Outpatient Quality Reporting Program

Support Contractor

Hospital OQR Imaging Efficiency Measures

Presentation

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Pam Harris: Hello, and welcome to the Hospital OQR Program Webinar. Thank you for joining us today. My name is Pam, a Project Coordinator for the Hospital OQR Program.

Before we begin today's program, I would like to highlight some important dates and announcements.

May 15, 2016, is the deadline to submit your web-based measures using your 2015 data via QualityNet and the 2015-2016 flu data to NHSN.

Due to the partial release of the Hospital Outpatient Quality Reporting CART abstraction tool, CMS has extended the Hospital OQR submission deadline for patient-level, chart-abstracted data from May 1, 2016 to June 1, 2016, for Quarter 4 2015 patient encounters. CMS extended the Quarter 4 2015 deadline to June 1 to provide hospitals sufficient time to submit their patient-level, chart-abstracted data due to the current system constraints. Only the Hospital OQR patient-level chart-abstracted data submission deadline has been extended. You will still be required to submit your web-based measures by the May 15 deadline.

Now, if you were signed up with the ListServe, this information was sent out on March 16th. So, see how important ListServe sign-up is? And one last note is to please keep your QualityNet Secure Portal password active by signing in at least every 60 days. On May 18, 2016, we will present "Tracking Quality Improvement by Using Hospital OQR Data," so be sure to join us then.

The learning objectives for this program are listed on this slide. This program is being recorded. A transcript of today's presentation, including the questions and answers reviewed in the chat box and the audio portion of today's program, will be posted at www.qualityreportingcenter.com at a later date.

Now, let me introduce our speaker. We are lucky today to have a special presentation by The Lewin Group regarding this subject matter. I am pleased to introduce our speaker today, Dr. Charlie Bruetman. Dr. Bruetman holds an MD from the University of Buenos Aires and an MBA from Northwestern University. Dr. Bruetman has over 20 years of experience in healthcare consulting both in the U.S. and abroad. He joined The Lewin Group in 2008 as the senior vice president and practice director for the federal health and human services market. Dr. Bruetman currently directs the subcontract with the Yale Center for Outcomes Research and Evaluation to maintain the CMS Outpatient Imaging Efficiency measures within the Hospital OQR Program.

Dr. Bruetman.

Charlie Bruetman: Hello, everyone. As Pam said, I am Dr. Bruetman, and I am a senior vice president at The Lewin Group and the project director for the Lewin team for the Hospital Outpatient Imaging Efficiency measures contract.

Today, we will discuss the six Outpatient Imaging Efficiency, or OIE, measures. This set of measures has been publicly reported since 2010.

I would like to begin today's presentation by walking through the agenda. We will first discuss the background and the measure development process for the

OIE measures. Next, we will review the measure specifications and the data collection methodology for each measure. We will conclude with questions and answers followed by a brief overview by the Health Services Advisory Group, HSAG, team on how to obtain continuing education credit for attending this presentation. Our first section provides background information on the OIE measure development process. So, we will go to slide 12 to start with the discussion.

Let me start with the overall purpose of the program. The Centers for Medicare and Medicaid Services, or CMS, has four primary goals in mind when selecting concepts evaluating imaging efficiency. First, CMS aimed to promote high-quality, efficient care and reduce waste. Doing so would be accomplished by encouraging providers to align with guidance from clinical practice guidelines and other empirical evidence when determining whether to image or not a patient.

Second, where possible, CMS wanted to reduce unnecessary exposure to radiation and contrast materials since radiation exposure is a significant concern. Many of the types of scans included in the OIE measures -- for example, CT -- expose patients to radiation or to contrast agents. By decreasing imaging that is not truly needed, providers can prevent excessive radiation exposure and limit side effects of contrast materials which, we are all aware, can range from itching to life-threatening emergency.

Third, CMS sought to encourage adherence to evidence-based medicine and clinical practice guidelines. CMS used clinical practice guidelines, appropriate use criteria, studies from the literature, and other empirical evidence to precisely specify each OIE measure during the measure development process.

Each year, CMS performs a review of the literature to identify updates to clinical practice and emerging evidence that may impact the measure specifications (we will go into more detail about this process later in the presentation), and presents new evidence to its technical expert panel.

