The Merit Based Incentive Payment System (MIPS) for the 2018 Performance Period

The Requirements and the Changes for Imaging

Acclaim Radiology Management

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Overview

MACRA, APMs and MIPS

2018 Major Changes

Performance Category Weighting

Individual vs Group Reporting

Performance Category Reporting Requirements

2018 Performance Period & 2020 Payment Adjustments

Special Statuses

2018 Radiology Measure Changes

Resources

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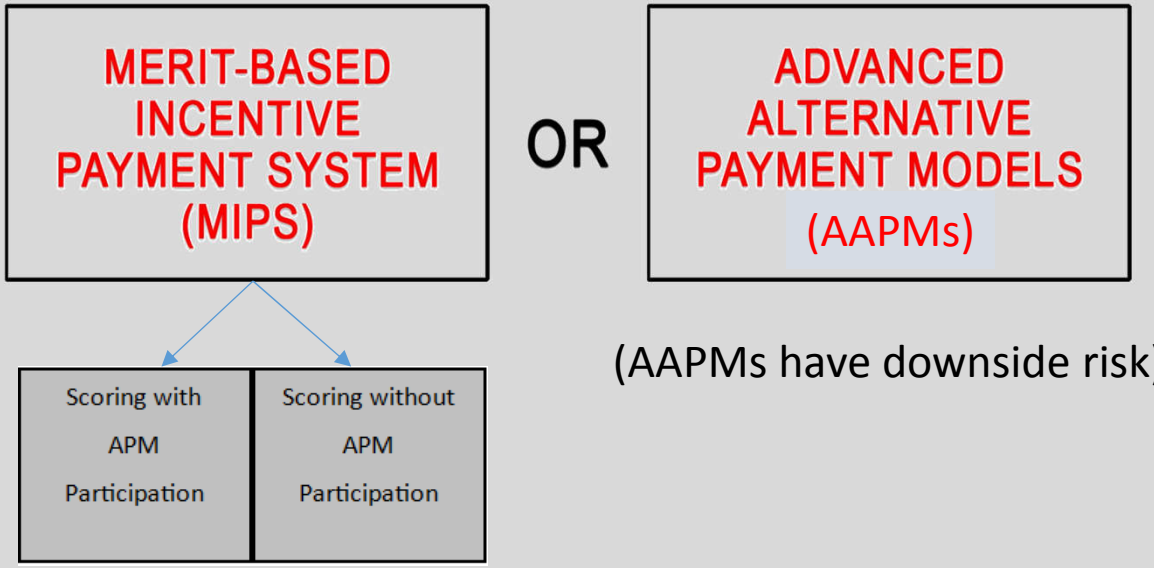
MACRA -Two Potential Paths



(AAPMs have downside risk)

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2018 MIPS Performance Categories

50%	10%	15%	25%

Credit to CMS for information provided

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2018 MIPS Major Changes

- Quality
  - Weight moved from 60% to 50%
  - Scoring on improvement will be included-up to 10%
    - Improvement Score based on statistically significant changes at the measure level
- Cost
  - Weight moved from 0% to 10%
  - Limited to two cost metrics
  - Scoring on improvement will be included- up to 1%
    - Improvement Score requires same cost measures for 2 consecutive performance periods

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2018 MIPS Major Changes

- Low volume threshold increased-eliminating more physicians
  - Medicare Billings of =<$30,000 to =<$90,000
  - Patients seen from =<100 to =<200
- Reporting as a Virtual Group is available
  - Non-patient facing, Small practice, Rural and HPSA status available
  - Available to groups with 10 or fewer clinicians
  - Must elect prior to the end of the performance period
- Quality and Cost reporting period
  - Change from 90 day to 12 months data required
  - Change from 50% to 60% of eligible exams required

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2018 Burden Reducing Efforts

- Quality
  - Small practices receive minimum 3 points for ANY quality measure reported
- Other
  - Small practices (15 or fewer) automatically receive a bonus of 5 points
- CPIA
  - Small, Rural, HPSA practices and non-patient facing physicians report half the requirements and receive full credit for CPIA (20 pts = 40 pts credit)
- ACI
  - Allowed to use either 2014 or 2015 CEHRT or a combination
  - Hospital based and non-patient facing physicians not required to report ACI

