Physician Quality Reporting System: What Neurosurgeons Need to Know for 2016

Prepared by the:

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Physician Quality Reporting System

What Neurosurgeons Need to Know for 2016

The Physician Quality Reporting System (PQRS) is a federal program that requires physicians and other eligible professionals (EPs) to report to the Centers for Medicare and Medicaid Services (CMS) quality measures data related to services furnished to Medicare Part B beneficiaries. Eligible professionals who do not participate or do not satisfactorily report data in 2016 will be subject to a 2.0% penalty on all Medicare Physician Fee Schedule services in 2018.

Although PQRS payment adjustments are based on reporting success and not performance, CMS relies on PQRS measure data to calculate a separate performance-based payment adjustment known as the Value-Based Payment Modifier. When payment penalties from these two programs are combined and added to the penalties associated with a third program, the Medicare Electronic Health Records (EHR) Incentive Program, ***neurosurgeons could be at risk of losing nearly 10% of their Medicare payments in 2018***.

CMS plans to make available to the public in late 2017 virtually all 2016 PQRS measure data. Up until this point, CMS has only indicated to the public whether an EP participated in the PQRS. However, going forward, CMS plans to release physician-specific performance data.

Given the increasing significance of successful PQRS participation, it is critical that neurosurgeons understand the 2016 PQRS reporting requirements and the program's various reporting options.

PQRS Reporting Options for 2016

EPs can choose from multiple reporting options to satisfy PQRS reporting requirements, including:

- Reporting as an individual physician or as a group practice under the Group Practice Reporting Option (GPRO);
- Reporting individual measures or measures groups, which are sets of clinically relevant measures that must be reported together *(note: for 2016, there are no measures groups entirely relevant to neurosurgeons);*
- Reporting measures data via claims, an electronic health record (EHR), qualified registry, or a qualified clinical data registry (QCDR).

How to Get Started

1. Determine your eligibility

Click here for more information on which professionals are considered eligible for purposes of the PQRS. Note that PQRS participation is not limited to physicians. Other non-physicians in your practice, such as nurse practitioners and physician assistants, may also be subject to payment penalties for non-compliance.

2. Determine whether you will participate as an individual or part of a group practice

An EP may participate in the PQRS as an individual or as a group practice, but cannot receive credit for both. In fact, once a group practice elects to participate in the GPRO, professionals tied to that

group are no longer eligible to participate in the PQRS as individuals. If you practice as part of a larger group, it is important to determine whether your group plans to participate under the GPRO. For purposes of group practice reporting, CMS defines "group practice" as those with two or more EPs, identified by individual National Provider Identifiers (NPIs), who reassign their billing rights to a single Tax Identification Number (TIN).

If a group practice self-nominates to participate in the GPRO and satisfies PQRS requirements *as a group*, CMS will automatically consider all individuals in that group as satisfying the requirements of the PQRS. This means that a neurosurgeon in a larger multi-specialty group practice could potentially avoid a PQRS penalty without taking any action if others in the group (e.g., primary care physicians or other specialists) report on a sufficient number of measures to satisfy the program's reporting requirements.

Registration is required for group practices wishing to participate via the GPRO. Authorized representatives of group practices can register for GPRO via the CMS website through **June 30, 2016.** Once a group practice registers for the GPRO, it cannot withdraw its registration, and individual members of the group cannot participate in the PQRS as individuals.

Individual eligible professionals do not have to register with CMS to participate in the 2016 PQRS. However, if using a third party entity to submit your measure data to CMS, such as a qualified registry, you will want to check with the entity to determine whether it has its own set of registration and reporting deadlines.

Click here for additional information about reporting options available to group practices under the ***GPRO***.

3. Review the criteria for each specific reporting option to determine which method is best for you.

After determining whether you will participate in the PQRS as an individual or group practice, you will need to select the most relevant and least burdensome mechanism to report your quality data to CMS. Slightly different options are available depending on whether you participate in the program as an individual physician or as a group practice.[1] Additional resources are listed below:

- Click here for additional information about reporting via a ***QUALIFIED CLINICAL DATA REGISTRY or QCDR***. The QCDR reporting mechanism is relatively new and allows physicians to satisfy PQRS by reporting to specialty-sponsored registries that have the flexibility to offer more specialty-focused measures not included in the traditional PQRS measure set. Organized neurosurgery's Quality Outcomes Database (formerly known as the National Neurosurgery Quality and Outcomes Database or N^{2}QOD) has been qualified by CMS as a QCDR for purposes of the 2016 PQRS. The QOD aims to provide neurosurgeons with a more meaningful set of quality measures. For 2016, the QOD QCDR will offer 21 measures related to surgical spine care and 9 measures related to non-surgical spine care. In the future, the QOD QCDR hopes to offer additional modules that target other subspecialties of neurosugery. Additional information about the final set of measures being offered by the QOD for 2016 is available here.

