



# Inpatient Quality Reporting Program

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## Support Contractor

### Navigating IQR Reports: Tips to Access, Run, and Review

#### Presentation Transcript

##### Moderator:

**Debra Price, PhD, MEd**

*Inpatient Quality Reporting Support Contract Education Coordinator, HSAG*

##### Speaker:

**Candace Jackson, RN**

*Inpatient Quality Reporting Support Contractor Lead, HSAG*

**April 27, 2015**

**2 p.m. ET**

**Mike Seckman:** This is conference #17029583.

**Matt McDonough:** Good afternoon everybody and thank you for joining us for today's Navigating IQR Reports webinar. My name is Matt McDonough and I'm going to be your virtual training host for today's event.

Before we turn the speakers' rights over to our first presenters for the day, I'd like to cover some housekeeping items with you so that you know how today event is going to operate and how you can interact with all of our presents on today's event.

You'll see on your screen that audio for this event is available via internet streaming, and if you hear my voice you know that is the case. And that means that no telephone line is required, but you do need to connect computer speakers or headphones to your computer to listen to streaming audio.

Now if at any point during today's event, your audio experiences some difficulty and you need some assistance, please do not hesitate to send a chat message to me so that I can help you resolve those issues at any time during today's event.

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Now, as I just noted, today's event is via streaming audio, but you still do have the ability to submit questions to our presenters throughout the course of today's event. To do so, you'll notice that there is a chat panel on the left side of your screen.

Simply type your question in the box at the bottom left corner of your screen. It says "Chat with Presenter." Type your question in there, and click the "Send" button. When you do that, your question will be sent to all of our panelists and as time and resources allow today, we'll try to do our best to answer your questions. But your questions are being archived and will be addressed in another manner if we don't get to them today. But at any time during today's event, if you have a question, do not hesitate to send it in via that chat panel.

That's going to do it for my brief introduction, so without further ado, I'd like to hand this over to Deb Price, who will be our first speaker of the day. Deb, the floor is yours.

### **Deb Price:**

Well thank you, Matt. Hello and welcome everyone. Thank you for joining us today. As Matt said, my name is Deb Price and I will be your moderator for today's webinar. Before we dive into the presentation today, I would like to cover a couple more housekeeping items.

As many of you know, the slides for the presentation were posted to the *Quality Reporting Center* website prior to the event. This session is being recorded and the slides, transcripts, webinar recording, and question and answers from the presentation will be posted on the *Quality Reporting Center* and *QualityNet* website at a later date.

The speaker for today's event is Candace Jackson. Candace is the lead for the Inpatient Quality Reporting Program at Health Services Advisory Group, the VIQR Support Contractor. Prior to this role, Candace worked for nine years as a senior member of the Hospital I2R Program Team at a Quality Improvement

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Organization, and nine years as a Hospital Quality Improvement and Compliance Director. Candace served over 20 years as a registered nurse in various nursing positions specializing in critical care and End Stage Renal Disease nursing. Candace received her associate degree in Nursing from Presentation College in Aberdeen, South Dakota.

And now I will turn the webinar over to Candace Jackson. Candace, the floor is yours.

**Candace Jackson:** Thank you, Deb.

**Deb Price:** And we will proceed with the next slide please.

**Candace Jackson:** Today's presentation will provide information regarding the Inpatient Quality Reporting Program reports that are available through the *QualityNet Secure Portal*.

Next slide.

By the end of this presentation, you will be able to identify reports that are available to you, what their purpose is, and how to locate the reports on the *QualityNet Secure Portal*. In addition, you will be able to select the appropriate report and interpret the data provided.

Next slide please.

Prior to being able to view reports, a provider, facility, healthcare system, or vendor, must have a *QualityNet* account with the appropriate rights and roles. The roles can be assigned by your *QualityNet* security administrator. To log into the *QualityNet Secure Portal* for access to reports, users must have a *QualityNet* user ID and password provided by their security administrator and must complete the new user enrollment process that includes identity proofing and multi-factor credential enrollment. Please see the *QualityNet Secure Portal*

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User Guide on the *QualityNet* website for detailed information on completing this process.

