National Quality Forum

Comments on Draft Report: National Voluntary Consensus Standards for Imaging Efficiency, 2010

The Steering Committee reviewed the submitted comments and proposed response during a conference call on July 16, 2010.

Comment #	Council	Organization Contact	Topic	Comment	Proposed Response
17	Public	Kay Schwebke, Ingenix	General Comments	Some of these measures are restricted to the Medicare population (e.g., IEP-010-10 and IEP-010-130); yet they have broader application. We would suggest defining the population by age criteria; not insurance coverage. Also, suggest defining the population using an age range that includes a non-Medicare age group. These changes would result in more usable measures and would increase the number of patients impacted by these important overuse measures.	**(MD Response):**CMS is supportive of the use of its measures (when applicable) in other population groups. CMS does think that the measures submitted in this imaging efficiency measures cycle can have applicability to other populations. However, in order to submit tested measures, CMS uses the Medicare population data. Hence the measure submission can only speak to the use of the tested measures as they apply to the Medicare population.
18	Health Professional	Joyce Bruno Reitzner, American College of Chest Physicians	IEP-005-10	Approve with comments. On behalf of the American College of Chest Physicians (ACCP) the ACCP Quality Improvement Committee (QIC) appreciates the opportunity to comment on this measure. The QIC notes that although the background documentation for this measure is adequate, they are concerned that this measure, as written, is not as clear as it should be with regard to the target population for this measure. While the measure references that the indication should be consistent with guidelines, the QIC recommends that the NQF add the specific inclusion criteria to the measure specification.	(**MD Response**):1. The inclusion criteria are specific. The measures is designed to assess imaging efficiency, and is directed at measuring the appropriateness of CT use. As such the measure is not designed to identify inclusion criteria based on patient clinical characteristics, but is rather defined based on the imaging test. 2. The guidelines referenced in the measure do not mandate the use of a specific clinical decision rule, but rather recommend structured assessment of pre-test probability for PE as this measure is designed to improve appropriateness of CT use.

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19	Purchaser	Jennifer Eames Huff, Consumer-Purchaser Disclosure Project	General Comments	Health care costs continue to escalate and for many Americans, has become unaffordable. Imaging services are one of the highest growing services among Medicare beneficiaries and significant geographic variation, without necessarily achieving better outcomes, indicates the presence of overuse and inappropriate care. We wholeheartedly support NQF working in this important area. In general, we support the measures that are being recommended for endorsement. However we view these, combined with the previously endorsed imaging efficiency measures, to still be a limited set of measures. We believe this would be a much stronger set if it were to include more utilization based measures, adjusted for population severity. Overuse of imaging is not just a financial issue; it is a patient safety issue. We need a much broader set of measures to protect patients and reduce waste.	**(NQF Staff Response)** Thank you for your comment and for helping to push the field of healthcare efficiency forward. NQF and the Steering Committee acknowledge the dearth of imaging efficiency measures and has worked hard over the last couple of years to fill efficiency measurement gaps. While it is not within the scope of NQF's mission to create measures, NQF is actively engaging other avenues to encourage the development of efficiency measures and fill measurement gaps. We anticipate that increased collaboration and the development of an NQF endorse Resource Use Framework will help fill efficiency measurement gaps in the coming years. We encourage external support on how to fill efficiency measurement gaps.
20	Purchaser	Jennifer Eames Huff, Consumer-Purchaser Disclosure Project	General Comments	Measures should not be restricted to a particular insurance population (e.g., Medicare). We need alignment across public and private sector measurement. These measures should apply to the entire adult population, not just seniors. As a developer of measures for the public good,CMS needs to ensure its measures can be applied broadly.	**(NQF Staff Proposed Response):** The Steering Committee acknowledged the need for measures to capture all types of insurance populations and pushed measure developers to broaden their population scope. Particular measure developers due to funding and testing constraints indicated that adequate measure testing in other populations (or insurance products) requires more time. The Committee supports testing for measures in many populations.

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21	Purchaser	Jennifer Eames Huff, Consumer-Purchaser Disclosure Project	General Comments	We were pleased to see measures that rely on electronically available data. We need more measures with feasible mechanisms for data collection, especially those that are real-time and can inform point-of-care delivery.	**(NQF Staff Response)** Thank you for your comment. In a continued effort to improve performance measurement within the boarder health care sector, NQF is actively building the foundation and support systems to move quality measurement to a real-time electronic platforms. NQF is working on re-tooling currently NQF endorsed® quality measures for electronic format and will stipulate that future quality measures be integrated into an EHR system. We encourage external support on how to improve the transition to electronic platforms.

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22	Purchaser	Susan Arday, CMS	#IEP-009-10	NQF #IEP-009-10 Mammography Follow-up Rates. The Mammography Follow-up Rate measure calculates the percent of Medicare patients with mammography screening studies done in the outpatient hospital setting that are followed up within 45 days by a diagnostic mammography or ultrasound. CMS is disappointed that this measure was ultimately not recommended for endorsement, as prior discussion during the Steering Committee meeting and subsequent follow-up calls indicated that the Committee was divided with regard to endorsement, and members on the Committee did think that the proposed measure had value. The Steering Committee requested the following changes or additional information to better inform their decision: Expanding scope to include both hospital outpatient and other outpatient settings, Age stratification of the measure, Validation of the CPT codes to show the distribution of current screening/diagnostic codes ,CMS and its measure developer, The Lewin Group, submitted additional information that addressed each of these requests. The additional information is as follows:1.CMS and its measure developer were amenable to expanding the scope beyond hospital outpatient departments to other outpatient settings.	**(NQF Staff Proposed Response):** The Steering Committee appreciates CMS's and The Lewin Group's efforts in expanding the measure, however, during the voting period the Committee ultimately did not believe the measure was ready for public reporting for quality improvement purposes. The Steering Committee and NQF encourage the measure developer to address potential issues with the measure and resubmit to NQF at a later date.

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23	Purchaser	Susan Arday, CMS	NQF #IEP-009-10	NQF #IEP-009-10 Mammography Follow-up Rates. With regard to age stratification CMS and its measure developer submitted results of analyses of Medicare claims data showed small differences in the rate of follow-up studies across age cohorts in the Medicare population. These results suggest that there is neither analytic nor practical reason to divide the Medicare population (which is overwhelmingly age 65 and older) into finer age cohorts for interpretation of the measure. Furthermore, the size of the Medicare under-65 population is too small to affect a facility's overall rate. The measure developer and CMS do think that stratification by age cohort may be appropriate in certain instances if the measure is applied to commercial and other non-elderly patient populations. However, the size of the patient population receiving a screening and a diagnostic mammogram in any individual facility may make age stratification difficult due to the need for adequate sample size.	Refer to response on comment #22

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24	Purchaser	Susan Arday, CMS	NQF #IEP-009-10	NQF #IEP-009-10 Mammography Follow-up Rates. For example, one study by Schell and colleagues (2007) attempts to retrospectively identify target recall rates for screening mammography on the basis of how sensitivity shifts with recall rate. The study indicated that recall rates between 4.3% and 12.3% provided increased cancer detection within an acceptable range of increase in screenings. For example, the study showed that increasing the recall rate from 4.3% to 6.7% increased the estimated AW/ACD from 80 to 132, which rendered 6.7% the desirable target recall rate given the authors' determination of approximately 100 as the desirable AW/ACD. Increasing the recall rate from 6.7% to 12.3%, increased the estimated AW/ACD to 304 (i.e., 304 women would have to be recalled to detect one additional cancer), suggesting little benefit for any higher recall rate. Consequently CMS and its measure development team believe use of AW/ACD, or follow-up rate with cancer detection rate, is a worthwhile measure to investigate. However, given the discussion around the ACR proposed cancer detection measure we are concerned about whether it is feasible to measure and publicly report at the facility level because of the issue of inadequate case volume.Schell MJ, Yankaskas BC, Ballard-Barbash R, Qaqish BF, Barlow WE, Rosenberg RD, Smith-Bindman R. Evidence-based target recall rates for screening mammography. Radiology 2007;243(3):681-9.	Refer to response on comment #22

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25	Purchaser	Susan Arday, CMS	NQF #IEP-009-10	NQF #IEP-009-10 Mammography Follow-up Rates. The CMS would be supportive of considering the development of a measure related to cancer detection rates. However, a proposed cancer detection rate measure developed by the American College of Radiology (ACR) was not recommended by the NQF Steering Committee for endorsement due to concerns that such a measure may lack meaning or fail to provide actionable information at the facility level. The Committee expressed reservations over the proposed cancer detection rate measure, citing that facilities must have enough breast cancer events to make the measure meaningful. This may be a potential problem for facilities with too few breast cancer events, which based on information discussed by ACR at the Steering Committee meeting, would be the situation for many facilities. Despite these expressed limitations to the proposed ACR measure, the Committee encourages CMS to explore further development options that would measure performance for both mammography follow-up rates and cancer detection rates.	Refer to response on comment #22

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26	Purchaser	Susan Arday, CMS	NQF #IEP-009-10	NQF #IEP-009-10 Mammography Follow-up Rates. CMS and its measure development team, agree that a measure that takes into consideration both mammography follow-up rates and cancer detection rates would be of great value. Indeed, the literature indicates that for a given mammographer, sensitivity increases with recall rate, and if all women were recalled, very few cancers would be missed; however establishing a target range for recall rates should not be based on sensitivity alone. Instead, using the metric of additional work-ups per additional cancer detected (AW/ACD: i.e., the estimated number of additional women needed to be recalled at a given rate to detect one additional cancer) may be useful in developing a target threshold.	Refer to response on comment #22
27	Purchaser	Susan Arday, CMS	NQF #IEP-009-10	Duplicate comment, same as 24	Duplicate comment, same as #24

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29	Purchaser	Susan Arday, CMS	NQF #IEP-012-10	NQF #IEP-012-10 Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)The Simultaneous Use of Brain CT and Sinus CT measure aims to assess the rate of patients who received both a brain CT study and, simultaneously, a sinus CT study (i.e., brain and sinus CT studies performed on the same day at the same facility). The intent of the measure is to lower the number of potentially unnecessary sinus CTs performed for patients who have already had a brain CT. The CMSA and its measure developer, The Lewin Group, are disappointed that this measure was ultimately not recommended for endorsement as discussion during the Steering Committee meeting indicated strong support for this measure that addresses an important opportunity to change the clinical behavior with respect to ordering practices while lessening the potential undue harm to patients from radiation exposure.	**(NQF Staff Proposed Response):** The Steering Committee appreciates CMS's and The Lewin Group's efforts in NQF's Imaging Efficiency Project, however, during the voting period the Committee ultimately did not believe the measure was suitable for public reporting or quality improvement purposes. The Steering Committee and NQF encourage the measure developer to address potential issues with the measure and resubmit to NQF at a later date.

