Hospital Inpatient Quality Reporting Program

Support Contractor

Specifications Manual, Version 4.4a, Changes & Hospital VBP Program Improvement Series: MSPB

P.M. Presentation Questions and Answers

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Question 1: AMI-7a... we do not provide fibrinolytic therapy here... do we still need to participate in AMI for Core measures?

Answer 1: Yes, you are still required to identify the AMI population and sample size and abstract and submit those cases for AMI-7a even if you do not administer fibrinolytics.

Question 2: How did you get the physicians to take on such an active role at McLeod Health?

Answer 2: McLeod has found that physicians want to engage in improvement if given the data, someone to help their engagement be easy, and if we in fact do what they ask

us to do at the end. We did all of these things – we showed them the data to drive urgency for improvement; the clinical effectiveness care manager is dedicated to a specific team for the three-month improvement cycle and does the support work for the team; an executive is engaged on each team to make sure that any solutions being generated can be operationalized; and then we roll out their improvements. Physicians actually volunteer to serve because it is making a meaningful difference, and that is what they long to do!!

Question 3: Can we get the name of the High-Risk tool McLeod Health used for assessing readmission risk?

Answer 3: We originally used the LACE tool but have since developed our own tool that is very similar and housed it within our case management workflow.

Question 4: IS THE SPECIFICATIONS MANUAL VERSION 4.4a AVAILABLE TO DOWNLOAD AT THIS TIME?

Answer 4: Version 4.4a of the Specifications Manual is available for download on the *QualityNet* website.

Question 5: Is there any reason for a hospital to continue to abstract HF if it is only one voluntary element?

Answer 5: The benefit of continuing to abstract the voluntary measures is to ensure that the highest quality of care is being provided to your patients and to continue to identify areas of quality improvement.

Question 6: I'm not clear how removing cost in the inpatient stay will affect MSPB in a DRG system.

Answer 6: You are probably technically right, but facility cost does have influence on payment even within the DRG model. The reduction of readmissions and complications and moving outside our walls at McLeod Dillon were the biggest driver. I just wanted to talk about our entire program for improvement.

Question 7: Will the voluntary measures impact our VBP?

Answer 7: No. Measures that become voluntary for a discharge period are not included in the Hospital Value-Based Purchasing Program using the same performance period. For example, measures that became voluntary for Calendar Year 2015 discharges were removed from the Fiscal Year 2017 Hospital VBP Program utilizing Calendar Year 2015 discharges for the Clinical Care - Process Measures. The only measures included in the

FY 2017 Hospital VBP Program for the Clinical Care - Process domain are the AMI-7a, IMM-2, and PC-01 measures.

Question 8: Are voluntary measures reported on *Hospital Compare*?

Answer 8: CMS will report voluntary measure data on *Hospital Compare*.

Question 9: We do not do cardiac surgery here... do we still need to participate in SCIP for SCIP-4?

Answer 9: Yes, you will still need to participate in SCIP for SCIP-Inf-4. You will continue to submit the population and sample sizes for each of the eight SCIP strata. The cases in the sample for each of the SCIP strata will then be abstracted and submitted.

Question 10: What are the required Core Measures and what is the number required to meet IQR Program requirements?

Answer 10: If submitting chart-abstracted measures only for the IQR Program, this includes AMI-7a, SCIP-Inf-4, VTE-1, VTE-2, VTE-3, VTE-5, VTE-6, STK-1, STK-4, STK-6, STK-8, ED-1, ED-2, IMM-2, and PC-01.

Question 11: Why were all these measures removed?

Answer 11: The measures that were removed from the IQR Program were considered "topped-out," meaning that there was no further room for improvement.

Question 12: What is the reasoning behind making a measure voluntary to report? Is it to our hospital's benefit to report these?

Answer 12: The benefit of continuing to abstract the voluntary measures is to ensure that the highest quality of care is being provided to your patients and to continue to identify areas of quality improvement.

Question 13: For Memorial Hospital, are your providers you refer to employed by your hospital?

Answer 13: So when we started with our hospital group, they were employed through contract with our hospital, but we are almost in a transition period of where our providers - that same hospital group - they're becoming employed by our affiliate hospital. And during that transition period, currently they are employed by our hospital. But throughout all these changes back in 2013, they were through a contract group.