To access the reports, once you have logged into the *Secure Portal*, select “My Reports” and then select either “Run,” “Search,” or “Analytics” reports. In the event that a user is experiencing problems accessing reports, they should contact their security administrator and or the *QualityNet* Help Desk to verify that they have the appropriate system access rights and roles set up.

Next slide.

On the “Start Reports” page, click “Run Reports” to produce a new report. On the “Run Reports” tab, select the appropriate program from the “Reports Program” drop down menu. After the program is selected, select the report category you need. Options displayed in “Report Program” and “Report Category” menu will vary and will depend on the roles that you have been assigned as the user. You must first select a program before the corresponding “Report Category” is displayed and is available for selection. Once the selections are made, click “View Reports.”

Next slide.

Once you select “View Reports,” the list of applicable reports for the “Report Category” will display. Click on the link with “Report Name” to run a report. Once you have selected a report, the “Report Parameters” page will be populated. Various parameter options appear on the “Report Parameter” page, depending upon the report. Select your choices from the field and drop down controls. Required parameters are marked with a red asterisk. To generate a report with the parameters you have assigned, you will then click “Run Report.”

Next slide, please.

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To view the reports that you have run, click the “Search Reports” tab in the “Reporting” application.

And next slide, please.

The “Search Reports” screen lists reports that you have run in chronological order with the most recent report being on top of the list. The status icons on the left indicate that the report execution is in progress, and this will display with a counterclockwise blue, circular arrow icon, or that it has completed, which will be displayed with a green checkmark icon. You can use the search features to find a specific report in the list by searching on the report name, or specify a date range. You can also specify which reports to search on based on status. The table also shows the last time specific reports were downloaded, along with their size.

The column on the right of the table contains icons for the actions you can take with reports: “View,” “Download,” “Save as Favorite,” and “Delete.” Click the magnifying glass icon to view the report. The green down arrow icon is used to download a report which you may then save. The red circle icon is used to delete a report.

Next slide, please.

For today’s presentation, we will be going over the *Claims Detail and Provider Participation Report* under the “Annual Payment Update Reports” category and several of the Feedback reports that have been listed here in this slide.

Next slide, please.

The *Claims Detail Report* will provide users with the ability to monitor claims submitted in Final Action status. The report includes only Medicare fee-for-service claims, which is Medicare Part A [claims] that have been finalized. Claims related to the Inpatient Quality Reporting Global and the Venous

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Thromboembolism, the No VTE Sub-Population, are excluded from this report. And these are excluded as there are so many claims that it would make the report not feasible to use because it would be so long.

As mentioned earlier, the parameters that are displayed are based on your access role. For the *Claims Detail Report*, the parameters include “State,” and as I mentioned earlier, the parameters that are displayed, again, are based on your access, so not all providers are going to see the State parameter. If the “State” parameter is displayed, you can select one, several, or all States from the drop down. “Provider” displays all providers associated with the user signed-on to *QualityNet*. You will then select a “Discharge Quarter,” which is a required field. You are then able to select one, several, or all of the desired measure sets within the “Measure Set” field drop down list. If nothing is selected, it will default to “All.” The report format for this report includes both PDF and CSV. When the report is generated, the report headers contain the report title, report run date, and retrieval criteria entered by the user.

Next slide.

The information included on the *Claims Detail Report* includes the “Date As Of,” which displays the last time claims data was loaded for the provider, the “Beneficiary Claim Number” for the episode of care or record, which would assist in trying to locate the claim. And this column will be updated monthly until approximately 15 days prior to the submission deadline for that quarter, the Beneficiary Claim start date and Beneficiary End Date, and then the Measure Sets associated with the claim.

Next slide.

And now we should be on the slide that says *Provider Participation Report Parameters*. The *Provider Participation Report* summarizes the provider’s data submission. Inpatient

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Quality Reporting providers can use this report to monitor their data submission to make sure they have submitted all information necessary to comply with the IQR Annual Payment Update Requirements.

