Alphabetical Data Element List

Data Element Name: ***Arrival Time***

Collected For: All records (used in algorithms for OP-1, OP-2, OP-3, OP-5, OP-18, OP-20, OP-21, OP-23)

Definition: The earliest documented time (military time) the patient arrived at the outpatient or emergency department

Suggested Data Collection Question: What was the **earliest** documented time the patient arrived at the outpatient or emergency department?

Format:
Length: 5 – HH:MM (with or without colon) or UTD
Type: Time
Occurs: 1

Allowable Values:
HH = Hour (00–23)
MM = Minutes (0–59)
UTD = Unable to Determine

Time must be recorded in military time format.

With the exception of midnight and noon:
- If the time is in the a.m., conversion is not required.
- If the time is in the p.m., add 12 to the clock time hour.

  Examples:
  - Midnight = 0000 Noon = 1200
  - 5:31 a.m. = 0531 5:31 p.m. = 1731
  - 11:59 a.m. = 1159 11:59 p.m. = 2359

Note: 0000 = midnight. If the time is documented as 0000 11-24-20XX, review supporting documentation to determine if the *Outpatient Encounter Date* should remain 11-24-20XX or if it should be converted to 11-25-20XX.

When converting midnight, or 2400, to 0000, do not forget to change the *Outpatient Encounter Date*.

Example:
- Midnight or 2400 on 11-24-20XX = 0000 on 11-25-20XX.

Notes for Abstraction:
- For times that include seconds, remove the seconds and record the time as is.

  Example:
  - 1500:35 would be recorded as 1500
- If the time of the arrival is unable to be determined from medical record documentation, select UTD.
- The medical record must be abstracted as documented (taken at "face value"). When the time documented is obviously in error (not a valid time) **and** no other documentation is found that provides this information, the abstractor should select UTD.

  Example:
  - Documentation indicates the arrival time was 3300. No other documentation in the list of Only Acceptable Sources provides a valid time. Since the *Arrival Time* is outside of the range in the Allowable Values for Hour, it is not a valid time, and the abstractor should select UTD.

Note: Transmission of a case with an invalid time as described above will be rejected from the CMS Clinical Data Warehouse. Use of UTD for *Arrival Time* allows the case to be accepted into the Warehouse.

- Review the Only Acceptable Sources to determine the earliest time the patient arrived at the ED or observation. The intent is to utilize any documentation which reflects processes that occurred after the arrival at the ED or after arrival to observation.
- Documentation outside of the Only Acceptable Sources list should **not** be referenced (e.g., ambulance record, physician office record, H&P).

  Examples:
  - ED Triage Time 0800. ED rhythm strip 0830. EMS report indicates patient was receiving EMS care from 0805 through 0825. The EMS report is disregarded. Enter 0800 for *Arrival Time*.
  - ED noted arrival time of 0945. Lab report shows blood culture collected at 0830. It is not clear that the blood culture was collected in the ED because the lab report does not specify it was collected in the ED (unable to confirm lab report as an Only Acceptable Source). Enter 0945 for *Arrival Time*.
- *Arrival Time* should **not** be abstracted simply as the earliest time in one of the Only Acceptable Sources, without regard to other substantiating documentation. When looking at the Only Acceptable Sources, if the earliest time documented appears to be an obvious error, this time should not be abstracted.

  Examples:
  - ED arrival time notes as 2300 on 10-28-20xx. ED MAR shows an antibiotic administration time of 0100 on 10-28-20xx. Surrounding documentation on the ED MAR makes clear that the 10-28-20xx date is an obvious error- Date was not changed to 10-29-20xx. The antibiotic administration date/time would be converted to 0100 on 10-29-20xx. (Please see the note under the Allowable Values section of this data element). Enter 2300 for *Arrival Time*.
  - ED face sheet lists arrival time of 1320. ED Registration Time 1325. ED Triage Time 1330. ED Consent to treat form has 1:17 time but "AM" is circled. ED record documentation suggests the 1:17 AM is an obvious error. Enter 1320 for *Arrival Time*.
  - ED ECG timed as 1742. ED Greet Time 2125. ED Triage Time 2130. There is no documentation in the Only Acceptable Sources which suggests the 1742 is an obvious error. Enter 1742 for *Arrival Time*.
  - ED RN documents on the nursing triage note, "Blood culture collected at 0730." ED arrival time is documented as 1030. There is no documentation in the Only Acceptable Sources which suggests the 0730 is an obvious error. Enter 0730 for *Arrival Time*.
- The source "Emergency Department record" includes any documentation from the time period that the patient was an ED patient.
- The source "Procedure notes" refers to procedures such as cardiac caths, endoscopies, and surgical procedures. Procedure notes do not include ECG and x-ray reports.
- The *Arrival Time* may differ from the admission time.