[1] For the full list of reporting options available under the individual or group practice options, please see Tables 1 and 2.

- Click here for additional information about reporting via a ***QUALIFIED PQRS REGISTRY***. Organized neurosurgery is not a sponsor of a qualified registry for 2016. However, there are multiple third party registry vendors approved by CMS to collect PQRS measure data on behalf of EPs. Many of these vendors rely on Web-based portals to collect data and charge a user fee. A list of qualified vendors for 2016 is available here.

- Click here for additional information about the ***EHR*** reporting option, including a guide titled, "2016 PQRS Reporting Using an EHR Made Simple." Note that EPs and group practices using this reporting option may be able to satisfy both the PQRS and the electronic clinical quality measure (eCQM) component of the Medicare EHR Incentive Program.

- Click here for more detailed instructions on how to report quality measures data via ***CLAIMS.***

4. Select your measures

Most reporting options now require that the individual or group practice report on nine measures, including one "cross-cutting" measure, for 50% of all applicable Medicare Part B patients over the reporting year. PQRS measures are categorized into National Quality Strategy (NQS) domains, and the nine measures selected must cover at least three of these domains.[2]

If not reporting via neurosurgery's QCDR, you will have to select measures from the traditional PQRS measure set, which includes a fairly limited number of measures that are directly relevant to neurosurgery. Click here for a list of individual 2016 PQRS measures that *might* be relevant to a neurosurgical practice. Neurosurgeons are encouraged to download and review the entire list of 2016 PQRS measures to dertermine which are most applicable to their practice. It is important to carefully review the measure specifications, which describe the measure's numerator, denominator and any applicable exclusions. The numerator details the clinical quality action that is the focus of the measure, while the denominator — defined by a set of ICD-10, CPT, HCPCS codes, and other demographic and/or place of service data — identifies all of the patients to which a measure applies.

5. Start Reporting

If using the claims-based reporting option, you will need to submit Quality-Data Codes (QDCs) with applicable Medicare Part B claims. QDCs are listed in each measure's specifications. Note that QDCs must be reported at the same time applicable claims are submitted to CMS. You cannot go back and re-attach QDCs to claims already submitted.

Registry-based reporting offers a more flexible approach to data submission since registries can retrospectively analyze a physician's data across the entire reporting year and determine which quality measure indicators a physician needs to submit to CMS at the end of the reporting year. If using a third party entity, such as a qualified registry, to submit your measure data to CMS, please check with the entity to determine whether it has its own set of data submission requirements and deadlines.

[2] Domains include: Patient and Family Engagement, Patient Safety, Care Coordination, Population and Public Health, Efficient Use of Healthcare Resources, Clinical Processes/Effectiveness.

While it is recommended that you choose a single reporting option, CMS does allow data submission via multiple reporting mechanisms if you are reporting as an individual (as opposed to a group practice). If a physician submits data through multiple methods, CMS will evaluate the data from each submission method separately, and the data that most favorably reflects the physician's participation will be used. In other words, data received from a registry and via claims will not be combined.

Measures Applicability Validation (MAV) Process

If an EP or group reports fewer than nine measures and/or reports measures that cover fewer than three domains, it will trigger a review by CMS. CMS uses the Measures Applicability Validation (MAV) process to evaluate whether there were other measures that an EP could have reported on. CMS will not use the MAV to evaluate the *appropriateness* of any nine measures selected by an EP so long as the measures cover three domains.

The MAV process relies on two steps:

1. Evaluating whether any of the measures reported by the EP are part of a CMS-defined cluster of clinically relevant measures. If so, CMS evaluates whether the EP reported on the other measures in the cluster.
2. For claims-based reporting, CMS also subjects the EP to a minimum threshold test that evaluates whether any potentially relevant, but non-reported measures in the cluster could have applied to more than 15 Medicare patients. If so, CMS will conclude that the EP did not report on a sufficient number of measures and subject that EP or group to the PQRS penalty.

CMS recognizes that for certain specialists, there simply might not be a sufficient number of applicable measures to report on. If an EP reports on less than nine measures and CMS is unable to identify any other relevant measures through the MAV process, the EP can still satisfy the PQRS and avoid the penalty.
Additional information about the MAV process is available here.

Note that the MAV process only applies to measures reported via claims or qualified registry. If reporting via a QCDR, you must report on 9 measures to avoid a penalty.

