ePC-01:

**QUESTION #1:** We noticed that the codes for Unstable lie and Malpresentation were removed from the possible excluded list, please verify.

**ANSWER:** This is in the paper based measures for ICD10 updates for October of 2017. We did remove the malpresentation codes from the early elective delivery list. This code was mapped from the ICD10 code that was both multiple gestations and malpresentations and was not intended to be excluded. Malpresentations are not a reason to deliver a patient early.

**QUESTION #2:** Why only 24 hours for Active labor – there are patients that may be in active labor longer than 24 hours and end up having a C-Section.

**ANSWER:** The 24 hours logic is just a look back period for which we’re look for the active labor to start before the cesarean birth, and this was based on guidance from our technical expert panel that 24 hours was a reasonable timeframe or one day prior to the cesarean.

**QUESTION #3:** For prior uterine surgery – what about resection of a septum in bicornate uterus?

**ANSWER:** We provide numerated lists for the prior uterine surgeries which are most common in this population. As Susan mentioned, it would be impossible to innumerate every single condition that would always exclude the patient. So that’s why our techs suggests that a good performance rate on this measure is 5%. We’re not expecting we’ll end up excluding every single patient.

**QUESTION #4:** The date of the gestational age (GA) must be < 1 day before the Time of Delivery (within the encounter date/time). The way this specification is written is flawed. The “< 1 day” means calendar day. No patients will meet the denominator unless they have a documented GA and a time of delivery documented on the SAME calendar day. We have found at least one patient that had a GA and Time of Delivery within 24 hours, but the specification requires a calendar day so it did not meet the denominator. Is there a fix coming for this?
ANSWER: The intent of the measure is to find Time of Delivery recorded within a day, and your < 1 day is different than a 24-hour period. If the GA is recorded within a day of the Time of Delivery, it'll pass the measure. But if it's in a 24-hour period outside of one day, you're correct, that case would not.

QUESTION #5: Can you please expand on how GA is to be established? Is this GA on Admit versus GA at Delivery?

ANSWER: We're looking for GA based on obstetrical estimate, or estimated due date, and so we would be looking for GA estimated on admission, rather than GA captured on delivery by assessment of the newborn.

QUESTION #6: We are getting several patients that come up as failures due to receiving oxytocin for augmentation of labor. What can we do to correct this within documentation?

ANSWER: This gets back to the timing relationship between the documentation of oxytocin and the documentation of labor. The logic is looking for the administration of oxytocin prior to the start of labor as a case of augmentation. If the oxytocin is being documented after the time of labor is documented in the EHR, then you may have a myth in this case.

QUESTION #7: We noticed that the codes we had used for “history of stillbirth” were also removed. Please verify.

ANSWER: This is also from the October addendum for the paper based measure, and this is a code that has been further clarified in the coding guidance as a code that can only be used during the delivery episode, so the code was removed for that reason. We are working with our technical advisory panel to identify if there’s another code that might be appropriate for this condition.

QUESTION #8: Active genital herpes is no longer an acceptable reason for C-Section. Why?

ANSWER: A fellow attendee responded to this question with Question #21 on this transcript: Just to help with the active genital herpes question. Yes, it's a reason for C-Section but it's not a reason to deliver prior to 39 weeks.

QUESTION #9: We have had issues with our eCQMs not counting documentation made during the hospital stay for exclusions.
ANSWER: I am guessing that you are referring to the prior uterine surgeries that are captured in the numerator. This is an limitation that we recognize. The numerator looks for prior uterine surgeries, and to capture a prior uterine surgery using codes, we need to look for procedures or diagnoses documented before the start of encounter. There are not codes to indicate history. There's just the actual diagnosis, there’s procedure codes, and so the only way that we are able to note history is that it occurred prior to the encounter. This is an issue we've heard from the field before. We recently opened this as a topic for discussion with the change review process, which is the CMS posted online forum that includes EHR vendors, implementers, and measure developers, where we try to work through some of the known issues of eCQMs. The field did provide several recommendations for how we might address this in the future. However, no suggestions were provided which could address the issue today.

QUESTION #10: We have had cases fall out because codes do not exist in the tables for delivery. However, perinatology recommends the delivery at a specific time. Could there be an exclusion for patients with perinatology consults and recommendation for delivery < 39 weeks?

ANSWER: It goes back again to the issue we understand that there are going to be conditions that are rare and that’s that 2% to 4% that we know are not going to pass the measure because of these rare conditions that we can’t enumerate, or we can’t identify within the measure itself.

QUESTION #11: Macrosomia seems to be a code that causes many failures. Will that be added to the exclusion dx code list?

ANSWER: There are no plans to add that to the list at this time.

QUESTION #12: We have a physician who insists that “failed Biophysical Profile” is an indication for delivery. Can you explain why it is not?

ANSWER: Again, that’s something that we had talked with our technical advisory panel, and we do not feel that it is a blanket always exclusion for the measure, and a reason for always delivering early.

QUESTION #13: For PC-01, often the prior uterine surgery is entered in the documentation when the patient arrives, even if the procedure was prior to entering the hospital for delivery. The date then gets listed as the same day as delivery and we are having problems with separating this info.

