

NQF 0389: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients

Clinical Quality Measure Quick Reference Guide and Technical Supplement

Provided By:

The National Learning Consortium (NLC)

Developed By:

Health Information Technology Research Center (HITRC)

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NATIONAL LEARNING CONSORTIUM

The National Learning Consortium (NLC) is a virtual and evolving body of knowledge and tools designed to support healthcare providers and health IT professionals working towards the implementation, adoption and meaningful use of certified EHR systems.

The NLC represents the collective EHR implementation experiences and knowledge gained directly from the field of ONC's outreach programs ([REC](#), [Beacon](#), [State HIE](#)) and through the [Health Information Technology Research Center \(HITRC\)](#) Communities of Practice (CoPs).

The following resource is an example of a tool used in the field today that is recommended by "boots-on-the-ground" professionals for use by others who have made the commitment to implement or upgrade to certified EHR systems.

DESCRIPTION

The Clinical Quality Measure (CQM) quick reference guides provide a summary of key information for CQMs and are intended to be shared with clinical staff using an electronic health record (EHR). The first two sections may be distributed as stand-alone references.

The first section, *Quick Facts*, comes from the CQM e-specifications and is intended to provide an overview of the measure. This section provides information on the measure definition, whether the measure is a core, alternate core, or menu set measure, whether it is related to other measures by common data elements, and what data goes into a numerator, denominator, and exclusions or exceptions.

The second section, *Key Clinical Activities* and *Planning Your EHR Documentation*, is intended to be a space to plan EHR documentation. It provides a "to-do list" of clinical and documentation activities for the measure and lists each data element that is required to calculate the numerator, denominator, and exceptions or exclusions. Providers can use this space to assign individuals or roles to tasks in the to-do list.

The third section, *Technical Supplement*, provides clarifications regarding what "counts" toward this measure. First, it provides English "translations" of the numeric SNOMED-CT, HL7, ICD, and CPT codes that may be used in this measure. Second, it includes clarifications on what constitutes a numerator "hit" or a denominator exclusion based on questions that have arisen during technical assistance calls.

To access the official electronic specifications, visit the CMS Electronic Specifications page <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/ElectronicSpecifications.html> and locate the "EP Measure Specifications" zip file, which contains electronic specifications for all 44 Stage 1 Meaningful Use clinical quality measures.

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Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer.

Quick Facts	
Type of measure: core, alternate core, or menu?	<ul style="list-style-type: none"> Menu measure
Related to other measures?	<ul style="list-style-type: none"> Not related to other Stage 1 MU clinical quality measures
Data required to identify the <u>denominator</u> (total cases eligible to be counted in measure)	<ul style="list-style-type: none"> Active diagnosis of prostate cancer¹ Procedure performed: prostate cancer treatment² Procedure result of AJCC cancer stage low risk recurrence prostate cancer³ Laboratory test result for prostate specific antigen test less than or equal to 10 mg/dL³ Laboratory test result for Gleason score less than or equal to 63
Data required to identify the <u>exceptions</u> or <u>exclusions</u>	<ul style="list-style-type: none"> Active diagnosis of pain related to prostate cancer⁴, or Procedure performed: salvage therapy⁴, or Reason for performing bone scan⁴ (diagnostic study)
Data required to identify the <u>numerator</u> (cases in which the process or outcome being measure occurred)	<ul style="list-style-type: none"> Bone scan (diagnostic study) performed⁴

Note: This document is meant to supplement and not replace the official electronic specifications for the measure. To access the official specifications, please visit: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/ElectronicSpecifications.html>

Key Clinical Activities		Planning Your EHR Documentation	
To-Do List	Why Needed?	Data Elements Needed	Responsible Person or Role
1. Check patient record or assess active diagnosis of prostate cancer	<ul style="list-style-type: none"> Ensures only patients with an active diagnosis of prostate cancer are included in the denominator 	<ul style="list-style-type: none"> Active diagnosis of prostate cancer, if indicated 	

¹ This data element(s) must be documented before or during the measurement period.