The report *does not* guarantee a provider receives their full, annual payment updates.

The parameters for the *Provider Participation Report* include “State” and “Provider,” if applicable for the user role, [and] “Calendar Year.” And if you were running a report for fourth quarter 14 discharges, you would select Calendar Year 2014. The “Discharge Quarter” displays available discharge timeframes for selection. Click on the “Discharge Quarter” drop down to display available quarters for the selected calendar year. This parameter is optional.

And the Report Format – the “Report Format” is only available for a few user roles. When the “Report Format” field is not available, a PDF-formatted report is generated by default.

The PDF-formatted reports are available for all years, and contain the report title, report run date, and retrieval criteria entered by the user.

Next slide.

The *Provider Participation Report* is updated nightly with the data that was successfully submitted or processed from the previous day, so that means if you submitted your data today, it will not display on the *Provider Participation Report* until tomorrow. For the Clinical Measures, you are going to want to pay attention to the “Total Patient Population,” “the Medicare Claims,” and “Cases Accepted column.” The “Total Patient Population” column displays the providers self-reported Medicare and non-Medicare combined population. Totals are by clinical measure set, measure set strata, and sub-populations,

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as applicable. In instances where no population size is reported, “No” is displayed.

The “Total Medicare Claim” displays on a quarterly basis the total number of Medicare claims submitted for the provider. Totals are by clinical measure sets, measure sets strata, and sub-population. The column remains blank until quarterly summarized Medicare claims counts are available. The “Total Medicare Claims” column will be updated monthly, with a cumulative total until approximately 15 days prior to the submission deadline for that quarter.

“Total of Cases Accepted” displays the count of unique clinical cases, both Medicare and non-Medicare combined together, that successfully met all clinical status submission requirements.

This “Discharge Quarter Sampling Frequency” displays the provider’s identified population sampling frequency, and available sampling frequencies are “Monthly,” “Quarterly,” “Not Sampled,” and “Submission Not Required.” In situations where no sampling frequency has been reported, “No” is displayed, and when you see “No” displayed in any of the columns, that means you have not met that IQR requirement.

For the determination of whether or not a provider has submitted data or is under-submitted, CMS uses both the Total Patient Population and the Total Medicare Claims count. Whichever is great over the two is then used to determine if the hospital has met the minimum sample size requirement for the specific measure set, measure set strata, or sub-population.

So for example, in this slide, the provider has a total patient population of four for heart failure, and has a Medicare claims count of one. Since the population size is greater than the Medicare claims count, the population size will be used to determine how many cases the provider must have accepted into the CMS Clinical Warehouse. In this case, since their heart

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failure population is four, they would be expected to have four cases accepted into the Warehouse. In regard to the sampling frequency, if the sampling frequency is monthly, then CMS uses the monthly sampling table to determine if the hospital has met the minimum sample size requirement. If the sampling frequency is "Quarterly," "Not Sampled" or "Submission Not Required," then CMS uses the quarterly sampling tables to determine submission and or under-submission.

And when you are referencing the sample tables for each of the measure sets, you want to make sure you go into the "Measure Information Form" with that measure set and use the tables in that section and not use the sampling examples that are in Section Four of the Specification Manual under Population and Sampling. Section Four is only examples of what is –how the population and sampling is determined. So again, you want to make sure you access the appropriate tables for the appropriate measure set.

Next slide please.

On the second page of the *Provider Participation Report*, you will find the data submission information for PC-01, which is the web-based measure, and for HAI. For PC-01 the report displays the "Total Numerator," which is the count of patients with an elective delivery, and please remember that this is an inverse measure, so you want the numerator to be low; you want it to be as close to zero as possible. The "Total Denominator" displays the count of patients delivering newborns with greater than or equal to 37 and less than 39 weeks of gestation completed. The "Total Patient Population" is the count of the mother population that met the population criteria. Quite frequently we see people submitting the Global Population as the Total Population for PC, but remember, this is just the count of the mother total patient population, as described in the Specifications Manual on the Joint Commission's website. If zero is entered, the field will

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display zero. If no data exists, then the report will display “No,” and then the “Total Exclusion” is the combined total, or count, of patients that met any of the exclusion criteria.