Observation Status:

- If the patient was admitted to observation from an outpatient setting of the hospital, use the time the patient arrived at the ED or on the floor for observation care as the *Arrival Time*.
- If the patient was admitted to observation from the ED of the hospital, use the time the patient arrived at the ED as the *Arrival Time*.

Suggested Data Sources:
Only Acceptable Sources:

- Emergency Department record, which may include:
  - ED face sheet
  - ED consent/Authorization for treatment forms
  - ED/Outpatient registration/Sign-in forms
  - ED ECG reports
  - ED telemetry/rhythm strips
  - ED laboratory reports
  - ED x-ray reports
- Observation record
- Procedure notes
- Vital signs graphic record

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction:

- Addressographs/stamps

Data Element Name: ***Birthdate***

Collected For: All records

Definition: The month, day, and year the patient was born

Note: Patient Age on *Outpatient Encounter Date* (in years) is calculated by *Outpatient Encounter Date* minus *Birthdate*. The algorithm to calculate age must use the month and day portion of encounter date and birthdate to yield the most accurate age.

Suggested Data Collection Question: What is the patient's date of birth?

Format:
Length: 10 – MM-DD-YYYY (includes dashes)
Type: Date
Occurs: 1

Allowable Values:
MM = Month (01–12)
DD = Day (01–31)
YYYY = Year (1880–Current Year)

Notes for Abstraction:
Because this data element is critical in determining the population for all measures, the abstractor should **not** assume that the claim information for the birthdate is correct. If the abstractor determines through chart review that the date is incorrect, correct and override the downloaded value. If the abstractor is unable to determine the correct birthdate through chart review, default to the date of birth on the claim information.

Suggested Data Sources:
- Outpatient record
- Emergency Department record

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

Data Element Name: *Documentation of colonoscopy with interval < 3 yrs due to medical reason*

Collected for: OP-30

Suggested Data Collection Question: Documentation of < 3 year interval since the patient's last colonoscopy due to medical reasons (e.g., last colonoscopy incomplete, last colonoscopy had inadequate prep, piecemeal removal of adenomas, or last colonoscopy found > 10 adenomas):

Allowable Values: Y (Yes)
N (No)

Notes for Abstraction:

- If there is documentation of a medical reason for an interval of less than 3 years since the last colonoscopy, select "Yes" (Reasons may include, but are not limited to: high risk for colon cancer, last colonoscopy was incomplete, inadequate prep for last colonoscopy, piecemeal removal of adenomas or last colonoscopy found greater than 10 adenomas)last colonoscopy found greater than 10 adenomas)
- If there is no documentation of a medical reason for an interval of less than 3 years since the last colonoscopy, select "No"

Suggested Data Sources:

- Prior Colonoscopy Report

Data Element Name: *Documentation of colonoscopy with interval < 3 yrs due to system reason*

Collected for: OP-30

Suggested Data Collection Question: Documentation of < 3 years since the patient's last colonoscopy due to system reason (e.g., unable to locate previous colonoscopy report, previous colonoscopy report was incomplete):

Allowable Values: Y (Yes)
N (No)

Notes for Abstraction:

- If there is documentation of a system reason for an interval of less than 3 years since the last colonoscopy, select "Yes" (Reasons may include: unable to locate previous colonoscopy report)
- If there is no documentation of a system reason for an interval of less than 3 years since the last colonoscopy, select "No"

Suggested Data Sources:

- Prior Colonoscopy Report

Data Element Name: *Documentation of colonoscopy with interval ≥ 3 yrs*

Collected for: OP-30

Suggested Data Collection Question: Documentation that patient had an interval of ≥ 3 years since last colonoscopy:

Allowable Values: Y (Yes)
N (No)

Notes for Abstraction:

- If the patient is aged 18 years or older, has a history of prior colonic polyp(s) and has had an interval of 3 or more years since their last colonoscopy, select "Yes"
- If it has been less than 3 years since the previous colonoscopy, select "No"

Suggested Data Sources:

- Prior Colonoscopy Report
- Prior Colonoscopy Operative Report

Data Element Name: ***First Name***

Collected For: All records

Definition: The patient's first name

Suggested Data Collection Question: What is the patient's first name?

Format:
Length: 30
Type: Character
Occurs: 1

Allowable Values:
Enter the patient's first name.

Notes for Abstraction: None

Suggested Data Sources:
- Outpatient record
- Emergency Department record

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

Data Element Name: ***Hispanic Ethnicity***

Collected For: All records

Definition: Documentation that the patient is of hispanic ethnicity or Latino

Suggested Data Collection Question: Is the patient of hispanic ethnicity or Latino?

