DEPARTMENT: Clinical Operations Group – Clinical Data & Analytics	**POLICY DESCRIPTION:** Purging of COMET Core Measure Records
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EFFECTIVE DATE: November 3, 2025	**REFERENCE NUMBER:** COG.COM.003 (formerly QM.COM.003 & CSG.COM.003)
APPROVED BY: Ethics and Compliance Policy Committee	

SCOPE: All Company-affiliated colleagues responsible for performing, supervising or monitoring the Core Measure abstraction process within the Clinical Outcome Measure Evaluation and Transmission (COMET) Application.

This policy applies to purging of chart-abstracted Core Measure records. For information related to correction of non-editable Core Measure data elements, see the Correction of Non-Editable Core Measure Data Elements in COMET, COG.COM.002.

PURPOSE: To define a standardized process for purging Core Measure records that do not meet the International Classification of Diseases, (ICD) population definition for the measure in accordance with The Joint Commission (TJC) Data Quality guidelines and the Centers for Medicare & Medicaid Services (CMS) Specifications Manuals.

POLICY: Core Measure records can only be purged in accordance with TJC's contractual agreement and CMS requirements. Consideration will be given to remove a record from Clinical Outcome Measure Evaluation and Transmission (COMET) when it does not meet the criteria for inclusion. The HCA Healthcare Clinical Services Group (CSG) Clinical Analytics (CA) Department can approve a facility's request to purge a record only if it meets the criteria for purging.

1. All purge requests must be:
   a. approved by the CSG Clinical Analytics Manager or designee;
   b. tracked within the COMET application; and
   c. supporting documentation for the purge request must be attached to the COMET purge record at the time the request is made (when indicated).
2. Missing or lost medical records do not meet criteria for deleting a record from the COMET database.
3. Records not meeting the ICD population definition and thereby meeting the criteria for purging from COMET are categorized as follows:
   a. Straddle cases: records which have fallen into a measure set with split Electronic Health Records (EHRs) and possibly split account numbers and/or claims. This occurs for accounts when a hospital is acquired mid-stay, a hospital location splits COIDs to reflect multiple sites for reporting and billing purposes mid-stay, a hospital transitions to a new EHR system mid-stay, or a hospital opens or closes a location or sub-unit with separate COIDs mid-stay. These Straddle (aka "cutover") accounts often result in split medical records in separate EHR systems limiting access for Abstractors, and can result in inaccurate Admission and Discharge dates affecting length of stay inclusions and exclusions.

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b. Duplicate Registration: Core Measure data must be abstracted for a single episode of care. When a record is in COMET more than once for the same episode of care, the case with the account number which reflects the care provided during that episode of care and in which charges are present (confirmed by Casemix) should be maintained in COMET and the additional record in COMET should be purged.

c. Pick List Inclusion Error: only Psychiatric visits in Distinct Part Unit (DPU) beds are included in the Hospital Based Inpatient Psychiatric Services (HBIPS) measures. Other bed types are excluded. Facility using “Pending HBIPS Patient” tool in COMET (aka “Pick-List”) should use this purge reason to identify when a selection was made in error.

d. Exempt Status: COMET sources data from the Casemix database that includes all acute care and non-acute care admissions (e.g., Skilled Nursing Facilities, Swing Bed, Residential Psychiatric Units, Inpatient Rehabilitation Facilities, or Hospice). Non-acute care patients are excluded from the ICD population of Core Measures. When the care was provided in a unit which is exempted from Core Measures, the entire record should be purged from all of the Core Measure sets.

   i. Exempt Status Types within the request screen include: SNF (Skilled Nursing Facility), LTC (Long Term Care), Rehab/IRF, Hospice, and Swing

e. Incorrect Status: Each Core Measure has defined criteria for inclusion of a record in the ICD population. COMET sources data from claims data in the Casemix database. A variety of other factors can result in a record falling into a measure set for which it does not meet the ICD population. When this occurs, in order to meet TJC and CMS requirements to include only records meeting the population definitions, the record must be purged. Records for services provided in an outpatient level of care (e.g., Same Day Surgery, Emergency Department, Endoscopy, Cath Lab, Radiology) are specifically excluded from all Hospital Inpatient (INP) and Hospital Based Inpatient Psychiatric Services (HBIPS) Core Measures. Records final-billed with INP Status are specifically excluded from all Hospital Outpatient (OP) Core Measures. Records final-billed under the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) are excluded from INP and OP Core Measures by CMS. Exception: Records final billed under the IPF PPS may still be required by TJC depending on the measure set.