Finally, CMS set out to provide data for the OIE measures to stakeholders about facility imaging use. These data are publicly posted and can be used by consumers, facilities, physicians, and others to ensure that the care provider is of high quality.

Beginning with the calendar year 2010 payment determination -- and just to clarify, this is a pay-for-reporting program -- CMS added four Imaging Efficiency measures to the Hospital Outpatient Quality Reporting, or Hospital OQR Program. These four measures are still in use today, including MRI Lumbar Spine for Low Back Pain, or OP-8; Mammography Follow-Up Rates, or OP-9; Abdomen Computed Tomography–Use of Contrast Material, OP-10; and Thorax CT–Use of Contrast Material, OP-11.

In 2012, CMS added another three imaging measures to the Hospital OQR Program including Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery, or OP-13; Simultaneous Use of Brain CT and Sinus CT, or OP-14; and Use of Brain CT in the Emergency Department for Atraumatic Headache, or OP-15.

In the most recent Outpatient Prospective Payment System, or OPPS, final rule release in November of 2015, CMS removed OP-15 from the program for payment determinations beginning in calendar year 2017.

These seven OIE measures were selected based on opportunity for improvement. Analysis performed by CMS and its contractors identified a high rate of overuse for the imaging scan included in each measure and noted that there was a large range, or variation, in performance among facilities, with some facilities conducting few unnecessary scans while other facilities performing a significant number.

As I noted earlier in the presentation, when CMS was specifying each measure concept, they used currently available evidence from clinical practice guidelines and the literature, and incorporated empirical finds with feedback from stakeholders and experts from different medical specialties.

Before each measure was implemented, CMS performed a dry run. Just to make you familiar with the concept of the dry run, CMS generally performs one for each measure prior to implementation. During the dry run process, CMS creates detailed reports specific to each facility that contain patient-level data showing whether the patient would have been included in the measure, in its denominator, numerator, or as an excluded case.

This dry run gives facilities an opportunity to provide feedback and measure calculation in advance of public reporting. CMS used this feedback to ensure the measure rate and specifications were precise before publicly posting facilities' state and national results. The dry run is only done once before the first time each measure is publicly reported.

CMS wants to ensure that OIE measures continue to be relevant to the practice of medicine. And to do so, CMS completes an annual maintenance cycle for the six OIE measures that are currently publicly reported. Measure maintenance begins by performing a structured review of the literature, new or updated clinical practice guidelines, and other publicly available evidence.

CMS then reviews measure clearinghouses for measures that are related or competing, meaning that they have a similar patient population or measure focus including the process, event, or outcome. Finally, CMS works with its technical expert panel to review any potential updates to the measure specifications.

As I noted on the previous slide, CMS has convened the technical expert panel, or TEP, that provides periodic feedback on the six measures. This is a critical part of the measure development and maintenance process. The TEP is composed of a variety of stakeholders including patients and caregivers, consumer advocates, clinicians, health system and hospital representatives, payers, and experts in health disparities and measurement science. The current TEP members are listed on the CMS website along with summary information for each of the TEP meetings that have occurred.

CMS holds discussions with its Imaging Efficiency TEP to gain information on a number of different topics. As I noted a couple of slides ago, CMS reviews proposed measure updates, including the evidence supporting each change, with the TEP each year. When conducting measure testing used for submission to the National Quality Forum or doing comprehensive measure maintenance, CMS reviews summary testing data with the TEP to gain their insights and feedback on the results.

One of the primary goals of measuring imaging efficiency is to share performance results with facilities, consumers, and other stakeholders. To that end, CMS updates facility, state, and national performance data each July on Hospital Compare. Hospital Compare is a CMS-maintained website that contains information on the quality of care provided at more than 4,000 Medicare-certified hospitals across the country.

Users of Hospital Compare can locate local hospitals and compare their performance results against other facilities and state or national averages. More information about each of the OIE measures, including additional information about the measure rationale and why measuring imaging efficiency is important, is available on the website Hospital Compare. The site link is on this slide. The purpose of public reporting is to provide information on hospital performance and quality for consumers and other stakeholders.

I would like to now turn to the review of each of the measure specifications of the six OIE measures that we currently report.

