# Hospital Outpatient Quality Reporting (OQR) Program 2017 Specifications Manual Update

## Presentation

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**Pam Harris:** Hello, and welcome to the 2017 Specifications Manual webinar. Thank you for joining us today. My name is Pam Harris, Project Coordinator for the Hospital OQR Program.

Our presenters today incorporate the different measure writers for the Outpatient Quality Reporting Program 2017 Specifications Manuals. We are very fortunate that they are here today sharing their knowledge.

Our first speaker today is Colleen McKiernan, Senior Consultant at the Lewin Group; followed by Jennifer Witt, Senior Health Informatics Solutions Coordinator at Telligen; Marianna Gorbaty, Lead Program Analyst at Mathematica Policy Research; and Jackie Hudson, Project Lead for the Specifications Manual with the Hospital OQR Support Contractor. We invite you to view their biographies at the end of this presentation.

Before we begin today's program, I would like to highlight some important dates and announcements. January 1st, 2017 begins the submission period for the web-based measures entered through the QualityNet Secure Portal.

February 1st, 2017 is the submission deadline for Clinical Data and Population and Sampling for Quarter 3 2016. This will be for encounter dates from July 1st, 2016 through September 30th, 2016.

And as always, please be sure to keep your NHSN and QualityNet access active. The easiest way you can do this is by logging in to the NHSN and QualityNet Secure Portal at least every 60 days. As a reminder, these are two different platforms, and they do not speak to one another. They are completely separate and require separate registrations and password processes.

Please join us on January the 18th. We will be presenting a webinar geared for those who are new to the reporting for this program. On February 15th, we will present an overview of the validation process.

Any information regarding program updates or educational opportunities will be sent via ListServe. If you are not signed up for this automatic email service, you can do so at the QualityNet home page.

Now, without any further ado, let me turn things over to our first speaker, Colleen McKiernan. Colleen?

**Colleen McKiernan:** Thank you, Pam.

To begin, we will walk through changes made to Appendix A in versions 9.0a and 9.1 of the manual. Appendix A includes lists of codes, such as ICD-10 and CPT codes, that are used to identify patients eligible for inclusion in each measure. For versions 9.0a and 9.1 of the manual, all ICD-10 codes in this appendix were reformatted to remove the decimal points, which aligns to its formatting requirements in the Hospital OQR Program. The *ICD-10-CM Other Diagnosis Codes* and *ICD-10-CM Principal Diagnosis Code* data element in the manual reflect these formatting changes. The Web addresses used to access the online ICD-10 master code tables were also updated in these versions of the manual effective for encounters beginning on the 1st of October 2016.

Additional changes were made to Appendix A in version 9.1 of the manual. These updates impact reporting for Q4 encounters only and affect the ICD-10 codes used to identify the initial patient population for OP-18, which is Median Time from ED Arrival to ED Departure for Discharged ED Patients; OP-21, which is Median Time to Pain Management for Long Bone Fracture; and OP-23, which is Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT Or MRI Scan Interpretation Within 45 minutes of ED Arrival. The table for Appendix A impacted by these updates include Table 7.01, or Mental Disorders ICD-10 codes, which is used for OP-18; Table 8.0, or Ischemic and Hemorrhagic Stroke ICD-10 codes, which is used for OP-23; and Table 9.0, or Long Bone Fracture ICD-10 codes, which is used for OP-21.

These changes were made to align with the Fiscal Year 2017 ICD-10 code update released by CMS in August 2016, which impacts discharges and patient encounters occurring from the 1st of October 2016 through the 30th of September 2017. Collectively, 128 new codes were added and seven expired codes were removed across these three tables. These changes are effective as of the 1st of October 2016.

We will now transition to measure-specific updates made in versions 10.0 and 10.0a of the Hospital OQR Specifications Manual beginning with the five acute myocardial infarction, or AMI/Chest Pain measures. The Hospital OQR Program includes five AMI/Chest Pain measures: OP-1, which is Median Time to Fibrinolysis; OP-2, which is Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival; OP-3, which is Median Time to Transfer to Another Facility for Acute Coronary Intervention; OP-4, which is Aspirin at Arrival; and OP-5, which is Median Time to Electrocardiogram.

