

Centers for Medicare & Medicaid Services
Special Open Door Forum:
Outpatient Imaging Efficiency Measures

Wednesday, May 20, 2009

2:00PM – 4:00PM ET

Conference Call Only

Featuring:

John Cooper, M.D. (CMS),
Mark Zezza, Ph.D. (The Lewin Group),
Thomas G. Dehn, M.D., FACR (National Imaging Associates, Inc.),
Joan DaVanzo, Ph.D. (Dobson | DaVanzo & Associates, LLC).

The Centers for Medicare & Medicaid Services (CMS) will hold a Special Open Door Forum (ODF) to discuss the development and implementation of facility-level hospital Outpatient Imaging Efficiency measures. The CMS has contracted with The Lewin Group, to develop a set of imaging efficiency measures. National Imaging Associates, and Dobson & DaVanzo are subcontracted by Lewin to support this effort.

During this Special ODF, CMS staff will discuss:

- Each of the four outpatient imaging efficiency measures currently required under the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) for CY2010 payment determination;
- Highlight some frequently asked questions;
- New Outpatient Imaging Efficiency measures under development.

Afterwards, there will be an opportunity for the public to ask questions.

To make the call as informative as possible, we recommend that participants:

- Visit the QualityNet (<http://www.qualitynet.org>) and Choose “Imaging Efficiency Measures” under “Hospital – Outpatient” and also <http://www.ImagingMeasures.com> ;
- Pre-submit any questions you wish to have addressed on the call to Imaging.Measures@lewin.com . Please type “Question for National Open Door Forum” in your Subject line. The most frequently asked questions received by 5 pm ET on Thursday, May 14, 2009, will be addressed on the call. Submitted questions not selected for the call will be answered individually via e-mail reply.

We look forward to your participation.

Special Open Door Forum Participation Instructions:

Dial: 1-800-837-1935 Conference ID 94281978

Note: TTY Communications Relay Services are available for the Hearing Impaired.

For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will A Relay Communications Assistant will help.

An audio recording of this Special Forum will be posted to the Special Open Door Forum website at http://www.cms.hhs.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading beginning May 29, 2009.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) and to view Frequently Asked Questions please visit our website at <http://www.cms.hhs.gov/opendoorforums/> .

Thank you for your interest in CMS Open Door Forums.

Audio File for this Transcript:

<http://media.cms.hhs.gov/audio/SpcFrmODFMIPPASECTION135.mp3>

Centers for Medicare & Medicaid Services
Special Open Door Forum:
Outpatient Imaging Efficiency Measures
Moderator: Natalie Highsmith
May 20, 2009
2:00pm-4:00pm ET

Operator: Good afternoon. My name is Clara and I will be your conference facilitator today. At this time I would like to welcome everyone to the Centers for Medicare and Medicaid Services Special Open Door Forum on Outpatient Imaging Efficiency Measures.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number 1 on your telephone keypad.

If you would like to withdraw your question, press the pound key. Thank you. Ms. Natalie Highsmith, you may begin your conference.

Natalie Highsmith: Thank you Clara and thank you everyone for joining us and welcome to this Special Open Door Forum to discuss the development and implementation of facility-level hospital outpatient imaging efficiency measures.

CMS has contracted with The Lewin Group to develop those measures. National Imaging Associates and Dobson and DaVanzo are subcontracted by Lewin to support this effort.

During today's Special Open Door, CMS staff will discuss each of the four outpatient imaging efficiency measures that are currently required under the hospital outpatient quality data reporting program for calendar year 2010 payment discrimination, highlight some frequently asked questions, and review new outpatient imaging efficiency ledgers that are under development.

I will now turn the call over to Ms. Susan Arday who is the CMS Project Officer for this effort. Susan?

Susan Arday: Hi. This is Susan Arday and I'd like to thank you for joining our Special Open Door Forum today. I would like to first start off by introducing our members and if you would, as I introduce you, would you please give a little bit of information on yourself.

First of all, one of our presenters is Mark Zezza at Lewin.

Mark Zezza: Hi. This is Mark. I'm the Project Manager at The Lewin Group of this effort.

Susan Arday: Joan DaVanzo?

Joan DaVanzo: Hi, Joan DaVanzo with Dobson and DaVanzo. I'm a subcontractor to Lewin. We've been working together for years on the imaging measures.

Susan Arday: Dr. Thomas Dehn? Anita Bhatia?

Fatima Millar: She'll be joining us momentarily.

Susan Arday: Fatima Millar?

Fatima Millar: I'm the Division Director that this project falls under.

Susan Arday: Dr. Dehn may have stepped out for a minute. He is with the National Imaging Associates. He's one of the principals there and he also works as a subcontractor with The Lewin Group on this endeavor.

Thomas Dehn: This is Tom. Well said, Susan.

Susan Arday: Hi Tom. Do you want to say anything more about yourself?

Thomas Dehn: No, that's enough.

Susan Arday: Fantastic. The purpose of these measures are to promote high quality efficiency care that reduces waste, adheres to evidence-based medicine and practice guidelines, and reduces unnecessary exposure to contrast materials and radiation.

And this is consistent with CMS' pay for reporting initiative, like the hospital outpatient quality data reporting program. The measure criteria that we use are: one, importance and relevance which would involve prevalence, cost burden and vulnerable populations; two, scientific soundness, in other words is there consistent evidence-based clinical guidelines; three, usability - is it clear and is there room for improvement on these issues; and four, feasibility. In other words is there minimal data collection or effort of burden required on someone.

Our measure domains that we've considered with this outpatient imaging efficiency project are duplication. By that we mean duplicative within a short period of time of each other without identified clinical indications; overlap, where different imaging modalities are done on the same area of the body within a very short timeframe of each other that serve, in a sense, the same clinical purpose; screening - imaging studies without identified clinical

indications based on symptoms or existing diagnoses; negative studies, which are clinically non-contributory studies; issues of with and without contrast, which is imaging studies repeated in short timeframes on the same body area differing only in whether contrast is used or not; and finally, our final measure domain is adjacent body areas. And those are imaging splays repeated in the short timeframe on adjacent body areas.

I'd now like to turn this over to Dr. Zezza at Lewin where he'll cover the outpatient imaging efficiency measures that are currently in the hospital outpatient quality data reporting program. Mark?

Mark Zezza: Thanks Susan. So I - let's talk about the first set of outpatient imaging efficiency measures. And basically what I'm going to do is I'm going to quickly introduce these measures and basically reiterate the numerator and denominator statements that I'm sure all of you are familiar with, just so that we'll have them fresh in our minds. And then I'll turn it over to Dr. Dehn who can provide some more background and clinical insights on why we chose these measures and what these measures are about.

And then afterwards I'll provide an overview of just the logistics of the measures. I know a lot of people on the phone probably have questions about, you know, when we'll be rolling them out and just want some more information on the measures. And, you know, I'll be discussing the data that'll be used for the measures and provide more details about the dry run and the actual 2010 payment determination run.

So the first measure for measure set one is MRI lumbar spine for low back pain, and just note that this measure has been endorsed by the National Quality Forum. And basically this measure calculates the percentage of low back pain MRI, the lumbar spine studies, without claims based evidence of antecedent conservative therapy.

So Susan discussed the measure domains. We consider this a negative study domain measure, as there's a low correlation between MRI findings and clinical course particularly for patients with low back pain that do not need invasive therapies.

So higher measures can imply less compliance with medical guidelines for treating low back pain and note that the guidelines are fairly consistent that in most cases the first course of treatment should be conservative therapy.

As far as numerator and denominator statements, the numerator, the patient had an MRI of the lumbar spine for low back pain without claims based evidence of antecedent conservative therapy. And note that we use a 60-day look back period for, you know, one looking for some sign of conservative therapy being done.

And the denominator are patients having an MRI of the lumbar spine for low back pain. This measure does have denominator exclusions. These exclusions are essentially red flag cases where an MRI may be appropriate without first having the conservative therapy and these exclusions deal with patients that have diagnoses related to cancer trauma, IV drug use, neurologic impairment, immunodeficiency virus, HIV, unspecified immune deficiencies and intraspinal abscess.

And we'll talk about in a few minutes where you can find more details, technical specifications for each of these measures actually. The second set of the second measure is the mammography follow up rates measure. Note that this was not endorsed by NQF, the National Quality Forum. This measure calculates the percentage of patients with a diagnostic mammography or ultrasound of the breast study following a screening mammography study within 45 days.

The measure's domain for this measure is duplication as measures - as higher measures may imply an inability to adequately determine one additional imaging is necessary. So - but actually measures that are extreme on either end that's materially higher or lower from published ranges which usually are around 10 to 14% range may want additional study by a facility.

And the numerator in this case are patients with a diagnostic mammography or ultrasound of the breast study following a screening mammography within 45 days. The denominator is patients with a screening mammography study.

