

QOPI CERTIFICATION PROGRAM™

QCP Initial Chart Documentation Submission Guide

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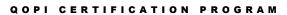
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PREPARING YOUR DOCUMENTATION

WE CANNOT ACCEPT ANY DOCUMENTS IN THE QOPI CERTIFICATION E-MAIL BOX THAT ARE PATIENT SPECIFIC (ORDERS, MEDICAL RECORD PAGES ETC.). WE USE DATABANK A HIPAA COMPLIANT DATA REPOSITORY WHICH ALLOW US TO COLLECT REDACTED INFORMATION WITH LIMITED PHI TO CONFIRM COMPLIANCE WITH STANDARDS. THIS "LIMITED DATA SET" MUST BE SUBMITTED TO DATABANK..

Instructions for submitting patient records:

Preparing the documentation to send to Databank: *HIPAA Compliance & Chart Preparations*

- You must remove patient-identifying information on the copies of your patient's records (or copies of the printed documentation if your practice maintains electronic health records) so that the copies you submit qualify as a HIPAA Limited Data Set (for which we have signed a data use agreement, as required by HIPAA). Specifically, HIPAA requires that you remove all of the following information about the patient and his/her relatives, household members, and employers from every page of the copies you submit* (See Appendix for the complete list):
 - Patient Names
 - Patient Medical Record Numbers
 - Patient postal address information
 - o Patient Telephone and Fax Numbers
 - Patient E-mail Addresses
 - Patient Social Security Numbers
 - o Patient Health Plan and other Account Numbers
- Exception: please keep the patient's date of birth and date of death (where applicable) present on one page of the documents submitted. This information will be used to verify the data that has been abstracted. This will qualify as a limited data set and will not violate HIPAA agreements that we have.
- Please write the QOPI Chart ID at the top of each page of the chart documentation.
- Your Documents are scanned to Black and White- **no highlighting** will show; you must circle or underline the information.
- Please use the attached Chart Data Spreadsheet to help you identify
 the portions of the records that should be used to verify the data
 submitted for the QOPI measures listed on the Chart Data
 Example Spreadsheet.
- Review what information was entered for each chart from your QOPI account and send documents that will confirm the data you entered during the abstraction process

PLEASE NOTE EXCEPTION: Limited Data Set

- Do NOT send the patient's entire medical record;
 - Send only the documentation needed to verify the information documented for the measures listed on the Chart Data worksheet (see appendix).
 - Organize and package documents so that each patient's chart information is collated and can be clearly identified (use a folder, binder clip, to group all of the information for chart #1, chart #2, etc.).
- You MAY organize the charts into the following separate tabs so that the reviewers can easily locate the information. Use dividers separate sections, and label them.
 - 1. Pathology pathology and cytology reports
 - 2. Initial Consult first visit to the practice, initial clinical documents filled out by patients (past history, medication list, distress tool, etc.)
 - 3. Flow Sheets Anything the practice might use to track vital signs, progress notes, chemo administration forms
 - 4. Treatment Plan- A note that states the planned treatment and rationale
 - 5. Office Visit Notes
- It is helpful to circle or arrow (highlighting will not display on scans) pertinent information (such as smoking status, presence/absence of pain) that may be not as easy to find in the medical record as the patient's diagnosis, for example. Patient-identifying information can be removed by cutting off the top section of a page where a patient's name/info appears and/or using a marker to completely black out this information throughout the medical record.

*IMPORTANT:

*IMPORTANT: HIPAA requires that you make reasonable efforts to disclose no more than the minimum necessary amount of patient information needed to accomplish the intended purpose of the disclosure. If you do not remove patient identifiers, we will destroy the copies you send us and will notify you that you need to re-submit copies without patient identifiers.

Sending Paper or Electronic Documentation to Databank

Where/How to send Documentation

To submit Paper Copies documentation:

1) Chart documentation <u>must</u> be shipped to DataBank IMX, from your practice using an overnight service. Charts cannot be emailed.

- Using an overnight service will shorten exposure of the records to loss or damage in transit.
- Overnight services also have the ability to reliably track location and document delivery of the records.
- We suggest that you double box the records;
 - A small box should be placed within a large box to ensure that if the outer box is damaged, the papers will be intact and identifiable in the inner packaging.
 - This will serve as an added protection for you to meet requirements of HIPAA regulations.
- 2) Documentation should be addressed to:

DataBank IMX Attn: Jim Mullican 12000 Baltimore Ave., Suite 300 Beltsville, MD 20705

- 3) Please include a completed Cover Sheet, which was attached to the instructions email, in front of your packet of charts (see appendix)
- 4) If you have any questions regarding these instructions, please do not hesitate to email qopicertification@asco.org

Electronic Mailing instructions for Charts: E-Mail

- 1. You may send electronic PDF copies via e-mail
 - a. To email your documentation, you must ensure that you have an encrypted computer connection or use an encrypted File Transfer system
 - b. After you have create an electronic PDF file of your documentation use the encrypted system to email to ascocert@databankimx.com
 - c. <u>Please notify the QOPI Certification HelpDesk</u> (Qopicertification@asco.org) to let us know that you have sent documentation to Databank.