The first measure I will review today is MRI Lumbar Spine for Low Back Pain, or OP-8. OP-8 calculates the percentage of MRI lumbar scans for patients with low back pain for which antecedent conservative therapy was not attempted prior to the MRI scan. They are a significant evidence of overuse of cases when physicians immediately request an MRI for patients presenting with low back pain.

The denominator consists of the MRI lumbar spine studies with a diagnosis of low back pain on the imaging claim. In the numerator, we capture the MRI of

the lumbar spine studies with a diagnosis of low back pain for which patients did not have antecedent conservative therapy. Antecedent conservative therapy can be captured in one of three ways through claims as physical therapy, chiropractic evaluation and manipulation, or evaluation and management visits, or as it's called, E&M visits.

Imaging scans associated with several conditions are excluded from the measure. For example, these include cancer, HIV, trauma, and others listed on the side, as you can see, on denominator exclusions. Please note that some of these exclusion conditions require a look-back period, that is, CMS looks backward in the patient's history, using claims data, to find a claim for the exclusion.

So, for example, let's take a patient with HIV that can be identified up to 12 months before the imaging scan, causing their MRI to be excluded from the measure. Therefore -- in other words, if a patient had HIV and it's detected on a previous claim, we will not include that MRI in either the denominator or the numerator.

For OP-8, a higher score may mean that the facility is performing too many MRI lumbar spine studies without attempting antecedent therapy first.

Let's move on to the next slide, slide 22, OP-9. OP-9 is Mammography Follow-Up Rates. This measure calculates the percentage of patients with mammography screening studies that are followed by a diagnostic mammography, ultrasound, or MRI of the breast in an outpatient or office setting within 45 days of the initial mammography screening.

In this case, the denominator includes patients who had a mammography screening performed. Of the patients in the denominator, the numerator captures those patients who had a diagnostic mammography, ultrasound of the breast, or MRI of the breast on the day of or within 45 days following the screening mammography.

This measure has an upper and lower bound range, which makes it different from others that we will see. Facilities with a score above 14 percent may be recalling too many patients for a follow-up scan, while facilities with performance scores near zero may be recalling too few patients and potentially missing cases of cancer.

This is OP-10, or Abdomen CT–Use of Contract Material. It calculates the percentage of abdomen CT scans that are performed with and without contrast out of all abdomen CTs performed: in this case, those with contrast, those without contrast, and those with and without contrast, which we call combined studies.

The denominator consists of the number of abdomen CT studies performed with contrast, without contrast, and combined studies, while in the numerator we capture only those abdomen CT scans with and without contrast or, as we call them, combined studies.

OP-10 excludes several conditions for which combined studies imaging may be appropriate including adrenal masses, blunt abdominal trauma, hematuria, kidney infections and diseases of the urinary system, jaundice, liver lesions, neoplasms of the bladder or pancreas, pancreatic disease, and other unspecified disorders of the kidneys and ureter. These excluded conditions must be included on the imaging claim.

In this case, a higher score may mean that the facility is performing too many combined CT scans when one, either with or without contrast, may be needed. There are very few cases where a combined study is deemed appropriate.

I will now talk about OP-11, or Thorax CT–Use of Contrast Material. This is very similar to OP-10 that I just mentioned. In this case, OP-11 calculates the percentage of thorax CT scans that are performed with and without contrast out of all the thorax CTs performed: like those with contrast, those without contrast, and the combined studies.

The denominator consists of the number of thorax CT studies performed with contrast, without contrast, and combined studies, while in the numerator we capture only those CT thorax scans that are combined studies.

Much like OP-10, there are a few conditions for which combined imaging may be appropriate including internal injury of the chest, abdomen, and pelvis; injury to blood vessels; and crushing injury. These conditions must also be captured on the imaging claim to be excluded.

And just like OP-10, a higher score for OP-11 may mean that the facility is performing too many combined CT scans when only one, either with or without contrast, may be necessary.

The fifth OIE measure is Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery, or OP-13. This measure calculates the percentage of stress echocardiography, Single Photon Emission Computed Tomography Myocardial Profusion Imaging, also known as SPECT MPI, or Stress Magnetic Resonance Imaging, or MRI, scans performed at a hospital outpatient facility in the 30 days prior to an ambulatory low-risk non-cardiac surgery.

