Outpatient Quality Reporting Program

Support Contractor

An Introduction to OP-33: External Beam Radiotherapy for Bone Metastases

Questions & Answers

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Question: For Calendar Year 2015, are we to use the new denominator criteria for OP-29? (Ages 50-75 only)

Answer: No, the new criteria would be for 2016 data reported in 2017.

Question: Is there a latest Specifications Manual for OP-33 on QualityNet? I know that the specs were not up to date with the CPT codes.

Answer: Yes, the Specifications Manual v9.0a has been updated with a Supplemental Document. The supplemental document includes an update to OP-33. Please visit the QualityNet website to download the updated Specifications Manual.

Question: For Specifications Manual 8.0a and 8.1 for OP-29, there are no age changes, but for Specifications Manual 9.0a and 9.1, collecting 2016 data, the age change 50-75 years of age is in effect, correct?

Answer: Correct. For OP-29, the age requirement of 50 to 75 years of age begins in the reporting year 2017, using 2016 data.

Question: We ran a report and have plenty of patients with the correct ICD-10 code but didn't have any of the CPT codes listed when the report was run. What should we do?

Answer: Are you using the updated codes 77402, 77407, or 77412? If you are using the updated CPT codes and still not pulling a population, you may want to discuss this with the billing department to see how they are billing these procedures.

Question: If the physician documents that the plan is to complete 10 fxns of 30Gy, but for that particular admission encounter, the treatment ordered is only 1 fxn of 3Gy because in subsequent admissions the remaining treatments will be administered, does that record pass? Or must documentation indicate that 30Gy/10 fxns is given during that particular admission? How do we know if the patient will end up receiving the other treatments at the point in time when we are reviewing that record?

Answer: If the patient has the order of 30Gy/10 fx, then it will not matter if the patient completes the entire number of treatments, as the intent was there. So, yes, this patient would meet your denominator population, and if no denominator exclusions apply, then it would also be counted in the numerator population.

Question: I wanted to clarify the sampling wording for OP-33: "selecting the population from cases that meet requirements to be included in the denominator," right? This means all denominator exclusions would be answered as "No"?

Answer: This is correct. The initial eligible population is determined by the CPT and ICD-10 codes for denominator inclusion. Following the flowchart, all denominator exclusions answered as "Yes" will remove the cases from the population. The remaining cases, where the exclusions were answered "No," will remain as the denominator population, which must meet the sample size requirement.

Question: Is the OP-33 measure only for treatment performed in the hospital setting, or does it include radiation/oncology practices that are affiliated with the hospital?

Answer: If the radiation/oncology facility bills under the hospital's CCN, then the hospital is required to report the data. The data you need to report on should only include those CPT codes billed under your hospital's CCN. If the affiliated practices bill under the hospital's CCN, then you would include those cases in your data collection.

Question: If documentation is present for "centigray (cGy)" and not "Gray (Gy)," are we allowed to convert the dose unit to Gray in order to determine if the appropriate fractionation scheme was provided to the patient, or are we only allowed to accept documentation in "Gray," not "Centigray"?

Answer: Yes, you can convert from cGy to Gy to determine if the fractionation scheme is correct.

Question: I'm not sure I understand the concern with OP-29 submission for January –May of 2016; the measure didn't change to 50-75 age limits until January 2016, correct?

Answer: You are correct. This would not present an issue for your current reporting period. However, some facilities collect this data concurrently and not retrospectively, which is the reason for the information.

Question: Our organization bills monthly for radiation patients and then opens a new account the following month if the treatment continues. A second bill is sent at the end of that month. We see a case to abstract in both months. How should we handle these as two cases (but it's only one patient)?

Answer: You would abstract the initial encounter where you would find the physician's original prescribed treatment plan. All treatments that are generated as a result of the original physician's prescribed treatment plan are grouped into one case and abstracted as one entry into the population.

Question: In the submission tool for OP-29, the denominator change will not be given as an option. Does this mean that once the counts are entered in QualityNet those cannot be updated?

Answer: No, OP-29 data (or data for any of the web-based measures) may be updated until the submission period expires on May 15, 2016.

Question: What does Slide 6, "In the submission tool for OP-29, the denominator change will not be given as an option," mean?

Answer: It is referring to the QualityNet reporting page. When you go in to QualityNet to report your OP-29 data, the measure description may not have the updated age requirements listed. This refers to the 2016 data reported in 2017.

