MSN HEALTHCARE SOLUTIONS
2357 Warm Springs Rd 4th Floor
Columbus, GA 31904
800-889-8610
706-653-1230 (Fax)

2025 MSN QCDR - Radiology
Provider Documentation Guide

No changes / minor changes

Major / measure specification changes

Measure #	Measure Description Denominator Type	Measure Requirements Summary	Documentation Requirements	Significant Change Notes
~~24~~ (HP)	**Communication with the Physician or Other Clinician Managing On-Going Care Post-Fracture for Men and Women Aged 50 Years and Older** ***(E&M Services and procedures where patient is dx with a non-osteoporotic fracture, such as Kyphoplasty, vertebroplasty)***	**Eligible Definition**: Patients 50 yrs. and older who experienced a fracture, except fractures of the finger, toe, face or skull (excludes hospice patients). **To Pass**: Document communication to the ordering provider, or the clinician managing the patient's on-going care, that a fracture occurred and that the patient was, or should be, tested or treated for osteoporosis.	**Provider must document in the Final Report their communication with the physician or other clinician managing the patient's on-going care that a fracture occurred and that the patient was or should be considered for osteoporosis testing or treatment.** **Example of Required Verbiage for MSN to code from a visit note:** "Recommend DEXA for bone density/. Communicated this recommendation to (insert clinician name) on (insert date & time)" "Recommend patient for osteoporosis evaluation/treatment. Communicated this recommendation to (insert clinician name) on (insert date & time)" **Required format for MSN to code from a charge ticket:** ☐ No Fracture present ☐ Fracture present and patient currently being treated for osteoporosis ☐ Fracture present and patient recommended for osteoporosis testing/treatment ☐ Fracture present, no mention of, or recommendation for, osteoporosis testing/treatment **If using pMD to document** - please work with MSN to program pMD correctly for this measure.	
~~47~~ (HP)	**Advance Care Plan** ***(IP & OP E&M Services)***	**Eligible Definition**: Patients 65 yrs. and older that had at least one visit during the calendar year (excludes hospice patients). **To Pass**: Document that you asked about Advance Care Plan or Surrogate Decision Maker and Document response. **Telehealth Note**: Telehealth Visits ARE INCLUDED in this measure (modifiers: GQ, GT, 95, POS 02). *Eligibility Note: This measure is applicable to all healthcare settings except the Emergency Department.*	**Provider must document in the patients medical record one of the following:** * Patient confirmed they have an Advance Care Plan and were/were not able to provide a copy, OR * Name of Surrogate Decision Maker, OR * Note in MR that patient was asked and does not wish to have an Advance Care Plan or Surrogate Decision Maker, OR * Patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning **Example of Required Verbiage for MSN to code from a visit note:** "Patient has named her husband, John Doe as her surrogate decision maker" "Patient verified s/he has an Advance Care Plan and a copy is on file" "Patient verified s/he has an Advance Care Plan, but did not have a copy available at the time of the visit" **Required format for MSN to code from a charge ticket:** Patient's Advance Care Plan and/or Surrogate Decision Maker (SDM) was… ☐ Obtained and available upon request ☐ NOT obtained – with appropriate reason documented ☐ Measure was not met **If using pMD to document** - please work with MSN to program pMD correctly for this measure.	
~~130~~ (HP)	**Documentation of Current Medications in the Medical Record** ***(IP & OP E&M Services)***	**Eligible Definition**: All patients that had at least one visit during the calendar year. **To Pass**: Document in the medical record that the patient's current medication(s) were obtained, updated, or reviewed at the time of the visit, OR Document patient was in an urgent/emergent medical situation where delay in treatment to do so would jeopardize the patient's health status on date of encounter.	The medication list in the medical record must include ALL known prescriptions, over-the-counters, herbals, vitamin/mineral/dietary (nutritional) supplements, and cannabis/cannabidiol products AND must contain the medications' name, dosages, frequency and route of administration. **Definitions:** **Current Medications** – Medications the patient is presently taking including all prescriptions, over-the- counters, herbals and vitamin/mineral/dietary (nutritional) supplements, and cannabis/cannabidiol products with each medication's name, dosage, frequency and administered *route* . **Route** – Documentation of the way the medication enters the body (some examples include but are not limited to: oral, sublingual, subcutaneous injections, and/or topical). **Example of Required Verbiage for MSN to code from a visit note:** "Patient's current medications were documented and reviewed at time of visit, including medication name, dosage, frequency, and route of administration." **Required format for MSN to code from a charge ticket:** M130– Patient's medication(s) was/were: ☐ Documented and reviewed at time of visit. ☐ NOT obtained, updated, or reviewed - with medical reason documented ☐ NOT obtained, updated or reviewed - no medical reason documented (measure not met) **If using pMD to document** - please work with MSN to program pMD correctly for this measure.	**Updated Denominator Criteria:** removed age criteria.