Question 14: What do I do when I submit a question to the Q&A tool and a month later, I still do not have an answer? I have also resubmitted the question a couple more times without an answer.

Answer 14: Thank you for the feedback. For questions submitted from September onward, we are working through these as quickly as possible. Many data element queues are current or near current, while others lag by several days. For the lagging queues, we have added staff to address these questions. For questions submitted prior to September, a lapse in contract coverage created a backlog that we are addressing through data analyses to develop standardized questions and answers based on these questions. When possible, we are addressing these directly once current queues are completed. We appreciate your patience as we develop and improve our processes.

Question 15: Hi, if you are submitting eCQMs under the IQR Program, can you have zero for the Denominator and/or Numerator?

Answer 15: A zero denominator does count for the IQR Program. A hospital could also have a zero for the numerator depending on the measure and its patient population.

Question 16: What should we do when we don't receive answers that were submitted via the Q&A tool?

Answer 16: Thank you for the feedback. For questions submitted from September onward, we are working through these as quickly as possible. Many data element queues are current or near current, while others lag by several days. For the lagging queues, we have added staff to address these questions. For questions submitted prior to September, a lapse in contract coverage created a backlog that we are addressing through data analyses to develop standardized questions and answers based on these questions. When possible, we are addressing these directly once current queues are completed. We appreciate your patience as we develop and improve our processes.

Question 17: I'm wondering if you could share with us the purpose of submitting SCIP and AMI data for cases that are certain to be excluded (e.g., hip cases for a cardiac glucose measure and AMI-7a cases when no fibrinolytics are used)?

Answer 17: SCIP-Inf-4 was not deemed as being “topped-out” as CMS did not yet have sufficient data to accurately assess whether the measure met “topped-out” criteria. In addition, AMI-7a did not meet the criteria for being “topped-out”.

Question 18: In regards to AMI-7a: If a hospital does not provide fibrinolytics, why is it necessary to abstract the data for AMI-7a only to have all of the cases excluded? We have not needed to do this abstraction in the past.

Answer 18: AMI-7a has always been a required measure for CMS whether you provide fibrinolytics or not. As currently or in the past, if no fibrinolytics were given, the case was excluded from the measure denominator.

Question 19: In regards to SCIP-Inf-4: Would you please explain why cases that are not eligible for the cardiac strata should be abstracted and included only to be excluded since they will not have a code on Table 5.11? Non-cardiac cases have never been included in this sample in the past.

Answer 19: The determination of the SCIP strata initial patient population and sample sizes did not change. The hospitals will continue to determine the population and sample sizes for all eight strata and abstract those for SCIP-Inf-4 just as they are currently doing. If the case(s) does not have a principal procedure on Table 5.11 (cardiac surgery table for SCIP-Inf-4), then the case(s) will excluded from the denominator of the measure, just as it is doing now, but will still be submitted to the CMS clinical warehouse.

Question 20: Why are some measures voluntary?

Answer 20: The reasons to keep the measures voluntary for a period of time is multi-faceted including the opportunity to assess the measures' feasibility and/or to allow programming time for data processing.

Question 21: Is there anything that is mandatory for PNA core measures?

Answer 21: No, there are no PN measures that are "required" to be submitted to CMS.

Question 22: So if I understand this correctly... We will still send all of our SCIP cases to CMS, e.g., total knee replacements, hysterectomies, etc. But since we do not provide cardiac surgery, none of these cases will be in the SCIP-4 measure, and since we are not going to submit these as voluntary measures, all of our cases will be excluded.

Answer 22: Your understanding is correct.

Question 23: *Quality Net* has been very slow or not even answering questions submitted concerning core measures. Will this be resolved in the near future?

Answer 23: Thank you for the feedback. For questions submitted from September onward, we are working through these as quickly as possible. Many data element queues are current or near current, while others lag by several days. For the lagging queues, we have added staff to address these questions. For questions submitted prior to September, a lapse in contract coverage created a backlog that we are addressing through data analyses to develop standardized questions and answers based on these questions. When possible, we are addressing these directly once current queues are completed. We appreciate your patience as we develop and improve our processes.