   i. Incorrect Status Reason Types within the request screen include:

      a. Incorrect Status INP to OP Measure-records final billed under IPPS are excluded from Outpatient Core Measures

      b. Incorrect Status Psych in Medical Measure-Inpatient Psych stays are billed under IPF-PPS, not IPPS and those cases are excluded from Medical Core Measures

c. Incorrect Status Medical in HBIPS- records final billed under IPPS are excluded from HBIPS Core Measures which only includes inpatient Psych stays billed under IPF-PPS

d. Incorrect Status non-DPU in HBIPS- HBIPS Core Measures only includes inpatient Psych stays in a Distinct Part Unit (DPU) bed billed under IPF-PPS. Non-inpatient psych stays i.e. Adolescent/Residential, Alcohol or Chemical Dependency Units are excluded.

f. "Billing": COMET sources data from the Casemix database that includes all levels of care. Each Core Measure set defines the population it should include and is specific to the level of care in which the services were provided. Billing Guidance for certain outpatient and inpatient charges includes protocols for "combining" or "splitting" charges for certain outpatient and inpatient services billed to Medicare and other insurance providers. Ultimately, per CMS Guidance, Core Measures are abstracted "as billed." Once a patient is admitted to inpatient status, the case is excluded from the outpatient measures regardless of if there are also outpatient charges on the account. These cases should be purged from outpatient measures. Scenarios and billing guidance further defined below:

i. Incorrect status related to billing reasons within the request screen include:

a. Continuous Stay

b. Split billing-certain third-party payer contractual agreements (e.g., TriCare, Medicare Part B) which requires split billing for a single episode of care into separate outpatient and inpatient claims for billing purposes.

c. 3-Day (72 hour)- Under the Medicare payment window policy, a hospital must include on the claim for a beneficiary's inpatient stay, the diagnoses, procedures, and charges for all outpatient diagnostic services and admission-related outpatient nondiagnostic services that are furnished to the beneficiary during the 3-day (or 1-day) payment window.

d. Referred (often identified as REF, Shell, ZZZB, ZShell, ancillary acct) is created for billing only to separate charges for certain services considered as outpatient to a separate outpatient account with outpatient claim.

e. Recurring Visit-certain payer contracts require charges for outpatient recurring visits (i.e. wound care, infusion, radiology, dialysis, chemotherapy, etc.) to be combined with any Emergency Department (ED) visit occurring within 30 days of the recurring account. These accounts are commonly and mistakenly entered as purge requests. After verifying the account in Casemix, these are usually denied for purge and recommendation is for the account to be abstracted.

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f. Merged/Combined- certain payer contract require charges for an ED visit to be combined with any ED visit occurring within 30 days of the other account. These accounts are commonly and mistakenly entered as purge requests. After verifying the account in Casemix, these are usually denied for purge and recommendation is for the account to be abstracted.

g. Other: Other scenarios not fitting the above criteria will be addressed using this purge reason type

i. One example includes OP-Endo cases with CPT modifier code added. There is no 'code correction' field in the tool specific to modifier.

4. The record will remain in open status until it is either approved or denied and completed in COMET.
5. Purging a Core Measure record could result in the addition of another case being added during the normalization process. Normalization is a monthly process conducted within the COMET application to ensure that a facility meets the population requirements due to the decision to sample their Core Measure population. If another case is added into the sampling population, the routine abstraction process must be followed.

PROCEDURE:

Abstractor Responsibilities

1. The COMET abstractor or designee will complete the COMET Record Purge Request within the COMET application.
2. Within the data abstraction screen for the patient, the COMET abstractor will link to a request entry screen in which they will indicate the measure sets(s) from which the record should be purged.
3. The requester will note the purge request Reason category (Straddle, Duplicate Registration, Pick List Inclusion Error, Exempt Status, Incorrect Status, Continuous Stay, Split, 3-Day, Referred, Recurring Visit, Merged/Combined, or Other) and document the reason for the purge in the comments section.
4. The requester will attach a copy of billing, coding, or other medical record documentation that supports the need for the requested purge in the COMET Purge/Data Correction Tool attached to the COMET purge record (where indicated).
5. Purge requests submitted without receipt of the required supporting documentation will be denied.
6. Requestor will monitor for request approval or denial

a. Certain actions result in COMET record re-opening. Requestor must re-complete record in compliance with internal Open Records Policy

b. Denials: Requestor will be notified via email with rationale and necessary actions to take. Requestor is required to take recommended actions to adjudicate the record, including escalation if necessary.

All purge requests are subject to audit by Clinical Services Group (CSG) and Regulatory Compliance Support.

Corporate Responsibilities

The CSG Clinical Analytics Department will:

1. Review all COMET purge requests.
2. Document within COMET the final purge determination.
    a. When final determination is to deny the request, CSG-CA will directly notify the requestor via email and include rationale and recommended actions.
3. Monitor and trend all purge requests.
4. Maintain a record of purged cases within the COMET application, making it available to TJC, CMS, HCA Healthcare Internal Audit, and other oversight entities upon request.

REFERENCES:

1. The Joint Commission Data Quality Manual
2. CMS Specifications Manual for National Hospital Quality Measures