

Hospital Outpatient Quality Data Reporting Program
Compiled Question Answer Grid

***Please note:** To search this document, hold down the "ctrl" (Control) button and strike the "F" key. A window will pop up in which you can type the key word, then select "Find Next" or "Find All". This will take you to the question(s)/answer(s) that contain your key word.

Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
128	Antibiotic Administration: Allergy	If two data sources in the outpatient encounter have conflicting allergy documentation (one lists an allergy, the other does not), would we abstract this as a "Yes" for antibiotic allergy? Is one affirmative enough to document an allergy, regardless of the rest of the encounter documentation? If we reply yes to the allergy question, does the provider have to connect the allergy to the vanco.... ie. in some way document that the vanco was used because of the allergy? OR Is documentation of the allergy in the record adequate without connecting it to the vanco use.	Yes, The allergy does not have to be connected to the use of Vancomycin.	OMW	8/27/2008
244	Antibiotic Administration: Allergy	Regarding allergies, what if a patient develops a new allergy from this surgical encounter? For example, given ancef prior to procedure then 10 minutes later patient develops a hive. Post-procedure (recovery room) documentation would now list ancef as an allergy, do we answer yes or no to "Allergy"?	If there is documentation of an allergy to a beta-lactam, penicillin, or cephalosporin, answer "yes" to Antibiotic Allergy. It doesn't matter when it is documented.	OMW	10/15/2008
245	Antibiotic Administration: Allergy	Given that a patient has an allergy to Penicillin, I noticed that the administration of Clindamycin is appropriate for almost every category of procedure with the exception of Neurological. Therefore, according to the manual, a patient undergoing a Laminectomy procedure who is allergic to Penicillin should not receive Clindamycin as a prophylactic antibiotic. I cannot understand why this would be so. Can you please confirm if this is correct?	That is correct. Clindamycin will be added as an acceptable antibiotic for neurological procedures for 7/1/09. The reason it was not listed as acceptable is because the guidelines do not recommend it. Because we have traditionally allowed Clindamycin to be used with other allergy documentation on the inpatient side, we will change it for the outpatient setting.	OMW	10/15/2008
463	Antibiotic Administration: Allergy	Regarding Question #244 on grid on antibiotic allergy, should the documentation of allergy only refer to pt status prior to procedure? If you document "Yes" for allergy, then it would be confusing as to why he received ancef?	The algorithm looks for the correct antibiotic given. If Ancef is the appropriate antibiotic, the case will pass regardless of how Antibiotic Allergy is answered.	OMW	10/15/2008

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52	Antibiotic Administration: Documentation	We have an electronic med MAR, we have 2 different terms as given and performed, sometimes the times are different, which one should we use, given may say 1800, but performed may say 17:57.	As long as one of the antibiotics is given within 60 minutes prior to incision, the abstractor can answer "yes" to Antibiotic Timing.	OMW	7/16/2008
53	Antibiotic Administration: Documentation	Date/time/initials on ED record for Antibiotic administration. Nurses put time and initial on ER face sheet and the date is on the top of this sheet so therefore nurses do not place a date because it is noted at the top of the sheet. Is this acceptable.	Yes.	OMW	7/16/2008
54	Antibiotic Administration: Documentation	Does each medication given have to have the route listed even if it is a medication that can only be given IM?	Yes. This is a Joint Commission standard.	OMW	7/16/2008
55	Antibiotic Administration: Documentation	Regarding antibiotic administration: Our MARs are set up so the ordered medications take up about 2/3 of the page. For the nurses who administer medications to the patients for that day, the bottom of the MARs page leaves space for the nurses to sign their names and a place for their initials. Several nurses' initials and signatures will be listed in the signature space. Each medication on the MAR is timed and when given the nurse puts a line through the time to signify the medication was given. Do the nurses need to initial next to the time or is it sufficient that the nurses have signed the bottom of the MAR?	No, that is not necessary.	OMW	7/16/2008
56	Antibiotic Administration: Documentation	If there is a order for a ATB written on an Order sheet or the ER face sheet the RN must date, time, and show that the ATB was given and Initial the transaction as well as show the route of the ATB. But in surgery if the CRNA or RN transcribes the order onto a pre-op sheet, anesthesia record, or a recovery room preprinted form or checklist, do they need to complete all of the same requirements as mentioned above? Or do I just need to make sure that the requirements of date, time, route, and Signature are found all on one place, page on the form?	That is acceptable.	OMW	7/16/2008

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57	Antibiotic Administration: Documentation	For antibiotic admin, is date, time and initials ONLY required for outpatient cases.	There must be documentation of administration. The date, time and initials do not have to be on the same line, but should be present in the medical record to show administration.	OMW	7/16/2008
58	Antibiotic Administration: Documentation	You have mentioned that there must be a date/time by the name of antibiotic/initials. If there is an EP log and the antibiotic/route listed in a time frame on the log and the date is located on the bottom of the page and the physician signs the log ... Is this acceptable?	Yes.	OMW	7/16/2008
59	Antibiotic Administration: Documentation	For antibiotic documentation- our anesthesia record has date listed on the top of the form- the antibiotic is timed and signature of person administering antibiotic- It is acceptable for SCIP. Why would it be different for HOPS?	It is acceptable. The date/time/initials or signature do not have to be on the same line.	OMW	7/16/2008
60	Antibiotic Administration: Documentation	I want to clarify: if my nurses initial a medication on an MAR, does that count? I understand the noting of the med, but initialing next to the time the med is given should be plain to see and be abstract-able.	That is acceptable.	OMW	7/16/2008
61	Antibiotic Administration: Documentation	For the HOP surgery do you list all antibiotics given during the stay? Even if some of the antibiotics are after surgery?	Yes. All antibiotics are collected regardless of when they were administered. Example: If Ancef if given IV 3 times during the stay, Ancef IV is entered once. If another antibiotic is given postoperatively orally, the name and route of that antibiotic is collected also.	OMW	7/16/2008
62	Antibiotic Administration: Documentation	On an anesthesia record, the anesthesiologist wrote the antibiotic on a line in the lower section of the record with a vertical line which appear to correspond with a time line from the upper section w/no actual time - can this be used for time abstraction	This seems to be common practice. If the antibiotic corresponds to a time on the timeline, it can be used as the administration or start time of the antibiotic written on the line.	OMW	7/16/2008
109	Antibiotic Administration: Documentation	Is there any thought about excluding a case from OP-6 when OP-7 falls out with no antibiotic ordered? This would appropriately reflect the data and care of the patient.	We are actually going to exclude the case from OP-7 if no antibiotics are given during the outpatient encounter. The case will only fail one measure and be excluded from the other.	OMW	8/27/2008

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110	Antibiotic Administration: Documentation	For surgical procedures (OP-6 and OP-7), the description for antibiotic ROUTE instructs abstractors to consider any antibiotics administered via an appropriate route (IV, PO, UTD). The algorithms, however, do not seem to indicate that the abstractors are supposed to enter all medications that are prescribed during the stay. For instance, consider a patient that receives the appropriate antibiotic(s) for the procedure as per the tables, by the appropriate route (IV with the exception of transrectal biopsy) and within the 60 minute period (or 120 minutes for Vanco or Quinolones) prior to surgical incision. Our abstractor will enter this ABX. If this same patient receives an oral Abx the next day or any time prior to discharge, the abstractors are also entering that medication into the vendor tool. Is this the way the indicator was intended to be interpreted? It is my understanding that this causes cases to fail.	The algorithms may not USE the route, but the oral, IV, and UTD routes should be entered into the collection tool. If oral antibiotics only are administered, the case is excluded from OP-6.	OMW	8/27/2008
111	Antibiotic Administration: Documentation	For Outpt surgeries in the data field Antibiotic Name, do we enter every dose of antibiotics the patient received during the outpatient event? For example, I have a patient who stayed 23 hours and received 2 different antibiotics, one of which had several doses. Do I enter each antibiotic dose given or just the 2 different antibiotic names and routes? What if the route changes with the multiple dose ATB? What about the patient who stays longer than 24 hours (i.e., 48 hours)? Are we to collect all antibiotics through 48 hours, regardless of name, or do we just put down the names of the different antibiotics?	The outpatient stay should not be longer than 24 hours, but if it is, the antibiotics for the entire outpatient encounter should be collected. You list the name and route of every antibiotic administered during the encounter, but if the same antibiotic is given more than once with the same route, it is entered once only. For example, if Ancef were given IV three times during the stay, only Ancef and IV would be collected once. If Cipro IV was given twice and then changed to PO route, you would collect Cipro twice, once for IV route and once for PO route.	OMW	8/27/2008
112	Antibiotic Administration: Documentation	For data elements Antibiotic Name & Route - do we abstract/report only those antibiotics which fulfill the timing & selection measures (IE: appropriate drugs received w/in 60-120 minutes prior to incision), or do we abstract/report ALL antibiotics received by an appropriate IV route during the ENTIRE outpatient encounter?	The abstractor is to collect all of the antibiotics given during the outpatient stay. The antibiotics given orally should also be collected.	OMW	8/27/2008

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113	Antibiotic Administration: Documentation	If a pt is NOT on an antibiotic and therefore you answer 'No', then is it correct to also answer 'No' to Timing Question? Seems like for the Timing question there would be a 'NA'. If you can not determine the 'Time' from the medical record (I.E., there is none recorded- just the antibiotic and route), do you just answer 'No'. Seems like there should be an option of "Undetermine" for time.	There are two separate measures and adding the UTD option to the "no" value would still fail the measure. It has been decided that cases will only fail one measure instead of both for the 1/1/09 manual.	OMW	8/27/2008
114	Antibiotic Administration: Documentation	GU case – Cipro was noted in the Brief Op-Note under “antibiotic prophylaxis, if indicated” and the Op-report noted that a confirmation of “preoperative antibiotics” was obtained. No other doc. of prophylaxis was found. How are we going to answer this as to antibiotic started within 60 minutes?	There is no documentation of administration in your example. Answer "no" to Antibiotic Timing.	OMW	8/27/2008
115	Antibiotic Administration: Documentation	If the cath lab nurse documents a timed note "Ancef 1 Gm IV, VOV" (VOV = verbal order verified) in the nurse's procedure notes, and the medication list at the end of the procedure notes (listing all medications given during the procedure) has the same time & same note ("Ancef 1Gm IV, VOV") documented, can we consider the time documented in the nurse's procedure notes / list of meds as the medication administration time? Per routine practice, there is no anesthesia record or intra-procedure medication administration record associated with outpatient procedures done in our cath lab. We have only the nurse's procedural notes & the physician's handwritten procedure note & physician's dictated procedure report. Per cath lab staff interviews, this is the time that the medication was administered, but we need to know if their documentation meets core measures specifications requirements.	Yes, that is acceptable.	OMW	8/27/2008
116	Antibiotic Administration: Documentation	For antibiotic initiated within 60 minutes...what should we answer if the antibiotic is given at the same time as the surgery starts? For example, if the prophylactic abx is given at 1758 and the surgery start time is 1758 would that be a “no” for abx timeliness for Ancef?	If the antibiotic is given at the same time as the surgery starts ... Answer "yes."	OMW	8/27/2008

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235	Antibiotic Administration: Documentation	The general abstraction guidelines include "hung" as acceptable indication of administration of IV med on physician order form-is this term acceptable in nursing documents as well?	Because we do not specifically exclude that type of documentation, we will accept it as indication that the medication was administered.	OMW	10/15/2008
236	Antibiotic Administration: Documentation	Our Urologist is only documenting that "the patient states he took his antibiotics". There is no other specific documentation. Can I still count this as receiving an ATB for this encounter even though I do not know specifically which medication or route...was used for the transrectal prostate biopsy?	From this documentation, you cannot determine what antibiotics were taken and you cannot determine the route. Because the data element specifies that it must be oral antibiotics, you will have to answer "no" to Antibiotic.	OMW	10/15/2008
237	Antibiotic Administration: Documentation	If the preop antibiotic is charted on the nurses notes in the holding area and it states time, antibiotic, route administration, and signature. Is that acceptable. There is no given or other such documentation.	That is acceptable documentation of administration.	OMW	10/15/2008
238	Antibiotic Administration: Documentation	OP Note by Surgeon documents that antibiotic given e.g., Prior to the surgery beginning "Kefzol @ 2 gm IV was given to the patient." If for some reason other documentation did not get made can we use this as proof an antibiotic was given?	The data element says that the documentation must reflect actual administration. Usually, the surgeon is not going to be administering the antibiotic. The anesthesiologist (MD) may administer and document on the anesthesiology record, but the information in the Operative Report would most likely NOT reflect actual administration. If the nurse is documenting that she gave the antibiotic but does not document the time, it can be collected but it cannot be used to answer Antibiotic Timing because a time is not available.	OMW	10/22/2008

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246	Antibiotic Administration: Documentation	If the administration of IV Ancef is documented on the preop record, but Ancef (without a route noted) is also listed on the anesthesia record (for informational purposes, in a space labeled Preop Antibiotic), must we abstract both Ancef with an IV route AND Ancef with an UTD route? (For inpatient SCIP, we are receiving mismatches on validation review when we don't abstract the preop antibiotic listed on the anesthesia record, even though we don't consider that documentation to represent actual administration of the antibiotic.) ... Signature or initials signifying administration of the antibiotic are required in order to abstract it. For inpatient core measures, we are advised that the signature does not have to be next to the antibiotic documentation; it just has to be somewhere on the form. Is this also true for outpatient measures?	Because the route differs, abstract them both. The signature does not have to be next to the administration information.	OMW	10/15/2008
247	Antibiotic Administration: Documentation	I was wanting further clarification on the documentation of the pre-op antibiotic. My EP lab currently uses an order set to document their antibiotic administration. They have the antibiotic listed, the appropriate route, and time, and then sign their name at the bottom of the order set. Would this be considered correct for abstracting info, or would they have to write "given" or "administered" in addition to the previous? They also document their antibiotic on the EP lab record, however, the route is currently not listed (being incorporated for future use). Can the antibiotic information be abstracted from more than one source??	Because this is an order set, additional documentation would be required. There must be documentation that the antibiotic was actually administered. Combining information from more than one source is not acceptable. UTD should be used for missing information.	OMW	10/15/2008
248	Antibiotic Administration: Documentation	For OP-7, can you please clarify the rationale in submitting antibiotics that were given during the outpatient encounter (i.e., in addition to pre-op)?	If the correct antibiotic is given anytime during the outpatient encounter, the case will pass OP-7.	OMW	10/15/2008
249	Antibiotic Administration: Documentation	Is it true if a patient is prescribed oral antibiotics at a visit prior to the encounter visit; as a preparation for the encounter, you may not use the prior visit information?	It must be documented that the patient took the oral medication in preparation for the encounter. The prior visit instructions are not acceptable at this time.	OMW	10/15/2008

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250	Antibiotic Administration: Documentation	Our anesthesiologists give the pre-op antibiotics but never chart the route because they say they only give them IV unless otherwise noted on the chart. The instructions say not to make inferences or assumptions, is it alright to abstract these as IV?	No. We have suggested that the forms be modified or a sticker attached that states "All antibiotics given IV unless otherwise specified" for the inpatient surgery measures. The same concept could apply here.	OMW	10/15/2008
251	Antibiotic Administration: Documentation	Are you saying that if the anesthesiologist puts the time & dose on the anesthesia grid (next to the preprinted antibiotic name), we can't accept that because he/she didn't write "hung" or "given"?	The anesthesia record does not require that. The signature on that form is enough to collect as documentation of administration.	OMW	10/15/2008
252	Antibiotic Administration: Documentation	You mentioned that on the physician's order form, an antibiotic cannot be abstracted as being given if there is only a time and initials and that it must also have "given" hung", etc. because it can be misinterpreted as the order being noted. Our nurse notes a time and initials beside the antibiotic when he/she gives it and also notes the entire order with "noted" and date, time and initials. Would this count for actual administration?	There should be additional documentation indicating that the antibiotic was administered.	OMW	10/15/2008
253	Antibiotic Administration: Documentation	If a medication reconciliation form is present on the procedure visit, can that list be used to verify if antibiotic is taken prior to incision?	Yes, definitely.	OMW	10/15/2008
254	Antibiotic Administration: Documentation	Anesthesiologist documents admin of the pre-incision antibiotic on the anesthesia grid (vertical lines at 5 minute intervals) w/statement that abx given IV. A horizontal line is drawn on the grid from the drug start time to end time. How do I abstract?	You can use the left end of the grid line to determine the initiation time.	OMW	10/15/2008
129	Antibiotic Administration: Name	Can we use the generic name of an ATB even if the product name is listed?	Yes. Either name on the crosswalk can be used.	OMW	8/27/2008
239	Antibiotic Administration: Name	When there is more than one IV antibiotic listed, do I abstract all antibiotics or only the one closest to cut time?	The abstractor is to collect all of the antibiotics that are given during the outpatient encounter. If one antibiotic is given more than once by the SAME route, it is to be collected and entered into the grid only once.	OMW	10/15/2008

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255	Antibiotic Administration: Name	If more than one dose of an IV antibiotic is given do we record all doses given? For example patient receives one pre-op dose of IV Kefzol and two post-op doses of IV Kefzol. Do we abstract and enter Kefzol IV once or three times?	Abstract Kefzol with IV for the route just once. If the route of an antibiotic were to change during the stay (from IV to PO), the antibiotic is abstracted twice. Once with IV route and once with PO route.	OMW	10/15/2008
256	Antibiotic Administration: Name	For urology procedure a physician indicates in H/P that appropriate oral quinolone given prior to arrival without name of drug - How do I abstract this?	Do not collect it if there isn't any indication that the patient took the antibiotic. If there was documentation that the patient actually took an ORAL quinolone, you could enter Antibiotic NOS into the grid.	OMW	10/15/2008
257	Antibiotic Administration: Name	Patient listed oral antibiotic on home med list...there is no documentation of infection or that the antibiotic was prophylactic. How do I abstract that?	If it's not documented as prophylaxis or that it was only taken once prior to surgery, do not collect this antibiotic in the grid.	OMW	10/15/2008
258	Antibiotic Administration: Name	The patient had a PROSTATE BIOPSY. The patient was given LEVAQUIN PRIOR TO ARRIVAL. Gentamycin IV and Ampicillin IV were given within 60 min. prior to incision time. Which antibiotics are going to be entered in the ANTIBIOTIC GRID?	If there is documentation that the Levaquin was given PO and that the patient took the Levaquin prior to arrival, it can be collected as given during the stay. If the Levaquin is documented as above, collect Levaquin PO, Gentamycin IV, Ampicillin IV in the antibiotic grid.	OMW	10/15/2008
259	Antibiotic Administration: Name	How should #7 for OPPS SCIP be answered if Vancomycin was not administered as the antibiotic? Should it be left blank or should we answer as 9-UTD?	If your electronic tool requires that the Vancomycin data element is answered whether it was administered or not, use Allowable Value 9.	OMW	10/15/2008
260	Antibiotic Administration: Name	If in the procedure note the physician documents the patient following pre-operative instructions is this enough of a reference to refer to previous physician note to review for preop instructions and possible medications ordered?	No. That's not adequate documentation.	OMW	10/15/2008

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261	Antibiotic Administration: Name	Antibiotic with urological procedures – Can you provide clarification regarding the guideline for oral antibiotics taken prior to arrival for prophylaxis? If we have documentation of a prescription for a specific antibiotic (name, dose, route, schedule) being phoned to a pharmacy with instructions to start the day prior to the procedure but we do not have documentation that this specific antibiotic was taken prior to the procedure, we have not collected it, even if the surgeon documented in the procedure note that the patient had received “pre-procedure antibiotics” (without specifying name/route).	That is correct. There should be documentation that the patient actually took the prescribed antibiotic.	OMW	10/15/2008
262	Antibiotic Administration: Name	I submitted a question earlier this year (5/1/08) re: Cipro listed as a home med but also with the notation “taken the past 3 days” as ordered by MD (for a prostate biopsy). I was told it is okay to say “yes” in this case to Antibiotic received during this encounter. Is this still okay? And, if so, is a clarification addressing this situation coming with the next manual?	There will be additional instructions in the 7/1/09 manual addressing oral antibiotics taken prior to arrival.	OMW	10/15/2008
263	Antibiotic Administration: Name	Q&A Grid # 111 - Is this the same requirement as inpatient? [Q#111 - Do we enter every dose of ATB the patient received during the outpatient encounter or just the different antibiotic names and routes? Do we collect through 48 hours?]	This is different from the inpatient side because the inpatient measures require documentation of every dose and time.	OMW	10/15/2008
264	Antibiotic Administration: Name	If a patient receives Ancef as a prophylactic antibiotic, I answer "yes" to antibiotic. However, what if Ancef is not on the Approved Antibiotics (Appendix C) for the procedure I am abstracting. Am I correct in abstracting "yes" to antibiotic?	Yes. It doesn't matter if the antibiotic is the appropriate antibiotic.	OMW	10/15/2008
464	Antibiotic Administration: Name	The "antibiotic given in episode" Question allows IM antibiotics per spec manual, but the timing Question only will accept IV antibiotics, as well as antibiotic listing-we don't put in IM antibiotics. These cases get rejected, we certify complete. Is this acceptable?	If the only antibiotics given during the outpatient encounter are IM, answer "no" to Antibiotic. If the cases get rejected, they will need to be resubmitted to get credit.	OMW	10/15/2008

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470	Antibiotic Administration: Name	AMI pt presents to ER at 11:30pm on 10/1. Medication given 12:05 am . Date 10/1 is on first pg. The Med section on ER record is on pg 2 and does not have a date column. It is implied the date would be 10/2. Is this ok or do we have to write in the date?	The correct date can be implied and collected.	OMW	10/15/2008
478	Antibiotic Administration: Name	Please verify how to abstract if a patient lists abx as a home med but does not have infection or prophylaxis documented.	Do not collect that antibiotic and do not answer "yes" to Infection Prior to Anesthesia.	OMW	10/15/2008
484	Antibiotic Administration: Name	Regarding question 238: if MD or RN state ABX given prior to surgery but we cannot find a time is it still "yes" on the HOP extraction?	The data element says that the documentation must reflect actual administration. Usually, the surgeon is not going to be administering the antibiotic. The anesthesiologist (MD) may administer and document on the anesthesiology record, but the information in the Operative Report would most likely NOT reflect actual administration. #238 will be clarified. If the nurse is documenting that she gave the antibiotic but does not document the time, it can be collected but it cannot be used to answer Antibiotic Timing because a time is not available.	OMW	10/15/2008
486	Antibiotic Administration: Name	We are required to collect all antibiotics given IV or orally but OP-6 excludes patients who receive oral antibiotics only from the measure. Why are we required to collect the data on the oral antibiotics?	Because an oral antibiotic may allow the case to pass OP-7. If oral antibiotics alone are given, the case is excluded from OP-6, but may still be used for OP-7.	OMW	10/15/2008
47	Antibiotic Administration: Need For	A question from our physicians, please verify that each procedure included on the list requires the administration of an antibiotic.	That is correct.	OMW	7/16/2008
132	Antibiotic Administration: Need For	We are having cases that are considered non-compliant for Outpatient Surgery Antibiotic Administered within 1 hour of Incision for G-tube replacements. These cases, done in ER, GI lab and Radiology either replace a G-tube that a pt. accidentally pulled out or replace a G-tube with a new one. For these cases, there in no incision made. It is also not a standard to give antibiotics, since there is no surgical incision. How should we handle these cases?	Abstract these cases for now. The codes have been removed for 1/1/09. These measures are not being publicly reported at this time.	OMW	8/27/2008

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265	Antibiotic Administration: Need For	I am confused about what a routine antibiotic might be given for? Is this related to a possible infection at other than the surgical site, or possibly acne treatment? Please be more specific. Thank you	A routine antibiotic may be one given for an infection present prior to arrival or one that is given a prophylaxis for recurrent UTIs or one that is given for acne.	OMW	10/15/2008
266	Antibiotic Administration: Need For	I am finding on our anesthesia records for patients who have prostate needle biopsy they are documenting antibiotics not indicated.	The AUA guidelines recommend antibiotic prophylaxis for that procedure.	OMW	10/15/2008
267	Antibiotic Administration: Need For	Please clarify why we are collecting antibiotics given post-operatively for surgical outpatients. My institution only gives antibiotics prior to surgery.	We give the facility credit if the correct antibiotic is given anytime during the outpatient encounter. One preop dose of antibiotic is the recommended prophylaxis, so your facility is providing prophylaxis according to guidelines.	OMW	10/15/2008
551	Antibiotic Administration: Need For	Why are the antibiotics used in genitourinary (GU) cases included in the measure specifications?	There are recommendations by the American Urological Association (AUA) to provide antibiotic prophylaxis for those procedures. The AUA guidelines can be found at: http://www.auanet.org/guidelines/ . Scroll down to Antimicrobial Prophylaxis for Urologic Surgery.	OMW	8/6/2008
51	Antibiotic Administration: References	In regards to the abx selection for outpatient surgery - I understand there are issues related to the podiatry codes that will be changed mid 2009. I have surgeons who are questioning where the evidence is for the selection of abx for their specific specialty. I have tried to pull the information together for them based on the references in the specification manual, but it is a daunting task. Do you have specialty specific guideline references for the OP abx choices that you could share?	See the end of this document for a complete list of references from the Measure Information Form for OP-7. The Medical Letter, the ACOG Practice Bulletin Number 74, the Johns Hopkins online guide, The Sanford Guide, and ASHP were all used for the antimicrobial prophylaxis recommendations.	OMW	7/16/2008
127	Antibiotic Administration: References	The MDs state that the ABX literature used to develop the outpatient measures is old, especially the GI literature. Please comment.	We used the most current guidelines available. Please emphasize that we used guidelines, not just studies done on certain antibiotics.	OMW	8/27/2008

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268	Antibiotic Administration: References	I had received an email on June 16 through Rita Smith (On SCIP list serve) in reference to updating the recommendations to allow Clindamycin for OPPS laminectomy. However, on the new specs manual for 1/2009, I still show that only Vancomycin is allowable for a laminectomy procedure. My concern is that I have an orthopedic surgeon doing lamis and he is giving Clindamycin for beta-lactam allergy. I had held off on educating him, because in the email from Rita, you had stated that you were having an upcoming TEP teleconference and this would be addressed. Could you please give me some feedback as to why this is still recommending Vancomycin, I need rationale to give to the orthopedic surgeon.	The specifications for the January 2009 manual were completed in July of 2008. The next manual (for 7/1/09 encounters) will have this change.	OMW	10/15/2008
474	Antibiotic Administration: References	I need the sources for antibiotic choice for procedure 57288-synthetic pubovaginal sling. Can you please tell me where to find these?	The new AUA guidelines have been posted. Updated AUA guidelines: http://www.auanet.org/content/guidelines-and-quality-care/clinical-guidelines/main-reports/antimicroprop08.pdf	OMW	10/15/2008
522	Antibiotic Administration: References	Is there a summary sheet that shows acceptable antibiotics by procedure? It is cumbersome to switch between the data definition and Tables/Appendices as presented in the Spec Manual.	Please contact the HOP QDRP SC at hoppqdrp@fmqai.com with a request and we will forward the resource to you.	HOP QDRP SC	10/15/2008
523	Antibiotic Administration: References	You mentioned on the call that you have received tools from some facilities, i.e.: medication table. Are these posted to MedQIC or you web site or will they be in the future? Could you post these to an HOP email for the time being?	In the future, these tools, as well as other tools and materials shared by hospitals, will be posted on the HOP QDRP website. This website is currently under development and is anticipated to be 'live' by the first of the year.	HOP QDRP SC	10/15/2008

