HOSPITAL OQR MEASURES SUBMITTED VIA A WEB-BASED TOOL SUBMISSION GUIDELINES FOR PAYMENT YEAR 2020

Contents

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GUIDELINES FOR SUBMISSION

- In order for a hospital to submit data, the hospital must authorize a QualityNet Security Administrator (SA), a prerequisite necessary for accessing the QualityNet Secure Portal. The QualityNet SA must enter measure data via the QualityNet Secure Portal.
- The Hospital OQR Program requires only one SA for each facility; however, it is highly recommended that facilities have two – a primary and an alternate.
- If a facility does not perform a particular measure, enter zero on the web-based tool on *QualityNet* at submission time.

TIMELINES FOR SUBMISSION

Payment Year 2020

- Data for OP-12, OP-17, OP-22, OP-29, OP-30, OP-33 are reported during the submission period that begins on January 1, 2019 and extends through May 15, 2019, for the reporting period of January 1, 2018 to December 31, 2018.
- OP-31 continues as a voluntary measure in the calendar year (CY) 2019 OPPS/ASC final rule. While reporting of data is not required for this measure, all data submitted will be publicly reported.

OP-12: The Ability for Providers with HIT to Receive Laboratory Data Directly into their ONC-Certified EHR System as Discrete Searchable Data

Measure Questions:

- Does/did your facility have the ability to receive laboratory data electronically directly into your ONC-certified electronic health record (EHR) system as discrete searchable data? Yes/No
- Did your facility use this feature during the performance period? Yes/No
  Note: This question would be answered only if the previous question was answered "Yes."

Laboratory Data: Incorporation of laboratory test results into the EHR as structured data includes the following:

- Electronically receiving clinical laboratory test results in a structured format and displaying such results in a human-readable format,
- Displaying test report information, and
- Incorporating results by electronically attributing, associating, or linking a laboratory test result to a laboratory order or patient record.

ONC-Certified EHR System: An ONC-certified EHR system is defined as an EHR system that has been certified according to the Office of the National Coordinator for Health Information Technology (ONC) criteria. Please visit the Department of Health and Human Services website at https://www.healthit.gov/policy-researchers-implementers/certified-health-it-product-list-chpl for additional information.

Q: If the hospital enters laboratory results into the patient's EHR, is the answer to the measure "Yes" or "No"?

A: Yes. In this case, the hospital receives laboratory values into its EHR directly from the lab via electronic interchange.

Q: If the hospital's EHR is capable of receiving data electronically but the facility did not use the feature **consistently** throughout the reference period, how is this measure answered?

A: Answer "Yes" if the hospital used this feature of its EHR system at **any** time during the reference period.

OP-17: Tracking Clinical Results between Visits

Measure Questions:

- Does/did your facility have the ability to track pending laboratory tests, diagnostic studies (including common preventive screenings), or patient referrals through the ONC-certified EHR system? Yes/No
- Did your facility use the ONC-certified EHR to track pending laboratory tests, diagnostic studies (including common preventive screenings), or patient referrals during the performance period? Yes/No
  Note: This question would be answered only if the previous question was answered "Yes."

Q: If the hospital uses its EHR to track lab results, but does not use it to track referrals, how is the measure answered?

A: The measure is answered "Yes." Demonstrating that the EHR is capable of reminding clinicians to take certain actions, regardless of whether all reminders are activated, allows the hospital to answer "yes" to the measure.

Q: What is the difference between a reminder and an alert in the electronic medical record?

A: A reminder prompts the user to take an impending or follow-up action. An alert typically requires immediate action or warns that an action is contraindicated.

OP-22: Left Without Being Seen

Measure Questions:

- What was the total number of patients who left without being evaluated by a physician/APN/PA? _____ (Numerator)
- What was the total number of patients who presented to the ED? _____ (Denominator)

Patient Population: All patients who sign in to be evaluated for emergency services are included in the denominator, including Medicare patients.

Provider: Patients seen by an institutionally credentialed provider (e.g., an obstetric nurse providing an assessment of an OB patient) acting under the direct supervision of a physician are considered as having been seen by a physician/APN/PA.

Q: If a patient is triaged then leaves the ED, is the patient included in the measure?

A: Yes. All patients who sign in to be evaluated for emergency services are to be counted for inclusion in the measure.

Q: What is the difference between left without being seen and left against medical advice?