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30	Purchaser	Susan Arday, CMS	NQF #IEP-012-10	(CONTINUED FROM 29) NQF #IEP-012-10 Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)Although the NQF Steering Committee ultimately decided not to endorse the measure over concerns of sample size and importance, there is still substantial concern surrounding this clearly inappropriate radiation exposure from the simultaneous use of these two imaging modalities. Literature and consulted technical experts agree that given the specifications of and proposed exclusions for this measure, there is no further instance when use of both Brain CT and Sinus CT is appropriate. Although the relative incidence of inappropriate imaging is low for this measure, the measure establishes a clear opportunity for improvement. The NQF Steering Committee members initially suggested expansion of this measure to the general population as other non-Medicare patients would likely benefit from such a measure (e.g., children). Further, analysis of Medicare data shows that approximately 75,000 Medicare patients are receiving this dual radiation exposure, and therefore, from a national perspective, there are likely other populations affected. The CMS thinks that the public reporting of this measure could address this unnecessary radiation exposure.	Refer to response on comment #29

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31	Purchaser	Susan Arday, CMS	NQF #IEP-012-10	(CONTINUED FROM 29 & 30) NQF #IEP-012-10 Simultaneous Use of Brain Computed Tomography (CT) and Sinus Computed Tomography (CT)American Imaging Management. Top Inappropriate Requests for High-Tech Imaging. Available online: http://www.priorityhealth.com/pdfs/radiology/inappropriate-high-tech-imaging-requests.pdf ACR Appropriateness Criteria – Headache. Reston, VA: American College of Radiology, 2009. Accessed November 25, 2009 at http://www.acr.org/SecondaryMainMenuCategories/quality_safety/app_criteria.aspx American Imaging Management, Diagnostic Imaging Utilization Management: 2008 Program Guidelines. 2008, also updated for 2009-2010, v.6.1.0 at: http://www.americanimaging.net Brenner D and E Hall. November 29, 2007. Computed Tomography — An Increasing Source of Radiation Exposure. N Engl J Med;357(22):2277-84.	Refer to response on comment #29

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32	Purchaser	Susan Arday, CMS	#IEP-011-10	NQF #IEP-011-10 Use of Stress Echocardiography, SPECT MPI, and Cardiac Stress MRI Post CABG The Use of Stress Echocardiography, SPECT MPI, and Cardiac Stress MRI Post CABG measure aims to evaluate the rate of post-CABG patients being treated with an outpatient service in an outpatient hospital facility, who also had a cardiac imaging procedure done at a hospital outpatient facility. The CMS and their measure developer, The Lewin Group, are disappointed that this measure was ultimately not recommended for endorsement; however, the CMS would like to clarify comments made in the Consensus Report. With regard to the NQF Steering Committee requests to modify the measure specifications and sample size, the Report states that "While the measure developer acknowledged the Committee's concern and 'believes that adjustment to increase sample size likely may be needed,' they were unwilling to make the necessary changes." The CMS would like to clarify that CMS is willing to modify the measure; however, in submitting measures, CMS believes that it is essential to have conducted adequate data analysis to support a submission. The short timeline permitted by NQF and available resources did not allow for such significant changes.	**(NQF Staff Response):** NQF appreciates the comment and clarification from CMS. The draft report originally read "While the measure developer acknowledged the Committee's concern... they were unwilling to make the necessary changes". NQF revised the draft report to more adequately reflect the constraints faced by all parties. The report now reads as follows "While the measure developer acknowledged the Committee's concern... they were unable to make the necessary changes do to time constraints within the Imaging Efficiency Project".

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33	Purchaser	Susan Arday, CMS	Not Recommended	(CONTINUED FROM 32) NQF #IEP-011-10 Use of Stress Echocardiography, SPECT MPI, and Cardiac Stress MRI Post CABG The CMS prefers to have done adequate data analysis testing of its proposed measures prior to submission for NQF endorsement. CMS measures for hospital outpatient reporting go through the rulemaking process, and time-limited endorsement is of limited utility in that context. Thus in the current imaging efficiency measures cycle there was not sufficient time to accommodate the suggested changes recommended by the Committee. The characterization of CMS and its measure developer as being unwilling to make necessary changes is not accurate.	(Continued from 32) **(NQF Staff Response):** NQF appreciates the comment and clarification form CMS. The draft report originally read "While the measure developer acknowledged the Committee’s concern... they were unwilling to make the necessary changes". NQF revised the draft report to more adequately reflect the constraints faced by all parties. The report now reads as follows "While the measure developer acknowledged the Committee’s concern... they were unable to make the necessary changes do to time constraints within the Imaging Efficiency Project".

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34	Purchaser	Susan Arday, CMS	General Comments	Feasibility of the Measures Recommended for Endorsement•Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, etc.) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). Of the seven measures recommended for endorsement by the NQF Steering Committee, five do not appear to meet at least one of the aforementioned requirements for Feasibility. For example, five measures required data elements that do not appear to be available in electronic sources or as the by-product of clinical care, three measures are proprietary, and two involve exclusions that require additional data sources beyond what is required for scoring the measure. Table 1 provides an overview of these shortcomings in the Feasibility of some of the measures recommended for endorsement. For purposes of measure development and use in public reporting, CMS believes that Feasibility is an important consideration, as there are significant implications for providers when CMS chooses to adopt a measure for its public reporting purposes. CMS would encourage NQF to remind measure developers as well as its Committee reviewers of the importance that endorsed measures are feasible to implement and do not place undue burden on providers.	**(NQF Staff Response)** In accordance with NQFs Consensus Development Process (CDP) each measure submitted to NQF is evaluated by a Steering Committee on four evaluation criteria. NQFs four sets of standardized evaluation criteria: importance to measure and report, scientific acceptability of measure prosperities, usability, and feasibility are applied equally across all measures. “Not all acceptable measures will be strong – or equally strong – among each set of criteria. The assessment of each criterion is a matter of degree” (NQF Measure Evaluation Criteria, 2009). NQFs fourth standardized evaluation criteria – feasibility, assess the “extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement” (NQF Measure Evaluation Criteria, 2009). “Not all acceptable measures will be strong – or equally strong – among each set of criteria. The assessment of each criterion is a matter of degree” (NQF Measure Evaluation Criteria, 2009). The Steering Committee reviewed each measure in isolation and in comparison to currently endorsed or submitted measures and voted to recommend or not recommend a measure accordingly. While the Steering Committees acknowledges that each evaluation criteria or sub criteria may not be as “strong – or equally strong” amongst all criterion, they elected to recommend seven measures for endorsement based on consensus. In a continuous effort to improve the CDP, NQF recently convened an Evidence Task Force and a Measure Testing Task Force to review, provide technical expertise and bolster NQFs evaluation criteria as needed. The results of these task forces can be found on the NQF webpage (http://www.qualityforum.org/Home.aspx). We appreciate your continued support as we make improvements to NQF processes and strengthen performance measurement.

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36	Purchaser	Susan Arday, CMS	General Comments	Feasibility of the Measures Recommended for Endorsement Table 1: Feasibility Concerns NQF #IEP-005-10 Pulmonary CT Imaging for Patients at Low Risk for Pulmonary Embolism. Not Electronically Collected; Requires Extra Data for Exclusions. NQF #IEP-007-10 Appropriate Head CT Imaging in Adults with Mild Traumatic Brain Injury. Not Electronically Collected; Requires Extra Data for Exclusions. NQF #IEP-014-10 Preoperative Evaluation in Low-Risk Surgery Patients. Not Electronically Collected; Proprietary. NQF #IEP-015-10 Routine Testing After Percutaneous Coronary Intervention. Not Electronically Collected; Proprietary.NQF #IEP-016-10 Testing in Asymptomatic, Low-Risk Patients. Not Electronically Collected; Proprietary.	See comment #34

17	Public	Kay Schwebke, Ingenix	General Comments	Some of these measures are restricted to the Medicare population (e.g., IEP-010-10 and IEP-010-130); yet they have broader application. We would suggest defining the population by age criteria; not insurance coverage. Also, suggest defining the population using an age range that includes a non-Medicare age group. These changes would result in more usable measures and would increase the number of patients impacted by these important overuse measures.	**(MD Response):**CMS is supportive of the use of its measures (when applicable) in other population groups. CMS does think that the measures submitted in this imaging efficiency measures cycle can have applicability to other populations. However, in order to submit tested measures, CMS uses the Medicare population data. Hence the measure submission can only speak to the use of the tested measures as they apply to the Medicare population.
37	Health Professional	Rita Munley Gallagher, PhD, RN, American Nurses Association	General Comments	The American Nurses Association concurs that the outpatient imaging is a critical component of today's healthcare delivery system, with important applications in establishing diagnoses, prognosis, and monitoring therapy. ANA applauds NQF's efforts to promote the appropriate use of outpatient imaging services, thus, avoiding redundancy and unnecessary exposure to radiation, reducing the use of painful and wasteful follow-up procedures, and ensuring that patients get the right healthcare service the first time. NQF's efforts in that regard are laudable. ANA believes the measures as presented clearly address overuse of imaging as well as promote safe patient care and consistency regarding the use of evidence-based-practice guidelines for ordering imaging services. Although licensed independent clinicians (physicians, APRNs) write the orders for these tests, the measures are relevant for other registered nurses as they practice collaboratively with these clinicians examining and assessing patients. Therefore imaging efficiency is an interprofessional issue of relevance to a variety of clinicians. Geographic ordering differences were noted for some of the measures. ANA recommends examination of ordering practices between and among the various types of practitioners.	**(NQF Staff Response):** NQF would like to thank the American Nurses Association for their participation in the Consensus Development Process, we appreciate your response.

17	Public	Kay Schwebke, Ingenix	General Comments	Some of these measures are restricted to the Medicare population (e.g., IEP-010-10 and IEP-010-130); yet they have broader application. We would suggest defining the population by age criteria; not insurance coverage. Also, suggest defining the population using an age range that includes a non-Medicare age group. These changes would result in more usable measures and would increase the number of patients impacted by these important overuse measures.	**(MD Response):**CMS is supportive of the use of its measures (when applicable) in other population groups. CMS does think that the measures submitted in this imaging efficiency measures cycle can have applicability to other populations. However, in order to submit tested measures, CMS uses the Medicare population data. Hence the measure submission can only speak to the use of the tested measures as they apply to the Medicare population.
38	Provider	Thomas Lee, Partners Community HealthCare, Inc. (PCHI)	IEP-013-10	We oppose measure #IEP-013-10. We applaud the NQF for initiating this important project. Measure #IEP-013-10 identifies significant variation in use of a high cost imaging procedure and would be useful for internal hospital improvement. We recommend that CMS share these data with hospitals. Unfortunately, this measure does not meet NQF's Measure Evaluation Criteria or the NQF's framework for efficiency and is therefore not appropriate for public reporting. A common case example best illustrates these weaknesses. If an 85-year-old Medicare beneficiary taking warfarin presented to the ED with a new onset severe headache, had a head CT that was read as normal and was discharged with an assigned final diagnosis code "784.0, Headache" they would be included in the measure, and counted as an inefficient head CT. The published guidelines and clinical experts at Partners agree that a head CT would be appropriate for this patient. We urge you to re-examine this measure. It would produce results that suggest that facilities that care for the sickest patients in a population, such as safety net hospitals and academic medical centers have high rates of inappropriate head CT use. Publicly reporting this measure would encourage policymakers and the public to equate use of head CT in older adults with inappropriate care and lead them to inaccurate conclusions about the quality and efficiency of care delivered at hospitals. Please see our emailed detailed comment letter.	**(MD Response)**: The classification of patients will vary by institution, one of the very elements that we seek to examine. We would anticipate most patients such as the one described by Dr Lee as being in the complicated or thunderclap category, especially if on warfarin, and therefore excluded from study. **(NQF Response):** This measure was not recommended for endorsement, please see the draft report for details.