No changes are made to the measure information forms or data elements for OP-1 and OP-2 in versions 10.0 and 10.0a of the Specifications Manual.

Over the next few slides, I will review updates to the MIF and data elements for OP-3, OP-4, and OP-5. The *Reason for Not Administering Fibrinolytic Therapy* data element collected for OP-3 was updated in version 10.0 of the Specifications Manual. For this data element, the Notes for Abstraction include new guidance that clarifies the type of documentation that is sufficient to select allowable value 1, which indicates that there's a documented reason for not administering fibrinolytic therapy.

Also for the *Reason for Not Administering Fibrinolytic Therapy* data element, we've removed one bullet about the reasons and contraindications for not administering fibrinolytic therapy, replacing it with more specific information about appropriate documentation necessary to abstract the value of 1. In this update, we clarified that it is acceptable to abstract the value of 1 if a clearly documented reason is listed under the Inclusion Guidelines for Abstraction in the patient's emergency department record.

A second bullet was added to the Notes for Abstraction section of the *Reason for Not Administering Fibrinolytic Therapy* data element to clarify that if a reason for not administering fibrinolytic therapy is not listed under the Inclusion Guidelines for Abstraction in the patient's ED record, but that there is clear documentation by a physician, advanced practice nurse, physician assistant, or pharmacist that links this reason to a provider's decision to not administer fibrinolytic therapy, then the abstractor may also select the value of 1 for this data element.

The next data element we will discuss is *Transfer for Acute Coronary Intervention*, or ACI, which is also collected for OP-3. For this data element, the Notes for Abstraction were clarified to indicate the type of documentation that is sufficient to select the value of 1, which indicates that there is documentation the patient was transferred from one facility's ED to another facility for ACI. A new bullet was also added to clarify that the Inclusion Guidelines for Abstraction does not contain an all-inclusive list. If an ACI is described in the patient's ED record using a word or phrase not explicitly listed in the Inclusion Guidelines for Abstraction for this data element, but ACI is a defined reason for the patient's transfer, an abstractor may select the value of 1 for this data element.

The *Aspirin Received* data element is collected for OP-4. In version 10.0 of the Specifications Manual, a bullet was added to the Notes for Abstraction section of this data element to clarify the type of documentation that is sufficient to select the value of Yes, which indicates that aspirin was received within the 24 hours preceding the patient's ED arrival or was administered in the ED prior to a patient's transfer. This change was made in response in stakeholder feedback and aims to decrease the abstractor burden. On slide 18, we provided the verbatim text that is included in version 10.0 of the Specifications Manual for this change to the *Aspirin Received* data element.

The electrocardiogram, or *ECG*, data element is collected for OP-5. Updates to this data element affect the Notes for Abstraction in version 10.0 and incorporate feedback from an expert panel convened by CMS' contractor on pre-hospital ECGs. The new guidance for this data element instructs abstractors to select the value of No for *ECG* if it's pre-hospital ECG. That is an ECG performed prior to a patient's arrival at the ED that cannot be confirmed as a 12-lead ECG based on EMS documentation or on the ECG readout. If, however, there is documentation of an ECG performed in the ED that is an ECG performed after a patient's arrival to the emergency department that is not explicitly documented as a 12-lead ECG, the abstractor may select Yes for the *ECG* data element.

OP-4 and OP-5 uses the *Probable Cardiac Chest Pain* data element. For version 10.0 of the Specifications Manual, we have revised the guidance for its exclusion terms. Abstractors may select Yes to this data element, even if there is documentation of an exclusion term, if there is also a documentation of a differential or a working diagnosis of AMI. With the addition of this new bullet, we have revised other sections of the existing guidance to reduce redundancy and help clarify words or phrases that have similar meaning to those already listed as exclusion terms that can be considered as an exclusion.

