
2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), or cardiac magnetic resonance (CMR) performed in low risk surgery patients 18 years or older for preoperative evaluation during the 12-month reporting period

INSTRUCTIONS:
This measure is to be reported once per procedure of cardiac stress imaging (ie, SPECT, MPI, ECHO, CCTA, CMR) for patients seen during the reporting period. There is no diagnosis associated with this measure. It is anticipated that clinicians who provide the physician component of diagnostic imaging studies for cardiac stress will submit this measure.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure’s denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All instances of stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), or cardiac magnetic resonance (CMR) performed on patients aged 18 years and older during the reporting period

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Cardiac Stress Imaging Performed – Procedure Codes (CPT): 75559, 75563, 75571, 75572, 75573, 75574, 78451, 78452, 78453, 78454, 78491, 78492, 78494, 93350, 93351

NUMERATOR:
Number of stress SPECT MPI, stress echo, CCTA, or CMR primarily performed in low risk surgery patients for preoperative evaluation within 30 days preceding low-risk non-cardiac surgery

Definition:
Low-Risk Surgery – Cardiac death or MI less than 1% including, but are not limited to, endoscopic procedures, superficial procedures, cataract surgery, and excisional breast surgery.

Numerator Note:
- A lower calculated performance rate for this measure indicates better clinical care or control. This measure is assessing overuse of cardiac stress imaging in low-risk surgery patients.
- Patients that did not have a surgery performed or had a surgery other than those defined as low-risk would report G8962.
- Clinical quality outcome is cardiac stress imaging NOT performed on patient who is a low risk surgery patient within 30 days preceding procedure.

**Numerator Options:**

**Performance Met:**
Cardiac Stress Imaging Test primarily performed on low-risk surgery patient for preoperative evaluation within 30 days preceding this surgery (G8961)

**OR**

**Performance Not Met:**
Cardiac Stress Imaging Test performed on patient for any reason including those who did not have low-risk surgery or test that was performed more than 30 days preceding low-risk surgery (G8962)

**RATIONALE:**
Cardiac imaging is a mainstay in medical decision-making for patients with known or suspected heart disease. However, expenditures related to imaging comprise a significant portion of the health care budget. Much scrutiny has been focused on cardiovascular imaging with regard to the potential for overuse, especially in view of substantial geographic variation in ordering patterns and the limited amount of evidence-based data supporting the use of imaging as it relates to patient outcomes. Given the significant contribution of heart disease to morbidity and mortality and the prevalence of cardiovascular disease, it is important to determine the appropriate use of diagnostic tests such as stress echocardiography, stress SPECT MPI, CCTA, and CMR.

**CLINICAL RECOMMENDATION STATEMENTS:**
Diagnostic testing, such as stress SPECT MPI, stress echocardiography, CCTA, and CMR is used to detect disease and provide risk assessment used to modify treatment strategies and approaches. Information provided by such testing can initiate, modify and stop further treatments for coronary heart disease (medications and revascularization) which have an impact on patient outcomes.

In addition, false positives and false negatives can adversely impact the patient and their treatment outcomes. Lastly, radiation from stress SPECT MPI and CCTA poses a minimal but still important consideration for patient safety. Ensuring proper patient selection can avoid using resources in patients not expected to benefit from the testings and for which the associated risks would be unnecessary.