And please remember that if you do not treat OB patients or if you do not have an OB unit, you are still required at this time to enter zeros for all the data fields in the web-based PC-01 measure.

For the HAI data, the report displays the IQ-HAI data that was submitted. The report displays the value “Yes” for various, individual HAI measures when the provider successfully submits data to the CDC’s National Healthcare Safety Network, or referred to as NHSN, with an applicable quarterly submission period, otherwise, “No” is displayed.

The Last NHSN File Update to CMS column displays the date the NHSN file was last updated for the discharge quarter. HAI data is updated monthly until the submissions deadline for the respective quarter.

And for more information regarding the HAI data, please access the NHSN website at <http://www.CDC.gov/NHSN>.

Next slide please.

The *Hospital Reporting Case Status Summary Report* is a total of unique cases submitted to the CMS Clinical Warehouse. The report parameter fields are “State” and “Provider,” depending upon the user role; the “Discharge Quarter,” which limits the report generation to a specific discharge date range; the “Submitter,” which is an optional field that provides a list of valid submitter IDs and the submitter names associated with each ID returned by a query of the submitters for that provider discharge date range; the “Measure Set,” which allows the user to select one or more measure sets for the report; and the “Report Format.” The available formats for this report are PDF and CSV.

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When the report is generated in the PDF format, the report contains the report title, report run date, and retrieval criteria entered by the user. This information will not be included in the reports generated in CSV format.

Next slide please.

The *Case Status Summary Report* includes the number of cases submitted, accepted, and rejected. Duplicate submissions of the same case are counted only once. If multiple submissions have been made of the same case, the status of the most recently submitted case within the designated discharge period will be displayed. The report is grouped by provider and then measure. For a case to be included in the “Case Accepted” column, it must have met the acceptance criteria and was successfully submitted and stored in the Clinical Data Warehouse. Rejected cases do not count towards successful submissions. For cases that are rejected, it is recommended that you review the *Submission Detail Report* to ascertain why the case is rejected so that you can correct the errors and resubmit the case. And the expectation is that cases that are rejected from the Warehouse will be corrected and resubmitted. Additionally, deleted and test cases are removed from all case count.

Next slide, please.

The *Hospital Reporting Facility State and National Report* displays the number of hospital records abstracted for a provider and summarizes and compares, by quarter, the data for the measures chosen at the facility, state, and national level. This report can also be used to verify that you have submitted your data for the applicable discharge quarter. Your report parameters include the ability to filter by “State” and “Provider,” if you have the appropriate user roles. For hospitals, the provider fields will display the organization. If more than one organization is displayed, select the desired organization. You

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will then select a “Discharge Quarter.” This parameter limits the report generated to a specific calendar quarter. Select the measure set by clicking on one or more of the desired measure sets within the measure set field’s drop down list, and then select the report format. The available options for this report are PDF and CSV, depending upon the user role that you have. For providers, the report is available only in the PDF format. When the reported is generated in the PDF format, the report contains the report title, report run date, and the retrieval criteria entered by the user.

Next slide.

For the Facility State and National Reports, all data and calculations are obtained from cases that have been successfully accepted into the CMS Clinical Warehouse. The medical records abstracted, which is for clinical chart-abstracted measures only, displays the total number of successfully accepted cases for the measure set for the selected timeframe. A zero appears if no data is available. Each measure set has associated measure rows. Rows contain values in numerator, denominator, and percent of total column. Values are provided in each of these columns at facility, state and national levels. The facility data is available in real-time, however, the state and national column will display blank until approximately 30 days after the submission deadline for the quarter.