Question: For our facility, the CPT codes 77261, 77262, and 77263 for the qualifying patients are billed under professional billing, so it is not available under hospital transactions. So, we are not able to get any patients that satisfy both the diagnosis code and CPT code conditions. For outpatients, do we take into consideration professional billing cases? A professional billing is physician-specific CPT codes. For example: a case where our hospital physician goes to another hospital's setting/facility and delivers services there, that case will be billed under physician services.

Answer: The correct updated CPT codes are 77402, 77407, and 77412. There has been an update to the original measure information form (MIF) for OP-33, in Specifications Manual v9.0a.

Question: We are noticing that these procedures are occurring for patients that are registered as a "series" type encounter. That means multiple procedures that are done are tied to the same account number. How would we abstract these records?

Answer: Patients receiving EBRT will incur multiple encounters; **only** the first encounter needs to be abstracted. The initial encounter contains all relevant information required for the OP-33 measure.

Question: Would I delete the second case in multiple encounters?

Answer: Yes. If you have determined that the second encounter was generated from an order, the prescribed fractionation scheme, from the first encounter, then you can disregard it.

Question: Our radiation oncologist writes the order for 800 cGy, which is the same as 8 Gy. Is this acceptable?

Answer: 800 cGy is 8 Gy. If this is in 8Gy/1fx, then it is acceptable.

Question: Do you have an example of how we will see femoral axis cortical involvement greater than 3 cm in length documented in a typical record? Will that be coded?

Answer: This information would come from the imaging report; there is no code for femoral axis cortical involvement greater than 3 cm in length.

Question: Will all these questions and answers be available later? Many of us are not radiology oncology specialists, and the language is challenging.

Answer: Yes. All questions asked during the presentation will be available at a later date. The transcripts and Q&As will be posted on QualityReportingCenter.com go to **Outpatient,** then **Archived Events**. The events are listed in reverse chronological order.

Question: We treated a patient with an acceptable fxns scheme to his hip but will be treating a lung mass with SBRT. Would this patient be excluded?

Answer: If you are treating the bone met in the hip with 3D CRT (EBRT) with the appropriate fractionation scheme, this would be acceptable. SBRT for the lung is not part of the measure, and would not make it an exclusion (the SBRT exclusion is if a bone met is being treated with SBRT).

Question: Should this measure be abstracted by our Cancer Center nurse manager and reported to our system administrator, since it is web-based?

Answer: This would be an individual facility decision.

Question: Radiosurgery exclusion: Is it radiosurgery to any site or the specific treatment site for the treatment area in question?

Answer: Radiosurgery should not be used to treat uncomplicated bone mets. For this measure, it is only for treatment of uncomplicated bone met that has not been previously irradiated. Radiosurgery should not be used in those cases.

Question: Is the population size determined before or after the exclusions that were described in the flowchart?

Answer: To obtain your sample size, pull all EBRT charts based on the ICD-10 codes (C79.51 or C79.52). Pull from this list the charts that have CPT codes 77402 or 77407 or 77412. This total (cases that meet your ICD-10 and CPT codes) is your total population. This is the number you base your sample size on. You would then pull your sample size and check for denominator exclusions. If you have charts that are excluded, then you would continue to pull from your remaining total population charts until your sample size is fulfilled.

Question: I am confused as to when to report. The first slide gave some other dates. The presenter said to report by 5/15/17.

Answer: The 2015 web-based measures are due to be reported via the QualityNet website by May 15, 2016. This submission deadline also applies to OP-27, the influenza vaccination measure that is reported via the NHSN. Reporting of OP-33 will not occur until 2017**.**

Question: If you are treating multiple sites, do you report each one?

Answer: If each site met the denominator ICD-10 and CPT codes, then yes, each EBRT site would be counted as a unique entry into the denominator population.

Question: As an outpatient hospital clinic, are our population numbers the number of oncology patients, radiation patients, or total hospital population?

Answer: Your OP-33 population is the number of patients that meet the OP-33 denominator criteria. This is patients that meet the ICD-10 code of C79.51 or C79.52, **and** at least one of the following CPT codes: 77402, 77407, or 77412.

Question: How do we sign up for the ListServe?

Answer: Go to QualityNet.org, fill out the ListServe registration, and select the Hospital OQR (Outpatient Quality Reporting) tab under Program Notifications. Go to the bottom of the page and select **Submit**. You are then registered into the ListServe. If you would like help in walking through this process, call the Support Contractor at 866-800-8756, and we'll be glad to assist.

Question: How do you know if you are signed up for the ListServe?