Format:
Length: 1
Type: Character
Occurs: 1

Allowable Values:
Y (Yes) Patient is of hispanic ethnicity or Latino.

N (No) Patient is not of hispanic ethnicity or Latino or unable to determine from medical record documentation.

Notes for Abstraction:
- The data element *Race* is required in addition to this data element.

Suggested Data Sources:
- Outpatient record
- Emergency Department record

Inclusion Guidelines for Abstraction:
A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic or Latino."

Examples:
- Black-Hispanic
- Chicano
- H
- Hispanic
- Latin American
- Latino/Latina
- Mexican-American
- Spanish
- White-Hispanic

Exclusion Guidelines for Abstraction: None

Data Element Name: ***Last Name***

Collected For: All records

Definition: The patient's last name

Suggested Data Collection Question: What is the patient's last name?

Format:
Length: 60
Type: Character
Occurs: 1

Allowable Values:
Enter the patient's last name.

Notes for Abstraction: None

Suggested Data Sources:
- Outpatient record
- Emergency Department record

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

Data Element Name: ***Outpatient Encounter Date***

Collected For: All records

Definition: The documented month, day, and year the patient arrived in the hospital outpatient setting

Suggested Data Collection Question: What was date the patient arrived in the hospital outpatient setting?

Format:
Length: 10 – MM-DD-YYYY (includes dashes)
Type: Date
Occurs: 1

Allowable Values:
MM = Month (01-12)
DD = Day (01-31)
YYYY = Year (20xx)

Notes for Abstraction:
- The intent of this data element is to determine the date the patient arrived in the hospital outpatient setting.
- UTD is **not** an allowable value.
- Consider the outpatient encounter date as the earliest documented date the patient arrived in the applicable hospital outpatient setting.

Suggested Data Sources:
- Outpatient record
- Emergency Department record

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction:
- Preoperative tests or screening

Data Element Name: ***Patient Identifier***

Collected For: All records

Definition: The number used by the hospital to identify this patient's hospital outpatient encounter. The number provided will be used to identify the patient in communications with the hospital outpatient setting, e.g., Medical Record Number, Account Number, Unique Identifiable Number as determined by the facility, etc.

A *Patient Identifier* is required.

Suggested Data Collection Question: What was the number used to identify this outpatient encounter?

Format:
Length: 40
Type: Character
Occurs: 1

Allowable Values:
Up to 40 letters and/or numbers

Notes for Abstraction: None

Suggested Data Sources:
- Outpatient record
- Emergency Department record

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

Data Element Name: ***Payment Source***

Collected For: All records

Definition: The source of payment for this outpatient encounter

Suggested Data Collection Question: What is the patient's source of payment for this outpatient encounter?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:
1 Source of payment is Medicare.
2 Source of payment is Non-Medicare.

Notes for Abstraction:
- If Medicare is listed as the primary, secondary, tertiary, or even lower down on the list of payers, select 1.
- If the patient is an Undocumented Alien or illegal immigrant, select 1.
  Undocumented Alien: Section 1011 of the Medicare Modernization Act of 2003 allows for reimbursement for services rendered to patients who are: Undocumented or illegal aliens (immigrants), aliens who have been paroled into a United States port of entry, and Mexican citizens permitted to enter the United States on a laser visa.

Suggested Data Sources:
- Face sheet
- UB-04

Inclusion Guidelines for Abstraction:
Medicare includes, but is not limited to:
- Black Lung
- End Stage Renal Disease (ESRD)
- Medicare Fee-for-Service (includes DRG or PPS)
- Medicare HMO/Medicare Advantage
- Medicare Secondary Payer
- Railroad Retirement Board (RRB)

Exclusion Guidelines for Abstraction: None

Data Element Name: ***Physician 1***

Collected For: All records (optional element)

Definition: The first physician identifier

Suggested Data Collection Question: What is the first physician identifier?

Format:
Length: 50
Type: Alphanumeric
Occurs: 1

Allowable Values:
Enter the first physician identifier, as directed. Up to 50 letters, numbers, and/or special characters can be entered.
Note: Only the following special characters will be allowed:
~ ! @ # $ % ^ * ( ) _ + { } | : ? ` - = [ ] \ ; ‘ . , / and space

Notes for Abstraction:
This data element may be used to capture physician information that might be helpful in internal analysis. This information is for internal analysis only and will not be shared with any external parties in any data output.

Suggested Data Sources: None

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

Data Element Name: ***Physician 2***

Collected For: All records (optional element)

Definition: A second physician identifier

Suggested Data Collection Question: What is the second physician identifier?

