

Second Quarter 2008 Questions and Answers April 1, 2008 through September 30, 2008 discharges

GENERAL

QUESTION: I noticed that the words "typed and stamped" were removed from Exception noted under the 3rd bullet. My question: Is an electronic signature within 30 days acceptable on a Physician-dictated medication list given to the patient at discharge?

ANSWER: *For 4/1/08+ discharges: Yes, an electronic signature is acceptable.*

QUESTION: Program Management: ICD Population and Sampling file completion, by vendor or hospital, required with 1/1/2008 discharges. The data submission deadline for 1Q2008 discharges is August 15, 2008. Does the Program Management ICD Population and Sampling file completion follow the same dates for data submission?

ANSWER: *The Initial Patient Population and Sampling counts deadline is 15 days prior to the clinical data submission deadline. The deadline for 1st Qtr 08 population and sampling counts will be August 1, 2008.*

QUESTION: In cases where a patient is initially admitted to observation status and then subsequently converted to an inpatient admission by a physician order. What date would we use for the admission date (date of physician admission order or date of physician order for observation)?

ANSWER: *The data element Admission Date asks what was the date that the patient was admitted to acute inpatient care. For purposes of abstraction, a patient of a hospital is considered an inpatient upon issuance of written physician orders to that effect. From the information you provided, the Admission Date would be the date the physician inpatient admission order was written.*

QUESTION: Can you please explain the ICD Population and Sampling? (several questions regarding ICD Population & Sampling)

ANSWER: *Beginning with 1Q 2008 discharges, ICD Population and Sampling is required for PPS hospitals, is not required for Critical Access Hospitals. This will enable CMS to have a better picture of each hospital's total population, since presently they can only see Medicare claims. If a hospital uses a vendor for data collection, you will want to check with your vendor to see if this information is something they will be providing. For hospitals that will manage this process themselves, whether reporting 100 percent or sampling, the process of data collection always begins with identifying the total population for each topic and/or strata. This information will need to be enhanced to include payer source. Once the total population has payer source included, you can proceed with either abstracting 100 percent, or if you sample, performing your sampling per defined guidelines. Then you divide into Medicare & non-Medicare and enter the information into the respective tables in Program Management. *If the patient has any type of Medicare, Medicare could be listed as primary, secondary, tertiary or lower on the list of payment sources for the patient. In addition, patients who are participating as a member of a Medicare HMP/Medicare Advantage are included in the Medicare counts. E.g., Medicare Blue, Humana Gold, Secure Horizons, AARP, Coventry Advantra, etc. (*This info taken originally from Quest #149314, which was submitted for clarification.)*

QUESTION: Regarding comfort care pt arrived at 0250 + nstami, cardiac arrest in cicu, made comfort care and expired at 0912. admission < 7 hours. the rule states if written day of discharge do not count. I'm questioning how to abstract this case. Admission and discharge date is the same.

ANSWER: *Per the Specs Manual effective with 4/1/08+ discharges: If the earliest day that comfort measures was documented is on Day 0 (day of arrival) select option 1- 'Day 0 or 1'. Whether or not this was also the day of discharge does not matter. The guideline that stated documentation of comfort measures on day of discharge does not count has been removed in the 4/1/08 manual.*

QUESTION: In the Abstraction Guidelines for April 2008, there is one that we were wanted to understand a little better. It has do with sending charts for validation "hospitals will need to provide a paper copy of the medical record in its entirety, including definitions of symbols/abbreviations used." We have a standard printed booklet that highlights the entire list of symbols and abbreviations that are acceptable at our hospital. Staff are required to follow those guidelines. Will we meet the criteria for submission to CDAC if we send that booklet every time we send our cases for validation?

ANSWER: *For 04/01/2008 and forward discharges, the medical record is considered to be the official documentation of the care provided during the episode or care. Hospitals should use abbreviations according to their policy. Frequently flow sheets or other documentation contain a 'key or legend' that explains what the abbreviation or symbol stands for, especially if it is unique to that facility. If the record is selected for validation, it is not necessary to send your policy. There is a chance of a mismatch if the hospital uses a symbol or abbreviation that might not be known to an external abstractor. If a hospital determines they have received a mismatch for this reason, you may contact the QIO for guidance.*

QUESTION: What is the document change for 4/1/08+ discharges related to Pharmacist?

ANSWER: *Pharmacist documentation (pharm D, R.Ph., etc) now **acceptable** as "other reason" for not prescribing medication X. Please note this change has been made across all topics. Pharmacist documentation **can be** used to answer Antibiotic Allergy, Contraindication to Beta-Blocker Perioperative, Contraindication to VTE Prophylaxis and Vancomycin*

QUESTION: 2.4 version of the Specifications Manual. If Comfort Measures Only is documented on the day of discharge, is that documentation to be disregarded? If the only documentation of Comfort Measures Only is documented on the day of discharge, is it "no" to Comfort Measures Only? Or is it "yes" to Comfort Measures Only, with the allowable value specific to the day on which it was written, day 0-1, day 2, etc?