Answer: If you have forgotten or you are unsure what lists you are subscribed to, then click on the "What lists am I subscribed to?" link. Enter your email address and click on the **Submit** button. A listing of the lists you are subscribed to will be emailed.

Question: Do the age parameters begin with January 2016 charts?

Answer: Assuming you are referring to OP-29, then yes. The age parameters do begin with 2016 encounters; this data will be reported in 2017.

Question: Collection of OP-33 began with January 2016 cases, correct?

Answer: The encounter period for OP-33 began January 1, 2016, and goes through December 31, 2016. You will report this data from January 1, 2017 through May 15 2017.

Question: Does any clinical study or registry qualify for exclusion for this study?

Answer: No, you would only exclude patients who are part of a prospective clinical protocol or registry study that involves radiation.

Question: Referring to Scenario 3: if the patient received 3 out of the 6 treatments because they refused, would this be an exclusion, or would they still be in the numerator and denominator?

Answer: If the patient refused after 3 treatments, this would not be considered an exclusion, as completion of the treatment plan is not a requirement of this measure. The intent is to identify the percentage of patients who are prescribed one of the recommended dosing schemes.

Question: What if the patient received an additional boost treatment and this is where I am abstracting for. Would I exclude this patient if they have already received EBRT on the same site for the initial treatment?

Answer: Patients who receive a re-treat to the same site that was previously treated are excluded from this measure.

Question: Why is 25gy/5fxns not on the list of acceptable schemes?

Answer: Based on the research studies compiled by the American Society for Radiation Oncology (ASTRO), there were only four acceptable fractionation schemes, or treatment standards. For more information regarding ASTRO and the studies on EBRT for painful bone metastases, please see the reference slide at the end of the presentation.

Question: I would like clarification, please. Is the OP-33 measure only for treatments done in the hospital setting, or does it include radiation/oncology practices that are affiliated with the hospital?

Answer: The data you need to report on should only include those CPT codes billed under your hospital's CCN. If the affiliated practices bill under the hospital's CCN, then you would include those cases in your data collection.

Question: Does the recently released updated flowchart for EBRT display all denominator exclusions (with "Yes" go to the E bucket or Excluded from the measure)? Should this not be an X bucket? The numerator has the same Bucket E, which seems confusing.

Answer: Thank you for your evaluation of the flowchart. The flowchart is under constant review for improvements. We will certainly take your suggestion into consideration.

Question: Please restate what to do if your hospital has an outpatient campus radiation oncology area.

Answer: If the outpatient oncology facility bills under the hospital's CCN, then the hospital is responsible to report that data as a web-based measure.

Question: QualityNet is not available for testing Q4 submissions until Mar 21; will there be an extension for Q4 submissions then?

Answer: There has been an extension for the Outpatient Q4 2015 core measures only. The deadline was moved from May 1 to June 1.

Question: These ICD-10 codes – G95.20 or G95.29, G83.4, or M54.10, M54.11, M54.12, M54.13, M54.14, M54.15, M54.16, M54.17, M54.18 – are procedure codes, right?

Answer: No. The codes you have listed are ICD-10-CM codes.

Question: For the exclusion of "patients treated with radiosurgery" (77371, 77372, 77432) "or SBRT" (77373, 77435), is this referring to the current admission, or is it referring to treatment done in previous admissions?

Answer: Either, but the exclusions must relate to the current bone metastases. So, if you have a history of SBRT of the lung, this would not be an exclusion when the EBRT has been prescribed for a femoral bone mets.

Question: For the total population for the year, do you apply all of the exclusions first to get your population to sample?

Answer: No. To obtain your sample size, pull all EBRT charts based on the ICD-10 codes (C79.51 or C79.52). Pull from this list the charts that have CPT codes 77402 or 77407 or 77412. This total (cases that meet your ICD-10 and CPT codes) is your total population. This is the number you base your sample size on. You would then pull your sample size and check for

denominator exclusions. If you have charts that are excluded, then you would continue to pull from your remaining total population charts until your sample size is fulfilled.

Question: For a patient with multiple treatments, do we report that patient once for the first visit?

Answer: Yes, the subsequent treatments that are generated as a result of the initial treatment plan can be disregarded. However, if the patient is receiving EBRT to multiple different anatomic sites, each site treated with EBRT should be counted into the denominator population as a unique entry as long as there is a corresponding prescribed treatment plan.

Question: EBRT patients are billed as recurring OP accounts, billed every month. A patient could have 2 bills dropped if treatment expands into the next month. Would we have 1 case or 2 cases in the population?