Medicare Access and CHIP Reauthorization Act of 2015

In April 2015, the President signed into law the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which repealed the flawed sustainable growth rate (SGR) formula and created a new two-tracked framework for rewarding physicians for higher quality care. As a result of MACRA, the PQRS will end after the 2016 reporting year/2018 payment year, although many aspects of the program are expected to be incorporated under a new Merit-based Incentive Payment System (MIPS). MIPS seeks to consolidate and streamline current physician quality reporting mandates and their existing penalty-only structure. Under MIPS, which will begin with the 2017 reporting year, EPs will continue to face penalties, but only outlier physicians will be subject to the steepest penalties, which are capped at nine percent in later years. Unlike the PQRS, EPs also will be eligible for performance-based bonuses under MIPS. More details about MIPS will be provided in a separate publication once the rules and criteria for the 2019 payment adjustment year have been finalized.

Additional Resources

The CMS PQRS Website offers additional resources to assist EPs with reporting in 2016, including a 2016 PQRS Implementation Guide and a 2016 Beginner Reporter Toolkit. These resources includes information about how to select measures, how to read and understand measure specifications, and how to submit quality measure data to CMS.

Table 1: 2016 PQRS Reporting Options to Avoid a 2018 Penalty if Participating as an Individual

Reporting Period	Measure Type	Reporting Mechanism	Satisfactory Reporting Criteria
12-month (Jan 1-Dec 31, 2016)	Individual Measures	Claims	Report at least 9 measures, covering at least 3 of the NQS domains AND report each measure for at least 50% of the EP's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Of the measures reported, if the EP sees at least 1 Medicare patient in a face-to-face encounter, the EP will report on at least 1 measure contained in the PQRS cross-cutting measure set. If less than 9 measures apply to the EP, the EP would report on each measure that is applicable, AND report each measure for at least 50% of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate would not be counted.
12-month (Jan 1-Dec 31, 2016)	Individual Measures	Qualified Registry	Report at least 9 measures, covering at least 3 of the NQS domains AND report each measure for at least 50% of the EP's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Of the measures reported, if the EP sees at least 1 Medicare patient in a face-to-face encounter, the EP will report on at least 1 measure contained in the PQRS cross-cutting measure set. If less than 9 measures apply to the EP, the EP would report on each measure that is applicable, AND report each measure for at least 50% of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate would not be counted.
12-month (Jan 1-Dec 31, 2016)	Individual Measures	Direct EHR product or EHR data submission vendor	Report 9 measures covering at least 3 of the NQS domains. If an EP's direct EHR product or EHR data submission vendor product does not contain patient data for at least 9 measures covering at least 3 domains, then the EP would be required to report all of the measures for which there is Medicare patient data. An EP would be required to report on at least 1 measure for which there is Medicare patient data.
12-month (Jan 1-Dec 31, 2016)	Measures Groups	Qualified Registry	Report at least 1 measures group AND report each measures group for at least 20 patients, the majority (11 patients) of which are required to be Medicare Part B FFS patients. Measures groups containing a measure with a 0 percent performance rate will not be counted.
12-month (Jan 1-Dec 31, 2016)	Individual PQRS and/or non-PQRS measures reported by a QCDR	Qualified Clinical Data Registry (QCDR)	Report at least 9 measures available for reporting under a QCDR covering at least 3 of the NQS domains, AND report each measure for at least 50% of the EP's patients. Of these measures, the EP would report on at least 2 outcome measures, OR, if 2 outcomes measures are not available, report on at least 1 outcome measures and at least 1 of the following types of measures – resource use, patient experience of care, efficiency/appropriate use, or patient safety.

Table 2: 2016 PQRS Reporting Options to Avoid a 2018 Penalty if Participating as a Group Practice