Moving on to updates to the six Outpatient Imaging Efficiency, or OIE measures. The Hospital OQR Program includes six OIE measures: OP-8, which is MRI Lumbar Spine for Low Back Pain; OP-9, or Mammography Follow-Up Rates; OP-10, which is Abdomen Computed Tomography or CT – Use of Contrast Material; OP-11, which is Thorax CT – Use of Contract Material; OP-13, or Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac, Low-Risk Surgery; and OP-14, or Simultaneous Use of Brain CT and Sinus CT. Version 10.0 of the Hospital OQR Specifications Manual includes the measure name and description on the measure information form for each of the six OIE measures.

Within versions 10.0 and 10.0a of the manual, no changes are made to the measure information form for OP-8, OP-9, OP-10, OP-11, OP-13, or OP-14. More information about the OIE measures can be found on QualityNet at the link provided on the screen.

Updates for three of these measures, however, will affect public reporting for the OIE measures beginning in July of 2017. For OP-10 and OP-11, we have added one exclusion: non-traumatic aortic disease. For OP-13, we've added

one imaging modality: cardiac computed tomography angiography. Updates to the OP-10 and OP-11 specifications were made based on changes to the American College of Radiology appropriateness criteria recommendations. Updates to OP-13 were made to harmonize specifications with another measure evaluating cardiac imaging. More details about these updates will be published on QualityNet in early 2017.

The next set of measures we will review are the ED-Throughput measure set. The Hospital OQR Program includes three ED-Throughput measures: OP-18, which is Median Time from ED Arrival to ED Departure for Discharged ED Patients; OP-20, or Door to Diagnostic Evaluation by a Qualified Medical Professional; and OP-22, which is Left Without Being Seen. No changes are made to the master data elements for OP-18, OP-20, or OP-22 in versions 10.0 and 10.0a of the Specifications Manual.

Next, we will discuss the Pain Management measure. The Hospital OQR Program includes one Pain Management measure, OP-21, which is Median Time to Pain Management for Long Bone Fracture. No changes are made to the measure form or data elements for OP-21 in versions 10.0 and 10.0a of the Specifications Manual.

The Hospital OQR Program includes one Stroke measure, which we will review next. OP-23, which is Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 Minutes of ED Arrival. It's the single Stroke measure included in the Hospital OQR portfolio. Over the next few slides, I will review updates to its MIF and data elements in versions 10.0 and 10.0a of the Specifications Manual.

Slide 31 shows updates to the measure information form for OP-23 made in version 10.0a of the Specifications Manual, which were made in response to NQF stakeholder feedback. This change emphasizes that head CT and MRI scan results should be interpreted as soon as possible. It does not alter the clinical intent, specifications, or abstraction guidance for the measure.

The Notes for Abstraction for the *Last Known Well* data element were updated in version 10.0 of the Specifications Manual, adding one bullet to provide guidance to facilities on how to abstract unknown, uncertain, or unclear values for documentation of *Last Known Well*. The second bullet was revised to clarify instructions on strokes that occur after a patient arrives at the hospital.

These changes are based on stakeholder feedback and represent an effort to harmonize measure guidance for the stroke measure included in the Hospital OQR Program. Additional information on these updates follows over the next few slides.

The first addition to the *Last Known Well* data element emphasizes that there must be explicit documentation using terms such as unknown, uncertain, or unclear that a patient's time last known well is not known in order for abstractors to select the value of No for this data element. The same guidance also applies to documentation of a patient's symptom onset. Abstractors should not make inferences such as assuming that a patient woke with a stroke so his or her value for *Last Known Well* would be unknown if there is no supporting documentation to substantiate the assumption.

The second update to the *Last Known Well* data element revised its guidance on in-house strokes. As OP-23 is an outpatient measure, strokes that occur after a patient arrives at the hospital should not be included as part of the measure population. So, for example, if a patient presents to the ED with non-stroke symptoms such as a broken bone or abdominal pain and then experiences a stroke while in the ED waiting for care for the original presentation, the *Last Known Well* value should be abstracted as a No. If, however, there is documentation of a patient experiencing symptoms of a stroke before he or she arrives at the hospital and then a second stroke episode occurs while in the ED, information about the pre-hospital stroke should be used by abstractors for the OP-23 data elements including *Last Known Well*.