Looking at each of the “Facility” columns, the facility-level numerator values are either the number of cases that satisfy the conditions of the performance measure, or for time-based measures, a value in minutes. The facility-level “Denominator Values” are either the number of cases in the measure population successfully accepted, or a forward slash for time-based measures. A dash will display if there are no cases eligible for inclusion within the denominator. And the facility-level percent of total values are either the percent of cases

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included in the denominator that satisfy the performance measure or the numerator, or a forward slash for time-based measures. If an “N/A” displays on the report for the clinic measures only, then that indicates that no data is available, or the data is not applicable.

Next slide, please.

The Perinatal Care Measure information for the facility, state and national level will contain the following columns: “Exclusions,” which is the name of exclusions as per the measure information form and algorithm for PC-01; the “Numerator” and “Denominator,” which are the number of cases of elective delivery, and the number of cases of newborns delivered with greater than or equal to 37 and less than 39 weeks gestations completed; the “Percent of Total,” which is the percentage of the population included in the denominator that is included in the numerator; and the “Exclusion Count,” which is the count of patients that meet the specific exclusion criteria for each exclusion, again, as per the measure information form and algorithm for PC-01.

The HAI Measure rows will contain the following columns: the “Number of Observed HAI Occurrences” are the number –or the numerator for the applicable HAI measure; the “Number of Predicted Infection Occurrences” or the denominator for the applicable HAI measure; and the “Standardized Infection Ratio,” or “SIR,” for the applicable measure. Additionally, it displays the ICU “Location/Procedures,” which indicate the status of ICU location/procedures for the measure, if applicable. The valid values for this field includes “Yes,” “No,” “Not Applicable,” “Exceptions,” and “Blank” or “Null.” The “ICU Locations/Procedures” field displays “Exception” if the provider has an HAI exception waiver on file for the applicable measure. The field displays “No” if the provider indicates no ICU locations mapped, or does not perform the specified colon or

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hysterectomy surgery. If the hospital has ICU locations mapped, or performs the specified colon or hysterectomy surgery, the field should display “Yes.”

Again, this report can be used to verify and ensure that all required data has been submitted to the CMS Clinical Warehouse to meet IQR requirements.

Next slide. The next slide should say *Measure Designation Summary Parameters*.

The *Hospital Reporting Measure Designation Summary Report* allows the user to view a summary of measures and their data submission designation status by provider and reporting period. The report is available for the IQR program only. The report displays the designation status, most recent designation date and time, and the user responsible for the most recent designation. The report parameter fields include “State” and “Provider,” if applicable for the user role. The “Discharge Quarter” limits the report generation to a specific discharge time frame. The “Measure Set” allows the user to select one or more measure sets that are available from the drop down list to be included in the report. The “Designation Status” is an optional field that allows the user to designate whether to include the status of selected or deselected, or both for the report; and the “Report Format” allows the user to select either PDF or CSV formats. When the report is generated in the PDF format, the report contains the report title, report run date, and retrieval criteria entered by the user.

Next slide, please.

The information displayed in the *Hospital Reporting Measure Designation Summary Report* includes the current Warehouse designation status for the indicated measure, and the valid values for this field are selected and deselected, and if you are an eligible IQR-participating hospital, the measures that are

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required for the IQR program cannot be deselected. It also displays the date and time that the most recent designation was saved for the indicated measure and the individual or system responsible for the most recently saved designation for the indicated measure.

Next slide.

The *Hospital Reporting Measure Status by Case Report* is a detailed report that has an option to display detailed information of individual cases which include measure inclusion status and reason for exclusion. For each case, the report provides detailed information on the population eligibility, or denominator; whether the case was included in the numerator or excluded from the measure calculation, and if excluded, the reason for the exclusion. For the parameters you will select the discharge quarter from the drop down pick list, select the submitter if desired, as this is an optional field, select the measure set if applicable, and the measure set field should display the measure set for the associated submitter and provider. The user has the ability to select multiple measure sets and then select the report format. The available options for this report include PDF and CSV. Again, when the report is generated in the PDF format, the report contains the report title, report run date, and retrieval criteria entered by the user. (The report displays the population eligibility.) [Please disregard this last statement]

Next slide, please.

