



**ACC Comments on CMS/NIA/Dobson Imaging Measures
Submitted via imagingmeasures.com Public Comment Web Site**

Measure #1 – Stress imaging (SPECT, stress echo, and MR) for perioperative evaluation for low risk non-cardiac surgery

1. Importance/Relevance: As constructed, does the measure have epidemiological, financial and/or policy relevance?

Agree

The measure addresses the important issue of appropriate patient selection for cardiac stress testing prior to non-cardiac surgical interventions. Reduction of testing prior to low risk surgery in patients without symptoms or other indications for testing has epidemiological support given low incidence of cardiac complications from such procedures.

2. Scientific Acceptability: As constructed, does the measure provide adequate reliability, validity, risk adjustment, and stability?

Neutral

The measure does not currently account for patients who might present with other indications for testing. For example, a patient may have coincidental findings discovered during their pre-operative screening, such as the presentation of ischemic symptoms, that would justify the imaging test. Although the frequency of such coincidental findings may be low, the measure should validate that the rate of such findings is indeed low prior to certifying its scientific acceptability.

Lower volume facilities may be reported to have higher inappropriate rates even if their frequency of stress imaging for this indication is the same as higher volume facilities. This could adversely affect the ability to accurately label outliers. For example, a facility that performs 40 stress imaging procedures among 700 low risk surgeries would have an inappropriate rate of 5.7% while a facility that performs 40 stress imaging procedures among 1000 low risk surgeries would have an inappropriate rate of 4.0%. Both facilities have an equal number of stress imaging tests that could have been avoided, but their inappropriate rate appears different. In the above example, if the outlier threshold was set at 5% the higher volume facility would not be identified as an outlier but would still have an equal number of inappropriate tests to address.

The measure should be tested fully related to all aspects of scientific acceptability including but not limited to accuracy of the numerator and denominator, exclusions, attribution, and whether variation on the measure is truly a reflection of quality. Furthermore, the measure should not be used for identifying outliers and performance or public reporting until such testing has been completed.

3. Usability: As constructed, does the measure provide actionable decision support that is controllable and adaptable?

Neutral

The measure provides actionable decision support to the extent that it accurately reflects a patient population that should not receive testing. However, testing must validate that coincidental findings would not undermine the ability of clinicians to take action based on the measure.

The attribution of the measure based on the number of low risk surgeries in the denominator appears to be more closely associated with the ordering physician rather than the outpatient hospital imaging center. The measure developers also should consider reporting an alternate denominator that would be based on the total number of stress imaging tests performed by the outpatient hospital imaging center. The alternative would present the inappropriate stress imaging prior to low risk surgery in the context of all imaging performed by the outpatient hospital imaging center. By doing so, it could emphasize the care coordination and partnership between the ordering physician and outpatient hospital imaging center necessary to reduce inappropriate testing. The alternative also could help determine the relative frequency of this clinical indication compared to all testing.

4. Feasibility: As constructed, is the measure well-defined, with a reasonable burden of data collection with minimal distortion?

Agree

Clinical claims data will not be able to determine the rate of coincidental findings. Validation of the measure would require data abstraction or prospective data collection of clinical data to determine the rate of coincidental findings.

It does appear that the measure could be collected with a reasonable burden of data collection, as long as the coincidental findings don't reveal the need to track symptom status or other coincidental findings.

The determination of outlier facilities may be difficult depending on the variability in the frequency of stress imaging in this population across facilities. All facilities may be within a very narrow range making determining a cut-off value for an outlier difficult to determine. If an outlier threshold is set, it should be determined in such a way (e.g. using a baseline reporting period) to allow all facilities to take action such that no facility is labeled an outlier if all improve.