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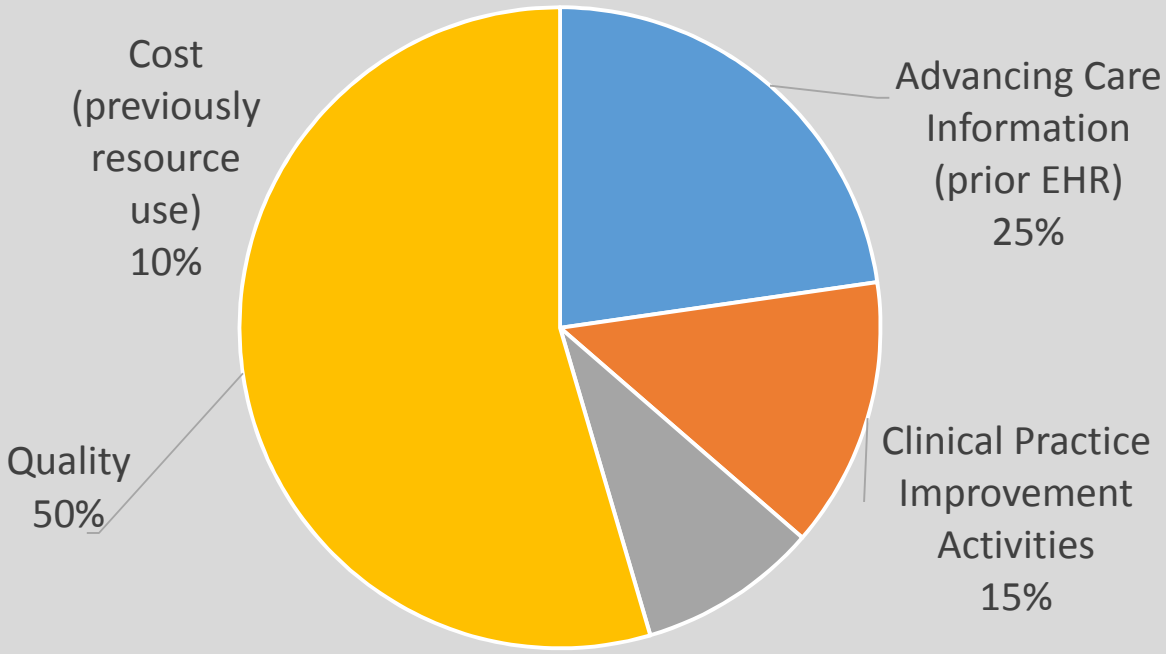
2018 Performance Category Weights



Hospital Based and Non-Patient Facing clinicians avoid ACI reporting and Quality Reporting weight increases to 75%.

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Individual vs Group Reporting Options

- Clinicians may report as an individual or the practice may elect to report as a group
  - Individual Reporting
  - Group Reporting Option
    - Once elected-all physicians must be included-even low volume physicians
    - No advance election is required-decide at time of data submission
    - Low volume reporting thresholds are determined at the TIN level
    - All physicians in the TIN share the same scores and payment adjustments
  - Reporting election must be same across all MIPS components

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Quality Performance Category

- 6 Quality Measures out of 270+ available measures
- 60% of all payer claims in 12 month period (if claims reporting-only Medicare)
- Include 1 outcome measure (or, if not available, a high priority measure)
- Individual measures vs specialty measure sets
- Bonus for reporting EXTRA high priority measure
- Population measure (automatic)
- Year 2 weighted at 50%

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Diagnostic Radiology Specialty Set

Indicator	Diagnostic Measures	Measure Title and Description
!	145	Fluoroscopy Exposure Time Reported
!	146	Screening Mammography: Inappropriate use of Probably Benign
!	147	Nuclear Medicine: Correlation with Existing Imaging for Patients Undergoing Bone Scintigraphy
	195	Stenosis Measurement in Carotid Imaging
	225	Reminder System for Screening Mammograms
!	359	Optimizing Patient Exposure to Ionizing Radiation: Standardized Nomenclature for CT Imaging
!!	360	Optimizing Patient Exposure to Ionizing Radiation: Count of Previous CT studies in Prior 12-months
!	361	Optimizing Patient Exposure to Ionizing Radiation: Reporting to a Radiation Dose Index Registry
!	362	Optimizing Patient Exposure to Ionizing Radiation: CT DICOM Images Available to Other Facilities
!	363	Optimizing Patient Exposure to Ionizing Radiation: Search for Prior CT Studies /Shared Archive
!!	364	Optimizing Patient Exposure to Ionizing Radiation: F/U on Incidentally Detected Pulmonary Nodules
!!	405	Appropriate Follow-Up Imaging for Incidental Abdominal Lesions
!!	406	Appropriate Follow-Up Imaging for Incidental Thyroid Nodules
	436	Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques

Indicator Symbol	Symbol Definition
*	Existing measures with substantive changes
§	Core measures that align with Core Quality Measure Collaborative (CQMC) core measure set(s)
!	High priority measures
!!	High priority measures that are appropriate use measures
Red	Change from CY2017

