

TIP SHEET

Preparation of Inpatient CDAC Validation Records

The purpose of the validation process is to verify that the data abstracted by the hospitals are consistent and reproducible.

Approximately one week after the quarterly data submission deadline, CMS randomly identifies a maximum of 12 inpatient abstraction cases across the four national inpatient measure sets (AMI, HF, PN, and SCIP) for each of the 800 PPS hospitals selected for RHQDAPU validation. The Clinical Data Abstraction Center (CDAC) sends a request to each of these hospitals to obtain copies of the identified records. Over the next two to three months, the CDAC re-abstracts the record copies sent to them. If there is **≥75%** agreement on comparison of **individual measure outcomes**, the hospital is deemed certified for submitting valid data.

Due to the sheer volume of records that must be abstracted by the CDAC within a relatively short time interval, hospitals are not allowed to send records or additional documentation following the submission deadline. This applies even if the wrong record is sent, if pages are missing or are illegible, etc. The CDAC will abstract every case with the documentation that the hospital sent to it. For this reason, ***it is critical that hospitals have a process for reviewing each of their records after they have been copied and prior to them being sent to the CDAC.***

The submission date for Inpatient clinical data submission is currently the 15th of the month every February, May, August, and November. The validation cases per hospital are identified during the following week. Approximately one to two weeks after the data submission deadline, the CDAC mails green record request sheets for each of the selected records to the Medical Records contacts. The exact date that the record copies must be received by the CDAC will be noted on the green request sheets. This is usually 45 days after the request date.

***Regardless of who copies your medical records
(hospital medical records staff, independent copying services, etc.),
ALL record copies should be carefully reviewed prior to mailing them to the CDAC!***

- 1. Verify that the patient's name, date of birth, and admission and discharge dates on the copied record match the CDAC request.**

The first step of the validation abstraction process is a comparison by the CDAC abstractor of the medical record copy against the identifiers listed on the green cover sheet. The identifiers are those submitted by the hospital or its vendor to the QIO Clinical Data Warehouse, such as the patient's name, date of birth, admission and discharge dates, social security number, medical record number, and/or account number.

For further detail, please refer to the "Data Validation Overview" and the "Invalid Record Selection/Incorrect Date(s) of Service Details" files posted at <https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1140537255912>.

The critical point to keep in mind is that errors pertaining to these data elements are not subject to appeal.

- 2. Verify that all documents are present—including, but not limited to, the following:**
 - *Face Sheet (and ED Registration Sheet, if present)*
 - *ED documentation*
 - *History & Physical and the Discharge Summary*

- *Physician orders and progress notes*
- *Nursing admission history and notes*
- *MARS*
- *Laboratory, x-ray, and other ancillary services reports*
- *Surgical care documents (i.e., anesthesia pre-op evaluation, anesthesia report, and perioperative report)*
- *A signed consent form if the patient was involved in a clinical trial in which patients with the same condition as the measure set were being studied*
- *Copies of electronic documentation that was accessible to the inpatient care team and used by the hospital abstractor during the abstraction process*

3. Make sure that none of the pages were skewed during the copying process so that parts of the page were cut off or are illegible.

If information isn't visible to the CDAC abstractors, they can't abstract it!

4. If you have any multiple-page documents that have a date written on at least one page of the set (e.g., on page 1 of 6), you are allowed to hand-write the date on the remaining pages of that set so the CDAC will know which pages go with which date.

If you do this, we recommend you use red ink and include a note to the CDAC informing them of what you have done.

Some additional tips . . .

Consider having an abstractor review your records, as they are most familiar with the location of the information needed for abstraction.

A report listing the records selected for validation is available on My QNet approximately one to two weeks after the green record request forms are mailed out. To download this report:

- Log in to My QNet and go to the “Run Reports” section. Select the “Hospital Validation Reports” category and click on “Case Selection Report.”
- Click on your hospital name and the appropriate quarter. Leave the report format as “PDF,” click on “Request Report,” and then on the “View Reports” tab near the top of the window to see the report.

After you have sent your records to the CDAC, you can re-run the Case Selection Report to verify that it has received them. Once they are logged in to the CDAC, you will see a “Y” in the final “Record Received” column.

Have more questions or need help? If so, please contact:

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Information for Healthcare Improvement

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