Inpatient Quality Reporting Program

Support Contractor

External Beam Radiotherapy for Bone Metastases

Presentation Transcript

Moderator:
Deb Price

Speaker:
Henrietta Hight, BA, BSN, RN, CCM, CDMS, CPHQ
PCHQR Program
Hospital Inpatient VIQR Outreach and Education Support Contractor

Stephen T. Lutz, MD
American Society for Radiation Oncology (ASTRO) Guidelines Subcommittee Chair

Barbara Choo, RN, FMP, PhD
Program Lead of PCHQR
Centers for Medicare & Medicaid Services

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Deb Price: Hello, and welcome to the EBRT Webinar. Thank you for joining us today. My name is Deb Price, and I am the moderator for today's event. The first slide that you see shows you how to use our Q&A feature for today's event.

If you move your mouse over the WebEx navigation panel at the top center of your screen– it's a little green bar– and then you will drop down, like the menu you see on the first picture. Click the Q&A icon. The Q&A panel will display on your screen.

Then click the dropdown arrow next to Ask, further down at the bottom of that square. Select All Panelists, if you want all panelists to see your question. And then type your question in where you see the word, Type

questions here. When you're satisfied with your question, please hit the Send button.

I would like to introduce one of our guest presenters today. Dr. Stephen Lutz is a practicing radiation oncologist in Findlay, Ohio, who also holds Board Certification in hospice and palliative medicine. Dr. Lutz has authored dozens of palliative, radiotherapy manuscripts, book chapters and treatment guidelines.

He currently serves as the Chair of the American Society for Radiation Oncology Guideline subcommittee, and he was the first author of the ASTRO bone metastases guidelines, which became the most downloaded article from the International Journal of Radiation, Oncology, Biology and Physics since 2011.

He also served as the most recent Chair of the National Quality Forum cancer steering committee that accepted the bone metastases guidelines as the first ASTRO-sponsored NQS Quality measure.

And now our other speaker, Henrietta Hight, will begin our presentation. Henrietta?

Henrietta Hight: Thank you, Deb. Hello. This is Henrietta Hight. We would like to welcome everyone to today's webinar on External Beam Radiotherapy for Bone Metastases. We will refer to the measure simply as EBRT measure. Because that's a long series of words to say.

The topics we will be covering today are the following: the goals of the EBRT measure; the identification of the initial population and denominator; the identification of the numerator; the sampling methodology used, then an overflow of what we are calling completing the steps, where we'll bring the initial population; denominator and numerator together with an example; the

process for data collection; the CMS reporting requirements; and then some important reminders and resources.

During the webinar, Dr. Lutz and myself will be sharing the presentation. So we'll be switching back and forth. Also towards the end of the webinar, Barbara Choo (ph) will be sharing some information also.

Again, as we go through the webinar, please use the Q&A feature to post any questions that you have. Depending on available time, we will try to answer as many questions as possible. All questions and answers will be compiled into a transcript and posted, so that we can all benefit from the questions and answers.

And now let's look at the goals of the EBRT measure itself. There are four major goals here. The EBRT measure wants to address the measure application partnership, abbreviated MAP, priority of palliative cancer care. We also want to support the National Quality Strategy, NQS, domain of effective clinical care. Also the EBRT measures wants to reduce the rate of EBRT services overuse. And then lastly, support the CMS commitment to promoting patient safety.

So the overall goal of the EBRT measure is to report the percentage of patients, regardless of age, with a diagnosis of painful bone metastases and no history of previous radiation who receive external beam radiation therapy, EBRT, with an acceptable fractionation scheme as defined by the guideline.

Now, Dr. Lutz will provide additional information regarding the EBRT measure. Welcome, Dr. Lutz. Dr. Lutz, are you on mute? I don't know if Dr. Lutz has joined us. Nadine, are you there? Or Barbara Choo, are you there?

Barbara Choo: Hey, Henrietta. Can you hear me? This is Barb.

Henrietta Hight: Yes, Barb. We're going to go– Deb is going to go out and see if we can contact Dr. Lutz and Nadine from ASTRO, in case maybe they're experiencing some difficulties logging in. But I was in touch with Nadine this morning.

So for the sake of time, what I will do is I will continue with the slide, or the slides, until we're able to contact Dr. Lutz.

Deb Price: They're both on the WebEx. But they haven't called in yet.