17	Public	Kay Schwebke, Ingenix	General Comments	Some of these measures are restricted to the Medicare population (e.g., IEP-010-10 and IEP-010-130); yet they have broader application. We would suggest defining the population by age criteria; not insurance coverage. Also, suggest defining the population using an age range that includes a non-Medicare age group. These changes would result in more usable measures and would increase the number of patients impacted by these important overuse measures.	**(MD Response):**CMS is supportive of the use of its measures (when applicable) in other population groups. CMS does think that the measures submitted in this imaging efficiency measures cycle can have applicability to other populations. However, in order to submit tested measures, CMS uses the Medicare population data. Hence the measure submission can only speak to the use of the tested measures as they apply to the Medicare population.
39	Health Plan	Catherine MacLean, WellPoint	IEP-005-10	WellPoint supports this measure.	**(MD Response):** We appreciate support for this measure.
40	Health Plan	Catherine MacLean, WellPoint	IEP-007-10	WellPoint supports the intent of this measure, as ER physicians are under a great amount of pressure to request CT imaging for patients with traumatic brain injury. However, we are concerned that given the environment in the emergency department (overcrowding, long hours) and the legal concerns faced by ED physicians, they will continue to order CT scans. We believe that for this measure to change physician behavior, physicians will need to be motivated to complete and document the Glasgow scoring. If EDs put the Glasgow score in the record, we believe this could be a strong measure.	**(NQF Staff Response):** The Steering Committee appreciates the comment and support for the project. While the Committee acknowledges the concern, the Committee believes the measure as currently stated is appropriate for public reporting and quality improvement. The Committee encourages the developer to continue to explore ways to improve the measure. Any sustentative changes to the measure will be run through an NQF Ad Hoc process.
41	Health Plan	Catherine MacLean, WellPoint	IEP-010-10	WellPoint supports this measure. We would like to note that we believe anesthesiologists also drive orders for cardiac imaging for non-cardiac low-risk surgery patients. In order for performance to change on this measure, this will have to be taken into account.	**(MD Response):**We appreciate the support for the measure. The specialty of the ordering physician does not impact the calculation of the measure. As facilities develop strategies for improvement, we agree that they will also need to consider that anesthesiologists may be among the ordering physicians.

17	Public	Kay Schwebke, Ingenix	General Comments	Some of these measures are restricted to the Medicare population (e.g., IEP-010-10 and IEP-010-130); yet they have broader application. We would suggest defining the population by age criteria; not insurance coverage. Also, suggest defining the population using an age range that includes a non-Medicare age group. These changes would result in more usable measures and would increase the number of patients impacted by these important overuse measures.	**(MD Response):**CMS is supportive of the use of its measures (when applicable) in other population groups. CMS does think that the measures submitted in this imaging efficiency measures cycle can have applicability to other populations. However, in order to submit tested measures, CMS uses the Medicare population data. Hence the measure submission can only speak to the use of the tested measures as they apply to the Medicare population.
42	Health Plan	Catherine MacLean, WellPoint	IEP-013-10	WellPoint supports this measure. As we mentioned with measure IEP-007-10, the emergency department is a tough environment for change (physicians are coping with crises with a limited amount of time, and there are legal concerns if patients are released with an incorrect diagnosis). ED physicians will need to be supported in order for performance to change.	**(MD Response):**We appreciate the support for the measure. The specialty of the ordering physician does not impact the calculation of the measure. As facilities develop strategies for improvement, we agree that they will also need to consider that anesthesiologists may be among the ordering physicians.**(NQF Response):** This measure was not recommended for endorsement, please see the draft report for details.
43	Health Plan	Catherine MacLean, WellPoint	No measure topic selected.	WellPoint supports this measure.	**(NQF Staff Response):** NQF would like to thank Wellpoint for their participation in the Consensus Development Process, we appreciate your response.
44	Health Plan	Catherine MacLean, WellPoint	IEP-015-10	WellPoint supports this measure.	**(NQF Staff Response):** NQF would like to thank Wellpoint for their participation in the Consensus Development Process, we appreciate your response.

17	Public	Kay Schwebke, Ingenix	General Comments	Some of these measures are restricted to the Medicare population (e.g., IEP-010-10 and IEP-010-130); yet they have broader application. We would suggest defining the population by age criteria; not insurance coverage. Also, suggest defining the population using an age range that includes a non-Medicare age group. These changes would result in more usable measures and would increase the number of patients impacted by these important overuse measures.	**(MD Response):**CMS is supportive of the use of its measures (when applicable) in other population groups. CMS does think that the measures submitted in this imaging efficiency measures cycle can have applicability to other populations. However, in order to submit tested measures, CMS uses the Medicare population data. Hence the measure submission can only speak to the use of the tested measures as they apply to the Medicare population.
45	Health Plan	Catherine MacLean, WellPoint	IEP-016-10	WellPoint agrees... inappropriate use of cardiac stress imaging for asymptomatic, low risk patients... However, we also believe that there is great variability in the way that physicians assess risk. Physicians often estimate a patient's risk is higher than the patient's actual calculated risk. Also, there may not be enough data to evaluate risk in all patients.	**(MD Response):** Risk has been documented to be under and overestimated in various CHD patient populations in the literature. As a result, while the measure specifications only require that an estimate be collected, the specifications also require that a maximum number of the variables should be used to construct the physician estimate, the physician must attest to the accuracy, and be subject to audit of the estimate. These three requirements for the estimate should address some of the potential for incorrect risk estimates. Below is the language from our Section 2a.3. Numerator Details, describing how this issue is recognized and addressed by the measure. The goal is recognize that in practice, not all data variables may be available to the lab (e.g. LDL) so that an actual definitive calculation may not be possible. At the same time, physicians should make their estimate as objective as possible. The reason for the estimate is not to allow a qualitative physician guess (documented in the literature to be incorrect), but rather provide an objective qualitative way to estimate risk. This approach has been used in other studies in the literature when incomplete data is available. "Submission of individual clinical data variables required for Framingham risk (ATP III criteria) calculation for asymptomatic patients is recognized to place a significant data collection burden upon institutions and may not be possible based on data elements that are readily available at the imaging laboratory. As such, a clinician estimate of CHD risk will be collected for all asymptomatic patients who are being seen for initial detection and risk assessment without known coronary heart disease. However, in making their estimate, clinicians should consider the maximum number of available patient factors used to estimate risk based on Framingham (ATP III criteria), typically age, gender, diabetes, smoking status, and use of blood pressure medication, and integrate age appropriate estimates for missing elements, such as LDL or standard blood pressure. While calculation of the estimate does not require submission of the actual clinical data elements other than the clinician estimate of CHD risk, clinicians are attesting to the accuracy of the estimate by submitting it. An audit of clinician estimates should be completed on a subset of clinicians to verify their estimates as being accurate based on the data that was available."

17	Public	Kay Schwebke, Ingenix	General Comments	Some of these measures are restricted to the Medicare population (e.g., IEP-010-10 and IEP-010-130); yet they have broader application. We would suggest defining the population by age criteria; not insurance coverage. Also, suggest defining the population using an age range that includes a non-Medicare age group. These changes would result in more usable measures and would increase the number of patients impacted by these important overuse measures.	**(MD Response):**CMS is supportive of the use of its measures (when applicable) in other population groups. CMS does think that the measures submitted in this imaging efficiency measures cycle can have applicability to other populations. However, in order to submit tested measures, CMS uses the Medicare population data. Hence the measure submission can only speak to the use of the tested measures as they apply to the Medicare population.
46	Health Prf	Nancy H. Nielsen, MD, PhD, American Medical Association	General Comments	The American Medical Association (AMA) is pleased to have the opportunity to comment on the National Quality Forum's (NQF) National Voluntary Consensus Standards for Imaging Efficiency: A Consensus Report. The AMA supports the NQF's efforts to advance the development of measures of healthcare efficiency. We strongly believe that evidenced-based, and appropriately specified and tested efficiency measures can help physicians and other healthcare professionals achieve the goal of increasing healthcare quality and safety while reducing costs. More specifically, reducing the inappropriate use of imaging services is well aligned with the "Overuse" priority set forth by the National Priorities Partnership (NPP). The AMA looks forward to continuing to work with others, such as NQF, to seek means for realizing a more safe, effective and efficient healthcare system. We appreciate the opportunity to comment on this report.	**(NQF Staff Response):** NQF would like to thank AMA for their participation in the Consensus Development Process, we appreciate your response.

17	Public	Kay Schwebke, Ingenix	General Comments	Some of these measures are restricted to the Medicare population (e.g., IEP-010-10 and IEP-010-130); yet they have broader application. We would suggest defining the population by age criteria; not insurance coverage. Also, suggest defining the population using an age range that includes a non-Medicare age group. These changes would result in more usable measures and would increase the number of patients impacted by these important overuse measures.	**(MD Response):**CMS is supportive of the use of its measures (when applicable) in other population groups. CMS does think that the measures submitted in this imaging efficiency measures cycle can have applicability to other populations. However, in order to submit tested measures, CMS uses the Medicare population data. Hence the measure submission can only speak to the use of the tested measures as they apply to the Medicare population.
47	Health Plan	Nancy H. Nielsen, MD, PhD, American Medical Association	General Comments	There are instances, in this report and others, when a measure is described in the draft document as being a clinician-level measure. However, when looking at the submission forms for such measures there is not consistency as to what "levels" are checked by measure developers. The AMA recommends that NQF provide information on how it decides whether a measure is appropriate for the clinician level or not. In a related matter, for this report and others, in the provided measure worksheets for which a measure developer has checked "Clinicians: Other", there is no indication of what they intend to mean by "Other". The AMA recommends that a measure developer be required to describe what is meant by "Clinician: Other" if it is checked, and that this information is made available to the public and NQF members when measures are up for review. This added specificity will help measure reviewers, and ultimately measure adopters, determine if a measure is truly appropriate for measurement at the indicated level.The AMA strongly believes that performance measures are only appropriate at the individual clinician level when it has been consistently shown that the process or outcome is directly dependent on the individual clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care an individual clinician provides.	**(NQF Staff Response):** The Committee reviewed the level of analysis for each measure and acknowledged NQF's efforts in collaborating with the measure developers to verify the level of analysis for each measure and update the draft report. The Committee recommends NQF explore options to improve the measure submission and review process as appropriate. After discussion of the comments, the Committee decided that the level of analysis for those measures recommended for endorsement were applicable and valid. **(For a detailed levels of analysis for each measures refer to the supplemental information, Appendix A from the Imaging Efficiency Draft Report).**

17	Public	Kay Schwebke, Ingenix	General Comments	Some of these measures are restricted to the Medicare population (e.g., IEP-010-10 and IEP-010-130); yet they have broader application. We would suggest defining the population by age criteria; not insurance coverage. Also, suggest defining the population using an age range that includes a non-Medicare age group. These changes would result in more usable measures and would increase the number of patients impacted by these important overuse measures.	**(MD Response):**CMS is supportive of the use of its measures (when applicable) in other population groups. CMS does think that the measures submitted in this imaging efficiency measures cycle can have applicability to other populations. However, in order to submit tested measures, CMS uses the Medicare population data. Hence the measure submission can only speak to the use of the tested measures as they apply to the Medicare population.
48	Health Professional	Nancy H. Nielsen, MD, PhD, American Medical Association	General Comments	For several of the measures recommended for endorsement, we believe the evidence provided for measure reliability and validity may be insufficient. For three of the measures, the reliability documented for the related appropriateness criteria (for which only a moderate degree of abstractor agreement was found) is not an acceptable surrogate for direct reliability testing of the measures themselves. Similarly, for other measures, the consistency documented for performance rates over time, using aggregated claims data, is not indicative of the reliability of the measures. As for validity, these measures are indicated to have face validity because they are based on analysis of administrative claims, but the data source used for a measure does not provide evidence of its validity.	**(NQF Staff Response):** The Steering Committee reviewed all measures submitted to the project against the four NQF Evaluation Criteria, 1. Importance, 2. Scientific Acceptability, 3. Usability and 4. Feasibility. Those measures recommended for endorsement were voted to have met or exceeded all four of the NQF Evaluation Criteria. While the Steering Committee acknowledges there are variation in the level of evidence and support for each measure, the Committee believes the measures recommended for endorsement are suitable for public reporting and quality improvement. The Committee encourages the developer to continue to explore ways to improve the measure. Any sustentative changes to the measure will be run through an NQF Ad Hoc process.