ANSWER: Please see our response to Question #9.
QUESTION: #14: I still don’t understand why gestational age would be measured at time of admission? What happened is a mother is admitted at 27 weeks yet is able to hold off delivery until 34 weeks?

ANSWER: Gestational age should be measured at or immediately prior to the time of delivery.

QUESTION #15: I didn’t see that ICD10 procedure codes for History of Uterine Surgery do not include history of classical Cesarean or history of myomectomy. Forgive me if you already mentioned how these are excluded electronically? Could you please explain?

ANSWER: Electronically, the record would need to contained ICD10 or SNOMED CT codes representing prior uterine surgeries that were documented prior to the start of the inpatient encounter.

QUESTION #16: Will a transcript of all of these question and answers be made available along with the slides? That would be very helpful!

ANSWER: Yes, a transcription will be posted to our website.

QUESTION #18: We recently had a patient with Documented Placenta Previa and it was not excluded. Why?

ANSWER: Based on the measure logic, this case would be excluded. Codes for Placenta Previa are included in the Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation value set, which has OID 2.16.840.1.113883.3.117.1.7.1.286.

QUESTION #19: If TJC states that an acceptable rate for PC-01 is 5%, why does CMS set a target of 2% on VBP?

ANSWER: The Joint Commission continues to find 5% to be an acceptable rate for PC-01.

QUESTION #20: Like other coding issues: finding that codes for pre eclampsia on the Table are for pre delivery. If pre eclampsia is noted at delivery, the code does not work to pass the measure 014.94.

ANSWER: If there are codes you believe should be added to the measure, please report this as an issue through the Jira CQM project: https://oncprojecttracking.healthit.gov/support/projects/CQM
QUESTION #21: Just to help with the active genital herpes question. Yes, it’s a reason for C-Section but it’s not a reason to deliver prior to 39 weeks.

ANSWER: Thank you!

ePC-05:

QUESTION #1: We often utilize Sweet Ease (a sucrose solution) – a few drops on a gloved finger – briefly to provide non-medicinal comfort while our newborns undergo circumcision. Would this be considered a failure?

ANSWER: Sweet Ease, or a similar sucrose and water solution, given to the newborn for the purpose of reducing discomfort during a procedure (such as circumcision), is classified as a medication, and is not considered a supplemental feeding. So that would not exclude the case.

QUESTION #2: You had mentioned active versus diagnosis, were you referring to labor?

ANSWER: I wasn’t referring to stages of labor. I was referring to how diagnosis changed technically in the eCQM in 2017.

QUESTION #3: Even if the Admission to NICU was for Observation for say an hour would the patient still be excluded?

ANSWER: Depends on how your EHR handles that patient. If the EHR includes a location of NICU, then yes, that patient would be excluded.

QUESTION #4: Clarification: What is the goal? Does level II nursery fill the NICU admission?

ANSWER: I would refer you to the American Academy of Pediatrics definition of what a NICU Intensive Care Unit is. If your hospital meets that definition, any time your patients are admitted to that unit, then you select “Yes” as an admission to the unit. Can you repeat what that reference was? It’s the American Academy of Pediatrics, definition of “What is a NICU?”, and it’s listed in the chart-based measure in the Data Element Admission NICU as a reference.
QUESTION #5: What constitutes parenteral nutrition?

ANSWER: Parenteral nutrition in the eCQM is represented as a procedure, so it’s actually not a list of medications. Parenteral nutrition would be TPN.

QUESTION #6: Should we exclude infants from PC-05 who are born on the way to the hospital or in the parking lot?

ANSWER: We’re looking for the live-born/newborns born in hospital, and we’re looking for the ICD10 codes for newborns born in hospital.

QUESTION #7: Does the “feeding” type need to be entered “breast milk” even though the feeding method is listed as “Breast”?

ANSWER: The breast milk feeding value set includes one SNOMED CT code, representing breast milk as a substance. In this measure, we are evaluating whether the newborn was fed breast milk, regardless of the method (i.e., breast or bottle).

QUESTION #8: Why are we bothering with 5a since it was dropped for the abstracted measure?

ANSWER: As I stated, this is because the release state of the eCQM specification was prior to the decision to remove PC-05a from the chart abstracted version of the measure. So you will report PC-05a if you select this eCQM in 2016. But as stated, once we get to 2017, PC-05a is removed from both the eCQM and chart-abstracted measure.

QUESTION #9: Are you able to provide links to the updated measures and their tables? I’ve had difficulty in the past accessing the measures from TJC website.

ANSWER: The eCQM versions of the measures are found on two different CMS sites. They have the same specifications posted: eCQI Resource Center, or the CMS eCQM Library, and that’s where you go to find the eCQM specifications. On the slides, you’ll see that I included a version number at the start to each section. The version number you see there is how you’ll find the eCQMs specification titled on either the eCQM Resource Center, or the CMS eCQM Library.

QUESTION #10: Why was PC-05a retired when sometimes the MD does not want the Mother to breast feed due to drug or medical issues?

