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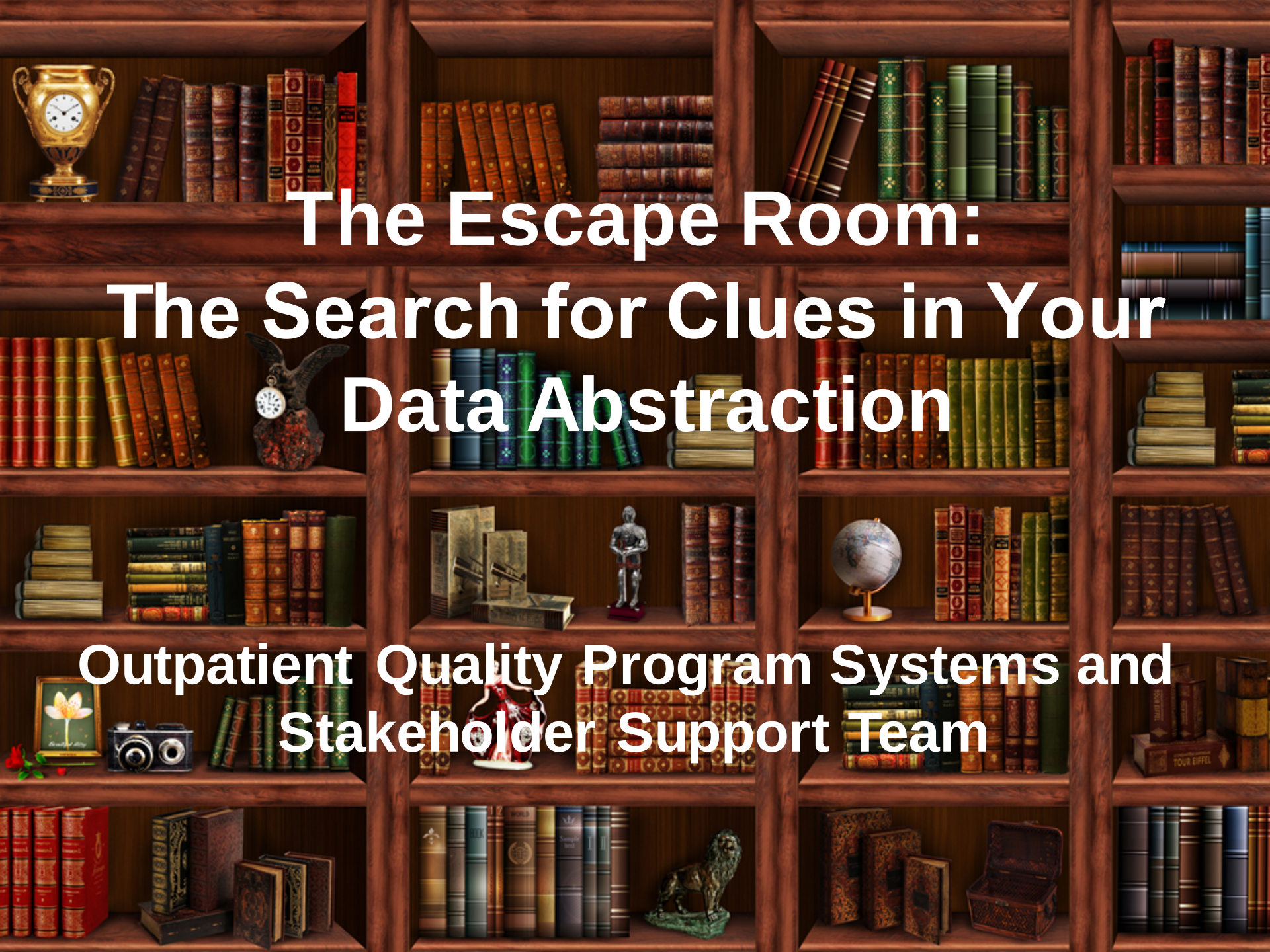