Henrietta Hight: Oh, they're both on the WebEx. But they haven't called in yet. Let me go ahead and do the next few slides. And then if Dr. Lutz, when he gets on, he needs to go back and add any additional information, since he's the subject-matter expert. That will be fine.

Okay. Looking additionally at the EBRT measure and its associated goals; the components of the EBRT goals include usage issues. However, they want to identify performance gaps in treatment variations, it wants to ensure the appropriate use of EBRT, and also to prevent the overuse of radiation therapy.

Components of the EBRT goals also include patient considerations. This includes addressing patient preferences for shorter EBRT schedules, and then also to ensure patient safety. Given that shorter treatment courses showed similar or fewer side effects, while producing similar clinical outcomes.

Stephen Lutz: Hey, this is Steve. Can you guys hear me now?

Henrietta Hight: Yes we can.

Stephen Lutz: You know what's interesting is I could hear everything going on, but somehow it wasn't letting us talk. So I would just say you're doing a good job, and I was just going to give a couple of just brief comments of background.

For the previous slide, in terms of identifying performance gap and treatment variation, it really wasn't that many years ago that a study was done, just a simple survey of those folks around the world, asking them what scheme they used fractionation-wise to treat bone metastases. And there was 101 different answers.

And so one of the things we were tasked with was to find in the guidelines a way if we could look over the data, and see what had been evaluated. And actually really in about 25 prospective trials, it had been shown that there was equivalency of a certain set of fractionation schemes. And so that's how we ended up where we are.

And one of the benefits to some of these schemes is that they're shorter, easier on patients and caregivers, and short-term side effects are actually less likely. So it wasn't just finding out there was variation, it was discovering that there were four equivalent schemes, and that they were shorter than had been used by a lot of the other practitioners.

So then in terms of specifications for the denominator, all patients with painful bone metastases and no previous radiation therapy to that same site. In terms of exclusions, that includes patients who have had previous radiation to that site; those that have a lesion that's greater than 3 centimeters on the femur because that can be associated with a higher risk of pathologic fractures, so that's an exclusion; those who have undergone a surgical stabilization procedure, because there may be other issues that come into play which complicates things; or those that have spinal cord compression or compression of the cauda equina, or things that might lead

to surgery; certainly just leaving out what we consider to be in terms complicated bone metastases patients.

So on the next page there is sort of an algorithm of how to consider things, and really it's just following what we already discussed. So even though there's tiny little print, all it does if you look, is it makes common sense.

So if a patient has diagnosis with bone metastases and has pain, then the prescription for the external beam is given for that specific reason. I think we had a comment just to make about some of the CPT codes, if I wasn't mistaken, was there–?

Henrietta Hight: Yes. Dr. Lutz and I was discussing this the other day. CMS is in the process of moving from the ICD-9 codes to the ICD-10 codes. It's anticipated that change will take place starting with fourth quarter 2015. So starting with October 1, 2015. So yes, the diagnosis code of 198.5 for secondary malignant neoplasm of bone and bone marrow that will be changing. And we'll certainly keep you informed on that. And there may be some changes to the current procedural terminology, CPT codes.

Before we go through the algorithm, just a couple things. We understand. We know that this slide is very hard to read. We did, when you registered for the slides, we did send on the website, not only the slides, but also some handouts. And when you're sitting at your computers and you're looking at the handout, just a little hint. If you go up to the top of your computer and you change it from 100% to 125% or 150%, it will make the slides or the handouts a lot easier to read. And then you can also print them out in that version-sized format.

I mean I had to do it, because I couldn't read the handouts and the slides, even with my glasses.

Okay. So let's look at the algorithm together. Dr. Lutz and myself are going to kind of go through it together, and explain a few things.

Dr. Lutz, would you like to get started?

Stephen Lutz: (Inaudible). So really it's just a way of putting an algorithm of what we had mentioned in the previous slides. So if the patient does not have any the exclusion criteria. So if they have a bone metastases diagnosis, receive a prescription for external beam radiation, have no previous radiation to that same site, do not have that lengthy lesion in the femur, have not had a previous surgical stabilization, and don't have any spinal cord compression or other reason where surgery might need to come first, then if there's no exclusions, they can be considered in the denominator for this measure.

Henrietta Hight: So just like– when you're going through an algorithm, just think you're answering this question. And the way the algorithm is set up you answer each question yes or no, and your answer is going to determine whether the case is included or excluded from the population.

So if you answer yes, you just continue on down through the algorithm. If you answer no, going off to the right, based on that no answer that case will not be included in the population for the denominator.

