



Outpatient Quality Reporting Program

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

Presentation

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Karen

VanBourgondien: Hello, and welcome to the Hospital OQR Program webinar. Thank you for joining us today. My name is Karen VanBourgondien, the Education Coordinator for the Hospital OQR Program. If you have not yet downloaded today's handouts, you can get them from our website at qualityreportingcenter.com. Go to the **Events** banner on the right side of the page, click on today's event, and go to the **Event Resources** tab at the bottom of the page. There should be a link there that will allow you to access and print the handouts.

Additionally, these slides are attached to your ReadyTalk reminder email that you received. You can find them at the right side of that email. As you can see, we are live streaming in lieu of using only phone lines. However, phone lines are available if needed.

Before we begin today's program, I'd like to highlight some important dates and announcements. January 1st started the submission period for web-based measures. These have a submission deadline of May 15. OP-27 is entered through the NHSN

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CDC online submission tool. May 1, 2016, is the submission deadline for clinical data and population and sampling for Quarter 4 2015. This will be for encounter dates from October 1 through December 31, 2015.

For OP-29, the denominator criterion was changed from 50 years and older to 50 to 75 years of age. The QualityNet tool currently does not provide an option for this change. You will abstract under the new specifications guidelines of 50 to 75. Just realize that there is not a specific option when you are entering your data.

Please be sure to keep your QualityNet access active. The easiest way you can do this is by logging into the QualityNet Secure Portal at least every 60 days.

On April 20th, The Lewin Group will be presenting an educational webinar on imaging measures and data that pertains to that. On May 18, we will be presenting analyzing two-year data for the OQR Program. Additional webinars and educational opportunities will be forthcoming. Notifications will be sent by ListServe by the support contractor. ListServe notification is our primary mode of communication with regard to this program.

The learning objectives for this program are listed here on this slide. This program is being recorded. A transcript of today's presentation, including the questions and answers, and the audio portion of today's program will be posted on qualityreportingcenter.com at a later date. During the presentation, as stated earlier, if you have a question, please put that question in the chat box located on the left side of your screen. One of our subject matter experts will respond.

We are fortunate today to have Elizabeth Bainger and Vinitha Meyyur from CMS to answer some questions that have come in over the last couple of weeks regarding this measure. That Q&A session will follow the presentation.

Now, let me introduce our speaker, Pam Harris. Pam has diverse clinical experience as well as experience in education, utilization, management, and quality. Pam is a project coordinator for the Outpatient Quality Reporting program. Pam?

Pam Harris:

Thanks, Karen. Hello everyone, and thank you for joining us today. The presentation today is an introduction to the OP-33 measure. This is a new measure for the OQR Program, so we are going to be starting at the basics. For those of you

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who have an oncology background, some of this may be very basic for you, and I apologize for that, but this webinar will give you the information needed in order to meet the OP-33 EBRT Measure.

So let's get started with: what is EBRT? Well, EBRT, or external beam radiation therapy or radiotherapy, is a beam of radiation from outside the body to cancerous tissue inside the body. This beam destroys cancer cells and can shrink tumors. Now, for the purposes of this measure, we're going to be focusing on EBRT for bone metastases. Bone metastasis is a common manifestation of malignancy. Some cancer types have bone metastasis prevalence as high as 70 percent to 95 percent. EBRT is a widely used modality to provide pain relief for about 50 to 80 percent of patients with painful bone metastases. In order to really understand EBRT and thus the OP-33 measure, let's take a quick look at the history.

In October 2009 the American Society for Radiation Oncology, or ASTRO, surveyed physicians around the world, asking them what dose and frequency they use to treat bone metastasis. There were over 100 different answers. ASTRO then organized a task force of experts to perform an assessment of the current practices in order to address a lack of palliative radiotherapy guidelines.

