

**WHITEPAPER**

KEEP CALM AND REPORT ON!

# Physician Quality Reporting System 2016

**A**s the calendar year 2016 begins, many providers may be getting nervous about their Physician Quality Reporting System (PQRS) participation. In the wake of many providers receiving PQRS penalty letters in the last few months, providers have reason for concern. Financial penalties associated with PQRS and the associated Value Based Modifier program (VM) continue to be between 2% and 6% of total Medicare payments in 2016. Furthermore, the administrative requirements of the program keep growing and growing. However, in 2016, there have been several changes and measure additions specific to radiology that should allow for more choices for reporting – and, more importantly, a higher probability of successful reporting.

With the above in mind, the purpose of this article is to assist radiologists in understanding their options for PQRS reporting in 2016 and the nine (yes 9!) new PQRS measures related to diagnostic and interventional radiology. Prepared with this information, the radiologist will be able to determine the best way to comply with the PQRS and VM programs and avoid those pesky penalties.

## What is PQRS? What is VM? How does PQRS fit in with the VM program?

The Physician Quality Reporting System (PQRS) is a “voluntary” reporting program for eligible professionals, who report data on quality measures for services provided to Medicare beneficiaries. If an eligible professional fails to successfully participate in PQRS

in 2016, the Medicare payments for 2018 will be reduced by 2%.

The Value-Based Modifier program (VM) uses a physician’s PQRS data to allow Medicare to apply an additional adjustment (positive/neutral/negative) to a physician’s payments under the Medicare Physician Fee Schedule based upon the quality and cost of care. Per the 2016 Medicare Fee Schedule Final Rule, the VM payment adjustments are as follows:

VM adjustment. In addition, if 50% or more physicians under one tax identification number successfully participate in PQRS, that group of physicians will not be subjected to a negative VM payment adjustment.

With this in mind, the best defense against the PQRS and VM payment penalties is to successfully participate in the PQRS program. And again, the 2016 PQRS reporting will determine the amount of the provider’s

**Table 48: Final CY 2018 VM Payment Adjustment Amounts with 2-9 Eligible Professionals and Solo Practitioners**

Cost/Quality	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+1.0%	+2.0%
Average Cost	-1.0%	+0.0%	+1.0%
High Cost	-2.0%	-1.0%	+0.0%

**Table 47: Final CY 2018 VM Payment Adjustment Amounts for Groups with 10 or More Eligible Professionals**

Cost/Quality	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+2.0%	+4.0%
Average Cost	-2.0%	+0.0%	+2.0%
High Cost	-4.0%	-2.0%	+0.0%

Unlike the PQRS payment adjustments, the VM payment adjustments are more subjective. Further, any VM payments must be budget neutral. Therefore, the distribution of VM payments or penalties is dependent on the PQRS participation and quality/cost reporting of other physicians. While the exact distribution of VM payments is unknown, Medicare has indicated that based on prior PQRS data, the majority of providers would receive no

PQRS and VM penalties for 2018 Medicare payments. In other words, if a physician simply ignores the PQRS program in 2016, that physician will receive a total reduction of 6% for all of their Medicare payments in 2018 if that physician is part of a group of 10 or more physicians. The reduction would be 4% of all Medicare payments for groups of less than 10 physicians.

## Who are the eligible patients and providers for PQRS and VM?

The patients covered by PQRS/VM include patients with Medicare Part B coverage as a primary or secondary payor, as well as Railroad Medicare patients. PQRS codes are not required or accepted by Medicare HMOs at this point.

In 2016, in order to be considered an eligible professional for PQRS and VM, the provider must provide services that are payable under the Medicare Part B Fee Schedule. For purposes of most radiology practices, these providers would be radiologists, physician assistants, and nurse practitioners. Additionally, the provider must use their individual NPI number to submit claims. Therefore, Independent Diagnostic Testing Facilities (IDTFs) continue to be excluded from the PQRS program.

## So, how do I participate in 2016? How do I minimize my chances of getting penalized?

There are seven general ways to report on PQRS: 1) individual claims-based reporting, 2) individual PQRS registry reporting, 3) Qualified Clinical Data Registries (QCDR) - radiologists can utilize this option via the QCDR offered by the American College of Radiology (ACR), 4) a qualified Electronic Health Records (EHR) product, 5) Group Practice Reporting Option (GPRO) through a PQRS registry, 6) PQRS Measures Groups and 7) Accountable Care Organizations (ACOs).

In order to successfully participate in PQRS in 2016 and avoid penalties, each eligible professional reporting on an individual basis must report on 9 PQRS measures. If using a group practice option, the group must report on 9 PQRS measures.

The 9 PQRS measures must cover three National Quality Strategy (NQS) domains. Further, if an eligible professional bills for any face-to-face encounters, a 'cross-cutting' PQRS measure must be chosen. The NQS domains are: Effective Clinical Care, Patient Safety, Communication and Care Coordination, Person and Care Giver-Experience and Outcomes, Efficiency and Cost Reduction, and Community/Population Health. Cross-cutting measures cover more than one NQS domain. The cross-cutting measures were denoted in Table 52 of the 2015 Medicare Final Fee Schedule. Additional cross-cutting measures were added in Table 29 of the 2016 Medicare Final Fee Schedule.

Traditionally, claims-based reporting has been the best choice for radiology groups. And given the claims-based PQRS radiology measure additions, claims-based reporting continues to be the best option in 2016. However, if a group is not comfortable with claims-based reporting or if claims-based reporting is determined to be unsuccessful/uncertain mid-way through the year, registry reporting can be a viable 'safety net' for PQRS reporting. Registry reporting can be accomplished either through a PQRS registry or through the QCDR administered by the ACR.

With the above in mind, this article will focus on PQRS reporting through the claims-based reporting mechanism and, secondarily, registry-based reporting through an individual registry or the ACR registry. If a radiologist wishes to consider participating in the PQRS program through the ACR QCDR, it would be best to visit the ACR website to obtain additional information on QCDR reporting.