The Escape Room: The Search for Clues in Your Data Abstraction

Outpatient Quality Program Systems and Stakeholder Support Team

Acronym List

Acronyms			
ACI	Acute Coronary Intervention	LKW	Last Known Well
AMI	Acute Myocardial Infarction	MI	Myocardial Infarction
APN	Advance Practice Nurse	MRA	Magnetic Resonance Angiography
CDR	Claims Detail Report	MRI	Magnetic Resonance Imaging
CMS	Centers for Medicare & Medicaid Services	OIE	Outpatient Imaging Measures
CT	Computed Tomography	PA	Physician's Assistant
CY	Calendar Year	PRN	Pro re nata (when necessary)
ECG	Electrocardiogram	Q	Quarter
ED	Emergency Department	RN	Registered Nurse
EMS	Emergency Medical Service	STEMI	ST Elevation Myocardial Infarction
EP	Electrophysiologist	TNKase®	Tenecteplase
FSR	Facility-Specific Report	TX	Treatment
HQR	Hospital Quality Reporting	UTD	Unable to Determine

Learning Objectives

Attendees will be able to:

- Resource the Specifications Manual to assist in abstracting measures for this program.
- Recognize some common difficulties with chart-abstracted measures.
- Describe tips for resolving issues.
- Locate online resources available to assist with successful reporting.

Program Announcements

- Quarter (Q)1 data (January 1—March 31, 2021) are due August 2, 2021.
- The Calendar Year (CY) 2022 proposed rule will be published soon.
  - A webinar discussing all proposals for this program will be presented shortly after the publication of the rule.
- Today's slides can be found on our website at: QualityReportingCenter.com.

ED-Throughput Measure Set

The ED-Throughput measure set includes:

- **OP-18:** Median Time from ED Arrival to ED Departure for Discharged ED Patients
- **OP-22:** Left Without Being Seen

OP ED Data Element Name	Collected for:
Arrival Time	OP-18
Discharge Code	OP-18
E/M Code	OP-18
ED Departure Date	OP-18
ED Departure Time	OP-18
ICD-10-CM Principal Diagnosis Code	OP-18
Outpatient Encounter Date	OP-18

Web-Based Measures

Measures Submitted via a Web-Based Tool include:

- **OP-29:** Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
- **OP-31:** Cataracts - Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery **(voluntary)**

OP-22: Left Without Being Seen is an ED-Throughput measure but is submitted annually via a web-based tool.

Scenario

Data Element: *Arrival Time*

The medical record shows the following documented events: RN documentation on 10/01/20: Door Time 2359, Start Triage 0001. The ED Event Log on 10/01/20: 0000 Patient arrived in ED.

What would be the earliest arrival time?

Review and Answer

Definition:

- The earliest documented time (military time) the patient arrived at the outpatient or emergency department.

In this scenario, abstract Door Time of 2359, as that is the earliest documented time the patient arrived at the ED.

Scenario

Data Element: *ED Departure Time*

A patient has an *ED checkout time* of 1518, and then has an *event for transfer* to the next department at 1525. The patient also had an order for observation written at 1131 the following day. There is no documentation in the ED provider notes after 1405.

What time would be acceptable for ED Departure Time?

Review

Notes for Abstraction:

- The intention is to capture the latest time at which the patient was receiving care in the emergency department, under the care of emergency department services, or awaiting transport to service/care.
- *ED Departure Time* is the documented time the patient physically left the emergency department.
- When more than one emergency department departure/discharge time is documented, abstract the latest time.

Answer

In this scenario, there are two times that may reflect the patient physically leaving the ED, the *ED checkout time* of 1518 and the *Event for Transfer*

at 1525.

You will abstract the later time of 1525 for

ED Departure Time.

Scenario

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

A 70-year-old patient had a colonoscopy done at our hospital. Other than "return PRN", there is no documentation of a recommended follow-up colonoscopy.

Would this case be excluded from the denominator?

Review and Answer

Denominator Exclusions:

- **"…….** Documentation indicating no follow-up colonoscopy is needed or recommended is only acceptable if the patient's age is documented as ≥66 years old, or life expectancy < 10 years….."

This case would be excluded from the denominator because no follow-up colonoscopy is needed or recommended is acceptable if the patient's age is greater than or equal to 66 years old.

Stroke Measure Set

OP-23: Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival

OP Stroke Data Element Name	Collected For:
Arrival Time	OP-23
Discharge Code	OP-23
E/M Code	OP-23
Date Last Known Well	OP-23
ICD-10-CM Principal Diagnosis Code	OP-23
Head CT Scan or MRI Order	OP-23
Head CT Scan or MRI Interpretation Date	OP-23
Head CT Scan or MRI Interpretation Time	OP-23
Last Known Well	OP-23
Time Last Known Well	OP-23

Scenario

Data Element: *Time Last Known Well*

The patient arrived at 0724. The notes state patient woke up at 0400 and developed a posterior headache with dizziness, general neck pain, no nuchal rigidity, and nausea and vomiting. The ED physician note states the patient presented with sudden severe headache this morning. Additional documentation states the patient arrived within one hour of sudden severe headache.

