PPS-Exempt Cancer Hospitals Quality Reporting (PCHQR) Program

Support Contractor

PCHQR Program: Lessons Learned in Population and Sampling and from EBRT

Questions and Answers

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Please note that this educational event and associated materials are for the PPS-Exempt Cancer Hospitals (PCHs) participating in the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program. Providers in other Programs are asked to refer to the education and support materials provided by their specific Program.

Question 1: **Do you mean simple random sampling with replacement or without replacement?**

When sampling for the Oncology Care Measures (OCMs) and the External Beam Radiotherapy (EBRT) measure and simple random sampling is used, it should be done without replacement. Simple random sampling with replacement means that after being randomly selected, a case is returned to the sample and may be selected again. Each case should be eligible for selection only once. Also, as you find randomly selected cases that do not meet the requirements for the denominator or have a denominator exclusion, you should supplement by continuing to randomly sample to reach at least the minimum sample size determined by your population.

Question 2: **Can one patient appear multiple times in the sample during the same measurement period?**

The answer to this question depends on what measure is being sampled. For further guidance, please refer to the Measure Information Form (MIF) that is specific to the measure. For the PCHQR Program these are located on QualityNet *on the PPS-Exempt Cancer Hospitals Tab. The MIFs are located on the Data Collection page.*

Question 3: **For National Quality Forum (NQF) #0382, what if your PPS-Exempt Cancer Hospital's coding for metastatic cancer is poor? Can you get down to your initial patient population based upon coding and then eliminate patients discovered to be metastatic when you abstract the sampled records? Or, would we need to check for metastatic status manually first and then sample after that process? In which case, sampling wouldn't be beneficial, since we have to manually abstract for metastatic disease status anyways?**

For NQF #0382 you would base your population based upon what is coded in the administrative data. Currently, this initial population would consist of the unique patients in the given quarter who have an International Classification of Diseases (ICD)-10 diagnosis code for pancreatic or lung cancer AND do not have an ICD-10 diagnosis code for metastatic cancer. From this population, if you are allowed to and choose to sample, select your sample size (as per the minimum sample size requirements). As metastatic cases are identified during the chart abstraction, exclude these cases from the denominator. You will then supplement with new randomly selected cases until you reach at least the required minimum sample size.

Question 4: **For NQF #383 and #384, if there is documentation of pain, but the pain is not quantified, then this patient would not be in the denominator for plan of care for pain?**

That is correct. Only include those patients in the patient population for NQF #0383 (Plan of Care for Pain) who have pain and for which the pain intensity is quantified using a standard instrument in NQF #0384 (Pain Intensity Quantified).

Question 5: **Our vendor only pulls the patient once, even though several sites may have received EBRT to bone (i.e. three bone sites). Should that patient show up for each site (three times)?**

Yes, treatment with EBRT of separate anatomic sites with bone metastases should be treated as separate cases. This is discussed on slide 30.

Question 6: **Can you please send out written terms that you explained in "Lesson 6" for various surgical stabilizations?**

This is not a comprehensive list of surgical stabilizations, but the examples shared in today's event on slide 33 were kyphoplasty, insertion of a rod or plate or screws, or an open reduction internal fixation (ORIF).

Question 7: **If there are three sites with EBRT, my understanding is that there is only one Current Procedural Terminology (CPT) code that covers all of them?**

The CPT codes for the administration of EBRT are 77402, 77407 or 77412. CPT codes 77407 and 77412 are used (in part) for EBRT to more than one anatomic site. Chart review of identified cases is required to determine the metastatic bone lesions being treated with EBRT. Each separate site should be treated as an independent case.

Question 8: **Yes, but if the same 77412 (only documented once) is used to identify the case how does this identify which case?**

The presence of the CPT code 77407 or 77412 along with an ICD-10 code for bone metastases only indicates that the patient has a diagnosis of bone metastases and received EBRT during the measurement period. Chart review is required to determine if the EBRT was administered to a site of bone metastasis, and also to determine which anatomic site received the EBRT.

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Question 9: **How does the vendor identify that they need to make multiple cases for NQF #1822?**

The participants in the PCHQR Program do not utilize a vendor for NQF #1822 at this time. A vendor is only allowed for use in the PCHQR Program for administration of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.

Multiple bone metastases receiving EBRT during the measurement period can only be determined with chart abstraction. Therefore, we suggest that you contact your vendor to address this issue.

Question 10: **For NQF #1822, how can we determine the overall population without reviewing each chart that may qualify? We ended up reviewing many charts to come up with a very small sample.**

Today's presentation provides extensive guidance on this topic, especially slides 24 and 25. The key is to use the presence of the ICD-10 codes and CPT codes to identify the individual patients who have a diagnosis of bone metastases and received EBRT during the measurement period. Use this number of individual unique patients to determine the patient population for NQF #1822 (PCH-25). From this, you can determine your minimum sample size. Then perform the clinical abstraction of the randomly sampled records to see if any of the denominator exclusion criteria are present. This will also identify those patients who have multiple anatomic sites of bone metastases receiving EBRT, remembering that each anatomic site is a unique case. For those cases that are excluded due to denominator exclusions, continue to randomly sample until you reach the minimum number of cases (bone metastases that received EBRT) to fulfill the minimum sample size based upon your patient population.