

Abstraction/Data Submission Checklist

1.	Pull ICD-9-CM Diagnosis/Procedure codes from Appendix A from the Specifications Manual for the appropriate data collection time period on each clinical topic*. Patient Age (<i>Admission Date – Birthdate</i>)>= 18 years. Acute Inpatient Stays ONLY (Have IS run list or manually pull list of records to be abstracted)
2.	Determine if you have enough cases to Sample and perform Sampling per <i>Section 4</i> of the Specifications Manual.
3.	Update ICD Population/Sampling and Measure Designation in QNET (Updates must be performed by Vendor or Hospital QNET Administrator). Measure Designation should be updated PRIOR to data submission to QIO Clinical Warehouse. ICD Population/Sampling should be updated 15 days prior to the data transmission deadlines (Medical Record Validation Schedules/Deadlines posted on www.qualitynet.org).
4.	Run RHQDAPU Provider Participation Status Report in QNET (Pull additional Medicare charts if needed per total Medicare Claims Column).
5.	Abstract data into Data Entry Tool. Refer to the data definitions in the appropriate Specifications Manual for the discharge period you are abstracting. Utilize QUEST (via www.qualitynet.org) to search and/or query specific case scenarios that you have questions about.
6.	Submit data EARLY to the QIO Clinical Warehouse or Vendor (at least two weeks prior to deadline). This will provide time to correct any critical errors; abstract additional cases to meet minimum sample requirements, and problem solve any abstraction errors prior to the deadline. No additional cases will be accepted in to the warehouse after the deadline – regardless of the reason.
7.	Run QIO Clinical Warehouse Feedback Report(s): <u>Case Status Summary Report</u> - Displays submitted, accepted and rejected cases from the QIO Clinical Warehouse. <i>If you have any rejected cases, run ...</i> <u>Data Submission Detail Report</u> - Displays why the case(s) were rejected from the QIO Clinical Warehouse

***Codes by Clinical Topic:**

AMI – Principal Diagnosis Code from Appendix A, Table 1.1

PN – Principal Diagnosis Code from Appendix A, Table 3.1 OR Principal Diagnosis of Septicemia (Table 3.2) or Respiratory Failure (Table 3.3) AND a Secondary Diagnosis of PN (Table 3.1)

HF – Principle Diagnosis from Appendix A, Table 2.1

SCIP – Principle Procedure Code from Tables: 5.01-5.08 and 5.25. Pull eight lists as follows:

CABG	Table 5.01
Other Cardiac Surgery	Table 5.02
Colon	Table 5.03
Hip	Table 5.04
Knee	Table 5.05
Hysterectomy	Table 5.06 or Table 5.07
Vascular	Table 5.08
Other Surgery	Table 5.25