Question 23: If we choose SCIP for one of our Core Measures, do we only send in the glucose measure for Cardiac Patients (sorry, I just came in)?

Answer 23: SCIP-Inf-4 is a required measure for the Inpatient Quality Reporting (IQR) Program. SCIP-Inf-1, -2, -3, -6 and -9, SCIP-Card-2, and SCIP-VTE-2 can be submitted voluntarily.

Question 24: Why do we have to abstract all eight STRATA for SCIP when only the Cardiac surgeries pertain to the glucose measure?

Answer 24: There were no changes to the reporting of the SCIP strata population and sample sizes in the IPPS Final Rule.

Question 25: Are voluntary measures still reported on *Hospital Compare*? If we choose not to submit these, will this reflect negatively?

Answer 25: Yes, if submitted, voluntary measures are reported on *Hospital Compare*. If you choose not to submit these, then there is no negative impact.

Question 26: Are all of the voluntary measures within measure sets required in The Joint Commission reporting?

Answer 26: Thank you for your question; however, we are unable to provide a response for The Joint Commission. Please submit your question to The Joint Commission.

Question 27: Will a patient level file be rejected if it includes removed/retired data elements or data elements for removed/retired?

Answer 27: If the hospital has not gone into the Measure Designation application and de-selected the voluntary measures, then a file could be rejected if those elements were not in the patient level file.

Question 28: Regarding: The slide that refers to: Abstraction questions need to be submitted to the Q&A tool on *QualityNet*: I have not been successful with getting a reply to questions I have submitted. I receive the following message:

> *Thank you for your inquiry. Due to unforeseen circumstances, a response to your question has been delayed until CMS names the new Measures contractor. This delay applies only to the following inpatient topics: PN, Perinatal, SCIP, ED, AMI, HF, STK, VTE, and IMM. We are requesting that you review responses to previously submitted questions in the Q&A tool. Often, a topic will already be covered in a published Q and A pair, available on this system by entering a search word or phrase. We regret this delay and appreciate your patience.*

Please advise; thank you.

Answer 28: Thank you for the feedback. For questions submitted from September onward, we are working through these as quickly as possible. Many data element queues are current or near current, while others lag by several days. For the lagging queues, we have added staff to address these questions. For questions submitted prior to September, a lapse in contract coverage created a backlog that we are addressing through data analyses to develop standardized questions and answers based on these questions. When possible, we are addressing these directly once current queues are completed. We appreciate your patience as we develop and improve our processes.

Question 29: If the hospitals submit the voluntary measure data, will they be reported on *Hospital Compare*?

Answer 29: Answer: Yes, that is correct.

Question 30: AMI-7a: Our hospital does have fibrinolytics; however, our patients go to the Cardiac Cath lab. We have not administered a fibrinolytics to an AMI patient in years. Do we still have to collect the data for AMI-7a?

Answer 30: Yes. You will continue to identify your AMI Initial Patient Population and sample size and then abstract those cases for AMI-7a.

Question 31: VTE 1: If we have nursing documentation in PACU that SCDs have been applied, will this meet the measure requirement?

Answer 31: Thank you for your question. We kindly request that you submit this question through the QualityNet Question and Answer tool for response by an appropriate subject matter expert.

Question 32: Am I understanding this correctly, for SCIP, we will obtain the population and sampling for all eight strata and abstract all measures? Or do we only need to abstract charts with a diagnosis of CABG or other cardiac surgery?

Answer 32: You will obtain the population and sampling for all eight strata and abstract all cases for SCIP-Inf-4. If the case does not have a principal procedure on Table 5.11, it will be excluded from the denominator of SCIP-Inf-4; however, they will still be part of the initial patient population.

Question 33: Are the "Abstraction Guidelines" Available to Download on *QualityNet*? Able to locate the Measure Information only. Thank you.

Answer 33: The “Abstraction Guidelines” are available in the alphabetical data dictionary on *QualityNet*.

Question 34: I have two data abstraction questions submitted to QualityNet in August. Can I still anticipate a response to these questions?