Interventional Radiology Specialty Set

Indicator	Measure	Measure Title and Description
!	76	Prevention of Central Venous Catheter (CVC) - Related Bloodstream Infections
!	145	Fluoroscopy Exposure Time Reported
* !	374	Closing the Referral Loop: Receipt of Specialist Report
	409	Clinical Outcome Post Endovascular Stroke Treatment
	413	Door to Puncture Time for Endovascular Stroke Treatment
	420	Varicose Vein Treatment with Saphenous Ablation: Outcome Survey
	421	Appropriate Assessment of Retrievable Inferior Vena Cava (IVC) Filters for Removal
	437	Rate of Surgical Conversion from Lower Extremity Endovascular Revascularization Procedure
	465	Uterine Artery Embolization Technique: Documentation of Angiographic Endpoints and Interrogation of Ovarian Arteries (new measure)

Indicator Symbol	Symbol Definition
*	Existing measures with substantive changes
§	Core measures that align with Core Quality Measure Collaborative (CQMC) core measure set(s)
!	High priority measures
!!	High priority measures that are appropriate use measures
Red	Change from CY2017

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Maximizing the Quality Component Score- Deciles determine the points

National Performance % by decile

See the performance for a specific measure below the decile boxes.

This determines resulting points assigned.

Decile	1	2	3	4	5	6	7	8	9	10
Possible Points	1.0-1.9	2.0-2.9	3.0-3.9	4.0-4.9	5.0-5.9	6.0-6.9	7.0-7.9	8.0-8.9	9.0-9.9	10
	0%	7%	16%	23%	36%	41%	62%	69%	79%	85%

100%

Participant with 19% performance rate would get about 3.3

Participant with 86% to 100% would get 10 points

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Performance Scores vs Points-

Highest Performance % not always the Highest Points

- Individual performance that exceed benchmarks earn higher point scores
- Benchmark performance is spread across point deciles

Example of Performance Scores vs Points Scored	Performance Score	Benchmark	Point Score
Measure 145 Fluoro Exposure & Radiation Dose	75%	72%	8
Measure 195 Stenosis Measure in Carotid Imaging	92%	96%	7
Measure 225 Mammography Follow Up System	100%	100%	8.5

These Performance Scores, benchmarks and points are for illustration purposes only.

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Deciles with Clustered Performance

Decile	1	2	3	4	5	6	7	8	9	10
Possible Points	1.0-1.9	2.0-2.9	3.0-3.9	4.0-4.9	5.0-5.9			8.5		
National Performance % by decile	0%	75%	80%	85%	95%	100%	100%	100%	100%	100%	100%

Top 5 deciles have 100 percent performance. Midpoint is middle of decile at 8.5 points.

Half of reporting physicians have a 100% performance percentage

Middle of the cluster is 8.5 points

Assign that cluster 8.5 performance points

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Topped Out Measures

- Topped out if no measurable improvement can be expected
- Removed over a 4 year phased out time period
- Measures identified as topped out for 2 years will earn max of 7 points
- Identified each year in published benchmarks
- Measures considered topped out for 2018
  - Q21 (Prophylactic antibiotic), Q224 (overuse of imaging in Melanoma), Q23 (VTE Prophylaxis), Q262 (image confirm of breast excision), Q359 (OPER-Use of common nomenclature), Q52 (COPD-inhaled therapy)

Don't count on these for full points even if you score 100%.

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Clinical Practice Improvement Activity

- Attest to 'Improvement Activities' (IA)
- Any 90 day period within 2018
- Over 112 IAs are available
- Must report 40 total points for full credit
- IA's weighting- Medium (10 points) or High (20 points)
- If group reporting- group obtains credit if one or more clinicians perform the IA(s)
- Year 2
- Weight: 15%

Non-patient facing physicians, physicians in small or rural practices or in HPSAs report half the requirement (20 points) for full IA credit.

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Resource Use or Cost Component Summary
Found on Quality Resource and Use Report (aka QRUR)

- Calculated by CMS using claims data
- Two Cost Measures will be averaged unless only one reported
  - Medicare Spending Per Beneficiary
  - Total Per Capita Cost
- Must meet case minimum of attributed patients
- Compared to current year performance of reporting physicians
- Future episode-based measures are being developed and tested
- Year 2 Weight: 10% (goes to 30% in 2019 and forward)

Note: Non-patient facing physicians may have no cost scores-
unclear how weighting for those with no cost score will be handled at this point.

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Advancing Care Information Summary

- Promotes IT interoperability, information exchange and patient engagement
- Two tiers- Base Score and Performance Score
- Two Measure sets based on 2014 or 2015 CEHRT or a combination
- E-prescribing and HIE exceptions available
- Bonus scores
  - 10% for reporting to Public Health and/or Clinical Data Registry as part of Performance Score
  - 10% for reporting additional Improvement Activities using a CEHRT
  - 5% for reporting to an additional registry not reported under Performance Score
  - Total bonus score available is 25%
- Year 2 Weight: 25%

Hospital Based and Non-Patient Facing clinicians avoid ACI reporting and Quality Reporting weight increases to 75%.

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Advancing Care Information-Technology

- 2 Participation Options Utilizing
  - 2014 CEHRT
  - 2015 CEHRT (10% bonus if used exclusively)
  - Combination
- Technology Question?
  - https://chpl.healthit.gov/#/search
  - Ask your vendors!!!