ANSWER: *For 4/1/08+ discharges: If the only documentation of comfort measures only is on the day of discharge, you would abstract the allowable value specific to that day - i.e., 'Day 0 or 1' if the patient was discharged on the day of or day after arrival, 'Day 2 or after' if the patient was discharged two or more days after arrival*

QUESTION: In cases where a patient is initially admitted to observation status and then subsequently converted to an inpatient admission by a physician order what date would we use for the admission date (date of physician admission order or date of physician order for observation)?

ANSWER: *The data element Admission Date asks what was the date that the patient was admitted to **acute inpatient care**. For purposes of abstraction, a patient of a hospital is considered an inpatient upon issuance of written physician orders to that effect. From the information you provided, the Admission Date would be the date the physician inpatient admission order was written.*

QUESTION: Criteria regarding comfort measures - I see that the statement from the 4Q07 criteria "Disregard documentation of comfort measures only written on the day of discharge in any source other than discharge summary..." has been deleted and the statement "Consider comfort measures only documentation in the discharge summary as documentation on the last day of the hospitalization, regardless of when the summary is dictated" was added. Could you please help clarify the following: (1) If there is documentation of comfort measures in the discharge summary, would you answer option 1 or 2 (depending on how long the patient was in the hospital?) (2) Would you answer option 2 to comfort measures only on a case where the

patient was in hospital for more than 2 days and has comfort measures documented in the progress notes/consult notes or physician orders on the day of discharge/death? Or does this documentation still need to be in the discharge summary only to be considered a "YES" to comfort measures?

ANSWER: For 4/1/08+ discharges:

1) If the only documentation of Comfort Measure Only is in the discharge summary, use the last day of the hospitalization to determine which option to select -- Option 1 if the patient was discharged on the day of or day after arrival OR Option 2 if the patient was discharged at least 2 days after arrival.

2) If the earliest documentation of Comfort Measure Only was in the progress notes, consult notes, orders, etc, on the day of discharge or death this DOES count as acceptable documentation and select option #2 if the date of documentation was two or more days after arrival day.

AMI

QUESTION: AMI PCI. Has there discussion related to changing the PCI measure to 60 minutes rather than 90 minutes? The subject has come up from time to time.

ANSWER: For 4/1/08+ discharges: We are not aware of any ACC/AHA or CMS/TJC plans to revise AMI-8a measure to 60 minutes.

QUESTION: For D/C medications, on page 3 of the Summary of AMI/HF Changes for April 1, 2008, please explain the last clarification item on this page, regarding if a comparison list is not available?

ANSWER: This clarification is intended to convey that if a comparison list is not available, you cannot take credit for medication **unless** the written instructions given to the patient is signed by the physician/APN/PA.

HF

QUESTION: Is the same true for LVF assessments documentation "about or around 40%"=40%?

ANSWER: For 4/1/08+ discharges: Documentation of EF as "around 40%" and "about 40%" would be abstracted as EF of 40% and considered as an estimated EF value

QUESTION: Can you explain the Comfort Measures reference on the first page of the Summary for AMI/HF Changes for April 1, 2008? For example, if a HF patient is discharged to a SNF?

ANSWER: The abstraction order has been modified to allow skipping the abstraction of Comfort Measures Only based on where the patient was discharged. For SNF discharge as referenced in this question, Comfort Measures Only would be excluded from the abstraction.

QUESTION: For a HF case, how would you abstract the admission source if the patient was first in observation then transferred to acute?

ANSWER: You need to go back to the original source. If the patient came into the ER and was admitted to observation and then acute the point of origin would be ER. If the patient were admitted directly to observation from the physician office, then the point of origin would be non-health care. See the Point of Origin release notes found at www.qualitynet.org under Hospital-Inpatient>Data Submission >CART>Abstraction Resources.

PN

QUESTION: Pneumonia Diagnosis-ED/Direct Admit. Our ED uses a number of protocols that have been signed by/approved by the medical director. Is this considered the equivalent of a pneumonia pathway?

ANSWER: *Pneumonia protocols would be considered equivalent to pneumonia pathways.*

QUESTION: Pneumonia - If a patient is on a prednisone taper, would this be YES or NO to Compromised? If a patient was on a course of prednisone, would this be YES or NO to compromised?

ANSWER: *4/1/2008 Discharges: For the data element Compromised both scenarios would abstract as No. A steroid taper would be considered a one-time course.*

QUESTION: the ED physician uses a protocol titled Infection/Pneumonia/Sepsis that has sites of infection listed that can be checked and pneumonia is not checked, would that protocol count as an indication of pneumonia diagnosis?