Many studies supported the conclusion that shorter EBRT schedules produce similar pain relief outcomes when compared to longer EBRT and that patients prefer shorter EBRT schedules because of their convenience, increased tolerance, and reduced side effects. In 2011, there was another study looking at EBRT dosing schedule data that was collected between 2009 through October 2011. This study noted a sizable performance gap in adherence to the guidelines for the use of EBRT to treat bone metastasis. In fact, the actual dose being ordered for EBRT had continued to include dosing schedules at a much higher rate than the dosing schedule standards set by ASTRO.

These continued widespread variations in dosing amounts and frequency was one of the reasons that ASTRO submitted this standard to CMS as a quality measure. CMS accepted ASTRO's standard of care on EBRT for bone metastasis as a quality measure. This measure was then finalized for the Inpatient cancer hospital's quality reporting program. Now, OP-33 will be reported for the Outpatient quality measures for the 2018 payment calendar year and beyond as a web-based measure.

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The goals for EBRT standardization are the prevention of radiation therapy overuse, increase of patient safety, appropriate use of EBRT, and increase in patient benefits. Let's take a closer look at patient benefits. In multiple studies, the standard four EBRT dosing schedules for bone metastasis supported the conclusion that shorter EBRT schedules, or number of treatments, produce similar pain relief outcomes when compared to longer EBRT schedules. Also, that the patients prefer the shorter EBRT schedules because of their convenience – they can tolerate it better, and it can reduce side effects.

Have you ever seen a patient with bone metastases struggle to get in and out of a vehicle? The full palliative effect of EBRT occurs four to six weeks after the completion of the treatment, so each outpatient visit may be just as painful and laborious as the first. If you could shorten the number of times this patient has to get transported to your facility and have the same outcome, now that is a patient benefit. That's just looking at one aspect of patient's convenience; patient safety, time, and cost are some of the others.

So, who has to report this measure? The measure is included in the OQR Program as it is not specific to cancer hospitals. CMS believes that OP-33 is broad in scope and merits inclusion in the OQR Program. The measure has been thoroughly tested in outpatient settings, and it's not limited to only cancer hospitals. CMS also believes it is a priority area to reduce the rate of EBRT services overuse, as we have already discussed, so, any hospital that conducts outpatient radiation oncology treatments.

Now, what happens if your hospital has an off-campus oncology facility? If the off-campus bills under the hospital CCN number, then the hospital is responsible for reporting this measure. If your facility does not perform EBRT, you will enter zeros in your online submission tool. OP-33 is a chart-abstracted web-based measure that will be submitted through QualityNet annually. The first reporting deadline for OP-33 will be May 15, 2017. This will be for 2016 data reported to QualityNet by the May 15, 2017, deadline for 2018 payment. Now that we've gone over a few housekeeping items about OP-33, let's look at what OP-33 is exactly.

OP-33 is an outpatient measure that looks at the percentage of patients with a diagnosis of painful bone metastasis who receives EBRT with an acceptable dosing schedule or fractionation scheme. Let me stop here for a moment and zone in on the

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term “painful bone metastasis.” The determination of painful bone metastasis is within the scope of both specialty and primary care medical practice. There is no specific code for painful bony met.

So, what's an acceptable fractionation scheme? There are the four acceptable fractionation schemes, or treatment standards, that you see in the Specifications Manual. Now, for someone without an oncology background, this is a different language. To be able to understand what exactly a fractionation scheme is, we're going to break it down a little bit more.

Let's start out with abbreviations and their definitions. The “Gy” is pronounced and stands for “Gray,” and this is the total dose or measurement of the external beam radiotherapy. Gray is the name of the man who discovered the different measurement of the external beam radiotherapy; he got to name it after himself. The “FXNS” stands for fractions and is the total number of doses or treatments. The total dose is fractionated, or spread out, over time. For fractionation schemes of 30 Gray over 10 fractions, that's three Gray for 10 different treatments for a total dosage of 30 Gray.

Now, let's look at the OP-33 denominator. What you see on this slide is OP-33's denominator statement that is in your Specifications Manual. No changes were made to the statement of “all patients with painful bone metastasis and no previous radiation to the same anatomic site who received EBRT.” All right, let's look at the denominator criteria update.