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MIPS Scoring Summary

Performance Category	Max Possible Points	MIPS Score %	Scoring Summary
QUALITY Quality: Clinicians choose 6 relevant quality measures to report to CMS. One of these must be an outcome measure or a high value measure (if a relevant outcome is not available) Non-patient facing physicians can select to report a specialty measure set.	80 to 90 points depending on group size	50%	Up to 10 points per measure for 6 measures compared to historical benchmarks. 0 points if required measure is not reported. Bonus points for reporting extra outcome, patient experience, appropriate use, patient safety and EHR reporting.
ADVANCING CARE INFORMATION Advancing Care Information: Clinicians will report key measures of interoperability and information exchange as they relate to their practice.	100 points	25%	50 Base points earned if report at least one case for each available measure. 80 Performance points available for additional reporting. Ability to score up to 130 points but only need 100 points for full category credit. Bonus points available.
CLINICAL PRACTICE IMPROVEMENT ACTIVITIES Clinical Practice Improvement Activities: Clinicians can choose activities best suited for their practice from over 90 activities in the final rule. If clinician participates in a medical home they will earn full credit for this category and those participating in an APM will earn at least half credit.	40 points	15%	Improvement Activities are weighted as High (20 points) and Medium (10 points). Sum the activity points and compare them to maximum required 40 points. Special consideration for non-patient facing and hospital based physicians sets the maximum required points to 20 points.
RESOURCE USE Cost/Resources: CMS uses claim data to calculate resource use if there is sufficient volume/information available. No reporting required.	Average score of all relevant cost measures	10%	Data calculated by CMS is compared to historical benchmarks.

Hospital Based and Non-Patient Facing clinicians avoid ACI reporting and Quality Reporting weight increases to 75%.

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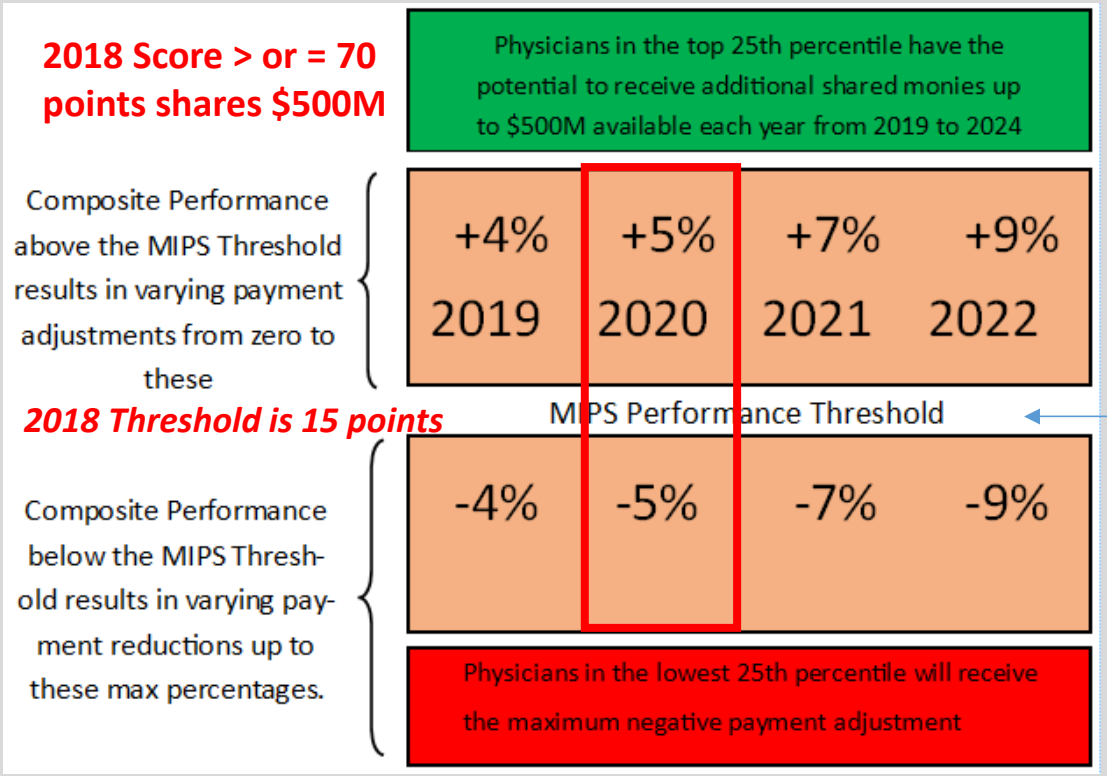
Incentives & Penalties-

2020 Payment Adjustments for 2018 Performance Period



The maximum payment incentive of 5% shown here has the potential of becoming +15% if more physicians/groups receive a negative payment penalty.