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552	Antibiotic Administration: References	What guidelines were used for recommended antibiotics for cases eligible for the OP 6 and 7 measures?	The recommended antibiotics that are included in these performance measures are based on published guidelines and a new guideline on antimicrobial prophylaxis that has been written by AUA (J Urology 2008, in press). The citations for the guidelines are listed in the Selected References section of the Measure Information Form for OP-7.	OMW	4/23/2008
130	Antibiotic Administration: Route	We have a patient that received Fluconazole post operatively. This is not in the drop down box, and there is no option for antibiotic NOS. Are antifungals not to be listed? How are we to handle this when listing antibiotics?	You are correct that fluconazole (as an antifungal) should not be collected as an antibiotic. There is an "Antibiotic Not Otherwise Specified" listed in OP Table 6.0 in Appendix C, but it should not be used for this medication.	OMW	8/27/2008
131	Antibiotic Administration: Route	Where there is documentation that the antibiotic was given via piggyback, am I able to abstract IV as the antibiotic route?	No. That is not enough to be able to determine that the antibiotic was given intravenously.	OMW	8/27/2008
234	Antibiotic Administration: Route	On the anesthesia form there is a section marked MEDS AND IV'S in which Vancomycin is listed. Even though no route is not documented the "MEDS and IV's" certainly implies the meds are given IV. Can this pass for antibiotic route? Please advise?	The section of the form is designated "Meds and IVs" but that does not indicate that all of the medications listed in that section are given IV. The Vancomycin can be used to answer "yes" to Antibiotic, but the route is missing, so Antibiotic Timing is "no."	OMW	10/15/2008
269	Antibiotic Administration: Route	OP-6, OP-7 Data Element "Antibiotic" – Guidelines for Abstraction specify inclusion of antibiotics given Intravenous, PO/NG/PEG tube, and Intramuscular. However, Data Element "Antibiotic Route" only specifies inclusion of antibiotics given Intravenous and PO/NG/PEG tube. Is any data collected from IM antibiotics?	No. Only IV, PO and UTD are collected for the data elements Antibiotic Name and Route.	OMW	10/15/2008
270	Antibiotic Administration: Route	The antibiotic was documented on the OR electronic record as Cefazolin 1GM/50 ml NS bag with date, time, initials, and site of administrations as RAC (right antecub) with a rate of 50. Can this be abstracted as IV since the site is antecubital?	No. The route is not documented.	OMW	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
271	Antibiotic Administration: Route	if there is documentation of an antibiotic and time administered but no route, we know we need to answer "UTD" for the route for question #4, but how should we answer question #5 regarding the time of antibiotic initiation in relation to incision time? Do we have to answer "no" since there is no route documented or is the time and antibiotic name enough?	The first bullet of Antibiotic Route indicates that the UTD route can be collected in the grid. However, for the data element Antibiotic Timing, answer "no" because it specifically collects information on the IV route only.	OMW	10/15/2008
271	Antibiotic Administration: Route	We have documentation for prostate needle biopsy patients that states "patient given oral Cipro" or "patient took Cipro tab". Can I pass this even though PO isn't given as a route? It is obvious the patient took the medication PO.	The documentation of "patient given oral Cipro" would be acceptable to abstract as given PO. The other documentation does not contain a route.	OMW	10/15/2008
458	Antibiotic Administration: Route	In reference to Q#246 - if both entries of the same antibiotic dose are abstracted, will the route then pass the measure? And if this record goes to validation will the validators look at both record pieces?	The UTD route will not be used to pass the measures. In validation, the abstractors will follow the guidelines in the data dictionary. The data dictionary instructs the abstractors to collect the two doses of antibiotics because the route differs.	OMW	10/15/2008
48	Antibiotic Administration: Selection	Regarding OP-6 and OP-7: The specification manual mentions that for urologic procedures, if a patient takes a P.O. antibiotic at home prior to arrival, you can answer yes to the question "Did the patient receive an antibiotic during this encounter?"	This is correct. This is acceptable practice for certain urological procedures and the facility will score appropriately if the correct antibiotic was administered as prophylaxis prior to arrival. By collecting this information as administered during the encounter, the algorithm will be able to determine whether the correct antibiotic was given as prophylaxis.	OMW	7/16/2008
49	Antibiotic Administration: Selection	My question is this: Can a PO antibiotic taken at home prior to coming in for transrectal biopsy of the prostate be considered timely for the OP-7 measure?	No. If oral antibiotics alone are given for the transrectal biopsy, the case is excluded from the timing measure or OP-6.	OMW	7/16/2008
50	Antibiotic Administration: Selection	In the in-patient measure when a patient has in his history a antibiotic prior to admission the antibiotic is not included in the data. I did not see this as an exclusion for the outpatient measure., yet a patient is not always due to infection i.e. may have (incomplete transcription.)	The physician should document an infection preoperatively. The HOP QDRP measures do not have the same exclusion as the inpatient measures. For the corresponding HOP QDRP quality measure, physician documentation is relied upon	OMW	7/16/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
119	Antibiotic Administration: Selection	We have a surgeon who orders Gent. to be given IM. I have not been including this as an antibiotic that has been given because the data dictionary says to only include given via an appropriate route - IV or PO. Is this correct?	That is correct.	OMW	8/27/2008
120	Antibiotic Administration: Selection	Why are lap cholecystectomies medicated ONLY if >70?	Antibiotic prophylaxis is only recommended for this procedure when the patient is at high risk. Increased age places this population at higher risk for infection.	OMW	8/27/2008
121	Antibiotic Administration: Selection	If the physician doesn't order an antibiotic for a procedure that is on Appendix A as one that requires it, can he just say, "the patient doesn't require it"?	No. The procedures listed in OP Table 6.0 should have antibiotic prophylaxis.	OMW	8/27/2008
122	Antibiotic Administration: Selection	The antibiotic table on OP-7-4 and 5 for hysterectomy appears to have a few different selection/combo's than the inpatient antibiotics for the same surgery. I think this must be an oversight. Can someone verify the antibiotics for the OP hysterectomies?	The hysterectomy recommendations are exactly the same. The recommendations for the pubovaginal sling (outpatient) are not the same as the inpatient hysterectomy recommendations.	OMW	8/27/2008
123	Antibiotic Administration: Selection	Since CMS has recognized that many of the original procedures don't require antibiotics it doesn't make sense for us to ask our MDs to administer them for the next 6 months. However, we don't want our publicly reported data to look like we are providing sub-standard care.	These measures are not being publicly reported at this time.	OMW	8/27/2008
124	Antibiotic Administration: Selection	What are preferred antibiotics for tissue expanders and implants?	There are no recommendations for plastic and reconstructive procedures at this time. For any of these clean operations, the preferred agent would be cefazolin or cefuroxime.	OMW	8/27/2008
125	Antibiotic Administration: Selection	The plastics surgeons put patients on extended antibiotic doses (>24 hrs) post-op when there are drains involved, but they are not entertaining possible or R/O infections. How would they justify this so it doesn't become a fall-out?	We exclude plastic and reconstructive surgery for antibiotic duration because of lack of studies. There is no theoretical reason that these operations should behave any differently than other operations with one exception - in major reconstructive surgery, the area is often relatively avascular.	OMW	8/27/2008
126	Antibiotic Administration: Selection	Discuss the use of Invanz for Laparoscopic Appendectomy. Why is this antibiotic not on the approved list?	There are no guidelines that recommend Invanz yet. There should be no need for carbapenems in the outpatient setting.	OMW	8/27/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
240	Antibiotic Administration: Selection	Our OP surgeons want to know if they document that an antibiotic is not deemed necessary for a particular outpatient surgical procedure (e.g. AVF formation, Lap. Appendectomy, etc.) would these cases fail to meet the indicator: "Did the patient receive an antibiotic during this outpatient encounter?" and thus be considered non-compliant or failure?	All of the procedures being collected for the surgery population should have antibiotic prophylaxis, according to guidelines. If an antibiotic is not given, the case will fail.	OMW	10/15/2008
241	Antibiotic Administration: Selection	Regarding OP-7 With our April and May abstractions, we had OFI Antibiotic Selection for Neuro OP cases in which patients with a documented PCN allergy received Cleocin. OP Table 6.0 suggests Cefazolin and Nafcillin (both PCN) and Vanco (which seems excessive). Why is Cleocin not acceptable?	Clindamycin will be added as an acceptable antibiotic for neurological procedures for 7/1/09. The reason it was not listed as acceptable is because the guidelines do not recommend it. Because we have traditionally allowed clindamycin to be used with documentation of allergy on the inpatient side, we will change it for the outpatient setting.	OMW	10/15/2008
242	Antibiotic Administration: Selection	I know that when we started the inpatient SCIP project we had some changes in the antibiotic regimen but having so many choices that differ vastly differ from the inpatient for this type of surgery makes it difficult to have doctors provide the same standard of care for patients. Why is there so many choices and why is it so different from what we expect for our inpatient cases?	The antibiotic selections are not that different for many of the procedures. The procedures are different, but the antibiotic recommendations only follow guidelines.	OMW	10/15/2008
243	Antibiotic Administration: Selection	We are trying to adjust our outpatient surgical protocols to meet the requirements for HOP antibiotic selection. We noted that the Genitourinary Section of the table for Antibiotic Selection has been deleted from the January 2009 HOP Manual. I was informed that the AUA is revising the guidelines and the codes would remain in the manual for OP-6 as a "placeholder" until the guidelines have been updated. Are you anticipating that this revision will be complete prior to 1/1/09 or for another quarter in 2009?	The codes remained in Appendix A and the urological procedures were abstracted for OP-6 only for 1/1/09. They will be added back to OP-7 starting with 7/1/09.	OMW	10/15/2008
272	Antibiotic Administration: Selection	For SCIP: Why is IM Gent not allowed for Transrectal prostate biopsies? We routinely give this, but I cannot include.	It is not recommended in the AUA guidelines.	OMW	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
273	Antibiotic Administration: Selection	CPT code 36830 Vascular access for hemodialysis - My understanding of the procedures that would be covered under this code are permacaths and quintons. Would the appropriate antibiotic selection be cefazolin or cefuroxime? Is Vancomycin reserved only if there is a B-lactam allergy?	That code is included in the Cardiac table (OP Table 6.1), so the recommendations are Cefazoline or Cefuroxime for first choice. Vancomycin is acceptable only with a reason for use as prophylaxis. If it is used because of a beta-lactam allergy, the allergy should be documented.	OMW	10/15/2008
274	Antibiotic Administration: Selection	Under the Prophylactic Antibiotic Regimen Selection for Surgery table under laparoscopic cholecystectomy it states in bold only if age >= 70. Does this mean that the antibiotic recommendations are only applicable to patients > = 70 and that patients less than 70 are not in the measure population for OP-7?	That is correct.	OMW	10/15/2008
275	Antibiotic Administration: Selection	If I enter the aminoglycoside (Gent) as the #1 antibiotic on a patient who received dual antibiotics (e.g., ampicillin & Gentamycin & both given at the same time) for a penile prosthesis insertion, will this case be accepted or rejected b/c of the ampicillin?.	The algorithm looks at all of the antibiotics entered into the grid. For the penile prosthesis insertion, the aminoglycoside must be given with either cefazolin/cefuroxime or Vancomycin. Ampicillin alone will not pass. Ampicillin combined with an aminoglycoside will not pass. Ampicillin/Sulbactam will pass or the aminoglycoside combined with the above-mentioned antibiotics.	OMW	10/15/2008
276	Antibiotic Administration: Selection	Pt under 70 years old, came in for elective lap chole. Had incidental lap appy along with scheduled procedure. Pt. received Ancef pre-op. This is the approved antibiotic for lap chole, but because the patient is under 70 years of age, the lap appy only pulls over as a procedure. Question: will this fall out because Ancef only was given?	We do not have an exclusion for this scenario. The case will fall out because the guidelines recommend Cefazolin + Metronidazole.	OMW	10/15/2008
477	Antibiotic Administration: Selection	My question concerns the Prophylactic Antibiotic Regimen Selection for Surgery. Lap Chole surgery only if age >= 70 do we interpret Clindamycin + or - Aminoglycoside as Clindamycin with or without Aminoglycoside or Quinolone.	Clindamycin monotherapy is acceptable. The other antibiotics do not have to be given to pass the measure.	OMW	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
277	Antibiotic Administration: Selection CPT Code: Multiple Procedures Infection Prior to Anesthesia	Surgeon takes a patient into surgery for some GI procedure - appropriate abx is given pre-op. Discovers "hot" appy and now, in addition, performs an appendectomy. The appendectomy becomes the primary dx. However, the abx given originally, is NOT the appropriate drug for the appy and so the abstraction fails on appropriateness of abx selection. Q#1. If the GI Procedure was done first chronologically, that is the procedure that is abstracted. (not sure what the GI procedure was at this time) Q#2. If the CPT code for that GI Procedure is not on the OP 6.0 CPT code list then this case isn't a Core Measures case. Q#3. If the Appendectomy was done first chronologically, and the MD/APN/PA documented an infection or possible/suspected infection (acute abdomen, Sepsis, UTI, etc.) then the case is kicked out. Q#4. If the Appy was done first with no pre-op infection documented then we fall out.	A #1: Not necessarily. If the GI procedure is on Table 6.0, it's the one abstracted. Both of the procedures have to be on Table 6.0 for the "first chronologically" rule to apply. A#2: No. Another procedure that WAS on Table 6.0 was performed. That's what pulled the case in to be abstracted. A#3: If the appendectomy case is the one to be abstracted (because it's the only one on OP Table 6.0 OR it was the first performed if more than one procedure from Table 6.0 was performed), then you would answer yes to Infection Prior to Anesthesia. However, if any infection is documented preoperatively, regardless of whether the appendectomy is the case to be abstracted, the abstractor answers "yes" to Infection Prior to Anesthesia. A#4: If no preoperative infection was documented, answer "no" to Infection Prior to Anesthesia. If an appropriate antibiotic is given for the abstracted case, the case will pass OP-7.	OMW	10/15/2008
63	Antibiotic Administration: Timing	I cannot find Procedure time or start time on forms used in my institution, however the antibiotic is given IV. How do I answer the antibiotic timing question?	You will have to answer "no" to Antibiotic Timing.	OMW	7/16/2008
117	Antibiotic Administration: Timing	For data element Antibiotic Timing - does the future hold more clarification and/or supporting documentation requirements for this element? Currently we're not required to report antibiotic administration dates/times or surgery start date/times. Will this change in the future? Is there a way that the time of incision and antibiotic could be abstracted followed by calculation whether or not it was within 60 minutes?	We were trying to reduce abstraction burden and we have had positive feedback that this method of collection is preferred over the inpatient collection of all doses, time/date, and routes. We do not plan to change that feature.	OMW	8/27/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
118	Antibiotic Administration: Timing	In regards to antibiotic timing, the specific surgical procedure requires 2 antibiotics for appropriate selection. Gentamycin was given within 2 hours prior to surgical incision (not timely) and cefazolin was given within 1 hour of surgical incision time (timely). One was timely and one wasn't. Because both antibiotics are needed to meet selection criteria, do they both need to be timely in order to meet the timely criteria? Does it matter when the second type antibiotic is given before surgical incision or after - as long as one is timely? When more than one antibiotic is given which one or both should be within 60 minutes?	As long as one antibiotic was given timely, the case will pass OP-6. If a combination of antibiotics is recommended for OP-7, both antibiotics have to be given during the stay, regardless of when they are given. One of the correct antibiotics can be given preoperatively within 60 minutes prior to incision and the other one can be given 8 hours later. That's not ideal, but it will pass the measure.	OMW	8/27/2008
278	Antibiotic Administration: Timing	In the op-report for PPM Generator replacement, the following was documented, "The patient was given Kefzol 1 gm during the procedure." Questions: 1) How will you answer "Did the patient receive an antibiotic during this outpatient encounter?" Yes or No 2) Are you going to enter Kefzol in the antibiotic grid? Yes or No 3) How are we going to answer "was an antibiotic started within 60 minutes (120 minutes for Vancomycin or Quinolones) prior to surgical incision? Yes, No, or UTD	1. Yes, there is documentation that the patient received an antibiotic during the outpatient encounter. 2. Enter Kefzol with UTD for route. 3. The data element Antibiotic Timing must be answered "no" if the route is not documented.	OMW	10/15/2008
279	Antibiotic Administration: Timing	Antibiotic Timing – This data element applies only to antibiotics administered via the IV route. § If the documentation of preop antibiotic administration does not have the route specified, do we have to answer "No" to this question even if the antibiotic was administered within an appropriate timeframe? (If this is like inpatient core measures, we cannot assume an IV route if it was not documented in the single source from which we are abstracting – even if the order was for an IV antibiotic, or the route was noted in another source.)	Answer "no" to Antibiotic Timing because it specifically addresses the IV route. A note was added for the 1/1/09 manual to clarify this.	OMW	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
280	Antibiotic Administration: Timing	How should we answer #5 for OPPS SCIP if there is no time documented for antibiotic administration? Should it be left blank or should we answer "no" since we cannot determine if the antibiotic was given within the appropriate timeframe?	Answer "no."	OMW	10/15/2008
281	Antibiotic Administration: Timing	Why does the abstractor have to determine if the preop abx was given within 60/120 minutes? It would be much easier to abstract the time and have algorithm place in appropriate category. Including the time also helps to drill down the data. Right now the vendor does not have a report that includes the time abx was given. We do not know if the abx was missed by 2 minutes or 2 hours and then can not drill down to which department needs to address.	If the abstractor answers "no" to Antibiotic Timing, your facility should be able to determine whether the documentation or the timing of the actual administration of the antibiotic needs to be addressed. We have had a large amount of feedback that supports leaving the question as is.	OMW	10/15/2008
282	Antibiotic Administration: Timing	The first Note for Abstraction for this data element states "When abstracting this data element, consider all antibiotics ...". If multiple antibiotics are given and only one antibiotic was given within the 60 minutes (120 minutes for Vanco or Quinolone) prior to surgical incision time, then do we answer No to the Antibiotic Timing data element? Example: First antibiotic initiated at 09:45. Incision Time at 10:00. Second antibiotic initiated at 10:05. How would we answer the data element?	Only one antibiotic has to be given in the 60/120 minute timeframe. Answer "yes" to Antibiotic Timing if at least one antibiotic is given in that timeframe.	OMW	10/15/2008
283	Antibiotic Administration: Timing	The guidelines for antibiotic timing states to answer yes or no if an antibiotic was initiated within 60 minutes (120 minutes for Vancomycin or Quinolones) prior to surgical incision. My question is should my answer be no, if there is no documentation in the chart to support the <u>time</u> that the antibiotic was administered, since choosing UTD is not an option?	That is correct. If there is no time documented, answer "no" to Antibiotic Timing.	OMW	10/15/2008
284	Antibiotic Administration: Timing	Even though we are to collect all antibiotics administered IV or PO we can only answer "yes" to the question "antibiotic administered within 60 minutes of incision (120 minutes for vanco)" if an <u>IV</u> antibiotic was administered within 60 minutes of incision, correct?	That is correct. The data element Antibiotic Timing specifically addresses the IV route.	OMW	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
285	Antibiotic Administration: Timing	If the only antibiotic administered within 60 minutes of incision was Unasyn and the route was UTD, would we answer "no" to antibiotic administered within 60 minutes of incision?	That is correct. The data element Antibiotic Timing specifically addresses the IV route.	OMW	10/15/2008
286	Antibiotic Administration: Timing	We have a case where an OB/GYN began performing a diagnostic laparoscopic procedure (CPT 49320) - which does not require pre-operative abx / therefore, none given. She found an abnormality of the appendix (not infected) and requested an intra-op consult, a general surgeon came in and proceeded to complete a laparoscopic appendectomy. Prior to continuing his portion of the procedure, the general surgeon did give the appropriate abx. Question - how do we answer the question on abx timing since it was not anticipated the patient would require the appendectomy at the start of the procedure? Do we consider the incisions by the OB/GYN to be the start of the procedure or when the second surgeon actually began his procedure (the procedure of interest)?	The initial incision is the one to be used to determine whether the antibiotic was given timely. Because the antibiotic was not administered prior to incision, answer "no" to Antibiotic Timing. The specifications cannot account for all scenarios. This case will fail, but the expectation is not 100% for the performance measures.	OMW	10/15/2008
287	Antibiotic Administration: Timing	Pt. has been on scheduled abx. and now has surgery. No abx given within the 1hr. requirement, because pt. is on scheduled. How do we answer? Will this become a fallout? Thank you.	Yes. If the patient has been on a scheduled antibiotic, it would most likely be because of an infection. The infection should be documented. This case will fail if no infection is documented.	OMW	10/15/2008
472	Antibiotic Administration: Timing	Follow Up to #238 -- Is the time of administration required for the measure? Also, is an Op Note an acceptable source for this information?	#238 will be clarified. The documentation should reflect actual administration. The time of administration is used to answer the data element Antibiotic Timing. It does not have to be entered into the antibiotic grid. The Op Note usually does not reflect actual administration of the antibiotic.	OMW	10/15/2008
475	Antibiotic Administration: Timing	If there are multiple antibiotics being given, both pre and post surgery, do I answer that all were given timely? There is no way I can find to denote an antibiotic was given postop.	Please contact your vendor for this issue. According to the algorithm and measure specifications, the data element Antibiotic Timing should only be answered once.	OMW	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
133	Antibiotic Administration: Vancomycin	Are we supposed to answer the vancomycin questions for all patients or just patients that received vanco?	That depends on the electronic tool that you are using. Even if your tool requires that the Vancomycin data element be answered, it is only used in the algorithm if it was administered.	OMW	8/27/2008
134	Antibiotic Administration: Vancomycin	If no vanco used, and allergy question is a yes, do we say yes or no to the allergy question in the vanco section?	Answer "yes" to Antibiotic Allergy if a beta-lactam allergy was documented.	OMW	8/27/2008
135	Antibiotic Administration: Vancomycin	For IP SCIP Vancomycin is acceptable antibiotic for device implants. The physician has to document valve surgery but does not have to link this with use of Vancomycin. Why is this not the same for OP SCIP for pacemaker and/or AICD implants? Does the reason found documented need to be linked with the decision to use vancomycin?	The inpatient measures still require a reason for use of Vancomycin. We don't require the physician to link the two.	OMW	8/27/2008
136	Antibiotic Administration: Vancomycin	If an OP-SCIP patient received both a Beta-lactam IV antibiotic & IV vancomycin prior to the procedure, does the reason for using vancomycin still need to be documented in the medical record?	If the beta-lactam given was the appropriate antibiotic, the algorithm will not check the answer to the data element Vancomycin. If the beta-lactam was not appropriate, the reason for the Vancomycin will be required.	OMW	8/27/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
288	Antibiotic Administration: Vancomycin	Vancomycin –The Specifications Manual effective in 2009 states that physician/APN/PA/pharmacist documentation of reasons for not prescribing Vancomycin must be documented prior to surgery. ... In 2008 can we use documentation of reasons from anytime during the stay, or should we consider only preoperative physician/APN/PA/ pharmacist documentation? (Current inpatient SCIP specifications state that the documentation must be preoperative.) ... If the allowable values that require physician/APN/PA/ pharmacist documentation must be documented preoperatively, can documentation for the other allowable values be made anytime during the stay (especially in 2009, when they include history of hospitalization or nursing home stay)? ... I believe our current advice for inpatient SCIP is that the reasons for using Vancomycin don't have to be linked to the use of Vancomycin. For example, if a physician documents known MRSA colonization but does not explicitly state that this is the reason for using vanco, we can still abstract "2". Is this true for outpatient abstracting as well?	At this time, the documentation for the reason for using Vancomycin does not have to be documented preoperatively. We will make that change for an upcoming manual. The reason for use of Vancomycin does not have to be linked by the physician, but the reason must be documented by a physician. If the physician documents "known MRSA colonization" in the outpatient record, the abstractor can select Value 2 without the physician stating that he used Vancomycin because the patient had known MRSA colonization.	OMW	10/15/2008
289	Antibiotic Administration: Vancomycin	Do you leave question #7 - "What reason was documented for using Vancomycin?" blank if Vancomycin was not used?	If Vancomycin was not given, select "9" for Vancomycin.	OMW	10/15/2008
290	Antibiotic Administration: Vancomycin	I have a patient who has an allergy to penicillin and was not given ANY antibiotic. For the antibiotic question I answered no, for antibiotic timing I answered no, for Antibiotic Allergy I answered yes. My question is for the element of Vancomycin. Since the patient was not given Vancomycin do I enter anything for this element? I know this patient has a beta-lactam (penicillin or cephalosporin) allergy but is this used only when Vancomycin is given OR is this documented just to show the allergy. Basically I am not sure if I enter anything for this element if no vanco was given?	It depends on the electronic tool. If your tool requires an answer to Vancomycin, but Vancomycin was not given, enter Allowable Value 9.	OMW	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
291	Antibiotic Administration: Vancomycin	In reference to Vancomycin as the antibiotic given, if you mark "no documented reason/ unable to determine" what does this do to this case?	It depends on whether Vancomycin is an acceptable antibiotic for the procedure.	OMW	10/15/2008
292	Antibiotic Administration: Vancomycin	Question regarding justification for Vancomycin use. Per the Data dictionary, this measure is not to be utilized for the Out-Pt population at this time. Is this correct?	No, that is not correct. Only Value 7 is not to be used for the outpatient setting. In the inpatient setting, Value 7 is for a continuous inpatient stay and would not apply to the outpatient setting	OMW	10/15/2008
293	Antibiotic Administration: Vancomycin	If a patient undergoes surgery for a vascular access and receives Vancomycin pre-op, does the doc have to specifically document that he is using Vancomycin because this patient is a dialysis patient to select the allowable 6?	The physician has to document that the patient is undergoing dialysis; he does not have to connect the two.	OMW	10/15/2008
294	Antibiotic Administration: Vancomycin	This is in response to your answer for question 135. Vanco is an appropriate antibiotic for outpatient pacemaker insertions, however, the tool still required a reason for Vanco use.	Vancomycin is only appropriate for cardiac procedures WITH a reason. Please see the statement that accompanies the asterisk in the table in OP-7.	OMW	10/15/2008
480	Antibiotic Administration: Vancomycin	Question #290 answer re: response to Vancomycin data element ... "it depends on the electronic tool." Is the electronic tool where your data is entered? if this is correct, I use Outcome and if no Vancomycin given I do not have to enter Vancomycin reason, Is this correct?	If your tool does not "gray out" the Vancomycin data element, you should most likely enter an answer. IF the appropriate antibiotic is given, the algorithm will not look at Vancomycin. Please contact your vendor for this issue.	OMW	10/15/2008
485	Antibiotic Administration: Vancomycin	Why do you have to answer reason for Vancomycin if it was not given?	Some of the tools require you to answer all of the data elements. If Vancomycin was not given, enter Value 9.	OMW	10/15/2008
46	Antibiotics for Podiatry	The Podiatrists are VERY disturbed about the requirement to give ABX prior to incision even if they need to obtain a culture prior to giving the ABX (QNet sent us that ans.) This practice does not make sense since we measure Pneumonia on BC prior to ABX.	If documentation of an infection or possible infection can be made preoperatively, the case can be excluded. This situation cannot be compared to the PN topic. A comparison can be made to inpatient SCIP where the practice is the same: documentation of infection is required.	OMW	7/16/2008
137	Antibiotics for Podiatry	Why is it considered a "fallout" if the podiatrist needs to get a culture before he administers antibiotics? That is the measure on PNE and it makes no sense that it is not appropriate on outpatient surgery.	If the podiatrist suspects infection, it should be documented preoperatively. That would exclude the case. NOTE: The physician is already suspecting (and documenting) infection in the inpatient PNE cases, so the two are not comparable.	OMW	8/27/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
138	Antibiotics for Podiatry	In reference to the determination that there is no data to support the use of prophylactic antibiotics for clean podiatric cases not involving implantation of foreign materials; please address what decisions have been made including timeframes, regarding the exclusion of these podiatric cases from OP Surgery measures 6 and 7.	At this time, the foot and ankle codes are being reviewed by the orthopedic surgeons. If they agree that these codes should be removed, the codes will come out of the July 2009 manual. Until then, those cases should be abstracted.	OMW	8/27/2008
139	Antibiotics for Podiatry	One of our surgeons is very concerned with the new outpatient surgical orthopedic requirements for antibiotic usage. He does not feel the procedures listed in Appendix A as Orthopedic Codes should have the required antibiotic usage prior to surgery. I have given the surgeon these reference material. He is now asked for the Reference sources for the selection of the CPT code/procedures tables themselves. He wants to have the reference source of the physicians/surgeons who decided on which orthopedic codes/procedures were chosen and why these orthopedic codes/procedures were the ones chosen. Any facts I can supply to him would be great. An orthopedic surgeon he could contact or anything??	For the foot and ankle procedures, we used the request from the American Podiatric Medical Association to the AMA. The request was made to include the CPT codes (found in Appendix A) for the PQRI measures on antibiotic timing, selection and discontinuation. A pdf of that request has been provided via email.	OMW	8/27/2008
140	Antibiotics for Podiatry	Our podiatrists do not routinely order antibiotics for a bunionectomy or hammertoe repair. Both of these procedures are on the orthopedic code table 6.2. Is there another procedure list specific for outpatient podiatry procedures that can be used as a reference?	No. For the foot and ankle procedures, we used the request from the American Podiatric Medical Association to the AMA. The request was made to include the CPT codes (found in Appendix A) for the PQRI measures on antibiotic timing, selection and discontinuation. A pdf of that request has been provided via email.	OMW	8/27/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
141	Antibiotics for Podiatry	We are noticing that most of our podiatry procedures are failing the Outpatient SCIP antibiotic timing and selection measure. For many of the selected procedures our podiatrists DO NOT use antibiotics and this is not an option. Since we have encouraged the decrease in use of antibiotics, why are we now requiring our physicians to give antibiotics for procedures that they state is not necessary and the misuse of antibiotics?	The OP measure for podiatry procedures was aligned with the AMA's Physician consortium measure to which the American Podiatric Medical Association provided the list of operations for which they recommended antibiotics. We are discussing with the AMA but again, the AMPA provided the list and the physician PQRI measure and OP measure are aligned. We can't revise the measure until they can come to a consensus about which operations always need prophylaxis. No change is feasible until at least mid-2009. NOTE: There are significant changes (deletions) to the OP-6 and OP-7 procedure lists beginning with 1/1/09 encounter dates. Some of the orthopedic CPT codes have been removed from the Specification Manual 2.0a.	Dr. Dale Bratzler/ OFMC	8/27/2008
295	Antibiotics for Podiatry	Are there any references available to support the use of prophylactic antibiotics in the podiatry population. The references given in the specifications manual are unfortunately quite old and do not target the specific use in the podiatry population.	The podiatry codes were specifically added because of a request the APMA made to the AMA to include these procedures in the PQRI measures. The outpatient measures were developed to mirror the PQRI measures, so the same codes were used. We have a copy of that request with the references the APMA used to justify their request.	OMW	10/15/2008
452	Antibiotics for Podiatry	Are there any updates on the status of the podiatry population remaining or being removed from the outpatient population?	We have not heard anything on this issue from the AAOS. We had asked them to provide feedback on the removal of the codes.	OMW	10/15/2008
466	Antibiotics for Podiatry	What is the current stance of Podiatry codes for 2009? I see that hammertoes are removed but what about bunions? Also can you tell what guidelines you referred to for neurosurgery and antibiotics?	Bunionectomies will not be removed. The podiatry codes will be remaining in the surgery measures for now. The guidelines for neurosurgery come from The Medical Letter and ASHP.	OMW	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
94	APU	During which reporting quarter will CMS approximate the number of HOP Acute MI, HOP Chest Pain, and HOP Surgical patient populations and IF the hospital is under reporting based on this approximation, FAIL to receive their OPPS?	Population and Sampling will be required to be submitted with encounters from Q2 2008 (April-Jun) with a deadline of October 15, 2008. The Provider Participation Report in QualityNet will also be generated with the Medicare claims count and population and sampling data submitted to the warehouse for this same time period. Complete data submission for all measures is a requirement for full APU beginning with April 1, 2008 encounters forward.	HOP QDRP SC	7/16/2008
296	APU	In the larger picture for all data submitted, when you have cases that do not meet time frames for antibiotics, correct antibiotic or antibiotic given how does this affect your reimbursement with the CMS OPPS?	At this time, reimbursement (APU) is not affected by the percent compliance with each of the measures. Reimbursement of full APU is dependent on meeting the requirements for participation, which include submission of accurate and complete data for all 7 outpatient measures.	HOP QDRP SC	10/15/2008
297	APU	Can you please provide clarification about what you were saying towards the end of the web conference on 8/27/08? I am confused about timing of data reported and which data will begin to impact payment. Is the data that we are submitting now for quarter 2 going to be used in this determination for payment for CY 2009?	The data you are collecting now (from April, May, and June 2008 services) is for the HOP QDRP SC as implemented in the OPPS CY 2008 rule -this rule covers OPPS services beginning January 2008 through December 2008 This data is due to the warehouse by November 1, 2008 as stated in the CY 2008 rule. This information will be used toward payment decisions affecting CY 2009 payment. Please note that CMS was statutorily required to establish a program under which hospitals would report data on the quality of hospital outpatient care using standardized measure of fact in order for these hospitals to receive the full annual OPPS update beginning with CY 2009 payments.	CMS	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
151	Aspirin: Contraindications	This patient was an acute MI. Pt. arrested at home and majority of the time in the hospital before transfer to another for intervention they were coding the patient. The patient did not receive ASA nor was there documentation that it was a home med. Can this be used as a contra to ASA? Patient was tubed and vented while here.	This will not abstract as a contraindication to aspirin. There must be a documented reason the patient did not receive the aspirin, If the reason is documented in the medical record, this may be used. Incidentally the Aspirin could be administered via suppository.	OMW	8/27/2008
152	Aspirin: Contraindications	Is a documented Heparin allergy a contraindication to giving Aspirin at Arrival? There is no other documentation that Aspirin was given prior to ED arrival, or during the ED stay, nor is there documentation of a contraindication to giving Aspirin .	This would not be considered an aspirin allergy.	OMW	8/27/2008
153	Aspirin: Contraindications	Would a diagnosis of subdural hematoma be an acceptable reason as a contraindication to asa?	This would not be sufficient documentation of Contraindication to Aspirin.	OMW	8/27/2008
298	Aspirin: Contraindications	If a patient has a history of PUD would this be considered a contraindication to ASA?	If the physician documents they did not give aspirin because of the history of PUD, this will abstract as value 3.	OMW	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
299	Aspirin: Contraindications	Contra to aspirin (ASA) - Instructions are contradictory. In one place it says there must be a documented reason, and comments like "ASA not prescribed" and "do not give ASA" can't be abstracted as reasons for not giving ASA. Yet the next sentence states that it is acceptable to accept a simple crossing-out of an ASA order (whether or not a reason is documented). Why is a cross-out an acceptable "reason", but a statement about not giving ASA is not an acceptable "reason"? The next bullet says that a pre-arrival hold, discontinuation, or notation of "No ASA" counts – even without a documented reason. Does this mean that a hold, discontinuation, or notation of "No ASA" is not acceptable if documented after arrival, but it is acceptable if documented prior to arrival? Not only do these instructions seem internally contradictory, they are not the same as the instructions for abstracting ASA contraindication for inpatient AMI cases in which "ASA not prescribed", "do not give ASA", and most holds or discontinuations of ASA can be abstracted as ASA contraindications, even if no reason is explicitly stated.	The outpatient data element was condensed to simplify abstraction. We are working to provide consistent instructions for both inpatient and outpatient abstraction. At this time you would need to abstract according to the data element. The instructions regarding pre-arrival hold apply only to pre-arrival holds, discontinuations, or other reasons.	OMW	10/15/2008
300	Aspirin: Contraindications	If the patient received an aspirin prior to arrival and another was given in the ER after arrival, would you mark #3 - Other Documented Reason for Contraindication to ASA or #4 NO. (There was no allergy, sensitivity, bleed, etc)	This would abstract as value 4.	OMW	10/15/2008
222	Canceled Surgical Procedures	We currently make a list of outpatient surgeries from the OR registration book. We also input the codes to form an outpatient surgery population. We compare the lists and pull questionable charts for review. Do we need to do anything further to assure capture of cancelled cases?	You need to be sure by checking with your billing department or IT department and have them run a list of patients who have a CPT code found on table 6.0.	HOP QDRP SC	8/27/2008
86	Cancelled Surgical Procedures	COMMENT: Cases sometimes cancelled by Anesthesia after pt arrival (ex: ptt elevated, Glucose out of control etc.) happens to the ASC area often.	This specific issue is being discussed. To resolve this issue, the addition of another data element may be necessary.	CMS	7/16/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
87	Cancelled Surgical Procedures	What is the rationale for including canceled surgeries in the population for OP surgery? This will result in missing data.	Canceled surgeries should be infrequent, but we do understand that this issue is causing concern. It could possibly mean the addition of a data element with the cost of increasing abstraction burden somewhat.	CMS	7/16/2008
88	Cancelled Surgical Procedures	Can you please define further a "cancelled case"? I don't think that they would normally generate a medical record. When would you ever code a procedure that wasn't done/cancelled? You can't bill/code for something that was not done.	Providers can submit a claim for these canceled procedures because of the amount of "set-up" and preparation that accompanies the scheduled procedure.	OMW	7/16/2008
89	Cancelled Surgical Procedures	If a surgical case is cancelled, it is not billed to my knowledge. How am I to find these to get a CPT code that will be accepted by the HOPQDRP code list to be abstracted? I don't understand how any cancelled cases would show up on a list for abstraction. There won't be a procedure code, just a diagnosis code with a notation of procedure cancelled.	There are modifiers that are attached to the CPT code (73 or 74) submitted on the claim.	OMW	7/16/2008
90	Cancelled Surgical Procedures	When any modifier is used for the CPT codes, but the 5-digit CPT code is on the inclusion list, are these charts included in abstraction? If a case is coded with a modifier 73 is it still included in the outpatient measure. For cancelled cases: The CPT code has a hyphenated modifier attached (74) are these cancelled cases with the modifier included in the sample.	Yes - without the modifier. These cases are rare, but if we determine that enough cases are being cancelled prior to incision and assigned a modifier, we will review adding modifier information to the specifications. At this time, the case should be abstracted.	HOP QDRP SC	7/16/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
91	Cancelled Surgical Procedures	I just want to verify, if a surgery is cancelled, we still need to abstract the chart, because on CMS's end they do not see the CPT with the modifier as cancelled?	That is correct, the case is selected as part of the outpatient surgery population because the CPT code is on Table 6.0, and the case is included in the population and should be abstracted and submitted. The modifier is not abstracted as part of the CPT code data element; the XML file only accepts 5 alphanumeric characters. If a surgery is cancelled before the patient goes to the holding area or the OR, a modifier does not apply. There will be no CPT code in this instance, and therefore the case will not show up on the population. This issue is under review by CMS.	HOP QDRP SC	7/16/2008
92	Cancelled Surgical Procedures	Why can't there be changes to the specification manual through CMS to exclude cancelled cases? Why does everything around the Inpatient and outpatient core measures have to be so complicated and difficult?????	It is not CMS' intent to make the collection of quality measure data difficult. It is a challenge to develop methods to obtain such information given issues that can arise from what is contained in the medical records versus how procedures are recorded and submitted on claims. The issue of cancelled case is under discussion; we are aware that the way some measures are currently constructed, a hospital can "fail" these measures while providing appropriate care and agree that this must be resolved.	CMS	7/16/2008
180	Cancelled Surgical Procedures	If a surgery was canceled prior to the patient ever entering the surgery suite, can we delete this case?	No, if the case is selected as part of the outpatient surgery population because the CPT code is on Table 6.0, and the case is included in the population and should be abstracted and submitted. If a surgery is cancelled before the patient goes to the holding area or the OR, a modifier may not apply. There will be no CPT code in this instance, and therefore the case will not show up on the population.	HOP QDRP SC	8/27/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
301	Cancelled Surgical Procedures	Patient w/ cervical spine stenosis (CPT 63030) whose case was cancelled b/c difficult intubation. Would I answer the question of an antibiotic as "No" and is the case included in our OP-Surg population b/c of the CPT code?	That is correct. For 7/1/09, there will be a data element added to OP-6 and OP-7 to exclude those cases.	OMW	10/15/2008
302	Cancelled Surgical Procedures	In regards to answering "no" to antibiotics rec. within 60 min. of incision time- why not allow abstractors to answer "yes" when a surgery is cancelled. The answer is truly neither yes nor no. Why penalize hospitals for your decision to include these pts?	This issue will be taken care of in the 7/1/09 manual. If the answer is truly neither yes nor no, we can't encourage the abstractor to answer either way.	OMW	10/15/2008
303	Cancelled Surgical Procedures	When do you anticipate that cancelled cases will be handled as an exclusion?	At this time, cancelled cases will have to be abstracted, but we plan to add a data element to exclude the cases if the procedure is canceled before incision for the 7/1/09 manual.	HOP QDRP SC	10/15/2008
43	Case Selection	Will you be developing a HORSE-type tool for the outpatient measures to help with case selection, pulling demographic material over and assisting with ICD9 populations and sampling.	The HORSE-type tool that you are referring tool was developed by a QIO. There is no plan by HOP QDRP or CMS to develop such a tool for outpatient data reporting at this time.	HOP QDRP SC	7/16/2008
76	Chest Pain: Inclusion Terms	If there is documentation in the ED record of "chest pain", and later it is documented as "indigestion"-is this still a YES?	This will continue to abstract as a YES as the documentation "chest pain" does not exclude a cardiac cause and an ECG should be performed.	OMW	7/16/2008
77	Chest Pain: Inclusion Terms	Chest Pain and Acute chest pain are now inclusions regarding probable cardiac in origin?	Chest pain and acute chest pain will abstract as a YES for the data element Probable Cardiac Chest Pain.	OMW	7/16/2008
78	Chest Pain: Inclusion Terms	RE: Probable Cardiac Chest Pain. How do you abstract if the patient complains of chest pain but the diagnosis/impression from the physician is palpitations, syncope, dysrhythmia or new onset a-fib?	If there is physician or nurse documentation of chest pain, this will abstract as a YES.	OMW	7/16/2008
79	Chest Pain: Inclusion Terms	Q: Slide 21. What do you mean by chest pain alone abstracts as a yes as long as it is NOT QUALIFIED AS NON-CARDIAC chest pain. Please explain.	Chest pain documented by itself will abstract as a YES. The only time chest pain will not abstract as a YES is if it is qualified by a non-cardiac cause, examples include non-cardiac chest pain, chest wall pain, chest pain musculoskeletal, chest pain due to anxiety...	OMW	7/16/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
80	Chest Pain: Inclusion Terms	I was initially told to abstract CP or Acute CP as a "No" in the PROBABLE CHEST PAIN data element. Do these charts have to be re-abstracted based on today's information to include these dx? If so, 1st and 2nd quarter? Is Atypical CP included?	Chest pain, acute chest pain, and atypical chest pain abstract as a YES, so you will need to reabstract.	OMW	7/16/2008
142	Chest Pain: Inclusion Terms	In the absence of the inclusion term "cardiac" for chest pain, should we assume that the following diagnoses are cardiac in nature: Acute chest pain, atrial tachycardia with chest pain, abnormal EKG--atrial fib--chest pain--palpitations, atypical chest pain with documentation of no chest pain?	All of these will abstract as a YES.	OMW	8/27/2008
143	Chest Pain: Inclusion Terms	Can "cardiac chest pain" be written anywhere on the ED record (physical exam, etc) or does it have to be final impression?	The documentation can be written anywhere as long as it is nurse or physician /APN/PA documentation.	OMW	8/27/2008
144	Chest Pain: Inclusion Terms	"Chest Pain, Elevated Troponins" - Could this be considered as an addition to the inclusion list for cardiac chest pain?	This will abstract as a YES.	OMW	8/27/2008
145	Chest Pain: Inclusion Terms	If the diagnosis is chest pain, is that enough to say "yes" to probable cardiac chest pain. None of the exclusions are in the medical records, but neither does the physician state it's cardiac.	Yes, if there is documentation in the medical record by the nurse, physician/APN/PA that chest pain is the diagnosis, this will abstract as a YES.	OMW	8/27/2008
146	Chest Pain: Inclusion Terms	We have an ED record that has a final impression of 1) chest pain 2) pneumonia. The transfer form reads: chest pain with pneumonia. Since they never say the chest pain is due to the pneumonia, would the chest pain be considered cardiac in nature?	Yes, if there is documentation of chest pain this will abstract as a YES.	OMW	8/27/2008
147	Chest Pain: Inclusion Terms	The inclusion of difficult or painful respiration as one of the diagnoses for chest pain spreads the net too wide and more often includes COPD and Bronchitis. Why did you choose this?	The expert panel included this because the code is used frequently in the diagnosis of chest pain. We use the data element Probable Cardiac Chest Pain to exclude cases the provider documents as non-cardiac in origin.	OMW	8/27/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
148	Chest Pain: Inclusion Terms	The chest pain is documented, and there is history of cardiac, stents, MI, etc, but no where is there documentation "presumed to be cardiac". Is there any chance that this part of the criteria will be dropped since it is obvious that the chest pain is cardiac in both the description of the patient's history, treatment, and documentation of symptoms.	If there is documentation of chest pain and it is not qualified as a non-cardiac cause, the guidelines would support evaluation and treatment as cardiac.	OMW	8/27/2008
149	Chest Pain: Inclusion Terms	The only documentation of cardiac related to chest pain is the transfer summary where it says transferred to tertiary coronary care center. Will this suffice as documentation of cardiac related chest pain?	This will abstract as a NO for the data element Probable Cardiac Chest Pain.	OMW	8/27/2008
304	Chest Pain: Inclusion Terms	If chest pain is mentioned in the impression and plan, is it abstracted as probable cardiac chest pain? Specifically, should this patient be abstracted yes for probable cardiac chest pain?	Any documentation is sufficient and this will abstract as a YES.	OMW	10/15/2008
305	Chest Pain: Inclusion Terms	My understanding is that the diagnosis of chest pain is not sufficient based on this sentence from the data dictionary: "documentation must include one of the Acute Myocardial Infarction & Chest Pain inclusions". Chest pain alone not part of inclusion list. However, question #145 implies that it is sufficient. For chest pain, if the first documentation mentions just "chest pain", but subsequent ER documentation says "probably gastric pain", do we answer yes or no for cardiac chest pain?	Chest Pain has always been considered an inclusion. The list is titled Acute Myocardial Infarction and Chest Pain Inclusion so consider chest pain an inclusion. This has been updated in the most recent manual to provide better clarity for abstractors.	OMW	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
306	Chest Pain: Inclusion Terms	Probable Cardiac Chest Pain – In the Specifications Manual version for 2009, unspecified “chest pain” has been added to the inclusion list. Why? ... For 2008, I assume we should NOT consider unspecified “chest pain” to be an inclusion. Is that correct? ... Instructions say that if both an inclusion term and an exclusion term are documented select “Yes”. Because unspecified “chest pain” is an inclusion term in 2009, this means that we would answer “Yes” for a 2009 case with documentation about a patient being seen because of “chest pain” and then a later statement about it being “musculoskeletal chest pain”. Is that correct? (This doesn’t seem appropriate!)	Chest Pain has always been considered an inclusion. The list is titled Acute Myocardial Infarction and Chest Pain Inclusion so consider chest pain an inclusion. This has been updated in the most recent manual to provide better clarity for abstractors. At the time of inception of the measures, the expert panel included any documentation of chest pain not qualified as non-cardiac in origin.	OMW	10/15/2008
307	Chest Pain: Inclusion Terms	In making the determination of whether a patient has probable cardiac chest pain, should the abstractor answer no if there isn’t any documentation that includes an inclusion, exclusion, or qualifiers that support the diagnosis?	Correct.	OMW	10/15/2008
308	Chest Pain: Inclusion Terms	The ED physician Chest Pain TSheet, in the Impression area, has Chest Pain as a selection option. Underneath Chest Pain, the physician has choices to circle: precordial, painful respirations, chest wall, discomfort, tightness, pressure, and angina. Are all these considered "probable cardiac chest pain" except if chest wall is circled?	Correct.	OMW	10/15/2008
309	Chest Pain: Inclusion Terms	What is the definitive source of information for 'chest pain'? Do we consider only the final assessment or impression, or is any notation within a progress note or ED record allowable for abstraction? Is documentation of a patient symptom or a patient complaint of 'chest pain' sufficient to answer Yes to this data element?	For encounters through 6/30/2009 this is correct. Nurse/physician documentation of "chest pain" will abstract as a YES.	OMW	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
310	Chest Pain: Inclusion Terms	Reason for Not Administering Fibrinolytic Therapy, not all inclusions are clear to me: please define "major surgery <3 weeks", "dementia", "bleeding diathesis", "noncompressible vascular punctures", "active peptic ulcer" Would you also clarify "history of chronic, severe, poorly controlled hypertension"? Is this a patient with a past history of high blood pressure and an ED blood pressure of 140/90? Do vital signs count? What do you need to answer yes?	Major surgery is any operation that included an incision and required general, regional, or neuraxial anesthesia. Dementia could be identified as dementia, Alzheimer's disease, senility. Bleeding diathesis would be documented bleeding risk which could include any coagulopathy, thrombocytopenia, hemophilia, etc. Non-compressible vascular puncture is primarily subclavian and internal jugular lines where you cannot stop bleeding with pressure. Most other vascular punctures can be dealt with by direct pressure. Active peptic ulcer would be recent bleeding or ongoing treatment. Chronic hypertension is a relative, not absolute contraindication. For patients who present to the ED the guidelines state: "Severe uncontrolled hypertension on presentation (SBP greater than 180 mm Hg or DBP greater than 110 mmHg)". Documentation of hypertension listed in the patient's H&P will abstract as a contraindication.	OMW	10/15/2008
311	Chest Pain: Inclusion Terms	Probable chest pain: ED doc documented abdominal spasm chest pain. Will this documentation sufficient to answer NO response to this data element? or does the doctor has to explicitly write chest pain non cardiac due to abdominal spam?	This will abstract as a NO as the chest pain is qualified by a non-cardiac cause (abdominal spasm).	OMW	10/15/2008
312	Chest Pain: Inclusion Terms	If the physician does not document an inclusion for chest pain presumed to be cardiac, but transfers the patient to cardiology services at a tertiary care facility - does this count as chest pain considered to be cardiac?	Unless the physician documents an inclusion term, this will abstract as a NO.	OMW	10/15/2008
313	Chest Pain: Inclusion Terms	If the ED physician does not document an inclusion term for chest pain presumed to be cardiac, but the observation admitting physician documents an inclusion term in the discharge summary - does this count as chest pain presumed to be cardiac?	Yes, this counts.	OMW	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
314	Chest Pain: Inclusion Terms	Chest pain presumed to be cardiac: If the physician documents the following: "the following diagnoses considered:" and then lists multiple diagnoses including MI - does this count as chest pain presumed to be cardiac?	Yes.	OMW	10/15/2008
449	Chest Pain: Inclusion Terms	When abstracting OP chest pain, I have two pts that were transferred to a psych facility; one of the pts has documentation of SOB, CP, muscle spasms to chest by the RN. The MD final dx Acute Asthma Acute ETOH intox, Suicidal ideation. Do I answer yes?	This will abstract as a YES if the nurse documented Chest Pain by itself. If it is documented together with the muscle spasms this will abstract as a NO.	OMW	10/15/2008
451	Chest Pain: Inclusion Terms	A July 2008 chest pain chart was coded with dx code 413.9 (angina pectris nec/nos) as the physician documented the pt had a past history of angina. This is the only mention of chest pain in the chart. Do I answer yes to probable cardiac chest pain?	For encounters through 6/30/2009 this will abstract as a YES.	OMW	10/15/2008
454	Chest Pain: Inclusion Terms	Chest Pain: In reference to question #308 underneath Chest Pain it states if discomfort , tightness or pressure are circled this will abstract as probable cardiac chest pain. I had submitted a question prior to this and was told these terms would not qualify ...	If the terms are documented alone, they will not be sufficient, but if they are documented under the chest pain heading, they will.	OMW	10/15/2008
457	Chest Pain: Inclusion Terms	I have a problem with stating "consider" as a positive finding when "consider" has the same meaning as "possible". Are you planning to add "consider" to the exclusion terms?	Consider and possible will both abstract as a YES for the data element Probable Cardiac Chest Pain.	OMW	10/15/2008
471	Chest Pain: Inclusion Terms	CP without qualifiers doesn't begin until 2009 correct? Would we still answer "no" if cardiac in origin if there are no qualifiers/inclusion terms for the remainder of 2008 quarters.	The qualifiers are listed to provide guidance. If you see documentation of a term without a qualifier, this will continue to abstract as a YES.	OMW	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
545	Chest Pain: Inclusion Terms	Will documentation of "Chest Pain" only abstract as YES for "Probable Cardiac Chest Pain" in OP-4 and OP-5?	Documentation of chest pain alone will abstract as a YES for the data element Probable Cardiac Chest Pain. Other types of chest pain documentation that does not include a non-cardiac descriptor (i.e. acute chest pain, non-specific chest pain, atypical chest pain, cardiac chest pain, heavy chest pain) also abstracts as a YES. Chest pain that is qualified by a non-cardiac cause (i.e. non-cardiac chest pain, chest wall pain, chest pain musculoskeletal) will abstract as a NO.	OMW	8/6/2008
45	Clinical Trials	where can we find an updated list of medications in clinical trials?	We do not have that information. There is a Clinical Trials website (http://clinicaltrials.gov/) that might contain the information you are interested in finding.	OMW	7/16/2008
150	Coding	The ED MD states "chest pain" and the attending/admitting cardiologist states "AMI" and documents reasons for not giving thrombolytics. This codes out as a Chest Pain Outpatient. Should this chart be reviewed by the Coding Department for consideration of AMI Outpatient?	If Chest Pain is a diagnosis, this case will be eligible for the Chest Pain population (OP-4 and OP-5) and if the diagnosis is AMI, the case is eligible for the AMI population (OP-1 through OP-5).	OMW	8/27/2008
315	Coding	Should our coders code any chest pain as primary regardless of final diagnosis?	No, not necessarily. Coders must follow their coding rules.	HOP QDRP SC	10/15/2008
512	Coding	When a CPT code or date is wrong, how do we go about getting that changed.	Please contact the HOP QDRP SC at hopqdrp@fmqai.com with clarification for this question. The action will be determined based on where the code and date are wrong - the medical record, the abstraction in CART, in the data already submitted to the warehouse, etc.	HOP QDRP SC	10/15/2008
226	CPT Code	Many hospitals are struggling with the fact some of the CPT codes required for HOPs cases are attached to billing. Is CMS considering allowing hospitals to use ICD-9 codes to identify cases? In our hospital, OP cases have both ICD-9 and CPT. CPT codes are sent to CMS, however, the process to get the CPT codes on the bill is not done in the coding abstract.	Cases are determined by the CPT code submitted on the bill. An accurate crosswalk has not been developed that will allow the ICD-9-CM code to be matched to a CPT code.	OMW	8/27/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
506	CPT Code	I always have CPT codes already entered in my online tool and I get my CPT codes from the coders sheet (Abstract Summary Form) in the chart but do I need to enter the other CPT codes that are on this sheet into my tool?	For the HOP QDRP, only the CPT code from Table 6.0 that was performed first chronologically is to be abstracted. There are no data fields for additional CPT codes.	HOP QDRP SC	10/15/2008
316	CPT Code: Multiple CPT Codes	48 y/o female, admitted for lap chole and incidental lap appy. The lap chole was performed first. This patient is <70 y/o, so she is not included as part of my lap chole population, but do I include her in our sample for the lap appy?	Because a qualifying procedure existed on table 6.4b and a qualifying procedure existed not on table 6.4b, abstraction is required to determine the procedure that was performed first. The data abstractor determined that the procedure that was performed first was the lap chole, therefore, patient should NOT qualify for the HOP Surgery patient population.	OMW	10/15/2008
317	CPT Code: Multiple CPT Codes	For CPT codes and choosing which one was performed first when more than one listed, I had a chart in which the pt had a biventricular ICD placed. CPT codes for this procedure were 33249 (electrode/insert pace-defib) and 33225 (I ventric pacing lead add-on). When reading through the procedure notes the leads are placed first and then connected to the pacer/defib. However the first code (33249) does encompass some leads, just not all of them - the reason for the extra CPT code. I chose the 33249 CPT code as the earliest qualifying CPT procedure as it encompassed more, but am not sure if this is correct?	The CPT Code selected for abstraction should be the one from Table 6.0 performed first chronologically. If more than one CPT code from Table 6.0 is present, the abstractor should review all documentation of procedures, including the operative note/report to determine which was performed first.	HOP QDRP SC	10/15/2008