Okay. Dr. Lutz, I think–

Stephen Lutz: I think that's good. And I think you were going to help us with the next one. Because I think there's some things that you have a little bit more knowledge of in terms of the flow there.

Henrietta Hight: Okay. The next slide is an algorithm just like we saw, but it has some examples of how you would answer the questions, and then what would be the result of your answer of either yes or your answer no. And again, this is

just an example. The numbers that are provided are just to give you a feel for how things flow.

So let's look at the algorithm for the initial population and denominator with the example. And remember, as we go through the example, the cases that have an answer of yes are included in the population. And we've kind of put that number, the resulting number, over just to the right of the diamond, right about the line.

If you look all the way over to the right, you have some cases with numbers. And those are the cases that because you answered no to the question, are excluded from the population and the denominator.

So based on your first question, diagnosis; did the patient have a diagnosis of bone metastases during the measurement period?

Okay, you started off with an initial population of 1500 cancer patients. I jumped ahead a little bit. I apologize. So we want to find out of those 1500 cancer patients, how many of them are going to fit in with– will have a yes answer to our first question.

So our first question is, did the patient have a diagnosis of bone metastases during the measurement period? And you're going to be looking at Table 1, which is your diagnosis code over there on the left.

If your answer is yes, then 400 of those patients have a yes answer that they were diagnosed with bone metastases. There were some patients that answered no, who answered no to that question. And in our example, the result is 1100 patients had an answer of no. So they're excluded from the denominator.

Your next question is, does the patient have a prescription for EBRT? And if you look over to the left under the CPT code table, there are the three

codes, the CPT codes, that you could use or you would use to determine whether you answer yes or no to that question.

To answer that question, 350 of your patients– remember you had 400, now you answered the next question. 350 out of the 400 did have a prescription for EBRT. 50 patients didn't. So they're excluded.

Your next question that you need to answer either yes or no is did the patient have a history of previous radiation therapy to the same anatomic site? If you answer no, you have 275 patients who had no history of previous radiation therapy to the same site. And again, think about the inclusions and exclusions that Dr. Lutz reviewed.

Then we go down to the next question. Did the patient not have a femoral axis cortical involvement more than 3 centimeters in length? The answer to that question, 220 of your patients had no femoral axis cortical involvement more than 3 centimeters in length.

So now you're down to a denominator of 220 cases, and 55 of your patients were excluded.

The next question is whether or not the patient did not undergo a surgical stabilization process. In this situation you had 215 that did not undergo a previous surgical stabilization process. So now your denominator is down to 215, with five patients excluded.

These questions are kind of like double negatives in a way. Okay. Then the next question, is there a spinal cord or cauda equina compression or radicular pain? In your situation, you had 150 cases where they did not have any spinal cord or cauda equina compression or radicular pain. So now you're down to 150 patients in your denominator. 65 patients were excluded.

And then your next question, whether or not there was no specific patient reasons for not having EBRT treatment. You have 125 patients who had no specified patient reason for not receiving EBRT. And there were 25 patients who did have a reason. So now you're down to 125 cases that remain in your denominator population.

So next we'll let Dr. Lutz explain the specifications for the numerator.

Stephen Lutz: All right. So specifications for the numerator; we'll assess the percentage of patients, both Medicare and non-Medicare, with painful bone metastases and no history of previous radiation therapy who receive an acceptable dose schedule of external beam radiation.

So I had alluded earlier to the four different fractionation schemes that we found in the guidelines should be equivalent for pain relief. If you're not familiar with radiation oncology, the capital G small y is reference to dose, based upon the man who discovered it, Gray, and the fxns is the number of fractions or treatments.

So any of these four treatment schedules are considered equivalent to be acceptable for pain relief. So 30Gy/10fxns, 24GY/6fxns, 20Gy/5fxns, or 8Gy/fxn. So anyone that meets those fractionation schemes is considered part of the numerator.

So if we look again at the next slide that basically is an algorithm which simply puts into a decision tree what we've already read or looked at in the previous slide, again diagnosis of bone metastases, prescribed with radiation. And if the patient received one of those four fractionation schemes, then they fit in the numerator measure population. And if not, they don't.

So essentially, from 30,000 feet, fairly easily understood, especially the numerator part. If they got one of those four fractionation schemes, fine. Anything else, they don't count as part of the numerator.