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2018 Minimum for No Payment Adjustment

- Submit 6 Quality Measures meeting data completeness criteria OR
- Attest to all required Improvement Activities OR
- Meet ACI base score requirement AND 1 Quality Measure meeting data completeness criteria OR
- Meet ACI base score requirement AND Attest to one medium weighted Improvement Activity

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2018 Scoring and 2020 Payment Adjustments

Final Score 2018	Change Y/N	Payment Adjustment 2020
≥70 points	N	• Positive adjustment greater than 0% • Eligible for exceptional performance bonus—minimum of additional 0.5%
15.01-69.99 points	Y	• Positive adjustment greater than 0% • Not eligible for exceptional performance bonus
15 points	Y	• Neutral payment adjustment
3.76-14.99	Y	• Negative payment adjustment greater than -5% and less than 0%
0-3.75 points	Y	• Negative payment adjustment of -5%

The maximum payment incentive of 5% shown here has the potential of becoming +15% if more physicians/groups receive a negative payment penalty.

Data from the CMS Website
https://qpp.cms.gov/

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Effect of Special Status on MIPS Reporting

How special status affects 2018:	ACI	CPIA	Cost	Quality	Overall
Non-patient facing (**Individual clinicians with 100 or fewer F2F codes Groups with >75% Non patient facing clinicians)**	Exempt from reporting -25% reweighted to Quality	Reporting half the required IA receives full credit	Suspect insufficient cost measures-not clear what happens to cost weighting		
Hospital Based **(>75% with POS: IP,OP,ER, (off campus OP included)**	Exempt from reporting -25% reweighted to Quality				
Small Practice **(15 or fewer clinicians)**		Reporting half the required IA receives full credit		3 point minimum for reported measure even if does not meet data completeness	5% bonus points if report in any category
Rural		Reporting half the required IA receives full credit			
HPSA		Reporting half the required IA receives full credit			

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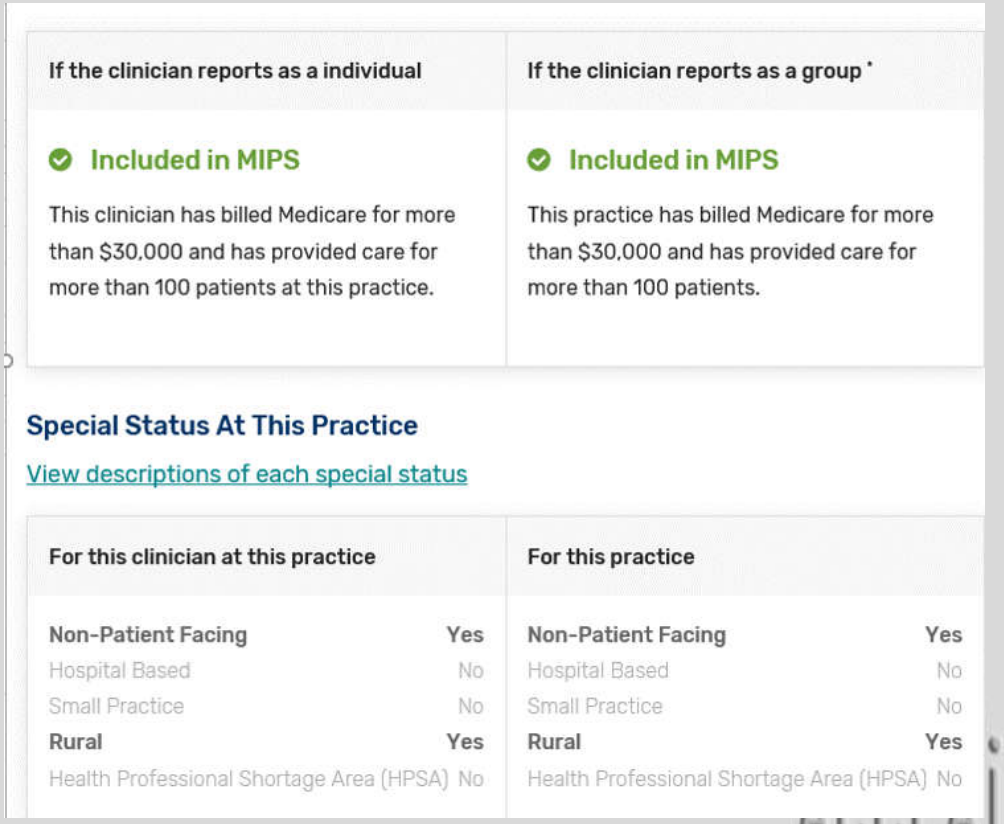
CMS Special Status Designations

CMS releases the determination of special statuses at the website link below. Enter the individual NPI and it will show all practice affiliations in the CMS system.

The website shows whether the clinician must report as an individual or if they must be included when the practice is reporting under the group reporting option.