² This data element(s) must be documented during the measurement period

³ This data element(s) must be documented before or on date of prostate cancer treatment listed

⁴ This data element(s) must be documented after or simultaneous to the date of prostate cancer active diagnosis

Key Clinical Activities		Planning Your EHR Documentation	
To-Do List	Why Needed?	Data Elements Needed	Responsible Person or Role
2. Check patient record for procedure performed indicating prostate cancer treatment. Or, if appropriate, order procedure	<ul style="list-style-type: none"> Ensures only patients with a prostate cancer treatment procedure performed are included in the denominator 	<ul style="list-style-type: none"> Prostate cancer procedure performed, if any 	
3. Check patient record for procedure result indicating AJCC cancer stage low risk recurrence prostate cancer. Or, if appropriate, order procedure	<ul style="list-style-type: none"> Ensures only patients with procedure result indicating AJCC cancer stage low risk recurrence prostate cancer are included in the denominator 	<ul style="list-style-type: none"> Document procedure result indicating AJCC cancer stage low risk recurrence prostate cancer, if any 	
4. Check patient record for prostate specific antigen test result. Or, if appropriate, order test.	<ul style="list-style-type: none"> Ensures only patients with a prostate specific antigen test result ≤ 10 mg/dL are included in the denominator 	<ul style="list-style-type: none"> Document prostate specific antigen test result (particularly if result ≤ 10 mg/dL), if any. 	
5. Check patient record for Gleason score lab test result.	<ul style="list-style-type: none"> Ensures only patients with Gleason score result ≤ 6 are included in the denominator 	<ul style="list-style-type: none"> Document Gleason score laboratory test result (particularly if Gleason score ≤ 6), if any 	
6. Check patient record or assess for active diagnosis of pain related to prostate cancer, salvage therapy, or reason bone scan performed	<ul style="list-style-type: none"> Ensures patients with an active diagnosis of pain related to prostate cancer, or documentation of salvage therapy or reason bone scan performed are identified as exclusions or exceptions 	<ul style="list-style-type: none"> Document the active diagnosis, the salvage therapy performed, or the reason for doing the bone scan, if needed 	
7. If not excluded, check if patient has received a bone scan (diagnostic study) after or at the same time as having an active diagnosis of prostate cancer	<ul style="list-style-type: none"> Ensures patients <i>without</i> a bone scan performed during the measurement period are counted in the numerator 	<ul style="list-style-type: none"> Document if bone scan performed⁵ 	

⁵ See Technical Supplement for numerator inclusion details (bone scan): [pp. TS-2](#)

Technical Supplement

The following pages list the technical definitions of the codes that could be included in the calculation of this measure. Use these lists as needed to confirm that your clinical documentation includes item(s) that are on this list, where appropriate, to ensure accurate calculation of your quality measure denominator and numerator.

NUMERATOR INCLUSION CRITERIA

What constitutes a bone scan (diagnostic study)? (CPT codes)

- Bone and/or joint imaging; limited area
- Bone and/or joint imaging; multiple areas
- Bone and/or joint imaging; whole body
- Bone and/or joint imaging; 3 phase body
- Bone and/or joint imaging; tomographic (SPECT)
- Bone density (bone mineral content) study, 1 or more sites; single photon absorptiometry
- Bone density (bone mineral content) study, 1 or more sites; dual photon absorptiometry, 1 or more sites

What constitutes a bone scan (diagnostic study)? (CPT codes)

- Bone imaging of limited area (procedure)
- Bone imaging, vascular flow study (procedure)
- Isotope static scan skull (procedure)
- Radioisotope scan of bone (procedure)
- Radionuclide bone imaging of femur (procedure)
- Radionuclide bone imaging of head and neck (procedure)
- Radionuclide bone imaging of lumbar spine (procedure)
- Radionuclide bone imaging of pelvis (procedure)
- Radionuclide bone imaging of thorax (procedure)
- Radionuclide bone study delayed (procedure)
- Radionuclide bone study first pass (procedure)
- Bone imaging of limited area (procedure)
- Bone imaging, vascular flow study (procedure)
- Radionuclide dynamic bone imaging (procedure)
- Radionuclide imaging of bone of ankle and foot (procedure)
- Radionuclide imaging of bone of knee (procedure)
- Radionuclide imaging of bone of lower leg (procedure)
- Radionuclide imaging of bone of upper limb (procedure)
- Radionuclide imaging of bone of wrist (procedure)
- Radionuclide study of bone of head (procedure)
- Radionuclide three-phase bone study (procedure)
- Radionuclide two-phase bone imaging of ankle and foot (procedure)
- Radionuclide two-phase bone imaging of femur (procedure)
- Radionuclide two-phase bone imaging of head and neck (procedure)
- Radionuclide two-phase bone imaging of knee (procedure)
- Radionuclide two-phase bone imaging of lower leg (procedure)
- Radionuclide two-phase bone imaging of lumbar spine (procedure)
- Radionuclide two-phase bone imaging of pelvis (procedure)
- Radionuclide two-phase bone imaging of thorax (procedure)
- Radionuclide two-phase bone imaging of upper limb (procedure)
- Radionuclide two-phase bone imaging of wrist (procedure)