So I think we have, I think maybe an example on the next sheet. You can show folk how that would go.

Henrietta Hight: Yes. So picking up where we left off, when we went through the algorithm for the denominator, remember we ended up with 125 cases in the denominator. Over on the right-hand side is what Dr. Lutz just referred to, but with some numbers put it in.

So in our example, there were 125 cases in the denominator. There were 25 cases in the numerator, based on the sample size. And we'll be looking at numerator population and sample size in a few minutes. Out of the 25 cases in the numerator, three patients did not meet the EBRT criteria.

And again, I know this is small. It's hard to read. But again, when you get back to your desk, if you take the handout that we sent you, and enlarge it to 125-150% or maybe 200%, you'll be able to make it out much clearer.

We had to kind of squeeze some of these algorithms onto one slide, so they would flow well.

So as a result, and regard to the EBRT measure in our example, 22 cases let's say passed the measure for a percentage of 88%. And we know there are going to be probably questions about the population sampling methodology. Again, please submit your question using the Q&A function. And also we're talking about some planning regarding additional training in 2015 for the whole approach for population and sampling.

So if you send us your questions, based on this webinar, we'll be in a better position to plan our different training.

Next this is the data collection tool developed by ASTRO. And again, it's helping you looking at your records, at your patients, to determine number one, to answer the questions. You're confirming the bone metastases diagnosis. So determine if the patient had a documented diagnosis of painful bone metastases, and no previous radiation to that anatomic site, and was prescribed external beam radiation therapy.

Simply you answer yes, or you answer no, or not documented.

Then you're looking at the information regarding bone metastases, and what scheme of EBRT treatments did they receive. So you're going to determine if the patient with painful bone metastases was prescribed either EBRT with any of the following fractionation schemes.

And I have to admit. I asked Dr. Lutz, what does the Gy stand for? So he explained it to me. It was the man's name, Mr. Gray.

So what you're going to do is you're going to either answer yes, or no not documented, or no medical reasons contained in the medical record. And then if the patient has reasons for not undergoing EBRT, you will include exactly what the patient said.

The next slides will help you. There are a couple slides that will help you as a resource to go through answering the questions and completing the data collection tool. I won't go through it page by page, but again, this is something you can refer to when you start with first quarter 2015, going through your records for your patients, and starting to collect your data on the EBRT measure.

Okay. Next, let's look a little bit more on the sampling methodology. CMS has finalized a sampling methodology that is consistent with the sampling

methodology standards that have been finalized for the Oncology Care Measures and the SCIP measures.

So again, we will be planning some training providing some more information regarding the sampling methodology. And then CMS will also incorporate this EBRT sampling methodology into the next feasible regularly scheduled PCHQR specifications manual, which happens on a semi-annual update schedule.

Okay. Just a little bit more about the sampling methodology; the purpose of the methodology is to allow for different numbers of cases to be reported, based on each PCH cancer patient population size. So from talking to the different PCH contacts, I know some of you have more beds, more patients. And some of you have a smaller number. So the sampling methodology does accommodate bedside variations among the PCHs with a PCH that has 20 beds, up to more than 250 beds.

One of the purposes of the sampling methodology is to decrease the reporting burden on the PCHs, while also producing reliable measure rates. So let's look at the population and sampling grid for the EBRT measure. And this is a screen shot. It comes directly from the final rule for 2015, fiscal year 2015. Note that those of you who participated in the webinar back on October 30th, where we talked about the final rule for 2015, you'll probably notice that the EBRT population sampling numbers are the same as for the oncology care measure population and sampling.

You will notice that both measures use the same initial population size and associated minimum sample size. So what you will do on a quarterly basis, you will determine what your initial patient population was. If it's less than 10, your sampling– there's no sampling. You'll be reporting on 100% of the initial patient population.

If your quarterly initial patient population is 10 to 50, then you're going to report a minimum– these are minimum– a minimum of 10 cases. If your initial patient population is 51 to 125, then you're going to report on 20% of initial patient population. If your initial patient population is more than 125, then your minimum sample size is going to be 25.

And I know Deb is sitting here and she's paying attention to me–

Deb Price: Oh no, you're not going to do that.

Henrietta Hight: So Deb?

Deb Price: 10% right, of 125?

Henrietta Hight: No. You're jumping ahead. Deb, if my average quarterly initial patient population is 100, what is going to be my minimum sample size?

Deb Price: 20% is going to be 20.

Henrietta Hight: Exactly, exactly.