Okay. Now I'll briefly talk about measures three and four, which are fairly similar in their construction. Measure three is the abdomen CT use of contrast material. Measure three was not endorsed by NQF and this calculates the percentage of abdomen CT studies that are performed with and without contrast out of all abdomen CT studies before. Meaning those with contrast, those without contrast, and those with both.

Obviously there are measures that are made for - this measure is going to be with and without contrast. And the higher value basically indicates a high use of combination studies and could raise questions of inefficient examination protocols.

So the numerator and denominator are fairly straightforward. The numerator is the number of abdomen CT studies with and without contrast, the combined studies. And the denominator is the number of abdomen CT studies performed with contrast, without, or with and without.

In this case there are also some denominator exclusions. We exclude patients with certain diagnoses such as kidney disorder and other certain malignant

neoplasms, and again, I'll point you towards where you can find a full list of exclusions in a few minutes.

And for measure four that is thorax CT use of contrast material. This measure was endorsed by the NQF and it calculates the percentage of thorax CT studies that are performed with and without contrast out of all thorax CT studies performed. It is again a with and without contrast measure domain measure. And again, higher values indicating a high use of combination studies and could raise questions about inefficient examination protocols.

And the numerator and denominator are again self-explanatory. The numerator is the number of thorax CT studies with and without contrast and denominator is the number of thorax CT studies performed with contrast, without contrast, or both with and without.

And, maybe at this point I'll pause a little bit and let Dr. Dehn from NIAR Clinical Experts and Partners perhaps provide some more clinical insight on these measures.

Thomas Dehn: Yeah, thanks a lot, Mark. I think that most people that are participating in this Open Door Forum are fairly familiar with these and probably have heard any one of us talk about them on occasion, so I'll make this - at least this first set of measures fairly brief.

We took the charge to look at imaging efficiency measures very literally and very seriously and so what I want to point out - it's important about the measures is that we're not trying to invent new science. We're looking at situations where examinations are being performed that are not necessarily in the most efficient way.

And we feel that performance of a lumbar MRI basically on the first visit is an inefficient way to handle patient complaints of back pain. And this has been underwritten - that opinion has been underwritten by several organizations including the AHCPR, which is a governmental organization from the mid-80s.

The second efficiency measure that Mark referred to is the mammography additional study rate. And again what we're looking at is what are the common additional study rates that we see in the country and does your facility significantly vary from those.

By that I mean that if you have an initial mammogram and there is a question and additional studies are needed, either ultrasound or diagnostic studies, that should run somewhere around 10 to 14%. So out of 100 studies that your radiologist will be reading or your facility is working with, you should see about 14%, maybe a little more, maybe a little less, percent of those initial mammograms requiring additional information.

And we've seen variation all the way up to 60 to 65% so we're going to take a look at whether we see some outliers and then try to delve into with the facilities why that - those statistics remain or exist. And we'll quickly offer some recommended improvements or correctional action if you so desire.

The third and the fourth measures - one was approved by the NQF, one was not. One relates to use of contrast material during the performance of an abdomen study and the other relates to the use of contrast material in conjunction with a CT of the thorax.

And the idea here is that while most ordering physicians will submit an order for a CT of the abdomen or a CT of the thorax, they rarely if ever specify whether they want a contrast enhanced or not - which means that the imaging

provider, usually a radiologist, has the discretion of performing it with, without contrast material or a combined study.

So with that discretion, we've seen again very substantial variations. It looks as though across the country at least in the commercial sector, not the Medicare sector, but in the commercial sector that number tends to be around 30 to 35% with variation all the way from 10% up to 80 to 85%.

We suspect that the very high incidence of the use of combined studies relates to what seems to be an efficient measure for the imaging provider. And that is just do everything with and without and we'll sort it out later, or in a situation where there's low use of contrast material it may be performed in a facility where a radiologist is rarely present to inject the contrast material.

So we're concerned about that and we're concerned about the variation that we see and those things seem to represent as I was about to mention before, possibly efficiency measures for the imaging facility, but pretty inefficient for the payer. And Mark, I think that kind of wraps up just the overview of the four that were developed for run number one.

Mark Zezza: Great. Thanks. So I guess next we'll just - I'll just review some logistics concerning measure set one. First of all the technical specifications and I'm sure most of you are aware of this and have seen them already, but they are available on the QualityNet Web site which can be found at <http://www.qualitynet.org> . And once you're there all you'll need to do is choose imaging efficiency measures, which will be towards the - it's a link towards the top of the Web site, top left of the Web site.

And then once you put your - once you click on it or just put your cursor on top of it a little drop-down list will come down and then you'll - you can

select hospital outpatient measures and you'll be directed towards the Web page that has all the technical specifications on measure set one.

So okay, now let me just try and answer some questions that we have been receiving regarding measure set one. First of all I just want to clarify that these measures are going to be calculated at the facility level and all facilities that are required to report these outpatient measures for their payment determination will be reporting the measure for all of those facilities basically. So this includes critical access hospitals.

The measures are calculated from 100% of the paid fee for service Medicare claims data. That is just fee for service. We are not using an A claims. And although the measures focus on outpatient facility claims those will be the basis of these measures. We will also need to use other Part B claims for these measures.

You know, particularly when, for instance, for measure one, the MRI lumbar spine measure, we'll be checking to see if there were - if there was any anti-conservative therapy done in the office setting. We'll also be checking to see if there are any diagnostic mammographies done in the office setting for measure set two - two examples of how we'll be using non-outpatient facility claims for these measures.

So even though we will be reporting the measures we'll be giving each hospital a ratio on that hospital's specific reports. And I know for at least the dry run we'll also be providing specific numerator and denominator figures, and we will also be available to work with the hospitals, to share the information that we have regarding the hospital's specific claims that are used for the measures. We should be able to share those with each hospital if you have any issues during the dry run.

It's not going to be possible in some cases for the hospitals to calculate the exact ratio that we'll be reporting on and may not have the access to the other Part B claims necessary for the calculation.

So one other thing to note about data - facilities do not need to submit any additional data that is - there is no chart abstraction that will be used for these measures. Right, and it's only Medicare based. And in terms of the schedule I mentioned the dry run. Our goal is to have a dry run done in the fall of 2009. There has - there is no set date at this point and that dry run will be using the 100% paid fee for service Medicare claims data from 2007.

This dry run will not be publicly reported but we will be sharing the hospitals' specific reports with each hospital and we will be giving each hospital the opportunity to validate those numbers and to work with us to make sure that we're doing the calculations correctly.

After the dry run we'll also have the calendar year 2010 payment determination run. This again will be using 100% paid Medicare fee for service claims, this time from calendar year 2008 and the reason why we're using 2008 is this will be the most recent full year of data that we have, the full year of adjusted paid claims.

This payment determination will eventually be publicly reported, probably some time in calendar year 2010, and again CMS does not determine exactly how or where this will occur.

And as I noted there will be plenty of opportunities during the dry run and even during the payment determination to provide comments and to validate the data on the HSRs, the hospital specific reports. And we think - we believe that the method, the tools to do this through will be through QMIS and the HOP QDRP right now tool via e-mail messages submitted to

hopqdrp@fnqai.com . So I keep saying QDRP - it almost sounds like a disease or something.

So, okay, at this point we'll start talking about measures set two. These are the measures that we are currently working on. And again I'm just going to give a brief quick overview of the measures, kind of take care of the grunt work, talk about the numerators and denominators and then I'll turn it over to Dr. Dehn to provide the insight on the measures and more of the clinical background.

But before getting too far on the measures I just want to be clear that we are still finalizing the technical specifications for these measures. We have put a brief description of the measures, including numerator and denominator statements, on a Web site, <http://www.imagingmeasures.com> and I think many of you have been looking at that. We have been receiving comments on the e-mail that's listed on the Web site and that's great. Thanks again for those.

So, but I just want to say, you know, please don't be too surprised if you'll notice that some of these measures may undergo some modifications over the next few months as, you know, we've been receiving some great comments from the ACR on our two cardiology measures, the Academy - the Association of - American College of Cardiology. And we'll be taking those into account.

So like I said, we're in the middle of working on this. We had a technical expert panel kick off meeting on October of 2008. So that's one of the - the bulk of the work, when the work really get ramped up on these measures was in the fall of last year and we have many experts on our panel from relevant medical societies, experts that practice in all of the relevant fields and some of them run major medical teaching centers. And some of them even sit on measure endorsing panels such as at the National Quality Forum.

We also had a 30-day public comment period that closed on December 14, 2008, and again thank you to all of you who are on the phone who sent in your comments during that period. That was very helpful.

And so at this point let me just go right into the measures. The first two are cardiology measures. Measure one of set two is SPECT MPI and stress echocardiography for preoperative evaluation for low-risk non-cardiac surgery risk assessment.