Reporting Period	Group Practice Size	Reporting Mechanism	Measure Type	Satisfactory Reporting Criteria
12-month (Jan 1-Dec 31, 2016)	25-99 eligible professionals (EPs); 100+ EPs (if CAHPS for PQRS does not apply)	GPRO Web Interface	Individual GPRO measures in GPRO Web Interface	Report on all measures included in the web interface; AND populate data fields for the first 248 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 248, then the group practice must report on 100 percent of assigned beneficiaries. In other words, we understand that, in some instances, the sampling methodology we provide will not be able to assign at least 248 patients on which a group practice may report, particularly those group practices on the smaller end of the range of 25– 99 EPs. If the group practice is assigned less than 248 Medicare beneficiaries, then the group practice must report on 100% of its assigned beneficiaries. A group practice must report on at least 1 measure for which there is Medicare patient data.
12-month (Jan 1-Dec 31, 2016)	25-99 EPs that elect CAHPS for PQRS; 100+ EPs (if CAHPS for PQRS applies)	GPRO Web Interface + CMS Certified CAHPS Survey Vendor	Individual GPRO measures in the GPRO Web Interface + CAHPS for PQRS	The group practice must have all CAHPS for PQRS survey measures reported on its behalf via a CMS-certified survey vendor. In addition, the group practice must report on all measures included in the Web Interface; AND populate data fields for the first 248 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 248, then the group practice must report on 100% of assigned beneficiaries. A group practice will be required to report on at least 1 measure for which there is Medicare patient data. Please note that, if the CAHPS for PQRS survey is applicable to a group practice who reports quality measures via the Web Interface, the group practice must administer the CAHPS for PQRS survey in addition to reporting the Web Interface measures.
12-month (Jan 1-Dec 31, 2016)	2-99 EPs; 100+ EPs (if CAHPS for PQRS does not apply)	Qualified Registry	Individual Measures	Report at least 9 measures, covering at least 3 of the NQS domains. Of these measures, if a group practice sees at least 1 Medicare patient in a face-to-face encounter, the group practice would report on at least 1 measure in the PQRS cross-cutting measure set. If less than 9 measures covering at least 3 NQS domains apply to the group practice, the group practice would report on each measure that is applicable to the group practice, AND report each measure for at least 50% of the group's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted.

Reporting Period	Group Practice Size	Reporting Mechanism	Measure Type	Satisfactory Reporting Criteria
12-month (Jan 1-Dec 31, 2016)	2-99 EPs that elect CAHPS for PQRS; 100+ EPs (if CAHPS for PQRS applies)	Qualified Registry + CMS Certified Survey Vendor	Individual Measures + CAHPS for PQRS	The group practice must have all CAHPS for PQRS survey measures reported on its behalf via a CMS-certified survey vendor, and report at least 6 additional measures, outside of the CAHPS for PQRS survey, covering at least 2 of the NQS domains using the qualified registry. If less than 6 measures apply to the group practice, the group practice must report on each measure that is applicable to the group practice. Of the additional measures that must be reported in conjunction with reporting the CAHPS for PQRS survey measures, if any EP in the group practice sees at least 1 Medicare patient in a face-to-face encounter, the group practice must report on at least 1 measure in the PQRS cross-cutting measure set.
12-month (Jan 1-Dec 31, 2016)	2-99 EPs; 100+ EPs (if CAHPS for PQRS does not apply)	Direct EHR Product or EHR Data Submission Vendor Product	Individual Measures	Report 9 measures covering at least 3 domains. If the group practice's direct EHR product or EHR data submission vendor product does not contain patient data for at least 9 measures covering at least 3 domains, then the group practice must report all of the measures for which there is Medicare patient data. A group practice must report on at least 1 measure for which there is Medicare patient data.
12-month (Jan 1– Dec 31, 2016)	2+ EPs	Qualified Clinical Data Registry (QCDR)	Individual PQRS measures and/or non-PQRS measures reportable via a QCDR	Report at least 9 measures available for reporting under a QCDR covering at least 3 of the NQS domains, AND report each measure for at least 50% of the group practice's patients. Of these measures, the group practice would report on at least 2 outcome measures, OR, if 2 outcomes measures are not available, report on at least 1 outcome measures and at least 1 of the following types of measures – resource use, patient experience of care, efficiency/appropriate use, or patient safety.

Table 3: 2016 PQRS Measures Potentially Relevant to Neurosurgery

PQRS Measure #	Measure Title	Measure Description	Quality Domain	Reporting Option	Neurosurgical Subspecialty
9	**Anti-Depressant Medication Management**	Percentage of patients 18 years of age and older who were diagnosed with major depression and treated with antidepressant medication, and who remained on antidepressant medication treatment. Two rates are reported a. Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks). b. Percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).	Effective Clinical Care	EHR	General

PQRS Measure #	Measure Title	Measure Description	Quality Domain	Reporting Option	Neurosurgical Subspecialty
21	**Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin**	Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic, who had an order for a first OR second generation cephalosporin for antimicrobial prophylaxis	Patient Safety	Claims, Registry	General
22	**Discontinuation of Prophylactic Parenteral Antibiotics (Non-Cardiac Procedures)**	Percentage of non-cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics AND who received a prophylactic parenteral antibiotic, who have an order for discontinuation of prophylactic parenteral antibiotics within 24 hours of surgical end time	Patient Safety	Claims, Registry	General
23	**VTE Prophylaxis (When Indicated in ALL Patients)**	Percentage of surgical patients aged 18 years and older undergoing procedures for which VTE prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time	Patient Safety	Claims, Registry	General
46	**Medication Reconciliation Post Discharge**	Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and **seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented**	Patient Safety	Claims, Registry	General
47	**Care Plan**	Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan	Communication/ Care Coordination	Claims, Registry	General
48	**Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older**	Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months	Effective Clinical Care	Claims, Registry	General
50	**Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older**	Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence with a documented plan of care for urinary incontinence at least once within 12 months	Person and Caregiver-Centered Experience/ Outcomes	Claims, Registry	General