Answer 34: Thank you for the feedback. For questions submitted from September onward, we are working through these as quickly as possible. Many data element queues are current or near current, while others lag by several days. For the lagging queues, we have added staff to address these questions. For questions submitted prior to September, a lapse in contract coverage created a backlog that we are addressing through data analyses to develop standardized questions and answers based on these questions. When possible, we are addressing these directly once current queues are completed. We appreciate your patience as we develop and improve our processes.

Question 35: Do all of the 2015 measure changes from CMS align with TJC?

Answer 35: The Joint Commission will not collect any of the measures that were made voluntary for CMS.

Question 36: For the SCIP measure, do we only have to abstract our cardiac/OCS population, or do we still need to abstract the entire surgical list that is provided this year as well? I may have misunderstood what was said with the example regarding the 17 cases.

Answer 36: The reporting of the SCIP strata has not changed. Per the IPPS Final Rule and the Specifications Manual, the hospital will still identify the patients in each of the SCIP strata and will have to report the population and sample counts for each of those strata just as they do now. If they do not have any population in a specific strata, they will report zero, again, as they do now. For any strata for which they have actual population (numbers other than zeros), they will have to determine their sample size and abstract and submit those cases for SCIP-Inf-4. For SCIP-Inf-4, if the case(s) do not have a principal procedure on Table 5.11, the case will result in a denominator exclusion (will have a measure outcome of “B”); however, those cases will still be submitted to the CMS clinical warehouse.

Question 37: I am confused by this response, "Candace Jackson: We do not do cardiac surgery here.... do we still need to participate in scip for SCIP-4? Answer: Yes, you will still need to participate in SCIP for SCIP-Inf-4. You will continue to submit the population and sample sizes for each of the eight SCIP strata. The cases in the sample for each of the SCIP strata will then be abstracted and submitted." SCIP-INF-4 is for hospitals that do CABG surgery. What are we abstracting?

Answer 37: Answer: In most cases, e.g., if the case does not have a principal procedure on Table 5.11, you will be abstracting only the general/demographic data elements, e.g., ICD-9-CM data elements, Admission Date, Discharge Date, Race, Payment Source, etc.

Question 38: HF and PN populations: since the measures are either voluntary or deleted, do we still have to participate in those measure sets or can we discontinue them all together?

Answer 38: You can discontinue them all together.

Question 39: When reading Candace Jackson's questions and answers, we are now a little confused. As per The Joint Commission, we had to pick 6 measures to submit and were instructed not to choose AMI if you do not administer fibrinolytics and not to choose SCIP if you do not

perform cardiac surgery. This being said, am I correct in my understanding that CMS is still requiring us to submit for AMI and SCIP even if we do not provide the services?

Answer 39: That is correct. For CMS, the hospitals are still required to submit AMI-7a and SCIP-Inf-4.

Question 40: Please tell me how to meet the Assessment of Patient Experience of Care. If we do a Press Ganey patient survey, would the answer be yes?

Answer 40: Thank you for your question. To best assist you, we recommend you submit your question to the Inpatient Q&A Tool on QualityNet with additional clarification.

Question 41: For clarification, did you say that the voluntary measures will be removed October 1, 2015? Therefore, facilities can choose to abstract/submit the voluntary measures Jan 1-Sept 30, but after that it will no longer be an option.

Answer 41: That is correct. The CMS voluntary measures will be completely removed from the Specifications Manual beginning with October 1, 2015 discharges. At that time, they will no longer be able to be submitted to the CMS Clinical Warehouse.

Question 42: I have submitted questions via Q&A tool but have not received a response; it has been two weeks.

Answer 42: Thank you for the feedback. For questions submitted from September onward, we are working through these as quickly as possible. Many data element queues are current or near current, while others lag by several days. For the lagging queues, we have added staff to address these questions. For questions submitted prior to September, a lapse in contract coverage created a backlog that we are addressing through data analyses to develop standardized questions and answers based on these questions. When possible, we are addressing these directly once current queues are completed. We appreciate your patience as we develop and improve our processes.

Question 43: If we do not perform fibrinolytic, why do we still have to submit a sample, even though all of our patients will be excluded? That is large abstraction burden, reading initial EKG and CMO for all of those cases.

