Outpatient Quality Program Systems and Stakeholder Support Team

The Escape Room: The Search for Clues in Your Data Abstraction

Question and Answer Summary Document

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Subject-matter experts researched and answered the following questions during the live webinar. The questions may have been edited for grammar.

Question 1: **We have an Observation Bed Emergency Department (OB ED), where the patient is evaluated by the OB mid-level provider. The depart time is documented in what is labeled as a Labor and Delivery Record. Is this record an acceptable source for capturing the *ED Departure Time*?**

According to version 14 (v14) of the Hospital Outpatient Quality Reporting (OQR) Program Specifications Manual, the only acceptable data source is the Emergency Department (ED) record. So, if the Labor and Delivery Record is part of the ED record, and it includes the ED discharge time, then it would be acceptable.

Question 2: **With regard to *Arrival Time*, can you clarify how you can consider documentation from an unallowable source, such as Occupational Safety and Health (OSH) or Emergency Medical Services (EMS) records, that show the patient could not possibly have been in our hospital ED at the earliest time documented in our hospital record's allowable sources? It is sometimes difficult to determine what to consider if it is obviously in error when the times may only be 30–60 minutes off.**

EMS records are not included in the ED Emergency Record and would not be included in the medical record requests should the encounter be selected for validation. Therefore, only the acceptable sources can be used in abstraction. Any obvious error would need to be determined based on the acceptable data sources in the medical record.

Question 3: **Is Event For Transfer acceptable for *ED Departure Time*?**

Transfer Time is an inclusion for abstracting *ED Departure Time*, so it is acceptable to use as long as it is part of the ED record. Per the Hospital OQR Program Specifications Manual, the ED record is the only acceptable data source for the *ED Departure Time* data element.

Question 4: **If the patient had order for Observation by the physician, would you not count that time as the *ED Departure Time*?**

Orders for observation can be abstracted for *ED Departure Time*, if the patient is still physically in the ED when the order is placed.

Question 5: **When abstracting for the OP-29 measure, does the physician need to document the age or can we get it from the record?**

The age can be documented by the physician or documented in the medical record.

Question 6: **When abstracting for OP-29, if the patient is 70 years old, how do we abstract when the physician is recommending follow-up PRN (when necessary)?**

The documentation of "return PRN" would be consistent with the guidance that states, "Documentation indicating no follow-up colonoscopy is needed or recommended." Since the patient is 70 years old and there is documentation "return PRN," the case could be excluded.

Question 7: **On slide 19, what if the patient had a polypectomy and the documentation states PRN?**

The Denominator Statement indicates the denominator should include patients without biopsy or polypectomy. If the patient had a biopsy or polypectomy, they do not meet the denominator statement criteria and would be excluded from the denominator.

Question 8: **Does the age of the patient need to be documented in the colonoscopy report?**

The age does not have to be documented in the colonoscopy report.

Question 9: **If a patient was admitted as an inpatient (IP) and is inpatient at time of discharge, but, due to insurance/payment issues, the patient was changed to Observation post-discharge and billed as Observation, is it correct that this case should not be included in the outpatient (OP) measure population (unless the patient never actually left the ED after the IP order was written)?**

If the patient was ultimately billed as an outpatient, the encounter may be included and abstracted in the OP population.

Question 10: **For the data element *Last Known Well (LKW),* what physician documentation do we use if the ED resident lists a time then the attending physician lists a different time?**

If there are multiple times of Last Known Well, documented by different physicians or the same provider, use the earliest time documented.

Question 11: **For the data element *Last Known Well,* must there be a specific time and date to answer Yes?**

Yes. The definition of the *Last Known Well* data element states: "The date and time prior to hospital arrival at which it was witnessed or reported that the patient was last known to be without the signs and symptoms of the current stroke or at his or her baseline state of health."

Question 12: **A psychiatric patient held in the ED awaiting placement was moved to the behavioral health unit, which is within the ED. Do we abstract the time he is moved to behavioral health or the time he is transferred out to another facility as the *ED Departure Time*?**

The intent is to capture the time the patient physically departed the ED or, if an Observation order is placed when patient is still in the ED, the Observation order time can be abstracted for *ED Departure Time*. If the patient is moved into another area within the ED, and there is no Observation order, then the patient is still considered in the care of the ED; therefore, abstract the time the patient physically departed the ED.

Question 13: **What if the nurse documents a specific time of last known well and the physician documents "onset unclear"? The Specifications Manual seems to say that the term "onset unclear" does not equate to last known well unclear.**

Per the 2021 Hospital OQR Program Specifications Manual, "Select No if there is any physician/APN/PA documentation that the Time Last Known Well is 'unknown.' Documentation must explicitly state that the Time Last Known Well is unknown/uncertain/unclear. Documentation that time of symptom onset is unknown/uncertain/unclear is also acceptable when Time Last Known Well is not documented." (v14.0a, page 2-108)

Question 14: **I have a question regarding slide 19 for OP-29. In March 2021, we sent a question through the Question & Answer Tool on QualityNet (CS1284764): "In the this patient's colonoscopy procedure report the surgeon states, 'Repeat colonoscopy for symptoms of colon disease. Stop screening colonoscopies after age 75 due to age and start high fiber diet.' In the same colonoscopy report, the patient's date of birth (DOB) shows he/she is currently 69 years old. We asked if we could use the documentation to exclude the patient from the denominator." We received this answer: "The documentation provided would not likely suffice excluding the patient based on the guidance provided from the Specifications Manual**."

In this situation, the documentation in the procedure report does not clearly indicate no follow-up colonoscopy is needed or recommended for this patient who is 69 years old, and the case would not be excluded.