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Compiled Question Answer Grid

Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
318	CPT Code: Multiple CPT Codes	CPT code selected when there are more than one CPT codes for the encounter – We have interpreted the abstraction guideline to select the procedure performed first chronologically as requiring us to identify the procedure which was performed first during a single operative episode. For example, if a patient had a pacemaker generator replacement, removal of the old generator would be selected as the CPT code since that occurred before insertion of the replacement generator. Or, if a patient had multiple foot/toe procedures with codes on Table 6.0, we would select the CPT code for the procedure performed first. Have we interpreted the CPT code guideline correctly?	Yes, you have interpreted the abstraction guidelines correctly.	HOP QDRP SC	10/15/2008
491	CPT Code: Multiple CPT Codes	For earliest documented CPT code, alot of the times there are multiple CPT codes, how do we determine which CPT code is the earliest? Is it the one which was performed first?	If there are multiple CPT codes for the case, the abstractor must review the record to determine which CPT code/procedure from Table 6.0 was performed first chronologically. This is the procedure that is then abstracted.	HOP QDRP SC	10/15/2008
495	CPT Code: Multiple CPT Codes	We sample our outpatient measures. I received a case to validate for a specific CPT code. While abstracting it, I find that a different procedure was done first. Is there any way to indicate this?	When there are more than one applicable CPT code from Table 6.0, the abstractor must review the record to determine which was performed first chronologically. That is the procedure (CPT) to use for abstraction. If your tool has auto-populated the CPT Code field, the abstractor may need to override the value with the more accurate CPT code (the one performed first chronologically).	HOP QDRP SC	10/15/2008
505	CPT Code: Multiple CPT Codes	For the outpt surgical procedures: does the CPT code of interest have to be listed first, or can it be anywhere in the CPT code list on the bill? In the inpt measure the surgery of interest must be listed first.	The CPT code 'of interest' can be in any position on the bill. If more than one procedure was performed, the abstractor must determine through record review which was performed first chronologically.	HOP QDRP SC	10/15/2008

