Abstraction Tips
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Validation

Healthcare Quality Strategies, Inc., (HQSI) wants to remind providers of the requirements for medical records submitted to the Centers for Medicare & Medicaid Services' Clinical Data Abstraction Center (CDAC) for validation.

When providers submit medical records for validation to CDAC, they must submit all portions of the medical record that are to be considered by CDAC for their abstraction. Once the requested medical record is received at CDAC, additional portions of that specific medical record will not be accepted. Also as a reminder, 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 CDAC for validation. CDAC will disregard these types of actions during the adjudication process. The CDAC abstractor will review the medical record as if he/she were the original abstractor.

Invalid Record Selection

A record is still included in the hospital validation calculation when CDAC assigns a status of "Invalid Record Selection." The numerator will be zero. The denominator is calculated from the original (hospital) file based on the measures (indicators) sent. If an element is on the inclusion list, and it is in the original file, then it is counted in the denominator.

Below is a list of situations that would merit a record status of "Invalid Record Selection:"

- The Admission date, Discharge date, or the Patient date of birth on the submitted medical record does not match what was requested
- The cover sheet includes the patient name, but clearly does not coincide with the date(s) of service requested
- The record does not meet the population eligibility
- The record was not an acute inpatient stay (i.e., emergency department [ED] care, skilled care only or contained only demographic or administrative information)
- The record is submitted as one episode of care, but when the record is received at CDAC, it is apparent that the record contains two episodes of care
    - According to Medicare guidelines and for billing purposes only, if a patient is discharged and readmitted within a three-day time frame, you would combine the two episodes of care
    - For abstraction purposes, you would abstract the record as two separate episodes of care. If this record would be selected for validation, you would only send the record for which the date of service matches the information from CDAC's validation record request

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Specification Manual for National Hospital Quality Measures Effective with Discharges Beginning 07/1/06 and Forward

HQSI will be holding a conference call/Webex on Wednesday, June 14, 2006, at 10:00 am to present a detailed review of the major changes to the Specification Manual. HQSI requests that you review this version of the Specification Manual prior to this call and submit questions by Friday, June 9, 2006, via E-mail to Suzanne Dalton at sdalton@njqio.sdps.org or Joyce Pontbriand at jpontbriand@njqio.sdps.org or via fax to their attention at 1-732-432-5637. The Specification Manual is available online at **www.qualitynet.org/dcs/ContentServer?cid=1141662756099&pagename=QnetPublic%2FPage%2FQnetTier2&c=Page**.

In the interim, we want to highlight some of the changes:

The Alphabetical Data Element list has been updated

- All Surgical Infection Prevention (SIP) data elements have changed to Surgical Care Improvement Project (SCIP)-Inf: e.g., SIP 1 is now SCIP-Inf 1
- Several data elements have been eliminated: e.g., Prophylactic Antibiotic is eliminated while type of surgery is replaced with Infection Procedure of Interest, etc.
- Several data elements have been added, such as Non-Primary Percutaneous Coronary Intervention, Chest X-ray for pneumonia (PN) and those pertaining to three new SCIP Infection process measures: hair removal, glucose control in cardiac surgery patients, and normothermia in colon surgery patients
- Data element names have been changed: e.g., Thrombolytic Administration is changed to Fibrinolytic Administration

Arrival date and time

Medical record information needs to be abstracted from only acceptable source documents and is not abstracted simply as the earliest time of arrival.

Comfort Measures

This data element will be collected for acute myocardial infarction (AMI), heart failure (HF), and PN.

PN Working Diagnosis on Admission

- If PN is found on the admitting order, it is an automatic “Yes” for all patients including ED patients, even if it is not timed
- When trying to determine working diagnosis, it is necessary to determine the time of admission. Admission time **must** be taken from physician documentation and not the time nursing noted orders as taken off. This must be labeled, “admit time.” **Do not** use ED discharge time or patient transfer time
- If PN is found on a patient’s chest x-ray, select ‘Yes,’ if the ED physician on the ED record notes the results **or** if the x-ray report itself is timed (either read or dictated) prior to or at the time of admission. This would include results called to the ED and the ED physician’s own interpretation, if PN is included

Antibiotic Recommendations

PN Antibiotic Consensus Recommendations Table Changes

- For non-intensive care unit (ICU) patients—add: “Or, if less than 65, with no Risk Factors for Drug-Resistant Pneumococcus (see data element), macrolide monotherapy (IV or oral) Table 2.5”
- Pseudomonal Risk: Add “PO Quinolone is allowed for Non-ICU only,” under each recommended antibiotic combination

Antibiotic Recommendations (continued)

Prophylactic Antibiotic Regime Selection for Surgery Table Changes

- Add “Vancomycin” as first line prophylaxis for Coronary Artery Bypass Graft, Other Cardiac, Vascular and Hip/Knee Arthroplasty (Vancomycin is acceptable with a physician documented justification for its use [see data element Vancomycin])
- Add Ampicillin/Sulbactam as first line prophylaxis for Colon and Hysterectomy
- Change Ciprofloxacin Table 2.8 to Quinolone Table 3.12 for Colon and Hysterectomy each place it appears
- Special Considerations: Remove “Levofloxacin 750 mg given once may be substituted for Ciprofloxacin”
- Remove the footnote below the table regarding dosages

SCIP

New measure information and data abstraction for SCIP-Inf 4, 6, and 7 are required only for SCIP Identified Participant Group hospitals.

Sampling Methodology for SCIP
Changes in sample size for SCIP-Inf 1, 2, and 3

Continuing Education Credits

The SCIP Module 1: Infection Prevention self-study course is now available on MedQIC, and has also been officially released on Medscape. Nurses and physicians nationwide can obtain credit for taking the course. The official link is found at: **http://www.medscape.com/viewprogram/5402**