MSN HEALTHCARE SOLUTIONS
2357 Warm Springs Rd 4th Floor
Columbus, GA 31904
800-889-8610
706-653-1230 (Fax)

2025 MSN QCDR - Radiology Provider Documentation Guide

No changes / minor changes

Major / measure specification changes

Measure #	Measure Description Denominator Type	Measure Requirements Summary	Documentation Requirements	Significant Change Notes
145 (HP)	**Radiology: Exposure Dose Indices Reported for Procedures Using fluoroscopy** ***(Procedures and diagnostic studies that include a description of fluoroscopy in the CPT narrative)***	**Eligible Definition**: All Final Reports for procedures listed in the measure where Fluoro could have been used. **To Pass**: Document fluoro dose, including *radiation exposure indices* . **Radiation exposure indices** - For the purposes of this measure, "*radiation exposure indices* " should include at least one of the following: 1. Reference air kerma ($K_{a,r}$) in Gy or mGy 2. Kerma-area product (P_{KA}) or Dose area product (DAP) in uGy*m², mGy*cm² 3. Peak skin dose (PSD) in Gy or mGy CAUTION: TO ONLY DOCUMENT FLUORO TIME AND NUMBER OF IMAGES IS NOT SUFFICIENT TO PASS THIS MEASURE. YOU MUST DOCUMENT RADIATION EXPOSURE INDICES (AS DEFINED ABOVE).	**Provider must document in the Final Report the radiation exposure indices**, as defined to the left. *** Note:** When reporting indices, the report must clearly state what radiation quantity is being submitted. Only reporting dose in mGy is insufficient. PSD in mGy is very different from Ka,r in mGy. As an example, PSD = 10 mGy or Ka,r = 10 mGy would meet numerator performance, but "10 mGy" alone would not. In the case where the procedure is eligible for the measure (based on the CPT billed), but Fluoro was not used, be sure to document that Fluoro was not used. **Examples of proper documentation:** "Reference Air Kerma (Ka,r) = 2668 mGy" "DAP= 45 mGy*cm^2" "NO FLUORO WAS USED."	
~~226~~	**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention** ***(Two OP E&M Service Encounters)***	**THERE ARE THREE SUBMISSION CRITERIA FOR THIS MEASURE:** 1) All patients who were screened for tobacco use, AND 2) All patients who were identified as a tobacco user and who received tobacco cessation intervention, AND 3) All patients who were screened for tobacco use and, if identified as a tobacco user received tobacco cessation intervention, or identified as a tobacco non-user. **In the Portal you will see three measures**: **226.1, 226.2, and 226.3.** **Eligible Definition**: Patients **12 yrs. and older** with at least 2 visits or 1 preventative visit (excludes patients in hospice) during the performance year. **To Pass**: Provide Tobacco status AND if status is "yes" (aka: tobacco user), document that counseling was performed or pharmacologic intervention was made. **Telehealth Note**: Telehealth Visits ARE INCLUDED in this measure (modifiers: GQ, GT, 95, POS 02).	**Provider must document whether patient is/is not a tobacco user.** IF patient is identified as a tobacco user, provider must document that **tobacco cessation intervention** occurred (see Intervention definition below). CAUTION: REMEMBER THIS IS A TOBACCO-USE MEASURE, NOT A SMOKING MEASURE. THIS MEASURE APPLIES TO ALL TOBACCO PRODUCTS. ASKING IF THE PATIENT IS A SMOKER IS NOT ENOUGH. INSTEAD ASK IF THEY ARE A TOBACCO USER. **Tobacco Cessation Intervention Definition:** Includes brief counseling (3 minutes more or less), and/or record of a pharmaceutical to assist quitting tobacco (pharmacotherapy). Note: For the purpose of this measure, brief counseling (e.g., minimal and intensive advice/counseling interventions conducted both in person and over the phone) qualifies for the numerator; written self-help materials (e.g., brochures, pamphlets) and complementary/alternative therapies DO NOT. **Example of Required Verbiage for MSN to code from a visit note:** "TOBACCO USER = YES, AND APPROPRIATE INTERVENTION WAS PROVIDED TO PATIENT" "TOBACCO USER = NO" **Required format for MSN to code from a charge ticket:** M226 – Patient is: ☐ NOT a tobacco user ☐ A tobacco user - Patient counseled w/in previous 12 months and/or pharmacologic intervention documented ☐ Measure was not met **If using pMD to document** - please work with MSN to program pMD correctly for this measure.	
~~359~~ (HP) (Outcome)	**Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Infrarenal Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post Op. Day #2)** ***(Endovascular non-ruptured AAA repair)***	**Eligible Definition**: Patients 18 yrs. and older undergoing endovascular repair of small or moderate non-ruptured infrarenal abdominal aortic aneurysms (AAA). **To Pass**: Patient does not experience a major complication (discharged to home no later than post-operative day #2).	**Provider must document discharge date/time of patient and discharge disposition (i.e., home, SNF, Acute Rehab, etc.).** **The following patients are excluded from this measure:** * Women with Aortic aneurysm ≥ 5.5 cm maximum diameter on centerline formatted CT (or minor diameter on axial formatted CT) * Men with Aortic aneurysm ≥ 6.0 cm maximum diameter on centerline formatted CT (or minor diameter on axial formatted CT) **Definition:** **Home** – the point of origin prior to hospital admission prior to procedure of AAA. For example, if the patient comes from a skilled facility and returns to the skilled facility post AAA repair, this would meet criteria for discharged to home.	