As you know, CMS sent out an update via the ListServe for the OP-33 measure. The changes made to OP-33 were the CPT codes in the denominator criteria, and there are additional exclusions and clarifications to the denominator exclusions. You start out with all patients, no matter their age. Now, that's a huge amount of charts or lists. Then, out of all the patients you have seen and treated for the encounter year, you pick only the patients that have an ICD-10 code of C-79.51 or C-79.52. Now your stack has gotten much smaller. Then, out of every patient that has these specific ICD-10 codes, pick only the ones that have at least one of the CPT codes of 77402 or 77407 or 77412. You can have any of these codes. These particular codes relate to the EBRT delivery. If you do not have at least one of these CPT codes, then that chart would not meet your denominator. Put it back. Mark it off your list. So, now

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your stacks of charts are much smaller. Then, with these remaining charts that had the specified ICD-10 code and at least one of the listed CPT codes, you take these remaining charts and check for any denominator exclusions.

Now, let's take a look at what your denominator exclusions are. The denominator exclusions have been updated to include an additional exclusion and ICD-10 codes. In the next two slides we will go over the updated list of denominator exclusions. We start off with the exclusion of previous radiation treatment to the same anatomic site: patients treated with radiosurgery or stereotactic body radiation therapy, or SBRT. This would exclude these patients. Notice the CPT codes that help define these denominator exclusions. Next is any patient who is part of a prospective clinical protocol or registry study. Then, femoral access cortical involvement greater than 3 centimeters in length; usually you can find this information regarding the length in the patient's imaging studies. We then move on to patients that have undergone a surgical stabilization procedure, spinal cord compression, cauda equina compression, or radicular pain. CMS has further defined the spinal cord compression and cauda equina by adding the ICD codes of G-95.20 or G-95.29; it is for the spinal cord compression. The ICD-10 code G-83.4 is for the cauda equina compression. Only if you have these listed ICD-10 codes that are specific for the spinal cord compression or the cauda equina compression can the codes be used to identify denominator exclusions. There was also a request to define radicular pain using ICD-10 codes, and these updated codes are seen here as well.

Let me clarify something here before we go on because we've received numerous questions regarding the issue of denominator exclusions. You can only use the ICD or CPT codes provided to exclude a patient. If there is not an ICD or CPT code for one of the exclusions but the physician documents it, that will suffice. For example, let's say that a physician documents that the patient has a history of spinal cord compression, but there is no ICD-10 that delineates that. The fact that the physician documents it is sufficient. The reason for the ICD-10 and the CPT codes is clarity and ease of abstraction.

Now that we've gone over denominator exclusions for OP-33, let's take a look at the number that always comes out on top – the numerator. The numerator definition is pretty straightforward. All patients, regardless of age, with painful bone metastasis, who receive EBRT with any of the following recommended fractionation schemes:

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the 30-Gray in 10 fractions, 24-Gray in 6 fractions, 20-Gray over 5 fractions and 8-Gray in 1 fraction, or visit, are included in the numerator. Now, I want to show you a flowchart that was developed as a tool to facilitate your understanding of OP-33.

I know the first thing everyone is thinking is “that's too small to read,” and I agree with you, and I promise I will show you this form up close. But I wanted you to see the general look of the form. We have also posted this form as a supplemental document to the presentation slides. In addition, this flowchart is also located on our website, qualityreportingcenter.com, under the **Videos, Resources, and Tools** tab for the Outpatient Program.

This is the information found at the top of the flowchart. It gives you your measure description, numerator statement, and denominator statement. The next thing I want you to look at is the green box on the right-hand side. This is just a quick reference for the sampling size per year. This is the minimal number of cases based on your denominator population that must be submitted to meet the OP-33 measure. Look at the red box to the left of that green box; this is your first step in selecting your population. This is where you would sort your chart or run the report by the denominator criteria, the ICD-10 and CPT codes.