Answer 43: That is correct. You will still have to submit a sample even though all of the cases will be excluded from the measure denominator.

Question 44: Will AMI-2 and AMI-10 be voluntary eCQMs as noted in the IPPS final rule or will it be removed entirely? Or only removed from the specification manual? Both were previously listed on the list of 28 eCQMS.

Answer 44: They have only been removed from the Specifications Manual.

Question 45: MSPB: what is IME and DSH add-on payments? What do the abbreviations stand for?

Answer 45: IME is the acronym for Indirect Medical Education and DSH is the acronym for Disproportionate Share Hospital.

Question 46: If we are only going to submit SCIP-Inf-4 and not the other voluntary measures, do we need to submit all other non-cardiac surgery patients?

Answer 46: Yes, that is correct. You will identify the population and sample sizes for all eight strata and abstract and submit all those cases for SCIP-Inf-4.

Question 47: VTE-3 was also removed according to the Final Rule. Why is it listed as included?

Answer 47: VTE-3 was inadvertently left off of the table in the initial IPPS final. This was corrected in the addendum to the rule that was posted on October 3, 2014 (79 FR 59679).

Question 48: Do you know if Joint Commission is aligning with the changes CMS is making?

Answer 48: The Joint Commission will not be collecting any of the measures that were made voluntary for CMS.

Question 49: I submitted a question to the Q&A tool on Nov. 5 for inpatient pneumonia - compromised. As of today, 11/18/14, I still have not received a reply, and it remains unresolved. With this webinar today, I see that a question should contain the data element being abstracted, if applicable, the Specifications Manual page number, and the specific notes for abstraction being used or in question. My question did not have the Spec. Manual page number. Should I update my question or resend it as a new question?

Answer 49: Thank you for the feedback. For questions submitted from September onward, we are working through these as quickly as possible. Many data element queues are current or near current, while others lag by several days. For the lagging queues, we have added staff to address these questions. For questions submitted prior to September, a lapse in contract coverage created a backlog that we are addressing through data analyses to develop standardized questions and answers based on these questions. When possible, we are addressing these directly once current queues are completed. We appreciate your patience as we develop and improve our processes.

Question 50: We decided to not abstract for AMI or SCIP in 2015 due to a lack of population in the remaining active questions, although in the past we did participate in the larger AMI & SCIP measures. Based on the responses to Ms. Jackson's question, we would still be required to report to CMS for the questions, even if there was a zero population. Is there a penalty for not doing so? We selected new measures for TJC to meet the six required measures.

Answer 50: AMI-7a and SCIP-Inf-4 are required measures for the Inpatient Quality Reporting (IQR) Program. If you do not report the population and sample sizes for these two measure sets and abstract accordingly, this could potentially affect your annual payment update reimbursement.

Question 51: How can you abstract SCIP-Inf -4 for strata that do not have a principal procedure code of cardiac surgery?

Answer 51: For those cases, you will most likely just abstract the general/demographic data elements, e.g., ICD-9 codes, Admission Date, Discharge Date, Race, Hispanic Ethnicity, etc. As the first check in the measure algorithm asks if there was a code on Table 5.11, you most likely will not abstract any measure specific data elements.

Question 52: To clarify the answer given to Candace Jackson – a hospital that does not do cardiac surgery will continue to report sample size counts for all eight strata; however, there will be no abstraction required since there are no surgeries on table 5.11 – is this correct?

Answer 52: There would be no measure specific data elements abstracted (as the first check in the algorithm asks if there was a principal procedure code on Table 5.11); however, you would still abstract and submit the required general/demographic data elements, e.g., ICD-9 codes, Admission Date, Discharge Date, Race, etc.

Question 53: We need clarification – although AMI-7a and many SCIP measures are now only voluntary, it sounded as if we will still be required to abstract them - is this correct?

Answer 53: You will be required to abstract and submit AMI-7a and SCIP-Inf-4. Those measures are still required for the IQR Program.

Question 54: Any atrial fibrillation includes paroxysmal post-operative afib in distant past even if cardiologist states no history?