The next series of slides will summarize updates for the *Date Last Known Well* data element, which is also collected for OP-23. In version 10.0 of the manual, we made several changes to clarify guidance on how to abstract unknown, uncertain, or unclear values for documentation of a *Date Last Known Well*. We also added general information about Code Stroke Forms. For this update, seven examples of Code Stroke Forms were added to the Inclusion Guidelines for Abstraction section. Another two examples were added to the Exclusion Guidelines for Abstraction. Here, we have provided a text that has been added to describe Code Stroke Forms in response to a series of stakeholder inquiries. To clarify, a Code Stroke Form can be used by a stroke team or ED staff to document information about a patient's acute stroke. Although we provide a list of acceptable terms for Code Stroke Form, we have added guidance to note that this is not all inclusive. Finally, we

clarify that the Code Stroke Form may be completed by a nurse or other authorized member of the care team.

Slide 37 provides seven examples of different Code Stroke Forms that have been added to the Inclusion Guidelines for Abstraction for the *Date Last Known Well* data element. These examples include the Stroke Activation Form, the Stroke Alert Form, the Assessment Form, the Stroke Intervention Form, the Stroke Rapid Response Form, the Thrombolysis Checklist, and the Tissue Plasminogen Activator, or TPA, Eligibility Form.

Here, we've listed two examples of Code Stroke Forms that are not acceptable based on feedback from an expert panel convened by CMS' contractor. The two forms added to the Exclusion Guidelines for Abstraction are the Stroke Education Form and the Core Measure Form.

Several updates were made to the *Time Last Known Well* data element in version 10.0 of the Specifications Manual. First, the Notes for Abstraction section was updated to clarify guidance on how to abstract unknown, uncertain, or unclear values for documentation of a *Time Last Known Well*. Three bullets were also added to this section to provide additional information on Code Stroke Forms.

In alignment with updates made to the *Date Last Known Well* data element, we've provided seven examples of potential Code Stroke Forms to the Inclusion Guidelines for Abstraction and added two examples of Code Stroke Forms that are not considered appropriate documentation to the Exclusion Guidelines for Abstraction.

A series of exceptions were added to the Notes for Abstraction for the *Time Last Known Well* data element which harmonize guidance with the Hospital IQR Stroke measure. First, we note if any physician, advanced practice nurse, or physician assistant documents the patient's last known well or onset of signs and symptoms of the stroke as unknown, uncertain or unclear, this documentation should take precedence over a specific time recorded on a Code Stroke Form. Next, we have added a bullet that provides guidance for abstracting *Time Last Known Well* if a documented time has been crossed out and replaced with a specific time or if there is documentation of a specific time on a separate Code Stroke Form. Abstractors often see guidance to help select the appropriate *Time Last Known Well* when there are multiple values in the patient's ED record. We have updated our guidance to instruct abstractors

to select a specific *Time Last Known Well* if one is available on a Code Stroke Form. A time range or estimate can also be used in the absence of a specific time. We then ask abstractors to refer to the Guidelines for Abstraction when multiple documented times last known well exist if there are multiple specific times on the same or different Code Stroke Forms. One common example is if the last known well and symptom onset time were documented, we instruct abstractors to select the time last known well. Finally, we have added guidance to clarify that if you are unable to determine if a form is a Code Stroke Form, abstractors should continue to review the patient's ED record for documentation of time last known well in other sources, such as in the EMS record, or included in the physician notes.

