



Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to sub criterion 1b).

Brief Measure Information

NQF #: 0509

Corresponding Measures:

De.2. Measure Title: Diagnostic Imaging: Reminder System for Screening Mammograms

Co.1.1. Measure Steward: American College of Radiology

De.3. Brief Description of Measure: Percentage of patients undergoing a screening mammogram whose information is entered into a reminder system with a target due date for the next mammogram

1b.1. Developer Rationale: Although screening mammograms can reduce breast cancer mortality by 20-35% in women aged 40 years and older, recent evidence shows that only 72% of women are receiving mammograms based on current guideline recommendations. The use of patient reminders is associated with an increase in screening mammography. Encouraging the implementation of a reminder system could lead to an increase in mammography screening at appropriate intervals.

Any facility that uses less than annual frequency of screening, greatly increases the importance of attendance at each scheduled screening. Even with annual screening recommendations screening does not always occur biennially. This demonstrates the importance of systematic reminders and active patient outreach.

The purpose of screening is to minimize interval or false negative cancers, as these are failures of the screening process. The 2011 article by Bennett, Sellars and Moss (Ref 1) and an earlier work by Woodman, Threlfall and Boggis (ref 2) examine the effect of interval cancer rates (false negative cancers) by time since screen out to three years in the United Kingdom's triennial screening program. The interval cancer rates (false negative cases) increase over time (ref 1,2) and begin to approach incidence rates by the third year (ref 2). Thus screening at greater than 2 year intervals will likely have poor overall outcomes in reducing breast cancer mortality. These papers may also underestimate the rate of interval cancers (ref 1) so the actual rates may be higher. Efforts to ensure regular screening are therefore necessary to eliminate any screening interval beyond 2 years.

1. Bennett RL, Sellars SJ, Moss SM. Interval cancers in the NHS breast cancer screening programme in England, Wales and Northern Ireland. *British Journal of Cancer*. 2011. 104: 571-577.

2. Woodman CBJ, Threlfall AG, Boggis CR et al. Is the three year breast screening interval too long? Occurrence of interval cancers in NHS breast screening programme's north western region. *BMJ*. 1995. 310:224-6

S.4. Numerator Statement: Patients whose information is entered into a reminder system with a target due date for the next mammogram

S.6. Denominator Statement: All patients undergoing a screening mammogram

S.8. Denominator Exclusions: Documentation of medical reason(s) for not entering patient information into a reminder system [(eg, further screening mammograms are not indicated, such as patients with a limited life expectancy, other medical reason(s)]

De.1. Measure Type: Structure

S.17. Data Source: Claims, Registry Data

S.20. Level of Analysis: Clinician : Individual

IF Endorsement Maintenance – Original Endorsement Date: Oct 28, 2008 **Most Recent Endorsement Date:** Oct 26, 2016

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results?

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. **Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.**

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

[NQF_evidence_attachment_0509-637235904189197570.docx](#)

1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?

Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

No

1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- Disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure (e.g., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.

Although screening mammograms can reduce breast cancer mortality by 20-35% in women aged 40 years and older, recent evidence shows that only 72% of women are receiving mammograms based on current guideline recommendations. The use of patient reminders is associated with an increase in screening mammography. Encouraging the implementation of a reminder system could lead to an increase in mammography screening at appropriate intervals.

Any facility that uses less than annual frequency of screening, greatly increases the importance of attendance at each scheduled screening. Even with annual screening recommendations screening does not always occur biennially. This demonstrates the importance of systematic reminders and active patient outreach.

The purpose of screening is to minimize interval or false negative cancers, as these are failures of the screening process. The 2011 article by Bennett, Sellars and Moss (Ref 1) and an earlier work by Woodman, Threlfall and Boggis (ref 2) examine the effect of interval cancer rates (false negative cancers) by time since screen out to three years in the United Kingdom's triennial screening program. The Interval cancer rates (false negative cases) increase over time (ref 1,2) and begin to approach incidence rates by the third year (ref 2). Thus screening at greater than 2 year intervals will likely have poor overall outcomes in reducing breast cancer mortality. These papers may also underestimate the rate of interval cancers (ref 1) so the actual rates may be higher. Efforts to ensure regular screening are therefore necessary to eliminate any screening interval beyond 2 years.

1. Bennett RL, Sellars SJ, Moss SM. Interval cancers in the NHS breast cancer screening programme in England, Wales and Northern Ireland. British Journal of Cancer. 2011. 104: 571-577.