Question 15: **What if a Computed Tomography (CT) is ordered, the order is cancelled, an order for a Computed Tomography Angiography (CTA) is ordered, and the report shows a CT was done with the CTA? We have CT results, but we have no order specifically for CT since it was cancelled. We have been told previously that we can answer No in this scenario if there is no specific order for a head CT. However, if an Magnetic Resonance Imaging (MRI) scan was also ordered and done in the ED, can we answer Yes and go with the MRI results (even though the results from the unordered CT is earlier)?**

If there is documentation that a head CT or MRI scan is ordered during the emergency department visit, but it is cancelled and there are no other head CT or MRI scans ordered during the emergency department visit, you would abstract No. If there is an MRI, you would answer Yes and use the time of the MRI results. Because the CT is part of the CTA and CTA is not included for the purposes of abstracting for the OP-23 measure, that time would not be used.

Question 16: **For the data element *Transfer for Acute Coronary Intervention*, which value would you choose? The doctor's documentation states, "Patient was transferred to Heart Hospital for further medical care and cardiology consultation." However, the EMS note states, "Patient care is transferred to Heart Hospital Cath Lab staff."**

This would be abstracted as value 3. A transfer for consultation and evaluation is not considered an acute coronary intervention (ACI). Likewise, transfer to "cath lab staff" does not specifically state it is for an ACI. Per the OQR manual guidance, the reason for transfer must be a defined ACI. As such, if implicit reasons for transfer, such as "Patient has STEMI" or "Transferred for cardiology consult to discuss possible cath lab" are listed, then select value 3. (v14.0a, page 2-128).

Question 17: **What are considered "system reasons"?**

The *Reason for Delay in Fibrinolytic Therapy* data element includes some system reason examples (v14.0a, page 2-119). Additionally, it can include waiting on lab results, electrocardiogram (ECG) results, transportation, etc.

Question 18: **If the physician does not include a LKW time, should we use the nurse LKW time or select No?**

The abstraction guidance for the *Time Last Known Well* data element reflects that nursing documentation of last known well is acceptable if physician documentation of last known well is not present.

When abstracting the *Time Last Known Well* data element, the order of precedence is to first determine if there is explicit provider documentation of last known well/symptom onset being unknown/uncertain/unclear. If not, then proceed to determine if there is documentation of last known well on a code stroke form. If there is no code stroke form, then proceed to determine if there is documentation of last known well in the record (using physician documentation first before other sources like nursing or EMS). If there is no documentation of last known well, then proceed to look for onset of symptoms, which can be used as the time of last known well when last known well is not documented.

Question 19: **For the data element *Initial ECG Interpretation,* the documentation is, "Posterior infarct, acute. Lateral infarct, acute. ST depression V1-V3, suggest recording posterior lead." Would this be abstracted as a value Yes?**

Correct. This would be abstracted as a Yes value based on the ST-segment elevation inclusion terms "Posterior infarct, acute" and "Lateral infarct, acute." Because there is at least one inclusion term and no exclusion terms, this would be a Yes value.

Question 20: **Are CT virtual colonoscopies included in the OP-29 population?**

No, the denominator criteria in the OP-29 Measure Information Form identify the acceptable procedures for this measure as CPT code 44388 (Colonoscopy through stoma), 45378 (Colonoscopy), and G0121 (Colonoscopy screening). The denominator criteria do not include a code for CT virtual colonoscopies.

Question 21: **Where do we find the manual for the in-depth criteria?**

The Hospital OQR Program Specifications Manuals can be found on QualityNet.cms.gov: https://qualitynet.cms.gov/asc/specifications-manuals Please note, you will need to click "agree" to the CPT pop-up box before it will allow you to view the manuals.

Question 22: **For the data element *Transfer for Acute Coronary Intervention,* is "cardiac intervention" enough documentation to select the allowable value 1?**

Yes. The *Transfer for Acute Coronary Intervention* data element Inclusion Guidelines for Abstraction include acute cardiac intervention.

Question 23: **If a patient is transferred from our ED to our cardiac catheterization (cath) lab for intervention, would we abstract value 1 for the *Transfer for Acute Coronary Intervention* data element?**

The 4th bullet under the *Transfer for Acute Coronary Intervention* data element Notes for Abstraction states, "If a patient receives acute coronary intervention prior to transfer, then abstract value 3." (2021 Hospital OQR Program Specifications Manual, v14.0a, page 2-128) Therefore, you would select value 3.

Question 24: **If you have a LKW date but no LKW time and answer No to *Last Known Well*, the case is excluded. If you answer Yes to *Last Known Well*, enter the date, and enter UTD for time, the case will be a missed opportunity for this measure (at least with our vendor's software).**

For abstraction purposes, there should not be a scenario where you would select UTD if either the *Date LKW* or *Time LKW* is not documented because the OP-23 measure algorithm checks the value of the *Last Known Well* data element before checking the *Date LKW* and *Time LKW* data elements. (See the measure algorithm on pages 1-14 through 1-45 of the 2021 Hospital OQR Program Specifications Manual v14.0a.) Per the *Last Known Well* data element, documentation of both a Date LKW and a Time LKW are required to select Yes. Therefore, if either the Date LKW or Time LKW is not documented or you are unable to determine from medical record documentation, you would select No (page 2-108). Selecting No to the *Last Known Well* data element removes the case from the OP-23 measure population and abstraction ends.

Question 25: **Are we required to submit data on each of these outpatient measures? If we don't have CT in our facility, what do we do?**

Under the Hospital OQR Program, hospitals are required to submit data on all of the specified outpatient quality measures in order to receive their full Medicare Annual Payment Updates (APUs). Outpatient imaging efficiency (OIE) measure results are calculated using fee-for-service claims submitted to and paid by Medicare; hospitals do not need to submit additional data or give any additional authorization for calculation of the OIE measures beyond what was already submitted through standard FFS claims for reimbursement.