How would we abstract Time Last Known Well?

Review

Definition:

- The time prior to hospital arrival at which 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.

Exception:

- If the only time documented is time of symptom onset without mention of when the patient was last known well, use the time of symptom onset for the *Time Last Known Well*.

Review (cont.)

- If there are multiple times of last known well documented in the absence of the *Time Last Known Well* explicitly documented on a Code Stroke Form, use physician documentation first before other sources, e.g., nursing, EMS.
- If the time is noted to be “less than” a period of time prior to ED arrival, assume the maximum range.

Answer

In this scenario, there is no documentation of last known well or symptom onset in a Code Stroke Form but there is physician documentation upon which symptom onset can be derived.

You would abstract 0624 as the

Time Last Known Well.

Scenario

Data Element: *Time Last Known Well*

The patient arrived to the ED at 1802. The ED physician documents the time last known well is one hour prior to arrival. EMS documents a specific time of last known well as 1700.

Which documentation do you use for the Time Last Known Well?

Review

Exception:

- If there are multiple times of last known well documented in the absence of the *Time Last Known Well* explicitly documented on a Code Stroke Form, use physician documentation first before other sources, e.g., nursing, EMS.

Answer

If time last known well is not documented on a Code Stroke Form, then look for documentation of last known well in other sources of the record, with physician documentation taking priority over other sources like nursing or EMS documentation. If the time last known well is documented as being a specific number of hours prior to arrival instead of specific time, you can subtract that from the arrival time to determine the *Time Last Known Well*.

Since the ED physician documented time last know well was one hour prior to arrival, you can subtract 1 hour from the arrival time of 1802 and abstract 1702 as the Time Last Known Well.

Scenario

Data Element: *Last Known Well*

The nurse documents a last known well date/time of 1/17/21 at 1700 and the ED physician documents both "LKW yesterday" and "Reason(s) tPA not ordered: Secondary to unknown onset."

Does the nurse's documentation of the Last Known Well date/time take precedence over the physician's documentation of "unknown onset"?

Can you clarify the guidance in the Last Known Well data element about Time Last Known Well/onset of signs/symptoms being unknown/uncertain/unclear?

Review

Definition:

- 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.

Allowable Values:

- Y (Yes) There is documentation that the date and time of *Last Known Well* was witnessed or reported.
- N (No) There is no documentation that the date and time of *Last Known Well* was witnessed or reported, **or** Unable to Determine from medical record documentation

Answer

Notes for Abstraction:

- Documentation must explicitly state that the *Time Last Known Well* is unknown/uncertain/unclear.

If a nurse documents LKW, but the physician notes LKW is unknown, you would abstract No.

Scenario

Data Element: *Head CT or MRI Scan Order*

A patient arrived at the ED at 1249. The physician ordered an MRI during the ED visit at 1300. However, the documentation indicates the MRI order was cancelled at 1431 as the patient was transferred to another facility at 1450.

Do I abstract Yes or No?

Review

Definition:

- Documentation in the medical record that a Computerized Tomography (CT) or Magnetic Resonance Imaging (MRI) scan of the head was ordered during an emergency department visit.

Allowable Values:

- Y (Yes) There is documentation a head CT or MRI scan was ordered by the physician/APN/PA during the emergency department visit.
- N (No) There is no documentation a head CT or MRI scan was ordered by the physician/APN/PA during the emergency department visit.

Review and Answer

Notes for Abstraction:

- If there is documentation a head CT or MRI scan is ordered during the emergency department visit but is cancelled and there are no other head CT or MRI scans ordered during the emergency department visit, abstract No.

Since the MRI was cancelled, you would abstract No for the Head CT or MRI Scan Order data element.

Scenario

Data Element: *Head CT or MRI Scan Interpretation Time*

A patient was admitted to one of our hospitals at 0934 and was transferred to our hospital at 1306 with the same Identifier and medical record numbers. A CT Scan was done at the first hospital at 1055 and interpreted at 1105. There was a CT Scan ordered at the second hospital at 1356 but was cancelled.