Lastly, it shows any special statuses determined to apply to the individual when they report individually and when the practice is reporting under the group reporting option.

https://qpp.cms.gov/participation-lookup



If the clinician reports as a individual	If the clinician reports as a group *
Included in MIPS	Included in MIPS
This clinician has billed Medicare for more than $30,000 and has provided care for more than 100 patients at this practice.	This practice has billed Medicare for more than $30,000 and has provided care for more than 100 patients.

Special Status At This Practice

View descriptions of each special status

For this clinician at this practice		For this practice	
Non-Patient Facing	Yes	Non-Patient Facing	Yes
Hospital Based	No	Hospital Based	No
Small Practice	No	Small Practice	No
Rural	Yes	Rural	Yes
Health Professional Shortage Area (HPSA)	No	Health Professional Shortage Area (HPSA)	No

2018 Measure Specification Release Notes

- Documents all changes to existing quality measures without reiterating the entire specification sheet
  - Added or deleted CPT or ICD10 codes
  - Updated clinical recommendation statements
  - Technical updates
  - Update Rational
  - Instruction changes

The changes…and only the changes!!

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2018 Registry Measure Specification Changes- Diagnostic Radiology

- 145 Fluoro Exposure Time /Images or Dose Reporting
  - Removed codes:

71023	CHEST X-RAY/FLUOROSCOPY,
71034	CHEST COMPLETE W/FLUORO
75658	ANGIO BRACHIAL RETROGRADE
75809	SHUNTOGRAM - NONVASCULAR
75952	ENDOVASCULAR REP INFRARENAL AAA S&I
75953	ENDOVASCULAR REPAIR EXTEN PROSTHE
75658	ANGIO BRACHIAL RETROGRADE
75954	ENDOVASC REPAIR ILIAC ARTERY S&I

- 195 Stenosis Measure in Carotid Imaging
  - Updated note:
  - In a small number of denominator cases the distal ICA may not be viewed e.g. an innominate artery or common carotid injection. Performance would be met if there is documentation, for example, that indicates “stenosis measurements are made with reference to the distal lumen”, as a matter of process and consistent practice method.

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2018 Registry Measure Specification Changes- Diagnostic Radiology

- 225 Reminder system for Screening Mammograms
  - Numerator instructions changed: *Use of the reminder system is not required to be documented within the final report to meet performance for this measure.*
- 265: Biopsy Follow-Up
  - *Added Denominator Coding, CPT: 99241, 99242, 99243, 99244 and 99245*
  - *Updated Denominator Criteria Telehealth Modifiers to include 95 and POS 02*
  - *Added a Numerator Note*
  - *Updated Numerator Instructions*
  - *Updated Denominator Note*

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Excerpt from Measure Specifications #265

- *And*
- Exam codes: 99201, 99202, 99203, 99204, 99205, 99241*, 99242*, 99243*, 99244*, 99245*
- *Without* Telehealth Modifier: GQ, GT, 95, POS 2.
- Denominator note: * Signifies that this CPT Category I code is a non-covered service under the Medicare Part B Physician Fee Schedule (PFS). These non-covered services should be counted in the denominator population for registry-based measures.
- **How to Report the Measure**
- **Claims and IRIS Registry Manual Reporting**
- *2018 additions in red.*
- Numerator: Patients whose biopsy results have been reviewed and communicated to the primary care/referring physician and the patient by the provider and/or office and medical team. There must also be acknowledgement and/or documentation of the communication in a biopsy tracking log and document in the patient's medical record.
- To satisfy this measure, the biopsying physician and/or office and medical team must:
- Review the biopsy results with the patient;
- Communicate those results to the primary care/referring physician;
- Track communication in a log; and
- Document tracking process in the patient's medical record.
- Numerator note: For denominator exception(s), patients are ineligible for this measure if at the time of encounter there are patient reason(s) for not communicating the results to the Primary Care or referring physician (e.g. patient self-referred or has no primary care physician, etc.) as further specified below.

https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Resources.html

2018 Registry Measure Specification Changes- Diagnostic Radiology

- 322 Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low Risk Surgery Patients
  - Updated Clinical Recommendation Statements
- 323 Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Routine Testing After Percutaneous Coronary Intervention (PCI)
  - Updated Clinical Recommendation Statements and Rationale
- 324 Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients
  - Updated Clinical Recommendation Statements

This was added to each:

AUC Indication
2013 ACCF/AHA/ASE/ASNC/HFSA/HRS/SCAI/SCCT/SCMR/STS multimodality appropriate use criteria for the detection and risk assessment of stable ischemic heart disease (J Am Coll Cardiol. 2014 Feb 4;63(4):380-406)
Indication 71: Pre-Operative Evaluation for Noncardiac Surgery: Moderate-to-Good Functional Capacity (greater than or equal to 4 METs) OR No Clinical Risk Factors: Any surgery – Rarely Appropriate Indication 73: Pre-Operative Evaluation
for Noncardiac Surgery: Poor or Unknown Functional Capacity (less than 4 METS): Low-risk surgery: Greater than or equal to 1 clinical risk factor – Rarely Appropriate

