Outpatient Quality Reporting Program

Support Contractor

Hospital OQR Imaging Efficiency Measures

Questions & Answers

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Question: Are the Imaging Measures chart-abstracted outpatient measures?

Answer: The OIE measures are calculated using claims data submitted to CMS for payment purposes; they are not chart-abstracted measures.

Question: Have the ICD-10s for the OIE measures been published?

Answer: Draft ICD-10 specifications for the OIE measures are posted on the QualityNet website and are available at the following link: http://qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228695266120.

Question: Will you be discussing OP-33, EBRT, today?

Answer: No, the entire webinar is on the imaging measures. We did a webinar in March designated for the OP-33 measure. You may wish to access this at: http://www.qualityreportingcenter.com/hospitaloqr/events/.

Question: Why did the number of exclusion codes increase so substantially in 4Q15 with the switch to ICD-10 coding, as opposed to the number of exclusion codes with ICD-9 coding prior to 4Q15?

Answer: The ICD-10 coding system includes significantly more codes than the ICD-9 coding system. To capture the same categories of conditions, additional codes are necessary for the ICD-10 specifications.

Question: Is there an estimated arrival time for final ICD-10?

Answer: The ICD-10 specifications will not be finalized until ICD-10 claims data are available to test the draft specifications. Finalized specifications, when available, will be posted on the QualityNet site.

Question: Has OP-8 data been updated? In the recent past it was being recalculated.

Answer: The recalculated values for OP-8 are not posted on the Hospital Compare site at this time. Updated values will be available in the coming month.

Question: Are CTs performed during ED visits included in the denominators?

Answer: Yes. For OP-10 and OP-11, CTs performed in any hospital outpatient setting are included in the measure denominator.

Question: Can hospitals elect to report on some, but not all, of the OIE measures?

Answer: Your hospital must report on all OIE measures if you are categorized as a subsection (d) hospital. Subsection (d) hospitals that do not comply are subject to a 2% reduction to their Annual Payment Updates. Subsection (d) hospitals, specified in the Social Security Act (Section 1886(d)(1)(B)), are NOT: psychiatric hospitals, rehabilitation hospitals, pediatric hospitals, hospitals which have an average inpatient length of stay of greater than 25 days, critical access hospitals, a hospital involved extensively in the treatment or research for cancer. However, depending on whether or not your hospital falls under one of the above categories, it may be able to withdraw from the Hospital Outpatient Quality Reporting (HOQR) Program without facing a penalty from Medicare. Please visit the below webpage on QualityNet.org to learn about withdrawing from the HOQR Program:
https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1205442133612

Question: Are Observation status patients included in the population for OIE measures?

Answer: Yes, any case paid under the Outpatient Prospective Payment System (OPPS) is included in measure calculation.

Question: Can you review the look-back time periods for the denominator exclusions? For example, for OP-8 the exclusions have a look-back period for up to five years. You mentioned others; can you review them? Also, where can I find the details related to the look-back period time periods, numerators, and denominators?

Answer: Look-back periods (if any) for exclusions to the OIE measures are described in detail in the measure specifications posted on QualityNet. As a summary, look-back periods for OP-8 extend up to five years, look-back periods for OP-13 extend up to three years, and there are no look-back periods for OP-9, OP-10, OP-11, and OP-14.

Question: Can you please go through each measure again to confirm if lower rates are better?

Answer: Lower rates are considered better for OP-8, OP-10, OP-11, OP-13, and OP-14. For OP-9, rates should fall below approximately 14 percent, but rates close to zero may indicate too low a follow-up rate.

Question: For OP-26, version 8.0a lists encounters performed from 1-1-15 to 9-30-15, and version 8.1 says for encounters 10-1-15 to 12-31-15. There are different codes. Do we use both?

Answer: For OP-26, for 2015 data reported in 2016, you would use the surgical procedure codes in the Specifications Manual version 8.1 only. Each year this measure will have the top 100 surgical codes. For example, in January of 2016, the top 100 surgical procedure codes for 2015 are published in the latest Specifications Manual, 8.1. So, looking at the entire year of 2015 data, you would use the surgical procedure codes in 8.1. This provides the most recently published Specifications Manual to obtain the surgical procedure codes for OP-26.

Question: If CTs are performed during ED visits and the patient is subsequently admitted to the hospital, would this claim be included or excluded?

Answer: If the imaging procedure performed in the ED is bundled into the inpatient claim, the procedure would not be counted in the OIE measures; however, if the imaging study is submitted as a separate claim paid under the Outpatient Prospective Payment System (OPPS), the imaging study is eligible for inclusion.

Question: What about newer digital mammography imaging? Our returns are low, but we do fewer repeat studies.

Answer: OP-9 accounts for a range of appropriate follow-up rates (based on imaging modalities and patient characteristics) by identifying facilities that have unusually high or low performance rates rather than setting a target value.

Question: Can we get the specific cases included in our hospital's numerator?

Answer: Patient-level claims data for the OIE measures are only provided to facilities during a one-time dry run reporting period that occurs before the first year that the measures are publicly reported on Hospital Compare. Once public reporting for OIE measures has begun, only facility-level data are made available.

Question: For OP-8, do you receive claims data from chiropractors?

Answer: Yes, claims from chiropractors are considered in the calculation of OP-8.

Question: It seems as the ER visits are where many opportunities are found.

Answer: Opportunities for improvement may vary across measures, departments, and hospitals. Each hospital should review results for the OIE measures and determine if there are specific opportunities for improvement.

Question: We work in a heart hospital where we perform multiple endograph CT studies which include with and without contrast. Our percentage was high because we do not perform a lot of general abdominal CT. Is there anything we can do so we are not flagged?

Answer: CMS excludes conditions for which clinical practice guidelines indicate use of combined studies may be appropriate. If your facility performance scores are above the national threshold, this is an opportunity to develop quality improvement protocols. The full list of exclusion conditions is available on the QualityNet site at the following link: http://qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228695266120.

If you believe additional conditions should be excluded from the measure, please submit a RightNow inquiry with additional documentation. RightNow inquiries can be submitted through the following link: https://cms-ocsq.custhelp.com/app/utils/login_form/redirect/ask

Question: How are facilities verifying that antecedent conservative therapies have been attempted prior to the MRI being ordered? Most facilities have zero interaction until the ordering provider has requested a procedure.

Answer: With respect to physician ordering of services and hospitals' responsibilities, hospitals do submit bills to Medicare for the services they deliver to both inpatients and outpatients. Consequently, hospitals have a responsibility to ensure that services delivered by the hospital and paid by Medicare are appropriate and necessary. As with other quality

improvement efforts, hospitals can work with physicians who order the services to improve quality.

Question: Do all hospitals have to participate in all the OIE measures?

Answer: Your hospital must report on all OIE measures if you are categorized as a subsection (d) hospital. Subsection (d) hospitals that do not comply are subject to a 2% reduction to their Annual Payment Updates. Subsection (d) hospitals, specified in the Social Security Act (Section 1886(d)(1)(B)), are NOT: psychiatric hospitals, rehabilitation hospitals, pediatric hospitals, hospitals which have an average inpatient length of stay of greater than 25 days, critical access hospitals, a hospital involved extensively in the treatment or research for cancer. However, depending on whether or not your hospital falls under one of the above categories, it may be able to withdraw from the Hospital Outpatient Quality Reporting (HOQR) Program without facing a penalty from Medicare. Please visit the below webpage on QualityNet.org to learn about withdrawing from the HOQR Program:
https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1205442133612