17	Public	Kay Schwebke, Ingenix	General Comments	Some of these measures are restricted to the Medicare population (e.g., IEP-010-10 and IEP-010-130); yet they have broader application. We would suggest defining the population by age criteria; not insurance coverage. Also, suggest defining the population using an age range that includes a non-Medicare age group. These changes would result in more usable measures and would increase the number of patients impacted by these important overuse measures.	**(MD Response):**CMS is supportive of the use of its measures (when applicable) in other population groups. CMS does think that the measures submitted in this imaging efficiency measures cycle can have applicability to other populations. However, in order to submit tested measures, CMS uses the Medicare population data. Hence the measure submission can only speak to the use of the tested measures as they apply to the Medicare population.
49	Quality Measurement, Research and Improvement Council	Bernard M. Rosof, MD, MACP, Physician Consortium for Performance Improvement®	General Comments	The Physician Consortium for Performance Improvement(R) (PCPI) is pleased to have the opportunity to comment on the National Quality Forum's (NQF) National Voluntary Consensus Standards for Imaging Efficiency: A Consensus Report. The PCPI supports the NQF's efforts to advance the development of measures of healthcare efficiency. We strongly believe that evidenced-based, and appropriately specified and tested efficiency measures can help physicians and other healthcare professionals achieve the goal of increasing healthcare quality and safety while reducing costs. More specifically, reducing the inappropriate use of imaging services is well aligned with the "Overuse" priority set forth by the National Priorities Partnership (NPP). As a member of the NPP, the PCPI looks forward to continuing to work with others, such as NQF, to seek means for realizing a more safe, effective and efficient healthcare system. We appreciate the opportunity to comment on this report.	**(NQF Staff Response):** NQF would like to thank PCPI for their participation in the Consensus Development Process, we appreciate your response.

17	Public	Kay Schwebke, Ingenix	General Comments	Some of these measures are restricted to the Medicare population (e.g., IEP-010-10 and IEP-010-130); yet they have broader application. We would suggest defining the population by age criteria; not insurance coverage. Also, suggest defining the population using an age range that includes a non-Medicare age group. These changes would result in more usable measures and would increase the number of patients impacted by these important overuse measures.	**(MD Response):**CMS is supportive of the use of its measures (when applicable) in other population groups. CMS does think that the measures submitted in this imaging efficiency measures cycle can have applicability to other populations. However, in order to submit tested measures, CMS uses the Medicare population data. Hence the measure submission can only speak to the use of the tested measures as they apply to the Medicare population.
50	Quality Measurement, Research and Improvement Council	Bernard M. Rosof, MD, MACP, Physician Consortium for Performance Improvement®	General Comments	There are instances, in this report and others, when a measure is described in the draft document as being a clinician-level measure. However, when looking at the submission forms for such measures there is not consistency as to what "levels" are checked by measure developers. The PCPI recommends that NQF provide information on how it decides whether a measure is appropriate for the clinician level or not. In a related matter, for this report and others, in the provided measure worksheets for which a measure developer has checked "Clinicians: Other", there is no indication of what they intend to mean by "Other". The PCPI recommends that a measure developer be required to describe what is meant by "Clinician: Other" if it is checked, and that this information is made available to the public and NQF members when measures are up for review. This added specificity will help measure reviewers, and ultimately measure adopters, determine if a measure is truly appropriate for measurement at the indicated level.The PCPI strongly believes that performance measures are only appropriate at the individual clinician level when it has been consistently shown that the process or outcome is directly dependent on the individual clinician, and not when such results are dependent on other healthcare professionals or other factors exogenous to the care an individual clinician provides.	**(NQF Staff Response):** The Committee reviewed the level of analysis for each measure and acknowledged NQF’s efforts in collaborating with the measure developers to verify the level of analysis for each measure and update the draft report. The Committee recommends NQF explore options to improve the measure submission and review process as appropriate. After discussion of the comments, the Committee decided that the level of analysis for those measures recommended for endorsement were applicable and valid.

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51	Quality Measurement, Research and Improvement Council	Bernard M. Rosof, MD, MACP, Physician Consortium for Performance Improvement®	General Comments	For several of the measures recommended for endorsement, we believe the evidence provided for measure reliability and validity may be insufficient. Similarly, for other measures, the consistency documented for performance rates over time, using aggregated claims data, is not indicative of the reliability of the measures. As for validity, these measures are indicated to have face validity because they are based on analysis of administrative claims, but the data source used for a measure does not provide evidence of its validity.	Refer to response on comment #48
52	Health Professional	Ella Kazerooni, MD, American College of Radiology	IEP-005-10	This is important to pursue. Among thoracic radiologists, this is the high tech test that is considered to be the most inappropriately overutilized with difficulty controlling utilization in the Emergency Department setting, in particular due to medicolegal concerns. Many ED physicians will cite examples of low risk patients with a negative d-dimer who turn out to have a PE on CTPA, as anecdotal evidence of why recommendations for appropriate use of imaging do not apply to the ED setting.	**(MD Response):** 1. The impact of medicolegal concerns on variation in ordering of CTPA in the ED is important to consider; however the exact importance of this consideration is unclear. 2. The focus of this measure is to improve the appropriate application of CTPA in patients with low pre-test probability, which represents a patient population in whom structured pre-test assessment combined with DDimer testing should be considered the standard of care in most geographic areas."The focus of this measure is to improve the appropriate application of CTPA in patients with low pre-test probability, which represents a patient population in whom structured pre-test assessment combined with DDimer testing should be considered the standard of care in most geographic areas.

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53	Health Professional	Ella Kazerooni, MD, American College of Radiology	IEP-010-10	Agree with the comments that this measure should include not only imaging performed in hospital outpatient facilities, but at any facility, including free standing imaging centers and physicians offices. To not include the latter will most likely result in substantial under reporting of the severity of this overutilization occurring in this area. Suggest adding coronary CT angiography to this measure. Calcium scoring CT alone is little used or reimbursed for in this setting and likely to be of little additional benefit to adding. For MR, suggest including non stress perfusion/delayed enhancement imaging as well, not just stress MR, as these may be more commonly performed forms of cardiac MR used in this setting.	**(MD Response):** This is an important comment and a frequently heard point of view. CMS is definitely supportive of the expansion of the use of the measure to other settings. Currently the Medicare statute only provides for the reporting on outpatient hospitals departments. Data from the current work will be foundational element in crafting such more expanded studies in future. Certainly Coronary CT Angiography is a widely available technology and inclusion of its use represents a welcome addition to this measure. Currently Cardiac MRI availability is somewhat limited but consideration of its use in this setting may well serve as a baseline for future comparison.
54	Health Professional	Ella Kazerooni, MD, American College of Radiology	IEP-014-10	Stress MRI and coronary CT angiography would be appropriate to add to this measure, and as with IEP-010-10, this should not be limited to hospital outpatient facilities. Calcium scoring CT alone is little used or reimbursed for in this setting and likely to be of little additional benefit to adding. For MR, suggest including non stress perfusion/delayed enhancement imaging as well, not just stress MR, as these may be more commonly performed forms of cardiac MR used in this setting. (Comments are very similar to IEP-010-10, Cardiac Imaging for Non-Cardiac Low Risk Surgery.)	**(MD Response):** Stress MRI and CTA have been added to this measure previously based on NQF steering committee feedback. ACC is willing to consider adding non stress perfusion MR, but as previously stated the addition of MR is unlikely to substantially change this measure as it is low volume.

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55	Health Professional	Ella Kazerooni, MD, American College of Radiology	IEP-015-10	Agree that this is an important measure and area of overutilization to address. Stress MRI and coronary CT angiography would be appropriate to add to this measure. It may be beneficial to put time frames on this, such as % patients falling into the definition undergoing one of these tests within 30days, 6 months and 1 year. Again, calcium scoring CT alone is little used or reimbursed for in this setting and likely to be of little additional benefit. For MR, suggest including non stress perfusion/delayed enhancement imaging as well, not just stress MR, as these may be more commonly performed forms of cardiac MR used in this setting.	**(MD Response):** Stress MRI and CTA have been added to this measure previously based on NQF steering committee feedback. ACC is willing to consider adding non stress perfusion MR, but as previously stated the addition of MR is unlikely to substantially change this measure as it is low volume. The goal of this measure is to identify testing not meeting appropriate use criteria rather than an analysis of when imaging is done within 2 years. As such, while the additional timeframes might be interesting for research are not necessary for the measure.
56	Health Professional	Ella Kazerooni, MD, American College of Radiology	IEP-016-10	Agree that this is an important measure and area of overutilization to address. Stress MRI and coronary CT angiography would be appropriate to add to this measure. It may be beneficial to put time frames on this, such as % patients falling into the definition undergoing one of these tests within 30days, 6 months and 1 year. Again, calcium scoring CT alone is little used or reimbursed for in this setting and likely to be of little additional benefit. For MR, suggest including non stress perfusion/delayed enhancement imaging as well, not just stress MR, as these may be more commonly performed forms of cardiac MR used in this setting.	**(MD Response):**Stress MRI and CTA have been added to this measure previously based on NQF steering committee feedback. ACC is willing to consider adding non stress perfusion MR, but as previously stated the addition of MR is unlikely to substantially change this measure as it is low volume. The goal of this measure is to identify testing not meeting appropriate use criteria rather than an analysis of when imaging is done within 2 years. As such, while the additional timeframes might be interesting for research are not necessary for the measure.

