Answer 2: The comment period closes 60 days following the initial display. We will not know the exact date until the Proposed Rule is displayed.

Question 3: What are the target times for OP-18 & -20?

Answer 3: Please refer to the Benchmarks of Care that are published on the QualityNet website, under the Hospital OQR tab.

Question 4: Does OP-18a include psych patients?

Answer 4: No, OP-18a does not include psych patients. OP-18c is the one that includes psych patients.

Question 5: For the OP-23 measure, is a doctor's note time (time the dr. note was started) to be abstracted as the head results time, if down in the note it states "Ct head results were negative"? Should the doctor note time be taken at face value, if CT head results are part of the doctor's note?

Answer 5: The medical record must be abstracted at face value. Abstract the result of the earliest Head CT or MRI interpretation closest to arrival.

Question 6 For OP-22, what constitutes "Being Seen"? Does it require physician documentation, or does greeting a patient prior to an official evaluation?

Answer 6: There should be documentation that the patient was seen by a institutionally credentialed provider.

Question 7: Can you briefly describe the requirement for CAH hospitals? Are all the quality measures voluntary for submission, and is the APU not applicable to CAHs?

Answer 7: Any submission by a CAH is voluntary for this program.

Question 8: What are the exclusions for OP-21 and OP-23?

Answer 8: Please consult your Specifications Manual, as there are several data elements included in each measure with their own exclusions.

Question 9: The Specs Manual states that the minimum number of cases for OP-29 and OP-30 is 20 cases each of the calendar year – just confirming that the five or fewer rule does not apply to these two measures. These two measures should have more than 20 cases each to submit?

Answer 9: Correct, the five or fewer rule does not pertain to the OP-29 and OP-30 measures. If you have less than 20 cases annually for these measures, you would not have to submit data for them.

Question 10: Could you please clarify the comment you made about OP-20 OB patients that are taken to the OB unit? Are these patients to be considered in the ED-Throughput population?

Answer 10: For purposes of OP-20, it is the time of the initial contact between the patient and a credentialed provider.

Question 11: For OP-21 we are challenged with patients not offered pain med on arrival but are medicated prior to a closed fracture reduction later in the stay. Is there a way to exclude these patients?

Answer 11: You can if there is a reason documented for not administering pain medication as defined in the Specifications Manual.

Question 12: For the five or fewer rule, is that for the quarter?

Answer 12: If you have five or fewer cases per measure per quarter, you are not required to submit patient-level data on the measure. This pertains to the clinical measures, not the web-based measures.

Question 13: What's the difference between overall indicator and overall reporting?

Answer 13: OP-3 is the median time from ED arrival to time of transfer to another facility for acute coronary intervention. You will notice on this slide and in your Specs Manual there are three parts, if you will to this measure: 3a, 3b, 3c. So when you look in your Specs Manual, you will notice the allowable values 1, 2, and 3. In short, these values decide whether the patient was transferred for an acute coronary intervention, admitted to observation status prior to transfer, or the patient was transferred to another facility for reasons other than acute coronary intervention or specific reason for transfer was unable to be determined. These different categories will basically decide what "bucket" the case will be in 3a, 3b, or 3c.

Question 14: When submitting records for validation, must the record all be in the same format? We are still a hybrid chart – most electronic, some paper. Would we have to print the entire chart to submit, or can we send part paper and part electronic?

Answer 14: If you are unable to submit the complete chart in electronic format, submit all paper. Make sure your paper submission is complete and contains screenshots of all electronic records.

Question 15: Does the CART have skip logic built into it?

Answer 15: Yes, this is explained in detail in the CART user guide.

Question 16: What version of the specs are to be used for OP-26 that will be entered starting July 1 2015? They are 2014 encounters.

Answer 16: For OP-26, you should utilize Specifications Manual v8.0a. This manual is updated to include the top 100 procedure codes that were billed in 2014.

Question 17: Is there an expected turn-around time when submitting a question through the QualityNet Q&A site? It used to be very prompt, but as of the past several months, has become unpredictable and often not timely.

Answer: 17 Due to the volume of questions in QualityNet Q&A, there may be a delay in receiving your answer. If you have not received an answer to your questions, you may resubmit. Please submit your question via the QualityNet question and answer tool so that we can provide appropriate direction. The question will be sent to the appropriate contractor.