Answer 54: Thank you for your question. We kindly request that you submit this question through the QualityNet Question and Answer tool for response by an appropriate subject matter expert.

Question 55: Slide 25 - Monitoring documentation - does this refer to STK or VTE measure?

Answer 55: The data element Monitoring Documentation is used for the VTE measure set. It was inadvertently added to the Stroke list.

Question 56: Question related to electronic submission for 2015, is the population to be included ALL payers, ALL patients? Is sampling ever used for electronic submission?

Answer 56: The electronic clinical quality measures (eCQMs) are all payer sources and all patients that meet the Initial Patient Population. Sampling is not used for the eCQMs; it is expected that 100% of the population be submitted.

Question 57: As a CAH, we have now been included in PQRS for our Medicare Part B claims. Is there any discussion of CAHs being required to participate in IQR as well?

Answer 57: There is no indication from CMS, at this time, that CAHs would be required to participate in the IQR Program.

Question 58: We are a CAH and are voluntarily submitting our data. We just began submitting through our EHR (Cerner). Do we no longer have a choice to voluntarily publicly report if we are submitting electronically? I'm told they can't upload unless we say "yes."

Answer 58: Currently, data submitted through *QualityNet* as QRDA Category I files to meet clinical quality measure requirements will not be publicly reported. Starting in 2015, hospitals that choose to submit QRDA Category I files to meet clinical quality measure requirements will be designated with an asterisk to show that eCQM data were, submitted but there will not be any numbers published from data submitted that way.

Question 59: Regarding the QualityNet Q&A tool, we have several questions that have never been answered, and we had to close the cases out with the clarification. Could you please go through the back log and answer those?

Answer 59: Thank you for the feedback. For questions submitted from September onward, we are working through these as quickly as possible. Many data element queues are current or near current, while others lag by several days. For the lagging queues, we have added staff to address these questions. For questions submitted prior to September, a lapse in contract coverage created a backlog that we are addressing through data analyses to develop standardized questions and answers based on these questions. When possible, we are addressing these directly once current queues are completed. We appreciate your patience as we develop and improve our processes.

Question 60: If we don’t submit data on voluntary measures, will this impact any other programs, e.g., Leapfrog, *Hospital Compare*, ACM scores, TJC?

Answer 60: For CMS, if you do not submit data on the voluntary measures, it will not have any impact on *Hospital Compare* or the ACM scores.

Question 61: Clarification. What are we "abstracting" for the non-cardiac surgery patient for SCIP-4?

Answer 61: For those cases, you will most likely just abstract the general/demographic data elements, e.g., ICD-9 codes, Admission Date, Discharge Date, Race, Hispanic Ethnicity, etc. As the first check in the measure algorithm asks if there was a code on Table 5.11, you most likely will not abstract any measure specific data elements.

Question 62: For VTE measure, what if MD only enters pharmacological prophylaxis contraindication but failed to address mechanical prophylaxis contraindication, will it fail this measure?

Answer 62: Thank you for your question. We kindly request that you submit this question through the QualityNet Question and Answer tool for response by an appropriate subject matter expert.

Question 63: Just want to be clear – for SCIP, are we to abstract and submit for any measure except SCIP-Inf-4?

Answer 63: SCIP-Inf-4 is a required measure for the Inpatient Quality Reporting (IQR) Program. SCIP-Inf-1, -2, -3, -6 and -9, SCIP-Card-2, and SCIP-VTE-2 can be submitted voluntarily.

Question 64: Would the cases submitted for all the SCIP strata only be abstracted and submitted for SCIP-Inf-4?

Answer 64: That is correct, unless you choose to submit the other voluntary SCIP measures.

Question 65: Will CMS have a call on the new tobacco measures?

Answer 65: The “tobacco measures” are not required for the IQR Program.

Question 66: What is the reasoning/value behind keeping voluntary measures?

Answer 66: The benefit of continuing to abstract the voluntary measures is to ensure that the highest quality of care is being provided to your patients and to continue to identify areas of quality improvement.

Question 67: Sorry. I missed part of the SCIP-Inf-4 information. Will we be abstracting SCIP-Inf-4 on all of the principle codes on table 5.10 in appendix A for patients >=18 years of age?