## Claims-Based Reporting

To report on PQRS through claims-based reporting, radiologists include additional documentation elements in their radiology reports. This documentation allows the coders at the radiologist's billing company to attach the appropriate PQRS CPT code to the HCFA. Medicare refers to these PQRS CPT codes as 'CPT II Codes'. The addition of this CPT II Code triggers participation in PQRS; no additional forms need to be completed. The PQRS codes submitted also will be used to evaluate the radiologists/radiology groups for the VM program.

There are currently fifteen radiology-specific PQRS measures: eight for diagnostic radiology and seven for interventional radiology. There are an additional nine PQRS measures related to patient visits (known as E&M codes). These nine E&M measures have no diagnosis criteria and should be considered by any radiology group that bills for patient visits. The relevant PQRS measure names, descriptions, NQS domains, cross-cutting indicators, and documentation requirements are listed in "Exhibit A: Measure Description and Documentation Requirements, Claims-Based and Registry Reporting Options." It is worth noting that the only cross-cutting measures available for radiologists are the PQRS measures associated with the E&M codes (patient visits).

Again, to avoid PQRS penalties for 2018, under the claims-based reporting method, each radiologist must report on 9 PQRS measures

covering at least 3 NQS domains and then report the PQRS codes on at least 50% of eligible patients. One of the measures must be a cross-cutting measure if the provider bills for face-to-face encounters. If fewer than 9 measures apply, the eligible professional must report on all applicable measures.

Since the PQRS program's inception nearly ten years ago, a significant percentage of providers have attempted participation in PQRS, but have suffered penalties due to a variety of reporting problems. For this reason, it is recommended that radiologists report on all possible measures. To facilitate reporting on the maximum number of measures, the documentation requirements and pros/cons of each measure are outlined below.

## How Do I Focus on the Best Radiology Claims-Based Measures for My Practice?

In order to avoid the penalties, radiologists must ensure that the 50% threshold requirement is met on at least nine measures. Radiologists should choose PQRS quality measures for services that are performed frequently if at all possible. Other considerations include:

▶ How onerous are the documentation requirements for each measure?

▶ Must we rely on outside sources of information (like the hospital) to obtain any of the necessary documentation elements? If so, will the outside party be willing to provide this information?

▶ How will these additional documentation elements be perceived by the referring physicians?

A thorough billing company that focuses exclusively on radiology billing, such as ADVOCATE Radiology and Billing Reimbursement Specialists, should be able to provide answers to all of these questions.

Based on ADVOCATE's extensive experience in radiology billing, we have found that different measures have vastly different success rates with regards to implementation. The PQRS radiology measures are listed below in order of ease of implementation and documentation. Any measure that is new for 2016 is noted as a new measure:

▶ **Measure #146:** Screening mammography

– This code is frequently used and requires no additional documentation efforts on the radiologist's part (the bi-rad codes are already on the report). No information is needed from outside sources and the referring physicians will not notice a change in the reports.

▶ **Measure #436:** Utilization of CT dose lowering techniques (NEW for 2016) – This new measure applies to all CT studies and requires the radiologist to report if the CT equipment has one or more of the following three dose lowering techniques: 1) automated exposure control, 2) adjustment for patient size, or 3) use of iterative reconstruction techniques. While this information does need to be obtained from the facility, this information should be readily available. Therefore, most groups can comply with this measure by obtaining the information and executing an attestation that is site specific. The ease of obtaining the information and the large number of applicable studies make this measure a favorable addition for radiologists in 2016.

▶ **Measure #405:** Abdominal lesion follow up (NEW for 2016) – This measure applies to all abdominal imaging (CT, MRI, and Ultrasound) and measures the frequency that the radiologist orders follow up imaging for patients for various liver, kidney, and adrenal lesions. As the radiologists are not required to document anything differently and this measure applies to a large number of studies, this new measure will not be difficult to report.

▶ **Measure #406:** Thyroid nodule follow up (NEW for 2016) – This measure applies to all CT and MRI studies of the chest and neck and Ultrasound of the neck and measures the frequency that the radiologist orders follow up imaging for patients with thyroid nodules that are less than 1.0 cm. As the radiologists are not required to document anything differently and this measure also applies to a large number of studies, this new measure will not be difficult to report.

▶ **Measure #195:** Carotid imaging – These codes are often used and no information is needed from outside sources. Since reporting the percentage of stenosis according to NASCET or velocity flow will satisfy the PQRS reporting requirements for this measure, the extra documentation efforts are minimal. Also, as these elements are commonly seen on these types of reports, the referring physicians will likely not notice a significant change to these reports.

▶ **Measure #147:** Bone nuclear medicine –

While this study is likely not performed as frequently as the first five measures, this study is performed fairly often in most groups. In addition, the documentation requirements are fairly minimal (the presence or absence of comparison studies simply needs to be documented). No information is needed from outside sources and the referring physicians will likely not notice a change to these reports.

▶ **Measure #225:** Screening mammogram reminders – Most facilities now have a reminder system for screening mammograms. Provided that the reminder systems are in place for all locations where screening mammography is provided, it is relatively easy to add the necessary documentation to the screening mammography report template to indicate that the patient has been entered into the reminder system to schedule their next mammogram.

▶ **Measure #145:** Fluoroscopy – Studies with fluoroscopic guidance are performed quite regularly and the additional documentation of the exposure time or dosage is not onerous. Furthermore, this added documentation would not cause a noticeable change to the report from the referring physician standpoint. One concern with this measure is that the radiologist is often dependent on obtaining this information from a hospital employee such as a technician. If this information can be obtained easily, this measure can be reported with relative ease.