What constitutes a bone scan (diagnostic study)? (CPT codes)

- Radionuclide two-phase bone study (procedure)
- Radionuclide whole body bone study (procedure)
- Skull isotope studies (procedure)

TYPES OF CODES REQUIRED FROM YOUR EHR FOR CALCULATING THIS CLINICAL QUALITY MEASURE

NQF0389	CPT	CPT Modifier	CVX	Grouping	HCPCS	HL7	ICD-9*	ICD-10	LOINC	RxNorm	SNOMED*
Numerator ¹				×			×	×			×
Denominator ²	×			×			×	×	×		×
Exceptions or exclusions ³	×			×			×	×			×

- Codes with an asterisk (*) are required from certified EHRs.
- ¹ To identify the numerator in this CQM, the following standard codes are required: no "diagnostic study" code from CPT or SNOMED
- ² To identify the denominator in this CQM, the following standard codes are required: (1) two laboratory test results from LOINC, SNOMED or GROUPING, and (2) one "diagnosis/condition/problem" code from ICD-9, ICD-10, SNOMED or GROUPING, and (3) two "procedure" codes from CPT, SNOMED, or GROUPING, AND (4) one "procedure" code from SNOMED.
- ³ To identify the exclusions in this CQM, the following standard codes are required: (1) a "diagnosis/condition/problem" code from ICD-9, ICD-10, SNOMED, or GROUPING, OR (2) a "procedure" code from CPT, SNOMED or GROUPING, OR (3) a "diagnostic study" code from CPT, SNOMED, or GROUPING

Abbreviation	Long Name	Definition/Description
CPT	Current Procedural Terminology	The CPT (Current Procedural Terminology) is produced by the American Medical Association (AMA). CPT codes are used to report medical procedures and services. (Source: CDC)
CVX	Codes for Vaccine Administered	This vocabulary provides terminology for Vaccine Administered. The vocabulary is defined in Health Level Seven (HL7) Version 2.5.1. (Source: USHIK)
HCPCS	Healthcare Common Procedure Coding System	Level I of the HCPCS is comprised of CPT (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA). Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. (Source: CMS)

Abbreviation	Long Name	Definition/Description
HL7	Health Level Seven	HL7 is an accredited ANSI standard organization that produces the HL7 messaging standard. It is the accepted messaging standard for communicating clinical data. It is supported by every major medical informatics system vendor in the US. (Source: ASPE)
ICD-9	International Statistical Classification of Diseases and Related Health Problems, 9th revision	The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is based on the World Health Organization's Ninth Revision, International Classification of Diseases (ICD-9). ICD-9-CM is the official system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States. The ICD-9 is used to code and classify mortality data from death certificates. (Source: CDC)
ICD-10	International Statistical Classification of Diseases and Related Health Problems, 10th revision	The International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10), published by the World Health Organization (WHO), is the foundation of ICD-10-CM. ICD-10 continues to be the classification used in cause-of-death coding in the United States. The ICD-10-CM is comparable with the ICD-10 (Source: CDC)
LOINC	Logical Observation Identifiers Names and Codes	A universal code system for identifying laboratory and clinical observations. (Source: LOINC)
RxNorm	RxNorm	RxNorm provides normalized names for clinical drugs and links its names to many of the drug vocabularies commonly used in pharmacy management and drug interaction software, including those of First Databank, Micromedex, MediSpan, Gold Standard Alchemy, and Multum. By providing links between these vocabularies, RxNorm can mediate messages between systems not using the same software and vocabulary. (Source: NLM NIH)
SNOMED-CT	Systematic Nomenclature of Medicine - Clinical Terms	SNOMED CT (Systematized Nomenclature of Medicine--Clinical Terms) is a comprehensive clinical terminology, originally created by the College of American Pathologists (CAP) and, as of April 2007, owned, maintained, and distributed by the International Health Terminology Standards Development Organisation (IHTSDO), a not-for-profit association in Denmark. (Source: NLM NIH)

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