Deb Price: Don't ask me any of the hard ones here.

Henrietta Hight: Okay. We're going to have fun with this, you know?

Okay, let's look at the data submission. And just some reminders; the EBRT measure uses what they call all-patient data. And you're going to be including both Medicare and non-Medicare data. And you're going to be collecting your data for the four quarters, starting four quarters of calendar year 2015.

You're going to submit aggregate data for the measure for each of these quarters during a data submission window open from July 1st thru August 15, 2016. And right now I'm just talking about what you're going to be doing in 2015.

You're going to submit aggregate level data through the CMS web-based measures tool, or if you're using a vendor, you'll submit aggregate data through your vendor who will be using the QualityNet infrastructure.

And just remember, if you're using a vendor, even though you're using a vendor, you're ultimately responsible for the data that's submitted.

So again, for PCHs, for your fiscal year, you're used to saying program year 2017, you're going to be starting with January 1, 2015 discharges, and then subsequent years. And you're required to report the EBRT measure to CMS using the CMS web-based measure tool, and it's on an annual basis.

So you're not going to be reporting every quarter. You're going to be collecting your data for every quarter for four quarters. But you're only really submitting your data once a year. And it's always going to be a submission period of July 1st through August 15. And I know that at some of the PCHs, you're already getting ready to submit PCHQR data using the same submission timeline.

So starting with January 1, 2015 discharges and for subsequent years, you're going to be using the CMS web-based measures tool. It's going to be a once-a-year annual data submission, as opposed to submitting your data four times a year on a quarterly basis. This is going to reduce the PCH's– that's going to reduce your costs and burden.

And the way the submission guideline or schedule's been set up, it's going to provide the PCHs with enough advance notice to prepare the report, the measure.

So again, I apologize if this grid is a little bit faint. This is taken directly out of– copied directly out of the final rule for 2015. So you'll get used to

thinking about this. But this grid provides the data collection periods and data submission deadlines for the EBRT measure.

We'll look a little bit at, for instance, program year 2017. Okay. The reporting periods are going to be quarter 1 2015 discharges, quarter 2 2015 discharge, quarter 3 2015 discharges, and quarter 4 2015 discharges. And then you're going to be submitting your data between July 1, 2016 through August 15, 2016.

So you're going to be collecting the data for discharges in 2015, reporting them in 2016, for your program year of 2017. And then subsequently the discharges for 2016, the four quarters, you'll report those in 2017 between July 1st and August 15. And then that's just how it goes on for your subsequent years.

Recommendation; just a couple recommendations. Submit your data before the deadline. You're given a submission period of July 1st through August 15. So it's a good idea, don't wait until the last minute. Right now, just to give you an example, the IPPS hospitals that are participating in the IQR program, they have a data submission deadline of the 20th, November 20th. And there are some apparently that looks they waited to the last minute. So don't put that pressure on yourselves.

And again, if you use a vendor, work with your vendor ahead of time to confirm the accuracy and completeness of the data.

Just a couple things about CMS and their follow-up; CMS supports the protection of patient safety in the PCH setting by addressing potentially unnecessary and harmful radiation doses. Therefore, CMS is going to be conducting what they call a performance gap analysis to assess the appropriateness of the EBRT measure in the PCH setting.

And CMS intends to conduct the analysis with data collected beginning with fiscal year 2017 PCHQR program. So that's the data that's going to be– you're going to be submitting for 2015 discharges.

Moving along, here are some resources as you start working with the EBRT measure. We strongly encourage you to take the time to read the CMS Final Rule Fiscal Year 2015 final rule. The link is there for you. Just keep in mind that the Fiscal Year 2015 Final Rule addresses not just the PCHQR program, but also the IPPS program and the LTCH program.

So we've given you the pages here where you will find the section specific to the PCHs. Also here is the ASTRO– their website address, the NQS website address, and also I don't know if any of you have been recently to the QualityNet web page and clicked on the PCHQR tab. If you haven't been there recently, you'll probably start seeing some real changes. We're working very hard to update the information, and also make the information more useful to you.

And now we have about 20-25 minutes to answer some of the questions submitted today, and I would like to introduce Nadine Eads, who works closely with Dr. Lutz at ASTRO. Nadine are you there?

Nadine Eads: Yes, I am. Good afternoon, everyone. So far, I've not identified any questions that came through on Chat, so we can just take questions. If you have any questions, just type your questions in, and we can get Dr. Lutz to address them.