A: Patients who leave without being seen are not evaluated by a physician/APN/PA. Patients who leave against medical advice do so after examination by a provider. Once a patient is evaluated by a provider, the patient is no longer considered for this measure.

Q: If a patient leaves before being seen by a provider, would the patient have a discharge code?

A: If the patient is assigned an E/M code and there is no documentation of when the patient left the ED, the discharge code would be UTD (#8). However, if the patient was not assigned an E/M code, they would not have a discharge code and would only be included in OP-22, not in the ED-Throughput measures.

OP-29: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients

Description: Percentage of patients aged 50 to 75 years of age receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report

Denominator: All patients aged 50 to 75 years of age receiving screening colonoscopy without biopsy or polypectomy

Numerator: Patients who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report

Q: When a patient comes in for a scheduled screening colonoscopy but has a biopsy performed, would this patient be included in the denominator for this measure?

A: No. If the patient has a biopsy performed, they should not be included because the patient would be expected to have a follow-up colonoscopy prior to 10 years from the date of the exam.

Q: Does the follow-up interval have to be documented in the colonoscopy report?

A: Yes. The physician must document the recommended follow-up time (e.g., 10 years) after the exam is performed in the colonoscopy report.

OP-30: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use

Description: Percentage of patients aged 18 years and older receiving a surveillance colonoscopy, with a history of a prior colonic polyp(s) in previous colonoscopy findings, who had a follow-up interval of three or more years since their last colonoscopy

Denominator: All patients aged 18 years and older receiving a surveillance colonoscopy, with a history of a prior colonic polyp(s) in previous colonoscopy findings

Numerator: Patients who had an interval of three or more years since their last colonoscopy

Q: If the physician documents a medical reason for performing a colonoscopy in less than three years but does not document the interval, is this acceptable for the measure?

A: No. Documentation of a medical condition or finding can be used as a medical reason(s) for denominator exclusion purposes only if the previous colonoscopy was documented to be less than three years prior.

Q: If the reason for performing the colonoscopy is charted in the patient's history and physical but not in the colonoscopy report, would this patient be included in the population?

A: Information regarding the performance interval can be obtained from medical record documentation.

Q: Can the physician document any reason to support an interval of less than three years since the last colonoscopy?

A: Yes. Documentation of medical reason(s) for an interval of less than three years since the last colonoscopy (e.g., patients with high risk for colon cancer, last colonoscopy incomplete, last colonoscopy had inadequate prep, piecemeal removal of adenomas/polyps, or last colonoscopy found greater than 10 adenomas/polyps) are at the discretion of the physician.

Q: Must documentation of a system reason for measure exclusion also include documentation of the interval of the previous colonoscopy?

A: Yes. An interval of less than three years must be documented to exclude the measure, including a documented system reason (e.g., previous colonoscopy report not available, unable to locate last colonoscopy report).

OP-31: Cataracts – Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery *This measure is voluntary. All data submitted for OP-31 will be publicly reported.*

Description: Percentage of patients aged 18 years and older who had cataract surgery and had improvement in visual function achieved within 90 days following the cataract surgery, based on completing a pre-operative and post-operative visual function survey.

Denominator: All patients aged 18 years and older who had cataract surgery and completed **both** a pre-operative and post-operative visual function survey

Numerator: Patients 18 years and older who had improvement in visual function achieved within 90 days following cataract surgery, based on completing **both** a pre-operative and post-operative visual function survey

- The encounter dates for OP-31 are January 1 through December 31, 2018. This data will be entered via the QualityNet Secure Portal during the submission period of January 1, 2019 through May 15, 2019.

OP-33: External Beam Radiotherapy for Bone Metastases

Description: Percentage of patients, regardless of age, with a diagnosis of bone metastases and no history of previous radiation to the same anatomic site who receive external beam radiation therapy (EBRT) with an acceptable fractionation scheme

Denominator: All patients with bone metastases and no previous radiation to the same anatomic site who receive EBRT for the treatment of bone metastases. The data for the denominator may be found in the consultation and office visit notes, outpatient treatment center record, and other-treatment summaries.

Numerator: All patients, regardless of age, with bone metastases, and no previous radiation to the same anatomic site who receive EBRT for the treatment of bone metastases with any of the following recommended fractionation schemes: 30Gy/10fxns, 24Gy/6fxns, 20Gy/5fxns, and 8Gy/1fxn. The data for the numerator may be found in the consultation and office visit notes, outpatient treatment center record, and problem/diagnosis list.