MSN HEALTHCARE SOLUTIONS
2357 Warm Springs Rd 4th Floor
Columbus, GA 31904
800-889-8610
706-653-1230 (Fax)

2025 MSN QCDR - Radiology
Provider Documentation Guide

No changes / minor changes

Major / measure specification changes

Measure #	Measure Description Denominator Type	Measure Requirements Summary	Documentation Requirements	Significant Change Notes
~~317~~	**Preventative Care and Screening: Screening for High Blood Pressure and Follow-Up Documented** ***(OP and ER E&M Services and Observation)***	**Eligible Definition**: All patients 18 yrs. and older (on Jan 1) that had at least one visit during the calendar year (excludes patients who already have an active diagnosis of hypertension). **To Pass**: Document patient's Blood Pressure at the time of the visit AND if the BP is abnormal, refer patient back to PCP for management of BP. **Normal BP Reading**: < 120 / < 80 **Abnormal BP Reading**: Systolic OR Diastolic over normal range above. **Telehealth Note**: Telehealth Visits are NOT included in this measure (modifiers: GQ, GT, 95, POS 02).	**Provider must document blood pressure at the time of the visit.** - BP must be taken by a provider or their staff (self-reported readings do not count). - Multiple BP readings may be taken at the same visit. Lowest reading will be taken for this measure. *** Note Exceptions:** If patient's blood pressure was unable to be obtained for one of the reasons below, be sure to document this, because they are acceptable exceptions to this measure: • Patient refuses to participate (either BP measurement or follow-up) • Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status. This may include but is not limited to severely elevated BP when immediate medical treatment is indicated **Example of Required Verbiage for MSN to code from a visit note:** "Patient's BP was 120/75" "Patient's BP was 120/90, patient was referred to their PCP for management of their BP" "Patient refused to have blood pressure reading taken at time of visit" **Required format for MSN to code from a charge ticket:** M317- Patient's Blood Pressure (BP) is: ☐ NORMAL (<120 / <80) – [if either systolic or diastolic are over, the patient's BP is abnormal] ☐ ABNORMAL (>120 / >80) – with appropriate intervention taken ☐ Measure was not met **If using pMD to document** - please work with MSN to program pMD correctly for this measure.	
~~358~~ (HP) (Outcome)	**Unplanned Reoperation within the 30 Day Postoperative Period** ***(INVERSE)*** ***(Multiple surgical procedures)***	**Eligible Definition**: Patients 18 yrs. and older who had a surgery listed in denom of measure specification (through Nov 30). **To Pass**: Document no unplanned surgery was performed within a 30 day window post-op.	**Provider must document in the Medical Record how s/he obtained the information AND:** * That patient was re-operated on due to complications related to the initial procedures, OR * That patient did not require an unplanned return to the O.R. for complications of the principal operative procedure. CAUTION: REOPERATION INCLUDES IF THE PATIENT GOES TO A DIFFERENT FACILITY/PROVIDER FOR REOPERATION(S). *** Note:** If two attempts to contact the patient to confirm whether s/he had an unplanned reoperation are made, but no response was received, document and keep record of the dates and method in which patient was contacted and that no response was received. These instances will be considered Mets. If claiming a Met (moving to "Performance Met" in the Portal), be sure to have documentation in your records of the two (or more) failed attempts to reach the patient to confirm unplanned reoperation.	**Updated Denominator Criteria:** Added coding for fissurectomy, including sphincterotomy.
357 (HP) (Outcome)	**Surgical Site Infection (SSI)** ***(INVERSE)*** ***(Multiple surgical procedures)***	**Eligible Definition**: Patients 18 yrs. and older who had a surgery listed in denom of measure specification (through Nov 30). **To Pass**: Document no surgical site infection occurred within a 30 day window post-op.	**Provider must document in the Medical Record how s/he obtained the information AND:** * That patient had surgical site infection within 30 days of initial procedure, OR * That patient did NOT have a surgical site infection within 30 days following initial procedure. *** Note:** If two attempts to contact the patient to confirm whether s/he had a surgical site infection are made, but no response was received, document and keep record of the dates and method in which patient was contacted and that no response was received. These instances will be considered Mets. If claiming a Met (moving to "Performance Met" in the Portal), be sure to have documentation in your records of the two (or more) failed attempts to reach the patient to confirm SSI.	
~~360~~ (HP)	**Optimizing Patient Exposure to Ionizing Radiation: Count of Potential High Dose Radiation Imaging Studies: Computed Tomography (CT) and Cardiac Nuclear Medicine Studies** ***(CT and cardiac NM Studies including PET/CT SPECT)***	**Eligible Definition**: All final reports for patients, regardless of age, undergoing a CT procedure and/or cardiac nuclear medicine (myocardial perfusion study) imaging. **To Pass**: Denote "count" of all known previous CT and Cardiac Nuc Med studies performed on patient in the last 12 months. **Telehealth Note**: Telehealth Visits are NOT included in this measure (modifiers: GQ, GT, 95, POS 02).	**Provider must document in the Final Report (CT and Cardiac Nuc Med Reports) the count of all known CT and Cardiac Nuc Med studies (including CARDIAC PET) performed in the last 12 months.** * Provider must query the patient AND do a lookback in their own system(s) to obtain the number of CT and Cardiac Nuc Med studies the patient has received in the last 12 months. *** Note:** Even if you do not perform Cardiac Nuc Med studies, you must include them in your count (obtained from querying the patient). This measure requires you to count all CT AND Cardiac Nuc Med studies in the final report (not just CTs), regardless of whether you are the provider that performed them or not. **Examples of proper documentation:** "Count of known CT and Cardiac Nuclear Medicine Studies performed in previous 12 months = __5__" "1 CT and 0 cardiac nuc. med. studies performed in the past 12 months."	