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Compiled Question Answer Grid

Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
227	CPT Code: Multiple CPT Codes	The SCIP outpatient specs just refer to the CPT codes, without distinguishing a principal procedure. If a patient had more than one procedure in a visit (i.e., more than one CPT code on Table 6.0), which one do we abstract? The first one performed? This will definitely affect the antibiotic timing indicator, and possibly the antibiotic selection indicator as well.	You are correct that the 'selected' CPT code will impact the antibiotic timing measure. The CPT Code selected for abstraction should be the one from Table 6.0 performed first chronologically. If more than one CPT code from Table 6.0 is present, the abstractor should review all documentation of procedures, including the operative note/report to determine which was performed first.	HOP QDRP SC	8/27/2008
450	Data Abstraction	Why do we answer the fibrinolytic given prior to the EKG? It would seem that we would answer the EKG first.	It appears they have provided the questions in alphabetical order, rather than according to the algorithms.	OMW	10/15/2008
102	Data Abstraction:	ECG had ST elevation, fibrinolytic was NOT given, and reason for not giving was documented by physician. We answered NO for question "Fibrinolytic Administration". For the question "Reason for Delay in Fibrinolytic Therapy OP", should we leave that blank OR answer NO, since it was not given? We did answer the subsequent question "Reason for Not Administering Fibrinolytic Therapy.	Even though the patient did not receive fibrinolytics, if your tool allows you to answer the question Reason for Delay in Fibrinolytic Therapy, you should do so in the event the chart is pulled for validation and the validating facility abstracts as a YES for Fibrinolytic Administration, you would not want a potential mismatch on a subsequent data element.	OMW	8/27/2008
14	Data Abstraction: Extra Data	In the demographic area, I have been having the abstractor list the discharge time for the Surgical Patient and now realize that it is only required for AMI/CP patients. I asked the vendor if I should remove the time from this section for surgical patients and they told me I could leave it - it could be used for data gathering. Is this o.k.? Or should I remove it?	The discharge time for Surgical patients is not a required field. Some vendors are still asking for the date and time for these cases and it should not be an issue. It is suggested that you work with your vendor on this issue to verify that reporting this information is not a problem.	HOP QDRP SC	7/16/2008
100	Data Abstraction: Acceptable Data Source	Scenario: An ED patient with the diagnosis of chest pain, has admission orders written by the attending/admitting cardiologist. Prior to the patient being transferred from the ED to the inpatient floor, develops increasing chest pain and the decision is made to transfer the patient from the ED to another facility. This patient has been coded as an Outpatient. Can the documentation that the attending cardiologist (not the same MD from the ED) written be used for the outpatient measures?	If the patient was never billed as an inpatient, all documentation is consider outpatient and may be used.	OMW	8/27/2008

Hospital Outpatient Quality Data Reporting Program
Compiled Question Answer Grid

Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
319	Data Abstraction: Acceptable Data Source	If RN put in an order and the co-signed by a physician - does this count as documentation by a physician?	A verbal order that is signed (or will be signed) by a physician counts as physician documentation.	OMW	10/15/2008
320	Data Abstraction: Acceptable Data Source	Does the documentation need to be only listed in the ED documentation, or can it be any place in the outpatient record?	Any place in the record is acceptable.	OMW	10/15/2008
321	Data Abstraction: Acceptable Data Source	Is the Anesthesia Record considered a Physician Order Form, i.e. does the prophylactic antibiotic given prior to incision start time need to say "given or started"?	No. The anesthesiologist's signature on the form is adequate to abstract antibiotic administration information from the record.	OMW	10/15/2008
322	Data Abstraction: Acceptable Data Source	Our hospital policy doesn't require an update for H&P's if dictated w/i 24 hrs prior to surgery. If there is an infection/possible infection listed there can that be abstracted as yes prior to anesthesia even though it was not dictated the day of surgery?	Not at this time. Further documentation will need to be found. We will review revising that bullet in the data element.	OMW	10/15/2008
323	Data Abstraction: Acceptable Data Source	What are the guidelines for infection prior to anesthesia when the H&P is not updated the day of surgery? And for OP-7 can the operative report be used as a data source for antibiotic given?	The H&P that is not updated cannot be used to determine that an infection is present at the time of the outpatient encounter. The operative report does not usually contain documentation of actual administration of antibiotics.	OMW	10/15/2008
324	Data Abstraction: Acceptable Data Source	If inclusion list is not all-inclusive how are we to determine if a term is to be abstracted as inclusive without inference?	The inclusion lists cannot possibly contain all of the terms that might be acceptable. Every facility has their own way of documenting patient care, so it would be impossible to include all of the terms.	OMW	10/15/2008
325	Data Abstraction: Acceptable Data Source	Can we use the Emergency Department generated facesheet for arrival time, if that is the earliest time documented?	There are no restricted data sources for this element. If the ED generated facesheet is part of the emergency department record, then it can be used.	HOP QDRP SC	10/15/2008
326	Data Abstraction: Acceptable Data Source	My facility's face sheet for emergency room patients does not have information regarding patient's race and ethnicity. Must it be written or printed on that form, or can I take that information from the patient's other charts and/or our admission database?	These data elements will be handled similarly as the CPT codes and E/M codes, in that they are required for abstraction, but do not have to be part of the medical record ... they could get the information from anywhere they want. Since we are moving to a measure match rate, race/ethnicity information is extraneous.	HOP QDRP SC	10/15/2008

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Compiled Question Answer Grid

Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
557	Data abstraction: Acceptable Data Source	When abstracting data for AMI or Chest Pain measures OP-1 through OP-5 with an associated observation stay, can the documentation from the observation stay be used for abstraction purposes?	Suggested Data Sources are listed in the Specification Manual for each data element. However, the abstractor is not limited to these sources. A review of the entire medical record is encouraged and documentation from the observation stay may be used.	HOP QDRP SC	8/6/2008
17	Data Abstraction: Antibiotic Allergies	Starting time: 09:01 Are they going to include antibiotic allergies to outpt SCIP? We had an antibiotic fall out because they were give Clindamycin due to a PCN allergy.	The data element Antibiotic Allergy is present in the current specifications. After discussion with the Infection Expert Panel, there are places in the recommendation table that clindamycin will be added, similar to the specifications for reporting inpatient quality measure data.	OMW	7/16/2008
535	Data Abstraction: CART	When will the CART software be available? How do I access it? Are there paper abstraction tools?	The CART software is available on the QualityNet.org website; click on Hospital-Outpatient then "Data Collection (& CART) to download the program. The paper abstraction tools are also available at this site.	HOP QDRP SC	4/23/2008
103	Data Abstraction: CART	When I click on the question mark for the CPT code table ... under the OP table 6.0 Surgery Procedure Codes, it shows the CPT code # 47562—which is Laparoscopic Cholecystectomy. But if you scroll down to the OP Table 6.4b: Gastric/biliary, the CPT code # is 45762 for Laparoscopic Cholecystectomy.	Because the 'patches' for updates and corrections to the released modules create such a nightmare, they chose not to do anything with it. However, in the next release of the CART module for outpatient reporting, the lap chole CPT codes have been removed, so it will be a mute point :-)	HOP QDRP SC	8/27/2008
15	Data Abstraction: Date Change	Pt was adm. late on 4/9 through the ER. Pt was adm. 4/10 @ 0130. Surg. was done on 4/10. Pt was changed to OBS on 4/11 and d/c'd. A 'validation box' stated that the d/c date is more than 1 day after OP encounter date. Will there be a problem with accepting this case?	This should not be a problem as the validation box is asking you to verify the information. This may be a flag that was written into the program. If you are working with a vendor, please confirm with them that this is the situation. If there are continued concerns with this issue, please contact us again for further assistance.	HOP QDRP SC	7/16/2008
327	Data Abstraction: E/M Codes	If a surgical patient has presented to the ED and went straight to surgery, do we abstract the E & M code??	An E/M code is not a required data field for the OP-Surgery patient; it is only applicable for the ED-AMI and ED-CP population.	HOP QDRP SC	10/15/2008

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Compiled Question Answer Grid

Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
328	Data Abstraction: E/M Codes	If a Patient is assigned to Observation directly from the Physician's office for chest pain and the E/M code is not one you require do we report it. If so, how do we report because CART will not take it.	The inclusion criteria for the ED-CP patient requires an E/M code from Table 1.0. If the E/M code is not on that table, then the patient is not included in the population.	HOP QDRP SC	10/15/2008
329	Data Abstraction: E/M Codes	Re: Q&A 194, will we still need to include the E/M code in CART abstraction information, even though it does not need to be a permanent part of the chart?	Yes, because it is a required data element in determining inclusion in the population.	HOP QDRP SC	10/15/2008
330	Data Abstraction: Incision Time	For cardiac catheterization, is sheath insertion time synonymous with incision time?	No.	OMW	10/15/2008
331	Data Abstraction: Inclusion/Exclusion Terms	In the Guidelines for Abstraction table, under Inclusions/Contraindications it lists "Traumatic or prolonged CPR or major surgery". Please define Major Surgery. Is a pacemaker insertion considered Major Surgery?	Major Surgery would be any surgery within the previous three weeks.	OMW	10/15/2008
16	Data Abstraction: Paper Tools	We are using the same abstraction worksheets for Outpatient Chest Pain and AMI. Is there a separate form/worksheet for CP and AMI on Outpatients? If so, where is this form found?	Yes, there are separate abstraction tools for CP and AMI. The forms can be found on the QualityNet.org website under Hospital-outpatient, Data Collection (&CART), Abstraction Resources or: http://qualitynet.org/dcs/ContentServer?cid=1205442056833&pagename=QnetPublic%2FPPage%2FQnetTier3&c=Page .	HOP QDRP SC	7/16/2008
104	Data Abstraction: Procedure Start Time	For cases like Pulse generator change: There is no documentation that can be found in the medical record for procedure start time, however, there is documentation of antibiotic administration: How will you answer the question: Was an antibiotic started w/in 60 min prior to surgical incision?	Answer "no" if the incision time or procedure start time is not documented.	OMW	8/27/2008
105	Data Abstraction: Procedure Start Time	For needle biopsy procedures, in this case CPT 5570, needle biopsy of the prostate, this procedure is done in Radiology Ultrasound. There is no Incision Time, surgical start time or anesthesia time documented for these cases. Can we use procedure start time or specimen collection time to answer this question?	The procedure start time can be used. If the antibiotic was given AFTER the procedure start time, the abstractor should answer "no" to Antibiotic Timing. Because an incision time was not used, but procedure start time was used, the antibiotic was given after the start time.	OMW	8/27/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
106	Data Abstraction: Procedure Start Time	In regards to OP surgeries that involve the placement of a pacer. Often when the pt is in the cath lab there is only documentation of "pocket made". Would this suffice for "incision" or would we have to refer back to the start of the procedure. When we have to use the start time as the start of the procedure , instead of the "pocket made" we do not meet the time requirement.	If an incision time is not documented, the abstractor will need to use the procedure start time. It may be advisable to include an incision time on the forms used.	OMW	8/27/2008
107	Data Abstraction: Procedure Start Time	The Anesthesia Record has an "Operation Time" of 2032 and the Intraoperative Record has a "Start Time" of 2033. Which time would I use to answer the question? (The pre-op antibiotic was given at 2032, so if I were to use the "Start Time", the antibiotic would be late.)	The abstractor should use the earliest time of the priority. Both Start Time and Operative Time are comparable, so the earliest of the two should be used.	OMW	8/27/2008
108	Data Abstraction: Procedure Start Time	We had a case where surgery was cancelled after anesthesia had begun, so there was no incision/procedure start time. How can we answer the timing of the prophylactic antibiotic since the surgery never took place?	Answer "no" to Antibiotic Timing.	OMW	8/27/2008
332	Data Abstraction: Procedure Start Time	For AICDs and pacemakers, is 'device pocket formed with cautery' acceptable to use as the start time for the procedure? I am educating the staff to use the word 'incision' but I am still seeing 'device pocket formed'.	The documentation of the pocket creation does not indicate that an incision was made (even though we know it had to be), look for a second or third priority synonym if "incision" is not documented.	OMW	10/15/2008
18	Data Abstraction: Procedure Start Time	Can "Time In" be abstracted as procedure start time? Our form has a "Time In " , "Time Out"	Yes, however, you may have an issue with using this information if "Time In" corresponds to the time that the patient enters the OR and antibiotics are not given within 60 minutes.	OMW	7/16/2008
101	Data Abstraction: Skip Logic	When entering the antibiotics, and no allergy, reason for Vancomycin is remaining bolded. There is no way to answer the question since Vancomycin was not given. In other indicators, when question remains bolded, you must answer.	That depends on your electronic tool. You should ask your vendor. If you are using CART and the data element is not grayed out, you will have to answer it. If Vancomycin was not given, use Value 9 and it will not count against the case. The algorithm will only check for the reason for administration if Vancomycin is administered.	HOP QDRP SC	8/27/2008

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Compiled Question Answer Grid

Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
181	Data Submission	What happens if we do not have our interface working and are unable to abstract the SCIP portion of the HOP by the submission deadline? How can I do it manually?	If you have cases that should be included in the outpatient surgery population but fail to submit the data by the deadline, you will risk receiving 2% of your annual payment update. If your interface is not ready, you can abstract the cases and upload (submit) them through CART. CART is a free tool available on the public QualityNet site at www.qualitynet.org .	HOP QDRP SC	8/27/2008
182	Data Submission	Does the order of ICD-9 diagnosis codes, CPT procedure codes, & E/M code submitted to HOP via vendor software have to exactly match the order that they are listed in the medical record?	No, just the principal diagnosis for AMI and the CPT of interest for surgery. The ICD-9-CM code for chest pain must be abstracted as either the principal into the first "other" field for the system to recognize it.	HOP QDRP SC	8/27/2008
183	Data Submission	What are the submission deadlines for outpatient data and the deadlines for submission of population and sampling.	The data submission deadline for 2nd Quarter 2008 encounters is November 1, 2008. The Population and Sampling deadline for the same period is October 15, 2008.	HOP QDRP SC	8/27/2008
333	Data Submission	When we reported our 2 nd Quarter 08 cases the surgical case with a code of 47562 were rejected and we got a critical error on the reports.	Remember that the patient must be ≥ 70 years of age to be included in the population with a CPT code of 47562. If the patient is not ≤ 70 years old, the case is not included in the population (should not even be pulled or abstracted.) Most likely, the reason your case with CPT code 47562 is being rejected is the patient ≤ 70 years old.	HOP QDRP SC	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
334	Data Submission	Where can I go to get training on data submission and information on the July 16, session?	The HOP QDRP Support Contractor has conducted monthly education sessions beginning in December 2007 to support the HOP QDRP processes. These sessions were recorded and can be located on QualityNet.org under the Hospital Outpatient tab ... select Resources - Program from the drop down list. there is also a recorded training session specific to Submitting Inpatient and Outpatient Clinical Data on QualityNet.org under the Hospital Outpatient tab ... select Training from the drop down list.	HOP QDRP SC	10/15/2008
335	Data Submission	For the Outpatient Surgery measures, how many CPT codes are required to be sent in the XML file? If a patient has 3 CPT codes that are on Table 6.0, should all codes be sent or only the first one performed?	The XML file for data transmission to the OPSS Clinical Warehouse should only contain one CPT code. The file the hospital sends to the vendor with patient encounters should list all CPT codes ... the vendor runs the list through the population algorithms and if any CPT code 'pings' as being on Table 6.0, then those patients with a CPT code that pings are included on the list to send back to the hospital for abstraction. This list back to the hospital does not necessarily have to have all the CPT codes on it --- because the hospital must now abstract the record and if there are more than one CPT code from Table 6.0, then he/she needs to determine through record review, which one was done first chronologically.	HOP QDRP SC	10/15/2008
488	Data Submission	Please clarify the freeze of data by Medicare two weeks prior to the data submission date. Is this the population and sampling data submission date? If not, they will be freezing data after the recount is due and we won't be able to change it.		IFMC	10/15/2008

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Compiled Question Answer Grid

Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
517	Data Submission	Can we print instructions only for the process to submit population selection and data submission? We have completed the on-line slide show but would like a step-by-step guide for easy reference.	The specifications manual contains a section on population selection and completion of the grid. Further written instructions are available in the QualityNet User's Guide.	HOP QDRP SC	10/15/2008
13	Data Submission: Deadlines	Our vendor has been unable to make our OP data pristine as yet (encounter date errors).....Will we be penalized if we do not meet submission by deadline.	Yes, there will be a penalty for not meeting the submission deadline. However, you have until November 1, 2008 to rectify the situation. It is suggested that you work to get some data accepted into the warehouse so that you can understand what is and is not accepted. By submitting data early, you will have time to problem solve any errors so you will be able to comply with the reporting requirements by the deadline.	HOP QDRP SC	7/16/2008
337	Data Submission: Deadlines	What is the data submission deadline schedule for OP data??	November 1, 2008	HOP QDRP SC	10/15/2008
511	Data Submission: Deadlines	Since the pop and sampling was extended to Nov 1, has the CMS data submission been extended?	No, there is no plan to extend the data submission deadline.	HOP QDRP SC	10/15/2008
530	Data Submission: Deadlines	What is the purpose of extending the submissions and abstractions if you have stick to your own deadline for data processing purposes?		CMS	10/15/2008
558	Data Submission: Deadlines	When is Population & Sampling due?	The deadline for submission has been extended to November 1, 2008.	HOP QDRP SC	10/15/2008
11	Data Submission: Measures	Will the Outpatient Clinic Encounters that were in the original specifications but then removed eventually be included in HOP?	At this time there is no plan to include measures proposed in the CY 2008 OPPS rule, but not contained in the CY 2008 OPPS final rule for the HOP QDRP. You may want to read the proposed CY 2009 rule and offer comments, especially in regard to measures under consideration for CY 2011 and subsequent calendar years.	CMS	7/16/2008

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Compiled Question Answer Grid

Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
338	Data Submission: Population & Sampling	Does the Population and Summary grid need to be completed at QualityNet if we are submitting all of our cases? With larger hospitals that do sample and a vendor does the sampling who completes this form?	The population and sampling grid must be completed to comply with the participation requirement to transmit population and sample data to CMS each quarter. Data entry is required despite sampling frequency (i.e., sampling or not) or zero cases. The grid can be completed in QualityNet by the hospital or the vendor (if authorized by the hospital). The data can also be submitted to the OPPS Clinical Warehouse by uploading an xml file.	HOP QDRP SC	10/15/2008
499	Data Submission: Population & Sampling	How do we know if what we submitted for Pop & sampling match the M18 says our Pop & sampling #s should be?	The hospital is expected to report their best estimates of measure populations available by the reporting deadline. CMS will use the Medicare claims data and the hospital's self-reported data to determine data completeness.	HOP QDRP SC	10/15/2008
508	Data Submission: Population & Sampling	If our ICD count is wrong and we use a vendor, do we need to send the correct number through the vendor or do we enter it directly into QNet?	As long as it is prior to the deadline, updates to the population and sampling grid can be made directly in QualityNet	HOP QDRP SC	10/15/2008
339	Discharge Date	Patients that go from the ED to the same hospital cath lab and then are transferred to another facility for CABG are included in the HOP QDRP SC - Would the discharge date and time be when they left the facility (i.e. from the cath lab) and not when they went from the ED to the cath lab?	The discharge date and time are when the patient physically left the <i>building</i> ; in this scenario, the discharge date and time would be when the patient left the cath lab.	HOP QDRP SC	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
83	Discharge Status	We use a discharge code that identifies our DC status for AMI's and chest pain being transferred out to another facility. But our code numbers are not that same as your E/M codes 2, 43, etc- will this still pass validation? Or do we have to add these?	The Discharge Status codes and the E/M codes are not the same. The Discharge Status codes of "02", "43", and "66" are taken from the National Uniform Billing Committee (NUBC) document that is a standard for discharge status codes. Your 'system' may use different values internally, however, for billing purposes, these internal values are most likely being converted/translated to the standard NUBC codes. These are the codes you must use for identifying your AMI/CP patients who transfer to another healthcare facility. The E/M codes are not related to discharge status, however, again, these are standard billing codes used for payment determination for services provided in the ED. If it is determined that these data elements must be documented in the permanent medical record (and are subject to validation), then a mismatch would occur if the numbers/values are different. Further clarification regarding guidelines for abstraction of E/M and CPT codes will be provided at the 8/20/08 educational presentation.	HOP QDRP SC	7/16/2008
160	Discharge Status	In the administrative data section, the Discharge Status comes up for all cases, we are currently populating this field during the download process for all cases including Elective Surgical patients, however the specifications manual defines this as a place or setting to which the patient was discharged from the Emergency department. How do we answer this question for elective pts who are not seen in the ED? If we leave the discharge status in this field for elective, non-emergency dept patients will this negatively affect our data or validation?	We are researching this one with the warehouse. Leaving this field blank because it's not required for the OP surgery cases will not count against you at this time. We will determine how this should be handled soon.	OMW	8/27/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
184	Discharge Status	If the patient's discharge disposition from the ER is observation, there is nothing under the discharge disposition from the ER question that would meet this situation.	If an ED patient is 'admitted' to observation status, the discharge disposition/status is coded when the patient is discharged from the observation status. Because the ED patient in observation status is still an ED/outpatient, you will assign the discharge status code when the patient leaves the facility ... if transferred for a higher level of care, the code would be 02, 43 or 66.	HOP QDRP SC	8/27/2008
185	Discharge Status	What are we supposed to do with cases that have an unconfirmed DC status, since they don't qualify for the study?	All medical records must have a discharge status documented. A thorough review of the chart should reveal documentation of what the patient's discharge disposition was. If documentation reveals the patient was transferred to a short term acute care hospital (02), a federal hospital (43) or a critical access hospital (66), the case will be eligible for inclusion in the outpatient measures.	HOP QDRP SC	8/27/2008
340	Discharge Status	Regarding the discharge status codes on the AMI/CP measures, my facility uses certain codes to tell which hospital the patient was transferred to. On the abstractions I answered 02. I am concerned as to what impact this will have when validation begins and what we need to do to correct this so it will not affect validations.	Because the methodology for validation has not yet been determined, we are unable to determine the impact on validation. The discharge status codes are those developed for use in Medicare billing by the National Uniform Billing Code. If your facility is using a variation of these in documentation, the expectation for abstraction is to use the allowable values from the specifications manual.	HOP QDRP SC	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
341	Discharge Status	I have a medical record that has a discharge status in COMET (our abstraction database) as a 01: discharged to home care or self care (routine discharge). On review of the medical record, this patient had a discharge order for home care with a home care agency and the discharge status should therefore be 06 according to case management. As an observation patient is an out-patient, I have been informed that the discharge status coding for OBS patients does not affect the DRG and therefore the discharge status code does not need to be changed from 01 to 06. I am concerned that this lack of changing the discharge status will negatively impact our validation scores, in the DEAR or other validation reports. Please advise if we are to change the discharge status in our abstraction database.	Generally speaking, because the methodology for validation has not yet been determined, we are unable to determine the impact on validation. Specific to the scenario you describe, the patient will not be included in the ED-AMI or ED-CP population with a discharge status of 01 or 06. For the OP-Surgery population, discharge status is not one of the required data elements, therefore is not relevant to the case abstraction.	HOP QDRP SC	10/15/2008
186	Discharge Time	We have a chest pain patient that clearly was transferred from Hospital A by EMS on 5/10/08 @06:50am to Hospital B for a heart cath. Later that same day the Hospital B reported that the patient was being dc'd from their facility if it was okay with Hospital A's attending. The patient never returned to Hospital A and the final discharge time is 2pm on 5/10. Would we use the transfer time of 5/10 @ 06:50 since this is the time the patient physically left Hospital A?	Yes, the discharge time is the time the patient left your facility.	HOP QDRP SC	8/27/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
187	Discharge Time	In regards to the exact Discharge/Transfer time to abstract: Scenario #1: On the ER record for Departure Date/Time 7/14/08 – 18:45. The Coding Summary sheet that lists Dis DT/TM: 7/14/08 18:45. Then I have an EMTALA MEMORANDUM OF TRANSFER form on the chart. In the box for Accompanying Documentation is Time of Transfer and 18:47 is written in. For Vital Signs just prior to transfer the time is 18:47. According to the guidelines when I have 2 or more times, I am to use the latest time of transfer which would be 18:47. I am used to only seeing the ER Record with the Departure time that matches the Coding summary sheet and have been using this. Is the EMTALA Transfer form an acceptable source to abstract the latest time?	All hospital forms in the record can be used for abstraction. Since the discharge time is the latest time documented that shows when the patient actually left the facility, the discharge time would be 18:47.	HOP QDRP SC	8/27/2008
188	Discharge Time	Scenario #2: I have a discharge time marked at 14:00, "time transfer initiated" is 13:52, Patient signed transfer form at 14:12, and a nursing note documented at 14:22 stating that EMS (for transfer) was at the patient's bedside. The last vitals are at 14:28. So would I abstract 14:22 as the discharge time even though I know the patient had not physically left the hospital or would I abstract the last vitals since that is the latest time? Depending on documentation, I may not have an actual time the patient physically left the hospital.	The discharge time would be 14:28	HOP QDRP SC	8/27/2008
189	Discharge Time	Our vendor is selecting "UTD" for the Discharge Time for all Outpatient measures. Will skip logic be used so that only the ED Outpatients will be validated for Discharge Time?	You will need to check with the vendor regarding the skip logic question. The only discharge time required for the outpatient measures is for the AMI patient OP-3 measure. If UTD is abstracted for the Discharge Date/Time data element, the case will be in the measure, however will not be used in calculation of the measure. Therefore, if all records are, by default, UTD for this data element, you will have no cases used in the calculation of OP-3.	HOP QDRP SC	8/27/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
342	Discharge Time	If a patient is transferred from ED to the floor for observation status is the date of discharge and time of discharge the time transferred from ED or transferred out to another hospital/left the observation unit?	The discharge date and time are when the patient physically left the building; in this scenario, the discharge date and time would be when the patient transferred out to the other hospital/left the observation unit.	HOP QDRP SC	10/15/2008
343	Discharge Time	If there is not a specific Discharge Time documented, may we use the time of the last documented vital signs? Example: ED flowsheet shows: "10:00 Temp 98.6, Pulse 100, Resp 22. " "Pt Discharged"	The last bullet for this data element indicates "If the date of discharge is not documented, but you are able to determine the date from other documentation, this is acceptable. Therefore, yes, you can use this documentation.	HOP QDRP SC	10/15/2008
501	Discharge Time	AMI discharge time: ED nurse documented transfer by medlife at 1300 under transfer section. For disposition, the documentation states "Remove from ER w/ system time of 1500." Which time will we use - 1300 or 1500?	The data element directs abstraction of the latest documented time that the patient physically left the building. The abstractor should review the record to determine what that time is, and override any auto-populated field if necessary to reflect the most accurate discharge time.	HOP QDRP SC	10/15/2008
345	E/M & CPT Codes: Requirement on Medical Record	Please discuss what is going to be done about the E & M codes issue.	Abstraction of E/M codes will continue to be required as a data element - this data element determines whether the patient is included in the population. However, information that is not a standard inclusion in the medical record, including information related to billing such as E/M and CPT codes, will not be included in validation efforts.	HOP QDRP SC	10/15/2008
490	E/M & CPT Codes: Requirement on Medical Record	EM codes, CPT codes and ICD-9 codes do not have to be part of the permanent record for validation for OP measures - correct?	That is correct. Please refer to question # 345 and 494.	HOP QDRP SC	10/15/2008
494	E/M & CPT Codes: Requirement on Medical Record	We heard on the call that E/M and CPT codes do not need to be part of the final record, when did this start?	There has been a lot of discussion regarding the need to have E/M and CPT codes documented in the permanent medical record. CMS ultimately decided and directed that information that is not a standard inclusion in the medical record, including information related to billing such as E/M and CPT codes, will not be included in validation efforts.	HOP QDRP SC	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
81	E/M Codes: Definition	What does the E/M code mean?	Evaluation and Management - levels of care in the ED translate into E/M codes for billing purposes. This most likely occurs through the charge master processing the care/services provided to the patient in the ED. The E/M codes used to identify the outpatient AMI/CP patient population can be found on Table 1.0 of Appendix A, Specification Manual v1.0a	HOP QDRP SC	7/16/2008
82	E/M Codes: Definition	In reference to observation patients, how do they have E/M codes or is an E/M code not required for obs patients. Then do we just use ICD-9 codes or CPT codes? Is there clarification of this in writing?	ED patients who are in observation will have one of the specified E/M codes from their time in the ED. ICD-9-CM Codes are required for determining the AMI/CP populations. CPT codes are used in determining outpatient surgery populations. You can find the detail for use of the ICD-9-CM and CPT codes in the Specifications Manual - Measure Information Forms section.	HOP QDRP SC	7/16/2008
190	E/M Codes: Definition and Use	If we are just collecting for Medicare/Medicaid, what is the reasoning for the data elements for E/M and CPT codes?	We are collecting data for both Medicare and non-Medicare patient populations. The E/M code is required as part of the determination of the population. In addition to being used to identify surgery patients that require prophylactic antibiotics, the CPT code is used in the OP-7 algorithm for determining whether the correct antibiotic selection was used for the particular surgery type.	HOP QDRP SC	8/27/2008
191	E/M Codes: Definition and Use	Define the purpose of E/M codes. State when they are used. Where do we find them and how many there are.	E/M stands for Evaluation and Management and are used for billing the appropriate level of care in the ED. The E/M codes used in determining the Hospital Outpatient population are listed in the Specifications Manual Appendix A, Table 1.0. They include 99281 (Level 1), 99282 (Level 2), 99283 (Level 3), 99284 (Level 4), 99285 (Level 5), and 99291 (Critical Care).	HOP QDRP SC	8/27/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
192	E/M Codes: Definition and Use	Please clarify the E/M code requirement. Do you want the facility level code, the physician professional level code or both?	The facility level E/M codes should be used.	HOP QDRP SC	8/27/2008
193	E/M Codes: Use in Validation	We use contracted physicians in our Emergency Department, EMCARE, and they do their own billing. EMCARE is providing that information to me when requested so that the data can be abstracted for the Chest Pain/AMI cases. How will this data element be validated since E/M codes are not in our outpatient medical record?	For purposes of validating hospital-reported quality of care data, information that is included in the outpatient medical record concerning clinical care will be utilized. Information that is not a standard inclusion in the medical record, including information related to billing such as E/M and CPT codes, will not be included in validation efforts. E/M and CPT codes pertain to the responsibility of hospitals to bill for services correctly. For determining case populations, it is the goal of the HOP QDRP to remain as consistent as possible to billing practices, keeping the claim as the unit of interest. It is noted that under Medicare outpatient billing, it is standard practice to bill unrelated services separately.	HOP QDRP SC	8/27/2008
74	ECG	Can we use the telemetry strip performed by EMS as the earliest ECG time?	Yes, if you are able to determine the ECG is a 12 lead.	OMW	7/16/2008
75	ECG	On EKG interpretation, if a physician documents Jpoint elevation, but does not say ST elevation, is that a no?	This will abstract as a NO.	OMW	7/16/2008
358	ECG: Date & Time	If I don't have a time printed on the ED EKG, can I use the "Time Seen" on the ED Physician T/Sheet, since on the back of the T/Sheet is the physician's interpretation of EKG? (or do I enter UTD?)	If the time indicates it is the time the ECG was performed, this is acceptable, but if it is the time of interpretation you would need to select UTD.	OMW	10/15/2008
359	ECG: Date & Time	If I don't have a time printed on the ED EKG, can I use the Emergisoft "Patient Chart" form, the "Triage Treatment" section that has "EKG" documented with a date and time next to it? (or do I enter UTD?)	Yes, this time may be used.	OMW	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
360	ECG: Date & Time	The data dictionary says that when 2 conflicting time exist, choose the machine report over nursing notes. Unfortunately, we have problems with the accuracy of our machine time. and nursing notes is more accurate. For example - time on the hospital ECG machine was when the patient was in the ambulance. So can we use the nurses notes time?	You would need to abstract as UTD	OMW	10/15/2008
167	ECG: Interpretation	Does an EKG read by another physician, after patient has been transferred (possibly 1-2 days later) satisfy the interpretation criteria (2-44 in specs manual)?	If this documentation is made part of the current medical record, this will be used for abstraction.	OMW	8/27/2008
168	ECG: Interpretation	I'm finding it difficult to determine Yes or No on this question. If the ECG in question describes a definite ST elevation or LBBB then I'm okay. It's when it does not that I'm having trouble. On the inclusion list it list MI, with any mention of location or combinations; so if it just says MI, or evolving MI it's a "Y"?	You would need to see documentation of a location, so just MI or evolving MI would not be sufficient.	OMW	8/27/2008
169	ECG: Interpretation	ECG reading with "consider" ie (1) Nonspecific ST & T wave abnormality consider inferior ischemia, (2) Nonspecific ST & T wave abnormality, consider arteralateral ischemia or (3) consider anterior infarct. Since "consider" is not in the exclusion list, but it has an ST abnormality, do we answer "yes" to initial ECG interpretation.	For the data element Initial ECG Interpretation -- Non-specific ST & T wave abnormality consider inferior ischemia = NO, Non-specific ST & T was abnormality consider arteralateral ischemia = NO, consider anterior infarct = YES (consider anterior infarct is an inclusion).	OMW	8/27/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
170	ECG: Interpretation	Initial ECG interpretation, Date, Time: The ambulance will often do an ECG prior to arrival. However, the ECG is not in the chart and in the ambulance record, the interpretation is not done by a physician and it is in the chart usually after discharge. Unless there is an interpretation by a physician referring to it as the "initial ECG" or "ECG in ambulance" (if only one), I don't use it. I use the first ECG that was done here. For ECG date/time, I abstract the date and time of the ECG that I used for interpretation, regardless if it was the initial. Is this the correct way to be abstracting this?	For the data element Initial ECG Interpretation, you would use the closest to arrival ECG, so if the one done in the ambulance is done closer to arrival than the one done in the facility, this must be used. Again you would only use documentation that references this ECG. For the data element ECG Date and Time, if the ECG done in the ambulance is done within one hour prior to arrival, this is the one you would use, and the date and time will abstract as the arrival date and time as this is what the data element instructs. Keep in mind the data elements used for OP-5 are ECG and ECG Date and Time they are not tied to the data element Initial ECG Interpretation.	OMW	8/27/2008
346	ECG: Interpretation	What if your ECG tracing is not signed and you do have documentation of MD interpretation of the ECG?	If you have MD documentation tied to the closest to arrival ECG, this may be used.	OMW	10/15/2008
347	ECG: Interpretation	I have 1 12 Lead EKG on the MR. The printout states: NSR @ 84. Inferior Infarct, possibly acute. Cannot rule out Anterior infarct, age undetermined. T wave abnormality, consider lateral ischemia. *** Acute MI ***. This EKG is initialed and timed as to the time spent in the ER. ER Dr. interpretation on the T-sheet in the EKG box-- It is not labeled #1 or initial. It states: ST (arrow up) II, II, F. Q in III F, ST (arrow down) I.L. Ante Inf wall STEMI. The T-sheet is timed from 23:30 – 0005 (transfer to short term hospital) What would the answer to the initial EKG be?	This will abstract as a NO.	OMW	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
348	ECG: Interpretation	Re: initial EKG interpretation. The pt had just 1 EKG so all this pertains to that initial EKG. The initial EKG is officially read as NSR, possible left atrial enlargement, septal infarct age undetermined, ST&T abnormality, consider inferior ischemia or inferior infarction, ST&T abnormality consider anterolateral ischemia, abnormal EKG. The ER MD's EKG interpretation reads: NSR ant-lat inferior ischemia. The ER MD's final diagnosis is Acute MI Unspecified location. How should we answer the initial EKG interpretation question? Is consider an exclusion? We do not find it on the list of exclusion terms. The EKG interpretation does not include acute or evolving, but the ER MD's final diagnosis does.	Consider would be an inclusion and you would be unable to use the ED physician final diagnosis.	OMW	10/15/2008
349	ECG: Interpretation	A patient receives an EKG prior to arrival. The EKG done prior to arrival was done by EMS. The EMS personnel document that the EKG notes an acute MI. The patient then does not have an EKG done immediately at the hospital. It may be 20 minutes after arrival (where the EMS EKG was done 5 minutes prior to arrival making it the earliest). The EKG done 20 minutes after arrive has a MD interpretation of an acute MI (as the EMS personnel noted in their progress notes). On a MI patient the question is asked: Is there documentation of ST-segment elevation or left bundle branch block (LBBB) on the electrocardiogram (ECG) performed closest to emergency department arrival? The earliest EKG is the one by EMS which has no documentation of an MI by a MD – just by EMS personnel. Does the question above have to be answered on the EKG with the closest time? Realizing that the EMS EKG will not ever have a MD interpretation should we eliminate these EKG's from our abstraction of earliest time? If we eliminate the EMS EKG from our abstraction, then our median time would result in a higher timing correct?	If the earliest EKG done in the ambulance is not signed or does not contain any reference of documentation by the physician, this will abstract as a NO.	OMW	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
350	ECG: Interpretation	Small hospital - EKGs are "sent" out electronically - 2 results - computer and then physician follow up - EKGs do not have a physician's signature - just the physician name with the results - is this acceptable as a "signed" EKG result?	If the physician name indicates the physician interpreted or acknowledge the results, this may be used.	OMW	10/15/2008
351	ECG: Interpretation	Regarding the statement in the Guidelines for Abstraction table, under Exclusions, it states "LBBB or any of the other left bundle branch block inclusion terms, with mention of pacemaker/pacing (unless atrial only or nonfunctioning pacemaker)". Does the pacemaker reference need to be on the same ECG tracing that mentions the LBBB? Or can the pacemaker reference be documented by a physician/APN/PA in a separate source such as a progress note?	It would need to be tied into the ECG interpretation or documentation.	OMW	10/15/2008
352	ECG: Interpretation	ER pt comes in with CP. Physician diagnosis is Acute MI. Under EKG interpretation he writes "lateral infarct" but does not refer to any ST elevation or LBBB. 12 Lead EKG on the chart (unsigned) states " lateral infarct - age indeterminate. Under initial ECG interpretation would it be yes or no since there is no reference to ST elevation, but the physician in his record did document lateral infarct under EKG interpretation?	This will abstract as a YES.	OMW	10/15/2008
354	ECG: Interpretation	For an outpatient who had an acute MI that was seen in ER, the only EKG had a reading indicating a LBBB. This was also confirmed in the note documented by the ER physician. The ER physician also documented in the note that the patient had a NonSTEMI (which normally do not get TNK) and gives this as the final diagnosis. NonSTEMI is however not documented on the EKG. The patient by the way did not get a clot buster, and I see NonSTEMI is in the exclusion list. For the question, "Is there documentation of ST segment elevation or left bundle branch block (LBBB) on the ECG performed closest to emergency department arrival" do I answer this Yes or No?	This will abstract as a YES. The documentation by the physician of the Non STEMI would need to be linked to his interpretation of the ECG.	OMW	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
355	ECG: Interpretation	On interpretation of ST elevation/LBBB on EKG performed closest to arrival, how do we determine this to be the case on EMS EKG's done as they are not interpreted officially by the ED MD.	Unless they are interpreted by a physician, the documentation cannot be used.	OMW	10/15/2008
356	ECG: Interpretation	For May 08--- initial EKG interpretation NSR, inferior-posterior infarct, possibly acute; T wave abnormality, consider lateral ischemia; ***acute MI*** abnormal EKG. The ER MD's EKG interpretation is "IWMI, NSR". His final diagnosis on the ER record is "acute MI, inferior". Since the EKG says "possibly" acute, is this still an exclusion given the "acute" in the final ER Diagnosis by the ER MD? Please advise how to answer the initial EKG interpretation question.	You would not be able to use the final diagnosis of the ER as it does not reference that this was the interpretation from the ECG and you would need to disregard the findings qualified by the word possibly.	OMW	10/15/2008
161	ECG: Selection	Can we abstract a 12-lead EKG done in the ambulance if there is an ambulance bill in chart indicating one was done, but no other documentation or result?	If there is documentation in the medical record that a 12 lead was billed for in the ambulance and the documentation supports the ECG was collected by EMS in the ambulance within one hour prior to arrival at the facility, this will abstract as a YES for the data element ECG.	OMW	8/27/2008
162	ECG: Selection	Guidelines for outpatient AMI state EKG done closest to time of arrival " <u>can be within 1 hour prior to admission to ED</u> " but abstraction not accepted in CART, stating reason for not accepting "cannot accept EKG due to time of EKG is prior to arrival.	For the data element ECG Date and Time, you can accept ECGs done within one hour prior to arrival, but you are to abstract the date and time as the arrival date and time.	OMW	8/27/2008
163	ECG: Selection	Must the initial EKG be signed/initialed by a Physician, PA, or ARNP in order to count in abstraction? If the initial EKG is not signed; then do you say No to the EKG question or go to the next signed EKG? What do you consider a "SIGNED tracing" (2-43 in specs manual)?	A signed ECG would contain documentation/ interpretation by the physician/APN/PA and you would need to see documentation they were aware of the results to abstract. If the initial ECG is not signed and there is no additional documentation that references this ECG, this will abstract as a NO.	OMW	8/27/2008
164	ECG: Selection	The most confusing area seems to be when you can count the ER Dr.'s interpretation on the ER T-Sheet. All say you must be sure that interpretation is linked to the initial EKG but how can you do this unless the ER. Dr. documents #1 EKG or states "initial EKG and then writes an interpretation?	You are correct. You would need to see documentation that confirms it is in reference to the closest to arrival ECG.	OMW	8/27/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
165	ECG: Selection	Can I always infer and use the EKG Dr. interpretation in abstraction if there is only 1 EKG on the chart and it is initialed by that ER Dr. and only 1 interpretation written in on the ER Dr. T-sheet?	Yes. If there is only one ECG done you may assume all documentation refers to this ECG unless otherwise specified.	OMW	8/27/2008
166	ECG: Selection	If pt had ECG in ambulance but has no time on ambulance record and had ECG in ER. Also ECG in ambulance does not state 12 lead (just says ekg-SR with elevated T-wave. and in notes has EKG-SR with PVC's. ECG in ER reads Inferior Infarct, Possibly Acute, T-Wave Abnormality, Consider Lateral Ischemia or Digitalis Effect," Acute MI" . How would I answer ECG performed within 1hr of ED arrival or in the Ed prior to transfer? How would I answer documentation of St-Elevation or LBBB on ECG performed closest to ED arrival?	For the data element ECG, this will abstract as a YES as although you don't know if the ECG done in the ambulance was done within one hour prior to arrival, you do know there was an ECG done prior to transfer. This will abstract as a NO for the data element Initial ECG Interpretation.	OMW	8/27/2008
357	ECG: Selection	Regarding EKG on the AMI/CP measures, I am only to use 12 lead EKG'S not monitor strips correct?	Correct.	OMW	10/15/2008
549	ECG: Selection	If a 12-lead ECG is performed 50 minutes before the documented arrival time and another ECG is performed 5 minutes after arrival, is the ECG performed prior to arrival considered as the ECG performed closest to arrival? (OP-5)	For the data element ECG Date and Time, you would use the ECG done 50 minutes prior to arrival, which according to the notes for abstraction, will abstract as arrival time.	OMW	9/19/2008
550	ECG: Selection	If a 12-lead ECG is done 50 minutes before the documented arrival time and another ECG is performed 5 minutes after arrival, which one should be used for Initial ECG Interpretation? (OP-1, OP-2, OP-3)	You would use the ECG done closest to arrival time, which in the scenario presented is the ECG done 5 minutes after arrival.	OMW	8/6/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
195	ED Arrival Time	Upon arrival to the ED, patients complete a 'complaint form' that remains a part of the ED record. The patient documents the date and time of arrival on the form. The triage nurse documents the date and time of arrival on the triage assessment. The time documented by the patient and the triage nurse do not match. The patient's time of arrival is earlier than the triage nurse's documented time of arrival. Which time do I use: the triage nurse time or the time the patient documented on the complaint form? If face sheets shows an earlier time than the ER triage sheet would that be the correct arrival time?	You should use the earliest documented time of arrival from review of all applicable data sources to determine the ED Arrival Time. The time abstracted should have substantiating documentation, and not simply taken as the earliest time listed in the record. If the 'complaint form' is a permanent part of the medical record, it can be used as a data source; this data element does not restrict any data sources.	HOP QDRP SC	8/27/2008
196	ED Arrival Time	Can we use the time recorded on our EKG printouts as the ED arrival time? Our ER staff is getting the EKG first before any other admission process. So our EKG printout is showing a time of 1-3 minutes faster than any nursing documentation of ER arrival or the face sheet admission arrival time. The EKG is being performed inside the ER by the ER staff and the EKG printout does have our hospital name imprinted on it along with the time and date of EKG??	You should use the earliest documented time of arrival from review of all applicable data sources to determine the ED Arrival Time. The ECG is an acceptable source and therefore you should use that time as the ED Arrival Time.	HOP QDRP SC	8/27/2008
361	ED Arrival Time	Do we use the registration record time if it is prior to the ED record? It isn't clear if we can use that document.	There are no restricted data sources for this element. If the registration record is part of the emergency department record, then it can be used.	HOP QDRP SC	10/15/2008
509	ED Arrival Time	OP AMI/Chest Pain-The first thing done with these patients is the EKG so that is first documentation. Can I use that time for arrival time if it is prior to documented service/admission time	Yes, the ED Arrival Time is to be the earliest documented time the patient at the ED. The abstractor should review all data sources to determine the earliest time documented.	HOP QDRP SC	10/15/2008
513	ED Arrival Time	When entering the earliest arrival time, I have been using the triage note. In two cases, an EKG was done prior to the triage note. As a result, that data was thrown out as missing data. Should I use the EKG time if it is prior to the triage note?	You should use the earliest documented time of arrival from review of all applicable data sources to determine the ED Arrival Time. The ECG is an acceptable data source as well as the triage note.	HOP QDRP SC	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
526	ED Arrival Time	At times, we have a patient come to the ED prior to transfer directly from the stress lab if there is positive test. Is the arrival time the time they arrived to ED or the time they arrived to Stress lab?	Patients must have an E/M code, as well as the ICD-9 code and appropriate discharge status code to be included in the population. If the patient has an E/M code, then they would be included. In this case, the arrival time will be the time the patient arrived in the stress lab (i.e., the earliest documented time the patient arrived in the outpatient setting).	HOP QDRP SC	10/15/2008
548	ED Arrival Time	There is an arrival time on the patient's face sheet that is earlier than the arrival time on the Emergency Department (ED) triage sheet. Which time should be abstracted?	Abstract the earliest time of arrival. If the registration time is the earliest, use the registration time; conversely, if the triage time is earliest, use the triage time. However, if documentation suggests the earliest time in the ED medical record does not reflect the time the patient arrived at the ED, this time should not be used.	HOP QDRP SC	8/6/2008
66	Fibrinolytics: Contraindications	Although I have not abstracted many outpatient records to date, our physicians do not typically document a reason for not administering fibrinolytics. Typically our patients are transferred out with Heparin gtt/Integrelin. Will we fail for this quarter	If there is not a documented reason, the case will be placed into the D' measure category assignment. This data element is used to allow cases in which a delay is known (potentially causing the time of arrival to intervention to be greater than 90 minutes) but administering fibrinolytics is not an option, to be separated out.	OMW	7/16/2008
67	Fibrinolytics: Contraindications	If a patient is transferred out for PCA, is this considered a reason for not getting fibrinolytics?	No. Only use reasons/contraindications listed in the data element Reason for Not Administering Fibrinolytic Therapy. Transfer for PCA is not a listed reason.	OMW	7/16/2008
68	Fibrinolytics: Contraindications	Our facility always transfers out the AMI / CP for cardiac intervention to our sister facility which is only approximately 7 miles away. What documentation is appropriate for a contraindication as there is none and we always get them in within 90 minutes.	The data element is used to allow cases in which a delay is known (potentially causing the time of arrival to intervention to be greater than 90 minutes) but administering fibrinolytics is not an option, to be separated out. In scenarios where the transfer is timely, you would not expect to administer fibrinolytics.	OMW	7/16/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
69	Fibrinolytics: Contraindications	All AMI outpatient records must have fibrinolytic documentation as to why fibrinolytics were not administered?	Reason for Not Administering Fibrinolytic Therapy is only used for OP-3. Depending on whether your vendor utilizes skip patterns, you may be required to answer this for all AMI cases.	OMW	7/16/2008
70	Fibrinolytics: Contraindications	On Fibrinolytics. We try to get the patient to our sister hospital w/in 30 mins. Stabilize here and send out. 95% of the time Fibrinolytics are not started here because we try DOOR to Deal. Do we still have to have physician document why fibrinolytic not given?	The data element is used to allow cases in which a delay is known (potentially causing the time of arrival to intervention to be greater than 90 minutes) but administering fibrinolytics is not an option, to be separated out. In scenarios where the transfer is timely, you would not expect to administer fibrinolytics.	OMW	7/16/2008
71	Fibrinolytics: Contraindications	For AMI outpatients who transfer out for coronary intervention, if their ECG did not show ST segment elevation, would this case fail if there was no documentation of thrombolytics given?	Per the algorithm and measure information form for OP-3 if the data element Initial ECG Interpretation is a NO, the case is excluded.	OMW	7/16/2008
72	Fibrinolytics: Contraindications	For documentation of fibrinolytics and reasons for not giving them, if the transfer sheet lists the reason for transfer as "for cardiac cath", or something similar, is that considered as a documented reason?	No. Only use reasons/contraindications listed in the data element Reason for Not Administering Fibrinolytic Therapy. Transfer "for cardiac cath" is not a listed reason.	OMW	7/16/2008
154	Fibrinolytics: Contraindications	We are a small, 56 bed, rural hospital about 90 minutes from any Coronary Care Center. We often have a period of 30-45 mins before the attending or on call cardiologist returns the call to our ED physician to discuss transfer of patients. We also have a hospital affiliated EMS service in our county. This translates into EMTALA regs that prevent EMS transport of a patient without an accepting physician and a bed assignment. We may have an accepting physician but he then has us hold the patient until "bed control" has a bed. This can take up to hours. I know that we can document contraindications but what about circumstances beyond our control, like those above?	These would not be acceptable reasons. These are the exact scenarios facilities should work to improve on. Guidelines recommend if the patient cannot receive acute coronary intervention in under 90 minutes, then fibrinolytics should be administered.	OMW	8/27/2008

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Compiled Question Answer Grid

Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
155	Fibrinolytics: Contraindications	<p>ED record with MD documentation of "Thrombolytics" that has a line through it. Other documentation states pt will be transferred to Dr. at Hospital B and Dr. requested pt receive no more than 3 medications (listed out, but none of them considered fibrinolytic therapy).</p> <p>Question: does reason for no fibrinolytic therapy have to be linked to Dr.'s request or is the documentation of "thrombolytics" crossed out enough to answer yes to contraindication to fibrinolytic therapy? If MD simply states "no thrombolytics," is this enough to answer yes or does there need to be a specific reason associated with it? Can I look for a reason for no thrombolytics (ex: look for a documented history of chronic, severe, poorly controlled hypertension) or does the reason (on the inclusion list only) have to be linked to no fibrinolytic therapy (ex: "no thrombolytics due to . . .")?</p>	<p>You must see documentation of a contraindication as defined in the data element. Documentation of the contraindication is sufficient. There does not need to be documentation explicitly linking the contraindication as the reason. Also, documentation the receiving physician requested the patient to not receive fibrinolytics etc is not an acceptable reason/contraindication.</p>	OMW	8/27/2008

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Compiled Question Answer Grid

Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
156	Fibrinolytics: Contraindications	All of our AMI patients are transferred to a tertiary center for PCI so we do not give thrombolytics, as it would be contraindicated. Will our ED physicians have to make a statement in each record specifically that they are not giving thrombolytics because they are transferring the pt for PCI? That seems redundant. Would you please clarify this issue?	This will not abstract as an appropriate reason/contraindication according to the data element. If they are being transferred out for acute coronary intervention, the expectation is they will be transferred out to receive the therapy in under 90 minutes and will not need the fibrinolytics. This data element is used to allow the provider to document a contraindication to fibrinolytics and place the case in a separate group in the event the transfer is expected to take longer. Cases in which the provider is aware the patient will not receive acute coronary intervention within 90 minutes should receive fibrinolytics according to guidelines, unless contraindicated. Thus we check for a contraindication/ reason for not administering fibrinolytic therapy. If the transfer is expected to take a long time and there are no contraindication/reasons for giving fibrinolytics, the patient should receive fibrinolytics and will be excluded from the measure.	OMW	8/27/2008
157	Fibrinolytics: Contraindications	Our ED (ambulance) transfers ACS patients to 2 different hospitals (within 35 miles) with cath labs for intervention. They use a "Rescue1" form that is a permanent part of the chart listing the steps and medications given to the patient prior to transfer. There is a box that serves as a guideline that basically says to consider fibrinolytics if door to cath lab time will be greater than 90 minutes. There is no other specific documentation on the chart as to why fibrinolytics were not given other than guidelines for contraindications. A heparin drip is initiated. If nothing is circled or checked, etc., is this adequate for the "not administered reason" data element?	Only use reasons/contraindications listed in the data element. This would not be sufficient documentation of one of the reasons/contraindications.	OMW	8/27/2008

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Compiled Question Answer Grid

Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
158	Fibrinolytics: Contraindications	When the plan is to transfer patient with STEMI to another facility for PCI (angioplasty within 90 minutes), fibrinolytics are not administered. Since PCI is not listed as an exclusion, it sounds like we get a "failure" for not administering fibrinolytics even if we document that "the patient did not receive fibrinolytics because the patient was sent for PCI instead."	There are no failures for OP-3. It is correct that patients who are transferred to receive acute coronary intervention in under 90 minutes should not received fibrinolytics. However, we expect that if the provider is aware the patient will not make the 90 minutes, they will give fibrinolytics and the patient will be excluded from the measure. However, if the patient has a contraindication/ reason not to receive fibrinolytics, they will not be able to be excluded from the measure, so we allow for them to be placed in a separate category-D prime.	OMW	8/27/2008
365	Fibrinolytics: Contraindications	If a patient came to the ED in a full Cardiac Arrest and had CPR for 25 minutes can I answer yes for contraindications to Fibrinolytic therapy even if there is no specific documentation by the MD that this is why the patient did not receive fibrinolytic therapy?	Correct.	OMW	10/15/2008
366	Fibrinolytics: Contraindications	AMI abstraction. Yes, we had ST elevation, No, we did not give the Fibrinolytic . There was no supporting documentation as to why the Fibrinolytic was not given. Yes the pain was cardiac in origin. By all indications we should of failed the question on Fibrinolytic administered in 30 min. But when I click on Patient details, in the abstraction area- it lists OP#1 and OP# 2 questions as both Denominator Exclusion. Which is great and fine for our hospital. It just makes me think I have done something in Error. I just cannot locate the supporting documentation as to why it should be a Denominator Exclusion. We did transfer to a higher level of care hospital and the final Principal Diagnosis was AMI but with Unspecified site, but we still should of given the Fibrinolytic in our own ER, correct?	If the patient did not receive fibrinolytics, they are not eligible for OP1 and OP-2.	OMW	10/15/2008

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Compiled Question Answer Grid

Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
367	Fibrinolytics: Contraindications	Looking at abstraction of these AMI OP, if fibrinolytics is not given, then we should not fail in that measure if we put UTD, however in the grid it comes up D', how can that not be perceived as pass fail for public reporting.	If the patient did not receive fibrinolytics, they are not eligible for OP1 and OP-2. If there is no contraindication/reason for administering fibrinolytics and the patient did not receive fibrinolytics, the case will be placed in the D' measure category assignment for OP-3 and become eligible for public reporting. There are no failures for OP-3.	OMW	10/15/2008
368	Fibrinolytics: Contraindications	What are the implications that a patient will be put in D group versus Dprime group when fibrinolytics are not given because they are transferred to another facility for PCI? Could you explain what the D-prime Category is?	It is expected that if providers are aware they will meet the 90 minute window, the patient will not receive fibrinolytics ... which for most cases should not be a problem. This only factors in to cases in which the provider is aware they will not meet the 90 minute window. The appropriate standard of care is to administer fibrinolytics to these patients. When you have a patient you know will not meet the window and they have a medical contraindication to fibrinolytics, you would need to document the medical contraindication to fibrinolytics. When that is done, the case is placed into the D prime measure category assignment. This group is identified as patients who were transferred for acute coronary intervention, but it was taking a long time and you wanted to give fibrinolytics but couldn't. It is only used for internal improvement at your facility. These cases were kept in the population rather than excluded because national experts and guideline writers agreed it was still important to look at these times and see what could be done to improve, but not hold the facility publicly accountable.	HOP QDRP SC	10/15/2008
369	Fibrinolytics: Contraindications	I am still confused on the contraindications for not giving fibrinolytics. I thought that the only acceptable contraindications were patient refusal or cardiogenic shock regardless of what the physician documents. Is this not correct?	It is patient refusal, cardiogenic shock or any of the contraindications listed in the data element.	OMW	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
370	Fibrinolytics: Contraindications	Looking at OP-AMI 2nd qtr I see D not D' listed when I put UTD for reason for not doing fibrinolytics, Will this be a failure for public reporting? Please clarify	This will not be a failure as there are no failures for OP-3, however the case will be placed in the D' measure category assignment and eligible for public reporting.	OMW	10/15/2008
371	Fibrinolytics: Contraindications	Should we be telling our ER DOCS to write reason for no fibrinolytics, since we don't give because we are transferring out.	Transfer for acute coronary intervention is not an acceptable reason for not administering fibrinolytics. Only use reasons/contraindications listed in the data element.	OMW	10/15/2008
372	Fibrinolytics: Contraindications	For small hospitals that ship pts. to bigger facilities for cardiac F/U, cardiac cath, etc. - fibrinolytics are not given - timely transport is the goal - what is acceptable documentation for reasons not to give the Fibrinolytic?	Transfer for acute coronary intervention is not an acceptable reason for not administering fibrinolytics. Only use reasons/contraindications listed in the data element.	OMW	10/15/2008
373	Fibrinolytics: Contraindications	Reason for Not Administering Fibrinolytic Therapy", it appears that the documentation of any contraindication in MD/APN/PA notes or pharmacy documentation is sufficient, and there does NOT need to be a direct statement from an MD/APN/PA or pharmacist regarding why fibrinolytics were not given. Is this true?	True.	OMW	10/15/2008
374	Fibrinolytics: Contraindications	Reason for Not Administering Fibrinolytic Therapy - I don't know if this would happen, but if we had both cardiogenic shock and another reason for not administering fibrinolytic therapy documented, would we answer "1" or "2"? ... If any of the conditions in the inclusion list are documented, is that sufficient to answer "1" – or does a listed condition need to be specifically noted as the reason for no lytic therapy? (For example, if a history of intracranial hemorrhage is noted, is that enough or must there be documentation that this is the reason for not administering fibrinolytics?)	Use value 1.	OMW	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
375	Fibrinolytics: Contraindications	We have asked this question before, but would like clarification regarding what are acceptable 'other reasons' when a there is a contraindication or other reason documented by a physician/APN/PA or pharmacist for not prescribing fibrinolytic therapy. Does the physician/APN/PA's other reason need to be one of the contraindications or risk on the Inclusion Table under Guidelines for Abstraction? Are other reasons besides those listed acceptable?	Yes, only use reasons/contraindications listed in the data element	OMW	10/15/2008
376	Fibrinolytics: Contraindications	In the situation when our OP-AMI patients are transferred for acute coronary intervention and no fibrinolytic is administered in our ED, are we penalized for answering question 19 as a number 3 "No contraindication/UTD"?	You are not penalized, this just places the case in the D' measure category assignment.	OMW	10/15/2008
453	Fibrinolytics: Contraindications	Can the terms thrombolytic and fibrinolytic be used interchangeably when referring to a patient's refusal for thrombolytic therapy?	Yes.	OMW	10/15/2008
456	Fibrinolytics: Contraindications	Fibrinolytics contraindication: if we don't give because we are transferring the patient for PCI and the patient will be there within 90 minutes, is this a contraindication?	Transfer for acute coronary intervention is not a medical contraindication to administer fibrinolytics to those patients who are to receive acute coronary intervention or other levels of care. However, we expect that if providers are aware they will meet the 90 minute window, the patient will not receive fibrinolytics. Which for most cases should not be a problem. Here is a summary of the standard. Patients receive Acute Coronary Intervention within 90 minutes IF unable to meet the 90 minute window-administer fibrinolytics IF unable to meet the 90 minute window and patient has a medical contraindication-document this. IF patient will meet the 90 minute window-do not administer fibrinolytics.	OMW	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
460	Fibrinolytics: Contraindications	OP-AMI If interventional hospital is within 30miles, do you need to have specific documentation of reason fibrinolytics were not given?	No. See response for question 456.	OMW	10/15/2008
461	Fibrinolytics: Contraindications	Our hospital system transfers STEMI patients from secondary hospitals to our primary hospital for PCI within 90 minutes. According to the measures, we fail OP1 AND OP2 because there is not a contraindication for fibrinolytics. Please recommend how to address this.	If patients do not receive fibrinolytics, they are not eligible for OP-1 and OP. If there is a delay in transfer and the provider makes the decision to administer fibrinolytic therapy, they must document the reason for delay. The case will be included for the timing measure, however this is a median time measure so occasion outliers should not greatly impact the median time.	OMW	10/15/2008
465	Fibrinolytics: Contraindications	We are a rural hospital and for AMI we try to get them shipped out to our sister hospital w/in 30 mins. to meet the door to deal time. We do not give fibrolytics because hospital is only 10 minutes away. What do we do w/this issue?	Continue to do what you are doing. See response for question 456.	OMW	10/15/2008
546	Fibrinolytics: Contraindications	What can physicians document as appropriate reasons/contraindications for Reason for Not Administering Fibrinolytic Therapy?	The only valid reasons/contraindications for not administering fibrinolytic therapy that can be used are those listed for the data element, which includes patient refusal or Cardiogenic Shock. Transferring the patient for acute coronary intervention is not a valid reason for this data element. If there is no valid contraindication/reason as listed in the data element the case will fall into the D measure category.	OMW	8/6/2008
73	Fibrinolytics: Timing	Re: Fibrinolytics--what is considered an extended time in reaching acute coronary intervention that would fail the core measure OP-3 if the pt did not receive fibrinolytics and with no reason documented. Would it be the same 90 min for PCI inpt.?	This measure calculates a median time, therefore there are no failures for this measures. Ideally patients who are being transferred for acute coronary intervention will be transferred in a timely manner in order to facilitate acute coronary intervention in the receiving hospital within 90 minutes of arrival at the initial facility.	OMW	7/16/2008
476	HOP QDRP	Is there any plan to expand the outpatient SCIP measures to beyond just the two OP-6 and OP-7?	There may be other ambulatory surgery measures introduced in the future.	OMW	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
521	HOP QDRP	Is there a resource person to contact to clarify data definitions and/or clinical questions - other than the Help Desk?	You should contact the HOP QRP Support Contractor (HOP QDRP SC) for all questions related to the outpatient data reporting and submission processes. If necessary, we will refer the issue to the appropriate subject matter expert, including the outpatient measures writers (OMW) or the qualitynet helpdesk.	HOP QDRP SC	10/15/2008
531	HOP QDRP	What is the best way to stay informed regarding the HOP QDRP initiative?	Providers and vendors should sign-up for the HOP QDRP list serve via QualityNet.org. Regular visits to the QualityNet home page for News Updates is also recommended.	HOP QDRP SC	4/23/2008
197	HOP QDRP	When will Maryland hospitals need to participate in the outpt quality data reporting?	The rule does not require participation by CAHs or Maryland hospitals, however, CMS has determined that CAHs will be permitted to voluntarily participate in the HOP QDRP. Providers will be able to begin the Notice of Participation (NOP) process in November 2008 with the deadline for submission of a completed NOP by January 31, 2009. Information will be communicated via the HOP QDRP list serve as specifics relating to the process for signing up gets closer.	CMS	8/27/2008
198	HOP QDRP	Does the HOP QDRP apply to critical access hospitals as well? In the proposed OPSS rule changes, there is no mention of inclusion for Critical Access Hospitals to report data for the outpatient measures. Do you believe that this group of hospitals will be excluded in the Final Rule, and if so, can you explain why?	The rule does not require participation by CAHs or Maryland hospitals, however, CMS has determined that CAHs will be permitted to voluntarily participate in the HOP QDRP. Providers will be able to begin the Notice of Participation (NOP) process in November 2008 with the deadline for submission of a completed NOP by January 31, 2009. Information will be communicated via the HOP QDRP list serve as specifics relating to the process for signing up gets closer.	CMS	8/27/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
496	HOP QDRP	When can Critical Access Hospitals begin submitting data?	CAHs and other non-PPS hospitals will be allowed to participate in the HOP QDRP beginning with January 1, 2009 encounters. Information about signing the Notice of Participation, deadlines, etc will be communicated via the HOP QDRP list serve in the next couple weeks.	HOP QDRP SC	10/15/2008
9	HOP QDRP Email List ("List serve")	How may I sign up for list serve? Do I register for communications at the e-mail address posted hopqdrp@fmqai.com	You can sign up for the list serve by going to the QualityNet.org website, lower left corner, Auto Notifications or to this link: http://qualitynet.org/dcs/ContentServer?pagename=QnetPublic/ListServe/Register (cut and paste)	HOP QDRP SC	7/16/2008
199	HOP QDRP Email List ("List serve")	I signed up on the list serve when it was first available. It has been a while since I received an email. I want to make sure I'm still on the list serve	Users are able to verify their subscription to any listserve via www.qualitynet.org . On the home page, click on the "Register for Notifications" link in the lower left side of the screen, then click the link in the upper left blue box. You can also use the following web address: http://www.qualitynet.org/dcs/ContentServer?pagename=QnetPublic/ListServe/RegisteredLists to see if you are registered.	HOP QDRP SC	8/27/2008
395	HOP QDRP Email List ("List serve")	Is there a List Serve and how does one access it?	Yes, there is a HOP QDRP email list serve used for communicating important information about the program as well as notices and announcements of upcoming educational presentations. You can subscribe to the list serve via qualitynet.org . Go to the lower left corner and click on "Register for Notifications" ... complete the form and put a check in the box for HOP QDRP ... click submit.	HOP QDRP SC	10/15/2008
489	HOP QDRP Email List ("List serve")	Will there be an HOPQDRP list serve that will have Q&A that will be guided by an MD etc. ? For example; Dr. Brazler with SCIP?	The clinical questions are currently being answered by the subject matter experts at the Oklahoma Foundation for Medical Quality, of which Dr. Bratzler is the CEO. We are not aware of any plans at this time to have a discussion list serve.	HOP QDRP SC	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
171	Infection Prior to Anesthesia	For outpatient abstraction, at patient's pre op visit for bunionectomy, patient is requesting a STD test that is ordered by APN. This is one week prior to surgery. Is this considered Infection prior to anesthesia?	No. The physician is not documenting an infection.	OMW	8/27/2008
172	Infection Prior to Anesthesia	I would like more information on what constitutes an infection with SCIP and the documentation required in the Medical Record.	Please review the data element for examples of infection. We will accept preoperative documentation of cholecystitis and appendicitis as infections, but most of the "-itises" are inflammation or irritation and not infections.	OMW	8/27/2008
173	Infection Prior to Anesthesia	I would like the definition of "infection prior to surgery" clarified. Would surgical patients with documented "acute cholecystitis" or "acute appendicitis" be defined as having a preoperative infection? I assume cases with known peritonitis with these conditions would be a definite yes. I would like scenarios clarified during the open forum.	Physician documentation of appendicitis and cholecystitis would allow the abstractor to answer "yes" to Infection Prior to Anesthesia. Please see above.	OMW	8/27/2008
378	Infection Prior to Anesthesia	Would you please enumerate conditions that would be accepted as Infection prior to anesthesia...i.e. appendicitis, cholecystitis.	Acute appendicitis and acute cholecystitis are considered infections. Appendicitis and cholecystitis are considered infections. Chronic appendicitis and chronic cholecystitis are NOT considered infections.	OMW	10/15/2008
379	Infection Prior to Anesthesia	I had a case of appendectomy for chronic appendicitis . There is nothing in the notes saying pt has current active infection. Can I still say yes to infection prior to anesthesia? The pt did not come in on antibiotics and it was noted no acute symptoms.	Answer "No" because the appendicitis is being documented as 'chronic' and may not represent a current, active infection.	OMW	10/15/2008
380	Infection Prior to Anesthesia	This case has a principal diagnosis of chronic cholecystitis . How will the question : Did the patient have an infection during this outpatient encounter prior to surgery be answered? YES or NO	Answer "No" because the cholecystitis is being documented as 'chronic' and may not represent a current infection.	OMW	10/15/2008
381	Infection Prior to Anesthesia	Patient is status-post a Lap Appendectomy for a Perforated Appendix (given Ancef prior to incision). Does a perforated appendix qualify as an infection prior to surgery?	Documentation of "appendicitis" will allow the abstractor to answer "yes" to Infection Prior to Anesthesia.	OMW	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
382	Infection Prior to Anesthesia	If patient has HIV, +MRSA and Hep C are any of these considered an infection prior to Anesthesia?	HIV is caused by a virus. Hepatitis C is caused by a virus. Active MRSA ("+MRSA) can be considered an infection. Answer "yes" to the MRSA only.	OMW	10/15/2008
383	Infection Prior to Anesthesia	Re: OPPS- infection prior to anesthesia for a case May 08. The pt had a pacemaker battery change. Physician's H&P dated 5/19 states " Pt placed on Cipro 500mg BID x 7 days for UTI". OR procedure date is 5/23. We see no further reference that the pt is on Cipro- it is not noted on med reconciliation form. Should we answer yes to infection prior to surgery?	If the H&P were updated once the patient arrived for the battery change and the UTI were mentioned again as being active, it would be acceptable. In your scenario, without the H&P being updated (by physician signature and date that information was still correct and current), the past history of UTI should not be used to answer "yes" to Infection Prior to Anesthesia. The data element asks whether there was an infection DURING the outpatient encounter prior to surgery.	OMW	10/15/2008
384	Infection Prior to Anesthesia	If on the preop consult by anesthesia it is documented patient on Ampicillin -keep on for cold- runny nose. Is this a Infection prior to anesthesia?	No. The common cold is caused by a virus.	OMW	10/15/2008
385	Infection Prior to Anesthesia	If a physician documents a preoperative diagnosis of appendicitis and the same diagnosis postoperatively after a laparoscopic appendectomy, but the path report (which I understand can be used for outpatient coding) disagrees....no acute inflammatory changes seen, how do we answer the question "did the patient have an infection during this outpatient encounter prior to surgery?" The principal diagnosis was hyperplasia of appendix.	Only the preoperative documentation is allowed (see the first and third bullet in the data element). The pathology report should not be used to answer this chart-abstracted data element.	OMW	10/15/2008
386	Infection Prior to Anesthesia	Infection Prior to Anesthesia – We are not counting “chronic cholecystitis” as an infection, although we abstract “acute cholecystitis” as an infection. Is this appropriate?	That is correct.	OMW	10/15/2008
387	Infection Prior to Anesthesia	Does URI documented on the anesthesia record count as an infection prior to surgery?	That stands for "upper respiratory infection" so that would be considered documentation of an infection by a physician.	OMW	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
388	Infection Prior to Anesthesia	Since I have answered "no" for infection p/t surgery for the pt's with appendicitis for April, May and June 2008, should I go back and fix the answer to "yes" or just start from July 2008?	The correct answer is "yes" to Infection Prior to Anesthesia if "appendicitis" was documented. Those codes will be removed for 1/1/09. The charts that have been previously abstracted do not have to be re-abstracted and re-submitted because the cases will not be validated for this quarter.	OMW	10/15/2008
389	Infection Prior to Anesthesia	Is there a table somewhere or a list of infections that would qualify as being present prior to surgery? For example, what about documentation of appendicitis in a patient that undergoes a laparoscopic appendectomy? What about cholecystitis?	There is no table. Acute appendicitis and acute cholecystitis are considered infections. Appendicitis and cholecystitis are considered infections. Chronic appendicitis and chronic cholecystitis are NOT considered infections.	OMW	10/15/2008
390	Infection Prior to Anesthesia	Do the outpatient measure guidelines align with the inpatient guidelines for abstraction? Case in point is infection prior to surgery. Do we follow the same guidelines as the inpatient measures on what constitutes an infection. Also, I needed to clarify that acute appendicitis and acute cholecystitis were considered as infections.	We have attempted to keep the infection information the same across both inpatient and outpatient. Cholecystitis and appendicitis are considered infections for the outpatient setting.	OMW	10/15/2008
391	Infection Prior to Anesthesia	Would HOPQDRP consider "diverticulitis" an infection prior to anesthesia? SCIP does, but did not want to use them as a reference.	Yes, that is acceptable.	OMW	10/15/2008
392	Infection Prior to Anesthesia	If we are to answer "yes" for infection for all pt's who are diagnosed with appendicitis (with or without peritonitis) wouldn't this exclude all appendicitis pt's from the measure?	Yes, that is why the appendectomy codes have been removed from the 1/1/09 manual.	OMW	10/15/2008
393	Infection Prior to Anesthesia	For pre-op infection, does the pre-op diagnosis of appendicitis/cholecystitis also include "possible or rule out" in the diagnosis?	Yes.	OMW	10/15/2008
394	Infection Prior to Anesthesia	Appendicitis on the ER documentation will be considered infection for a ER patient that is taken to surgery and has an appendectomy?	Yes.	OMW	10/15/2008
473	Infection Prior to Anesthesia	For the data element Infection Prior to Anesthesia, can the abstractor answer yes if there is documentation that the patient has been diagnosed with appendicitis or is there additional documentation needed to reference an infection before answering yes?	If there is physician documentation of appendicitis, the data element Infection Prior to Anesthesia can be answered "yes."	OMW	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
396	Measure Calculation	Still want to clarify the Measure for Time for Transfer, Am I correct in understanding that the D and D' are included measures but not pass or fail. Inpatient D meant a failure in the measure. What is the failure letter for the OP measures?? (e.g. if patient does not receive ASA in our ER, it is abstracted as No then D shows up on screen, still not a failure?? Are there any of these measures PASS or FAIL?	D category means the case is in the measure population. OP-2 and OP-4 are rate based measures. Cases for OP-1, OP-3, and OP-5 are continuous variable measures (median times).	OMW	10/15/2008
459	Measure Calculation	Is there a median time from order to EKG and order to fibrinolytics? If so, where do I find this?	There is not a measure for the time or the order to the time of the action for ECG and fibrinolytics.	OMW	10/15/2008
462	Measure Calculation	Please Clarify: AMI patients with positive ECG and transfers to another facility without fibrinolytic being given. Am I correct that this pt. is excluded from OP1 and OP2. If this is correct, why?	Correct. OP -1 and OP-2 only look at the timeliness of fibrinolytic administration. If the patient does not receive fibrinolytic therapy you are unable to calculate the time to administration.	OMW	10/15/2008
469	Measure Calculation	OP-AMI ... When will charts begin "failing" when we do not meet the criteria of within 10 minutes of arrival?	The measure for ECG is not "within 10 minutes". It is a median time measure.	OMW	10/15/2008
479	Measure Calculation	Pt arrives w/ right shoulder pain, no cardiac symptoms. MD sees pt 60 min after arrival. EKG order at that time and pt admitted. EKG time will fall out, what can be done about those kind of situations.	The measure is a median time measure, so occasion outliers such as this should not greatly impact the median time.	OMW	10/15/2008
481	Measure Calculation	Regarding #442, in a smaller facility that may only have 6-10 total cases that fall into the category, one long transfer time WILL affect our overall times quite a bit. So it would seem that a category for this would be indicated.	There is a category (D prime) unless the patient does not have a contraindication and should have received fibrinolytics (which would excluded them) and the did not. With median times, one case such as this should not greatly impact your calculation. See question 456.	OMW	10/15/2008
482	Measure Calculation	Regarding AMI/Chest Pain: How does it count if our facility is able to provide all cardiac procedures however the patient has HMO and is being transferred because his MD and coverage is at another facility.	It would continue to apply such as all other cases. You would still have a responsibility of timely transfers of patients for acute coronary intervention. See response for question 456.	OMW	10/15/2008

Hospital Outpatient Quality Data Reporting Program
Compiled Question Answer Grid

Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
483	Measure Calculation	Regarding Fibrinolytics in OP AMI, we do not give fibrinolytics in our small hospital because the cardiac interventionist at our referring hospital will not accept patients for a cardiac cath if the patient has received the medication. I am not sure why those of us in a small hospital will receive a D measure for doing what the cardiologist asks us to do from the receiving hospital. Suggestions?	See response for question 456.	OMW	10/15/2008
547	Measure Calculation	How is the Median Time to Transfer calculated?	The Median Time is calculated from the cases that fall into both the D and D prime measure categories. There is no pass or fail status for the measure since it is a variable time measure only. Only the median time for category D will be eligible for public reporting. The D prime category is to be used for internal quality improvement purposes at your facility. It is recommended that providers use the data in both the D and D prime categories in determining process improvement for decreasing transfer times and/or administering fibrinolytic therapy.	OMW	8/6/2008
553	Measure Calculation	How are oral antibiotics considered in regard to the antibiotic timing measure (OP-6)?	Patients who receive oral antibiotics only are excluded from OP-6 (timing). If the patient receives oral antibiotics and IV antibiotics, only the IV antibiotics will be considered in the timing measure.	HOP QDRPS C	4/23/2008
159	Medication	Is Integrillin considered a fibrinolytic therapy? It is not on the list of named agents.	This is not considered a fibrinolytic and will abstract as a NO.	OMW	8/27/2008
64	Medication Administration: Documentation	Is the requirement for documentation of the aspirin given in the ED same as for the antibiotic?	For the data element Aspirin Received you would just need to see documentation the patient was administered aspirin prior to transfer.	OMW	7/16/2008

Hospital Outpatient Quality Data Reporting Program
Compiled Question Answer Grid

Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
175	Medication Administration: Documentation	In the webinar on July 16, when referring to antibiotics given by the ED nurse, webinar instructions were as follows: the documentation must include the written word "given" or "administered". Not only a time and initials but actual documentation as given or administered. During the webinar reference was given to antibiotics. Therefore do all medications given in the ED for AMI and CP require documentation of given or administered? Our practice has been, the nurse times and initials next to the physicians written order but does not write given or administered. Please clarify.	The documentation should reflect administration. Usually ED documentation is a little sparse, so we accept it on the inpatient side.	OMW	8/27/2008
176	Medication Administration: Documentation	The ED record (the one they hand-write on) is dated at the top of the page. When a nurse administers a drug, he/she writes the time given and initials it. Why do they also have to date it within the body of the page when the date is at the top of the page?	The date at the top of the page is sufficient.	OMW	8/27/2008
177	Medication Administration: Documentation	If a patient presents to ER just before midnight, receives the medication(s) after midnight, and the medication time is charted as xx am with initials and route, it follows logically that the medication was given the next day from the date on the ER record. The patients are transferred from the ER with a transfer sheet with the new date on it, which would further validate date. Should we educate ER staff to begin entering a date beside all medications given in ER?	That is not necessary. The date can be carried over.	OMW	8/27/2008
200	Misc	Does QualityNet deal with outpatient SCIP?	Yes, QualityNet has been upgraded to include information on the public page for Hospital-Outpatient Data Reporting. Additionally, the secure pages of My QualityNet have also been upgraded to include tasks and reports to support the Hospital – Outpatient reporting program. There are unique user roles for Hospital – Outpatient reporting; see your QualityNet Security Administrator to obtain the appropriate user roles.	HOP QDRP SC	8/27/2008

Hospital Outpatient Quality Data Reporting Program
Compiled Question Answer Grid

Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
201	Misc	Would it be possible to combine both the demographic information and surgical information on one page? With the amount of patients abstracted at our facility, having to enter one page, save the data, wait, enter the other page of information, save the data.... it can be cumbersome.	This may be a vendor-related issue regarding how your tool is formatted.	HOP QDRP SC	8/27/2008
397	Misc	Regarding hospitals that do not have to participate in the HOPQDP...does Maryland hospitals mean hospitals in the STATE of Maryland?	"Maryland" refers to the state.	HOP QDRP SC	10/15/2008
398	Misc	What is the difference between a medical student and an intern or resident?	A medical student has no legal status as a provider of health care services. A student can not use MD/DO credentials, whereas a resident can.	HOP QDRP SC	10/15/2008
399	Misc	Do the outpatient measure guidelines align with the inpatient guidelines for abstraction? Case in point is infection prior to surgery. Do we follow the same guidelines as the inpatient measures on what constitutes an infection. Also, I needed to clarify that acute appendicitis and acute cholecystitis were considered as infections.	No. The outpatient record is smaller and contains less information. The data elements for the outpatient measures do not contain the amount of information that is present in the inpatient data elements. The abstractor should follow the guidelines that are in the outpatient data element, which may differ than the inpatient data element. Acute appendicitis and acute cholecystitis are considered infections.	OMW	10/15/2008
400	Misc	Is it possible to obtain an actual patient list from the Ad hoc analysis Medicare HOP measure set estimate from one of the quarters in 2007?	We are able to provide only the aggregate data for this report and not the claims that make up the data.	CMS	10/15/2008
492	Misc	On the Q & A grid - who are the responders?	The responders are HOP QDRP SC - Hospital Outpatient Quality Data Reporting Program Support Contractor (FMQAI); OMW - Outpatient Measures Writers; CMS - Centers for Medicare and Medicaid; IFMQ - Iowa Foundation for Medical Quality	HOP QDRP SC	10/15/2008
510	Misc	Please forward help desk # and email address.	The email address is "qnet support@ifmc.sdps.org" and the qnet helpdesk phone number is 866-288-8912.	HOP QDRP SC	10/15/2008

Hospital Outpatient Quality Data Reporting Program
Compiled Question Answer Grid

Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
555	Misc	What is the definition of an outpatient?	"Outpatient" refers to a person who has not been admitted as an inpatient but who is registered on the hospital records as an outpatient and receives services (rather than supplies alone) directly from the hospital.	HOP QDRP SC	4/23/2008
44	Outpatient Encounter Date	I have a question regarding the " Outpatient encounter date". If the patient is admitted through the ED and does not go to surgery until the next day, what is going to be my outpatient encounter date?	The outpatient encounter date is the date the patient arrived in the hospital outpatient setting.	HOP QDRP SC	7/16/2008
203	Outpatient Encounter Date	Why is "admission date" a question? These pts are not supposed to be admitted to the hospital.	There is no data element named "admission date" in the Hospital Outpatient Specifications Manual. The data element you may be referring to is titled Outpatient Encounter Date and should reflect the earliest documented date the patient arrived at the hospital outpatient setting. If your tool uses the terminology "admission date", you may want to speak with your vendor.	HOP QDRP SC	8/27/2008
204	Outpatient Encounter Date	For the outpatient chest pain indicator: Patient is admitted to the ED on 5/6/08 at 23:55, but our "system" sees the admit as 5/7/08 so it's giving me an error message for admit date... what do I do?	The Outpatient Encounter Date should reflect the earliest documented date the patient arrived at the hospital outpatient setting. Your abstraction should reflect the earliest date documented that the patient arrived at the hospital outpatient setting. You may need to override the 'auto-populated' field in your tool.	HOP QDRP SC	8/27/2008

Hospital Outpatient Quality Data Reporting Program
Compiled Question Answer Grid

Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
205	Outpatient Encounter Date	A patient arrives to the ER at 2200 on 5/2 (for example) and it is determined in the ER that he has appendicitis and goes for an apy at 0500 on 5/3. My question is, which date is the admission date and which is the outpatient encounter date. The data dictionary isn't very specific on these questions. Is the admission date the date the patient was admitted to ER or admitted to the observation status? Is the outpatient encounter date the date that the patient arrived to the ED or the date the pt. had surgery?	There is no data element named "admission date" in the Hospital Outpatient Specifications Manual. The data element you may be referring to is titled Outpatient Encounter Date and should reflect the earliest documented date the patient arrived at the hospital outpatient setting. If your tool uses the terminology "admission date", you may want to speak with your vendor. The outpatient encounter date is the date the patient arrived in the hospital outpatient setting. In your case it would be 5/2 at 2200.	HOP QDRP SC	8/27/2008
362	Outpatient Encounter Date	Patient arrives to ED 6/22/08 at 22:05. The patient is admitted to observation on 6/23/08 at 01:05. What is the admission date? Is it the ED encounter date or the observation date?	It is the earliest documented date the patient arrived at the outpatient setting ... in this case, it is 6/22/08.	HOP QDRP SC	10/15/2008
363	Outpatient Encounter Date	Outpatient Encounter date is defined as the month, day and year the patient arrived in the hospital outpatient setting. The data dictionary further states to consider the outpatient encounter date as the earliest documented date the patient arrived in the applicable hospital outpatient setting. If a patient arrives in the ED or endoscopy and remains in the hospital overnight and has outpatient surgery the following day what would be considered the outpatient encounter date? What is the definition of "applicable outpatient hospital setting"?	The outpatient encounter date is the earliest date the patient arrived in the outpatient setting. In your scenario, it would be the date the patient arrived in the ED.	HOP QDRP SC	10/15/2008
364	Outpatient Encounter Date	Instructions state to record all antibiotics given via the IV or PO route during this outpatient encounter. Is the outpatient encounter considered to be from the time the patient first arrived at the hospital until the time they were discharged? For example, patient arrives in the ED on 4/22/08, gets admitted to observation status, has surgery 4/23/08 and is discharged to home 4/24/08. Is the outpatient encounter considered to be from arrival time in the ED 4/22/08 through discharge home on 4/24/08?	Yes, you have interpreted the abstraction guidelines correctly.	HOP QDRP SC	10/15/2008