And in the numerator we have patients having a low-risk surgery proceeded within 30 days by a single photon emission computed tomography SPECT MPI stress echocardiography or stress MRI study. And in the denominator we have patients having a low-risk surgery and those surgeries include endoscopic procedures, superficial procedures, cataract surgeries and breast biopsies, just to give you a few examples.

Once we have the technical specifications ready we'll provide full details on all the low risk surgeries that we use for the measures. For measure two we have use of stress echocardiography or SPECT MPI post-revascularization coronary artery bypass graft - CABG. This proposed measure seeks to estimate relative use of stress echo and SPECT MPI in asymptomatic patients less than five years after a CABG procedure.

In this case the numerator is patients who have a stress echo or SPECT MPI study in the five-year period following their CABG procedure. The denominator are all patients who have a CABG procedure in terms of - there are several exclusions that we are investigating for this measure. Initially all tests performed in the first six months post-CABG are excluded, as well as any patients with certain clinical risk predictors.

For measures three and four, they deal with brain CT studies, measure three deals with the use of computed tomography in the emergency department for headache. And the numerator is ED visits with a presenting complaint of headache with a coincident brain CT study. The denominator is - are ED visits with a presenting complaint of headache.

Exclusions include patients who are hospitalized, admitted into the inpatient hospital, patients with a lumbar puncture as well as patients with certain diagnoses indicative of dizziness, paresthesia, lack of coordination, subarachnoid hemorrhage, or thunderclap.

And measure four is the simultaneous use of brain computed tomography and sinus computed tomography. The numerator is patients with the presenting complaint of headache who have a brain CT and sinus CT study performed simultaneously, that is on the same day at the same facility. And the denominator are patients with a presenting complaint of headache who have a brain CT study. And we'll also be looking at some exclusions, including patients with trauma diagnoses, tumor or orbital cellulitis.

And I'll just mention real quickly before I turn it over to Dr. Dehn that, you know, please go on the <http://www.imagingmeasures.com> Web site to look at the explanation - brief explanation of these measures. And you'll see a link on that Web site to an e-mail address, imaging.measures@lewin.com and, you know, we're keeping tabs of all the comments that come in and we'll definitely make use of those comments and try to get back to everyone that sends something in.

And so I guess at this point I'd like to turn it over to Dr. Dehn.

Thomas Dehn: Thanks again, Mark. These are, as Mark indicated, this second set of measures is still in this kind of gestation phase, although it's probably about 8 and a half

months we'll say. The first two measures take a look at cardiac imaging. And we were directed as a group to include the cardiac imaging not necessarily to look at cardiologists, but to look at anyone who is doing or performing cardiac imaging in a manner that doesn't seem to be or is not consistent with the recommendations and guidelines of the American College of Cardiology.

And what we're looking at here from the first one is patients with low-risk surgery who have, for any one of a number of reasons, have undergone a preoperative kind - a pretty extensive cardiac workup that includes stress echo and stress MPI and as Mark indicated also MRI studies.

Now this will be kind of interesting because the American College of Cardiology only in the last few years has clearly indicated and within their guidelines the recommendation that or the suggestion that advanced imaging procedures are not really necessary. And so what we're looking at again not unlike we did in the first set, we're looking at places that might have protocols or physicians that might have had it.

And interestingly this may reflect on anaesthesia rules within a facility as much as it does on cardiology and internal medicine rules. So the idea is if we identify facilities that are still performing fairly extensive advanced imaging studies on patients undergoing low-risk surgery, we'll consider that a variation from what is recommended by the American College of Cardiology and incidentally by the Society of Anaesthesiology.

Now the second one, use of stress echo or SPECT MPI after a study, or excuse me, after a CABG procedure, has really been somewhat controversial through the years and, again, we're not trying to invent new science. But the recommendations that are in the literature from the Cardiology Society and others is that is clearly for stress echo that if a patient doesn't have any new presenting new - with new signs or symptoms after a CABG procedure, that

they should not be re-evaluated for curiosity purposes any sooner than five years.

It's a little less well defined for SPECT MPI but generally we're going to at least begin unless we change it somewhat, we're going to begin to apply those same guidelines to a SPECT study or a stress MPI study.

So that is, if a person has a known coronary artery disease, has had a myocardial revascularization or a CABG procedure, and has no changing signs or symptoms, but because they're interested or someone is curious, we see repeat examinations or follow up examinations as often as annually. And we're trying to get to the root of those kinds of habits and see if we can begin to change behavior in terms of efficiency.

Measure number three, computed tomography in the emergency department, I think most of the folks that are on the phone understand that there is a challenge in front of us as to how to evaluate and manage utilization of advanced imaging studies in the emergency room. And all too often they're ordered before the physician even sees the patient and equally as often they're ordered for very good reasons.

And what we want to do is to try to find out when a patient with a garden-variety chronic headache, not a thunderclap headache or an acute situation, has a CT of the head kind-of just out of curiosity. And so we're looking at - we want to exempt those that have had - subsequently been admitted to an acute care hospital. Obviously there's something pretty abnormal with them.

Similarly patients with a lumbar puncture, if the patient undergoes a lumbar puncture the likelihood is, is that the CT scan of the brain would be pretty appropriate. The diagnosis codes indicative of dizziness paresthesia, lack of coordination, subarachnoid hemorrhage, thunderclap, are still undergoing a bit

of consideration, certainly the one with dizziness. Most agree that dizziness is a pretty ordinarily, if it's not accompanied by other sensory changes, it's not a great reason to get a CT of the brain.

So we're going - we not only want to take a look at different specialties in imaging, but we also want to take a look at different sites of delivery, and in this case it's the emergency room.

And finally, number four is really, as Dr. Arday mentioned early in the program, is really a measure of duplication. And that is most radiologists will agree, that if you're concerned about perinasal sinusitis and you do a CT of the brain you do see - there is enough information on a conventional CT of the brain, but you don't have to order a separate CT examination specific to the sinus.

And so we consider that - or are working - the hypothesis is that when they're ordered together for headache, not for tumor or trauma, but for headache that they represent duplicative procedures. And so that's their - those are the thoughts behind that one in particular, and in terms of the full discussion those are the reasons behind the four measures now that are under development. And I'll turn it back to you Mark.

Mark Zezza: Thank you. I just have one other logistical type thing to discuss since we've received about six or seven questions on this and it deals with the literature review and the guidelines and evidence for these measures. Some of you wanted some more of that information in terms of what we use to develop these measures and so I'll make it clear.

We are updating that for measure set one, you know, since the - some time has elapsed since we have gone through the analysis of the measures and they will

be put up on the QualityNet Web site shortly, certainly before the - long before the dry run period.

And I think at this point Susan, we're going to turn it back to you to discuss some of the pay per performance payment implications and...

Susan Arday: No. No. Hi, this is pay for reporting. What I wanted to ask was if CMS were to eventually consider developing new outpatient imaging efficiency measures, we'd really appreciate your suggestions, your comments on that.

And if you would, send those to imaging.measures@lewin.com . So suggestions for future outpatient imaging efficiency measures that you would like to see be developed.

Now I'd like to turn this back over to Mark where we're going to address some of your questions that were sent in a priority to imaging.measures@lewin.com .

Mark, do you want to start on the dry run and timing and logistics?

Mark Zezza: Yes, I think we hit upon some of those issues during the discussion. Again, the dry run, we're aiming to do that by the end of the year 2009 this year.

So I believe we're shooting for the fall of 2009. And that is going to be using the calendar year 2007 data.

And we'll be developing hospital specific reports, making - and I believe we'll be delivering those reports through the Qmed system and - although that has not been finalized by CMS yet.

And at that point we'll be working very closely and against those available to work with all the hospitals to validate their specific information.

And I just want to be clear that the dry run reports will not be publicly shared. The hospitals will be just looking at their report. And only the hospital will be able to see their report.

Just trying to look through some of the other questions that were sent in to make sure we've covered everything.

In terms of the claims, some of you mentioned that there are multiple procedures and diagnoses on the claims. And yes, we will be looking at all the procedures that are available on the claims. All the diagnoses will be considered when we're making these measured calculations.

So yes, people can actually be eligible for, you know, to be included in multiple measures. You know, if they had a few procedures done on the same day for two different measures that they would be looked at for both measures.

And I think we touched upon just about everything else that is not -we touched upon just all the other major questions. So there's two questions that were written about a listserv. And Susan, I'm not sure if CMS is going to make available a listserv specific to these measures?

Susan Arday: Right now CMS has not proposed developing its own listserv for outpatient imaging efficiency measures.

You folks are probably thinking about the Medicare demo on imaging for that which does have its own listserv.

We announce our things through the other major CMS listservs that are run here at CMS and also in tandem with the National Institutes of Health listserv.

Another place to go always to find information about this is <http://www.qualitynet.org> and <http://www.imagingmeasures.com> .