The report displays population eligibility and will display a “Y” if the case was included in the measure denominator. The allowable values for the numerator or pass the measure column includes: “Y” if the case was included in the measure numerator; an [“N”] if the case was included in the denominator but failed or did not meet the intent of the measure; or an “asterisk” (in the CSV format only) if a time element was present. This field will be blank if a time element is present in the “Continuous

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Variable” column in the PDF version. If a case was excluded from the measure calculation or was not included in the denominator of a measure, the report will display a “Y” in “Excluded from the Measure Calculation.” Lastly, if the case was excluded from the denominator of a measure, the report will display the reason why the case was excluded under the “Reason for Exclusion” column. As a note, rejected cases are not included in this report.

Next slide.

The *Hospital Reporting Population and Sampling Summary Report* displays summary information on population and sampling data for Medicare and non-Medicare by quarter, measure set, and provider. Data may be submitted per XML file or the Population and Sampling Application on the *QualityNet Secure Portal*. As with the other reports, the “State” and “Provider” parameters may or may not be available depending on your user role. For this report, you will select the “Discharge Quarter,” which limits the report generation to a specific discharge quarter; the population type, in which the user may select one or multiple population types; and then the report format. The available report formats for this report include PDF and CSV. When the report is generated in the PDF format, the report contains the report title, report run date, and retrieval criteria selected by the user.

Next slide.

The report will display the sampling frequency selected by the provider. The values include: “Monthly,” “Quarterly,” “Not Sampled,” and “NA, Submission of clinical patient data is not required.” The report displays the breakdown of the population and sample sizes by Medicare, and non-Medicare, and then provides the total population and sample sizes, which is the Medicare and non-Medicare count combined. An “NA” in any of the data cells indicates that the population and sample size data

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has not been submitted for this quarter for the specific measure set, strata, or sub-population.

Next slide, please.

The *Hospital Reporting Potential Duplicate Report* identifies potential duplicate records submitted to the CMS Clinical Warehouse. To run the potential duplicate report, you will select the appropriate discharge quarter, and the report format. Only a PDF format is available for this report in the feedback category.

Next slide, please.

Multiple records submitted for the same patient's stay are considered potential duplicates. This could mean that they match on several of the key elements. The key elements used to identify potential duplicates are the CMS Certification Number or CCN, the measure set, the admission and discharge date, and the patient identifier. In some instances, the birthdate is also used to identify the potential duplicates. For example, if you submit a case with the same CCN, measure set, patient identifier, and admit date, but the two cases have different discharge dates, those cases will be identified as a potential duplicate. Please remember that this identifies potential duplicates only, so they may or may not be an actual duplicate. It is up to the facility to determine if it is a duplicate or not. The list of potential duplicates should be reviewed to determine if each record is a valid record or if it is a duplicate. Duplicate records can cause incorrect data to be reported through the IQR program and can potentially adversely affect the facility's outcome if the provider is selected for validation. As a result, it is critical that any duplicate records be deleted prior to the submission deadline.

The important areas of the report that you will want to review in determining if a record is a duplicate or not are the admit and discharge date, which is the month, day, and year that the

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patient was admitted and discharged from the hospital; the patient identifier, which is the unique number that is used by the hospital to identify the case; the first and last name, if available. And the first and last name will only display if those data fields were submitted in the patient-level XML file. If they were not submitted, then those fields will be – remain blank; and then the birth date.

Next slide, please.

The *Hospital Reporting Submission Detail Report* is a detailed report of cases submitted to the CMS Clinical Data Warehouse. The report includes all submissions for a particular case rather than just the most recent submission; so if the case was submitted multiple times, then it's going to show up multiple times on the report. After selecting the appropriate discharge quarter, the remainder of the parameters are optional and will assist you in drilling down the information that is included in the report. The optional parameters include: the ability to select the "Submitter," the drop down provides a list of valid submitter IDs, and the submitter names associated with each ID; the "File Status" field allows the user to designate whether to include Accepted, Rejected, or Both Statuses for the report; the "Measure Set" dropdown displays the applicable measure sets for the program type; the "Action Code" field allows the user to designate whether to include added data, deleted data, or both in the report; and the "Message Type Field" allows the user to select the type of messages to display.