Question 18: For OP-29, the fact sheet says to use any medical reason, such as diagnosis, symptom, or condition that is documented in the medical record to exclude a case from the denominator population. Say the physician documented sigmoid diverticulosis (which is listed as an example) in the colonoscopy report as a finding, but the physician does not mention anything about a follow-up interval. Would the patient be excluded from

the denominator because of the documented diverticulosis, or would the patient be included in the denominator but excluded from the numerator, as the physician did not document anything about a follow-up interval?

Answer: 18 Yes, the case would be excluded from the denominator because of the documented diverticulosis. There is no inclusive list of medical exclusions.

Question 19: What was the illegal alien = 1 for?

Answer 19: If the patient is an undocumented Alien or Illegal immigrant, select "1." Undocumented Alien: Section 1011 of the Medicare Modernization Act of 2003 allows for reimbursement for services rendered to patients who are: Undocumented or illegal aliens (immigrants), Aliens who have been paroled into a United States port of entry, and Mexican citizens permitted to enter the United States on a laser Visa.

Question 20: If an ED patient has no EM code designated, is it excluded from the measure?

Answer 20: Yes, if the patient does not have an E/M code from Appendix A, Table 1.0 then they will not be included in the outpatient population.

Question 21: For ECG, you said we use the ECG for arrival time or for interpretation?

Answer 21: The example used on slide 43 was in reference to the ECG time for arrival time. In the event that the patient has an ECG prior to arrival to the ED and within 60 minutes of arrival, you would abstract the ECG performed prior to arrival as the ED arrival time.

Question 22: The OP-26 measure for CY 2016 would be for reference period: January 1 2014 – December 31, 2014. The submission period is: July 1-November 1, 2015 - the Specifications Manual would be for 2014 which is Version 7.0b, as that is the manual that applies to the CY 2014 time frame being asked for. The answer above says to use the latest Specifications Manual 8.0a. Please clarify which answer is correct.

Answer 22: You should utilize Specifications Manual 8.0a when answering OP-26. The reason for this is because the current manual provides you with the top codes during CY 2014, rather than the codes that are listed in Specs Manual 7.0b from 2013. We update the Specs Manual at the beginning of the new calendar year to always include the newest top codes from the previous year. Please utilize Specs Manual 8.0a for your OP-26 data submission beginning July 1, 2015.

Question 23: If a CAH hospital submits data, are they included in the validation process?

Answer 23: Critical Access Hospitals that voluntarily submit data are not subject to validation.

Question 24: The Specs Manual states that the minimum number of cases for OP-29 and OP-30 is 20 cases each of the calendar year. Just confirming that the five or fewer rule does not apply to these two measures? These two measures should have more than 20 cases each to submit?

Answer 24: Correct, the five or fewer rule does not apply to OP-29 and OP-30.

Question: 25 In Time Last Known Well the Hierarchy was removed from the determination of time. The Code stroke Form is now the priority source for Time Last Known Well.

Answer 25: Correct. In an attempt to align with the Inpatient Stroke Measure, the hierarchy will no longer be used moving forward.

Question 26: For OP-29 and OP-30, are sample sizes based on how many colonoscopies are performed or how many cases qualify for the denominator (i.e., exclude cases with reasons for variation in follow-up times)?

Answer 26: You will first obtain your population for each measure by utilizing your ICD-9/HCPCS codes listed on the MIF. When you know the number in the population, you will determine the sample size required (which will be on the chart in your Specifications Manual). Again, this sample size will be either 63 or 96, based on the size of your population. All cases in the final sample size will be in your denominator. The last step is to decide if those cases fit the numerator criteria.

Question 27: If a patient has a transdermal patch listed as a home medication, is it excluded even though it is listed on the table in Appendix C?

Answer 27: In the Specifications Manual v8.0a, transdermal pain medications are exclusions for abstraction.

Question 28: For OP-30 if unable to determine when precious colonoscopy was done- if it is greater or less than three years since previous colonoscopy but patient is high risk or there is a reason for less than three years, how do we answer?

Answer: 28 When you are abstracting, first find the denominator. If the case has a denominator exclusion (such as high risk), it will not be in the measure.

Question 29: If the only source in the entire chart is the doctor's note that gives the full CT head results description, is it the doctor’s note time that should be reported?

Answer 29: You will abstract the result of the earliest Head CT or MRI Scan interpretation closest to arrival.

Question 30: If a case has a Medicare number "Medicare No Pay Bill" and there is a standard HIC number, do we include it even if an HMO Medicare paid for the patient stay?

Answer 30: The patient HIC # is collected by CMS for patients with a payment source of Medicare who have a standard HIC number.

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