Answer: Only abstract the initial encounter. All treatments that are generated as a result of the original physician's prescribed treatment plan are grouped into one case and abstracted as one entry into the population.

Question: Does the ICD-10 code for bone metastases need to be used to qualify in denominator?

Answer: Yes, your denominator criteria, or eligible cases, are obtained by pulling all cases meeting the ICD-10-CM code of C79.51 and C79.52. Then, from the cases that met the ICD-10 codes, pull out only the cases that have the CPT code of 77402 or 77407 or 77412. This would then be your eligible denominator total population.

Question: We are sampling for this measure since we have the required numbers to do so. However, since the patients come in for a series, the same patient may appear in the sample more than once. With that said, the EBRT exclusions will not be documented in every visit. Would the (exclusions) documentation have to be in every visit? How would you account for the exclusions? Can you use previous documentation since this is a series? Additionally, in one case (since this is a series), although the patient had bone metastasis for the visit, the patient was receiving radiation to the lung. How would you account for this case?

Answer: All but one of the treatment guidelines for EBRT will result in multiple encounters. As the intent is to measure the fractionation scheme prescribed, you only need to abstract the initial encounter. All subsequent encounters are generated as a result of the original physician's prescribed treatment plan and can be grouped into one case and abstracted as one entry into the population. Most, if not all, of the exclusion criteria, as well as the numerator data, can be found in the initial consultation encounter. As this measure is only interested in the EBRT fractionation schemes used

for bone metastases, please exclude any case that uses EBRT for any other reason, i.e., lung, brain, etc.

Question: We are assuming that our OP-33 selection will be automated. The flow you're presenting is useful for establishing that automated selection. It sounds like you're thinking there is a manual review of charts, or am I misunderstanding?

Answer: It would be both an automated selection based on listed denominator criteria and partial denominator exclusions. There would have to be a manual review of charts for the rest of the denominator criteria and numerator criteria.

Question: Is there a procedure code for the surgical stabilization procedure?

Answer: No. There is not a procedure code for the surgical stabilization procedure.

Question: Shouldn't the "excluded from the Measure" be category B instead of E? Also, why does the chart that has a "Yes" to denominator exclusion become an "E" as excluded and not a "B" as a booted out?

Answer: Thanks for your feedback on the flowchart. As we are constantly updating and improving our help tools, your feedback is important. We will take all feedback into consideration when the update is done.

Question: With using an automated selection report, is it acceptable to report 100% of cases, or must we select only a sample?

Answer: Yes, you can certainly report 100 percent of your total denominator population.

Question: Do you include a patient with EBRT of a different fractionation number, i.e., 36 Gy/15 fxns, or some other dosage?

Answer: You would include this case in your denominator population, as long as there were no other exclusions, but as this fractionation dosing is not one of the ASTRO-recommended schemes, it would not meet the criteria for the numerator population.

Question: If there is physician documentation that the plan is to complete one of the 4 treatment schemes included in this measure but the treatment will be over a series of visits, do we abstract the first visit or each visit as they come in for treatment?

Answer: You would abstract the initial encounter. All treatments that are generated as a result of the original physician's prescribed treatment plan are grouped into one case and abstracted as one entry into the population.

Question: I am not doing vaccines, so do I need to report? What are web-based measures?

Answer: The vaccine measure the OQR Program hospitals are responsible to report is OP-27: Influenza Vaccination Coverage among Healthcare Personnel. This is part of your web-based measure set and must be reported into NHSN by May 15, 2016, reporting on the 2015/2016 flu season data. Web-based measures for the Hospital Quality Reporting Program must be completed by May 15, 2016, for 2015 data submitted into the QualityNet website. Web-based measures include OP-12, OP-17, OP-22, OP-25, OP-26, OP-27, OP-29, and OP-30. If you continue to need help to understand these measures, call the Support Contractor at 866.800.8756, or visit: http://www.qualityreportingcenter.com/hospitaloqr/information/.

Question: If there is documentation of a patient declining treatment, they are excluded from the denominator, but if they don't finish the treatment and there is no documentation of refusal, they ARE included in the denominator?

Answer: If the patient starts the treatment and stops for **any** reason, you would still include this patient in your denominator population. The "patient declines treatment" exclusion is less of a factor in the OP-33 measure, which has been tailored to the HOP environment with the addition of CPT codes that indicate the patient has received at least one treatment. This change in the MIF was added to improve ease of abstraction so that treatment plans declined by patients during the planning phase are automatically excluded. So, you only need to abstract cases where patients have received at least one treatment, and as the measure is only looking for the fractionation scheme ordered, it is not relevant if the patient does not complete their treatment plan.