This is an important concept. We are talking about only low-risk and non-cardiac surgery.

OP-13's denominator captures stress echocardiography, SPECT MPI, and stress MRI studies performed at a facility in the outpatient setting. The numerator includes those stress echocardiography, SPECT MPI, and stress MRI studies from the denominator that are performed in the 30 days prior to an ambulatory low-risk non-cardiac surgery performed in any location.

As recommended by clinical guidelines, OP-13 excludes high-risk patients, who are identified as those with three or more of the following diagnoses: diabetes, renal insufficiency, stroke or transient ischemic attack, prior heart failure, or ischemic heart disease.

Similar to OP-8, CMS looks backward in a patient's history to identify the excluded diagnosis. For example, a claim with diabetes mellitus must have occurred within the last year, while a history of heart failure could occur in the three years before cardiac imaging.

With the appropriate exclusion defined previously for OP-13, a higher score may mean that the facility is performing too many cardiac imaging studies prior to non-cardiac imaging surgery.

OP-14, or Simultaneous Use Of Brain CT And Sinus CT. In this case, we calculate the percentage of brain CT studies with a simultaneous sinus CT, that is, brain and sinus CT studies performed on the same day at the same facility. OP-14's denominator includes brain CT scans. Its numerator captures brain CTs performed on the same day at the facility as a sinus CT.

In this case, OP-14 excludes four categories of conditions for which simultaneous brain and sinus CTs may be appropriate including neoplasm, trauma, orbital cellulitis, and intracranial abscess. Like OP-10 and OP-11, these excluded conditions must be included in the imaging claim.

A higher score for OP-14 may mean that the facility is performing too many brain and sinus CTs on the same day when only one, a brain CT or a sinus CT, may be appropriate.

Let's move on to slide 27. I will now transition to a review of the OIE data.

CMS uses 100 percent Fee-for-Service Medicare data to calculate the OIE measures. This means that only Medicare Part A and Part B claims are captured. Medicare Advantage and Part D information is not used. All claims data used to calculate the OIE measures are paid under the Outpatient Prospective Payment System, or OPPS, at facilities that are eligible to participate in the Hospital OQR Program.

No additional information needs to be or can be submitted by facilities or their vendors for inclusion in the OIE calculation process. There is no additional burden on providers since these are all claims data that CMS has.

So, what data are currently available to facilities? The performance scores publicly posted on Hospital Compare today were published in July of 2015 and reflect claims from July 1, 2013 through June 30, 2014. In July of 2016, data from claims of July 2014 through June 30, 2015, will be posted on Hospital Compare. As you see, we have a lag, as it reflects the prior year in the Hospital Compare website.

The OIE measures data are posted on Hospital Compare and are updated each year by CMS. CMS provides facilities with an opportunity to review their performance data in advance of its public posting. But, in this case, unlike the dry run conducted several years ago for each OIE measure, as I mentioned, this is done before the first time it is publicly reported, during the measure development and testing process. Preview reports only contain facility-level data.

Hospitals will have access to their preview reports for the next OIE refresh, describing performance data for claims from July 1 of 2014 through June 30, 2015, and they will have the refresh later this month [Editor's note: The preview period began May 3.]. CMS previews performance data to facilities a few months before refreshing Hospital Compare to allow facilities time to ask questions about their score and note any discrepancy.

We will talk about measure exclusions now.

One important thing to remember about attribution of claims for calculating the OIE measures is that if an imaging procedure is performed in your facility, it is linked to your hospital's CCN, or CMS certification number. Data used to calculate the OIE measures are aggregated at the CCN level. As I noted earlier in the presentation, some OIE measures exclude conditions or categories of conditions for which imaging may be appropriate.

Five of the six OIE measures have exclusions, all of which are identified using evidence from clinical practice guidelines or the literature. These exclusions may be captured on the imaging claim itself, as required in OP-10, 11, and 14, or may occur in a patient's history. As we presented in OP-8, you may recall, if we identified a patient with HIV, we would look at any claim in which we identified HIV. When a patient is excluded, that imaging study that is excluded is not included in the performance rate of each facility.

We will talk a little bit more about some exclusions.

Exclusions for OP-8, MRI Lumbar Spine for Low Back Pain, can occur up to five years before the imaging study. Exclusions for OP-13 can occur up to three years before the scan. The look-back window varies by exclusion or category of exclusions, with some being as short as a few months and others running up to three or five years.