Mark Zezza: Right. And, you know, those resources are open 24 hours a day. So please feel free to send in your comments anytime.

And I think at this point we can open it up to questions.

Susan Arday: Well actually there were some questions. Someone had asked if this conference counts as CEUs for coding professionals? The answer is no it does not.

These measures are as you are obviously aware that the development of these proposed imaging efficiency measures is supported by CMS.

The (listed here) we've got a whole lot of questions that came in which is fantastic. There were some cardiology measure questions that I think Dr. Dehn would be best to answer.

For example one was the cardiovascular measures use claims administrative data that does not take into account the patient's symptom status and that symptom status is often an important term and its whether or not an imaging test is appropriate. And how will the measures, these are - we're talking about the proposed measures, adjust or count for symptom status?

Thomas Dehn: Thanks Susan. We are actually able to find proxies within the claims and the billing data to indicate a changing severity. And we've listed a couple of them here.

Anybody who for instance has had a test performed in the first six months post-CABG and any patient with clinical risk predictors for silent ischemia, and we can find those by virtue of ordering this examination for a quick visit.

So the answer is it's not perfect, but there are proxies for some of the kinds of extenuating circumstances that may certainly justify. And the key word is try to identify any changing signs and symptoms.

And if we can eliminate changing signs of symptoms, we're in pretty good shape and - if we consider that essential to the examination.

Susan Arday: Tom, this is Susan Arday again. They also asked regarding the measures for the five year post-CABG, what's the start date that the denominator? Would the measure look back on CABG procedures up to five years ago even though the appropriate use criteria were only issued three years ago?

Thomas Dehn: Now that's a good question. I think we had a talk about that internally Susan.

Susan Arday: We did.

Thomas Dehn: Okay we did?

Susan Arday: These are proposed technical specifications. So they're currently in development. They're going to be tested across multiple look back periods. So alternative numerators and denominators for the cardiovascular measures in what we call development measures Set II are being tested based upon initial data results.

And (interpretation) is to the facility that performs the imaging.

Thomas Dehn: Well like we mentioned earlier too that especially with those two cardiology measures, we are considering different specifications, even, you know, even different numerators and denominators so - and most likely we'll see changes- we'll be updating the Web site soon with an alternative specification for those two measures in the next couple months.

Natalie Highsmith: Okay, we are now really to go into our open Q&A portion of the call. Claire if you can just remind everyone on how to enter the queue to ask their question.

And everyone please remember, when it is your turn, to restate your name, what state you are calling from and what provider or organization you are representing today.

Operator: Certainly ma'am. At this time I would like to remind everyone, in order to ask a question, please press star then the number 1 on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

Our first question comes from Beth Feldpush from Washington DC. Your line is open.

Beth Feldpush: Thank you. This is Beth Feldpush from the American Hospital Association. I have a question that is primarily directed towards the mammography follow-up rate measure that's currently implemented but I think is really relevant to some of the other measures as well.

And that is that as you look to develop and use and implement the imaging efficiency measures, we're really getting into some uncharted territory here instead of new measures that are assessing points of care that we really don't have a lot of experience measuring.

And our concern with a mammography measure is that it is assessing a follow-up or recall rate. And we really don't know at this point what the correct follow-up recall rate should be.

So I think there are concerns that hospitals and facilities serving particular different patient populations may see different recall rates. And that may be completely appropriate.

So for example, facilities that are serving younger patient populations, they may see women that - younger woman have denser breast tissue. So it may be appropriate to refer them out for further studies more frequently.

I think this measure, the mammography measure, has some pretty serious potential, unintended consequences of limiting access to those services for women. But again I think that this point can be more generally applied to the other measures as well.

So a word of caution that as you're looking to develop measures and therefore implicitly set performance benchmarks that there is consent that we really don't have enough of the scientific base yet around really what those appropriate benchmarks should be.

So want to throw that out there as a word of caution and ask you to what extent you are looking for, any of that evidence or keeping an eye on things in the future to really make sure that we're mitigating any of those potential unintended consequences.

Susan Arday: Hi. This is Susan Arday. First of all I'd like to emphasize, this is the Medicare only population which is largely 65 years of age and older. So I understand your issue about the younger woman and the denser breasts, the pre-

menopausal women. But for the most part, the women in this population at Medicare are not going to be in that cohort.

Tom, Mark, would you like to address some of the other issues?

Thomas Dehn: Well I think - this is Tom. Thanks Beth. I certainly appreciate your comments and we are proceeding with caution.

I want to reiterate the fact that we're not trying to develop new - you know, new science here. And I will also agree that relatively young people have - more often have additional studies, not so much for the reasons that you said however.

If you think about what a mammographer looking at an initial mammogram, one of the most important things that he or she has at their disposal is a previous study.

So we find a relatively high rate of additional examinations order in conjunction with one's first mammogram.

So we are taking that in consideration. And sometime at another point I can share some information from our private business that we do that will kind of underscore that for you.

But as Susan indicated, this is in a Medicare population. And there are - there is information in the literature suggesting the percentages that seem to be somewhat normal.

And we have a statistical ability to agents that suggest, obviously not such in this case, but to HHS and to identify through (bot slots) and other very significant outliers.

Natalie Highsmith: Okay, next question please.

Operator: Our next question comes from Wanda Marvel from Montana. Your line is open.

Wanda Marvel: Yes. This is Wanda Marvel and I'm Actually from Missouri, the Missouri Hospital Association.

I have a comment and then I guess I do have a question also especially on the mammography. What we see related to that is differences in practice.

And I realize this is a Medicare fee for service so it's a sub group of the Medicare population. So percentage may be older, but it also would include disabled younger people also.

And because depending on practice, if you do your women's wellness through a facility that the focus is preventive, that and your mammogram is being read before you leave the facility which we have - that's not a super uncommon scenario so that the mammogram is read by radiology before they leave or on some of the other tests also.

And those tests are suspicious. And then a second more invasive exam is ordered, is that going to be included in the description as far a exclusion?

And I guess I have a concern about what the inclusion, exclusion or we're looking totally at there's CPT codes and they fall in the denominator?

Thomas Dehn: I'll take this one. Thanks a lot Wanda. I hope things are going well in Missouri.

The - there is a great deal of interest and concern about this particular measure. And one of the things that I do - and I hope it doesn't sound too cliché, but I typically will do is to say look at, if you live in we'll say Springfield, Missouri and here are three providers in the area.

And the probability of you having an additional study whether it be ultrasound or biopsy or whatever from basis of a first mammogram is 40% and another group is 10%, and there doesn't seem to be any difference in the age and life styles of the patients of those facilities, there's no apparent of increased morbidity and mortality. So which one would you go to?

And I - I'm not sure if you'd necessarily go to the one that is within normal ranges or one that would go - that you would go to in the higher range.

And we felt that it was at least a measure of one's ability to come to a conclusion on the basis of a given set of diagnostic imaging films - mammograms in this case.

Now your other question is will there be aberrations in the collections of data based on whether you're a wellness center or not?

I really can't speak to that. I do applaud the fact that you apparently represent a facility that actually reviews the mammogram prior to the patient leaving.

That would actually not have any significant impact because what we're looking at is a mammogram alone versus that is really followed by or closely followed by an additional study whether it's done onsite or whether it's done in different facilities a couple of days later or whatever.

Not sure that I'm getting to the answer to your question but that's the philosophy behind it. And we are aware of the fact that there are different populations.

Wanda Marvel: And my comment would be that when you talk about the decision that you have to say three different organizations doing studies in the same locale but there's different rates of - percentage rates of what's being ordered.

And it really comes down to in my mind the decision typically many times, especially in a Medicare population fee for service, the physician's the one who's deciding which one of those imagery areas the patient will go to.

And I guess that's my concern about these measures is that I don't see them being determined by the facility or the hospital that I see these as being more physician driven. And in my mind may be more appropriate in the physician pay for performance as opposed to the outpatient hospital pay for performance.

Thomas Dehn: So thanks Wanda. I certainly can't disagree with you on the fact that the physician makes the decision. Certainly hospital staff but non-clinical staff would not venture to give a radiologist instructions on how to read mammography.

On the other hand, there should be quality insurance programs within a facility that identify physicians that seem to have a relatively high rate of - we'll not call them recalls, but we'll call them an additional study.

When I was in practice, I practiced - I'm a radiologist, practiced in a ten member group. And occasionally you would see that. I mean you would see radiologists who probably shouldn't be reading mammograms because they had trouble making up their mind.

And the radiologist in general should live in a pretty binary world. And if you're - you should be able to identify the uncomfortable radiologist through your normal quality assurance programs that your facility has and work with he or she to - him or her, to change their behavior or to work on some other specialty within diagnostic imaging.

Susan Arday: Hi. This is also Susan Arday. I'd like to reemphasize this is hospital pay for reporting, not hospital pay for performance.