2. Woodman CBJ, Threlfall AG, Boggis CR et al. Is the three year breast screening interval too long? Occurrence of interval cancers in NHS breast screening programme's north western region. BMJ. 1995. 310:224-6

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

This measure was included in the CMS Physician Quality Reporting System as measure #225 Reminder System for Screening Mammograms from 2009 until 2016, and in the CMS Merit-based Incentives Payment System from 2017 until now. There is a gap in care as shown by this data; between 2012 and 2014 15.0 % of patients reported on did not meet the measure.

Scores on this measure for 2012-2014 (calculated using data from CMS):

N=47,866 physicians with at least 10 patients had a non-zero reporting rate. Across these physicians, 15.0% of physicians did not meet the measure (100% - 85.0% who met the measure). Across physicians with at least 10 patients and a performance rate greater than zero for the 3-year period 2012-2014, mean performance rate= 85.0%.

The performance rate quartiles for the same period 2012-2014 for physicians with at least 10 patients and performance rate >0 were as follows:

Scores on this measure is N= 47,866

25th percentile: 91.15%

50th percentile: 100%

75th percentile: 100%

Exception Rate: This measure is not specified with exceptions. See attached performance data.

The performance rate for the three year period was calculated as the count of reported instances where performance was met (numerator=6,423,710) divided by the total number of reported instances (7,554,604). Performance rate was also calculated in this way for each year (2012-2014) with the following results:

2012-2014	85.0%
2012	79.4%
2013	86.0%
2014	87.6%

Among 47866 total physicians included in the analysis, 45380 submitted data by claims, and 2486 submitted data by registry (reporting_method). For our analyses we used the combined total of 47866 for both claims and registry reported cases.

Scores on this measure for 2015-2018 (calculated using data from CMS):

N= 79,450 physicians with at least 10 patients had a non-zero reporting rate. Across these physicians, 7.4% of physicians did not meet the measure. Across physicians with at least 10 patients and a performance rate greater than zero for the 4-year period 2015-2018, mean performance rate= 95.69%.

The performance rate quartiles for the same period 2015-2018 for physicians with at least 10 patients and performance rate >0 were as follows:

25th percentile: 99.5%

50th percentile: 100%

75th percentile: 100%

- The performance rate for the four year period was calculated as the count of reported instances where performance was met (numerator= 65,874,442) divided by the total number of reported instances (68,844,412). Performance rate was also calculated in this way for each year (2015-2018) with the following results:

2015-2018	95.7%
2015	88.0%
2016	94.4%
2017	96.4%
2018	95.6%

- Among 79,450 total physicians included in the analysis, 69,240 submitted data by claims, and 10,210 submitted data by registry (either QCDR or qualified registry). For our analyses we used the combined total of 79,450 for both claims and registry reported cases.

Rationale for Performance Calculations

- Medicare claims data with information on reporting measure #225 from years 2012-2018 was used for performance calculation and analyses.
- For each year, if the patient's eligible (pts_eligible) for a particular physician (npi) was greater or equal to 10, the physician was included in the analysis

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

There is sufficient performance data.

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. (This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.) For measures that show high levels of performance, i.e., "topped out", disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

Many American women do not receive mammograms at recommended intervals, as illustrated by 2010 data from the National Health Interview Survey (NHIS) which found that only 72% of women reported receiving a mammogram within the recommended two-year interval. Additional factors found to reduce the likelihood for a woman to receive a mammogram include Asian race, low education status, and recent immigrant status. Low mammography use was also noted for women who reported having no regular source of medical care or having no medical insurance.

Centers for Disease Control and Prevention (CDC). Cancer screening—United States, 2010. MMWR 2012;61(3):41-45.
<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6103a1.htm>. Accessed 2/3/2014.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4

The American College of Radiology advocates that performance measure data should, where possible, be stratified by race, ethnicity, and primary language to assess disparities and initiate subsequent quality improvement activities addressing identified disparities, consistent with recent national efforts to standardize the collection of race and ethnicity data.

A 2008 NQF report endorsed 45 practices including stratification by the aforementioned variables (1). A 2009 IOM report "recommends collection of the existing Office of Management and Budget (OMB) race and Hispanic ethnicity categories as well as more fine-grained categories of ethnicity (referred to as granular ethnicity and based on one's ancestry) and language need (a rating of spoken English language proficiency of less than very well and one's preferred language of health-related encounters)." (2)

1. National Quality Forum Issue Brief (no. 10) Closing the Disparities Gap in Healthcare Quality with Performance Measurement and Public Reporting. Washington, DC: NWF, August 2008.

2. Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement. March 2010. AHRQ Publication No. 10-0058-EF. Agency for Healthcare Research and Quality, Rockville, MD. Available at:
<http://www.ahrq.gov/research/iomracereport>. Accessed May 25, 2010.