▶ **Measure #76:** CVC insertion – If a radiologist provides this type of service frequently, this measure would be a good choice. While the additional verbiage is rather lengthy regarding the sterile technique, this verbiage can often be added to report templates for ease of documentation (these procedures would rarely if ever be performed without meeting all elements of the sterile barrier technique). Also, no information is needed from outside sources. The only downside to this code would be the frequency that the procedure is performed and the referring physicians' view of the length of the additional documentation.

▶ **Measure #418:** Osteoporosis management in women who had a fracture (NEW for 2016) – This "new" measure applies to vertebroplasties or patient visits/evaluations for vertebroplasties. The radiologist must document if the patient had a previous bone density mineral test or if the patient received a prescription for a drug to treat osteoporosis. This measure might sound familiar as it is the same documentation requirements as the old vertebroplasty measure (Measure #40). As many

radiologists who perform vertebroplasties are already well-versed with the documentation requirements for this measure, this recycled measure should be able to be reported with relative ease.

▶ **Measure #24:** Osteoporosis communication in women and men aged 50 and older (REVISED for 2016) – This measure concerning communication between the physician treating the fracture and the physician managing the patient's ongoing care again applies to vertebroplasties/kyphoplasties. The radiologist performing the vertebral procedure should document communication to the referring physician that a fracture occurred and that the patient was or should be tested for osteoporosis. For radiologists who perform vertebroplasties/kyphoplasties, this measure (along with Measure #418) would be a good choice.

▶ **Measure #21:** Use of prophylactic antibiotics in various surgical procedures – The applicable procedures for this measure have expanded and now include lumbar kyphoplasties, various endovascular repairs, angioplasty, and stent placements. In addition, reporting on the use of the prophylactic antibiotic is not difficult. However, the use of prophylactic antibiotics is often determined by the referring physician, not the radiologist. Therefore, radiologists may not be comfortable reporting on this measure.

▶ **Measure #22:** Discontinuation of prophylactic antibiotic - This is an add-on measure for measure #21 and requires the radiologist to report on the discontinuation of the prophylactic antibiotic within 24 hours of the surgery. The surgical procedures in this measure are the same as measure #21. However, there can be difficulties in reporting this measure because the discontinuation of the antibiotic may not be known at the time that the radiologist is dictating the radiologist report. The limited number of procedures and the difficulty in obtaining this information cause problems in reporting this measure.

▶ **Measure #23:** VTE prophylaxis - This measure applies to endovascular repairs, stent placements and cholangiography and requires the radiologist to report on the order for venous thromboembolism (VTE) prophylaxis (medication or mechanical). The low number of applicable measures and the ability to obtain this information and accurately include it in the radiology report make this measure extremely challenging to report.

▶ **Measure #437:** Surgical conversion for endovascular revascularization procedures

(NEW for 2016) – This new measure applies to endovascular revascularization and requires the radiologist to report if the patient had an unplanned amputation or bypass within 48 hours following the revascularization procedure. As the radiologist typically does not have this information, this measure will be very difficult to report.

## So, What about Patient Visit Measures?

As noted above, several of the registry PQRS measures are quite difficult to report. The applicable procedures are typically very low volume for measures #21, #22, #23, and #437; further, the documentation requirements can be difficult to obtain. Therefore, if a radiologist performs these types of surgical procedures and performs patient visits, the radiologist should consider reporting on a variety of PQRS measures related to patient visits. The PQRS measures related to patient visits are also included in “Exhibit A.” The documentation requirements for these measures are fairly straightforward and have been listed below in order of ease of documentation. The challenging portion for patient visit measures is getting the information from the patient to the radiology report.

▶▶ **Measure #110:** In order to fulfill the requirements of this measure, the patient simply needs to provide the date of their last flu vaccine. This measure serves as a cross-cutting measure.

▶▶ **Measure #111:** In order to fulfill the requirements of this measure, the patient needs to provide the date of their last pneumococcal vaccine. This measure serves as a cross-cutting measure.

▶▶ **Measure #130:** The patient must provide a list of all medications (prescription, over-the-counter, herbal, vitamins, etc.) to document this measure. As this information is typically obtained at all patient visits, this measure is often a good choice. This measure serves as a cross-cutting measure.

▶▶ **Measure #131:** Documentation of pain assessment on a standardized scale fulfills the requirements of this measure. This measure serves as a cross-cutting measure.

▶▶ **Measure #112:** The patients have to provide the date of their last mammogram to fulfill the requirement of this measure. In 2016,

this measure was designated as a cross-cutting measure and the dates of last mammograms are typically easy to obtain, especially for a radiology based practice.

▶▶ **Measure #226:** The patients should be asked about tobacco use. If there is a history of tobacco use, the patients should be asked if they received smoking cessation counseling intervention. This measure is a cross-cutting measure.

▶▶ **Measure #39:** The patients need to provide the date of their last DEXA scan or pharmacologic therapy for osteoporosis prevention to fulfill the documentation requirements of this measure. This measure is not cross-cutting, but is typically easy to obtain.

▶▶ **Measure #48:** Female patients need to be asked about the presence or absence of urinary incontinence. While this measure is not cross-cutting, the information is typically easy to obtain.

▶▶ **Measure #113:** The patient should indicate if they have had a colorectal screening as follows: Fecal occult blood test within the last 12 months or flexible sigmoidoscopy during the last four years or colonoscopy during the last nine years. Due to the variety of timeframes of the testing, this measure may be a bit more challenging to report (also, it is not a cross-cutting measure).

## How Do I Make Sure That My Billing Company Is Accurately Reporting PQRS for My Practice Using the Claims-Based Mechanism?

Per Medicare, PQRS penalties will be calculated at the individual level based on the eligible professional's NPI when reporting by the claims-based mechanism. Because Medicare tracks the use of the PQRS codes so thoroughly, it is essential that the radiologist's billing company provides accurate and timely feedback regarding the utilization of the PQRS codes.