ALL Medical Record Documentation sent to the ASCO QOPICERTIFICATION INBOX will be <u>Deleted</u> without being read.

If documentation is submitted incorrectly, you will have to resubmit!

Helpful Tips:

• Please feel free to provide clarifying information (when needed) in a cover note.

- If your practice used handwritten orders at the time you began the Certification application process but now uses an electronic system, please alert us about this change.
- Similarly, if your practice has merged with another or changed names, etc., please communicate these changes.

Patient information must be de-identified

See Appendix for List of 18 Identifiers that Constitute PHI (Protected Health Information).

- Cutting off the top section of a page where a patient's name & identifying information appears
- Use a marker to completely black out all personal information, including date of birth, phone number, and occupation
- Information must be blacked out everywhere it appears in the copies of the patient's record that you are submitting. [Not just headers].

Submissions containing identifiers will be destroyed without review, upon receipt, in accordance with ASCO policy, and the practice will need to resubmit properly de-identified records.

How to De-Identify

Policy upon receipt Of Non-Redacted PHI

Labeling Your Documentation for Databank

It is very important to label documentation correctly. Documents must be labeled with the correct Chart ID on each page.

We utilize a HIPAA compliant document imaging system. We convert paper into electronic documents and store them in our repository. A non-medical person frequently does this process; therefore, clear labeling is essential.

Labeling is an important part of a document imaging system, and ensures that end-users are able to retrieve documents from the document repository. The core of our document imaging system is our embedded label technology. To retrieve a scanned PDF image at a later date, key search words and numbers are used for identification.

Examples of commonly scanned materials for the Chart submission:

- Initial Consultation notes
- Most recent progress notes
- Flowsheet with vital signs, performance status, pain assessment, etc.
- Distress tool, if applicable
- Chemotherapy Flowsheet with start date
- Pathology reports
- Medical record copies
- Lab reports, KRAS, CEA, EGFR/Alk, etc.
- Surgical report
- Consent form
- Hospice admission date
- Evidence of date of death
- Correspondence

Paper documents submitted for scanning may be:

- loose or bound materials
- up to 11" x 17" in size
- black and white or color*

Examples of paper documents submitted correctly:

- Each page of the document is labeled with the Chart ID
- Highlighters are NOT used: Color cannot be seen.



^{*}Documents are scanned to black and white and highlighted text does not appear.

- Circle arrow, or otherwise indicate pertinent information
- Clarifying information is provided (when needed) in a cover note or by clearly writing on the document itself.
 - o Do not use post-it notes they are easily misplaced.

Appendix

Protected Health Information (PHI) Identifiers

List of 18 Identifiers that Constitute PHI Names

- All geographic subdivisions smaller than a state, including: street address, city, county, precinct, ZIP Code, and their equivalent geographical codes, except for the initial 3 digits of a ZIP Code if, according to the current publicly available data from the Bureau of the Census:
- All elements of dates (except year) for dates directly related to an individual, including birth date (we do need one visible DOB to confirm the abstraction data), admission date, discharge date, date of death (we need one visible DOD to confirm the abstraction data), and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older. ***
- o Telephone Number
- o Fax Number
- o E-mail Address
- o Social Security number
- Medical Record number
- o Health Plan Beneficiary number
- Account numbers
- Certificate/License number
- Vehicle Identifiers and Serial numbers (including license plates)
- Device identifiers and Serial numbers
- URL Address
- o IP Address
- o Biometric identifiers, like fingerprints and voiceprints
- Full-face Photos and Any Comparable Images
- o Any other unique identifying number, characteristic or code

*** The QCP chart submission requires Date of Diagnosis, Date of Birth, Date of Death, Surgical Date, ICD-9 code and Visit Dates.

The purpose of this resource tool is to aid in the consistent application and evaluation of the chemotherapy safety standards, based on the ASCO/ONS standards as applicable to the QOPI certification program. We recognize that all practices are unique. If you need additional guidance, or have questions regarding the submission of the chart documentation, please contact us at qopicertification@asco.org