Hospital Outpatient Quality Data Reporting Program
Compiled Question Answer Grid

Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
402	Payment Source	Why are the 'old' payment source definitions still being used for the outpatient measures when the inpatient measures, effective with October 1, 2008 discharges are going to just Y or N for Payment Source. This will require significant programming resources to maintain two separate methods and be a training issue for facilities as well.	The subject has been discussed and a specifications change request has been submitted. If there are going to be any changes, they will not occur until after July 2009.	HOP QDRP SC	10/15/2008
455	Population	Do you anticipate an ICD-9 recount requirement for HOP similar the inpatient ICD-9 recount?		CMS	10/15/2008
206	Population: Eligible Cases	I understand that cholecystectomies will be removed as an included procedure in an upcoming manual update, however, in the mean time, as I explain to our physicians their performance I want to be able to tell them that these procedures will be removed from the included population in an upcoming release due to.... but I don't know the reason. Why are cholecystectomies no longer going to be on the list of included procedures? What manual release will we see this change? Effective with January 09 Visits?	Because they will get excluded with the documentation of "cholecystitis" every time, so it doesn't make sense to make the abstractor open those charts. This change can be seen in the manual for 1/1/09, which has been posted to QualityNet.	OMW	8/27/2008
207	Population: Eligible Cases	We occasionally have cases that are not Medicare but a third party payer who will only pay observation or outpatient rate and the physician has maintained the chart as an inpatient. CMS tells us (Code 44) that a chart can only be changed based on a physician order. Billing is to the 3rd party payer as an outpatient chart but the record is kept as inpatient. Are we required to submit these under HOP QDRP? If the record were to come up for audit it was inpatient chart but billed as outpatient for reimbursement reasons - would that fail the audit?	For determining case populations, it is the goal of the HOP QDRP to remain as consistent as possible to billing practices, keeping the claim as the unit of interest. Therefore, if this case was billed as an outpatient, it is eligible for selection - and inclusion - in the outpatient measures population.	OMW	8/27/2008
208	Population: Eligible Cases	Is there a reason CMS will continue to collect all payment sources for the outpatient measures but only collect a payment source of Medicare on the inpatient side? Is there a plan to align the two as you have with most of the other data elements applicable to both the outpatient and inpatient populations?	This issue has been forwarded to the OPSS Specifications Manual Production Workgroup. Any potential changes to the specifications manual will not occur before July 2009.	OMW	8/27/2008

Hospital Outpatient Quality Data Reporting Program
Compiled Question Answer Grid

Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
25	Population: CPT Code	What procedures will fall under the outpatient surgery indicators? (i.e. endoscopy procedures, stereotactic breast biopsies, etc?)	Please see the Specifications Manual version 1.0a Appendix A Table 6.0 for a comprehensive list of CPT codes. This manual can be found on the QualityNet website at http://qualitynet.org/dcs/ContentServer?cid=1196289981244&pagename=QnetPublic%2FPage%2FQnetTier2&c=Page .	HOP QDRP SC	7/16/2008
26	Population: CPT Code	What if the out-pt procedure CPT codes are not on Appendix A? We are a large academic facility who does some advanced procedures on an out-pt. basis.	Quality measures under the HOP QDRP require only cases with CPT Codes on Table 6.0, Appendix A of Specifications Manual 1.0a be included in the outpatient population and be abstracted.	HOP QDRP SC	7/16/2008
27	Population: CPT Code	What if our CPT code for a procedure for example, an AV fistula is coded as 36818 instead of the 36830 on Appendix A? Do I submit it with your CPT code or one that is not on the list?	The HOP QDRP requires that only CPT Codes on Table 6.0, Appendix A of Specification Manual 1.0a be abstracted. HOP population selection should be made based on the codes billed; the abstractor does not need to change codes to "fit" the Appendix.	HOP QDRP SC	7/16/2008
28	Population: CPT Code	Temporary pacers are being included because of CPT code 33210. Many times the temps are placed after cath has started and it is too late to start ATBs. Are these procedures always going to be included.	Those codes have been removed in the latest Specification Manual, version 2.0a applicable beginning with January 2009 services.	OMW	7/16/2008
29	Population: CPT Code	Are ERCP patients included in the population if they remove bile duct stones during the procedure?	If CPT code 47630 is submitted on the bill, the case can be abstracted. Those codes have been removed for 1/1/09.	OMW	7/16/2008
30	Population: CPT Code	For outpatient SCIP patients, does this include those patients that are considered Surgical Day Care setting?	Outpatients with a CPT code found on Table 6.0 of Appendix A, Specification Manual v1.0a are included in HOP QDRP if they are being billed as outpatients and not as ASC. The specific location for the outpatient surgery/procedure is not relevant; Surgery, endoscopy, radiology, etc. will be included if the case meets the inclusion criteria.	HOP QDRP SC	7/16/2008

Hospital Outpatient Quality Data Reporting Program
Compiled Question Answer Grid

Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
31	Population: CPT Code	When CPT codes in the outpatient surgery are placed in the second position or other surgical codes, verify if this information is included in the abstraction process?	Everything on the abstracted chart that you have put in the record will be available for validation but may not be used in calculating the validation score. CMS requires only the one CPT code from Table 6.0, Appendix A, Specification Manual v1.0a.	HOP QDRP SC	7/16/2008
32	Population: ICD-9-CM Code	ED patient with chest pain.....primary and secondary diagnosis codes...correct?	The ICD-9-CM code can be in any location/level for chest pain cases, including principal or other diagnosis positions; it is not limited. However, for AMI cases, the population is limited to the AMI diagnosis as the principal diagnosis.	HOP QDRP SC	7/16/2008
33	Population: ICD-9-CM Code	Do we use chest pain when it is a secondary diagnosis and not the principal diagnosis?	The ICD-9-CM code can be in any location/level for chest pain cases, including principal or other diagnosis positions; it is not limited. However, for AMI cases, the population is limited to the AMI diagnosis as the principal diagnosis.	OMW	7/16/2008
34	Population: ICD-9-CM Code	If you have an obs patient with pneumonia that has documented chest pain what measures are we responsible for? It is very easy to have painful respiration or chest pain with other disease processes.	If there is a pneumonia case with chest pain as a diagnosis, and documentation of Probable Cardiac Chest Pain, who is transferred to another acute care facility etc, they will be eligible for OP-4 and OP-5.	OMW	7/16/2008
35	Population: Discharge Status	Just to clarify, to be included in the measure, chest pains, atypical or not, will only be included if they are transferred out. That is, chest pain measures only for patients transferred to another facility?	Correct --Patients with chest pain (CP) who are transferred with a discharge code of 02, 43 or 66 are included in the ED-CP measure population.	HOP QDRP SC	7/16/2008
408	Population: Discharge Status	Are we to abstract all discharge codes for chest pain or do we only abstract those discharge codes of 02, 43, or 66? I have been only abstracting these specific codes.	Correct, you are to abstract only those cases with a discharge status code of 02, 43, or 66.	HOP QDRP SC	10/15/2008
36	Population: Discharge Status	Chest pain observations discharged home should not be responsible for any CP\AMI measures/criteria. Correct?	Correct.	OMW	7/16/2008
37	Population: Discharge Status	Patient is admitted as observation with chest pain and it is not qualified as non-cardiac in origin. Patient is discharged to home (01). According to algorithm this case would be excluded and this case is not eligible for abstraction. Is this correct?	You are correct. All AMI/CP patients must have an E/M code, be >= 18 years of age and transferred out with a discharge code of 02, 43, or 66.	HOP QDRP SC	7/16/2008

Hospital Outpatient Quality Data Reporting Program
Compiled Question Answer Grid

Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
221	Population: Eligible Cases	It appears there is an issue on cases that have a discharge date that occurs in the first few days of the month but the encounter date is actually in the prior month. When this date is changed in TR it drops off the sample list for one month and appears on the sample list for the prior month even though we have already finalized the prior months' data. This is causing a lot of frustration and rework. What are our options to correct what will be an ongoing mess? Do we need to discuss changing the encounter date to be the actual encounter date rather than the discharge date so that we will not be changing these dates after the encounter lists have been determined?	HOP QDRP does not use discharge dates for the Chest Pain or Surgery measures. Only for AMI patients. All populations use encounter dates. The encounter date is the date the patient arrived in the applicable hospital outpatient setting. Your population/sample lists should be pulling your patient lists for abstraction based on the encounter date, not the discharge date.	HOP QDRP SC	8/27/2008
403	Population: Eligible Cases	Regarding question (103 in the Q/A grid) CPT code 47562 Laparoscopic cholecystectomy in CART ... do we delete these cases that we have already abstracted since the system will not take them?	No you can not delete these cases from the population. This error in CPT code # is only applicable to the CART help screens. The CART online tool lists the CPT Code # accurately for selection.	HOP QDRP SC	10/15/2008
409	Population: Eligible Cases	Difficulty that hospitals are having in identifying HOP surgery cases when CPT codes are unavailable for capture due to billing systems. We are having similar problems identifying cases that are "hard coded" for billing outside our facility and performed outside of the surgical suites such as US (prostate biopsies) and Cath and EP Labs (Cardiac Pacers and ICDs). The CPT codes cannot be captured for these procedures by our vendor interface at this time and we are frantically working to identify these cases, abstract them, and find a way to interface them with our vendor!	Level 1 HCPCS codes are, in fact, CPT codes. If the procedure is used in the course of providing medical diagnostics or treatment to a Medicare or Medicaid patient, then a HCPCS/CPT code is used to describe what was done.	CMS	10/15/2008

Hospital Outpatient Quality Data Reporting Program
Compiled Question Answer Grid

Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
410	Population: Eligible Cases	In Missouri there is a Medicaid billing requirement that ED patients admitted to same facility be split billed with a discharge from ED. Value 09 (admitted to this facility) is limited to Medicare pts, so these pts are falling into OPSS. Should they?	These patients, if being admitted to the same hospital (same CCN) from the ED will NOT be in the outpatient population. They will fall into the inpatient measure population (if all criteria met, of course). For the outpatient reporting program, I would suggest having the IT/billing folks include a criteria statement in the program that identifies the patient population something like "exclude patient with inpatient admission on the same day or +1 day (to account for those admitted after midnight)" Otherwise, they may need to 'weed' these out manually.	HOP QDRP SC	10/15/2008
500	Population: Eligible Cases	On chest pain we only have to abstract CPT codes that have disposition of 02 and 43 correct?	Disposition codes "02", "43", and "66" are those used for identifying ED-AMI and ED-CP patient populations.	HOP QDRP SC	10/15/2008
504	Population: Eligible Cases	For the HOP-Surgery we are getting an edit error in CART for question #2 - what was the CPT code selected - have selected 47562 Laparoscopic cholecystectomy which is on the list of eligible surgeries. What can we do to not get this error?	Verify the patient's age ... if the patient is \leq 70 years of age, they are not included in the surgery population if the CPT code is from Table 6.4b (i.e., 47562 - Lap Chole and 47630 - Remove Bile Stone Duct)	HOP QDRP SC	10/15/2008
507	Population: Eligible Cases	I have 3 cases that I accidently sent to the warehouse and they failed with critical errors but they do not belong in the population. How do I delete these cases from the warehouse.	If you use a vendor - contact your liaison to assist you. If you upload the data yourself, you will need to contact the helpdesk for assistance.	HOP QDRP SC	10/15/2008
556	Population: Eligible Cases	Which outpatients should be used to determine eligible cases for the measures under HOP QDRP? Should outpatients from separate campuses or only the outpatients seen in the main hospital be included?	Sampling population is determined by the Medicare Provider Number (MPN), now known as the CMS Certification Number (CCN), therefore, an organization is to include all services billed under a single MPN/CCN when determining the population of interest for that MPN/CCN. Thus, if an organization renders outpatient services at multiple sites billing under a single MPN/CCN, services rendered at all sites are eligible for inclusion in the measure set populations.	HOP QDRP SC	4/23/2008