Thorough reporting from the billing company back to the radiology group regarding PQRS would include three elements:

▶▶ 1. The billing company should provide information for each individual physician for each PQRS measure in order to identify problem areas in the radiologist's dictation. This information should be provided monthly, at a minimum. It will allow radiologists to address dictation issues promptly, and correct hospital information

flow as applicable.

▶▶ 2. The billing company should compile a listing of all CPT codes impacted by PQRS and compare these CPT codes to the number of PQRS codes billed out. This should be performed monthly, starting when the radiologist begins participation in the program, and continue at quarterly intervals, at the minimum, thereafter. If there is a discrepancy in the number of PQRS codes and procedure codes, this should be investigated immediately to determine the source of the problem. Frequent review of this information will ensure that the practice meets the 50% threshold with ease.

▶▶ 3. The billing company should verify that Medicare is accepting the PQRS codes by checking the remittances for the 'N-620' or 'CO 246 N572' remark codes. These two codes are used by Medicare to indicate the acceptance of PQRS codes with a \$0.00 charge or \$0.01 charge, respectively. The codes should be tracked by measure to ensure that all measures are being accepted. Otherwise, high frequency PQRS codes, like those associated with screening mammograms, could easily obscure Medicare acceptance problems with lower frequency codes, such as those associated with bone nuclear medicine measures.

## Individual Registry Reporting

Just like claims-based reporting, in order to successfully participate in PQRS through an individual traditional PQRS registry in 2016 and avoid penalties, each individual eligible professional must report on 9 PQRS measures across 3 National Quality Strategy (NQS) domains. The PQRS reporting must be applied to at least 50% of the applicable studies for Medicare patients. Further, if an eligible professional bills for any face-to-face encounters, one cross-cutting PQRS measure must be chosen. Cross-cutting measures cover more than one NQS domain.

To report on PQRS through individual registry reporting, radiologists include additional documentation elements in their radiology report for the measures chosen. At the end of the calendar year for 2016 and before March 31st of 2017, the radiologists or their billing company will gather the information for these measures and submit information on these measures all at once to a Certified PQRS Registry. A listing of Registry Vendors is available on the CMS website. The registry will then take this information regarding the measures and submit the measures to CMS. Also, the PQRS codes

submitted through the registry will be used to evaluate the radiologists/radiology groups for the VM program.

The fifteen radiology measures and nine patient visit measures that can be reported by claims-based reporting can also be reported by individual registry reporting. In addition, there are 12 more 'registry only' PQRS measures related to radiology. The relevant PQRS measure names, descriptions, NQS domains, cross-cutting indicators, and documentation requirements are listed in "Exhibit B: Measure Description and Documentation Requirements, Registry Reporting Options." While the requirements for these 'registry only' measures are more difficult in general, the information is provided below to assist in ensuring that each physician meets the 9 measure reporting requirement:

▶▶ **Measure #265:** To fulfill the requirements of this measure, the physician must document that biopsy results were reviewed and communicated to the patient/referring physician. This measure applies to nearly all biopsies (including breast biopsies, liver biopsies, etc.) if the patient is also billed for a patient visit. If a radiology group bills for patient visits before performing these biopsies, this measure would be a good choice.

▶▶ **Measures #322-324:** These three measures are applicable to cardiac nuclear medicine studies, cardiac CT and cardiac MR, which are performed fairly frequently. The specifics of the documentation are as follows:

- Measure #322: Document if the study is being performed within 30 days preceding low risk non-cardiac surgery.
- Measure #323: Document if the study is being performed within 2 years of the most recent Percutaneous Coronary Intervention (PCI).
- Measure #324: Document if the patient is at high or low risk for coronary artery disease.

If the information regarding the patient's medical history is readily available at the time of the cardiac nuclear medicine/CT/MR study, these three measures are viable options for most radiologists. This information can also be obtained from the patient's medical record for previous studies.

▶▶ **Measures #259 and Measure #347:** These two measures relate to endovascular repair procedures (EVARs). The specifics of the documentation are as follows:

- Measure #259: Document if the patient died while in the hospital following the

EVAR procedure

- Measure #347: Document if the patient died while in the hospital following the EVAR procedure.

The availability of this information may be more readily available in the patient's medical record for previous studies. However, as most radiologists do not perform these procedures very frequently, these measures could prove challenging. In addition, the radiologist would likely need to addend the radiology/surgical report after the procedure to accurately capture this information.

▶▶ **Measures #344-345:** These two measures relate to carotid artery stenting (CAS) procedures. The specifics of the documentation are as follows:

- Measure #344: Document if the patient was discharged by day #2 following the CAS procedure.
- Measure #345: Document if the patient suffered a stroke or death following the CAS procedure while in the hospital.

This information should be readily available in the patient's medical record for previous studies. However, the same difficulties with the EVAR PQRS measures listed immediately above apply to the CAS PQRS measures. Additionally, the CAS procedures are typically performed even less frequently than EVAR procedures. Therefore, the CAS measures would be very difficult for most groups to report.

▶▶ **Measures #409 and #413 (NEW for 2016):** These two measures relate to endovascular stroke treatment.

- Measure #409: Document the patient's mRs score 90 days post stroke treatment
- Measure #413: Document if the patient's door to puncture time was greater or less than 2 hours

This information is difficult to obtain and the procedures are not performed frequently. Therefore, these two measures would be difficult for most groups to report.

▶▶ **Measure #420 (NEW for 2016):** This new measure applies to patients who received varicose vein treatment. The physician needs to document if the patient reported improvement on an outcome survey post treatment for varicose veins. This measure would be very onerous to report unless a group has a vein clinic.

▶▶ **Measure #421 (NEW for 2016):** This new measure applies to patients who received an IVC filter. The physician needs to document if the patient was assessed for the appropriate-

ness of IVC filter removal or continued filtration three months post placement. Due to the low frequency of these studies and difficulty in obtaining this information, this measure would be very burdensome for most radiologists to report.