Claims for an exclusion could occur at your facility or in another location, inpatient, outpatient, or physician office. It is important to understand all the contractor looks at are the claims for a specific patient to identify any potential exclusions, and therefore, if that is identified, again, in any claim that is in your facility or in any other facility, the patient is not included in your performance rate.

Occasionally, CMS receives questions from stakeholders about their performance data. Because the OIE measures are calculated using post-adjudicated Fee-for-Service claims, CMS considers them as an accurate representation of services rendered.

Understanding and improving performance. If you identify a concern about your performance data, including the publicly-posted results or information in the preview reports -- and recall that the preview reports are not the same as the dry run, it is the information provided to each facility in advance of quality reporting -- you should, in that case, reach out to the OQR Outreach and Education support contractor.

Doing so can be accomplished through the Outpatient Questions and Answers tool, and the link that you need is on the slide. Or you can call customer service, which is also on the slide, and it is the number, the 1-866-800-8756. And in that information, you can clarify any concerns you have with the data.

In what ways can the OIE data be used outside of public reporting? This is something that has been asked many times. We encourage facilities to carefully review their performance results for all of the OIE measures. These data can provide an opportunity to facilities to identify areas for improvement. CMS cannot provide explicit guidance on how to do so. But facilities can, for example, work with their internal quality committees or the Quality Innovation Network/Quality Improvement Organization, or QIN/QIO, or brainstorm process improvements.

Again, we are not suggesting any specific approach, but we believe that facilities that are what we call outliers have rates, performance rates, above the average or above other facilities, or at the state or national level they can compare and should carefully look into this information and identify potential opportunities to improve the quality of care.

If facilities would like to develop internal quality improvement efforts using the OIE data, we had just pulled in claims data that meet the OIE measure specifications to identify patterns in ordering behavior that could be adjusted. Such an approach mirrors the type of support provided by your QIN-QIO.

And with that, I will turn it back to Pam to questions from participants on the content presented or provide other information on the OIE measures. Thank you very much.

Pam Harris: Thank you, Dr. Bruetman. We really appreciate all that great information you provided today.

Now, we have time to go over a few questions. Dr. Bruetman, have you found any that have come in yet?

Charlie

Bruetman: Yes, Pam. Thank you. We have several questions, and I will try to address some of them now.

So, one question is regarding the purpose of the OIE measures and why it is important to publicly report them. Well, the purpose of the use and reporting of these OIE measures is to promote efficient use of imaging procedures in hospital outpatient departments.

The OIE measures address important patient safety concerns related to exposure to excess radiation and/or contrast material and other unnecessary forms of imaging. These measures are important for consumers to help determine where they prefer to have their imaging performed or for other stakeholders to evaluate their performance compared to their peers.

Public reporting is important because of the health risk and cost associated with the use of imaging procedures in the Medicare beneficiary population, which we know consumes significant resources. Research has found that a significant portion of imaging services received by patients may be inappropriate. And this research is supported by numerous studies documenting variation in rates of use and spending for imaging services by as much as eight-fold between and within states in the U.S.

The OIE measures fill a significant gap in the availability of imaging efficiency measures at the hospital outpatient level. So, like a variety of measures, it was based upon the extent to which the OIE measures fulfill their four main criteria of importance, scientific soundness, usability, and feasibility.

Also, measures are evaluated for performance, not only potential overuse but also the range or variation among facilities. It is there we identified that facilities at the lowest end and a lot of facilities at the high end -- there are some challenges. And this is an important way to improve the quality of care within your facility.

There is a question regarding the potential of being excluded from public reporting on one of the OIE measures. Well, all the OIE measures on Hospital Compare are really part of the CMS reporting requirements. And most facilities, and I will explain why most, are required to report OIE measures and others in the HOQR program.

And this is important to understand that there are some types of facilities which are excluded. Hospital types like psychiatric hospitals, rehab hospitals, pediatric hospitals, and critical access hospitals are not included. Or hospitals which have research centers may not be included, but all other hospitals are included.