A user may select one or more message types. The message types include "Critical" and/or "Informational" edits. As a note, "Critical" edits are those that cause the case to be rejected from the Clinical Warehouse, whereas "Informational" messages are just asking the user to verify that the information submitted is correct. These will not reject the case from the Warehouse, whether the case was excluded, failed, included, passed the

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measure, or if the measure calculation was unable to be determined.

Next slide, please.

The *Submission Detail Report* displays the following pertinent information for each case: The date that the patient was admitted and discharged from the hospital; the date the case was submitted to the CMS Clinical Warehouse; the Warehouse submission status of the file for the selected measure; and the values for this is the Action Code – is either “Add,” which means the case is being added to the Warehouse, or “Delete,” which means the case is needing to be deleting from the Warehouse; the status of the case that was submitted, which will display either “Accepted,” “Rejected,” or “Unknown,” and the message, and, as discussed in the last slide, an “Informational Warning” message is a soft edit in which the submission will proceed. A “Critical Warning” message is a hard edit, meaning the submission was fatal, resulting in the file not being accepted into the Warehouse.

Next slide, please.

This slide just lists the resources that are available to you for the Hospital and Patient Quality Reporting Program. If you have questions related to the measure information forms, or the individual measures, or how to abstract the data elements for the individual measures, we ask that you submit those questions to the Q and A tools so that they can be routed to the appropriate measure developers.

If you have questions in relations to the IQR program requirements, submission deadlines, or other aspects of the program, then there is the email support, phone support, and Inpatient live chat that is available to you. And again, for additional information, we encourage you to visit our website at

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[www.qualityreportingcenter.com](http://www.qualityreportingcenter.com). And I would like to turn the presentation back over to Deb.

### **Deb Price:**

Well thank you, Candace, for all the information you shared with us today. Before we review questions that were sent in, I want to remind you that today's webinar has been approved for one Continuing Education Credit by the boards listed in front of you.

We now have an online CE certificate process. If you registered for the webinar through ReadyTalk<sup>®</sup>, a survey will automatically pop up when the webinar closes. After you complete the survey, a page will display to register you as either a new user, or if you've attended our previous webinars, as an existing user. A one-time registration into our Learning Management Center is required. Your complete email address is your user ID. Now if you did not receive the survey, don't worry, because we're going to be sending out an additional survey to all participants within the next 48 hours. It won't arrive today. If there are others in your room listening to the webinar but not registered in ReadyTalk<sup>®</sup>, just pass the survey you're going to get within 48 hours.

This is what the survey will look like; actually it's the last three questions of the survey. It will pop up at the end of the event and will be sent to all the webinar attendees. Look at the bottom [and] you'll see the word "Done." You will click "Done" when you're finished, and then this page will pop up. If you are a new user, you see in green, the top green area, there is the "New User" link. That is what you're going to register on. If you've attended our webinars before, click [the] "Existing User" link. This is what the new user screen looks like after you've clicked on the "New User" link. You put your first name, your last name, an email, and your phone number. We'd like to caution you to please put in a personal email like Yahoo or Gmail, because it appears that a lot of the hospitals' and other healthcare facilities' emails are blocked or firewalled.

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This is what the “Existing User” screen will look like if you’ve attended our past webinars. The user name is going to be your complete email address, and just put in whatever password you registered with.

And now, Candace will go over some questions that came in during the event. Candace, the floor is yours.

**Candace Jackson:** Thank you, and I think we are going to start. And I’m going to ask our subject matter experts if they have some frequently asked questions and responses that they would like to share with us today.

Suzette, would you like to share any questions that you see frequently?

**Suzette Gerhart:** Sure, Candace, and thank you. One question I have was, “How soon after I submit data can I run the Provider Participation Report?”