## How do I maximize my chances for successful reporting using a traditional PQRS registry?

The key to successful participation using a registry is early and frequent communication with your PQRS registry. Also, choose the measures that you will report as soon as possible. While you cannot submit the data before the calendar year ends, you should contact the registry to determine what elements the registry needs to submit your data. Based on this information, you can begin compiling the information that will be needed for your patients. By determining the elements that are needed as soon as possible, you will ensure that you meet the March 31, 2017 deadline for the calendar year 2016 submission.

## Qualified Clinical Data Registry (QCDR) via the American College of Radiology (ACR)

If a radiologist is having trouble finding PQRS measures that can be reported through a traditional PQRS registry, using the QCDR through the ACR is a great choice for radiologists. In addition to traditional PQRS measures, the QCDR offered through the ACR offered 24 additional measures that could be reported in 2016. While the specific measures for 2016 are still to be published, it is expected that this option will continue to be a viable option for radiologists in 2016.

More information regarding QCDR reporting for 2016 will be provided as it becomes available. Radiologists are also encouraged to visit the ACR website at [www.acr.org](http://www.acr.org) to obtain additional information about QCDR PQRS reporting for 2016.

## So, what is the bottom line for 2016?

While the PQRS penalties are higher in 2016, the choices for reporting and radiology-specific PQRS measures have increased. Through proper planning and investigating all of your options, you can avoid those aggravating PQRS penalties. So, keep calm and report on!

\*See EXHIBIT A & B on the next pages... 

**EXHIBIT A – MEASURE DESCRIPTIONS AND DOCUMENTATION REQUIREMENTS,  
CLAIMS-BASED AND REGISTRY REPORTING OPTIONS**  
ALL MEASURES IN EXHIBIT A CAN BE REPORTED VIA CLAIMS-BASED OR REGISTRY REPORTING

## Diagnostic Radiology

### ▶▶ Measure #195: Radiology: Stenosis measurement in carotid imaging reports

NQS Domain: Effective Clinical Care

- a. Measure description: Percentage of final reports for carotid imaging studies (neck MRA, neck CTA, neck duplex ultrasound, carotid angiogram) performed for patients that include direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement
- b. Documentation guidelines: For any Medicare patient, need to document:
  - i. Whether or not the final report for carotid imaging studies includes measurement above
  - ii. Indirect reference can also be reference to NASCET technique for CTA's, MRA's and carotid angiograms or velocity flow measurements for Doppler

### ▶▶ Measure #146: Radiology: Inappropriate use of “probably benign” assessment category in screening mammograms

NQS Domain: Efficiency and Cost Reduction

- a. Measure description: Percentage of final reports for screening mammograms that are classified as “probably benign”
- b. Documentation guidelines: For any Medicare patient that has a screening mammogram, need to document:
  - i. The bi-rad code (all practices already document)

### ▶▶ Measure #147: Nuclear Medicine: Correlation with existing imaging studies for all patients undergoing bone scintigraphy

NQS Domain: Communication and Care Coordination

- a. Measure description: Percentage of final reports for all patients, regardless of age, undergoing bone scintigraphy that include physician documentation of correlation with existing relevant imaging studies (e.g. x-ray, MRI, CT, etc.) that were performed
- b. Documentation guidelines: For any Medicare patient that has a nuclear medicine bone scan, need to document:
  - i. Documentation of correlation with existing relevant imaging studies
  - ii. If no documentation, document reason (i.e. 'no relevant studies exist' or 'no comparison studies available')

### ▶▶ Measure #225: Radiology: Reminder System for Mammograms

NQS Domain: Communication and Care Coordination

- a. Measure description: Percentage of patients aged 40 years and older undergoing a screening mammogram whose information is entered into a reminder system with a target due date for the next mammogram
- b. Documentation guidelines: For any Medicare patient aged 40 years and older that has a screening mammogram, need to document:
  - i. Age (date of birth is included on report)
  - ii. If the patient is entered into a reminder system with a target due date for the next mammogram
  - iii. If the patient is not entered into a reminder system, need to document that the patient was not entered into a reminder system.

NOTE: The reminder system must include the following elements: patient identifier, patient contact information, date(s) of the prior screening mammogram(s) if known, and the target due date for the next mammogram.

### ▶▶ Measure #145: Radiology: Exposure time reported for procedures using fluoroscopy

NQS Domain: Patient Safety

- a. Measure description: Percentage of final reports for procedures using fluoroscopy that include documentation of radiation exposure or expo-

sure time

- b. Documentation guidelines: For any Medicare patient that has a procedure using fluoroscopy, need to document:
  - i. Whether or not the radiation exposure (dosage) or exposure time was documented
  - ii. No exclusions exist for this measure (based on age, etc.)

### ▶▶ **Measure #405: Radiology: Appropriate follow up imaging for incidental abdominal lesions**

NQS Domain: Effective Clinical Care

- a. Measure description: Percentage of final reports for abdominal imaging studies for asymptomatic patients aged 18 years or older with one or more of the following noted with incidentally with follow up imaging recommended:
  - Liver lesion  $\leq$  0.5 cm
  - Cystic kidney lesion  $<$  1.0 cm
  - Adrenal lesion  $\leq$  1.0 cm
- b. Documentation guidelines: For any Medicare patient aged 18 years or older that has a CT, MRI or Ultrasound of the Abdomen, or a CT abdomen/pelvis, need to document:
  - i. Age (date of birth is included on report)
  - ii. Whether or not there is an incidental lesion, if follow up is recommended, and medical reason