Natalie Highsmith: Next question please.

Operator: Our next question comes from Lea Anne Gardner from Pennsylvania. Your line is open.

Lea Anne Gardner: Hi. This is Lea Anne Gardner for the American College of Physicians. My main question regards the evidence base behind these measures.

I know you said that you had the measure specifications which I've pulled. But I don't see where - like say for the mammography where the cutoff comes for, for the 10% to 14%.

And, you know, I guess what we were wondering is are these measures based on say ACR guidelines or other evidenced based?

And I guess the only other question I had was specific to the MRI lumbar spine. You know, when you refer to conservative therapy which is defined as a claim for say like physical therapy, would a physician say who described that therapy but the patient didn't follow through for whatever reason?

Maybe they're - they had inadequate coverage or they went to somewhere else, but somehow the claim never got to their - recognized before they had the MRI. How would that affect the physician who's being reported on?

Thomas Dehn: Thanks Lea Anne. Again, this is Tom. Chime in anybody else if you want to. But the first question that you have, that you presented was one that related to evidence based.

And I think it would be a good time to talk about maybe your organization sponsoring the whole open door forum on evidence base because frankly very little medicine, certainly the minority of procedures that we perform and studies that we interpret are actually evidenced based.

Now they may very well be consensus based, but if you look up the strict definition of evidence based, I think we are using it a little too commonly.

We have identified specific to mammography a couple of articles that indicate - and one of them actually I believe came out of Pennsylvania. And you'll be happy to know in your - in our outside work any valuation of practice in Pennsylvania.

You actually hit at about 12% for all radiologists doing interpretation across the states. But there are very, very large variations underneath that general percentage.

So my answer would be it is consensus based, at least what we can find in the literature. Evidenced based, you know, I'm not sure how you'd really calculate that out.

But I do know that statistically we can identify physicians who frankly probably should not be reading mammograms. And I think that many on this call would agree.

Now with regards to PT and MRI, the conservative therapy, we're interpreting conservative therapy pretty loosely because frankly literature does support and we're probably on more solid ground here than we are on some others. But the literature has been clear that diagnostic imaging is not indicated in a patient that doesn't have the red flag signs which we are excluding.

The conservative therapy has indicated that most recently it's really time.

And if you can identify the beginning of a conservative course of therapy, that demonstrates a time lapse of four to six weeks, that whether PT is performed or not performed. If there is evidence that a physician has been attending to this individual during a protracted time and that the key is don't do - don't obtain a lumber MRI on the first visit. And that's what we're really looking for.

So and again, if unusual circumstance occurred where there was no claims evidence of any participation in any kind of supervised therapy and it actually had an impact on the facilities to (hear) you, first of all I'd find that hard to believe. And secondly if it did, you'd begin to wonder whether you're really conveying the adequate information to the patient.

Mark Zezza: And this is Mark. I just want to add that maybe we should clarify that CMS is not setting any particular targets per se for any of these measures. But again, it's particularly (unintelligible) in here as Dr. Dehn has been saying is that the variability across facilities and, you know, really one way to think about it is, you know, maybe at your facility. And for some reason you seem to be at the extreme end of a particular measure, you know, it may warrant you looking at

your protocols and investigating whether or not something should be changed or whether there's room for improvement or...

Lea Anne Gardner: Is it possible though then when you put (unintelligible) and conservative therapy to somehow give some sort of general guidelines?

Because I guess when we read it, we were thinking of, you know, given that you're using claims data that you might want something like physician therapy, you know, on the record, you know, on their claim. You know, some way to elaborate a little more so that if somebody - or a facility wants to report this measure, they have some general idea of what's - you know, a little more clarity on what the measure is trying to get at?

Joan DaVanzo: I think - this is Joan DaVanzo. There are a couple of indications that are in - for (unintelligible) therapy that can be used, one of which is physician therapy, one of which is chiropractic therapy. And then there's some injection codes as well.

So in the measure we do suggest that there are some (unintelligible) therapies that you might look for off of the E&M codes that precede the MRI could also suggest if the patient is in a course of therapy prior to receiving the MRI. I don't know if that helped.

Mark Zezza: Yes, and this is Mark. Again, if you go to the technical specifications on the Quality Net Web site, you'll see that those codes that Joan was referring to are actually codes that we're looking for to try and identify the conservative therapy.

Thomas Dehn: And I think Mark we also just for completeness include the - there are codes in there for pharmacy as well.

Lea Anne Gardner: There's a J code for an injection I believe. But over-the-counter meds we can't look at.

Mark Zezza: Right.

Natalie Highsmith: Okay, next question please?

Operator: Our next question comes from Laurel Sweeney in Massachusetts. Your line is open.

Laurel Sweeney: Hi. This is Laurel Sweeney. I'm representing the Medical Imaging and Technology Alliance. And I just had a question.

We understand from the Q&A that was on the Web site and also from the comments in the beginning of the call that the focus of the outpatient imaging measures is to address a quality appearance concern and imaging specifically around reducing unnecessary exposure to radiation and contrast materials.

So it's unclear to us how these measures will achieve this focus. There's many factors Tom, certainly as you know, in determining radiation exposure risks including the age of the patient, the CT system use, the technician's skill level, et cetera, that won't be reflected in the claims data that CMS is reviewing.

And further in regards to the contrast agents, whether a moderate risk to the renal system I think for CT, there are protocols used to weed out high risk patients before the procedure in place and also further whether some complications associated with MR contrasts, these are extremely rare.

So given these issues it seems unlikely that these measures would achieve a stated focus. And my question is, is there plans for a more in-depth data or

additional measure that would do more than just measure how many scans occurred.

Thomas Dehn: Well clearly Laurel -- and nice hearing from you - the reduction of inappropriate diagnostic imaging regardless of whether we can precisely quantify the amount of radiation saved or avoided to the population does occur.

And any reduction in the amount of radiation exposure to the population that's inappropriate is a worthy cause.

Now nowhere in this particular either set number one or set number two are we portraying the - that as a specific goal, although it does relate to quality.

In terms of appropriateness in the future on the development of additional efficiency measures, again we're looking at practice patterns that suggest inefficiency.

And again, we're not trying to define new science. But Laurel, if you have a diagnostic imaging center, probability is you go into that diagnostic imaging center recommended for an abdomen CT. And you have an 85% chance of having it with and without contrast material when the national average is about 30 or 35, you have to know that that group must have a protocol where everybody gets everything.

And that's certainly been acknowledged in previous discussions by some of the hospital systems.

So these are - you know, these are very - of significant concern. They really don't deal much with - or don't deal directly with equipment manufacturers. And we applaud the work that you guys have done, certainly at GE, Phillips,

Siemens, Toshiba has done in the last couple of years in terms of reducing the amount of radiation. And that is clearly laudable.

And I think that at some point when we - hen we're prepared to collect radiation dosages per person for instance over a huge number of diagnostic (unintelligible) for instance, w might very well be able to work out a efficiency measure such as that.

Lea Anne Gardner: Okay thanks. I just wanted to raise that, just because in the future I think in terms of what's going to happen in the future, once you address the issue of, you know, volume, we may want to look at some other kinds of measures that would help drive more appropriate and use of the equipment and the appropriate equipment for the determined clinical problem so...

Thomas Dehn: Yes, I don't think there's any doubt about that. And there's certainly preferable equipment. And again, if you have a very large volume of - a large volume and a large market basket of studies, over a year you could say that all these people had a CT examination and their average dosage was 12 millisieverts or 20 millisieverts or whatever. But statistically you could find facilities that had - that were either not entering in the right factors or may have machines that are not really very efficient.

And in that regard, you know, we would really invite (Mita) to work along with us. We've seen some, you know, some rather caustic comments and not really they didn't get any of this anywhere. And I think if we work together to identify some of these efficiency measures that would emerge would benefit all of us.

Lea Anne Gardner: Yes, thank you. We would very much like the opportunity. So I appreciate the answer. Thanks.

Mark Zezza: This is Mark. I just want to reiterate something that Susan mentioned earlier in terms of providing us some feedback on possible next measures.

Please feel free to email us. In fact that was one of our major goals to have this open door forum was to get some of your feedback on what future measures should be.

Lea Anne Gardner: Thank you.

Operator: Our next question comes from Vince Polkus with - in Wisconsin. Your line is open.

Vince Polkus: Thank you. Thank you for taking my questions. Focus (unintelligible) Healthcare in Wisconsin.

And I have a question related to the mammography recall metric. Could you please comment on the consideration given to the additional monitoring of cancer detection rates at the facilities?

I mean certainly the recall rate is one of the elements that would relate to the performance or the quality of the institution relative to their ability to detect cancer sufficiently.

However if the recall rate in isolation is driven to a point of - to a minimum, it may be that certain practices are missing cancers. And the interval cancer rate will increase at these institutions.