17	Public	Kay Schwebke, Ingenix	General Comments	Some of these measures are restricted to the Medicare population (e.g., IEP-010-10 and IEP-010-130); yet they have broader application. We would suggest defining the population by age criteria; not insurance coverage. Also, suggest defining the population using an age range that includes a non-Medicare age group. These changes would result in more usable measures and would increase the number of patients impacted by these important overuse measures.	**(MD Response):**CMS is supportive of the use of its measures (when applicable) in other population groups. CMS does think that the measures submitted in this imaging efficiency measures cycle can have applicability to other populations. However, in order to submit tested measures, CMS uses the Medicare population data. Hence the measure submission can only speak to the use of the tested measures as they apply to the Medicare population.
57	Health Professional	Ella Kazerooni, MD, American College of Radiology	OIE-011-010	While the sample size and power at any one center in a short time frame may be small, given a large enough time window to aggregate larger numbers, similar to PCI, this is important to measure and a source of over utilization in asymptomatic post CABG patients. Similar to several recommended measures, would include stress MR, and coronary CT angiography. For MR, suggest including non stress perfusion/delayed enhancement imaging as well, not just stress MR, as these may be more commonly performed forms of cardiac MR used in this setting. Measure OIE-017-10 Adequacy of data to assess appropriate use of cardiac stress imaging. This seems more like an administrative record keeping measure than a patient care quality measure. (Measure OIE-011-010, Use of Stress Echocardiography, SPECT MPI and Cardiac Stress Post CABG.)	**(NQF Staff Response):** The Steering Committee reviewed measure number IEP-011-10 against the four NQF Evaluation Criteria. At the collusion of the measure review, the Steering Committee stipulated the following conditional recommendations: 1. consider removing the six month exclusion criteria from the numerator statement or provide justification for the use of a six month exclusion criteria, 2. Expand the measure to include PCI, but report CABG and PCI separately, 3. expand measure to include both hospital outpatient and free standing imaging facilities, and 4. expand the sample size or provide justification on how the feasibility and validity of the measure is addressed for smaller or rural hospitals with small patient populations. Due to time constraints the developer was unable to meet all of the Committee’s recommendations. As currently stipulated, the Committee did not believe the measure was suitable for public reporting and quality improvement. The Committee encourages the resubmission of the measure to future NQF project once the measure has been revised and further testing completed
58	Health Professional	Joseph Allen, American College of Cardiology	IEP-010-10	Measure IEP-010-10 is claims based and cannot account for other reasons that the test may have been ordered. This may result in incorrect inclusion of otherwise appropriate patients, such as those that have chest pain suggestive of CAD prior to surgery	**(Committee Response):** The Committee welcomes the comment and agrees with the measure developer in that they expect there to be misclassifications. However, the focus of the measure is on outliers and while the numbers may be small the outliers are meaningful to measure. **(MD Response):** We do not expect the measure ratio to be zero. The purpose of the measure is to identify facilities that are outliers. The guidelines generally indicate that cardiac imaging is not needed prior to low-risk surgery in regular- and low-risk patients; however, it is not possible to determine high-risk patients from claims data. Consequently, we have chosen not to make the calculation of the measure overly complex through the use of exclusions.

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59	Health Professional	Joseph Allen, American College of Cardiology	IEP-010-10	Measure IEP-010-10 is hospital based and may assign accountability incorrectly as the imaging test may be ordered and/or performed by an institution or physician outside the hospital in which the surgery is performed.	**(MD Response):** For the low-risk surgery Measure IEP-010-10 both the low-risk surgery (denominator) and the cardiac imaging procedure (numerator) are provided by the hospital outpatient department for which the measure is being calculated. Therefore, the hospital is the provider for both the surgery and the imaging services. With regard to physician ordering of services and hospitals responsibilities, hospitals submit bills to Medicare for the services hospitals deliver, and as such, hospitals have a responsibility to ensure that the services delivered by the hospital and paid by Medicare are appropriate and necessary regardless of who ordered the test.
60	Health Professional	Joseph Allen, American College of Cardiology	IEP-010-10	Measure IEP-010-10 has a denominator of all low risk surgeries that will likely overwhelm the numerator event rate such that identifying variations between institutions will likely be challenging	**(MD Response):** The commenter raises an issue that does need to be examined. As was noted during a steering committee conference call when discussing the low-risk surgery measures submitted by CMS and ACC, CMS had originally considered a measure specification similar to the one developed by ACC. However, our Technical Expert Panel (TEP) suggested using the low risk surgeries as the denominator rather than using the cardiac imaging at the hospital as the denominator because they felt it was a more valuable measure. The use of low risk surgeries in the denominator does, as the commenter notes, effects the ratio calculation.
61	Health Professional	Robert Pyatt, MD, American College of Radiology	IEP-007-10	The American College of Radiology and its Neuroradiology Commission support this measure.	**(MD Response):** We thank the ACR for their support. **(NQF Staff Response):** NQF would like to thank ACR for their participation in the Consensus Development Process, we appreciate your response.
62	Health Professional	Robert Pyatt, MD, American College of Radiology	IEP-013-10	The American College of Radiology and its Neuroradiology Commission support this measure.	**(MD Response):** We appreciate the support for this measure by the American College of Radiology and its Neuroradiology Commission. We believe their support is an important indication that this is a measure that can help to improve care. **(NQF Staff Response):** This measure was not recommended for endorsement, please see the draft report for details.

17	Public	Kay Schwebke, Ingenix	General Comments	Some of these measures are restricted to the Medicare population (e.g., IEP-010-10 and IEP-010-130); yet they have broader application. We would suggest defining the population by age criteria; not insurance coverage. Also, suggest defining the population using an age range that includes a non-Medicare age group. These changes would result in more usable measures and would increase the number of patients impacted by these important overuse measures.	**(MD Response):**CMS is supportive of the use of its measures (when applicable) in other population groups. CMS does think that the measures submitted in this imaging efficiency measures cycle can have applicability to other populations. However, in order to submit tested measures, CMS uses the Medicare population data. Hence the measure submission can only speak to the use of the tested measures as they apply to the Medicare population.
63	Provider	Cleveland Clinic, Cleveland Clinic	IEP-005-10	This represents a very conservative measure that should drive the use of high-sensitivity d-dimers in low probability patients which is a practice that is well supported by the data/literature. The reliability testing especially for actual efficiency of this measure has yet to be completed or published. The study the metric developers cite supporting the performance gap actually indicated that only 10% of CTPA were done on D-dimer negative patients' indicating overuse? The number seems small especially since many CTPA are done for other reasons other than PE rule outs, despite them being apparently ordered as such. The gap did not seem that large necessitating /indicating a measure. The practical implementation is concerning. CT angiograms are overused in some arenas and trying to limit overuse is worthwhile, but in many hospitals we think it will take time-consuming chart reviews to assess appropriateness of the test.	(**MD Response**):The commenter has several comments: 1. The performance gap cited in the measures is based on retrospective studies of CTPA use and may underestimate the actual overuse of CTPA in the ED. Given that retrospective studies do not include pre-test probability assessment and may not account for DDimer appropriateness, the actual overutilization of CTPA in low probability patient may be much higher. 2. We recognize that implementation and study of the effectiveness of this measure is significantly facilitated by CPOE systems that include decision support capability. For the short term, we have provided a paper-chart based tool for institutions that do not utilize CPOE. Over the medium to long term, as HIT is expanded, CPOE for radiology is included in meaningful use and will be widely available.
64	Health Professional	Joseph Drozda, American College of Cardiology	IEP-010-10	This measure is based on claims submitted for surgical and other services and cannot account for the reasons the imaging tests in question were ordered. Distinguishing between appropriate and inappropriate ordering on the basis of this measure is, therefore, impossible.	**(MD Response):** We do not expect the measure ratio to be zero. The purpose of the measure is to identify facilities that are outliers. The guidelines generally indicate that cardiac imaging is not needed prior to low-risk surgery in regular- and low-risk patients; however, it is not possible to determine high-risk patients from claims data. Consequently, we have chosen not to make the calculation of the measure overly complex through the use of exclusions.

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65	Health Professional	Joseph Drozda, American College of Cardiology	IEP-010-10	This measure is focused on hospital outpatient facilities making assignment of accountability for performance on the measure very difficult since the imaging test may have been ordered by a physician outside of the hospital's sphere of influence. In addition, the test may have been performed at a facility other than the one where the surgical procedure was performed--again leading to inappropriate attribution.	**(MD Response):** For the low-risk surgery Measure IEP-010-10 both the low-risk surgery (denominator) and the cardiac imaging procedure (numerator) are provided by the hospital outpatient department for which the measure is being calculated. Therefore, the hospital is the provider for both the surgery and the imaging services. With regard to physician ordering of services and hospitals responsibilities, hospitals submit bills to Medicare for the services hospitals deliver, and as such, hospitals have a responsibility to ensure that the services delivered by the hospital and paid by Medicare are appropriate and necessary regardless of who ordered the test.
66	Health Professional	Joseph Drozda, American College of Cardiology	IEP-010-10	The measures denominator includes all low risk procedures performed at the hospital in question. The large number of such procedures will likely overwhelm the numerator (the number of imaging studies performed) making it very difficult to discern significant variances in performance among hospitals.	**(Committee Response):** The Steering Committee acknowledge that the commenter is correct, however, the focus of the measure is on outliers and while the numbers may be small the outliers are meaningful to measure. **(MD Response):** The commenter raises an issue that does need to be examined. As was noted during a steering committee conference call when discussing the low-risk surgery measures submitted by CMS and ACC, CMS had originally considered a measure specification similar to the one developed by ACC. However, our Technical Expert Panel (TEP) suggested using the low risk surgeries as the denominator rather than using the cardiac imaging at the hospital as the denominator because they felt it was a more valuable measure. The use of low risk surgeries in the denominator does, as the commenter notes, effects the ratio calculation.

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67	Provider	Cleveland Clinic, Cleveland Clinic	IEP-007-10	The measure is important for improving efficiency and possibly decreasing the use of head CT in the ED. The indications for head CT as outlined in this measure have a 100% sensitivity for detecting intracranial injury, and there is some evidence of over use, so there is evidence to support the measure. The outcome of improved adherence to evidence based CT guidelines is important. It is important to realize that the use the Canadian guidelines would have the highest impact on reducing utilization rates(37%) while the NO criteria the impact would be less(5%). However the Canadian guidelines are less sensitive identifying significant CT findings, although not operable, findings none the less important to patients. The ACEP guideline incorporates both guidelines. The impact on utilization rates still need further study. This is actually an appropriateness measure that requires the documentation of the indication for CT scan for minor head injury. The outcome is the % of patients with a head CT for minor trauma with the appropriate documentation of the indication for the CT scan based on well developed guidelines. The practical implementation is concerning. The data source cited will be collected from the medical record necessitating manual chart review. If a hospital had a robust radiology computer order entry and reporting mechanism available it might be easy to implement but those hospitals are rare. Reliability testing has yet to be done on this measure.	**(MD Response):** We thank the Cleveland Clinic for its support

17	Public	Kay Schwebke, Ingenix	General Comments	Some of these measures are restricted to the Medicare population (e.g., IEP-010-10 and IEP-010-130); yet they have broader application. We would suggest defining the population by age criteria; not insurance coverage. Also, suggest defining the population using an age range that includes a non-Medicare age group. These changes would result in more usable measures and would increase the number of patients impacted by these important overuse measures.	**(MD Response):**CMS is supportive of the use of its measures (when applicable) in other population groups. CMS does think that the measures submitted in this imaging efficiency measures cycle can have applicability to other populations. However, in order to submit tested measures, CMS uses the Medicare population data. Hence the measure submission can only speak to the use of the tested measures as they apply to the Medicare population.
68	Provider	Cleveland Clinic, Cleveland Clinic	IEP-014-10	We agree that stress tests prior to low risk surgery is inappropriate. We worry about the unintended consequence of the patient with a legitimate need for stress testing and not having it ordered. This metric will likely need manual chart review on the patients who have the test to determine the clinical risk and the appropriateness of care.	**(MD Response):** AUC measures are never intended to reach 0% inappropriate due to exceptions to the measure that can't be captured in exclusions. The specifications for the measure include exclusion of patients that are documented to be appropriate for other reasons. It is anticipated that these measure will be collected through current imaging ordering systems and/or prospective manual collection. However, this information is required for other purposes such as lab accreditation and utilization review so should already be underway in many settings.