Hospital Outpatient Quality Data Reporting Program
Compiled Question Answer Grid

Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
209	Population: Included Population	I have a patient that was billed as outpatient, but during chart review, I found that the patient did have an inpatient order. I know that our Care Coordination staff reviews these charts and sometimes makes determination that the patient does not qualify for an inpatient stay. They document this in the billing notes, but not in the actual medical record. I want to verify that I would still review this as an OP chart since it was billed that way and that I would not be penalized on validation.	For determining case populations, it is the goal of the HOP QDRP to remain as consistent as possible to billing practices, keeping the claim as the unit of interest. Therefore, if this case was billed as an outpatient, it is eligible for selection - and inclusion - in the outpatient measures population.	HOP QDRP SC	8/27/2008
210	Population: Included Population	Are all patients age 18 and over to be abstracted and submitted, or just Medicare?	Both Medicare and non-Medicare patients age 18 years and older are included in the outpatient measure populations.	HOP QDRP SC	8/27/2008
211	Population: Included Population	Are we collecting for other payers besides Medicare & Medicaid? If so, Why?	Yes, Medicare and non-Medicare patients are included in the Hospital Outpatient reporting program.	HOP QDRP SC	8/27/2008
212	Population: Included Population	What is the operational definition of "outpatient"? Please also address observation patients in the defined term.	An outpatient is any patient that is billed as an outpatient and receives services that are billed under the OPSS structure. Observation patients are eligible for inclusion in the outpatient surgery population because observation status is billed as an outpatient.	HOP QDRP SC	8/27/2008
213	Population: Included Population	Patient presents to the Emergency Department with a diagnosis of rule out AMI principal and a diagnosis of chest pain is also documented. The patient is admitted to observation status and NOT admitted as an inpatient. From the observation unit, the patient is transferred to an acute care hospital for definitive cardiac care. Question 1. It is my understanding that these patients are to be included in the AMI/CP measure for HOP QDRP, is that correct? Question 2. If yes to question #1, what's the best way to ensure these types of patients are selected? (They will NEVER have an E/M code).	All patients presenting to the ED have an E/M code or the hospital will not receive payment for the care/services provided there. You can check with your billing department regarding the E/M code - most hospitals do not have this code documented on the medical record, rather it is a billing code that is used for billing the appropriate level of care/services. ED patients who leave the ED and are admitted to observation status are still outpatients; therefore, when they are transferred with a discharge status code of 02, 43, or 66, they will be eligible for inclusion in the outpatient measures population.	HOP QDRP SC	8/27/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
214	Population: Included Population	Are Ambulatory patients inpatients or outpatients?	An outpatient is any patient that is billed as an outpatient and receives services that are billed under the OPSS structure. Ambulatory Surgery Center patients are not included because these patients do not bill under the OPSS structure.	HOP QDRP SC	8/27/2008
215	Population: Included Population	We have a free standing satellite ER with the same Medicare provider number. When chest pain patients are seen there and then transferred to the main hospital the patient is viewed as a transport to another unit and keeps his/her same medical record number and encounter number. My question is if a patient is seen at the satellite facility for chest pain and transferred to the main campus where they remain an observation patient or outpatient would the patient get abstracted in the outpatient measure? We abstract records for both the main hospital and the satellite ER and I am thinking I should abstract this for the satellite ER since they transferred the case.	If the Free standing ED is billing using the hospitals CCN (MPN) and E/M codes then think of the patient as being in your facility's main ED. If they are brought to the hospital and placed in an observation bed, it is the same as if they were in the main ED. If the patient is admitted to inpatient status, they would be included in the inpatient (RHQDAPU) measure population. Only if they remain in the observation status and are transferred from your hospital with the discharge status code of 02, 43, or 66 would they be included in the outpatient measures.	HOP QDRP SC	8/27/2008
216	Population: Included Population	Are the included procedures for outpatient SCIP only those that are highlighted in Appendix A of the Specs Manual?	The outpatient surgery population includes all of the CPT codes listed on Appendix A, Table 6.0. The codes that are highlighted in Appendix A are those that were either added or revised with the release of version 1.0a.	HOP QDRP SC	8/27/2008
217	Population: Included Population	When a patient is admitted with chest pain under "observation status" and is transferred to an acute care facility, would this be an account that needs to be abstracted for core measures to QNET?	Outpatients are defined as any patient receiving care who is not an inpatient. Outpatient surgery patients who need to stay the night remain outpatients until admitted as inpatients or discharged. ED patients who are admitted to a floor or ICU and transferred the next day and have never been made an inpatient also remain outpatient in the HOP QDRP. Pts who go from the ED to the same hospitals cath lab and then are transferred to another facility for CABG or some other reason are also included in the HOP QDRP.	HOP QDRP SC	8/27/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
404	Population: Included Population	I have a patient pulled in the HOP population due to CPT 33211 insertion of heart electrode. This was due to coding abstracting transvenous pacing during a code. Pt code on arrival to facility and on arrival to cath lab and died before any procedure. how can I get this remove from the population. This case is failing OP 6 and 7.	Any procedure that has a CPT code in table 6.0 is included in the surgery measures. Please note that the codes for temporary pacing wires have been removed effective with the January 2009 episodes of care. For now, they are included. I would keep track of how many fail OP-6 and OP-7 that have these codes (33210 and 33211), so that you can report these to Senior Management as needed.	HOP QDRP SC	10/15/2008
405	Population: Included Population	If surgery centers are billed through a hospital accounting department and are owned by the hospital, then the data from these surgery centers are submitted with the surgical data from the main institution -- is that correct?	If the surgery center bills using the hospital's MPN/CCN then YES, the patients would be included in the population.	HOP QDRP SC	10/15/2008
406	Population: Included Population	Why are discharges to CAH's needed? By definition, they are not a tertiary care center or cardiac care centers. Also, VA nursing homes fall under category 43 along with VA hospitals. Is the definition going to change to separate these?	Some patients are transferred to CAHs as well as veteran facilities. Further changes may occur with benchmark data reports.	OMW	10/15/2008
407	Population: Included Population	If podiatry cases are being excluded Jan.09, why can't they be excluded now. It is very difficult to support antibiotics for these cases now when physicians don't support the use of antibiotics and know it will be stopped.	We don't know that the podiatry codes will be removed. At this time, they are not being removed for the 1/1/09 manual and should be abstracted.	OMW	10/15/2008
411	Population: Included Population	Regarding the reporting of AMI cases for this initiative, is it required that AMI cases that have coding consistent with both the AMI and Chest Pain measures be included in the reporting for both measures?	No, they will fall into the ED-AMI population only.	HOP QDRP SC	10/15/2008
412	Population: Included Population	I understand the CPT code for laparoscopic appendectomy (44970) will be going away as of 1/09. Does this exclusion only apply if there was an actual appendicitis? If the patient had an elective appendectomy and the appendix was found to be normal and no appendicitis was present, will this case still be excluded from the population for abstraction.	The code for appendectomy is being removed, so the case that has an appendectomy will not be pulled for abstraction based on the appendectomy code.	OMW	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
413	Population: Included Population	AMI case transferred from CAH to our hospital and then transferred out for PCI ... should this case be included in our upload or would the case be excluded since they were treated in the CAH ED first?	This case will be included, but keep in mind, if they did not receive fibrinolytics at the second facility, they will not be included in OP-1 and OP-2, they will be in OP-3 which is the time to transfer measure, and for OP-4 it checks if they received aspirin within 24 hours prior to arrival, so they should pass if there is documentation it was given at the previous hospital, also, for OP-5 if the previous hospital did an ECG within one hour prior to the patients arrival at the second facility, this can be used. If it was not within one hour, and they did not do one at the second facility, they will not be included in OP-5.	OMW	10/15/2008
467	Population: Included Population	G- Peg procedure will be excluded from HOP Surgery measure. When will this happen?	The CPT code for gastrostomy tube placement (43832) is not being removed. According to the code description, this is an open procedure. CPT codes 49440, 40441, 40442 and 40446 will be removed for 1/1/09.	OMW	10/15/2008
468	Population: Included Population	Bunion Procedure also will remove from HOP measure. When will this happen?	Bunionectomies will not be removed. The codes for hammertoe and cock-up fifth toe are being removed.	OMW	10/15/2008
503	Population: Included Population	For sampling...Do we include Medicare HMO or advantage plan?	For completion of your Population and Sampling Grid, Medicare refers to all patients with any Medicare plan at any level ... non-Medicare are all others. Your submitted cases (sample) should include both Medicare and non-Medicare patients.	HOP QDRP SC	10/15/2008
525	Population: Included Population	If a patient is put in OBS status with CP from the ED and then has a disposition of 01 do we include this patient in the population?	No, the patient must have a disposition of "02", "43", or "66" when they leave the facility.	HOP QDRP SC	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
537	Population: Included Population	What steps should be performed to determine which patients are eligible for the hospital outpatient measures?	<p>Determination of included patients is based on the [billed] claim i.e., the encounter must be billed as an outpatient claim, for the case to be eligible for inclusion in the population. Patient must be aged \geq 18 years of age or older, and have either 1) a ICD-9-CM Principal Diagnosis or Other Diagnosis code included in Table 1.1 or 1.1a or 2) a CPT code included in Table 6.0. For the AMI and CP populations, there must be a discharge status code of 02</p> <p>Discharged/transferred to a short term general hospital for inpatient care (Acute Care Facility), 43 Discharged/transferred to a Federal health care facility, or 66 Discharged/transferred to a Critical Access Hospital (CAH). Coding practices by Emergency Department team members should be monitored in order to assure that correct discharge codes are being applied to the claim and are not being defaulted to an incorrect code. The encounter date will determine which reporting period (Q2 2008, Q3 2008, etc.) the abstraction will "fall" into. The "pull" of billed services (both Medicare and non-Medicare) will be determined by encounter date-not billing date.</p>	HOP QDRP SC	4/23/2008
538	Population: Included Population	Sometimes an outpatient record may not be coded or billed for several months. If a record's billing date exceeds the submission date for a given reporting period, should the hospital still submit the record?	<p>The HOP QDRP population data should be verified two weeks prior to the submission deadline. At this time, all of the claims that have been placed in the CMS claims system are locked. This is the Medicare count that will be used to ensure that all cases have been captured. Claims that are billed after the submission deadline date will not count toward the hospital's final population count for that quarter.</p>	HOP QDRP SC	4/23/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
543	Population: Included Population	Do modifiers need to be considered when identifying the population?	CPT codes with modifiers should be considered when identifying the population (e.g., 99284 vs. 9928425). A hospital could be at risk for under-submission if modifiers are not considered when identifying claims in the hospital database. Note: Modifiers are not a consideration in the actual data submission since the CPT Code data element allows only for a length of five characters.	HOP QDRP SC	4/23/2008
544	Population: Included Population	Which primary and secondary ICD-9 codes are utilized for selecting cases for the AMI and chest pain measures?	The AMI measures (OP-1 through OP-5) utilize ICD-9-CM Principal Diagnosis Codes from Table 1.1. Chest Pain measures (OP-4 and OP-5) use ICD-9-CM Principal or Other Diagnosis Codes from Table 1.1a.	HOP QDRP SC	4/23/2008
554	Population: Included Population	For laparoscopic cholecystectomies, will only patients 70 years of age or older be evaluated for antibiotic selection and timing in regards to OP-6 and OP-7?	Yes. According to the population algorithm for OP-6 and OP-7, if the patient age is less than 70 and the CPT code is on Table 6.4b, the case will be excluded from both measures.	HOP QDRP SC	4/23/2008
38	Population: Observation Status	When ED and Surg patients get admitted to observation are they excluded?	Outpatients are defined as any patient receiving services, not just supplies, who is not an inpatient. Outpatient surgery patients who need to stay the night remain outpatients until admitted as inpatients or discharged. ED patients who are admitted to a floor or ICU and transferred the next day and have never been made an inpatient also remain outpatient in the HOP QDRP. Patients who go from the ED to the same hospital's cath lab and then are transferred to another facility for CABG or some other reason are also included in the HOP QDRP.	HOP QDRP SC	7/16/2008
39	Population: Observation Status	Do we use observation and post anesthesia complication patient types for surgery patients?	All surgical patients who remain outpatients (which would include observation patients) with the other appropriate criteria are included unless they are admitted as inpatients.	OMW	7/16/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
40	Population: Observation Status	For a patient that is admitted as on obs status and then advanced to inpatient status, will the inpt vs. o/p reporting depend on how the case was billed ???	If the patient is admitted to inpatient status and the case is billed as an inpatient, then the patient will NOT be included in the HOP QDRP population. The patient/case will be [potentially] eligible for inpatient measures.	HOP QDRP SC	7/16/2008
41	Population: Observation Status	I understand that observation patients with AMI and chest pain are included in abstraction. Does this require an initial ER visit before Observation or does it include direct admits? Can a patient come in as a Direct Obs without an EM code and be included in the population for CP or AMI?	All AMI/CP patients must have one of the specified E/M codes, be >= 18 years old and transferred out with a discharge code of 02, 43, or 66. A patient who is Direct Admit to OBS will not have one of these E/M codes, therefore are not included in the population.	HOP QDRP SC	7/16/2008
218	Population: Observation Status	My understanding of the Outpatient surgery population was that if a patient was admitted as an observation patient, then they would fall into surgical category. Is this correct, or should all of those cases not be in the measure?	That is correct; observation patients are eligible for inclusion in the outpatient surgery population because observation status is billed as an outpatient.	HOP QDRP SC	8/27/2008
219	Population: Observation Status	What are we doing with patients who retain outpatient status but have a length of stay greater than 24 hours?	As long as the patient remains an outpatient – regardless of the length of stay – they are eligible for inclusion in the outpatient population.	HOP QDRP SC	8/27/2008
220	Population: Observation Status	If a patient is transferred from the ED to an observation unit with chest pain to see the cardiologist in a few hours and then transferred to an acute care hospital, is that case to be abstracted and submitted?	Yes, as long as the patient remains an outpatient at the facility – and observation status is considered an outpatient – and then is transferred with a discharge status code of 02, 43, or 66.	HOP QDRP SC	8/27/2008
401	Population: Observation Status	I have a case where the patient was an observation for one day prior to the procedure. The patient stayed observation for the whole stay. It was billed as outpatient. Is there a reason not to include since the admit date is before the procedure date?	No. If the case meets all of the inclusion criteria for the measure set, it should be included, despite the procedure date occurring after the encounter date.	HOP QDRP SC	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
224	Population: Sampling	I am confused. Table 2.0 shows that if there is less than 80 cases per month that the facility should do all cases but if they have 81-100 records only 27 are required for the month. Since it is monthly sampling should there not be a couple more options before you get to 81-100?	The population numbers in column one represent the total population size for the quarter. The sampling numbers depict the appropriate monthly sampling that should be applied to this quarterly population size. Data submission and evaluation will be based on a quarter's worth of data. Since the population size may fluctuate from month-to-month, it is important to estimate sampling based on the total population size for the quarter in order to ensure that the sample size requirements are fulfilled. The HOP QDRP SC will recommend the incorporation of clarifying information in a subsequent release of the specifications manual to ensure proper interpretation of the Monthly Sampling table.	HOP QDRP SC	8/27/2008
520	Population: Sampling	How do we go about determining the "acceptable" population size for our facility; and how do we determine whether to abstract sample or total population?	The specifications manual outlines the minimum sampling requirements based on your population. At this time, if your population is <80 cases, you will need to abstract and submit 100%.	HOP QDRP SC	10/15/2008
524	Population: Sampling	With the OP measures, is there a minimum number of cases that should be submitted in order to meet the requirement. We have found that our OP scip/and chest pain visits are very nominal, as most of our patient's are admitted. And how will this effect our sampling population?	The specifications manual outlines the minimum sampling requirements based on your population. At this time, if your population is ≤ 80 cases, you will need to abstract and submit 100%.	HOP QDRP SC	10/15/2008
536	Population: Sampling	What is the minimum, quarterly population sampling size for the hospital outpatient measures?	If the measure population size that is ≤ 80 for the quarter, the hospital is required to use all cases. The complete table of minimum requirements for outpatient sampling can be found in the specifications manual.	HOP QDRP SC	4/23/2008
539	Population: Sampling	Since there are three distinct measures sets, should the sample size requirements be followed for each measure set, or is the sample size based on the population for all the measures sets?	Each of measure set will have its own population to sample, therefore, there will be a total of three sample populations. The sample size requirements should be applied to each measure set.	HOP QDRP SC	4/23/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
540	Population: Sampling	Can a hospital choose to conduct monthly sampling instead of quarterly sampling?	Hospitals have the option of sampling their population on a monthly or quarterly basis; however, all data is submitted quarterly. Each hospital's total population will be an aggregate of three months, and each hospital must submit a minimum sample based on the total (quarterly) population size. This minimum sample can be selected once a quarter, or on a monthly basis (which would be the equivalent of the total sample for the quarter divided by 3). For additional information, please refer to Sample Size Requirements sub-section of the Specifications Manual for Hospital Outpatient Department Quality Measures.	HOP QDRP SC	4/23/2008
541	Population: Sampling	When sampling, is there a target percentage that should be reached for both Medicare and non-Medicare populations?	Sampling is not payer dependent. Therefore, a hospital does not need to stratify its sampling by Medicare payment status. However, as a quality check to ensure that the sample has been pulled correctly, the hospital should run a basic comparative analysis of common demographic variables (e.g., age, gender, race), and the proportion of Medicare patients between the sampled set and the eligible patient population. If there are large deviations in these distributions between the sampled set and the entire eligible population of patients, review your sampling methodology/program.	HOP QDRP SC	4/23/2008
542	Population: Sampling	In determining the population for OP-6 and OP-7, is Appendix A, OP Table 6.0 the only table used? Or should OP Table 6.1, OP Table 6.2, OP Table 6.3, OP Table 6.3a, OP Table 6.4, OP Table 6.4a, OP Table 6.4b, OP Table 6.5, OP Table 6.5a, OP Table 6.6, and OP Table 6.7 also be used?	Table 6.0 is the complete list of CPT codes that are used for OP-6 and OP-7. The additional tables (OP Tables 6.1 - 6.7) are the same procedures provided in Table 6.0, but are grouped by surgery type for use in the algorithms to determine if the correct antibiotic was given.	HOP QDRP SC	4/23/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
7	Presentation Materials	Are these presentations available after the live session? If so will you send me the information to access.	The webinar was recorded and will be posted to www.fmqai.com . From the fmqai.com website, click on Professionals/Providers, then HOP QDRP from the box on the right hand of the screen. Click Events, then click on Archived Events.	HOP QDRP SC	7/16/2008
414	Presentation Materials	How do we get a copy of the QA grid if we were not part of the education session? How do we get the slides for this part? Where are the transcripts?	All presentation materials, including the recording and transcripts of questions asked during the session, are posted on www.fmqai.com >Providers/Professionals>HOP QRP>Events>Archived Events.	HOP QDRP SC	10/15/2008
415	Presentation Materials	If we are allowed to send questions in via the web, why are they not brought up during the Q&A session? I have sent several through the web, and were not brought up.	The Q&A grid was developed to provide hospitals with a resource for questions ... due to the large response to the request for questions, select ones were presented during the webinar. It was anticipated that if hospitals had additional questions or needed clarification of an answer on the grid, they would ask it during the open discussion period. During the next Open Forum call (October 15, 2008), individual questions from the Q&A grid will not be reviewed unless there is a specific question from the audience. The call will be devoted to live questions and answers from subject matter experts.	HOP QDRP SC	10/15/2008
498	Presentation Materials	Do you have any written materials for the 10/15/08 webinar? Are there slides?	The only slides we showed were 'placeholder' slides ... the lobby slide directing participants to fmqai.com for the Q&A grid, the slide announcing the submission deadline for Population and Sampling to November 1, 2008, the slide instructing participants how to enter/exit the queue for questions, and the final slide was the HOP QDRP SC contact information. The Q&A grid was not reviewed during the webinar - there was an occasional question that referenced a particular question.	HOP QDRP SC	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
502	Presentation Materials	Could you share the tools that you spoke of regarding antibiotics with all of us during next conf call?	Please send an email to hopqdrp@fmqai.com requesting a copy of the tool.	HOP QDRP SC	10/15/2008
1	Proposed Rule	Could you please discuss the CMS proposed additional measures possibly starting Jan 2009. What specifically are they and where can we find more info on them so we can determine our staffing needs?	The CY 2009 OPSS proposed rule with comment period can be found at a number of websites, including the site where comments are made, http://www.regulations.gov (search on outpatient hospital 2009). There are 4 new proposed measures, all of which are concerned with imagining efficiency and are claims-based, thus, not requiring any clinical data abstraction. For a listing of these proposed measures, please refer to pages 41539 - 41552 of the proposed rule in the Federal Register.	CMS	7/16/2008
3	Proposed Rule	Is there any plans to expand this to the outpatient ambulatory centers?	At this time data collection for quality measures is not required for ASCs. For CY 2009, CMS has proposed to defer such data collection by ASCs until a later rule making.	CMS	7/16/2008
416	Proposed Rule	The 4 new proposal measures are not AMI/CP/Surgery related. What's the reason of monitoring these 4? Thanks	MedPAC has expressed concern about potential overuse of imaging services based upon the rapid growth in the volume of usage over the last 5 years. Because of growing concerns regarding overuse of imaging services, CMS has developed and is now proposing 4 imaging measures which measure high quality, efficient use of services for the outpatient setting.	CMS	10/15/2008
418	Proposed Rule	is there a way to comment on the proposed 2010?	The comment period has closed; the Final Rule is expected to be published in the federal Register at the end of October or early November.	CMS	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
419	Proposed Rule	Was it a proposed ruling that if a facility has less five cases the facility would not have to report? Could you provide some more specific information? Would this be a total for the facility or would it be based on type of service? When would this go into effect?	The proposal stated that after January 1, 2009, hospitals that have five or fewer claims (both Medicare and non-Medicare) for any measure included in a measure topic in a quarter will not be required to submit patient level data for the entire measure topic for that quarter. However, the hospital would still be required to submit its aggregate measure population and sample size counts for the applicable measure topic as part of its quarterly data submission.	CMS	10/15/2008
420	Proposed Rule	On the four new measures proposed, are the abstractors going to be held responsible to make sure the coding and billing is accurate? The sounds of a link being provided to the abstractors makes it sound like we will be held accountable for this. What are we actually looking for to meet the criteria?	The proposed imaging measures will be taken from claims data and create no extra data collection for hospitals.	CMS	10/15/2008
421	Proposed Rule	The proposed quality measure for CY 2010 regarding requirement of MRI Lumbar Spine for low back pain will be a formidable burden to rural hospitals who do not have an MRI. Will we be required to transfer to another hospital via ambulance to get the MRI?	The proposed imaging measures will be taken from claims data and create no extra data collection for hospitals. There will be no requirement to transfer patients from one facility to another for testing.	CMS	10/15/2008
422	Proposed Rule	Is the Proposed rule for OP 8-11 based on specific DX or just based on Procedure? What exactly will we be abstracting when it comes to OP 8,9,10,& 11?	The proposed imaging measures will be taken from claims data and create no extra data collection for hospitals. There will be no requirement to transfer patients from one facility to another for testing.	CMS	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
423	Proposed Rule	Did you say that there are going to be 4 new outpatient groups to abstract to be added? MRI lumbar spine for LBP; Mammo follow up rates; CT abd use of contrast material and I didn't get the 4th. Will we have to abstract these like we do AMI, CP & surgery?	The proposed imaging measures will be taken from claims data and create no extra data collection for hospitals. There will be no requirement to transfer patients from one facility to another for testing. The measures proposed are: OP-8: MRI Lumbar Spine for Low Back Pain. OP-9: Mammography Follow-up Rates. OP-10: Abdomen CT—Use of Contrast Material: OP-10: CT Abdomen—Use of Contrast Material. OP-10a: CT Abdomen—Use of Contrast Material excluding calculi of the kidneys, ureter, and/or urinary tract. OP-10b: CT Abdomen—Use of Contrast Material for diagnosis of calculi in the kidneys, ureter, and/or urinary tract. OP-11: Thorax CT—Use of Contrast Material.	CMS	10/15/2008
424	Proposed Rule	What is start date for CY2010 proposal?	The start date for CY 2010 proposals would be data with encounters starting in January 2009.	CMS	10/15/2008
529	Proposed Rule	Imaging efficiency measures are aimed at eliminating the overuse of imaging services. NQF is working on specific measures at this point but my understanding is that it will be looking for medical necessity and utilization criteria. Is this the same as CMS's focus?	MedPAC has expressed concern about potential overuse of imaging services based upon the rapid growth in the volume of usage over the last 5 years. Because of growing concerns regarding overuse of imaging services, CMS has developed and is now proposing 4 imaging measures which measure high quality, efficient use of services for the outpatient setting.	CMS	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
229	Public Reporting	When will this data be tied to reimbursement?	The hospital's CY 2009 annual payment update is impacted by the complete reporting of all outpatient measures as specified in the CY 2008 OPSS Final Rule. If a facility does not participate or does not adhere to any one of the requirements for participation, which includes complete submission of data, their annual payment update may be reduced by 2%. There is no requirement for public reporting of the data at this time, however, there is language regarding this in the CY 2009 OPSS Proposed Rule.	HOP QDRP SC	8/27/2008
425	Public Reporting	Our questions are related to Critical Access Hospital participation. Is CMS planning to allow CAHs opportunity to participate? Will the CART tool be available for this purpose?	Providers will be able to begin the Notice of Participation (NOP) process in November 2008 with the deadline for submission of a completed NOP by January 31, 2009. Information will be communicated via the HOP QDRP list serve as specifics relating to the process for signing up gets closer. Yes, CART will be available to the CAH to use for data abstraction.	HOP QDRP SC	10/15/2008
426	Public Reporting	Could you please clarify how the Measure OP#3AMI will be publicly reported. I am new to PI, and looking at the info, data supports 90 minutes to Door to balloon. If we transfer out within 90minutes that still doesn't account for transportation and time in next facility prior to PCI. When minutes are calculated, how will this be measured, pass, fail and reported?	The measure is expected to be reported as a median time. It is expected that patient receive acute coronary intervention within 90 minutes from initial medical contact. So it may be presumed if you are transferring patients from your facility to another for acute coronary intervention, the times should be well under the median of 90 minutes.	OMW	10/15/2008
427	Public Reporting	Once the outpatient data is abstracted, is it possible to run a report comparing our data to the state data?	There is an outpatient Facility, State, and National report on QualityNet, however, as of 10/6/2008 the report is not accurate and QualityNet is working to resolve the issues. Refer to the Known Issues documents on qualitynet.org under Hospital-Outpatient>Data Submission.	HOP QDRP SC	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
428	Public Reporting	When does the HOP data begin to be publicly reported? Is it with 3rd quarter of this year?	CMS has not yet determined when the data will be released for public reporting. There is a proposal for publication in the CY 2009 OPPS proposed rule where it is stated that CMS intends to make the information collected under the HOP QDRP public in CY 2010 by posting it on the CMS web site. As soon as it is determined, HOP QDRP Support Center will send a hopqdrp list-serve e-mail blast notifying the hospitals.	HOP QDRP SC	10/15/2008
532	QualityNet: Security Administrator	Where does one find information about the registration of QualityNet Security Administrators (SAs) for HOP QDRP? What is the process?	Information about the registration process for new QualityNet SAs can be found on QualityNet.org. For the HOP QDRP, click on the Registration link under the Hospitals-Outpatient tab to find the instructions for obtaining the Registration form as well as completing the process. It is highly recommended that each organization designate two people as QualityNet SAs - one to serve as the primary security administrator and the other, to act as a backup.	HOP QDRP SC	4/23/2008
429	Question & Answer Database	Please review where the Q&As are posted on QNET. Will the Q&A be added to Quest for the OP Measures?	At this time, presentation materials, including the Q&A grids are being posted to www.fmqai.com. In the near future, there will be a website devoted to the HOP QDRP where all information will be posted. The HOP QDRP will not use QUEST as a Q&A database.	HOP QDRP SC	10/15/2008
430	Question & Answer Database	Is there a website or another resource that we can access for future questions on outpatient hospital data collection (like QNet Quest is available for inpatient Core Measures questions)?	Currently the HOP QDRP SC is posting Q&A grids, as well as a Frequently Asked Questions document, on fmqai.com under HOP QDRP.	HOP QDRP SC	10/15/2008
431	Question & Answer Database	When will the FAQs be placed in a searchable format?	It is anticipated that the Q&A grids will be in searchable format by the end of October.	HOP QDRP SC	10/15/2008
432	Question & Answer Database	When will a Q&A database like Quest be available for OP questions?	The database has been selected, however implementation has been delayed pending contract negotiations between CMS and IFMC.	HOP QDRP SC	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
497	Question & answer Database	Where can we find the list of Q & A's for OP measures? Are they on Quality Net or on FMQAI site?	The Q&A grids previously distributed as part of the handouts for the July and August webinars are posted on fmqai.com under the archived webinar bullets for July and August. With the completion of the October grid, all have been combined and the entire document will be posted to fmqai.com under the Frequently Asked Questions bullet.	HOP QDRP SC	10/15/2008
514	Question & answer Database	Where are the questions 1-233 on the Q&A grid that was distributed as part of the 10/15/08 presentation?	This grid is the third document developed specifically for this webinar. It will be combined with the July (Q1-94) and August (Q100-233) documents and posted on fmqia.com under the Frequently Asked Questions bullet in HOP QDRP>Events. The July and August documents are currently available on fmqai.com under HOP QDRP >Events>Archived Events.	HOP QDRP SC	10/15/2008
225	Rationale	Why is the population in this measure only outpts with ST elevation that did not receive fibrinolytic therapy. Isn't it important to measure pts transfer time for coronary intervention whether they receive fibrinolytics or not? Also what is the difference between the "(Reporting)" and the "(Total for Quality Improvement)" indicators that we have to select in the period setup?	Yes. Although it is not as critical to meet the 90 minute window. There are no failures for OP-3. It is correct that patients who are transferred to receive acute coronary intervention in under 90 minutes should not received fibrinolytics, However, we expect that if the provider is aware the patient will not make the 90 minutes, they will give fibrinolytics and the patient will be excluded from the measure. However, if the patient has a contraindication/reason not to receive fibrinolytics, they will not be able to be excluded from the measure, so we allow for them to be placed in a separate category-D prime. The D measure category is eligible to be publicly reported, however, we expect the D prime group to be used for internal quality improvement purposes as we expect these times could be substantially longer than the D group.	OMW	8/27/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
232	Reports	I thought the time from door to ECG was going to be reported. The time is captured, but I don't see it on any of our reports?	OP-5 is the door to ECG measure and will be reported in minutes on your QualityNet Facility Specific and Facility, State, & National Reports.	HOP QDRP SC	8/27/2008
433	Reports	How will the timing questions (i.e., time to EKG and time to transfer for PCI) be reported out publicly? Will these be reported out as a mean time to EKG and transfer. Are there any plans to implement a time expectation and then have the percentage of compliance with that time be reported, much like the antibiotic in 6 hours question for inpatients. We have been told by some that there will be an expectation that the EKG will need to be done in 10 minutes and transfer in 90 minutes, and then the actual compliance will be reported. Any clarification of this would be appreciated.	At this times there are no such plans.	HOP QDRP SC	10/15/2008
487	Reports	QNET data submission feedback report- the HOP test data has been made available for all users to see. Is this going to be corrected?	This report has been corrected (see Known Issues document posted on qualitynet.org under the Data Submission tab.)	IFMC	10/15/2008
42	Sampling	What is the minimum number of surgical charts that can be sampled per month?	The minimum number of surgical charts per month required for sampling depends on a hospital's surgical population size; please see Table 2 in the Population and Sampling Specifications section of the Specifications Manual. For example, all records are required to be abstracted for a quarter if the number of cases is going to be less than 80 for the quarter.	HOP QDRP SC	7/16/2008
223	Sampling	If our institution has no cases meeting the criteria for OP-1 – OP-5, do we need to submit anything indicating that?? Or do we just not submit? Should I enter zeros or leave the measure set section blank? We have cases and will be submitting for OP-6 and OP-7.	You will need to submit your population numbers to the OPPS Clinical Warehouse via the Population & Sampling grid in My QualityNet, or your vendor may submit the data for you via an xml file upload. Your population for OP AMI and OP CP will be zero (0) and yes, this needs to be entered.	HOP QDRP SC	8/27/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
434	Sampling	Why is there a difference between the manual sampling population for the surgical patients and our QI vendor sampling number? Yours is 80/quarter and our vendor is 50/month.	The HOP QDRP SC can not speak to the vendor's specifications or sampling methodology. Hospitals will be held to the specifications and sampling requirements laid out in the CMS Hospital Outpatient Specifications Manual.	HOP QDRP SC	10/15/2008
21	Specification Manual: Error Noted	Medical records at my hospital tells me that the code 411.10 is invalid. The code should be 411.1. Is this correct?	The code should be: 411.1 Intermediate coronary syndrome; this has been corrected in the next manual.	HOP QDRP SC	7/16/2008
22	Specification Manual: Format	Specifications Manual v2.0a outpt. When I download the document to my computer, the layout does not mimic the inpt manual in that it is not hyperlinked and you need to scroll through the entire document as opposed to click on even the section you want.	This comment has been forwarded to the team responsible for developing the outpatient specifications manual.	HOP QDRP SC	7/16/2008
435	Specification Manual: Format	Will the Data Dictionary be available on line?	The specifications manual is currently available in downloadable format from the Hospital-Outpatient tab on www.qualitynet.org .	HOP QDRP SC	10/15/2008
19	Specification Manual: Version	I thought you said at the beginning of this program to be sure we were using Spec Manual V 2.0a. This manual notes it is to be used with Q1 09 to Q2 09 encounter dates. What version of the HOP specification manual is to be used for April 2008 outpatients and when does the next version take effect?	At this time we continue to use Specifications Manual version 1.0a for encounters from April 2008 - October 2008. Specifications Manual 1.1 is exactly the same as version 1.0a with the exception of the dates in the footer. Version 1.1 is an extension manual that covers encounters for October 2008 - December 2008. Specifications Manual 2.0a will be used for January 2009 - June 2009 encounters.	HOP QDRP SC	7/16/2008
20	Specification Manual: Version	I printed spec manual 1(1).0 for April-June 2008 but do I understand that this has already been revised and I need to reprint?	Specifications Manual version 1.0a is the manual now being used. While updates will occur, the plan is to issue new versions of the manual only twice a year. Specifications Manual version 2.0a is presently online as the manual for January 2009 services. Please see the CY 2009 proposed rule, page 41541 of the Federal Register for a discussion of a proposal to establish a sub-regulatory process for updating technical specifications.	HOP QDRP SC	7/16/2008

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493	Specification Manual: Version	On the QNet site the manual with Version 1.0a does not have this number printed in the footer--only manual 1.1 and 2.0b	That is correct, however, you will know the version by encounter date range.	HOP QDRP SC	10/15/2008
95	TJC	In the future will outpt measures be required to be submitted to the Joint Commission in addition to CMS?	For 2008, Joint Commission performance measurement requirements for hospitals can be satisfied by selecting four of the available seven core measure sets. The Hospital Outpatient Measures are one of the seven available core measures sets that can be selected. Hospitals are guided to select core measure sets based upon the patient populations they serve. No specific sets are being required at this time.	TJC	7/16/2008
436	Transfer	For the OP-3, Median Time to Transfer to another facility for acute Coronary Intervention, current recommendations support a door-to –balloon time of 90 minutes or less. However, my question is what would be a good goal for a facility in setting a time frame to for completion of assessments, EKG, and meds in order to transfer the patient out in a timely matter? Shouldn't there be a place to answer if there was a delay in transferring the patient out for the HOP/MI focus study?	A good goal would be as close to zero as possible. If there is a delay in transferring the patient out, an option is to administer fibrinolytics and the case will be excluded from the measure. If the patient cannot receive fibrinolytics due to a documented reason/contraindication the case is eligible for the D prime category.	OMW	10/15/2008
437	Transfer	Patient to ER with Abd pain, N+V, worked up for GI I abstract Presumed chest pain is Cardiac? as NO Then continued eval shows ECG with ST elevations Impending MI Patient is then transferred out for PCI. Greater time for transfer due to the non cardiac presentation. The abstraction grays out questions of ASA given, ECG time, but doesn't gray out Arrival Time and transfer time. Will the transfer time fail since it was greater than 90 minutes?	If the patient diagnosis is MI, then Probable Cardiac Chest Pain will abstract as a YES for encounters through 6/30/2009. OP-3 is not a pass/fail measure and the cases will be placed into the D measure category, assuming there are not contraindications/reasons for not administering fibrinolytics.	OMW	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
438	Transfer	Transfer for Acute Coronary Intervention § Does “2” include patients transferred from observation status for acute coronary intervention only, or patients transferred from observation status for any reason? § The Specifications Manual for 2009 indicates that “2” requires an order to admit to observation status. Should we also follow that guideline for 2008 cases?	Yes, this includes any cases placed into observation prior to transfer.	OMW	10/15/2008
178	Transfer: Rationale re: Median Time to Transfer	We realize that it states what is the median time it takes us to transfer a patient for acute coronary intervention? At one point you mention the golden “90 Minute Rule”. Does that mean that we have 90 minutes to transfer someone to another facility that supplies these interventions in 90 minutes or less? If we don’t meet the 90 Minute time frame do we get penalized?	Guidelines recommend patients who are candidates for acute coronary intervention receive the treatment within 90 minutes of initial provider contact (this includes EMS contact). So in order to facilitate improvement in transfers, we track the time it takes for your facility to transfer the patient out. It can be expected that if you are transferring most of your patients out in times close to 90 minutes, it is likely the patient is not receiving the treatment within the recommended time frames. There are no failures for OP-3, however the closer your times to zero the better.	OMW	8/27/2008
439	Transfer: Rationale re: Median Time to Transfer	re: Q177: I thought that the measure was from MY door to THEIR cath lab. Are we to count the time from when the EMS got to the patient before getting to me?	It is the time the patient arrived at your facility to the time the patient leaves your facility. You are in control as to how much time the patient stays at your facility. The quicker you can transfer the patient out, the more likely they are to receive the acute coronary intervention within 90 minutes.	OMW	10/15/2008
440	Transfer: Rationale re: Median Time to Transfer	Also goal oriented to looking at time for transfer??? To PCI, we are looking at less than 90 minutes but also have to account for the transfer time and getting to the next hospital.	Your goal is to be as close to zero as possible.	OMW	10/15/2008
65	Transfer: Reason for Transfer	If the MD documents "cardiac care", "cardiology" as reason for transfer, is this sufficient to meet TRANSFER FOR CORONARY INTERVENTION or would it fall under OTHER OR UNABLE TO DETERMINE REASON?	These will abstract as value 3.	OMW	7/16/2008

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179	Transfer: Reason for Transfer	If the answer to the transfer was "unable to be determined", will this make the chart "fall out"? I have referred to pg 2-63 and see the acceptable documentation reasons for answer #1 to that question. Do the doctors need to document one of these reasons to keep the chart correct? (Some doctors say transfer to care of acute MI).	Unless there is documentation the patient is being transferred for acute coronary intervention (I.e. value 1) the case will be excluded.	OMW	8/27/2008
441	Transfer: Reason for Transfer	To answer the data element: Transfer for Acute Coronary Intervention - If the patient went for a CABG the answer would be "3" for this element due to the patient wasn't being transferred for a "Percutaneous Coronary Intervention, Angioplasty or cardiac cath"?	That is correct.	OMW	10/15/2008
442	Transfer: Reason for Transfer	I recently completed a focus study on a patient that admitted to the ED after having an ECG done for pre-op in an outpatient setting. Initially the patient refused transfer, and was going to be admitted into our facility, however later decided he wanted to be transferred, therefore this prolonged the time for the patient to be transferred. In the HOP AMI focus study shouldn't there an option of choosing why the transfer was prolonged under these circumstances.	The measure is a median time, so cases such as this should be outliers and not effective the reporting time as long as this is an unusual occurrence and not typical of your facility.	OMW	10/15/2008
443	Transfer: Reason for Transfer	How do answer for physician documentation for transfer such as: "Cardiology", "Cardiology/Monitored bed", "urgent cardiology evaluation for Acute Coronary Syndrome". Would you choose 3. other because these are not in the inclusion list does not specifically state intervention	These would all abstract as value 3.	OMW	10/15/2008
93	Validation	Do you know, at this point, how many charts will be used for validation?	Proposed data validation requirement are contained in the CY 2009 OPPS proposed rule. CMS proposes to randomly select per year, 50 patient episodes of care from what a hospital successfully submitted to the OPPS Clinical Warehouse. This is what is proposed; please see page 41546 of the Federal Register for details on requirements proposed for CY 2010 payment decisions as well as alternative data validation approaches for CY 2011.	CMS	7/16/2008

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233	Validation	I understand that we will not be officially validated on our HOP QDRP data until 1/1/09 discharges, but will there be a validation process in place prior to this that will give us feedback re: how we're doing and prepare us for formal validation in 2009?	No, there are no plans for a process for preliminary validation prior to the official validation process.	HOP QDRP SC	8/27/2008
444	Validation	If the proposed date for validation to start is Jan 2009. Will records from Q4 - 2008 be validated or would Q1 - 2009 be the first records to be validated?	If the proposed rule goes into effect unchanged, validation would start with January 2009 encounters.	CMS	10/15/2008
445	Validation	Regarding the proposed OPPS validation process, will there be an appeal process as well?	The validation methodology is still in the proposed rule process and is not finalized. Precisely how validation will be implemented is still undergoing managerial level discussion.	CMS	10/15/2008
446	Validation	Prior to the new proposed validation, will there be any validation for hospitals for the purposes of "learning". I believe this is crucial prior to taking money away.	The validation methodology is still in the proposed rule process and is not finalized. Precisely how validation will be implemented is still undergoing managerial level discussion. Thus, I simply am not able to answer your question at this time.	CMS	10/15/2008
447	Validation	When you mentioned what CMS is proposing for validation: 50 charts from 800 randomly selected hospitals, does this mean 50 charts per randomly selected hospital?	Yes, it means 50 records each from 800 randomly selected hospitals.	CMS	10/15/2008
516	Validation	When will data validation of the 2nd Q 08 data occur? What will the penalties or consequences be if our data consistency falls below the minimum threshold.	There will not be any validation of the Q2 2008 outpatient data. The OPPS proposed rule for CY 2009 sets validation to begin with Q1 2009 encounter data.	HOP QDRP SC	10/15/2008
528	Validation	We are a very small hospital. We do not have 50 cases that qualify for abstraction in Outpatient. If we are selected randomly for validation, how will that impact results?	The process for OPPS validation is in the OPPS CY2009 Final Rule, which has not yet been finalized or published, therefore the impact on validation can not be determined at this time.	CMS	10/15/2008

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Q #	TOPIC	QUESTION	ANSWER	RESPONDER	PROGRAM DATE
202	Vendor Authorization	According to yesterday's presentation on vendor authorization, this tool becomes available April 4. In the presentation, it was stated that backdating could not be done for entering encounter start date. The quarter begins with discharges April 1. Will this date be allowed in the start date for 'encounter'?	The Encounter Start Date should be entered as the first day of the encounter period you are beginning to abstract. If you are intending to submit data for Q2 2008 (April 2008 forward), then you will enter 04/01/2008 as your Encounter Start Date. The 'back date' was in reference to the Transmission Start Date ... this date can not be prior to the date you are entering the information.	HOP QDRP SC	8/27/2008
533	Vendor Authorization	How will providers be able to authorize vendors to submit data on their behalf? What is the process?	Providers can authorize vendors to submit data on their behalf via the secure pages of QualityNet at Hospitals: Outpatient Clinical. No paper forms are necessary. The Encounter Date - Start should be entered as 04/01/2008 and the Transmission Date - Start should be the date you enter the agreement with your vendor. This date can be entered as the date you are updating the authorization, but never after the deadline for submission for the quarter.	HOP QDRP SC	4/23/2008
534	Vendor Authorization	Who approves vendors for reporting HOP QDRP data?	CMS does not approve vendors. Currently, the Joint Commission is the only organization to "approve" vendors.	HOP QDRP SC	4/23/2008