Question: How to answer femoral axis question if not present in the note?

Answer: Femoral axis cortical involvement greater than 3 cm is usually found in the imaging studies.

Question: Would this include cases with an ICD-10 code with a primary or secondary diagnosis?

Answer: The ICD-10 code can be in any position in the billing process.

Question: If we do not provide this treatment, are we required to report "zero" cases in the annual population and sampling?

Answer: Facilities that do not perform EBRT should report "zero" in the numerator and denominator data fields under the OP-33 tab in the QualityNet Secure Portal.

Question: Is a case reportable in the quarter of the order date or in the quarter of the first treatment date?

Answer: EBRT is a web-based measure that is reported annually, not quarterly. Your first reporting deadline will be May 15, 2017, using January 1, 2016 to December 31, 2016 data. You would always defer to the initial encounter or the encounter where the EBRT treatment plan was documented to determine when to report.

Question: Do you have a sample form of what exact questions we will be abstracting on these cases?

Answer: At this time there is not a form of the exact questions asked in QualityNet. You will refer to the Specifications Manual v9.0a for guidance on abstraction for OP-33. For additional assistance, there is a flowchart and a fact sheet for OP-33 on qualityreportingcenter.com; go to Videos, Resources, and Tools.

Question: What about 20Gy in 4 treatments?

Answer: 20 Gy in 4 fxns (or treatments) will not meet the numerator for OP-33, as 20 Gy in 4 fxns is not one of the recommended fractionation schemes. With no exclusion criteria, this case would be in the denominator but not the numerator population.

Question: Should we wait until the patient is discharged from care before abstracting, or just look at the order irrespective of whether or not the patient has completed care? These treatments are set up as recurring visits, hence the question.

Answer: No, you do not need to wait for patients to complete their care. You can find the information for this measure in the initial encounter, so subsequent encounters and completion of treatment are not relevant to this measure.

Question: If a patient doesn't meet the recommended fractionation schemes as listed on slide 22, is this patient considered an exclusion?

Answer: No, they would be excluded from the numerator. If the patient meets the eligible denominator criteria with no other exclusions, they would be included in the denominator population. Remember, fractionation scheme is not a denominator exclusion. When determining the numerator population, you see this fractionation scheme is not one of the ASTRO-recommended schemes listed on the MIF, so this case would not be included in the numerator.

Question: How will the outcomes be measured? Is the goal not to exceed 30 Gy?

Answer: The goal is to determine the percentage of patients who receive EBRT for painful bone metastases with a treatment plan that follows one of the ASTRO-recommended fractionation schemes: 30Gy/10fxns, 24 Gy/6fxns, 20 Gy/5fxns, and 8 Gy/1fxn. The reason for this is due to research performed by ASTRO that determined over 100 variations in the prescribed dosing strategies for this treatment.

Question: What is the definition of surgical stabilization procedures? Are there specific procedure codes?

Answer: For the purposes of this measure, it is a bone stabilization procedure for a pathological fracture at the site of the bone metastases. And no, there is no specific procedure code for surgical stabilization.

Question: Denominator exclusion includes patients who have undergone a surgical stabilization procedure. Do you have the CPT codes that we can use to identify these surgical procedures?

Answer: At this time there are no CPT codes available to identify surgical stabilization procedures. The rationale for not providing general surgical stabilization codes is that they would exclude cases that would otherwise be included. For example, a stabilization of a spinal fracture would not be an exclusion for a patient undergoing EBRT treatment for femoral bone metastases.

Question: Why would the population not be the denominator criteria prior to the application of the exclusions? Did I not hear that correctly? This measure population determination seems very different from any other measure since you are moving through the denominator exclusions to determine the population...seems confusing.

Answer: The total eligible population is determined by the charts identified with the ICD-10 codes C79.51 *or* C79.52 and CPT codes 77402 *or* 77407 *or* 77412. This is your total eligible population and is how you determine your sample size. After determining this population, apply the ICD-10 codes provided in the MIF/algorithm to further remove cases with exclusion criteria based on diagnosis (spinal cord compression, cauda equina compression, and radicular pain). After these patients have been removed, then you will have to perform a manual review of the records for the remaining denominator exclusions. After applying all denominator exclusions, your denominator population must be equal to or greater than your required sample size.