Slide 41 provides a text that has been added to describe Code Stroke Forms to the *Time Last Known Well* data element in response to stakeholder feedback. As we previously noted in this presentation, a Code Stroke Form is used by a stroke team or ED staff to document information about a patient's acute stroke. Although this Specifications Manual provides an inclusion list of acceptable terms, we note that this was not all inclusive. We have also clarified that a Code Stroke Form can be completed by a nurse or other authorized member of the care team. The final change we have made for the *Time Last Known Well* data element is to add a bullet that provides guidance for abstracting *Time Last Known Well* if the time is noted to be less than a period prior to ED arrival. In this case, abstractors should assume the maximum range of time since last known well. So, for example, if there is documentation that a patient's time last known well is less than one hour ago, abstractors should subtract one hour from a patient's time of arrival to compute his or her *Time Last Known Well.*

And with that, I will turn it over to Jennifer Witt to walk us through the next portion of the presentation. Jennifer?

**Jennifer Witt:** Thank you, Colleen. My name is Jennifer Witt, and I'm a Senior Health Informatics Solutions Coordinator with Telligen. And now, we will discuss the web-based measures.

No changes were made in manual versions 10.0 and 10.0a for OP-12, OP-17, and OP-25. There were also no changes made for OP-26. As a reminder, Table 1, which contains the categories and procedure codes for outpatient surgical procedures, is updated in November of the calendar year that the manual covers, in this case, 2017.

The only change for OP-27 is in version 10.0a, and it's a clarification to better align the measure information form with the NHSN training materials. There are three required denominator categories for reporting healthcare personnel influenza vaccination data: employees, licensed independent practitioners, and adult students/ trainees and volunteers. The fourth category noted, other contract personnel, was not initially included in the definition as this category is not required to meet reporting requirements, but facilities can submit this data if desired. The measure information form for version 10.0a will now reference all four denominator categories. Please remember that the flu vaccine measure is entered into the NHSN online submission tool, not the QualityNet submission tool.

Under the denominator exclusions for OP-29, the following sentence was added: "Documentation indicating no follow-up colonoscopy is needed or recommended is only acceptable if the patient's age is documented as the reason." In version 10.0a, please note that "Endoscopy/Polyp Surveillance" was removed from the performance measure name to better align with the NQF-endorsed version of this measure.

For OP-30, code Z85.038 was removed from the denominator criteria. In version 10.0a, "Endoscopy/Polyp Surveillance" was removed from the performance measure name to better align with the NQF-endorsed version of this measure.

I will now turn the presentation over to Marianna. Marianna?

**Marianna Gorbaty:** Thank you, Jennifer. My name is Marianna Gorbaty. I'm a program analyst with Mathematica Policy Research.

Today, I will discuss the updates to two measures: OP-31, Cataracts - Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery; and OP-32, Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy.

And for OP-31, the update is real quick. There are no changes to the measure specifications, and we'll proceed to the discussion for OP-32.

CMS introduced OP-32, Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy, in the Outpatient Quality Reporting Program in

the 2016 calendar year. In versions 9.08a and in 9.1 of the OQR manual, in the introduction to the measure information form, we included the NQF, National Quality Forum, measure number for OP-32, which is 2539, and we also added to the 2015 Measure Specifications Report, and the 2016 Measure Updates and Specifications Report. This report details the measure methodology.

In the following slides, we will go over the version-specific updates applicable to version 9.0a, 10.0, and 10.0a of the OQR manuals. This slide lists the section of the measure information form that the changes applied to versions -- in version 9.0a and subsequent versions.

In version 9.0a, the updates include the Denominator Statement of -- changes to the Denominator Statement language, Included Population section, and Cohort Exclusions section of the MIF. In version 9.0a and the subsequent versions of the MIF, we updated the Denominator Statement to: "The target population for this measure includes low-risk colonoscopies performed in the outpatient setting for Medicare Fee-For-Service patients aged 65 years and older. For implementation in the OQR Program, the measure will be calculated among hospital outpatient departments, HOPDs." We italicized the specific language update on the slide; we tell specific updates on the language.

We updated the language in the Included Population section. The updates again are italicized on this slide. The updated second paragraph now reads: "The measure is focused on low-risk colonoscopies. The measure did not include colonoscopy CPT procedure codes that reflected fundamentally higher-risk or different procedures. Qualifying colonoscopies billed with a concurrent high-risk colonoscopy procedure code were not included in the measure; the 2016 Measure Updates and Specifications Report at the link above contains the complete listing of all high-risk procedure codes." So, the actual links to the statement that references this Specifications Report is provided in the introduction section to OP-32. And we also mentioned this Specifications Report earlier in the presentation on slide 15.