Henrietta Hight: So the people who are on the webinar, and last when we checked before we started the webinar, there were about 90 people who had registered. So I can't believe we did such a great job that there are no questions. Do we

need to go back to the first slide and review the process for submitting questions?

Okay, Jaime (ph), our assistant here, just said to look at the Q&A section, not the chat. There should be a box that says Q&A. Right, Deb?

Deb Price: Correct. And we can't– Henrietta and I cannot see it.

Stephen Lutz: I actually can see it on mine.

Deb Price: Oh, okay. Maybe you can read your own questions and answer them.

Henrietta Hight: And decide whether or not you want to answer a certain question.

Stephen Lutz: Well, and actually some of them may be things that I won't be able to answer. So if it's okay, I'll just read them.

There's one at 417 from Steve Flaherty (ph) that says that most of the PCHQR centers do not use CPT-2 codes, and will therefore be using registry data. Not a question, but I hope this informs HCQIA and CMS about the data sources that we will building from.

So I'm only familiar with some of those acronyms, so if anyone wants to say anything about that?

Henrietta Hight: So Steve Flaherty's question is saying that they use– they don't use CPT codes?

Stephen Lutz: No. It says they use– it says, most of the PCHQR centers do not use CPT-2 codes.

Henrietta Hight: They use ICD-9?

Stephen Lutz: I don't know. It just says they'll be using registry data. Funny how, this is just I guess for information sake.

Deb Price: We can look at that at a later time.

Henrietta Hight: What we can do is we will be compiling the questions and answers. And if it's a question– if we run out of time for questions, or if it's a question such as Steve's that we need to do some research on, we will do that. And then share that answer and all the answers with the whole community. Thank you, Steve.

Stephen Lutz: Sure. Next one is a good question. It says, is denosumab a contra indication? Basically injectables to try and increase bone strength. No, it's actually not a contra indication at all. So it's a very good question, but no concerns there.

Another couple of questions from Steven Flaherty at 419. It says, the existing measure set only has ICD-9 codes. Is there an existing ICD-10 crosswalk? Also is there a paper abstraction tool that has been created for this, as with the other OCMs?

Henrietta Hight: There is. If you look at the QualityNet website, under the hospital in-patient quality reporting program, if you click on that tab, and then you go down to a link for the specifications manual. There is for the newest version of the specifications manual, there is a link for the ICD-9 to ICD-10 crosswalk.

I would need to double-check and confirm whether or not the ICD-9 code that we were talking about in this webinar, whether or not it is represented on that crosswalk. So that's a good question. I will follow up on that.

Stephen Lutz: And then is there– I think this is separate. Is there a paper abstraction tool that's been created for this as with the other OCMs? Is that a separate question?

Henrietta Hight: Well, the paper abstraction tool is going to be that data collection tool.

Stephen Lutz: Okay. Next question, same questioner, he's on a roll and doing good. Can you please provide clarification regarding the system and medical exclusions for the denominator and how they should be documented?

I think the medical exclusions are the ones we listed. They're actually on the slide and in the algorithm. System– I'm not sure what that means. Does anyone know how to answer that? So looking for the system exclusions for the denominator and how to document them.

Henrietta Hight: I would need to do some research on that. That differentiation between medical reasons and system reasons came up in regard to some of the OCM measures. And I'm in the process of clarifying that. So I'll make a note.

Barbara Choo: Henrietta, this is Barbara. I was looking into that as I was reading the questions. The medical and systems exclusions do not apply to the EBRT measure. It applies only to the OCM measures, O-389 and I believe it was O-3902. So those are the two measures that the medical and systems exclusions apply. It doesn't apply to the EBRT measures. So that's your answer.

So to answer the questions earlier, because you guys were having a hard time hearing me, in terms of the CPT codes versus the ICD codes. In-patient hospitals only submit claims through the UB forms, and UB forms do

not apply to the physician's claims. That is why the facilities are asking is there any ICD codes that they can use in lieu of the CPT codes.

And I believe on the algorithm that you have went through with them, there is one ICD code on it that I've noticed.

Henrietta Hight: Well the ICD-9 code 198.5, which is an ICD-9 code, secondary malignant neoplasm of bone and bone marrow. On the algorithm, the CPT codes are for example, 77261 therapeutic radiology treatment planning, simple. Is that not something that could be utilized?