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area (check all the areas that apply):

Cancer, Cancer : Breast

De.6. Non-Condition Specific(check all the areas that apply):

Care Coordination, Screening

De.7. Target Population Category (Check all the populations for which the measure is specified and tested if any):

Populations at Risk

S.1. Measure-specific Web Page (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

https://www.acr.org/-/media/ACR/NOINDEX/Measures/2020_Measure_225_MIPSCQM.pdf

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

This is not an eMeasure Attachment:

S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

No data dictionary Attachment:

S.2c. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

No, this is not an instrument-based measure Attachment:

S.2d. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

Not an instrument-based measure

S.3.1. For maintenance of endorsement: Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

No

S.3.2. For maintenance of endorsement, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

There are no significant changes since last endorsement.

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome) DO NOT include the rationale for the measure.

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Patients whose information is entered into a reminder system with a target due date for the next mammogram

S.5. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Numerator Note:

The reminder system should be linked to a process for notifying patients when their next mammogram is due and should include the following elements at a minimum: patient identifier, patient contact information, dates(s) of prior screening mammogram(s) (if

known), and the target due date for the next mammogram. Use of the reminder system is not required to be documented within the final report to meet performance for this measure.

Performance Met: Patient information entered into a reminder system with a target due date for the next mammogram (7025F)

Performance Not Met: Patient Information not entered into a reminder system, reason not otherwise specified (7025F with 8P)

S.6. Denominator Statement (Brief, narrative description of the target population being measured)

All patients undergoing a screening mammogram

S.7. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Denominator Criteria (Eligible Cases):

All patients, regardless of age

AND

Diagnosis for mammogram screening (ICD-10-CM): Z12.31

Diagnosis for mammogram screening (ICD-9-CM)[for use 1/1/2015-9/30/2015]: V76.11, V76.12

AND

Patient procedure during the performance period (CPT or HCPCS): 77067

S.8. Denominator Exclusions (Brief narrative description of exclusions from the target population)

Documentation of medical reason(s) for not entering patient information into a reminder system [(eg, further screening mammograms are not indicated, such as patients with a limited life expectancy, other medical reason(s)]

S.9. Denominator Exclusion Details (All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

Documentation of medical reason(s) for not entering patient information into a reminder system (e.g., further screening mammograms are not indicated, such as patients with a limited life expectancy, other medical reason(s) (7025F with 1P)

S.10. Stratification Information (Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)

We encourage the results of this measure to be stratified by race, ethnicity, sex, and payer.

S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

S.12. Type of score:

Rate/proportion

If other:

S.13. Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

S.14. Calculation Algorithm/Measure Logic (Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)

To calculate performance rates:

- 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address).
- 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical.
- 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator

If the patient does not meet the numerator, this case represents a quality failure.

S.15. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

If an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.
This measure is not based on a sample or survey.

S.16. Survey/Patient-reported data (If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)

Specify calculation of response rates to be reported with performance measure results.

N/A

S.17. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.18.

Claims, Registry Data

S.18. Data Source or Collection Instrument (Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)

If instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.

We're using data submitted to CMS through claims and registries for the Merit-based Incentives Payment Program.

S.19. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

No data collection instrument provided

S.20. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Clinician : Individual

S.21. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Inpatient/Hospital, Outpatient Services

If other:

S.22. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

This is not a composite measure.

2. Validity – See attached Measure Testing Submission Form

NQF_Testing_Attachment_2019_225-637226353068492536-637235906990407072.docx

2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

Yes

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing

attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

No

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1,2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

No - This measure is not risk-adjusted

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

Generated or collected by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, depression score)

If other:

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields) Update this field for maintenance of endorsement.

ALL data elements are in defined fields in electronic health records (EHRs)

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources. For maintenance of endorsement, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Please also complete and attach the NQF Feasibility Score Card.

Attachment:

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Required for maintenance of endorsement. Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

IF instrument-based, consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

This measure was found to be reliable and feasible for implementation.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).

Not applicable

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Specific Plan for Use	Current Use (for current use provide URL)
Public Reporting	Payment Program
Quality Improvement (Internal to the specific organization)	Merit-based Incentives Payment System (MIPS)
	www.qpp.cms.gov
	MIPS
	www.qpp.cms.gov
	Merit-based Incentives Payment System (MIPS)
	www.qpp.cms.gov
	MIPS
	www.qpp.cms.gov

4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included
- Level of measurement and setting

This measure has been included in the Physician Quality Reporting System since 2009 as Measure #225. Shown below are national average performance rates as reported in the CMS Report: 2013 Reporting Experience Including Trends (2007-2014) Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program, APPENDIX, Table A27. Reporting and Performance Information by Individual Measure for the Physician Quality Reporting System (2010 to 2013).