2018 Registry Measure Specification Changes- Diagnostic Radiology

- 359, 360, 361, 362 & 363 OPER Standardized Nomenclature, Count of High Dose, Report to DIR, CT Images avail for comparison, Search of outside CTs available
  - Added code to denominator- 77014 CT GUIDED RADIATION THERAPY FIELDS
- 364 CT follow up recommendations on Incidental Pulmonary Nodules
  - Technical Update –Re: Five new evidence statements based on 2017 Fleischner Society Recommendations (See Resource page)

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Measure 364 CT with Incidental Pulmonary Nodules- change to Clinical Recommendation Statements

- Technical update to 2018 specifications: The following evidence statements are quoted verbatim from the referenced clinical guidelines and other sources:
- *Recommendation 1*: single solid noncalcified nodules.—Solid nodules smaller than 6 mm (those 5 mm or smaller) do not require routine follow-up in patients at low risk (grade 1C; strong recommendation, low- or very-low-quality evidence). (MacMahon et al., 2017)
  Solid nodules smaller than 6 mm do not require routine follow-up in all patients with high clinical risk; however, some nodules smaller than 6 mm with suspicious morphology, upper lobe location, or both may warrant follow-up at 12 months (grade 2A; weak recommendation, high-quality evidence). (MacMahon et al., 2017)
  Solitary noncalcified solid nodules measuring 6–8 mm in patients with low clinical risk are recommended to undergo initial follow-up at 6–12 months depending on size, morphology, and patient preference *(*grade 1C: strong recommendation, low- or very-low-quality evidence). (MacMahon et al., 2017)
  For solitary solid noncalcified nodules measuring 6–8 mm in patients at high risk, an initial follow-up examination is recommended at 6–12 months and again at 18–24 months (grade 1B: strong recommendation, moderate quality evidence). (Fleischner Society, 2017)5
  For solitary solid noncalcified nodules larger than 8 mm in diameter, consider 3-month follow-up, work-up with combined positron emission tomography (PET) and CT (PET/CT), tissue sampling, or a combination thereof; any one of these options may be appropriate depending on size, morphology, comorbidity, and other factors. (grade 1A; strong recommendation, high-quality evidence). (MacMahon et al., 2017)

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Measure 364 continued…

- *Recommendation 2: multiple solid noncalcified nodules.*—For multiple solid noncalcified nodules smaller than 6 mm in diameter, no routine follow-up is recommended (grade 2B; weak recommendation, moderate-quality evidence). (MacMahon et al., 2017) For multiple solid noncalcified nodules with at least one nodule 6 mm or larger in diameter, follow-up is recommended at approximately 3–6 months, followed by an optional second scan at 18–24 months that will depend on estimated risk. (grade 1B; strong recommendation, moderate-quality evidence). (MacMahon et al., 2017)
- *Recommendation 3: solitary pure ground-glass nodules.*—For pure ground-glass nodules smaller than 6 mm (ie, 5 mm and smaller) in diameter, no routine follow-up is recommended (grade 1B; strong recommendation, moderate quality evidence). (MacMahon et al., 2017) For pure ground-glass nodules 6 mm or larger, follow-up scanning is recommended at 6–12 months and then every 2 years thereafter until 5 years (grade 1B; strong recommendation, moderate-quality evidence). (MacMahon et al., 2017)
- *Recommendation 4: solitary part solid lung nodules.*—For solitary part solid nodules smaller than 6 mm, no routine follow-up is recommended (grade 1C; strong recommendation, low- or very-low-quality evidence). (MacMahon et al., 2017) For solitary part-solid nodules with a solid component 6 mm or larger, a short-term follow-up CT scan at 3–6 months should be considered to evaluate for persistence of the nodule. For nodules with particularly suspicious morphology (i.e., lobulated margins or cystic components), a growing solid component, or a solid component larger than 8 mm, PET/CT, biopsy, or resection are recommended (grade 1B; strong recommendation, moderate quality evidence.) (MacMahon et al., 2017)
- *Recommendation 5: multiple subsolid lung nodules.*—In patients with multiple subsolid nodules smaller than 6 mm, one must consider infectious causes. If lesions remain persistent after an initial follow-up scan at 3–6 months, consider follow-up at approximately 2 and 4 years to confirm stability, depending on the clinical setting (grade 1C; strong recommendation, low- or very-low-quality evidence). (MacMahon et al., 2017)

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2018 Registry Measure Specification Changes- Interventional Radiology