### ▶▶ **Measure #406: Radiology: Appropriate follow up imaging for incidental thyroid nodules in patients**

NQS Domain: Effective Clinical Care

- a. Measure description: Percentage of final reports for computed tomography (CT) or magnetic resonance imaging (MRI) studies of the chest or neck or ultrasound of the neck for patients aged 18 years and older with no known thyroid disease with a thyroid nodule  $<$  1.0 cm noted incidentally with follow-up imaging recommended
- b. Documentation guidelines: For any Medicare patient aged 18 years or older that has a CT or MRI of the chest or neck or Ultrasound of the neck, need to document:
  - i. Age (date of birth is included on report)
  - ii. Whether or not there is an incidental lesion, if follow up is recommended, and medical reason

### ▶▶ **Measure #436: Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques** **NQS Domain: Effective Clinical Care**

NQS Domain: Effective Clinical Care

- a. Measure description: Percentage of final reports for patients aged 18 years and older undergoing CT with documentation that one or more of the following dose reduction techniques were used:
  - Automated exposure control
  - Adjustment of the mA and/or kV according to patient size
  - Use of iterative reconstruction techniques
- b. Documentation guidelines: For any Medicare patient aged 18 years or older that has a CT procedure, need to document:
  - i. Age (date of birth is included on report)
  - ii. Whether or not the facility has one of the above dose reduction techniques (can execute a site specific attestation)

## **Interventional Radiology**

### ▶▶ **Measure #76: Critical care: Prevention of central venous catheter (CVC) related bloodstream infections**

NQS Domain: Patient Safety

- a. Measure description: Percentage of patients, regardless of age, who undergo central venous catheter (CVC) insertion for whom CVC was inserted with all elements of maximal sterile barrier technique, hand hygiene, skin preparation and, if ultrasound is used, sterile ultrasound tech-

niques followed

- b. Documentation guidelines: For any Medicare patient that has a central venous catheter placement, need to document:
  - i. Whether or not you followed all elements of maximal sterile barrier technique
  - ii. If technique was not followed, need to document reason

### ▶▶ Measure #21: Perioperative care: Selection of Prophylactic Antibiotic - First or second generation cephalosporin

NQS Domain: Patient Safety

- a. Measure description: Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic, who had an order for a first OR second generation cephalosporin for antimicrobial prophylaxis
- b. Documentation guidelines: For any Medicare patient that has a variety of surgical codes (lumbar kyphoplasties, endovascular repairs, stent placements, angioplasties, etc), need to document:
  - i. Age (date of birth is included on report)
  - ii. Whether or not there was an order for first or second generation cephalosporin for antimicrobial prophylaxis or that first or second generation cephalosporin was given
  - iii. If antibiotic not ordered/given, need to document reason

### ▶▶ Measure #22: Perioperative care: Discontinuation of prophylactic parenteral antibiotics (non-cardiac procedures)

NQS Domain: Patient Safety

- a. Measure description: Percentage of non-cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics AND who received a prophylactic parenteral antibiotic, who have an order for discontinuation of prophylactic parenteral antibiotics within 24 hours of surgical end time
- b. Documentation guidelines: For any Medicare patient that has a variety of surgical codes (lumbar kyphoplasties, endovascular repairs, stent placements, angioplasties, etc), need to document:
  - i. Age (date of birth is included on report)
  - ii. Whether or not there was an order for the prophylactic antibiotic to be discontinued within 24 hours of surgical end time or that the antibiotic was discontinued within 24 hours of the surgical end time
  - iii. If antibiotic not ordered to be discontinued or discontinued, need to document reason

### ▶▶ Measure #23: Perioperative care: Venous Thromboembolism (VTE) prophylaxis (when indicated in ALL patients)

NQS Domain: Patient Safety

- a. Measure description: Percentage of surgical patients aged 18 years and older undergoing procedures for which VTE prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time
- b. Documentation guidelines: For any Medicare patient that has a variety of surgical codes (cholangiography, endovascular repairs, stent placements, etc), need to document:
  - i. Age (date of birth is included on report)
  - ii. Whether or not there was an order for VTE prophylaxis to be given within 24 hours (before or after) of surgery or VTE prophylaxis was given within 24 hours of surgery
  - iii. If VTE prophylaxis not ordered/given, need to document reason

### ▶▶ Measure #418: Osteoporosis Management in Women Who Had a Fracture

NQS Domain: Effective Clinical Care

- a. Measure description: Percentage of women age 50-85 who suffered a fracture and who either had a bone mineral density test or received a drug to treat osteoporosis



- b. Documentation guidelines: For any female patient age 50-85 who had a fracture and a patient visit or vertebroplasty/kyphoplasty, need to document:
  - i. Age (date of birth is included on report)
  - ii. Whether or not there was a previous bone mineral density test or a prescription for a drug to treat osteoporosis
  - iii. If no previous bone density test or prescription, need to document reason

### ▶▶ **Measure #24: Communication with the Physician or Other Clinician Managing On-going Care Post-Fracture for Men and Women Aged 50 years and older**

NQS Domain: Communication and Care Coordination

- a. Measure Description: Percentage of patients aged 50 years and older treated for a fracture with documentation of communication, between the physician treating the fracture and the physician or other clinician managing the patient's on-going care, that a fracture occurred and that the patient was or should be considered for osteoporosis treatment or testing.
- b. Documentation guidelines: For any patient aged 50 and older who had a fracture and a patient visit or vertebroplasty/kyphoplasty, need to document:
  - i. Age (date of birth is included on report)
  - ii. Whether or not the fracture was communicated to the physician managing the patient's on-going care and if the patient was or should be treated for osteoporosis
  - iii. If not communicated, need to document reason

### ▶▶ **Measure #437: Rate of Surgical Conversion for Lower Extremity Endovascular Revascularization Procedure**

NQS Domain: Patient Safety

- a. Measure description: Inpatients assigned to endovascular treatment for obstructive arterial disease, the percent of patients who undergo unplanned amputation or surgical bypass within 48 hours of the index procedure
- b. Documentation guidelines: For any Medicare patient that has an endovascular repair as an inpatient, need to document:
  - i. If the patient had an unplanned amputation or surgical bypass within 48 hours of the index procedure