What time should be abstracted for Arrival Time? Additionally, which CT scan should be used?

Review

Abstraction Recommendations for Multiple Same-Day Encounters:

- 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. Because the data element *Arrival Time* is used to differentiate between two cases that occur on the same encounter date, if both cases are submitted with UTD for *Arrival Time*, the case submitted last will override the previous case.

Answer

If the first situation applies, you will use the arrival time at the first hospital for Arrival Time. You will also use the time 1105 at the first hospital for the Head CT or MRI Scan Interpretation Time.

If the second situation applies, then you would treat each facility as two separate cases to be abstracted. In this situation if the second ED visit is abstracted, no CT was ordered while the patient was in the ED, as it was ordered and then cancelled.

AMI Measure Set

The Acute Myocardial Infarction (AMI) measure set includes:

- **OP-2:** Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival
- **OP-3:** Median Time to Transfer to Another Facility for Acute Coronary Intervention

OP AMI Data Element Name	Collected For:
Discharge Code	OP-2, OP-3
E/M Code	OP-2, OP-3
ED Departure Date	OP-3
ED Departure Time	OP-3
Fibrinolytic Administration	OP-2, OP-3
Fibrinolytic Administration Date	OP-2
Fibrinolytic Administration Time	OP-2
ICD-10-CM Principal Diagnosis Code	OP-2, OP-3
Initial ECG Interpretation	OP-2, OP-3
Reason for Delay in Fibrinolytic Therapy	OP-2
Reason for Not Administering Fibrinolytic Therapy	OP-3
Transfer for Acute Coronary Intervention	OP-3

Scenario

Data Element: *Fibrinolytic Administration*

Many cardiologists are asking us to start Heparin before we ship, which is the recommendation we follow. Please clarify what medications count toward being a fibrinolytic for the OP-2 measure.

Can we use Heparin as a fibrinolytic being started?

Review

- Appendix C, Table 1.3 lists acceptable fibrinolytic agents for the purposes of abstracting the *Fibrinolytic Administration* data element.

OP Table 1.3 Fibrinolytic Agents

Medication Name
Activase
Alteplase
Anisoylated Plasminogen-Streptokinase Activator Complex
APSAC
Kabikinase
Retavase
Reteplase
rPA (RPA)
Streptase
Streptokinase
Tenecteplase
Tissue plasminogen activator
TNKase
tPA (TPA)

Heparin is not included in this table.

Answer

Allowable Values:

- Y (Yes) Fibrinolytic therapy was initiated at this emergency department.
- N (No) There is no documentation fibrinolytic therapy was initiated at this emergency department, or Unable to Determine from medical record documentation.

You would select No as there is no documentation that fibrinolytic therapy was initiated at your emergency department and heparin is not included in the list of acceptable fibrinolytic agents.

Scenario

Data Element: *Reason for Delay in Fibrinolytic Therapy*

The patient arrived at the ED, there was a 15-minute delay in getting the initial ECG and its interpretation. TNKase® was given within 33 minutes.

Is this an acceptable reason for delay in fibrinolytic therapy?

Review

Definition:

- Documentation of a reason for a delay in initiating fibrinolytic therapy after hospital arrival by a physician/advanced practice nurse/physician assistant (physician/APN/PA). System reasons for delay are **not** acceptable.

Allowable Values:

- Y (Yes) Reason documented by a physician/APN/PA for a delay in initiating fibrinolytic therapy after hospital arrival.
- N (No) No reason documented by a physician/APN/PA for a delay in initiating fibrinolytic therapy after hospital arrival, or unable to determine from medical record documentation.

Review and Answer

Notes for Abstraction:

- System reasons for delay are not acceptable, regardless of any linkage to the delay in fibrinolysis/reperfusion.

You would select No. Waiting on ECG results is considered a system reason. System reasons for delay are not acceptable.

Scenario

Data Element: *Initial ECG Interpretation*

The ECG interpretation reads: Normal Sinus Rhythm, Left axis deviation, right bundle branch block, inferior infarct, age undetermined. Abnormal ECG.

Would this be abstracted as a Yes for the Initial ECG Interpretation data element because of the term "inferior infarct"?