For the next few steps, this is where you will be looking at the denominator exclusion criteria. If history of previous radiation to the same site is “no,” then you follow the steps downward. Treated with radiosurgery or SBRT? Notice the CPT codes; only if you have one or more of the CPT codes are you able to use this as a denominator exclusion. So, you don't have one of the CPT codes? Well, continue to the next step. Again, you can only use the CPT codes provided to exclude a patient. If there is not a CPT code for one of the exclusions but the physician documents it, you can use that as a denominator exclusion.

Moving on down the flowchart, part of prospective clinical protocol or registry study? No? See how the steps in the flowchart are just walking you through the denominator exclusions? Now it's asking about the femoral access cortical involvement greater than 3 centimeters in length. No? Continue downward. Underwent surgical stabilization procedure? No? Spinal cord compression or cauda equina compressions or radicular pain? Notice the ICD-10 codes. No? Continue on. Did you find any specified patient reason listed? No? Then this patient will be

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included in your denominator. Once you have completed this process with every chart that met your initial ICD-10 codes and the CPT codes, then this number is your total denominator population. This is the number that will decide your sampling size population. We'll get to sampling size population in a minute.

Let's continue on with the flowchart. Now, let's back up to see what happens when you have a denominator exclusion and answer "yes." The three exclusions in this triangle – here in red – in this scenario, we are answering "yes" to one of the exclusions: either spinal cord compression, cauda equina compression, or radicular pain. Then, following the arrows, this chart falls out of the denominator. You would not count this chart in the denominator, so since the answer is "yes," this patient in this circumstance would be excluded from the measure. This is illustrated here in the outlined red box.

Once you have gone through the flowchart to get the included denominator, you will move down to obtain the numerator. Let's look at the outlined red triangle here in the flowchart. You look at each of your denominator charts for an acceptable fractionation scheme. That's your 30-Gray in 10 fractions or 24-Gray in 6 fractions, 20-Gray in 5 fractions or 8-Gray in 1 fraction. If the patient has an EBRT order that does not have the recommended fractionation scheme, then you would exclude that patient from the numerator. This continues as a denominator number but not a numerator number. If you do have the recommended fractionation scheme, then you would include this patient in the numerator. So that patient would be in your denominator and numerator.

Now, where can we look for this data? In the Specifications Manual you will find the information on this slide under the Data Source, Data Collection Instrument. However, you will notice under the numerator and denominator statements there are some slight variations of this. The reason for that is every software system is different, and electronic health records, or EHR types, can vary even within the same facility. Oncology treatments and documentation have specified software, and thus finding this information may be in different areas other than where you normally abstract from.

Now, remember we said we would be going over sampling size requirements? Well, here it is. Sampling is a process of selecting a representative part of a population in

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order to estimate the hospital's performance without collecting data for its entire population. Because Medicare does recognize the fact that reviewing every case for this measure could be burdensome, CMS has assigned a sample size for OP-33. The sampling size, or the minimal number of patients your facility is required to report for this measure, is based on your total denominator population. Remember on the previous slide where we discussed total population for the OP-33? This is why that number is important.

Let's say you go through the steps and you find that your total population for that denominator or measure is 145. Based on this chart, your sample size requirement would be 40 cases. Therefore, 40 is the minimal number of cases or charts you have to report or review. Now, what happens when your total population for that measure is 400? Well again, based on the sampling size requirements, you would have to report 20 percent of 400 and that's 80, so 80 cases or charts would be the number that you have to review and report. As you see here on this slide, if you have over 501 charts or cases, then you will report 100 charts or cases, which would be the maximum you would be required to report. The table in the Specifications Manual will also break these requirements down per quarter and per month.

We have gone over some of the basics of OP-33. Let's take a few scenarios and see if we can work out the answers.

A patient's order for treatment is 20 Gray over 5 fractions. The patient has an ICD-10 code of C-79.51 and a CPT code of 77402. This patient has had EBRT to the same anatomic site previously. Do you include this patient in your denominator? No, this case would not be in your denominator because the patient had received previous radiation treatment to the same site.