## **Patient Visits (E&M Codes)**

### ▶▶ **Measure #110: Preventive Care and Screening: Influenza Immunization**

NQS Domain: Community/Population Health – Cross Cutting Measure

- a. Measure description: Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization
- b. Documentation guidelines: For any Medicare patient aged six months and older who has a patient visit, need to document:
  - i. Age (date of birth is included on report)
  - ii. Whether or not the influenza immunization was administered or previously received after August 1st (current year for fourth quarter patients, previous year for first quarter patients)
  - iii. If immunization not received, need to document reason

### ▶▶ **Measure #111: Pneumonia vaccination status for older adults**

NQS Domain: Community/Population Health – Cross-cutting Measure

- a. Measure description: Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine
- b. Documentation guidelines: For any Medicare patient aged 65 and older who has a patient visit, need to document:
  - i. Age (date of birth is included on report)
  - ii. Whether or not the pneumococcal vaccine was administered or previously received ever

## ▶▶ Measure #130: Documentation of current medications in the medical record

NQS Domain: Patient Safety – Cross Cutting Measure

- a. Measure description: Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include all known prescriptions, over-the-counters, herbals and vitamin/mineral/dietary supplements and must contain the medications' name, dosage, frequency and route of administration
- b. Documentation guidelines: For any Medicare patient aged 18 and older who has a patient visit, need to document:
  - i. Age (date of birth is included on report)
  - ii. Whether or not the current medications, dosage, frequency and route of administration was documented
  - iii. If medications are not documented, need to provide reason (patient was seen in an emergent situation)

## ▶▶ Measure #131: Pain assessment and follow-up

NQS Domain: Communication and Care Coordination – Cross-cutting Measure

- a. Measure description: Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit and documentation of a follow-up plan when pain is present
- b. Documentation guidelines: For any Medicare patient aged 18 and older who has a patient visit, need to document:
  - i. Age (date of birth is included on report)
  - ii. Whether or not pain was assessed, the method of assessment and documentation of a follow-up plan
  - iii. If all elements not provided, document the reason (i.e. no pain present, no follow-up plan necessary)

## ▶▶ Measure #112: Breast cancer screening

NQS Domain: Effective Clinical Care - Cross-cutting Measure

- a. Measure description: Percentage of women 50 through 74 years of age who had a mammogram to screen for breast cancer within 27 months
- b. Documentation guidelines: For any Medicare patient aged 50-74 who has a patient visit, need to document:
  - i. Age (date of birth is included on report)
  - ii. Whether or not the patient had a mammogram in the last 27 months
  - iii. If no mammogram was performed in last 27 months, document the reason

## ▶▶ Measure #39: Screening or therapy for osteoporosis for women aged 65 years and older

NQS Domain: Effective clinical care

- a. Measure description: Percentage of female patients aged 65 years and older who ever had a central dual-energy X-ray absorptiometry (DXA) measurement to check for osteoporosis
- b. Documentation guidelines: For any Medicare patient aged 65 and older who has a patient visit, need to document:
  - i. Age (date of birth is included on report)
  - ii. Whether or not the patient had a DEXA scan since age 60 or pharmacologic therapy prescribed for osteoporosis within the last 12 months
  - iii. If no DEXA scan or pharmacologic therapy, document the reason

## ▶▶ Measure #113: Colorectal cancer screening

NQS Domain: Effective clinical care

- a. Measure description: Percentage of visits for patients 50 through 75 years of age who had appropriate screening for colorectal cancer
- b. Documentation guidelines: For any Medicare patient aged 50 through 75 who has a patient visit, need to document:
  - i. Age (date of birth is included on report)
  - ii. Whether or not the patient had appropriate colorectal cancer screening defined as follows: a fecal occult blood test during the measurement period (12 months), flexible sigmoidoscopy in the last 4 years or colonoscopy in the last 9 years

- iii. If screening did not occur, document the reason

### **▶▶ Measure #48: Urinary Incontinence: Assessment of presence or absence of urinary incontinence in women aged 65 years and older**

NQS Domain: Effective Clinical Care

- a. Measure description: Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months
- b. Documentation guidelines: For any female Medicare patient aged 65 and older who has a patient visit, need to document:
  - i. Age (date of birth is included on report)
  - ii. Whether or not the patient has been assessed for urinary incontinence within the last 12 months
  - iii. If screening did not occur, document the reason

### **▶▶ Measure #226: Preventive care and screening: tobacco use screening and cessation intervention**

NQS Domain: Community/Population Health – Cross-cutting Measure

- a. Measure description: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months and who received cessation counseling intervention if identified as a tobacco user
- b. Documentation guidelines: For any Medicare patient aged 18 and older who has a patient visit, need to document:
  - i. Age (date of birth is included on report)
  - ii. Whether or not the patient was screened for tobacco use within 24 monthsiii. If no DEXA scan or pharmacologic therapy, document the reason
  - iii. If the patient is a tobacco user, was cessation counseling intervention received
  - iv. If screening did not occur, document the reason

## EXHIBIT B – MEASURE DESCRIPTIONS AND DOCUMENTATION REQUIREMENTS, REGISTRY REPORTING OPTIONS

ALL MEASURES IN EXHIBIT B CAN ONLY BE REPORTED VIA REGISTRY (NO CLAIMS-BASED REPORTING)

### ▶▶ Measure #265: Biopsy follow-up

NQS Domain: Communication and Care Coordination

- a. Measure description: Percentage of new patients whose biopsy results have been reviewed and communicated to the primary care/referring physician and patient by the performing physician
- b. Documentation guidelines: For any Medicare patient who has a biopsy and patient visit, need to document:
  - i. Whether or not the biopsy results were reviewed and communicated to the primary care/referring physician and patient
  - ii. If communication did not occur, document the reason (i.e. patient request)