Barbara Choo: Henrietta, the CPT codes, they don't have it in-patient. That's not how the in-patients are being billed. They're only billed based on DRGs. And they do provide ICDs as well, but no CPT codes on the UB forms.

Henrietta Hight: Okay. So will that present an issue for the PCHs?

Barbara Choo: However, like I said, there is one ICD code available to use. And I think we need to work with Nadine to see if there are more ICD codes that are useful for this measure, applicable to this measure.

Henrietta Hight: Okay.

Nadine Eads: So we would have to follow up with our coding team and circle back, and make sure that's included in the responses to the questions.

Stephen Lutz: Right. Because there's actually a couple extra questions now about some of the centers do not code CPT codes at the hospital level, et cetera. So I think those seem to be the thrust of most of the questions is how to get those set up.

Henrietta Hight: This is good, sharing of ideas and thoughts. Are there any other questions?

Stephen Lutz: It looks like those really carry the day. That seems to be the main theme, is the– in terms of coding and such. There's a couple of questions about denosumab, but not a contra indication, so yeah. I think probably a lot of those questions that have been asked are all very good, but you may need written answers. And I don't know that all the details would be available to us right this second, right here.

Henrietta Hight: Very good. Okay. Well we will compile those questions and answers, and they will be available. What we're looking at is post it to the website that everybody used to register and get their slides, within 10 days.

Okay. Just a few more things; the PCHQR program does have its own ListServ. The PCHQR ListServ is the official means for CMS to communicate important and official PCHQR program information to subscribed users.

The notifications sent by CMS via the PCHQR ListServ are published for historical reference on the QualityNet website under email notifications. And that's very helpful, because sometimes you may have gotten a notification from CMS six months ago, and you're trying to refresh your memory, and it's wonderful to have that historical reference.

So we're encouraging the PCHs to subscribe to the ListServ by December 1, 2014. Here is the link, the website address where you would go on QualityNet to sign up for the PCHQR ListServ. And here is an example of what this page looks like, what the screen looks like to register or to subscribe for the ListServ. And you'll notice there's a box over there to the right with program notifications, and there are checkboxes there. You'll notice the second from the bottom is the PPS-exempt hospitals quality reporting program. And it's been checked.

One of the nice things about this ListServ is that you will not be overwhelmed with unnecessary information. So what we have been doing is sending out notifications or reminders by two functions. We've been sending information out through the ListServ, and then we also have been backing that up with Outlook emails. We're planning to stop using the Outlook email as a notification process, and using the ListServ.

And then, I think I need to turn it over to Barbara. Because Barbara said she wanted to share some information. Barbara?

Barbara Choo: Yeah, thanks Henrietta. Next slide. So just a piece of announcement here. Henrietta is retiring at the end of this month. She has been a registered nurse for over 34 years in many clinical areas, as well as quality improvement programs. In the last 15 years, she has been serving as an educator, trainer and project coordinator in many, many quality improvement programs.

She began her nursing career in 1980 and landed in quality reporting programs in 1999. And with that, I want you all to know that I have appreciated her help, and will miss her a lot with her breadth of knowledge, that's the biggest thing that I'm going to miss, and her personality; bubbly person, very easy to get along. And she really, really gets the work done.

With that said, Henrietta, I wish you, in your next chapter of your life, I wish you all the best. And please keep in touch with us. And moving forward, I don't have a replacement for her yet, not I– FMQAI do not have a replacement for her yet. And once we have that, we will let you know.

Meanwhile, Marie Hall (ph) will be assisting in her place. And also, if you have any questions, we do have the Help Desk link as well as the number to call if you need anything. And always, I'm here for you, too, if you have any questions. I'll be very happy to help you out.

So with that said, I want to thank Nadine and Dr. Lutz for taking the time to assist us with the training session, the education/training session. I don't have anything else to add to that, Henrietta. Back to you.

Henrietta Hight: Okay. Thank you, Barbara. Thank you, Nadine. Thank you, Dr. Lutz. We would like to thank everyone for participating in today's webinar. We always welcome your ideas for additional training sessions. So please share your ideas, your feedback, with us.

And just as a reminder, there will be a recording of this webinar. It will be posted to the website that you used to get your slides and the handouts. That recording will be available by Friday. The slides and handouts are already there on the website.

And then again the questions and answers that we received today will be available on the same website within 10 days.

So we thank everybody for participating. We hope this information was helpful. And we look forward to working with you some more. Thank you.

Barbara Choo: Thanks. Bye.

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