Format:
Length: 50
Type: Alphanumeric
Occurs: 1

Allowable Values:
Enter the second physician identifiers, as directed. Up to 50 letters, numbers, and/or special characters can be entered.
Note: Only the following special characters will be allowed:
~ ! @ # $ % ^ * ( ) _ + { } | : ? ‘ - = [ ] \ ; . , / and space

Notes for Abstraction:
This data element may be used to capture physician information that might be helpful in internal analysis. This information is for internal analysis only and will not be shared with any external parties in any data output.

Suggested Data Sources: None

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

Data Element Name: ***Postal Code***

Collected For: All records

Definition: The postal code of the patient's residence. For United States ZIP codes, the hyphen is implied. If the patient is determined to not have a permanent residence, then the patient is considered homeless.

Suggested Data Collection Question: What is the postal code of the patient's residence?

Format:
Length: 9
Type: Character
Occurs: 1

Allowable Values:
Any valid five or nine digit postal code, or "homeless" if the patient is determined not to have a permanent residence. If the patient is not a resident of the United States, use "non-US."

Notes for Abstraction:
- If the postal code of the patient is unable to be determined from medical record documentation, enter the provider's postal code.

Suggested Data Sources:
- Outpatient record
- Emergency Department record
- UB-04

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None

Data Element Name: *Prior colonic polyp*

Collected for: OP-30

Suggested Data Collection Question: Patient had a prior colonic polyp in a previous surveillance/diagnostic colonoscopy and is 18 years or older on date of encounter.

Allowable Values: Y (Yes)
N (No)

Notes for Abstraction:

- If the patient has a history of prior colonic polyp(s) from a previous colonoscopy and is at least 18 years of age, select "Yes"
- If the patient has no history of prior colonic polyp(s) from a previous colonoscopy, select "No"

Suggested Data Sources:

- Prior Colonoscopy Report
- Prior Colonoscopy Operative Report

Data Element Name: ***Race***

Collected For: All records

Definition: Documentation of the patient's race

Suggested Data Collection Question: What is the patient's race?

Format:
Length: 1
Type: Character
Occurs: 1

Allowable Values:

1 **White:** Patient's race is White or the patient has origins in Europe, the Middle East, or North Africa

2 **Black or African American:** Patient's race is Black or African American.

3 **American Indian or Alaska Native:** Patient's race is American Indian/Alaska Native.

4 **Asian:** Patient's race is Asian.

5 **Native Hawaiian or Pacific Islander:** Patient's race is Native Hawaiian/Pacific Islander.

7 **UTD:** Unable to determine the patient's race or not stated (e.g., not documented, conflicting documentation, or patient unwilling to provide).

Notes for Abstraction:
- The data element *Hispanic Ethnicity* is required in addition to this data element.
- If documentation indicates the patient has more than one race (e.g., Black-White, Indian-White), select the first listed race.
- Although the terms "Hispanic" and "Latino" are actually descriptions of the patient's ethnicity, it is not uncommon to find them referenced as race. If the patient's race is documented only as Hispanic/Latino, select "White." If the race is documented as mixed Hispanic/Latino with another race, use whatever race is given (e.g., Black Hispanic – select "Black"). Other terms for Hispanic/Latino include Chicano, Cuban, H (for Hispanic), Latin American, Latina, Mexican, Mexican-American, Puerto Rican, South or Central American, and Spanish.

Suggested Data Sources:
- Outpatient record
- Emergency Department record

Inclusion Guidelines for Abstraction:
Black or African American
A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black" or "African American."

American Indian or Alaska Native
A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment (e.g., any recognized tribal entity in North and South America [including Central America], Native American).

Asian
A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

White
A person having origins in any of the original peoples of Europe, the Middle East, or North Africa (e.g., Caucasian, Iranian, White).

Native Hawaiian or Pacific Islander
A person having origins in any of the other original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

Exclusion Guidelines for Abstraction: None

Data Element Name: ***Sex***

Collected For: All records

Definition: The patient's documented sex on arrival at the hospital

Suggested Data Collection Question: What was the patient's sex on arrival?

Format:
Length: 1
Type: Character
Occurs: 1

Allowable Values:
M = Male
F = Female
U = Unknown

Notes for Abstraction:
- Collect the documented patient's sex at admission or the first documentation after arrival.
- Consider the sex to be unable to be determined and select "Unknown" if:
    - The patient refuses to provide their sex.
    - Documentation is contradictory.
    - Documentation indicates the patient is transexual.
    - Documentation indicates the patient is a hermaphrodite.

Suggested Data Sources:
- Consultation notes
- Emergency Department record
- Face sheet
- History and Physical
- Nursing admission notes
- Progress notes
- UB-04

Inclusion Guidelines for Abstraction: None

Exclusion Guidelines for Abstraction: None