PQRS Measure #	Measure Title	Measure Description	Quality Domain	Reporting Option	Neurosurgical Subspecialty
109	**Osteoarthritis (OA): Function and Pain Assessment**	Percentage of patient visits for patients aged 21 years and older with a diagnosis of OA with assessment for function and pain	Person and Caregiver-Centered Experience/ Outcomes	Claims, Registry	General
110	**Preventive Care and Screening: Influenza Immunization**	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.	Community/ Population Health	Claims, Registry, EHR	General
111	**Pneumonia Vaccination Status for Older Adults**	Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.	Community/ Population Health	Claims, Registry, EHR	General
128	**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow- Up**	Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is **outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter.**	Community/ Population Health	Claims, Registry, EHR	General
130	**Documentation of Current Medications in the Medical Record**	Percentage of visits for patients aged 18 years and older for which the EP attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list ***must*** include ALL known prescriptions, over-the- counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND ***must*** contain the medications' name, dosage, frequency and route of administration	Patient Safety	Claims, Registry, EHR,	General
131	**Pain Assessment and Follow- Up**	Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow- up plan when pain is present	Community/ Population Health	Claims, Registry	General
134	**Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan**	Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen	Community/ Population Health	Claims, Registry, EHR	General
182	**Functional Outcome Assessment (PT only)**	Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies	Communication and Care Coordination	Claims, Registry	General
226	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention**	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months **AND who received cessation counseling intervention if identified as a tobacco user**	Community/ Population Health	Claims, Registry, EHR	General

PQRS Measure #	Measure Title	Measure Description	Quality Domain	Reporting Option	Neurosurgical Subspecialty
317	**Preventive Care and Screening: Screening for High Blood Pressure and Follow-up Documented**	Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented	Community/ Population Health	Claims, Registry, EHR	General
220	**Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Lumbar Spine Impairments**	Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the lumbar spine in which the **change in their Risk- Adjusted Functional Status is measured**	Communication and Care Coordination	Registry	Spine
223	**Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Neck, Cranium, Mandible, Thoracic Spine, Ribs, or Other General Orthopedic Impairments**	Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the neck, cranium, mandible, thoracic spine, ribs, or other general orthopedic impairment in which the change in their Risk-Adjusted Functional Status is measured	Communication/ Care Coordination	Registry	Spine
312	**Use of Imaging Studies for Low Back Pain**	Percentage of patients 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of diagnosis	Efficiency and Cost Reduction	EHR	Spine
265	**Biopsy Follow-Up**	Percentage of new patients whose biopsy results have been reviewed and communicated to the primary care/referring	Communication/ Care Coordination	Registry	Spine/Tumor
204	**Ischemic Vascular Disease [Stroke]: Use of Aspirin or Another Antithrombotic**	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period and who had documentation of use of aspirin or another antithrombotic during the measurement period	Effective Clinical Care	Claims, Registry, EHR	Vascular
260	**Rate of Carotid Endarterectomy (CEA) for Asymptomatic Patients, without Major Complications (Discharged to Home by Post-Operative Day 2)**	Percent of asymptomatic patients undergoing CEA who are discharged to home no later than post-operative day 2	Communication/ Care Coordination	Registry	Vascular

PQRS Measure #	Measure Title	Measure Description	Quality Domain	Reporting Option	Neurosurgical Subspecialty
344	**Rate of Carotid Artery Stenting (CAS) for Asymptomatic Patients, Without Major Complications (Discharged to Home by Post-Operative Day #2)**	Percent of asymptomatic patients undergoing CAS who are discharged to home no later than post- operative day #2	Effective Clinical Care	Registry	Vascular
345	**Rate of Postoperative Stroke or Death in Asymptomatic Patients Undergoing Carotid Artery Stenting (CAS)**	Percent of asymptomatic patients undergoing CAS who experience stroke or death following surgery while in the hospital	Effective Clinical Care	Registry	Vascular
346	**Rate of Postoperative Stroke or Death in Asymptomatic Patients Undergoing CEA**	Percent of asymptomatic patients undergoing CEA who experience stroke or death following surgery while in the hospital	Effective Clinical Care	Registry	Vascular