Let's try another. This is a 10-year old female who has a fractionation order of 20 Gray over 5 fractions and an ICD-10 code of C-7951 and a CPT code of 77407. Should you include this patient in your denominator? Yes, you would include this case in the denominator. The OP-33 measure includes all ages, so it does not matter if the patient is 10 years old. The ICD-10 and CPT codes correlate with the denominator criteria.

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This is an 84-year old male, and we know this measure is for all patients regardless of age. This patient has an ICD-10 code of C-79.52, so that meets the measure criteria. So, we go to the next step, and that's the CPT codes, and we have a CPT code of 77412, and this meets the measure criteria. Then we go to the next step and look for denominator exclusions and find none. We look at what was ordered, and it was 24 Gray in 6 fractions. However, the patient never completes all 6 treatments. After 3 of the 6 fractions or treatments, the patient stops. Would you count this patient in your numerator and denominator? Yes. This would be included in your OP-33 denominator because you have the correct ICD-10 code and the correct CPT codes with no exclusions. Then, you have a fractionation scheme that meets the measure, so yes, this meets the denominator and numerator criteria. It does not matter if the patient completes all the treatment or not because the intent of the measure is there, which is to capture the recommended fractionation schemes.

Your hospital's yearly outpatient population size for the EBRT measure is 978 cases. This is the number of EBRT cases that have met the denominator criteria and are eligible cases. What would your sampling size be for that reporting period? Your sample size will be 100. You can find the sample size table in your Specifications Manual, Version 9.0a under the Population and Sampling section, page 4.7, Table 5. You see that if you have 978 cases in your population for the year, your sample size requirement will be 100.

Let's discuss another population scenario here. In this situation the population size is 300, but the hospital wants to sample monthly. For this scenario, once again, we will refer to Table 5 in the Specifications Manual. The monthly sample size will be a minimum of 5 patients per month. We would calculate 20 percent. So, 20 percent of 300 cases is 60. 60 divided by 12 equals 5. The hospital is ultimately responsible for meeting the yearly sample size requirements, and in this case, that minimum is 60 patients per year.

We've covered a lot of information in this review session. The initial OP-33 specifications were updated, and new codes for this measure have been communicated via ListServe. The encounter period for this measure began on January 1. You will enter this data starting January 1, 2017, with the submission deadline of May 15, 2017. Again, please make sure that you're signed up for the

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Listserve; it's the easiest way to keep updated with this program. That's going to do it for me today. Karen, back to you.

Karen

VanBourgondien: Thank you, Pam. That was a lot of great information. We really appreciate that. We're now going to have the Q&A session, and we are fortunate today to have two guests that will be answering the questions regarding OP-33. Again, with us today we have the CMS Outpatient Quality Reporting Program Lead, Elizabeth Bainger, and Measures Lead, Dr. Vinitha Meyyur. So, let's start with some commonly asked questions.

Elizabeth Bainger: Hi, everyone. I, first of all, would like to thank Karen and Pam for their very informative presentation. Dr. Vinitha Meyyur and I would now like to take this opportunity to answer some of the questions that have been coming in. We've compiled a list of questions, and I'll present them, and then Vinitha, if you could provide the answer.

The first question that we have is: "Would a cranial orbit reconstruction be considered an exclusion from OP-33 for a patient receiving EBRT to that same cranial orbit?"

Vinitha Meyyur: If the procedure is not documented as a surgical stabilization, then the patient would not be excluded from the measure.

Elizabeth Bainger: "How do we abstract a patient who receives EBRT to two or more sites concurrently?"

Vinitha Meyyur: If the patient receives two or more prescribed treatment plans or orders for EBRT and those plans are specific to different anatomic sites that have not previously been treated with radiation, then each treatment plan would be abstracted as a separate case.

Elizabeth Bainger: OK, thank you. "How do we abstract a case if one patient has multiple encounters that span over months?"

Vinitha Meyyur: Group the encounters together as one case and abstract the initial encounter for the physician's prescribed fractionation scheme.