The Provider Participation report updates overnight, so any data submitted today will be reflected on a Provider Participation Report tomorrow.

The next question we often see, “Why can’t I see my annual Healthcare Worker Influenza Data when I run my Fourth Quarter 2014 *Provider Participation Report*?”

This is a known issue. As a workaround you will need to run the Quarter One 2015 *Provider Participation Report*, and that submitted data will be reflected on that report.

And the last question I had was, “Why doesn’t my Medicare Claims Count match the Medicare Population Count that I submitted on my Provider Participation Report?”

The Medicare Claims Count includes only pure Medicare Part A claims that are in the final status. The Medicare Population

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Count you enter includes any patient that has any type of Medicare, such as Medicare Part A, B, Medicare Secondary, Medicare HMO, regardless if it has been submitted or the claim has been finalized.

And that's all I had.

**Candace Jackson:** Thank you! And we will go to Chris. Do you have any frequent questions that you would like to share with the group?

**Chris Leber:** Yes I do, Candace. The first one is a question that we get regarding the "Measure Designation" screen in *QualityNet*. The "Measure Designation" screen still displays VTE 4 and SCIP Infection 4 as required measures and so folks are asking, "Why these are still displaying that way and they can't deselect them?"

We want to let you all know that this is a known issue, and it's being worked on, and we anticipate that this should be fixed fairly soon, hopefully, so that they won't display as "required."

The second question is, "Where is there a resource in *QualityNet* for all of the reports indicating how to get them, what they look like?"

There is a document called – it's called *Handbook Two*, and you can find it on *QualityNet* if you go to the main tab for Hospital-Inpatient and you hover over that. You'll see the "Training" link at the very bottom of that list. If you click on the "Training" link [and] open up the "Training" page, there is a box on the right side of the screen that says "Handbook" and you select *Handbook Two: Inpatient Quality Reporting*. All this information about the reports will be in there.

That's all I have, Candace.

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**Candace Jackson:** Thank you, Chris. And Lisa, would you have any frequently asked questions that you would like to add to our presentation today?

**Lisa McConeghey:** Yes, Candace, I have one. This is a known issue with the *Provider Participation Report*, “When working with the HAI data, the CLABSI is displaying “No,” even when the provider has already submitted data.” And the workaround is to use your Facility State and National Report to verify its CLABSI data has been submitted.

That’s the one I have.

**Candace Jackson:** Thank you. And I would just like to add that it is important that, as you are running some of your reports, that if you find things that do not look appropriate on the report, the first thing you want to do is look at the *Known Issues* document. The *Known Issues* document tells, explains any issues that are currently occurring with any of the reports and what the workaround is. You can find the *Known Issues Document* on the homepage of *QualityNet*. If you go to *QualityNet*, [www.QualityNet.org](http://www.QualityNet.org), on the bottom left-hand side of the page, you will find a section that says “Known Issues.” So you want to make sure that you always look at that first to see if there’s any known issues, because some of the known issues that our subject matter experts have identified today will be on that report, and then we’ll tell you what the workaround is.

So for example, on the *Provider Participation Report*, if it’s showing “No” for CAUTI and CLABSI, and you know that you have submitted that data, you will want to go to the *Facility State and National Report* to verify that yes, your data is submitted. So that is an important document that you will want to reference during the submission period.

Just a couple other bits of information – If you are a Critical Access Hospital, then you are not going to get a *Provider*

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*Participation Report.* Your report will show up blank because Critical Access Hospitals are not part of the IQR Program. So I know we frequently have Critical Access Hospitals asking us why there's no data showing up on your *Provider Participation Report*.

The *Claims Detail Report* is usually run at the beginning of the month, and then is run monthly. And it's a cumulative report, so if there was a claim that did not show up last month but you have submitted that claim, by the time the next claim count is run, then that will show up on the report at that time.

At this time, I don't have any other questions that we can provide to you today, so we thank everyone for joining our call. We hope that you have learned some useful information and that you will be able to access and run your reports and understand the data that is on it, and we thank you for participating and hope that you have a good day.

**END**

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