It is also important to know that there are cases where not all the measures will be included in public reporting because the hospital needs to meet what is called the minimum number of cases. If they do not meet the minimum number of cases, they do not have statistically valid information. Therefore, they are excluded from public reporting, not that the hospital decided not to report it, but that was why they might not find their hospital in public reporting or Hospital Compare.

Pam Harris: Dr. Bruetman, I've got one here -- a question. And it is: "For the current data submission period, what manual version do we use for the OP-26 measure?" And for the current submission period, which is the 2015 data reported in 2016, you are going to utilize Specifications Manual version 8.1. And that is where you are going to get your data listing or your surgical procedure codes from there. Okay?

Charlie Bruetman: Okay, Pam. I have another question here, interesting question on a two-hospital system with several outpatient facilities. The question is: "Both hospitals have their own Medicare provider number, and both have an outpatient facility using the same Medicare provider number as the hospital. Will the outpatient facility that's associated with the hospitals be included in the reports for imaging measures?"

The imaging measures will include all hospital outpatient facilities that submit Medicare claims, so all hospitals will include that. And during, of course, the applicable period, as we said, it's usually one year behind the reporting period, and it includes every department within a large hospital.

However, only outpatient claims are included. And this is important. It's not all the hospital claims, but only the outpatient. This is for the outpatient departments. Now, if an outpatient facility is using the same Medicare provider number as the hospital, its claim data will be included in the hospital statistics. So, if there are multiple facilities with the same provider number, they will all ramp up to one facility.

And here is another question on the timeline, data collection period, and the process for reporting of the outpatient imaging measures: "So, the facility-level data for the OIE measures are calculated and reported on Hospital Compare on an annual basis?"

It's usually on, well, it is in the month of July. So, in July 2015, Hospital Compare provided information for all the data between July 1, 2013 and June 30 of 2014. Hospital Compare will have the next release in July of this year, and that will include data between July 1 of 2014 and June 30 of 2015. So, as you see, there is always a lag of one year.

Again, just for those hospitals that need to know, we did not require any additional submission of data, and there is no additional information hospitals need to provide. The OIE measures are calculated on post-adjudicated claims data that were submitted by the hospital for payment.

So therefore, all these are considered valid, and therefore, they will be included in the public reporting. It is important because CMS does not want to have any additional burden on hospitals as they report in this process.

The hospitals -- again, before it goes to public reporting, the hospitals will have an opportunity to review the data. And sometime at the end of the month or around April -- I have April 22 through May of 2016 [Editor's note: The

preview period began May 3 and concludes on June 4, 2016.] -- the preview reports will be released for hospitals to look at before they are publicly reported, and they may submit any questions or concerns to CMS through the system that was provided previously.

Pam Harris: I have got one, Dr. Bruetman. "I've found a mistake on Quarter 3 2015 data. Can I correct the error now?"

And, no, unfortunately, you cannot. Once your quarterly data are submitted and accepted into the warehouse and the submission deadline has passed, then the warehouse closes for that quarter. So, you would not be able to make corrections.

Charlie Bruetman: Pam, I will move on to another question we received here. And this one is a question regarding OP-15. And it is: "Why is OP-15, Use of Brain Computed Tomography in the Emergency Department for Atraumatic Headache, not included in the list of OIE measures?"

As I mentioned, in the most recent Outpatient Prospective Payment System final rule, CMS removed OP-15 for the calendar year 2017 payment determination and for subsequent years. So, OP-15 will not be reported anymore. And, as you know, measures go through a rulemaking process, and there was a decision in the OPPS system not to include OP-15 in the OIE program.

This is -- here is another question on MRI services. And this is somewhat similar to others in terms of the hospitals and multiple facilities. It says: "Our MRI services are a contracted service through a joint venture. Do I report MRI findings in the OIE measures as if this service is part of the hospital?"

Well, let's see. In general, a case is included in the calculation of the facility's OIE measure performance score if it is billed as a claim through the CMS Outpatient Prospective Payment System program under the facility's CCN. So, if that facility, in this case your facility and the facility contracted for MRI services, bill under a different CCN, then your facility may not have

performance scores for the OIE measures involving MRI studies because in this case it might not be a hospital. But if they are using the same one, they will be all into one, and they will be included in the hospital outpatient.