ANSWER: The retiring of PC-05a had much more to do with the feasibility of capturing the data required for PC-05a, and a reasonable timeframe without an impact of care. The reason you
stated is a condition that occurs. The real reason for retirement was that we want people to focus on providing exclusive breast milk feeding when possible, rather than focusing on the measure exclusions.

**QUESTION #11:** Does the timing of the “mother’s choice” documentation matter? Can it be documented after the first feeding?

**ANSWER:** We’re looking for the documentation of “mother’s choice” within an hour of birth. So, it’s not in the relation to the time of the first feeding. It’s in relation to the time of the birth.

**QUESTION #12:** Just this month, I had two babies that were pulled into my sampling population. They were both re-admits. They had gone home and came back the next day. One was a transfer from another hospital and not born here. Should these be in my population?

**ANSWER:** I would not expect that to be in your population. I wonder if that could be because the codes representing birth were still present in the record on the re-admission.

**QUESTION #13:** Clarification: What is the goal rate?

**ANSWER:** According to our technical advisory panel, available evidence suggests that a performance rate of 70% is an achievable target for hospitals.

**QUESTION #14:** On occasion, a physician documents “admit to NICU” for a sick baby, however, our hospital does not have an NICU. How is the NICU question answered in this case?

**ANSWER:** Just referencing from the chart-based measure going back to the definition of the NICU, if your hospital has an NICU that meets the definition, then you would always select “Yes” for admissions to that unit. If it does not, then you would always select “No”.

**QUESTION #15:** Our coding department uses the diagnosis “Single Live Birth” for the mother exclusively. The diagnosis of single liveborn is used for the newborn. How will this impact our reporting numbers?

**ANSWER:** The code “Single Live Birth” is in the value set used in PC-05. So it should not affect your reporting numbers. What your coding department does makes sense, because as you have said, the code PC-01 looks at the mother’s record, and PC-05 looks at the newborns.
QUESTION #16: Regarding Term Newborn, PC-05, if the gestational age by dates and the gestational age by exam differs, which gestational age would be used to determine if the newborn is considered term?

ANSWER: For PC-05, either gestational age based on assessable due date or based on observation is acceptable. So you would select the gestational age that best represents the patient’s actual age, and that’s a determination that you would make with your organization as to which codes you would select and include.

QUESTION #17: Any suggestions on how to separate NICU from well-newborn admits if you only have one nursery location. Can you use a room accommodation code instead?

ANSWER: In the eCQM, the NICU location is represented with a SNOMED code. So you would have to have a place in your EHR to map to that code. If a room accommodation code is one way that you can indicate whether the patient in the room is a NICU patient or a well newborn, and you have a way to map that to SNOMED, I would think that would work for you. That would be something to explore with your EHR vendor.

QUESTION #18: If an infant has an ADT event of NICU admit but only stays for 4 hours, is this admission or observation?

ANSWER: Again, this depends on how you’ve implemented the data capture. If you have a patient in the NICU location, and that data is captured in the EHR, for the eCQM, that would be captured as an NICU admission.

QUESTION #19: Our breastmilk is built as parenteral nutrition under medications. Will this count?

ANSWER: That is something to explore with your EHR vendor. I could see using the medications as a way to record breast milk. It really depends on whether they’re able to attach the codes for breast milk to the place where breast milk is recorded.

QUESTION #20: I have a question from PC-01. A new ICD 10 code was introduced on October 1st that requires the code of 013.4 for gestational hypertension, however, this is not on the conditions justifying table, however gestational hypertension has been excepted as a reason in the past. Please advise.

ANSWER: Again, this is in the addendum that was posted for the chart-based measures, and the .4’s have been included. Those are in childbirth codes, and those have been included with October 1st discharges, and you can find the updated code tables at...
QUESTION #21: Where can we find updated benchmarks for the PC measures?

ANSWER: I would refer you to our annual report. It was in fact actually updated this week and posted to our website—page 17 of that report. If you download the PDF file, you will find the national averages from 2001 to 2015.

QUESTION #22: Mother’s choice < 1hr of birth isn’t listed in current posted eCQM spec document? Should we expect new version?

ANSWER: You are correct. If you are looking at the version of the measure for the 2017 reporting year, mother’s choice (PC-05a) is no longer included.

QUESTION #23: I wonder if the newborns readmitted or transferred hit the denominator because the newborn diagnosis was still on the problem list, at our facility old problems don’t necessarily fall off...

ANSWER: This is quite possible. I would further suggest to look at the time stamps for your diagnoses. The measure evaluates diagnoses based on whether they start during the inpatient encounter. This should prevent past diagnoses from being included, but it’s possible the past diagnoses are in some way updated with a new timestamp during the admission. I would explore this with your vendor.

QUESTION #24: Clarification question - When you say the timing of mother’s choice for breastfeeding should be documented within an hour of the time of birth, does that mean it can be documented at any point up to 1 hour after delivery? Or rather that it must be documented within an hour prior to or after delivery? Or that it must be documented within the hour prior to delivery and no other timeframe will meet the measure?

ANSWER: The measure evaluates whether the mother’s choice was documented at any point up to 1 hour after the time the birthdate is documented. The choice must be documented after and within an hour of birthdate.