Thomas Dehn: Well thanks. You know, and Vince I appreciate the work that you guys are doing on your imagination program.

Anyway for the folks on the phone as well as in Wisconsin, we actually are looking at that. And our data is pretty scarce right now.

But I think the point you're suggesting is that is there a correlation between discovered cancer, truly discovered cancers and a high rate of additional studies? Well that certainly vindicates the individual with performing additional studies. And we just aren't quite there yet.

But I do appreciate that. But certainly the physicians that are participating in the development of this guideline have taken that into consideration.

Again what we're looking at truly is statistically significant variations from what would be a norm.

Vince Polkus: Okay, thank you.

Thomas Dehn: Thank you.

Operator: Our next question comes from Dan Dennie in Colorado. Your line is open.

Dan Dennie: Thank you and my question has already been answered.

Operator: Thank you. Our next question comes from Beth Kujawski in Colorado. Your line is open.

Beth Kujawski: Yes, my question is as far as the ED ordering CTs of the head and spine, what are we supposed to do about that? We are - you know, we are an ancillary department. We receive orders. We can't refer to do these, same with the MRIs (Alzheimer). We have no idea of the patient's, the treatment before, during or after the MRI of the spine. So just kind of curious.

Thomas Dehn: This is Tom. And clearly while these are - while we're labeling these imaging efficiency measures, the attribution if we find a significant variation from norm, the attribution does not necessarily accrue to the diagnostic imaging group or the radiology group.

Clearly a radiologist is not going to turn down or, you know, or essentially deny performance of an examination when a request is made from the emergency room.

But we can identify unusual utilization within a facility, between facilities and then at some point within that facility between practitioners in the emergency room.

The answer to your question directly, we understand that the attribution if there is a significant anomaly in the data would not be to the diagnostic imaging department but would be to the practice - the practice and emergency department.

Beth Kujawski: Yes, that's great to hear because here's so much of a focus on imaging right now. And it just seems some of it comes unfairly to those of us who are towing the line like we should.

Thomas Dehn: Well there's no question about that Beth. And I don't think there's a radiologist in the country that feels that imaging is properly used in the emergency department. So it's a challenge to all of us.

Beth Kujawski: Thank you.

Thomas Dehn: Thank you.

Operator: Our next question comes from Seth Freedland in Washington DC. Your line is open.

Seth Freedland: Yes, hello. Thanks for taking the questions. I was wondering if the - if you thought the contiguous body part policy resulted in cutting growth?

Thomas Dehn: Well I'm not sure that that's relevant to this Open Door discussion. But again, this is Tom Dehn. And do I think that the graduated payment of procedure discounts has diminished the use of multiple examinations? And the answer is yes.

Seth Freedland: Would you mind explaining why - how you come to that conclusion? Thanks very much for answering it. It is a little off topic.

Thomas Dehn: I mean again, the answer is it's as unrelated to the imaging measures as your question was. And I would just say that in our normal course of business at National Imaging, we have seen a reduction in the number of multiple procedures, contiguous body parts, probably generated by the radiologist; they're not sure what the etiology is.

Seth Freedland: Thanks very much. Sorry about that.

Thomas Dehn: Thanks Seth, I hope that helped.

Seth Freedland: It does. Thank you.

Operator: Our next question comes from Madeline Smith in Washington, DC. Your line is open.

Madeline Smith: Thank you for taking my question. I actually have two areas that I'd like to see if I could get some response on. The first is does CMS intend to submit

these measures - the second set of measures to NQF for endorsement? And will CMS continue to use measures that the NQF has considered but has decided not to endorse?

And my second question is just a clarification question. Did I hear correctly regarding Measure 2 on CABG that the ACC has recommendations on the use of stress echo after a CABG but has no recommendations on spec MPI and if that's the case how can these both be included in the numerator of a measure?

Thomas Dehn: It's - Susan, if you'd handle the first one with regard to NQF I'll take the second one.

Fatima Millar: Sure, so we do have plans to submit the second set of imaging efficiency measures to NQF for their endorsement process. And as we stated in the rule last year we will - we have adopted measures that are NQF endorsed as well as we believe with achieved a consensus based endorsement through the measure development process.

As mentioned earlier the measures developed go to the public comment period separate from the rule making process. And this allows the opportunity for a broad range of stakeholders to provide input on the measures. So to that point I think that addresses the two questions or comments that were made. But we do intend to submit the second set of imaging efficiency measures through our regular measure development public comment period which was recently completed and we'll also submit it to NQF for endorsement.

Thomas Dehn: The second part of that question is with regard to guidelines that are clearly stated and guidelines that are inferred and I would only say that as you evaluate the literature you'll find that the indications for performance of an MPI or a spec study are nearly identical to those for a stress echo study.

The specificity and sensitivity actually in some cases are a little better for echo than it is for MPI. And it is reasonable to assume - our conclusion is it's reasonable to assume that because they're nearly identical studies in terms of the information provided and the indications that the five-year clearly defined intervals related to stress echo can be applied to spec.

Madeline Smith: Just to be clear so is it true that the (ACC) does not have recommendations on spec MPI?

Thomas Dehn: Certainly not in number of years, that's correct.

Madeline Smith: Thank you. Thank you.

Thomas Dehn: Sure.

Mark Zezza: And this is Mark. Also just to bring up some issues that we discussed with the (unintelligible) - we discussed this issue quite a bit. And as Dr. Dehn was mentioning because stress echo and spec MPI have similar indications in this case we did not want to leave one of those studies out of the measure because then that, you know, that may inadvertently create some incentives for providers to start prescribing one of the measures over the other.

And that's actually another reason why we're considering putting stress MRI into the measure even though it's actually currently not being used in the Medicare population because it's not reimbursed. But just in case that changes in the future we want to be prepared.

Operator: Our next question is from Sharon Duvall in Missouri; your line is open.

Sharon Duvall: Thank you. Do you have an estimate timeframe between when the dry run will be and the payment determination run will be?

Thomas Dehn: Thank you, Sharon, that's not a question for me. I appreciate that.

Mark Zezza: Sharon, this is Mark. I believe at this point there - has no definitive timeline been set by CMS, in fact I know there has not been a definitive timeline set. But we are aiming to have both the dry run and the payment determination completed by the end of this year.

Sharon Duvall: Okay, thank you very much.

Mark Zezza: Sure.

Susan Arday: Hi, this is Susan Arday. Anita Bhatia would like to add something to that that the calculation of the claim's based measures doesn't affect payment determination. Am I misstating that?

Anita Bhatia: No, Susan, you're not. What the values are (unintelligible) do not affect payment determination as has been stated several times on this call. This is pay for reporting. So it's whether or not the hospital allows reporting of that measure.

Sharon Duvall: Thank you.

Operator: Once again if you would like to ask a question please press star then the number 1 on your telephone keypad. We'll pause for just a moment to recompile the Q&A roster.

Our next question comes from Kathleen Woods-Smith in Arkansas, your line is open.

Kathleen Woods-Smith: Actually AK is Alaska. The questions that I have actually have been kind of answered already except that, you know, I just wanted to understand how a specific facility is supposed to govern these measures.

Since like in our case we're a tertiary care facility in a very large state with lots of providers throughout the state, and we end up getting a patient, you know, at some point down the line, or people come here on vacation and they've had a variety of other providers, we really don't know much about what their imaging history would be.

And so I'm just - it's just kind of - I'm just starting to wonder how this will really work? And I would like to echo I think Wanda said that these are sort of physician/provider kind of measures. You know, if you're - if we're trying to drive behavior in the ordering since we just do the test that the doctor orders isn't this best to look at what an individual physician orders?

And then last piece is, you know, in our state and actually in our town the number of providers who actually accept Medicare patients are very, very, very limited. And a lot of Medicare patients actually come to the emergency room for their care - a lot of their care. And so I believe that a lot of providers try to get as much done in one visit and as many orders in one visit as possible.

And so is there going to be any consideration taken to, you know, geographical differences or provider number differences? That's it, thanks.

Thomas Dehn: Thanks, Kathleen. And good to hear from Alaska. The - I think it's important again to reiterate that this outpatient imaging efficiency measure program is a pay for reporting program. And that it's not a pay for performance so if the kind of untoward things happen in your tertiary facility that you've described

will not make a difference certainly in the foreseeable future as to any kind of pay for performance.

So what we're going to do when all the data comes in we're going to analyze the data as it's identified. And we may very well see a considerably different pattern of performance in tertiary centers that can be explained on the basis of the issues that you just identified.

So I guess a fair number of the questions that have been kind of entertained and answered today really seem to be implicit concerns about whether your performance is going to be good enough and whether you're going to be unfairly judged.

And the fact is, is that it is really incumbent upon us to be able to take the data that you submit to us and be able to identify those mitigating factors that you just talked about.

Kathleen Woods-Smith: Okay. Thanks.

Thomas Dehn: Sure.