So, the measures, again, are calculated with Medicare Fee-for-Service claims of outpatient beneficiaries. And if it is not claimed through an outpatient claim, then it will not be included in the measure calculations. And these are all claims that have been submitted to CMS by hospitals.

Again, these were post-adjudicated, so they have been paid. And there is no need for additional supporting claims or information to be submitted by the facilities.

Pam Harris: Great Dr. Bruetman. I've got one. And it's: "How do you sign up for the ListServe?" And that is a great thing. Let's see. You sign up for the ListServe by going to qualitynet.org, and then you look on the left-hand side, the third blue box. And you will click on Join ListServes / Sign Up for Notifications and Discussions, and it will take you to a page where you can sign up. And it will take you less than five minutes. It's great. It's the best way to stay informed.

Charlie Bruetman: Pam, do we have time for a couple more questions?

Pam Harris: Yes, Dr. Bruetman. We've got time for a few more questions.

Charlie Bruetman: Okay. So, here is one that asks about the emergency department. It asks: "Will the imaging measures for CT scans include patients who come into the emergency department, have a CT, and then are discharged?" A very interesting question that has created some confusion over time.

And the answer is yes, all the measures involving CT scans -- for example, OP-10: Use of CT Abdomen Use of Contrast Material or OP-14: Simultaneous Use of Brain CT and Sinus CT -- include utilization from the emergency department since the emergency departments are considered

outpatient facilities and are paid under the Outpatient Prospective Payment System. So, any claims for imaging that come through the OPPS system will be included, and it could be from any department that bills in that form. So, emergency departments are included in this performance metric.

I have a question on mammography as well. The question is: "How are mammography follow-up rates for OP-9 captured?" Remember, OP-9 is our Mammography Follow-Up Rate, and basically, Medicare claims data are used to check if the mammography screening studies are followed by a diagnostic mammography, ultrasound, or MRI breast scan in an outpatient or office setting within 45 days. So, it's beyond the mammography. It could be any of these three other procedures.

The follow-up window of 45 days is inclusive of the same day that the screening was performed; that is, the numerator would include diagnostic mammography, the ultrasound, or MRI of the same day as the screening mammogram.

Pam Harris: Okay, I've got a question, and it is: "Is OP-31 still a voluntary measure?" And the answer to that is, yes, it is still a voluntary measure, but it still shows up on your QualityNet reporting area. You can leave this area blank, or you can report zeroes. Either method will not incur any financial penalty for your facility.

So, we've got time for, maybe, one or two more questions, Dr. Bruetman.

Charlie Bruetman: Sure. Here, we have one on education. "Are data collected for the Outpatient Imaging Efficiency measures used for educational purposes only? Will CMS be making recommendations on how to be more efficient, or is this something hospitals should work on by themselves?"

I think we briefly talked about this. So, the OIE measures provide an opportunity for hospitals to look for improvements in areas where they can involve their quality committee, etc. to improve care if they believe they are an outlier or overusing certain imaging, but CMS is not prescribing any

specific practices. Hospitals can work with their physicians or staff or quality committees or their QIN-QIOs to identify solutions to help them improve performance on the measures. So, they serve a purpose on being reported, and it really helps. It has the benefit for consumers or patients to look at how hospitals are performing in their area, and they can make their decision where they would prefer to have a study performed. Or hospitals can also look at them to compare themselves to other facilities in the area or at the national level to see how they are performing. And so, it has multiple purposes. And hospitals can also use the data to look into quality improvement opportunities.

And here are a couple of quick questions, I think. One is: "Why is my hospital's imaging measures' values larger or smaller than the national or state or regional rate values?" Well, a facility has statistics for comparison values, for example, the national value. It is because you are performing, or basically, you are performing more studies than the national average for that same study or that same type of measure. The numbers are reported as averages. State and regional values may also be larger than national values.

And a related question is: "Are the national or state or regional numbers just a sampling, or are they an average?" The national and state values provided in the reports are weighted averages, and these are calculated by taking all the eligible numerator counts and dividing by all the eligible denominator counts for a specific geographic area. And these values are an average of actual values taken from claims data. The values are not an aggregate, so it's important to understand how they are calculated at the regional level for national or local comparison purposes.

Pam Harris: I believe that is all the time we are going to have for today. Thank you, again, Dr. Bruetman, and our thanks to The Lewin Group.

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