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Elizabeth Bainger: OK, thank you. “For the exclusion that addresses the patient having received previous radiation, does this only refer to radiation to the site of the bone metastasis now treated with EBRT?”

Vinitha Meyyur: Yes. You would need to exclude patients who had any previous radiation treatment, which includes SRS or SBRT to the same anatomic site that was subsequently treated with EBRT.

Elizabeth Bainger: Thank you, moving on to the next question. “If the patient has a treatment plan that included EBRT with a recommended fractionation scheme but did not complete treatment, would the patient be in the initial population for this measure?”

Vinitha Meyyur: Yes. This patient would be included in the initial population. OP-33 was designed to gather data on the percentage of times the recommended fractionation schemes are being prescribed, so completion of the treatment plan is not relevant to the goal of this measure.

Elizabeth Bainger: Okay, and we have another person who wrote in: “I have cases in which the patient had a metastasis to both brain and bone, and both patients received EBRT to the brain but not to the bone metastasis. Do these patients qualify for the measure?”

Vinitha Meyyur: As OP-33 seeks to identify the population of patients who receive EBRT for bone metastasis, patients who are prescribed EBRT for a reason other than bone metastasis would be excluded from the initial population.

Elizabeth Bainger: Okay, thank you for that clarification. “For excluding patients for radicular pain, does radicular pain need to be explicitly documented, or can it be inferred from a set of symptoms documented in the chart? For example, pain and tingling in the ulnar nerve distribution.”

Vinitha Meyyur: As you know, the exclusion criteria for this measure are very specific, so documentation of general symptoms would not be considered acceptable. The exclusions are met when identified by the CPT or ICD-10 codes or when there is documentation that identifies specific criteria as they are written on the measure information form.

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Elizabeth Bainger: Okay. “Can documentation of exclusion reasons only be taken from the same encounter, or can it be abstracted from the entire medical record?”

Vinitha Meyyur: When abstracting this measure, you may reference the specified data sources from the entire medical record. You may reference the MIF, which is the measure information form, for numerator and denominator data sources. However, be sure that any exclusions you abstract are relevant to the current treatment plan and the anatomic site.

Elizabeth Bainger: Thank you. We have another person who wrote in and said: “I do not see physician orders listed in the data sources for numerator and denominator on the measure information form. Is physician order an acceptable data source?”

Vinitha Meyyur: Yes. This is an acceptable data source.

Elizabeth Bainger: Thanks. “Will documentation of any component of neurological or nerve involvement exclude a case based on radicular pain exclusion criteria?”

Vinitha Meyyur: No. The documentation must include the term “radicular pain” and also identify the site of the pain as being the same as the painful bone metastasis.

Elizabeth Bainger: This question is kind of lengthy. It says: “For clarification, can only the ICD-10 codes listed above be used to identify denominator exclusions on the measure information form? Meaning, can we only exclude the patient if they were assigned an ICD-10 for those conditions, or can an abstractor exclude the case if they see the term ‘spinal cord compression’ or ‘cauda equina compression’ documented?”

Vinitha Meyyur: The ICD-10 codes were added to improve ease and accuracy of abstraction; in the absence of those codes, you may use the physician's documentation of those specific exclusions as they are described in the denominator exclusion criteria. So, as you stated, if they see documentation of the diagnosis of “spinal cord compression” or “cauda equina compressions,” these cases may be excluded from the denominator.

Elizabeth Bainger: So, that concludes our questions and answers. Karen, I'd like to pass the presentation back to you.

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Karen

VanBourgondien: Thank you so much to Elizabeth and Vinitha for your expert answers. We really appreciate that. Now, I'm going to turn things back over to our host for instructions on our CE process.

Matt McDonough: Thank you. Today's webinar has been approved for one continuing education credit by the boards listed on this slide. We are now a nationally accredited nursing provider and, as such, all nurses must report their own credits to their boards using our national provider number. That number is 16578 and is listed here on this slide.

This concludes our program for today. We hope you've heard useful information that will help you in your reporting for this quality reporting program. Thank you again, and enjoy the rest of your day.