The next three slides summarize the updates to the Cohort Exclusions section of the MIF that applies to version 9.0a and subsequent versions. The first change is the updated third bullet in the Cohort Exclusions section which now states: "Colonoscopies for patients with a history of inflammatory bowel disease, or IBD, or diagnosis of IBD at the time of index colonoscopy, or on a

subsequent hospital visit outcome claim." And again, we italicized the specific change on the slide.

We updated the language in the fourth bullet of the Cohort Exclusions to: "Colonoscopies for patients with a history of diverticulitis with diagnosis of diverticulitis at time of index colonoscopy or on a subsequent hospital visit outcome claim."

We changed the language in the last two bullets of the Cohort Exclusions section of the MIF specifying the exclusion of colonoscopies that are billed on the same hospital outpatient claim as an ED visit and that are billed on the same hospital outpatient claim as an observation stay.

We added a bullet to the Cohort Exclusions that reads: "Colonoscopies that are billed on a separate claim on the same day and at the same time and at the same facility as an ED visit."

And we added a statement that: "The 2016 Measure Updates and Specifications Report contains complete coding for all exclusions." And again, as mentioned earlier, the link to the Specifications Report is included in the introduction to the OP-32 measure information form in the OQR Specifications Manual.

We've made further updates to the OP-32 MIF that applies to version 10.0 and subsequent versions of the OQR Specifications Manuals. These updates apply to the Cohort Exclusions sections, Tables 1 and 2, and to the risk adjustment section of the MIF. And this update that we are going to discuss now came from the removal of the ICD-9 codes from the measure information form.

For Table 1, we've removed the ICD-9 Diagnosis Codes column and updated the table name to: "Inflammatory Bowel Disease ICD-10 CM Diagnosis Codes." And we added a note that follows Table 1 referring the readers to version 9.1 of the OQR Specifications Manual for the ICD-9 diagnosis codes listed. Version 9.1 of the OQR manual is used for submitting data for encounters July 1st, 2016 to December 31st, 2016.

This slide summarizes Table 2 updates, as with Table 1. Since we removed the ICD-9 codes columns, we updated the table named: "Diverticulitis ICD-10-CM Diagnosis Codes." And we added notes referring the readers to

version 9.1 of the OQR Specifications Manual for the ICD-9 diagnosis codes listing.

This slide goes over the updates applicable to the Risk Adjustment section of the MIF in version 10.0 and subsequent versions. And for this section too, we've updated the language to reference the ICD-10 coding system. Specifically, with the updated narrative within the Risk Adjustment of the MIF now states: "The measure defines comorbidity variables using condition categories which are clinically meaningful groupings of the many thousands of ICD-10-CM diagnosis codes."

This slide discusses the updates to Table 1 of the MIF that apply to version 10.0a. Specifically, the ICD-10 codes listed in Table 1 were ending with an "X" to indicate that the exclusion applies to all diagnosis codes in a given group. We replaced the "X" with an asterisk sign since "X" could be confused with a part of the code. We also wanted to note that this change does not affect the underlying measure calculation logic. Following, we removed the wording: "without complications" from the relevant ICD-10 diagnosis codes descriptions, and we also removed the duplicate rows listing 51.8 and 51.80 codes, diagnosis codes as this duplication was only applicable in the 2016 versions of the MIF where we have the ICD-9 to ICD-10 mappings in the table.

We also would like to take this opportunity to state that the revisions to the OP-32 MIF, measure information form, did not change the definition of the outcome for this measure.

This concludes the overview of the updates applicable to OP-32, Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy.

And with that, I hand over the presentation to Jackie. Thank you.

**Jacqueline Hudson:** Thank you, Marianna. My name is Jackie Hudson, and I will be discussing the OP-33 measure with you.