### ▶▶ Measure #322: Cardiac stress imaging not meeting appropriate use criteria: Preoperative evaluation in low risk surgery patients

NQS Domain: Efficiency and Cost Reduction

- a. Measure description: Percentage of stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA) or cardiac magnetic resonance (CMR) performed in low risk surgery patients 18 years or older for preoperative evaluation during the 12- month reporting period
- b. Documentation guidelines: For any Medicare patient aged 18 or older who has a cardiac nuclear medicine study, cardiac CT or cardiac MR, need to document:
  - i. Age (date of birth is included on report)
  - ii. If the study is being performed within 30 days preceding low-risk non-cardiac surgery

### ▶▶ Measure #323: Cardiac stress imaging not meeting appropriate use criteria: Routine testing after percutaneous coronary intervention (PCI)

NQS Domain: Efficiency and Cost Reduction

- a. Measure description: Percentage of stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA) or cardiac magnetic resonance (CMR) performed in patients 18 years or older routinely after percutaneous coronary intervention (PCI), with reference to timing of test after PCI and symptom status
- b. Documentation guidelines: For any Medicare patient aged 18 or older who has a cardiac nuclear medicine study, cardiac CT or cardiac MR, need to document:
  - i. Age (date of birth is included on report)
  - ii. If the study is being performed within 2 years of most recent PCI

### ▶▶ Measure #324: Cardiac stress imaging not meeting appropriate use criteria: Testing in asymptomatic, low-risk patients

NQS Domain: Efficiency and Cost Reduction

- a. Measure description: Percentage of all stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA) or cardiac magnetic resonance (CMR) performed in asymptomatic, low coronary heart disease (CHD) risk patients 18 years and older for initial detection and risk assessment
- b. Documentation guidelines: For any Medicare patient aged 18 or older who has a cardiac nuclear medicine study, cardiac CT or cardiac MR, need to document:
  - i. Age (date of birth is included on report)
  - ii. If the patient is high or low risk for CHD

▶▶ **Measure #259: Rate of endovascular aneurysm repair (EVAR) of small or moderate non-ruptured abdominal aortic aneurysms (AAA) without major complications (discharged to home by post-operative day #2)**

NQS Domain: Patient Safety

- a. Measure description: Percentage of patients undergoing endovascular repair of small or moderate non-ruptured abdominal aortic aneurysms (AAA) that do not experience a major complication (discharged to home no later than post-operative day #2)
- b. Documentation guidelines: For any Medicare patient who has an EVAR procedure, need to document:
  - i. If the patient was discharged to home no later than post-operative day #2

▶▶ **Measure #347: Rate of endovascular aneurysm (EVAR) of small or moderate non-ruptured abdominal aortic aneurysms (AAA) who die while in the hospital**

NQS Domain: Patient Safety

- a. Measure description: Percentage of patients undergoing endovascular repair of small or moderate abdominal aortic aneurysms (AAA) that die while in the hospital
- b. Documentation guidelines: For any Medicare patient who has an EVAR procedure, need to document:
  - i. If the patient died in the hospital following the EVAR procedure

▶▶ **Measure #344: Rate of carotid artery stenting (CAS) for asymptomatic patients, without major complications (discharged to home by post-operative day #2)**

NQS Domain: Effective Clinical Care

- a. Measure description: Percentage of asymptomatic patients undergoing CAS who are discharged to home no later than post-operative day #2
- b. Documentation guidelines: For any Medicare patient who has a CAS procedure, need to document:
  - i. If the patient was discharged to home no later than post-operative day #2

▶▶ **Measure #345: Rate of postoperative stroke or death in asymptomatic patients undergoing carotid artery stenting (CAS)**

NQS Domain: Effective Clinical Care

- a. Measure description: Percentage of asymptomatic patients undergoing CAS who experience stroke or death following surgery while in the hospital
- b. Documentation guidelines: For any Medicare patient who has a CAS procedure, need to document:
  - i. If the patient suffered a stroke or death following the CAS procedure while in the hospital

▶▶ **Measure #409: Clinical outcome post endovascular stroke treatment**

NQS Domain: Effective Clinical Care

- a. Measure description: Percentage of patients with a mRs score of 0 to 2 at 90 days following endovascular stroke treatment
- b. Documentation guidelines: For any Medicare patient who has an endovascular stroke treatment, need to document:
  - i. If the patient had an mRs score of 0 to 2 at 90 days following treatment
  - ii. If not documented, report reason

▶▶ **Measure #413: Door to puncture time for endovascular stroke treatment**

NQS Domain: Effective Clinical Care

- a. Measure description: Percentage of patients undergoing endovascular stroke treatment who have a door to puncture time of less than 2 hours
- b. Documentation guidelines: For any Medicare patient who has an endovascular stroke treatment, need to document:

- i. If the patient's door to puncture time was greater or less than 2 hours
- ii. If greater than 2 hours, document medical reason

### **▶▶ Measure #420: Varicose vein treatment with saphenous ablation**

NQS Domain: Effective Clinical Care

- a. Measure description: Percentage of patients treated for varicose veins (CEAP C2-S) who are treated with saphenous ablation that report an improvement on a disease specific patient reported outcome survey instrument after treatment
- b. Documentation guidelines: For any Medicare patient who has an EVLT, need to document:
  - i. If the patient reported improvement (or no improvement) on an outcomes survey

### **▶▶ Measure #421: Appropriate assessment of retrievable inferior vena cava filters for removal**

NQS Domain: Effective Clinical Care

- a. Measure description: Percentage of patients in whom a retrievable IVC filter is placed, who, within 3 months post-placement, have a documented assessment for the appropriateness of continued filtration, device removal or the inability to contact the patient with at least 2 attempts
- b. Documentation guidelines: For any Medicare patient who has an IVC filter, need to document:
  - i. If the patient was assessed for appropriateness of continued filtration or removal
  - ii. If patient not contacted, document at least 2 attempts to contact the patient