Sorry for the really long email but the following includes info regarding quality measures. As you know, we have annual Summa performance measures which leaves a large amount of money at risk for us (2024: S findings on lung screening, incidental adrenal followup, CTR for positive stroke CTA, Aspects score, Ovarian cyst no followup) but there are other measures that we need to pay attention to in order to comply with CMS MIPS requirements. This has potential to put money at risk regarding reimbursement from CMS. Estimate is about $200k. The 2024 list was recently released, even though we are two months into the year - so we need to comply as much as possible. This is a moving target with CMS and quality measures come and go but we have selected 7 (possibly 8) for this year. We are fulfilling the criteria on most of these already.

1. Fluoro dose utilized
2. Statement in CT reports about dose reduction
3. Incidental thyroid nodules on CT or MR: As above, state "incidental" and give follow up or "no follow up recommended"
4. Thyroid US - use TIRADS recommendation for follow up
5. DXA with osteopenia results should include FRAX score and whether patients meet criteria for pharmacologic therapy. My updated macro includes the statement (just below the FRAX score): "The current National Osteoporosis Foundation Guide recommends pharmacologic treatment for patients with FRAX 10-year risk scores of > 20% for major osteoporotic fracture and > 3% for hip fracture, to reduce their fracture risk."
6. Pulmonary emboli: When reporting positive PE state the level of the most proximal embolus: main PA, lobar, segmental or subsegmental artery branch.
7. Screening mammo - include breast cancer risk in report. This is calculated and found in EPIC but we are trying to determine whether this is included in our reports to patients (we will hold on this one if not)
8. Coronary artery calcification on NON-contrast chest CT: State the presence of coronary artery calcification when noted on CT, but also state a pertinent negative like "heart - normal" or "no coronary artery calcification" when not seen.

There are additional quality measures available that we will not measure this year, but it makes sense to me that we start trying to develop some good reporting habits to eventually meet these as well.

1. AAA US. Please see my updated macro "reference aortic aneurysm" or "US aorta" in Summa and WRH powerscribe (also see below).
The follow up guidelines have been updated (2018 article). When below 2.5cm the statement "no future screenings are necessary" should be used.

Recommended follow-up imaging of AAA:
Reference: Chaikof E, et al. Society for vascular surgery practice guidelines on care of patients with AAA. JVS 2018: 2-77.

Diameter	Imaging interval
<2.5cm	No future screening is necessary
2.5-2.9 cm	10 y

3.0-3.9 cm	3 y
4.0-4.9 cm	1 y
5.0-5.4 cm	6 mo
>5.5 cm	Referral to vascular surgery (with CTR)

2. IVC filter management. When an IVC filter is seen on XR, CT or CTA, the following statement should be put in the impression section. Please see my macro "IVC recommendation" or "reference IVC" (also see here).

IVC filter recommendation (QCDR quality measure):

1. Assess if there is a management plan in place for the patient's IVC filter
2. If there is no management plan for the patient's IVC filter, refer the patient to interventional clinician on a non-emergent basis for evaluation.

3. Incidental lung nodules on CT: When detected (not screening) state the word "incidental" and "Fleischner guidelines" and also state the follow up recommended or specifically state "no follow up recommended"

4. Incidental adrenal nodule: Use follow up guidelines or when 1cm or less state "no follow up imaging recommended"

5. Renal cysts (Bosniak 1 or 2): State "no imaging follow up recommended" or "No follow-up imaging is recommended per consensus recommendations based on imaging criteria"

Thanks.

Jeff Unger