ANSWER: *4/1/2008 Discharges: In order to use PN pathway or standing order protocol you would need to see Pneumonia written as a diagnosis in the orders in order to answer as YES and select value 1, Pneumonia Diagnosis: ED/Direct Admit. And this can only be used if the:
' ED physician does NOT document pneumonia/infiltrate/pneumonitis as the ED final diagnosis/impression.... but then that SAME ED physician turns around and writes the admit note or admit orders and gives a diagnosis of pneumonia*

QUESTION: Pneumonia and SCIP 1. If there is a antibiotic documented with route, and there is no date and time, would an abstractor abstract the antibiotic name, route, UTD date and UTD time? 2. If the ED nurse documents Levaquin 500 mg IV given on 4/1/08 at 1200 and the physician documents in the progress note Levaquin 500 mg IV given in ED, how would you abstract the Physician's documentation? For example, abstractors will utilize Levaquin 4/2/08 at 1200 IV, would the abstractors have to also abstract the ED physician's note or can they infer that this was the same antibiotic? If the only documentation is listed in the ED physician's note, that Levaquin IV was given in ED, can this be abstracted?:

ANSWER: *4/1/2008 Discharges: 1) You are correct. For PN: If the Time is UTD, only abstract the doses with UTD that depending on the Date could have been given within 36 hours, and also abstract the first dose of each different antibiotic name that has a non-UTD Time. If the Date is UTD, abstract all doses with UTD as well as the first dose of each different antibiotic name that has a non-UTD Date. 2) You wouldn't abstract the physician's documentation. Per Notes for Abstraction: Antibiotic administration information should be abstracted from a single source that demonstrates actual administration of the specific antibiotic.*

SCIP

QUESTION: How are hospitals actually scored for "Surgery patients with recommended venous thromboembolism prophylaxis ordered". Normally blood thinners are stopped 7-10 days prior to surgery. Are they looking to see if these are re-started within 24 hours of cut time?

ANSWER: *April 01, 2008 Discharges Forward: There is no correlation between patients whose blood thinners are discontinued 7-10 days prior to surgery and the SCIP VTE Measures. The SCIP VTE Performance Measure names are: Surgery Patients with the Recommended Venous Thromboembolism Prophylaxis Ordered and Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery End Time.*

QUESTION: Are the following considered preop infections: appendicitis and cholecystitis

ANSWER: Beginning with April 01, 2008 Discharges: Appendicitis will be accepted as Yes to Infection Prior to Anesthesia with preoperative physician documentation. Only select Yes to Infection Prior to Anesthesia with preoperative physician documentation of acute cholecystitis.

QUESTION: Are foot pumps acceptable for hip and knee replacements with epidural catheters?

ANSWER: April 01, 2008 Discharges Forward: Please see the VTE Prophylaxis Selection for Surgery Table and Table 2.1, which is located in the manual on page SCIP-VTE1-5 for a complete list of the recommended prophylaxis listed by procedure. Foot pumps are acceptable if the patient has a contraindication to pharmacological prophylaxis such as Neuraxial Anesthesia.

QUESTION: SCIP Joint revision: Does this refer to joint revisions performed during the principal procedure hospital encounter or if the patient has a history of a joint revision and gets admitted for colon surgery, would abstractors still answer yes?

ANSWER: April 01, 2008 Discharges Forward: The data element, Joint Revision, applies to the principal procedure performed during the current hospitalization, was a joint revision, it is not associated with the patient's history.

QUESTION: The instructions for Preadmission Warfarin state that we should abstract Yes if warfarin was listed as home/current but placed on hold the day prior to surgery and we should abstract No if the warfarin was placed on hold greater than 7 days prior to surgery. What do we do if the patient was on warfarin at home but was placed on hold two to seven days prior to the surgery?

ANSWER: For April 01, 2008 Discharges Forward: If the warfarin was placed on hold two to seven days prior to surgery, answer Yes.

QUESTION: The instructions for Contraindication to Beta-Blocker Perioperative state that we should abstract Yes if the MD/NP/PA/Pharmacist documented a pulse rate to 50 bpm or less during the perioperative period. Does that apply to any time during the perioperative period, including intraoperatively? Are all cases in which the patient's pulse drops to 50 bpm during the surgery to be abstracted Yes for the contraindication?

ANSWER: For April 01, 2008 Discharges Forward: If there is documentation of a rate less than 50 that occurred during the perioperative period, which includes intraoperatively, select Yes to Contraindication to Beta-Blocker Perioperative. Note: The heart rate of less than 50 does not have to be documented by a MD/NP/PA/Pharmacist and VS obtained while the patient is on cardiopulmonary bypass cannot be used. Please review the Notes for Abstraction for the data element(s).