- 21 Selection of Prophylactic Antibiotic
  - Updated clinical recommendation statements
  - Added additional and deleted other surgery codes
- 22 Prophylactic Antibiotics discontinuation-deleted
- 23 VTE Prophylaxis
  - Added additional and deleted other surgery codes
- 76 Prevention of CVC related bloodstream infections
  - Updated clinical recommendation statements
- 259 EVAR without Complications
  - Added additional and deleted denominator codes
- 344 CAS without Complications
  - Added additional denominator code 37216

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Measure 21- Prophylactic Antibiotic- Clinical Recommendation Added Language

- Cephalosporins and carbapenems should not be used for surgical prophylaxis in patients with documented or presumed IgE mediated penicillin allergy (e.g., anaphylaxis, urticaria, bronchospasm). (ASHP, 2013)
  Cephalosporins and carbapenems can safely be used in patients with an allergic reaction to penicillins that is not an IgE mediated reaction or is not exfoliative dermatitis (Stevens-Johnson syndrome, toxic epidermal necrolysis), a life threatening hypersensitivity reaction that can be caused by b-lactam antimicrobials and other medications. Patients should be carefully questioned about their history of antimicrobial allergies to determine whether a true allergy exists before selection of agents for prophylaxis. Patients with allergies to cephalosporins, penicillins, or both have been excluded from many clinical trials. Alternatives to b-lactam antimicrobials are provided in Table 2 [of the guideline] based mainly on the antimicrobial activity profiles against predominant procedure-specific organisms and available clinical data. (ASHP, 2013)

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Measure 76-Sterile Barrier aka CVC Related Blood Infections-Clinical Recommendation Added Language

- **2012 American Society of Anesthesiologists Practice Guidelines for Central Venous Access**
  In preparation for the placement of central venous catheters, use aseptic techniques (e.g., hand washing) and maximal barrier precautions (e.g., sterile gowns, sterile gloves, caps, masks covering both mouth and nose, and full body drapes).
- **2014 American Institute for Ultrasound in Medicine Practice Parameter for the Performance of Selected Ultrasound-Guided Procedures**
  The use of sterile drapes, sterile probe covers, and sterile ultrasound gel may provide the best method to reduce the risk of contamination and infection.

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2018 Registry Measure Specification Changes-Interventional Radiology

- 345 CAS Stroke Free or discharged alive
  - Added Denominator Coding, CPT:37216
  - Updated Numerator to read: Patients who are stroke free or in the hospital or discharged alive following CAS
  - Measure Analytics Changed. Measure is no longer an inverse measure.
  - Deleted Numerator Instructions and Inverse Measure
- 404 Anesthesiology Smoking Abstinence
  - Updated Denominator, Numerator, Rationale and Clinical Recommendation Statements
  - Added Denominator Note
- 409 Clinical Outcome Post Endovascular Stroke Treatment
  - Added Denominator Coding, (ICD-10-CM): I63.343, I63.443
  - Deleted Denominator Coding, (ICD-10-CM): I63.6

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2018 Registry Measure Specification Changes-Interventional Radiology

- 413 Door to Puncture Time for Endovascular Stroke Treatment
  - Added Denominator Coding, (ICD-10-CM): I63.343, I63.443
  - Deleted Denominator Coding, (ICD-10-CM): I63.6
- 418 Osteoporosis Management in Women Who Had a Fracture
  - Added Numerator Note and Numerator Definition
  - Updated Instructions, Note, Measure Submission, Denominator, Clinical Recommendation Statements and Copyright
  - Added Option 1 and Option 2 Denominator Criteria Denominator Exclusion: (G9938)
- 420 Varicose Vein Treatment with Saphenous Ablation: Outcome Survey
  - Added Denominator Coding, (CPT): 36473
- 421 Appropriate Assessment of Retrievable Inferior Vena Cava (IVC) Filters for Removal
  - Added Numerator Note:
  - Updated Numerator Option Performance Met (G9541)

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2018 Improvement Activities

- There is a link to this list can be found on the Resource Slide
- R-SCAN provides credit to 7 different Improvement Activities
- Participation in a QCDR such as the ACR NRDR allows access to specific Improvement Activities

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Resources for reference

- Excel sheet of Radiology Relevant Quality Metrics- https://www.acr.org/Practice-Management-Quality-Informatics/MACRA-Resources and with 2017 to 2018 changes noted at https://www.Acclaimrad.com
- Excel sheet of Radiology Relevant Improvement Activities-on https://www.Acclaimrad.com
- R-SCAN Information- https://rscan.org/
- Side-by-side comparison of CY 2017 and CY 2018 final rules, please refer to CMS' Fact Sheet- https://www.cms.gov/Medicare/Quality-Payment-Program/resource-library/QPP-Year-2-Final-Rule-Fact-Sheet.pdf
- ***Quality Measure Specifications' supporting documentation including the Measure Specification Release Notes-*** https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Resources.html
- Fleischner Recommendations-Measure 364 technical change http://www.radiologyassistant.nl/en/p5905aff4788ef/fleischner-2017-guideline-for-pulmonary-nodules.html

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Thank you for your time!

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