Review

Definition:

- ST-segment elevation based on the documentation of the electrocardiogram (ECG) performed closest to emergency department arrival. The normal ECG is composed of a P wave (atrial depolarization), Q, R, and S waves (QRS complex, ventricular depolarization), and a T wave (ventricular repolarization). The ST-segment, the segment between the QRS complex and the T wave, may be elevated when myocardial injury (AMI) occurs.

Allowable Values:

- Y (Yes) ST-segment elevation on the interpretation of the 12-lead ECG performed closest to emergency department arrival.
- N (No) No ST-elevation on the interpretation of the 12-lead ECG performed closest to emergency department arrival, no interpretation or report available for the ECG performed closest to emergency department arrival, or unable to determine from medical record documentation.

Review (cont.)

Inclusion Guidelines for Abstraction:

ST-segment elevation

- Myocardial infarction (MI), with any mention of location or combinations of locations (e.g., anterior, apical, basal, inferior, lateral, posterior, or combination), if described as acute/evolving (e.g., "posterior AMI").
- Q wave MI, if described as acute/evolving
- ST ↑
- ST consistent with injury or acute/evolving MI
- ST abnormality consistent with injury or acute/evolving MI
- ST changes consistent with injury or acute/evolving MI
- ST-elevation (STE)
- ST-elevation myocardial infarction (STEMI)
- ST-segment noted as greater than or equal to .10mV
- ST-segment noted as greater than or equal to 1 mm
- STEMI or equivalent
- Transmural MI, if described as acute/evolving

Review (cont.)

Exclusion Guidelines for Abstraction:

ST-segment elevation

- Documentation of the absence of STEMI (In reference to the ECG performed closest to arrival) – e.g., "No STEMI," "not consistent with STEMI," "not diagnostic of STEMI."
- Non Q wave MI (NQWMI)
- Non ST-elevation MI (NSTEMI)
- ST-elevation (ST ↑) clearly described as confined to **one** lead.
- All ST-elevation (ST ↑, STE) in one interpretation described in one or more of the following ways:
  - Minimal
  - Non-diagnostic
  - Non-specific
  - ST-elevation or ST-segment noted as less than .10 mV in elevation
  - ST-elevation or ST-segment noted as less than 1mm in elevation
  - ST-elevation (or ST-segment noted as greater than or equal to .10mV/1mm) described using one of the negative modifiers or qualifiers listed under the Exclusion Guidelines for Abstraction

- ST-elevation (ST ↑) with any mention of the following in one interpretation:
  - Early repolarization
  - Left ventricular hypertrophy (LVH)
  - Normal variant
  - Pericarditis
  - Printzmetal/Printzmetal's variant
- ST, ST abnormality, or ST changes consistent with injury or acute/evolving MI or any of the "myocardial infarction" (MI) inclusion terms described using one of the negative modifiers or qualifiers listed under the Exclusion Guidelines for Abstraction.
- ST-segment elevation, or any of the other ST-segment elevation inclusion terms, with any mention of pacemaker/pacing (unless atrial only or nonfunctioning pacemaker) in one interpretation.

Answer

The Inclusion Guidelines for Abstraction indicate that if there is documentation of an MI, there must also be mention of a location or combination of locations and it must be described as acute or evolving.
In this scenario, infarct and location are documented but the "inferior infarct" is not described as acute or evolving. So, it is not considered an inclusion term. There are no exclusion terms noted in the ECG interpretation.

This would be abstracted as a No value for the Initial ECG Interpretation data element because the ECG does not contain any inclusion terms.

Scenario

Data Element: *Initial ECG Interpretation*

Initial signed ECG reads: Sinus Rhythm, Borderline Left Axis Deviation, ST elevation VI and AVL. The ED physician interpretation of the initial ECG is: normal sinus rhythm, no ectopy, normal PR & QRS intervals, EP Interpretation of initial ECG: There are minimal ST depressions in V1 and aVL measuring less than a millimeter. There is slight ST-depression in V3 and aVF, also less than 1 mm. The precordial leads are normal. Minimal degree of the EKG changes, but we have contacted cardiology early in this case.

How would you abstract for Initial ECG Interpretation?

Answer

Start by reviewing the signed tracing. The initial signed ECG contains an inclusion term (ST elevation), and no exclusion terms are noted. Next proceed to review other interpretations that clearly refer to the ECG done closest to arrival. There are no inclusion nor exclusion terms noted in the ED MD documentation. The EP documentation indicates the presence of ST depression, which is not mentioned in the manual, (only ST elevation) and is therefore neither an inclusion nor an exclusion.