Answer 67: Yes, that is correct.

Question 68: For AMI-7a, we do not admin fibrinolytic therapy; does the physician need to document reason for not administering fibrinolytic therapy?

Answer 68: No. If you do not administer fibrinolytics, you would answer “No” to the data element Fibrinolytic Administration, and this will exclude the case from the denominator of the measure. There is no data element that asks if there was a reason for not administering fibrinolytics.

Question 69: Please explain what the eight strata will apply to if we do not do cardiac procedures for SCIP if INF-4 is the only one required.

Answer 69: If the cases from the eight strata do not have a principal procedure of cardiac surgery, as per Table 5.11, they will be excluded from the denominator of SCIP-Inf-4. However, they will still be included in the strata initial patient population.

Question 70: Sometimes I am confused with the answers that I receive from QualityNet. I am guided back to reading the manual, and the question is not answered to clarify a specific case. Will this improve?

Answer 70: Thank you for the feedback. For questions submitted from September onward, we are working through these as quickly as possible. Many data element queues are current or near current, while others lag by several days. For the lagging queues, we have added staff to address these questions. For questions submitted prior to September, a lapse in contract coverage created a backlog that we are addressing through data analyses to develop standardized questions and answers based on these questions. When possible, we are addressing these directly once current queues are completed. We appreciate your patience as we develop and improve our processes.

Question 71: It sounded to me that the speaker stated that low risk for VTE must be documented by MD or PA. Is that the case, or can it be done by a nursing assessment?

Answer 71: Thank you for your question. We kindly request that you submit this question through the QualityNet Question and Answer tool for response by an appropriate subject matter expert.

Question 72: For VTE Overlap Therapy, is the intent of the measure met if the physician documents a reason for no overlap therapy when Coumadin is initiated but >1 day after the diagnostic test?

Answer 72: Thank you for your question. We kindly request that you submit this question through the QualityNet Question and Answer tool for response by an appropriate subject matter expert.

Question 73: RE: SCIP-4. Will all cases in all eight strata be required to be fully abstracted (e.g., all questions on antibiotics, Foley catheters, etc.) for all but the cardiac cases to be excluded from the denominator?

Answer 73: The reporting of the SCIP strata has not changed. Per the IPPS Final Rule and the Specifications Manual, the hospital will still identify the patients in each of the SCIP strata and will have to report the population and sample counts for each of those strata just as they do now. If they do not have any population in a specific strata, they will report zero, again, as they do now. For any strata for which they have actual population (numbers other than zeros), they will have to determine their sample size and abstract and submit those cases for SCIP-Inf-4. For SCIP-Inf-4, if the case(s) do not have a principal procedure on Table 5.11, the case will result in a denominator exclusion (will have a measure outcome of “B”); however, those cases will still be submitted to the CMS clinical warehouse.

For those cases, you will most likely just abstract the general/demographic data elements, e.g., ICD-9 codes, Admission Date, Discharge Date, Race, Hispanic Ethnicity, etc. As the first check in the measure algorithm asks if there was a code on Table 5.11, you most likely will not abstract any measure specific data elements.

Question 74: Currently, abstraction questions need to be submitted to the Q & A tool on QualityNet, and phone support is not available. Do you anticipate in the future that phone support will be available? If so, when?

Answer 74: We do not anticipate any phone support in the near future.

Question 75: Only the SCIP-Inf-4 is required now, which is cardiac surgery. Will other surgeries that are now required such as knee and hips not be required anymore?

Answer 75: The reporting of the SCIP strata has not changed. Per the IPPS Final Rule and the Specifications Manual, the hospital will still identify the patients in each of the SCIP strata and will have to report the population and sample counts for each of those strata just as they do now. If they do not have any population in a specific strata they will report zero, again, as they do now. For any strata for which they have actual population (numbers other than zeros), they will have to determine their sample size and abstract and submit those cases for SCIP-Inf-4. For SCIP-Inf-4, if the case(s) do not have a principal procedure on Table 5.11, the case will result in a denominator exclusion (will have a measure outcome of “B”); however, those cases will still be submitted to the CMS clinical warehouse.

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