

REPORTING
HOSPITAL
QUALITY DATA
FOR ANNUAL
PAYMENT
UPDATE

Abstraction Tips

January 2009

Important Change in Abstraction of Data Element, *Discharge Instructions Address Symptoms Worsening*, Effective with April 1, 2009, Discharges

Last month's tips included "Heart Care Fact Sheet: Abstraction of Discharge Instructions – Reminders, Effective with 10/1/08 through 9/30/09 Discharges," which provided information about an upcoming change in abstraction of this data element.

In order to meet this new requirement, discharge documentation forms may need to be revised. Recognizing the amount of time that is required to change a medical record form, HQSI is again alerting you in order to be prepared to meet the 4/1/09 requirement.

Generalized instructions on what to do if "symptoms worsen," "problems occur," "the patient's condition changes or worsens," etc., will NO LONGER COUNT. In order to select "Yes" for this data element, written instructions given to the patient must be specific to heart failure symptoms.

Examples:

- "Call the office if weight gain is greater than two pounds."
- "Come to the emergency room if you experience a problem with breathing."
- "Make an appointment if heart failure symptoms return, such as your ankles are swelling."

Validation Tips

Listed below are five tips to optimize your potential for passing validation:

Preparing Charts for Mailing to the Clinical Data Abstraction Center (CDAC)

Validation Tip #1:

- After photocopying (or scanning) a medical record, go through the entire record to make sure:
 - All information is legible (e.g., photocopied stickers are clear and do not appear as black boxes)
 - All information is visible (e.g., no information is concealed by folded paper or separate notes)
 - All forms from the original chart are part of the copied chart
 - All forms of the medical record are dated (e.g., multi-page folded flowcharts may have only one date on the spreadsheet; however, these forms are usually copied onto 8½" × 11" paper in sections. Therefore, each copied page may not have a date, making the abstraction date from that undated section of the form unable to determine [UTD])



557 Cranbury Road, Suite 21 ♦ East Brunswick, NJ 08816-5419
Phone: 732-238-5570 ♦ Fax: 732-238-7766 ♦ Website: www.hqsi.org

Validation Tip #2:

- When providers submit medical records for validation to the CDAC, they must submit all portions of the medical record that are to be considered by the CDAC for their abstraction. Once the requested medical record is received at the CDAC, additional portions of that specific medical record will not be accepted. Also, additional portions of the medical record cannot be submitted as part of the appeal process
- Providers are to refrain from flagging, highlighting or identifying abstraction information in any way in the medical record prior to sending the record to the CDAC for validation. The CDAC will disregard these types of actions during the adjudication process. The CDAC abstractor will review the medical record as if they were the original abstractor

Validation Tip #3:

- Use the attached HQSI Chart Submission Checklist prior to sending your medical records to the CDAC

Answering Parent-child Questions (skip logic methodology)

Validation Tip #4:

- Your answer to a “parent” question will determine whether or not the following “child” question(s) will be enabled. If a parent question is abstracted incorrectly, that one mismatch could automatically produce several additional mismatches to the linked “child” question(s).
- If you elect to use skip logic when abstracting a case, please have two abstractors review answers to “parent” questions.

Discharge Status

Validation Tip #5:

- Outside reviewers do not know the type of care a patient will be receiving after discharge based on the name of the healthcare facility. To determine the discharge status code, documentation in the medical record needs to reflect the level of care a patient will be receiving after discharge

Based on chart documentation, if a physician orders “discharge to rehab” and the patient is transferred to a nursing home for rehabilitation without any additional documentation, the abstractor would need to select “62.”

However, if the chart documented that the patient was going to Dalton Nursing Home for subacute rehabilitation, then the abstractor would select “03.”

- Clarification between “03” and “04”
 - Documentation, such as “patient went to Dalton Nursing Home,” without documentation of the level of care the patient will be receiving, should be abstracted as “04,” since the only information is that the patient is being sent to a nursing home. In order to abstract “03,” the documentation needs to reflect that skilled care is required
- Many transfer forms have an area that notes “SNF,” “EC,” or the like. Rarely do these areas of the transfer form have any documentation or checkboxes selected

Abstraction Guidance for Readmissions

The Centers for Medicare & Medicaid Services (CMS) has clarified its guidance that a case should be abstracted as it was billed. This guidance is designed to minimize the burden for hospitals using Medicare and other payer claims to identify cases for abstraction.

When a patient is discharged/transferred from an acute care hospital and is readmitted to the same acute care hospital, the original and subsequent stay may be combined into a single claim. Effective immediately, if the case was billed as one claim, then it should be abstracted as one episode of care.

For example, a patient is admitted on 11/10/08 and discharged on 11/13/08; the patient is readmitted to the same hospital on 11/13/08 and discharged on 11/16/08. If these two encounters/admissions are billed as one claim, it would be abstracted as one episode of care with the admission date of 11/10/08 and the discharge date of 11/16/08. If the two encounters/admissions are billed as two separate claims, then it would be abstracted as two episodes of care; the first episode being 11/10/08 – 11/13/08 and the second being 11/13/08 – 11/16/08.