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69	Health Professional	Rebecca Swain-Eng, American Academy of Neurology	IEP-013-10	Comments from two AAN members: Two NQF measures about the overuse of neuroimaging for headaches in the emergency room. They listed the exclusion criteria - persons with a tumor, etc. My concern is that neuroimaging should be ordered for patients with possible subarachnoid hemorrhage, though many patients will be found to have a normal scan, and therefore would not be able to justify ordering the scan after the fact (there is no code for suspected SAH, only actual SAH). If one only ordered a neuroimaging scan when it was very, very likely that someone has SAH, one is probably missing some actual cases. I think the analogy is a laparotomy for appendicitis. If every laparotomy for suspected appendicitis turned out to be a true positive, one is probably not operating on enough cases. (stated statistically, if the specificity is extremely high, then the sensitivity is probably too low - for a critical condition such as SAH and appendicitis, one should expect quite a few true negatives).For IEP-013-10,the exclusion for counting toward the denominator of the lumbar puncture procedure code may address this issue. If the scan is negative it should be followed by a LP if the clinical suspicion is SAH (in addition to an exclusion for thunderclap headache coding). If the emergency physician is diligent in coding accurately and using a thoughtful approach the "small net" should not apply.	**(MD Response):** Subarachnoid hemorrhage is an exclusion from study whether it is proven or the presumptive clinical diagnosis. In the entire review process no one argued against this exclusion. **(NQF Staff Response):** This measure was not recommended for endorsement, please see the draft report for details.

17	Public	Kay Schwebke, Ingenix	General Comments	Some of these measures are restricted to the Medicare population (e.g., IEP-010-10 and IEP-010-130); yet they have broader application. We would suggest defining the population by age criteria; not insurance coverage. Also, suggest defining the population using an age range that includes a non-Medicare age group. These changes would result in more usable measures and would increase the number of patients impacted by these important overuse measures.	**(MD Response):**CMS is supportive of the use of its measures (when applicable) in other population groups. CMS does think that the measures submitted in this imaging efficiency measures cycle can have applicability to other populations. However, in order to submit tested measures, CMS uses the Medicare population data. Hence the measure submission can only speak to the use of the tested measures as they apply to the Medicare population.
70	Public	Angela Franklin, American College of Emergency Physicians	General Comments	The American College of Emergency Physicians (ACEP) supports "appropriateness measures" based on high quality published scientific evidence as a means to ensure proper use of resources. In order to determine appropriateness in emergency medicine, it is critical that a patient's presenting symptoms (chief complaints) are accounted for, not just the final diagnosis, such as an ICD-9 discharge diagnosis. ACEP believes that measures of emergency medicine resource use based on ICD-9 diagnoses require risk adjustment in order to be "efficiency" measures, otherwise they are simply "utilization measures." ACEP also believes it will be difficult to implement the use of appropriateness measures that focus on emergency departments (EDs) until EDs uniformly have CPOE and electronic medical records with fields of data in a relational data base.	**(Committee Response):** The Committee acknowledges the challenges in conducting quality measurement within the emergency department setting, especially for those facilities that do not have electronic medical records. While challenges to quality measurement exist, the Steering Committee strongly believes that to delay the endorsement of a measure solely because a there is not a uniform adoption of electronic systems would be a disservice to the public and quality improvement. Furthermore, the Committee agrees with the commenter in that measures should account for a patient's presenting symptoms as well as the end diagnosis. The Committee welcomes efficiency measures which account for patient's presenting symptoms and encourages there submission to future projects.
71	Public	Angela Franklin, American College of Emergency	IEP-005-10	ACEP supports this measure as an appropriateness measure. ACEP suggests that the term "low-probability clinical assessment" be further defined to better clarify the denominator population.	**(MD Response):**The measure has been written a**llowing clinicians to use clinical gestalt to define low-probability** given that multiple studies have demonstrated the validity of using structured tools such as the Wells Score or Geneva Score as well as clinical gestalt to assign pre-test probability.
72	Public	Angela Franklin, American College of Emergency Physicians	IEP-007-10	ACEP supports this measure as an appropriateness measure.	**(MD Response):** We thank ACEP for its support. **(NQF Staff Response):** NQF would like to thank ACEP for their participation in the Consensus Development Process, we appreciate your response.

17	Public	Kay Schwebke, Ingenix	General Comments	Some of these measures are restricted to the Medicare population (e.g., IEP-010-10 and IEP-010-130); yet they have broader application. We would suggest defining the population by age criteria; not insurance coverage. Also, suggest defining the population using an age range that includes a non-Medicare age group. These changes would result in more usable measures and would increase the number of patients impacted by these important overuse measures.	**(MD Response):**CMS is supportive of the use of its measures (when applicable) in other population groups. CMS does think that the measures submitted in this imaging efficiency measures cycle can have applicability to other populations. However, in order to submit tested measures, CMS uses the Medicare population data. Hence the measure submission can only speak to the use of the tested measures as they apply to the Medicare population.
73	Public	Angela Franklin, American College of Emergency Physicians	IEP-013-10	ACEP does not support this measure as it is a flawed utilization measure; not an efficiency measure. The measure does not follow published guidelines for care, and will not produce reliable and valid results about the quality of care when implemented.1.Without high-quality evidence to guide appropriateness decisions, a measure comparing use of CTs between institutions is a utilization measure rather than an efficiency measure. A utilization measure for head CT use in the emergency department will be influenced by case mix and patient severity as by clinician behavior, and therefore does not accurately represent appropriateness or efficiency. In practice, the measure could divert attention away from other quality improvement goals without garnering a true improvement in quality. There are many variables here, for example, an institution, may be are doing more MRI's, so an ED may have lower CT use but higher MRI use. 2.The measure also deviates from the published scientific evidence and consensus guidelines for care of patients with acute headache by measuring the use of head CT in the Medicare population, primarily those 65 years of age and older, using ICD-9 discharge diagnoses. Published studies on headache have identified increasing age as a risk factor for significant intracranial pathology and headache guidelines have either excluded older adults or recommended a lower threshold for the use of CT scans.	**(MD Response):** No case mix and patient severity were deemed necessary since study group is Medicare population. MRI has very little use in the emergency department and would not have material effect on results. The measure follows accepted guidelines for headache as described in supporting references and input from TEP.

17	Public	Kay Schwebke, Ingenix	General Comments	Some of these measures are restricted to the Medicare population (e.g., IEP-010-10 and IEP-010-130); yet they have broader application. We would suggest defining the population by age criteria; not insurance coverage. Also, suggest defining the population using an age range that includes a non-Medicare age group. These changes would result in more usable measures and would increase the number of patients impacted by these important overuse measures.	**(MD Response):**CMS is supportive of the use of its measures (when applicable) in other population groups. CMS does think that the measures submitted in this imaging efficiency measures cycle can have applicability to other populations. However, in order to submit tested measures, CMS uses the Medicare population data. Hence the measure submission can only speak to the use of the tested measures as they apply to the Medicare population.
74	Public	Angela Franklin, American College of Emergency Physicians	IEP-013-10	(continued - from 73) 3.Finally, the measure is based on an ED discharge diagnosis of headache, which will not produce consistent (reliable) and credible (valid) results about the quality of care when implemented. The measure is based on the premise that if a patient was assigned an ICD-9 diagnosis for headache and discharged, then any head CT is inappropriate. In clinical practice, the decision to perform neuroimaging is based on a patient's chief complaint, history, and physical exam. ICD-9 codes do not accurately reflect patients' chief complaints, historical risk factors, or comorbidities in ED administrative records.	(Continued from 73) **(MD Response):** No case mix and patient severity were deemed necessary since study group is Medicare population. MRI has very little use in the emergency department and would not have material effect on results. The measure follows accepted guidelines for headache as described in supporting references and input from TEP. **(NQF Staff Response)**: This measure was not recommended for endorsement, please see the draft report for details.
75	Public	Angela Franklin, American College of Emergency Physicians	Not Recommended	ACEP recommends that measure IEP-006-10--relating to appropriate head CT imaging in adults with acute atraumatic headache--be included in the measure set, in place of IEP-013-10. The measure is based on the American College of Emergency Physicians (ACEP) Clinical Policy related to the safe and timely evaluation and management of patients presenting to the ED with acute nontraumatic headache, (available at http://www.acep.org/practres.aspx?id=30060). Unlike IEP-013-10, IEP-006-10 measures “appropriateness” based on the recommendations of a recent, evidence-based, and well designed policy.	**(MD Response)**:We appreciate support for this measure. We would ask the steering committee to formally reconsider this measure and vote on it. We appealed it's initial rejection but were told that our appeal was not reviewed by the full Committee or formally voted upon by the full committee. We ask that the committee reconsider our appeal at their meeting and take a formal vote on the measure. **(NQF Staff Response)**: This measure was reviewed on April 22, 2010 by the Steering Committee consequent to an appeal submitted by the measure developer following the Steering Committee meeting on February 12-13th where the Committee voted not to recommend the measure for endorsement. During this Webinar, the Committee discussed the appeal and reviewed the measure again; the Committee in the end maintained their decision to not recommend the measure for endorsement.

17	Public	Kay Schwebke, Ingenix	General Comments	Some of these measures are restricted to the Medicare population (e.g., IEP-010-10 and IEP-010-130); yet they have broader application. We would suggest defining the population by age criteria; not insurance coverage. Also, suggest defining the population using an age range that includes a non-Medicare age group. These changes would result in more usable measures and would increase the number of patients impacted by these important overuse measures.	**(MD Response):**CMS is supportive of the use of its measures (when applicable) in other population groups. CMS does think that the measures submitted in this imaging efficiency measures cycle can have applicability to other populations. However, in order to submit tested measures, CMS uses the Medicare population data. Hence the measure submission can only speak to the use of the tested measures as they apply to the Medicare population.
76	Public	Angela Franklin, American College of Emergency Physicians	Not Recommended	(continued) We disagree with the steering committee's review that measure IEP-006-10 is based on a "consensus statement." The ACEP Clinical Policy is a recent, multidisciplinary expert review committee that follows a systematic process to review the published literature and develop graded recommendations. The consensus guidelines used to develop this measure were prepared as part of a multidisciplinary group with expert review by professional society designees of the American Headache Society, Society for Academic Emergency Medicine, American Association of Neurological Surgeons and Congress of Neurological Surgeons. The guideline includes both level B and level C recommendations. Level C recommendations include "panel consensus," but also include recommendations based on lower quality studies. As the evidence base addressing Head CT for acute headache is of poor quality and includes no Level I evidence, the ACEP guidelines committee recommendations were graded Level B and Level C.	Refer to response on comment #75

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77	Public	Howard Blumstein, American Academy of Emergency Medicine	IEP-013-10	I am writing on behalf of the American Academy of Emergency Medicine, a professional society of over six thousand emergency physicians dedicated to the advancement of our specialty. I am writing to express our strong concern about proposed measure IEP-013-10 (Use of Brain Computed Tomography in the Emergency Department for Atraumatic Headache).It is easy to understand why CT scans for headaches would be of interest when developing a quality measure. CT scans are performed frequently and they are high cost, yet the majority of these scans are unremarkable. We believe, however, that the proposed measure is premature and flawed. Indeed, it is hard to imagine that experienced emergency physicians developed the measure. Our objections are outlined in the following comment fields (SEE BELOW, comment 79 & 80). AAEM believes that the measure is premature and inappropriate in its current form. Patients served by CMS frequently have vague and nonspecific emergency department presentations that require extensive testing, including neuroimaging. Such patients simply cannot be pigeonholed into neat categories that can reflect the need for CT scanning. An irreconcilable conflict will be established between standard clinical practice and pressure created by this measure.	**(MD Response):** From inception, recognized experts from the American College of Emergency Physicians and experienced practitioners in emergency medicine developed and repeatedly commented on the measures. **(NQF Staff Response):** This measure was not recommended for endorsement, please see the draft report for details.