For versions 9.0a and 9.1, OP-33 underwent revisions for denominator criteria, as well for denominator exclusions. Shortly after the introduction of OP-33, we found that the CPT codes provided on the measure information form were inaccessible to the hospital outpatient setting and, as a result, could not be used for the population for abstraction. Once this was noted, the

measure was updated with codes 77402, 77407, and 77412, which are available within the hospital billing systems and identify a population that has received at least one episode of radiation therapy.

In response to requests from the community, the measure writer provided additional clarification in regards to the denominator exclusions. The items on this slide were added to the measure information form in both versions 9.0a and 9.1 in an effort to improve the ease of abstraction.

After its first year in the Hospital Outpatient Quality Reporting Program, feedback from the community, along with ongoing review by the measure writer, ASTRO, has prompted changes that will be incorporated in to the OQR Specifications Manual version 10.0a for encounters starting January 1st of 2017.

In response to many questions that have come from the outpatient community regarding clarification of the term "painful," and as there is currently no standardized method or scale to differentiate painful and pain-free bone metastases, it was determined that this adjective be removed from the description, the numerator, and the denominator statements.

Additionally, as EBRT can be used as a treatment modality for metastases found in sites other than bone, a clarifying statement of: "for the treatment of bone metastases" will now be found in both the numerator and denominator statements.

To further support the end user, the measure writer has now included the statement: "The EBRT is used to treat anything other than bone metastases" as a distinct exclusion criteria, as the intent of this measure is external beam radiation specifically for the treatment of bone metastases. For the previous radiation treatment exclusion, the term "retreatment" has been added to assist abstractors in determining that this condition exists. The intent of this measure is to capture data on bone metastases that are receiving an initial radiation treatment; therefore, documentation of retreatment will support that this is not the initial treatment, and the case should be excluded.

In the version 10.0a of the Specifications Manual, you will also see that two of the exclusionary criteria have been merged to provide more specific guidance to the abstractors. In addition to the acronyms being fully spelled out, you will see that the clinical protocol or registry study exclusion has been further

defined by the statement involving the administration of radiation therapy, especially SRS or SBRT.

The measure writer has added this further clarification as SRS or SBRT should really only be seen as the initial treatment of a bone metastases when part of a clinical trial. The denominator exclusion regarding femoral axis cortical involvement for the clarification has now been provided indicating that this exclusion can only be applied if the current EBRT is to that femur. So, if you see an imaging report that indicates the patient has a left femoral axis cortical involvement greater than three centimeters, that the patient has received EBRT to the right hip, this exclusion would not apply.

Along with the other exclusion criteria, the surgical stabilization must be at the same anatomic site of the EBRT treatment in order to apply this as an exclusion. This exclusion has been updated to reflect this requirement.

Although initially thought to improve the ease and accuracy of determining the initial population for this measure, it has been found that using specific ICD-10 codes as exclusions may actually remove patients that do meet the criteria. For example, if a patient has a diagnosis of a radicular pain, but the radicular pain is related to an old injury and unrelated to the site of current EBRT administration, using the ICD-10 codes for this diagnosis would result in this patient being inappropriately removed from the population. In response to this finding, the measure writer has removed the specific ICD-10 codes from the measure information form; therefore, these exclusions may only be determined through chart abstraction.

In order to clean up the measure and provide the criteria that is most relevant, the Documentation of Patient Reasons section has been removed in its entirety. As the patients are pulled into this population by CPT codes that indicate they have received at least one radiation treatment, a patient's declination of treatment is no longer an applicable exclusion.

An Additional Instructions section was added to the MIF to assist the abstractor by providing direction to these frequently asked questions and common stumbling blocks encountered with regard to this measure. This section now provides guidance regarding abstraction of multiple encounters, as well as multiple anatomic sites.

Also found in the section is guidance on case inclusions regarding a treatment that only partially occurred in the outpatient environment in cases where the treatment plan was not completed.

Well, that's going to do it for me, so I'll go ahead and turn things back over to Pam.

**Pam Harris:** Thank you, Jackie. Thanks to all our speakers today. We really appreciate the time you have taken to go over the changes of the Specifications Manual.