2024 Measure Set Review (MSR): Final Preliminary Assessment

The following information was sourced in June of 2024 from the Centers for Medicare & Medicaid Services Measures Inventory Tool (CMIT), the PQM Submission Tool and Repository (STAR), discussions with CMS program leads, and publicly available CMS datasets (see links below).

I. Measure Information

CMIT ID	Title
00070-01-C-MIPS	Appropriate Follow-up Imaging for Incidental Thyroid Nodules in Patients
Measure Steward	**CMS Program**
American College of Radiology	Merit-Based Incentive Payment System Program (MIPS)

Measure Overview	
Rationale: Thyroid nodules are common, with estimates of prevalence as high as 50%. Due to the common nature of small thyroid nodules combined with the low malignancy, nonpalpable nodules detected on US or other anatomic imaging studies are termed incidentally discovered nodules or incidentalomas. Nonpalpable nodules have the same risk of malignancy as palpable nodules with the same size. Generally, only nodules >1 cm should be evaluated, since they have a greater potential to be clinically significant cancers.	
Description[1]: Percentage of final reports for computed tomography (CT), CT angiography (CTA), or magnetic resonance imaging (MRI) or magnetic resonance angiogram (MRA) studies of the chest or 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.	
Numerator: Final reports for CT, CTA, MRI or MRA of the chest or neck with follow-up imaging recommended for reports with an incidentally detected thyroid nodule < 1.0 cm noted. **Exclusions:** None	
Denominator: All final reports for CT, CTA, MRI or MRA studies of the chest or neck for patients aged 18 and older with an incidentally detected thyroid nodule < 1.0 cm noted. **Exclusions:** None	
Measure type: Process	**Measure is a composite:** No **Measure is digital and/or an eCQM:** Yes (a MIPS CQM is considered a dQM)
Level(s) of analysis/measured entity: Clinician	**Care setting:** Ambulatory Care Settings

[1] This is an inverse measure as reflected in the raw score calculation and accounted for in creation of reported performance score.

Risk adjustment and/or stratification: No. Process measures are generally not risk adjusted.	**Data source(s):** Claims Data; Registries[2]
Data collection method: Review of claim and registry data[3]	**Reporting frequency:** Procedure[4]
All required data are collected as part of clinical workflow: Yes	**Reporting overlap with similar/related measures:** 00070-01-C-PQRS is reported in the Medicare Physician Quality Reporting System.
Does this measure fill a statutorily required category for the program? No	**Is this measure included in upcoming rulemaking?** No

Measure Status	
Current CBE Endorsement Status: Not Endorsed	**CBE Endorsement History:** None

II. Measure Performance[5]

00070-01-C-MIPS Performance in MIPS 2020-2022

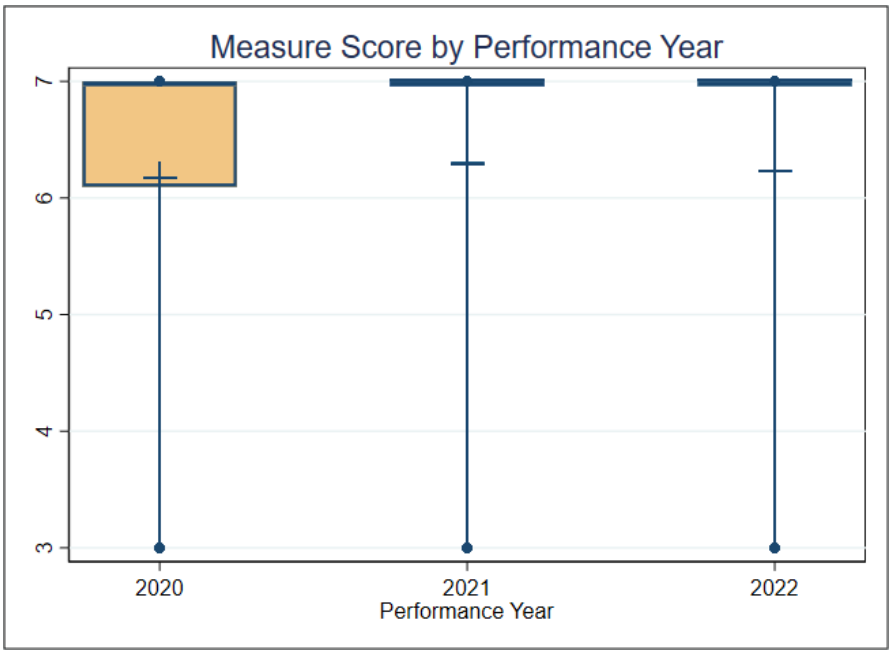
For this measure, the MSR evaluation and analysis team reviewed the following publicly available datasets at data.cms.gov: PY 2022 Clinician Public Reporting Overall MIPS Performance and the Quality Payment Program Experience.

Figure 1 is a boxplot that shows the distribution of the performance over the past 3 years (where available). For each performance year, the dots indicate the lower 5th and upper 95th percentiles, and the vertical line is the range between these values (90% of the measure scores are between the dots). The box spans the lower 25th to the upper 75th percentile (50% of the measure scores are within the box). The horizontal line in the box indicates the median score, and the "+" indicates the mean score. This plot can be used to assess overall trends in the score over time.

Interpretation: In the plot below, the median score is 7 for all three years. In 2021 and 2022, the lower 25th percentile and the upper 75th percentile are both 7, so no boxes appear for those years.

[2] Note from CMS program lead on MIPS CQMs: Data may be gathered from paper, electronic charts, or collected with the assistance of a third-party intermediary
[3] Note from CMS program lead. Other data collection methods are available for use with MIPS CQMs depending on clinician/system workflow and who is collecting the data.
[4] Reporting frequency provided by CMS lead. MIPS only allows reporting of data during the submission period January-March and ongoing reporting by episode, visit, or other defined frequency occurs during that period.
[5] Analyses presented in this PA may differ slightly from those conducted by MIPS program analysts due to variation in analytic methods. Additional resources and information about MIPS scoring and benchmarks are available at Quality Payment Program (QPP) (cms.gov).

Figure 1. Boxplot of Quality Measure Score by Year



Importance Table

Interpretation of measure scores: Table 1 shows the relative spread of the scores and can also be used to evaluate the impact of improving the score. For example, here, 4 of the 10 deciles have an average score of at least 7. Examining mean scores at the lower deciles show the relative change required to achieve a score of at least 7. Here 874 entities have a score of 3, so there would be significant impact for about 20% of the entities if they could achieve a score of at least 7.

Table 1. Importance (Decile by performance score, 2022)

Data Type	Overall	Min	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10	Max
Mean Score (SD)	6.23 (1.72)	3	3	3.04	6.53	7.00	7.00	7.00	7.00	7.00	7.00	7.75	10
Entities	4,510	874	451	451	451	451	451	451	451	451	451	451	113