QUESTION: SCIP changes, page 1 references Table 5.09 – please explain this bullet? 3/08

ANSWER: The Notes for Abstraction were added to advise that table 5.09 should not be used to answer the infection data elements. Abstractors should be using the inclusion tables within the data element to determine what should be considered an infection.

QUESTION: This question is regarding the 2.4 guideline for SCIP, effective 4/1/2008. According to the release notes for SCIP, the codes listed in the "Release Notes 2.4 Supplemental Document" should be REMOVED from Table 5.10 Major Surgery. In that case, the only valid Major Surgery codes are now those now listed in Appendix A, Table 5.10 (approximately 390 codes). Is that correct?

ANSWER: April 01, 2008 Discharges Forward: Effective with this discharge period, the codes listed in the manual for this period on Table 5.10 are the valid Major Surgery Codes.

QUESTION: For the new Specifications manual for March '08 discharges appendix A table 5.13 Hip fracture. What measure is this table connected to?

ANSWER: For April 01, 2008 Discharges Forward: The table 5.13 Hip Fracture, is used for SCIP-VTE to ensure patients with a diagnosis of hip fracture are evaluated for the proper VTE Prophylaxis. Please refer to SCIP-VTE-1 Measure Information Form.

QUESTION: QUEST #106727 says "At this time the only data source that can be used to document VTE prophylaxis is the physician's orders.... We are in the process of changing the allowable data sources for mechanical forms of prophylaxis to include other documentation (particularly since the use of protocols that allow for routine use of mechanical forms of prophylaxis is an effective strategy to improve prophylaxis) but this change will not take place until April 2008 discharges." Will you please clarify now that we are closer to 4/1/08: what will be allowable as proof of a protocol for SCD's? Our OR has a standard of care (SOC) that says every patient will have SCD's applied once they are in the OR, but there is not a specific physician order on the chart. Will this be acceptable? Will the documentation in the OR record that they were placed work for both VTE 1 and 2 starting 4/1/08?

ANSWER: For 04/01/08 discharges forward: b Please review the Notes for Abstraction for the data element(s). Collect any mechanical form(s) of prophylaxis for which there is documentation of being placed on the patient anytime from hospital arrival to 48 hours after Surgery End Time.
The only acceptable data source for pharmacologic prophylaxis are the physician orders.

QUESTION: According to the data element VTE prophylaxis, "collect any mechanical form(s) of prophylaxis for which there is documentation of being placed on the patient anytime from hospital arrival to 48hrs after Surgery End Time "with suggested data sources as nurses notes, OR records, operative notes, progress notes etc. It also states that the ONLY acceptable data source for pharmacologic prophylaxis is the physician orders. Please clarify--does this mean that I don't have to have a written order for mechanical prophylaxis in order to abstract SCDs, TEDs or VFPs as long as they are documented as being on the patient within 24 hours of incision to 24 hours after surgery end? If not, why are all those data sources listed instead of just physician orders?

ANSWER: April 01, 2008 Discharges Forward: If the mechanical form of VTE Prophylaxis is documented as having been placed on the patient, anytime from hospital arrival to 48 hours after Surgery End Time, should be abstracted as if there is a physician order for it. There must be an actual order for the pharmacological VTE Prophylaxis therefore the only Acceptable Sources are physician orders.

QUESTION: For 2Q 2008 SCIP: Would the following Physician documentation be scored a "2" for contraindication to VTE prophylaxis: "Lovenox inappropriate in face of hypotension, not stable today".

ANSWER: April 01, 2008 Discharges Forward: Select Yes with documentation, Lovenox inappropriate in face of hypotension, not stable today, if it is found within the timeframe of arrival to 24 hours after Surgery End Time.

QUESTION: On the SCIP changes for April 1, 2008, please explain the reference on page 3 to the addition of Table 5.13 – Hip Fracture codes?

ANSWER: Page 124 of the Release Notes 2.4 indicates this table was added to "... ensure that patients with hip fracture diagnoses are evaluated for the proper VTE Prophylaxis."

Quest Questions with Revised Responses

Action	Topic	Question #	Data Element/Subject
Revision	AMI Interventions	131026	Contraindication to Aspirin at Discharge
Revision	Hospital Data Collection	147236	Point of Origin
Revision	AMI Interventions	136275	Contraindication to Aspirin on Arrival
Revision	PN Measures	135958	ICU Transfer or Admission Within First 24 Hours
Revision	Hospital Data Collection	145218	Admission Date
Revision	SCIP Measures	147131	Infection Prior to Anesthesia
Revision	PN Measures	148036	PN DX: ED/Direct Admit
Revision	PN Measures	149165	Risk Factors for Drug-Resistant Pneumococcus
Revision	Hospital Data Collection	128710	Point of Origin

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