Year Average Performance Rate

2010 N/A
 2011 68.5 %
 2012 74.6 %
 2013 81.6%
 2015 88.0%
 2016 94.4%
 2017 96.4%
 2018 97.9%

The performance rate was calculated as the count of reported instances where performance was met (numerator) divided by the total number of reported instances that excluded reported exclusions (i.e., performance denominator).

The ACR believes that the reporting of participation information is a beneficial first step on a trajectory toward the public reporting of performance results, which is appropriate since the measure has been tested and the reliability of the performance data has been validated. Continued NQF endorsement will facilitate our ongoing progress toward this public reporting objective. Quality measures are tools that help measure health care processes and outcomes. These data are associated with the ability to provide high-quality health care and physician participation in quality programs such as MIPS.

4a1.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

This is an accountability measure and used in the CMS quality and payment programs.

4a1.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.

This is a MIPS measure currently in use through registries and claims. Detailed specifications are publicly available in the CMS Resource Library. Benchmarks are provided each year. MIPS reporters receive QRUR/MIPS reports. The current benchmark for the claims measure is 94.2-98.22 for decile 3, 98.23-99.67 for decile 4, 99.68-99.99 for decile 9 and 100 for decile 10. The registry measure has 100 for decile 10. Quarterly feedback reports are provided to QCDR users that report this measure. ACR staff is available to assist with the interpretation of this measure. This measure is mostly attributed to radiologists.

4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

ACR has been approved by CMS as a Qualified Clinical Data Registry since 2014. This measure is included in our portfolio of QCDR supported measures. Feedback is provided to all registry participants reporting any MIPS quality measure on a quarterly basis. Educational webinars are conducted monthly to explain measure requirements and interpretation of performance results.

4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

Overall, feedback is positive on this measure. Feedback is obtained from the registry and from CMS. The PQRS 2016 trend report shows Radiologists are in the top 10 specialty providers participating in PQRS via claims and registry. For claims 50.2% of our providers eligible for PQRS reporting participated in the program and 13.2% of providers participated through registries.

4a2.2.2. Summarize the feedback obtained from those being measured.

Feedback is obtained through our members, the CMS quality help desk, and CMS contractor QMMS.

4a2.2.3. Summarize the feedback obtained from other users

No other feedback has been provided on individuals not reporting the measure.

4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

This feedback is considered during the annual measure specification update process with CMS. The ACR Metrics Committee also review the feedback for annual updates.

Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results

could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)

If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

There is significant improvement from 2014 to 2018 for this measure.

4b2. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

We are not aware of any unintended consequences related to this measurement.

4b2.2. Please explain any unexpected benefits from implementation of this measure.

5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

Yes

5.1a. List of related or competing measures (selected from NQF-endorsed measures)

2372 : Breast Cancer Screening

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications harmonized to the extent possible?

Yes

5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.

5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

There are no competing measures (conceptually both the same measure focus and same target population).

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

Available at measure-specific web page URL identified in S.1 **Attachment:**

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): American College of Radiology

Co.2 Point of Contact: Judy, Burleson, jburleson@acr.org, 703-648-3787-

Co.3 Measure Developer if different from Measure Steward: American College of Radiology

Co.4 Point of Contact: Karen, Orozco, korozco@acr.org, 703-390-9848-

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

List of Work Group Members:

William Golden, MD (Co-Chair) (internal medicine)

David Seidenwurm (Co-chair) (diagnostic radiology)

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National Committee for Quality Assurance: Mary Barton, MD

PCPI measures are developed through cross-specialty, multi-disciplinary work groups. All medical specialties and other health care professional disciplines participating in patient care for the clinical condition or topic under study must be equal contributors to the measure development process. In addition, the PCPI strives to include on its work groups individuals representing the perspectives of patients, consumers, private health plans, and employers. This broad-based approach to measure development ensures buy-in on the measures from all stakeholders and minimizes bias toward any individual specialty or stakeholder group. All work groups have at least two co-chairs who have relevant clinical and/or measure development expertise and who are responsible for ensuring that consensus is achieved and that all perspectives are voiced.

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2007

Ad.3 Month and Year of most recent revision: 09, 2019

Ad.4 What is your frequency for review/update of this measure? We review this measure each year for coding updates.

Ad.5 When is the next scheduled review/update for this measure? 12, 2020

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Ad.8 Additional Information/Comments: Coding/Specifications updates occur annually. The ACR has a formal measurement review process that stipulates regular (usually on a three-year cycle, when feasible) review of the measures. The process can also be activated if there is a major change in scientific evidence, results from testing or other issues are noted that materially affect the integrity of the measure.