Operator: Our next question comes from Steven Welsch in Maine. Your line is open.

Steven Welsch: Good afternoon. Thanks for taking my call. Do you gentlemen believe there's going to be an increase in ED admissions or 23-hour observation patients with increased scrutinization of CT usage? And do you think this will affect medical costs in different direction?

Thomas Dehn: So this is Tom, Steven. I don't know how to answer that actually. Maybe I can ask one of our other participants. And if you could restate it a little - kind of a little more clearly?

Steven Welsch: Yes. I'm just wondering if we're going to be scrutinizing the use of CT which I think has gotten rather overused; do you think it's going to increase ED admissions or 23-hour observation patients having to stay in the hospital longer to be observed without using the CT? And do you think that will negatively affect the medical costs?

Thomas Dehn: Well I think if it did result in - if the failure or the diminution of performance of CT in the emergency room is truly indicated then it shouldn't have any impact. If you're suggesting that if the physician cannot be certain enough without getting a CT examination that he or she will admit the patient to the facility inappropriately it will certainly increase costs.

I think that's what we really have to analyze and that is how much utilization is - of imaging services is performed in the emergency department because of insecurity by the physician and is there a way to fix that?

Steven Welsch: Right, thank you.

Thomas Dehn: Thank you.

Operator: Our next question comes from Madeline Smith in Washington DC. Your line is open.

Madeline Smith: Thank you. I'm a little bit confused and interested in about the multiple times that you've called this a pay for reporting measure because these measures aren't reported. As far as I understand they're derived completely from claims data so there's really no reporting that the outpatient department is subject to in order for this information to be gathered.

And isn't it the case that CMS could simply look at the claims data on its own and evaluate what the use of these particular imaging procedures are in the outpatient department without going through this pay for reporting cover?

And then if it's not pay - it's not really a pay for reporting program or measure what's behind it? How are these going to be used? If they're not going to be used to determine reporting because they're not, what are they going to be used to determine?

Thomas Dehn: I'll lateral that one to Susan Arday.

Anita Bhatia: Actually, yeah, Susan is going to lateral that to me, this is Anita Bhatia. Okay this is a hospital outpatient quality data reporting program. And hospitals have typically reported clinically extracted data. In the terms of the claims-based measures hospitals in a sense are reporting in that they are submitting claims and are getting reimbursed.

We at CMS are going to calculate measures based on claims that hospitals have submitted and have been paid for. The reporting part in this case for claims-based measures will come with the public display of this information. It is - we do intend to publicly display the imaging efficiency measures as we do the other data - other measures that we calculate using clinically extracted measures.

Madeline Smith: I would have to echo then the concerns that have been raised by several commenters that the outpatient department performing the image has very little control over how many images are performed.

Anita Bhatia: That is true in that physicians order the services and (Loren) can probably address a little bit better than I do. But hospitals do get paid for these services so in a sense they do have oversight over these procedures because they

perform them and they do get paid for them. So in a sense they do have some responsibility for them.

Madeline Smith: Thank you.

Operator: Our next question comes from Brandon Mbuakoto in New Jersey. Your line is open.

Brandon Mbuakoto: Hi I just want to (unintelligible) the question about the reporting measures that was just talked about because it seems clear that the hospitals (unintelligible) particularly on the measures - the main - measures that were talked about. And clearly the physicians that are ordering these exams are - will be expecting us to perform these type procedure and patients will be expecting care at point of service.

So we need to look carefully how we expect this results to be forwarded through CMS.

Thomas Dehn: This is Tom. It's a point well taken. And I think that in general this is a variation on a number of concerns and that is really is a larger issue of is a hospital - is some quality concern attributable to a hospital when they allow the physicians that are practicing on that staff to perform in a manner that is somewhat inefficient and in fact inappropriate?

And one of the predicates of this whole program is that they do. And certainly the joint commission has felt that way for the last 40 or 50 years and has really worked hard on improving quality assurance programs within hospitals.

But if someone receives a diagnostic imaging study and it's an inappropriate study it's not just one person; it is - there is contingent liability on the part of the ordering physician, on part of the hospital or the facility that it's being

delivered in as well as the specific physicians involved in the delivery of the service.

So, you know, I guess if you start out and you're not convinced of that then some of this may not make any sense.

Brandon Mbuakoto: Thank you.

Thomas Dehn: Thank you.

Operator: Once again if you have a question please press star then the number 1 on your telephone keypad. Our next question comes from Sharon McIlrath in Washington DC. Your line is open.

Sharon McIlrath: Hi, I'm with the American Medical Association. I wondered if you could tell us at the point that you start putting this on a public Web site are you going to be at that point using data that the hospital has already received reports and they know that they're considered to be an outlier and have had an opportunity to correct that?

I mean, if you don't - if you start in 2010 with 2008 data then 2011 you'd have 2009 data. You couldn't start until 2012 and have had the hospital had an opportunity to see this data and act on it.

Mark Zezza: Hi Sharon, this is Mark. So, yes, the hospitals will have a chance to validate their data certainly for the dry run which will not be publicly reported. And then CMS please correct me if I'm wrong but I believe that they will also have the chance to look at their - it's called (unintelligible) determination run from 2008 and moving forward before they do get publicly reported.

Sharon McIlrath: By correct I don't mean correct the report. I mean they would not have had an opportunity having seen this data to then go back and change the protocol if it's the - because the anesthesiologist has a protocol or the hospital has a protocol. Or to try to figure out, you know, why they're high on something or too low on something and then go back and deal with the problem.

Susan Arday: The hospitals - this is Susan Arday. The hospitals will get a chance with their hospital specific report for the calendar year '08 data before it's publicly reported that you will be able to see your own facility's data.

Anita Bhatia: This is Anita Bhatia. I understand the hospital's concern about wanting to change things or fix things. We did discuss this in last year's rule that there's no expectation that the hospitals would be changing clinical practice based on the way these measures are calculated.

We also discussed how that the (fields) of its efficiency measures was rather in its infancy. So we wouldn't be looking for hospitals to change things, you know, based on these measures at this time.

Sharon McIlrath: But you're going to put them on a public Web site...

((Crosstalk))

Sharon McIlrath: ..that says that they're inefficient.

Anita Bhatia: No and there's no value judgment placed on, you know, that they're inefficient because as has been pointed out there can be some differences in populations. Just because a hospital might have a number that's off it does not necessarily mean that they are, you know, practicing in an inefficient manner.

Sharon McIlrath: Then why put it on a public Web site if it doesn't mean anything?

Fatima Millar: (Unintelligible) for that that mandates the hospital outpatient quality data reporting programming also mandates that we make the data that future payment determination publicly available.

Anita Bhatia: And it also doesn't mean that it doesn't mean anything. Okay? It does mean something because it is utilizing what the hospital bills for. The hospital was paid for these services, presumably they performed these services so it is providing you a measure of that hospitals activity in its realm.

Mark Zezza: And this is Mark again. And I think in terms of meaning of it I think it's very important that we do have these measures that are out there that show and calculate and give the precise estimate of exactly how much variation in the use of medical there is.

And, you know, considering how important of an issue and the growth of radiology over the last few years these types of measures hopefully will be able to bring some insight that will help for more efficient and more clinically correct care moving forward.

Operator: Our next question comes from James Coffin in North Dakota. Your line is open.

James Coffin: My question has two parts: number one, because CMS is looking at our patient satisfaction scores and that is going to affect reimbursement how do we, in a competitive environment, adjust for that if another facility close by is not following the new guidelines what is the penalty for them?

And it may look like their customer service scores are better than ours because they're not following the new mandates.

Susan Arday: First of all these are not customer service scores. And they're not new clinical guidelines. As Dr. Dehn has pointed out we're not trying to reinvent new science. Tom, do you want to elaborate on that?

Thomas Dehn: Yeah, I'm a little unclear, James as to your question. If you're suggesting that this is part of a survey - a satisfaction survey that's really not what this is. Perhaps you can...

James Coffin: No I'm not saying it's part of it but that is part of our reimbursement now is going to be based on customer service or patient satisfaction scores. And I think one relates to the other. I understand they're different but they relate to reimbursement for the facility.

Susan Arday: Are you - this is Susan Arday - referring to HCCAP under the IPPS?

James Coffin: (Unintelligible).

Fatima Millar: And we're discussing actually the hospital outpatient (unintelligible) data reporting program. I can - can they submit questions to someone at CMS? Or if you have a question about HCCAP...

Neil Gittings: There's actually an HCCAP (unintelligible) Web site...

Mark Zezza: Forward the question to them and maybe to this Lewin group of the imaging measures at Lewin. If you have any more...

Anita Bhatia: Yeah, are you concerned that somehow there might be some dissatisfaction...

((Crosstalk))

James Coffin: Exactly.

Anita Bhatia: ...and it might be bleed into the HCCAP survey?

