FACT SHEET FOR OP-33: EXTERNAL BEAM RADIOTHERAPY FOR BONE METASTASES

This guideline has been created to assist facilities with chart abstraction. This guideline’s intention is not to replace or supersede the official abstraction guidance located in the Hospital Outpatient Quality Reporting Specifications Manual.

**Description:** Percentage of patients, regardless of age, with a diagnosis of bone metastases and no history of previous radiation to the same anatomic site who receive external beam radiation therapy (EBRT) with an acceptable fractionation scheme.

**Numerator:** All patients, regardless of age, with bone metastases and no previous radiation to the same anatomic site who receive EBRT for the treatment of bone metastases with any of the following recommended fractionation schemes: 30Gy/10fxns, 24Gy/6fxns, 20Gy/5fxns, and 8Gy/1fxn.

**Denominator:** All patients with bone metastases and no previous radiation to the same anatomic site who receive EBRT for the treatment of bone metastases. The denominator population for OP-33 can be determined by claims submitted with ICD-10-CM codes C79.51 or C79.52 and CPT® codes 77402, 77407, or 77412.

Do use physician’s documentation of a medical reason to exclude patients from the measure only when the documentation clearly identifies one of the exclusion criteria and associates it with the site being treated with EBRT. Examples include:

- “Patient has previously received radiation treatment to the same anatomic site.”
- “Patient has a bone metastasis that has caused spinal cord compression; this bone metastasis will be treated with EBRT.”
- “Patient has radicular pain as a result of a bone metastasis that will be treated with EBRT.”
- “Patient has undergone surgical stabilization as a result of a bone metastasis that will now undergo treatment with EBRT.”

Do consider all encounters that result from a single treatment plan as one case, with the case being attributed to the first date of administration of EBRT.

Do consider the administration of EBRT to different anatomic sites as separate cases.

Do include cases when the treatment plan was initiated but not completed.

Do include cases where any portion of the EBRT treatment is billed as part of the outpatient bill.

Do not include patients who receive EBRT for a reason other than bone metastases.

Do not include patients who are part of a prospective clinical protocol involving the administration of radiation, especially stereotactic radiosurgery (SRS) or stereotactic body radiation therapy (SBRT).
**Sampling Size Requirements Per Year for OP-33**

<table>
<thead>
<tr>
<th>Population Per Year</th>
<th>Sampling Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 39</td>
<td>Include all cases</td>
</tr>
<tr>
<td>40–200</td>
<td>40</td>
</tr>
<tr>
<td>201–500</td>
<td>20% of cases</td>
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<tr>
<td>&gt;501</td>
<td>100</td>
</tr>
</tbody>
</table>

**Frequently Asked Questions**

Q: Patients receiving EBRT have multiple encounters; which encounter should I abstract for OP-33?
A: Group the encounters together as one case and abstract the initial encounter to determine the physician’s prescribed fractionation scheme.

Q: A patient previously received EBRT to the femur and is now being treated with radiation to the humerus. Should this patient be included in the measure for the humerus EBRT treatment?
A: Yes. The previous radiation was to a different anatomical site; therefore, it is not applicable in this instance. Since this is the first EBRT treatment to the humerus, the case should be included in the measure.

Q: A patient received EBRT, but the physician’s documentation on the initial treatment plan noted this was a “re-treatment.” Should this case be excluded?
A: Yes. When the documentation states the EBRT was prescribed as “re-treatment” or “re-irradiation,” this is an indication that the patient has previously received radiation to the same anatomic site.

Q: Is CyberKnife® or Gamma Knife® considered EBRT?
A: No. These are trade names for stereotactic radiotherapy (i.e., SRS and SBRT).

Q: Does the exclusion criteria “Patients with femoral axis cortical involvement > 3 cm” apply to all cases?
A: No. This exclusion is specific to patients with femoral metastases and is determined by imaging studies.

Q: If a patient has radiation treatments to both the right hip and left hip on the same dates of service, is this considered 2 separate sites that should be abstracted as such?
A: Yes, these would be considered separate sites but there are exceptions. If more than one isocenter (the point in space through which the central rays of the radiation beams pass) is identified (i.e. with separate fractionation schema), the bone metastases would be considered separate sites. The exception to this rule would be where physical limitations of the equipment would require two treatments to the same anatomical site. An example of this exception would be the upper and lower femur, a long bone that exceeds the equipment’s field of treatment. In this case, there may be two isocenters and one fractionation scheme but it should be considered one treatment site.

Q: If a patient has lung cancer with metastasis to the brain and bone comes in for radiation to the lung and brain, do you count the brain and lungs as sites?

A: No. The measure’s intent is to capture whether or not patients with bone metastases are receiving proper external beam radiation therapy (i.e. a recommended radiation fractionation scheme) to treat their bone metastases. Therefore, external beam radiation used to treat lesions or tumors that are not bone metastases should be excluded from the measure.

Q: Does the physician documentation have to specifically use the term "surgical stabilization procedure" or can we take into account documentation of internal fixation surgery?

A: While a note clearly indicating that a surgical stabilization procedure has occurred is the best way to identify this exclusion, if you review the procedure note and see evidence of any stabilization (cement, rods, screws, metal plates, pins, etc.) then the surgical stabilization exclusion would apply. The most common surgical stabilization procedures are hip replacements, artificial joints, and prosthesis.