17	Public	Kay Schwebke, Ingenix	General Comments	Some of these measures are restricted to the Medicare population (e.g., IEP-010-10 and IEP-010-130); yet they have broader application. We would suggest defining the population by age criteria; not insurance coverage. Also, suggest defining the population using an age range that includes a non-Medicare age group. These changes would result in more usable measures and would increase the number of patients impacted by these important overuse measures.	**(MD Response):**CMS is supportive of the use of its measures (when applicable) in other population groups. CMS does think that the measures submitted in this imaging efficiency measures cycle can have applicability to other populations. However, in order to submit tested measures, CMS uses the Medicare population data. Hence the measure submission can only speak to the use of the tested measures as they apply to the Medicare population.
78	Public	Howard Blumstein, American Academy of Emergency Medicine	IEP-013-10	Given the lack of high quality research based on presenting complaints and the need for CT scanning in the CMS patient population, AAEM opposes the implementation of this measure in its current form. We strongly endorse funding a large, high quality research effort intended to establish reliable and accurate, evidence based indications for CT scanning. Only then should an attempt be made to establish a measure which incorporates clinically appropriate indications for imaging. We would also encourage the NQF and the CMS to establish some sort of legal framework or safe harbor that would protect physicians from legal action as long as they comply with the proposed measure.	**(MD Response):** We believe that our analysis will provide the foundation for many prospective studies of imaging appropriateness, as described by authors. **(NQF Staff Response):** This measure was not recommended for endorsement, please see the draft report for details.
79	Public	Howard Blumstein, American Academy of Emergency Medicine	IEP-013-10	•The scientific evidence establishing acceptable indications for brain CT scans in the general emergency department population is far from definitive. Indeed, the largest and most comprehensive study of indications or a head CT in patients suffering head trauma failed to establish reliable indications.•The patient population to which this measure is intended to apply, those Americans served by CMS, is not reflective of the general ED population. It is significantly older and more likely to have patients with serious co-morbidities. To our knowledge, there are no large, high quality studies that establish reliable indications for a CT scan amongst the CMS population.	**(MD Response):** We are aware that Medicare beneficiaries do not represent the general medical population of an emergency department, but believe that will be critical population to study with many parallels in other groups. **(NQF Staff Response):** This measure was not recommended for endorsement, please see the draft report for details.

17	Public	Kay Schwebke, Ingenix	General Comments	Some of these measures are restricted to the Medicare population (e.g., IEP-010-10 and IEP-010-130); yet they have broader application. We would suggest defining the population by age criteria; not insurance coverage. Also, suggest defining the population using an age range that includes a non-Medicare age group. These changes would result in more usable measures and would increase the number of patients impacted by these important overuse measures.	**(MD Response):** CMS is supportive of the use of its measures (when applicable) in other population groups. CMS does think that the measures submitted in this imaging efficiency measures cycle can have applicability to other populations. However, in order to submit tested measures, CMS uses the Medicare population data. Hence the measure submission can only speak to the use of the tested measures as they apply to the Medicare population.
80	Public	Howard Blumstein, American Academy of Emergency Medicine	IEP-013-10	•As experienced emergency physicians, we can identify several indications (diagnoses) for a CT scan that are not included in the measure. They include an altered mental status, use of anticoagulants, presence of a ventricular shunt, and the presence of known vascular abnormality.•The measure is based on the logic that if a patient was assigned an ICD-9 diagnosis for headache and discharged, then a head CT was not appropriate. This logic does not reflect clinical practice, where the decision to perform neuroimaging is based on a patient's chief complaint, history and physical exam. ICD-9 codes do not accurately reflect patients' chief complaints, historical risk factors, or co-morbidities in ED administrative records. In short, hospitals would be penalized for failing to predict the CT findings before the study is performed.•There is no provision to adjust the CT utilization rate with patient population, or acuity, in each hospital emergency department.	**(MD Response):** We are keenly aware of the shortcomings of the ICD-9 coding system but nonetheless believe that the categorizations that the mechanism permits will allow important and reliable information to be gathered.**(NQF Staff Response):** This measure was not recommended for endorsement, please see the draft report for details.

17	Public	Kay Schwebke, Ingenix	General Comments	Some of these measures are restricted to the Medicare population (e.g., IEP-010-10 and IEP-010-130); yet they have broader application. We would suggest defining the population by age criteria; not insurance coverage. Also, suggest defining the population using an age range that includes a non-Medicare age group. These changes would result in more usable measures and would increase the number of patients impacted by these important overuse measures.	**(MD Response):**CMS is supportive of the use of its measures (when applicable) in other population groups. CMS does think that the measures submitted in this imaging efficiency measures cycle can have applicability to other populations. However, in order to submit tested measures, CMS uses the Medicare population data. Hence the measure submission can only speak to the use of the tested measures as they apply to the Medicare population.
81	Public	Rebecca Zimmermann, AHIP	General Comments	AHIP appreciates the opportunity to provide comments on measures related to imaging efficiency. NQF's work to develop a framework for Imaging Efficiency measures represents an important step in furthering the appropriate use of imaging services. General Comments The measures included in the set address appropriate use of imaging services for specific conditions and processes. While we appreciate the NQF's efforts to review imaging appropriateness, we believe that there are critical measures missing from this set. Measures that assess the frequency of additional imaging studies recommended by the interpreting physician (i.e. radiologist) will reduce the overuse of complex imaging. Measures that assess the frequency of imaging studies by the ordering or prescribing physician are also needed, as much of the overuse of imaging studies is generated by the ordering physician who may have initially ordered an inappropriate study which leads to additional radiological studies. Additionally, the set should include measures that track radiation levels delivered to patients per imaging study. Currently, patients do not have access to their cumulative radiation exposure from imaging studies, nor do they have sufficient information regarding their increased risk of cancers due to repeat imaging. We also recommend the development of tracking tools to assess instances of medical radiation overexposure.	**(NQF Staff Response):** Thank you for your comment and for helping to push the field of healthcare efficiency forward. NQF and the Steering Committee acknowledge the dearth of imaging efficiency measures and has worked hard over the last couple of years to fill efficiency measurement gaps. While it is not within the scope of NQF's mission to create measures, NQF is actively engaging other avenues to encourage the development of efficiency measures and fill measurement gaps. We anticipate that increased collaboration and the development of an NQF endorse Resource Use Framework will help fill efficiency measurement gaps in the coming years. We encourage external support on how to fill efficiency measurement gaps.

17	Public	Kay Schwebke, Ingenix	General Comments	Some of these measures are restricted to the Medicare population (e.g., IEP-010-10 and IEP-010-130); yet they have broader application. We would suggest defining the population by age criteria; not insurance coverage. Also, suggest defining the population using an age range that includes a non-Medicare age group. These changes would result in more usable measures and would increase the number of patients impacted by these important overuse measures.	**(MD Response):**CMS is supportive of the use of its measures (when applicable) in other population groups. CMS does think that the measures submitted in this imaging efficiency measures cycle can have applicability to other populations. However, in order to submit tested measures, CMS uses the Medicare population data. Hence the measure submission can only speak to the use of the tested measures as they apply to the Medicare population.
82	Public	Rebecca Zimmermann, AHIP	IEP-005-10	Comments on Specific Measures1. Pulmonary CT imaging for patients at low risk for pulmonary embolism (Brigham and Women's Hospital) 2. Appropriate head CT imaging in adults with mild traumatic brain injury (Brigham and Women's Hospital)These measures address important areas of overuse and are supported by a strong evidence base. The measure developers utilize a proprietary EHR to collect the various elements required to calculate the measure but have provided a paper-based data collection tool. Hospitals should be able to integrate the paper-based tool into whatever EHR they are using. Is it possible the tool could be designed in an electronic format for easier implementation and data sharing? Given physicians report that many of these studies are ordered because of patient or family demand rather than appropriateness, NQF should consider how best to collect information on physician ordering patterns versus patient/ family demands.	**(NQF Staff Response):** The Steering Committee debated at great length on the feasibility of the measure as specified. The measure is based on a proprietary electronic data collection tool used at the Brigham and Women's Hospital and thus was initially perceived to impeded widespread adoption. The measure developers in response to the Steering Committees qualms regarding the feasibility of the measure provided a paper data collection tool to accompany the measure, making the measures accessible to the public. NQF and the Steering Committee support the adoption of "best in class" measures along with the migration of paper-based tools to electronic health records (EHR). NQF is working on re-tooling currently NQF endorsed® quality measures for electronic format and will stipulate that future quality measures be integrated into an HER. The Committee acknowledges that the tool could be integrated into an EHR , but until the broader healthcare system transitions to EHRs the Committee believes this measure in its current form will help improve the efficiency of pulmonary CT imaging. **(MD Response):** 1. The measure utilizes very basic decision logic based on the provided flowchart. We believe institutions can incorporate this logic into existing EHRs without significant difficulty as along as there is electronic imaging order entry combined with decision support capabilities in the ordering system. Such CPOE with decision support is in most definitions of meaningful use and will therefore be widespread in several years. 2. While patient preference is cited anecdotally to drive some utilization, there has not been any study to date demonstrating variation in CTPA use based on patient preference. In the absence of compelling data demonstrating this as a predictor of variation it may be premature to include such a factor as an exclusion criterion. While patient preference is cited anecdotally to drive some utilization, there has not been any study to date demonstrating variation in CTPA use based on patient preference. In the absence of compelling data demonstrating this as a predictor of variation it may be premature to include such a factor as an exclusion criterion.