James Coffin: Correct. Correct.

Mark Zezza: So the question where a patient is expecting to have an MRI done that day...

James Coffin: And we follow the rules and we don't do it because we're doing things the way we're expected to, yet the facility down the street takes all comers. So it looks like we're not providing as good a patient - or customer service or patient satisfaction which affects our reimbursement so it's a double-edged sword in my view.

Susan Arday: We're not establishing clinical practice guidelines.

James Coffin: I know that. I understand that.

Thomas Dehn: James, you know, I think we certainly understand the fact that if the results of our initial study on efficiency measures result - if those results wind up upsetting some of your potential patient clientele that you would be at a competitive disadvantage because the other facility doesn't care how they look online or wherever. Is that pretty much what you're saying?

James Coffin: Exactly, yep.

Thomas Dehn: Okay. So here's the really good news for you. North Dakota has the lowest utilization of diagnostic imaging of anywhere in the country per thousand enrollees per year. So I doubt that many would ever be turned down. And if - I think I'm familiar with the facility and the group that you're with. And so you personally don't - I don't think you have to be concerned about this.

But I suppose by virtue of some stretch of the imagination, you know, if you had a facility - we'll go to the extreme that we're giving away everything. And suddenly they couldn't give away as much as they used to give away but people will be concerned about that. I think that's a reasonable, you know, it's a reasonable observation. I don't think it's relevant. I don't think we're going to see it happen.

Mark Zezza: Right and also towards that point I think that there has been a lot of studies out there and I know that there are many providers such as the (unintelligible) that are now investing in these programs where they'll educate the patient more. The, you know, have the patient understand which care is inappropriate, which care is unnecessary. And in that sense actually the patient - they can become more satisfied realizing that, you know, this CT was not an unnecessary service or the MRI can be put off another couple months.

Thomas Dehn: I couldn't agree with you more. I think that the work that (Wennberg) and the group at Dartmouth have done in terms of identifying variations is pretty remarkable. And we're just, I think, in a very, very early stage of truly educating our - the consumer of healthcare.

James Coffin: Thank you.

Thomas Dehn: Thank you.

Operator: Our next question comes from Wanda Marvel of Missouri, your line is open.

Wanda Marvel: Yes, my question has to do with I want to make sure I understood something I heard. On the dry run it was stated that the hospitals could validate their data for 2008. Would a hospital really be able to do that or are they just going to get a total number of cases that fell into 2008 or will they be receiving ID numbers of the patients?

Mark Zezza: This is Mark from Lewin again. And Susan or anyone - (Christina) please again correct me if I'm wrong. But for - on the hospital specific reports there will not be any patient identifiable data. We will just be reporting the ratio and the numbers and - possibly the numbers in the numerator and denominator.

However if your hospital looks at that data and says this data does not make any sense, when we calculate the number we're coming up with a completely different calculation, then at that point we can certainly share the data we use with the hospital. That, you know, in terms of the claims that come directly from your hospital - we'd be able to share with you and then review the data together to make sure that we are doing the measure correctly.

Wanda Marvel: And how...

((Crosstalk))

Mark Zezza: But I think - but I believe that level of detail will have to be initiated by the hospital.

Anita Bhatia: Okay and this is Anita Bhatia. I just want to clarify because of this use of the word validate. Hospitals will be able to check their, you know, their data as Mark has described with what they use for the calculations. But this is not to be confused at all with the validation process that would occur for clinically data extracted measures where medical record documentation is requested by us and it is checked.

So please don't confuse the use of the word validate that's being used here; it's more of a check. It's not the same at all as the validation process.

Wanda Marvel: Well and that was my confusion is that when I heard that statement it didn't fit with what I thought was going to occur because I didn't think that the hospitals really had the ability to run numbers and verify numerators and denominators that they will see on the dry run.

And if they can we would like to have that algorithm so that they could do it.

((Crosstalk))

Susan Arday: Hi, this is Susan Arday. We - you do have the measure specs and we certainly can provide you with your hospital-specific data knowing that it's the paid claims for Medicare fee for service; it's not going to be all the patients that you might have available in your chart-based information for all patients that they received a certain procedure.

Wanda Marvel: And to identify the cases on the claims are you doing that through Medicare patients with a standard HIC number?

Anita Bhatia: This would be Medicare fee for service. This would not include Medicare Advantage. But please be aware that it will include any claim that comes in that was paid for by Medicare. So if Medicare was a secondary or tertiary payer and there was a paid, you know, an amount paid that claim will be included.

Wanda Marvel: Okay where I'm going with this is that in the outpatient project under payer scores there is standardization of what patients fall into Medicare fee for service which is the Medicare with the standard HIC number.

Anita Bhatia: Yes, so that...

Wanda Marvel: That's not going to be the same thing? They'll be utilized to identify these cases or imagery?

Anita Bhatia: Wanda, yeah, this is Anita. I understand where this confusion is coming from possibly because the reports that appear through the clinical warehouse will designate Medicare as being - Medicare fee for service or Medicare Advantage. But these measures that are claims based are fee for service only. So in that sense - in that regard they would have standard HICN.

Wanda Marvel: Right and see I think that would be very confusing to the public and to hospitals as far as that distinction.

Anita Bhatia: Yeah, I agree with you. I think that we need to provide clarification because of the difference is being used with - in regard to the clinical warehousing and in regard to these measures. I agree with you.

Wanda Marvel: Okay that would be great.

Anita Bhatia: Okay thanks.

Wanda Marvel: Thank you.

Operator: Your next question comes from Sherry Nance in North Carolina, your line is open.

Sherry Nance: Yes it is unclear the measures - the one, two, three and four measures that are on the imagingmeasures.com Web site? How do those differ from the quality met measures? And are those not yet publicly reported?

Mark Zezza: This is Mark from Lewin again. The measures on the imagingmeasures.com Web site for measure set one, they should be identical to the ones that are on

the quality (unintelligible) Web site. We just put them on the imagingmeasures.com Web site as like a second place where people could find them.

Susan Arday: This is Susan Arday. Are you referring to when you first go to imagingmeasures.com you see four measures there?

Sherry Nance: Yes.

Susan Arday: Those are the proposed; those are the four measures we're developing right now. Those are not anywhere near any kind of a reporting situation.

Sherry Nance: So you're telling me that - so in the future the - say for instance the use of CT and the ED for headaches, that would eventually go to the HOP QDRP?

Susan Arday: I couldn't predict that at this time because we're still so far off. We have to take them through the NQF endorsement process and a lot of more steps before we could ever get to that point to know whether they would end up in the HOP QDRP or not.

Sherry Nance: Okay. Thank you.

Susan Arday: You're welcome.

Operator: Once again if you would like to ask a question please press star then the number 1 on your telephone keypad. We'll pause to recompile the Q&A roster.

Your next question comes from Cheryl Martin in Michigan. Your line is open.

Cheryl Martin: Yes, I'm curious about the NQF rationale for endorsing or not endorsing a measure. If you could explain that or clarify please?

Susan Arday: Hi, this is Susan Arday at CMS. The NQF does have criteria and does follow steps but really this call is not about trying to explain how NQF goes about endorsing something or not. What you - should go is look at qualityforum.org which is the NQF Web site and there's a pretty lengthy explanation and description of the processes they go through. It's pretty exhaustive, it's pretty extensive.

Cheryl Martin: I guess then the follow-up would be some measures were endorsed and others were not then what was the rationale for including a measure that wasn't endorsed or was endorsed? I'm just curious of the - your evaluation process of their review then?

Fatima Millar: (Unintelligible) and as I stated earlier we determined that these two measures were - received consensus-based endorsement based on the public comment that we received on the measures that were developed. And also through the technical expert panels that were convened to go over the measures because it represented a broad range of stakeholders. And I would just urge you to look at the rule and - to better understand the rationale and for more detail.

Cheryl Martin: Thank you.

Operator: At this time there are no further questions in queue.

Natalie Highsmith: Okay well we can go ahead and start ending the call now. I'll turn the call over to Susan Arday for closing remarks.

Susan Arday: I would like to thank everyone for joining us today on this call; it was very enlightening. And I appreciate your comments. I'm sure that Dr. Dehn and Dr.

Dr. Zezza and Dr. DaVanzo have also found this very informative. And as I had said previously I would really appreciate it if you have any suggestions for proposed outpatient imaging efficiency measures or questions please send them to imaging.measures@lewin.com - LEWIN.com.

Thank you very much.

Natalie Highsmith: Okay, (Claire), can you tell us how many people joined us on the phone line?

Operator: Yes, ma'am, we had a max total of 485 listeners.

Natalie Highsmith: Okay, wonderful. Thank you everyone.

Mark Zezza: Thank you.

Thomas Dehn: Thank you.

Joan DaVanzo: Thank you.

Operator: And this does conclude today's conference, you may now disconnect.

END