Select Yes for this case, since there is an inclusion in the initial signed tracing and no exclusions in any interpretations of the initial ECG.

Scenario

Data Element: *Transfer for Acute Coronary Intervention*

A patient arrived in our ED and the physician documented "transfer for higher level of care."

Is this enough to answer the allowable value of 1 for this question?

Review

Definition:

- Documentation the patient was transferred from this facility's emergency department to another facility for acute coronary intervention**.**

Allowable Values:

- 1 There was documentation the patient was transferred from this facility's emergency department to another facility specifically for acute coronary intervention.
- 2 There was documentation the patient was admitted to observation status prior to transfer.
- 3 There was documentation the patient was transferred from this facility's emergency department to another facility for reasons other than acute coronary intervention, or the specific reason for transfer was unable to be determined from medical record documentation.

Answer

You should not select value 1 in this case because the documentation states the transfer was for a "higher level of care" but does not specifically define the reason for transfer is for an acute coronary intervention.

You would be abstract allowable value 3.

Scenario

Data Element: *Transfer for Acute Coronary Intervention*

The ED provider documents: “Hospital interventional cardiology physician will see patient in the ED for likely Cath Lab. Patient has been accepted to the ED by physician. Disposition: Transfer to Another Facility". In the Non-Emergency Ambulance Transportation documentation completed by the nurse, the Reason for Transport is documented as "Tx for cardiac cath“. The Transport Location is defined as "Hospital Cath Lab".

Would we select value 1 or value 3 for Transfer for Acute Coronary Intervention in this case?

Review and Answer

The Transfer for Acute Coronary Intervention data element is defined as "Documentation the patient was transferred from this facility's emergency department to another facility for acute coronary intervention."

According to the information provided, there is documentation in the ED record of "Tx for cardiac cath." As cardiac catheterization is an inclusion term for this data element, you may select a Value 1 in this scenario.


CLUE

Outcome Measures

The outcome measures include:

- **OP-32:** Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy- Opens in new browser tab
- **OP-35:** Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy- Opens in new browser tab
- **OP-36:** Hospital Visits after Hospital Outpatient Surgery

Imaging Efficiency Measures

The Outpatient Imaging Efficiency (OIE) measures include:

- **OP-8:** MRI Lumbar Spine for Low Back Pain- Opens in new browser tab
- **OP-10:** Abdomen CT - Use of Contrast Material- Opens in new browser tab
- **OP-13:** Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery

Reports

Question: What is the difference between my Facility-Specific Report (FSR) and Claims Detail Report (CDR)?

Answer: FSRs include additional information (facility-level measure results, state and national results, Medicare claims data to calculate measure results, measure performance information, and a summary of each facility's case mix). The FSRs and CDRs released in 2021 cover different payment periods.

- FSRs released in spring 2021 include public reporting period 2021 only.
- The CDRs released in 2021 include partial preliminary data for public reporting period 2022.

Data Collection

Question: How is data-collection for the OIE measures impacted by COVID-19?

Answer: In response to the COVID-19 pandemic, as a relief to facilities and providers, CMS will not use data from January 1, 2020, through June 30, 2020, for performance calculation (including for the identification of cases for exclusion). Therefore, the data collection period for values to be reported on the public reporting site in summer 2021 ran from July 1, 2019, through December 31, 2019.

Additional information: https://www.cms.gov/newsroom/press-releases/cms-announces-relief-clinicians-providers-hospitals-and-facilities-participating-quality-reporting


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Resources

- Today's presentation can be found on www.QualityReportingCenter.com.
- For measure-specific questions, use the *QualityNet* Quality Question and Answer Tool.
- For program-related questions, call the support team help desk:
  - Phone: 866.800.8756


Thank You!

Continuing Education Approval

This program has been approved for one CE credit for the following boards:

- **National credit**
  - Board of Registered Nursing (Provider #16578)
- **Florida-only credit**
  - Board of Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling
  - Board of Registered Nursing
  - Board of Nursing Home Administrators
  - Board of Dietetics and Nutrition Practice Council
  - Board of Pharmacy

Note: To verify CE approval for any other state, license, or certification, please check with your licensing or certification board.

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