17	Public	Kay Schwebke, Ingenix	General Comments	Some of these measures are restricted to the Medicare population (e.g., IEP-010-10 and IEP-010-130); yet they have broader application. We would suggest defining the population by age criteria; not insurance coverage. Also, suggest defining the population using an age range that includes a non-Medicare age group. These changes would result in more usable measures and would increase the number of patients impacted by these important overuse measures.	**(MD Response):**CMS is supportive of the use of its measures (when applicable) in other population groups. CMS does think that the measures submitted in this imaging efficiency measures cycle can have applicability to other populations. However, in order to submit tested measures, CMS uses the Medicare population data. Hence the measure submission can only speak to the use of the tested measures as they apply to the Medicare population.
83	Public	Rebecca Zimmermann, AHIP	IEP-010-10	Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery (CMS)4. Use of brain computed tomography (CT) in the emergency department (ED) for atraumatic headache (CMS)These measures address important areas of overuse and are supported by a strong evidence base. The measures are collected via electronic claims are implementable by hospitals.	**(NQF Staff Response):** NQF would like to thank you for your participation in the Consensus Development Process, we appreciate your response.

17	Public	Kay Schwebke, Ingenix	General Comments	Some of these measures are restricted to the Medicare population (e.g., IEP-010-10 and IEP-010-130); yet they have broader application. We would suggest defining the population by age criteria; not insurance coverage. Also, suggest defining the population using an age range that includes a non-Medicare age group. These changes would result in more usable measures and would increase the number of patients impacted by these important overuse measures.	**(MD Response):**CMS is supportive of the use of its measures (when applicable) in other population groups. CMS does think that the measures submitted in this imaging efficiency measures cycle can have applicability to other populations. However, in order to submit tested measures, CMS uses the Medicare population data. Hence the measure submission can only speak to the use of the tested measures as they apply to the Medicare population.
84	Public	Rebecca Zimmermann, AHIP	IEP-014-10	The measures address important areas of imaging overuse and are supported by evidence. Measures IEP-003-10 and measures IEP-005-10 of this set appear to assess the same clinical process (i.e., preoperative evaluations for low risk surgery patients). It is unclear in the accompanying document why the measure review panel opted to recommend two very similar measures for endorsement. AHIP recommends that only one measure for a clinical process be recommended. Given that the American College of Cardiology measures rely upon medical records, flow sheets, and provider surveys, we support measure 3 which is collected via claims data. We also encourage NQF to move toward recommending measures that are "best in class." Measures 6 and 7 in the set rely upon lab data, registry data, and "special or unique data." Before these measures can be supported, AHIP seeks additional clarity on how many hospitals will be able to implement these measures; if the registry data needed to calculate the measure comes from a specific registry; and the data source needed to access the "special or unique data."	**(NQF Staff Response):** The Steering Committee acknowledges that both measures IEP-014-10 and IEP-010-10 address a similar topic area in relation to efficiency in the emergency department setting; however, there are distinct differences in the measures constructs. The measures utilize different types of tests, timeframes, data source, and the level of measurement. Please refer to section 2a of the measure submission for form for more details regarding the measure specifications. The Committee reviewed both measures and determined that while both have similar constructs there were important distinctions. The Steering Committee in recommending measures IEP-014-10 and IEP-010-10 for endorsement, worked with both measure developers to align their lists of "low-risk surgeries." Aligning the lists of "low-risk surgeries" improves public reporting, interpretability, and dissemination of the measures and their results. **(MD Response):** The ACC measure is at the level of the imaging laboratory while the CMS measure is only focused on the hospital outpatient setting. The calculation and attribution is different for each measure and examines different parties. The CMS measure is limited by its reliance on claims that other legitimate reasons for testing will be included that just happen to be within the timeframe of a low risk surgery. In addition, the denominator of the CMS measure is all outpatient surgeries which will be large and likely make variations between providers more difficult to detect.

17	Public	Kay Schwebke, Ingenix	General Comments	Some of these measures are restricted to the Medicare population (e.g., IEP-010-10 and IEP-010-130); yet they have broader application. We would suggest defining the population by age criteria; not insurance coverage. Also, suggest defining the population using an age range that includes a non-Medicare age group. These changes would result in more usable measures and would increase the number of patients impacted by these important overuse measures.	**(MD Response):**CMS is supportive of the use of its measures (when applicable) in other population groups. CMS does think that the measures submitted in this imaging efficiency measures cycle can have applicability to other populations. However, in order to submit tested measures, CMS uses the Medicare population data. Hence the measure submission can only speak to the use of the tested measures as they apply to the Medicare population.
85	Provider	Cleveland clinic, Cleveland Clinic	IEP-013-10	This measure is flawed. It uses of Medicare data (usually 65 and older) which many of the guidelines and studies use as exclusion criteria because of the high risk nature of this population when presenting with a chief complaint of headache. As the measure is written, it is too easy to miss appropriate indications for a head CT. For example the exclusionary diagnosis codes do not include: all the stroke diagnosis codes, seizure/epilepsy, confusion. The literature does not provide enough evidence on the utility of head CT in this patient population. The guidelines published to date on this issue do not provide clear guidance on when head CT should NOT be performed. Moreover some patients 65 and older with a chief complaint of headache who are taking blood thinners(coumadin, aspirin, plavix) may warrant neuroimaging but there is currently no ICD 9 code for this situation, which would fail with this measure as written. The proposed measure cannot reliably account for important clinical variables that influence the appropriateness of imaging, as it is based on ICD-9 diagnoses rather than data that accurately reflects the patient's presenting chief complaint, exam and comorbidities. The measure is based on ED discharge diagnosis and unlike hospital inpatient diagnoses ED coding does not include the other variables that could be coded that may effect this measure.	**(MD Response):**We are aware that Medicare beneficiaries do not represent the general medical population of an emergency department, but believe that will be critical population to study with many parallels in other groups. **(NQF Staff Response)**: This measure was not recommended for endorsement, please see the draft report for details.

17	Public	Kay Schwebke, Ingenix	General Comments	Some of these measures are restricted to the Medicare population (e.g., IEP-010-10 and IEP-010-130); yet they have broader application. We would suggest defining the population by age criteria; not insurance coverage. Also, suggest defining the population using an age range that includes a non-Medicare age group. These changes would result in more usable measures and would increase the number of patients impacted by these important overuse measures.	**(MD Response):**CMS is supportive of the use of its measures (when applicable) in other population groups. CMS does think that the measures submitted in this imaging efficiency measures cycle can have applicability to other populations. However, in order to submit tested measures, CMS uses the Medicare population data. Hence the measure submission can only speak to the use of the tested measures as they apply to the Medicare population.
86	Public	Cleveland clinic, Cleveland Clinic	IEP-013-10	This measure seems to be a utilization measure that does not take into account that some hospitals see very low acuity patients while other large regional referral centers may see more complex patients. These regional referral centers may end up with higher CT head utilization rates and mistakenly listed as poorer “quality” when in fact the higher utilization rate were due to higher comorbidities and more complicated patients in general. This was one of 2 metrics NQF evaluated for CT in headache population. We are unsure why the TAP for this measure set selected this measure(006-13) over 006-10 for headache. 006-10 seemed to be an appropriateness measure while 006-13 seems more a utilization measure. NQF should possibly consider revisiting metric 006-10 for headache especially since it focus on larger population not one excluded from most guidelines and studies(i.e. 65 and older) like this measure does.	**(MD Response):** The measure was developed to include patients without pre-existing illnesses. For that reason those with trauma, HIV, subarachnoid hemorrhage, tumor, mass, focal neurologic mass and other conditions were excluded from the analysis as well as excluding those who went on to be admitted to the hospital.The measure was created to serve as a foundation for the identification of outliers, those providers practicing in a way significantly in variance from their peers. In the testing phase, there were no significant differences in the measure when comparing teaching to non-teaching hospitals, nor when comparing medium to large institutions. **(NQF Staff Response):** This measure was not recommended for endorsement, please see the draft report for details.

17	Public	Kay Schwebke, Ingenix	General Comments	Some of these measures are restricted to the Medicare population (e.g., IEP-010-10 and IEP-010-130); yet they have broader application. We would suggest defining the population by age criteria; not insurance coverage. Also, suggest defining the population using an age range that includes a non-Medicare age group. These changes would result in more usable measures and would increase the number of patients impacted by these important overuse measures.	**(MD Response):**CMS is supportive of the use of its measures (when applicable) in other population groups. CMS does think that the measures submitted in this imaging efficiency measures cycle can have applicability to other populations. However, in order to submit tested measures, CMS uses the Medicare population data. Hence the measure submission can only speak to the use of the tested measures as they apply to the Medicare population.
87	Consumer	Debra Ness, National Partnership for Women & Families	General Comments	The National Partnership for Women & Families supports the full set of seven measures recommended by endorsement for imaging efficiency. We believe these measures reflect clinical areas where 1) opportunity for improvement is clearly evident; 2) there is significant variation in provider performance; and 3) overuse of services is becoming more apparent, despite evidence-based guidelines for when and where these services are most appropriately used. Addressing the issues of overuse and variation in care are critical to tackling the continued rise in health care costs faced by many consumers. At the same time that we support the measures put forward by the imaging steering committee, however, we note the importance of creating a broader set of imaging measures that reflect the utilization of these types of services, adjusted by patient's health status and population severity. This broader set of measures should be designed to close the gap in imaging measures that relate to patient safety addressed. Measuring quality of care as it relates to imaging services is not only about getting closer to appropriateness of use, but also about reducing harm among patients. Finally, we believe that measures – both in this project and others – should be applicable to a broad population of consumers regardless of whether their care is paid for in the private or public sectors.	**(NQF Staff Response):** Thank you for your comment and for helping to push the field of healthcare efficiency forward. NQF and the Steering Committee acknowledge the dearth of imaging efficiency measures and has worked hard over the last couple of years to fill efficiency measurement gaps. While it is not within the scope of NQF's mission to create measures, NQF is actively engaging other avenues to encourage the development of efficiency measures and fill measurement gaps. We anticipate that increased collaboration and the development of an NQF endorse Resource Use Framework will help fill efficiency measurement gaps in the coming years. In an effort to determine "best in class" NQF strives to identify measures with the broadest application throughout the healthcare system. While NQF does not create measures, both NQF staff and Steering Committees work hard to encourage measure developers to take the broadest scope possible when developing and refining measures. The Steering Committee for the Imaging Efficiency Project affirms their stance that all measures should span both private and public sectors when applicable. Despite the Steering Committees continued affirmation some developers were unable to amend their scope due to time constraints and testing matters. We encourage external support on how to fill efficiency measurement gaps.

17	Public	Kay Schwebke, Ingenix	General Comments	Some of these measures are restricted to the Medicare population (e.g., IEP-010-10 and IEP-010-130); yet they have broader application. We would suggest defining the population by age criteria; not insurance coverage. Also, suggest defining the population using an age range that includes a non-Medicare age group. These changes would result in more usable measures and would increase the number of patients impacted by these important overuse measures.	**(MD Response):** CMS is supportive of the use of its measures (when applicable) in other population groups. CMS does think that the measures submitted in this imaging efficiency measures cycle can have applicability to other populations. However, in order to submit tested measures, CMS uses the Medicare population data. Hence the measure submission can only speak to the use of the tested measures as they apply to the Medicare population.
			IEP-014-10	Feasibility Concerns: Not Electronically Collected; Proprietary.	**(MD Response):** The ACC measure does not rely on proprietary software. Our methods for calculating have been described in the measure documentation. The measure may be collected electronically through third parties or internal CPOE systems. The data also may be collected through prospective data collection ordering sheets.