

MCMP-PAT General Abstraction Guidelines

The MCMP-PAT General Abstraction Guidelines are a resource designed to assist in determining how a question should be answered. All of the allowable values for a given question are outlined, and “notes” are often included which provide the necessary guidelines to abstract a data element. It is important to utilize the information found in the “notes” when entering or selecting the most appropriate answer.

When abstracting a medical record, the abstractor should first refer to the specific abstraction instructions for the data element. These notes should take precedence over the MCMP-PAT General Abstraction Guidelines.

Sources

- Documentation from any medical record source or other clinical information that is available at the point to care can be utilized in abstraction.

Dates

Dates must be recorded in the following format: MM/DD/YYYY.

Example:

February 16, 2007 would be recorded as 02/16/2007.

- If a date is unknown/illegible, enter “X” in the date field.
- If the month and year are provided but not the actual date a service is provided, use the first day of the month.

Example:

March of 2007 would be recorded as 03/01/2007.

Conflicting Information

- If there is conflicting information between the practitioner and office staff during an office visit, abstract the practitioner findings. If there is conflicting information by the practitioner during an office visit, determine and abstract the most abnormal condition or finding, unless otherwise specified in the abstraction instructions. Use the information that most accurately answers the question.

Inclusions for Data Elements

- Inclusions are “acceptable terms” for particular data elements, which should be abstracted as *positive findings* (e.g., “yes”). The list of inclusions should not be considered all-inclusive.

Exclusions for Data Elements

- Exclusions are “unacceptable terms” for particular data elements, which should be abstracted as *negative findings* (e.g., “no”). Exclusion lists are limited to those terms an abstractor might question whether or not to abstract the term as a positive finding

(e.g., “cardiomyopathy” is an unacceptable term for confirmation of heart failure and should be abstracted as “no”). The list of exclusions should not be considered all-inclusive.

- When both an inclusion and exclusion are documented in a medical record, the inclusion takes precedence over the exclusion.

Qualifiers

Qualifiers are words used as adjectives to indicate some uncertainty about whether or not a condition really exists.

- The following qualifiers should be abstracted as *positive findings*, unless otherwise specified in the abstraction instructions:
 - Apparent
 - Appears to have
 - Consider
 - Consistent with (c/w)
 - Diagnostic of
 - Evidence of
 - Indicative of
 - Likely
 - Most likely
 - Probable
 - Representative of
 - Suggestive of

Example:

If the practitioner documents “probable heart failure,” heart failure should be abstracted as a *positive* finding.

- The following qualifiers should be abstracted as *negative findings*, unless otherwise specified in the abstraction instructions:
 - Could be
 - Could have been
 - Questionable
 - Possible
 - Risk of
 - Ruled out (r’d/o)

Example:

If the echocardiogram report documents “questionable LVSD”, LVSD should be abstracted as a *negative* finding.

- When the qualifier *rule out (r/o)* is used, continue to review the medical record to confirm the presence or absence of the condition. If unable to confirm the presence or absence of the condition, abstract as a **negative** finding, unless otherwise specified in the abstraction instructions.
- When the terms vs., +/-, or and/or are used in considering two or more conditions, continue to review the record to see if either condition was ruled in. If neither

condition was ruled in, abstract both as negative findings, unless otherwise specified in the abstraction instructions.

Laboratory

- If it is determined a laboratory test has been performed, however the corresponding results are not available in the record, enter “0” in the laboratory value field.

Medications

- The medication tables may not be all-inclusive lists of available therapeutic agents acceptable for a particular data element. If you are questioning a particular medication not included on the list, use additional resources to confirm the type of medication.

Contraindications to Treatment/Therapy

- To determine if a patient had contraindications (medical/patient reasons) to a particular treatment/therapy, it is acceptable to use historical information (entire medical record).

Example:

If ACE inhibitor therapy was discontinued five years prior to the measurement period due to an ACE-associated cough, this should be considered a medical reason for the patient not receiving ACE inhibitor therapy.