MSN HEALTHCARE SOLUTIONS
2357 Warm Springs Rd 4th Floor
Columbus, GA 31904
800-889-8610
706-653-1230 (Fax)

2025 MSN QCDR - Radiology Provider Documentation Guide

No changes / minor changes

Major / measure specification changes

Measure #	Measure Description Denominator Type	Measure Requirements Summary	Documentation Requirements	Significant Change Notes
364 (HP)	**Optimizing Patient Exposure to Ionizing Radiation Appropriateness: Follow-up CT Imaging for Incidentally Detected Pulmonary Nodules According to Recommended Guidelines** ***(CT and CTA of various body areas including the neck, chest, abdomen and pelvis, spine)***	**Eligible Definition**: Patients 35 yrs. and older undergoing CT imaging studies with a finding of one ore more incidental pulmonary nodule(s) (excludes patients who are heavy tabacco smokers or with history of cancer* as well as characteristically benign findings**). **To Pass**: Document follow-up recommendations in Final Report that are in accordance w/ Fleischner criteria (or another industry accepted guidance) based on nodule size & patient risk factors (at a minimum), OR Document clinical reason(s) why recommendations differ from Fleischner recommendations. ** Except basal cell and squamous cell skin carcinoma* *** Excluded from measure - Granulomas, hamartomas or lesions with internal fat, or other characteristically benign findings are not considered incidental findings in the context or intent of this measure.*	**Include the following in the Final Report for MSN to identify eligible reports for this measure (i.e. CTs w/ incidental findings):** * Use the word "**incidental**" when an unexpected pulmonary nodule is present (helps coders identify eligible encounters). * Reference the specific **size of the nodule** (e.g. 3 mm). * State specific follow-up recommendations. If no follow-up is necessary based on referenced source criteria, then that must be noted in the report. * Make a note in the final report that the follow-up recommendations are in accordance with Fleischner or another industry accepted source. **Examples of proper documentation:** "Incidental note is made of a lung nodule measuring [size]. No additional follow up is necessary at this time for the incidental findings of lung nodule(s), based on the nodule size and patient's risk factor per Fleischner Society guidelines." "2 mm left upper lobe nodule. As per Fleischner Society guidelines for follow-up and management of pulmonary nodules less than 6 mm: For patients at low risk (minimal or absent history of smoking and of other known risk factors), no follow-up needed. For patients at high risk (history of smoking or of other known risk factors), consider follow-up chest CT at 12 months."	
405 (HP)	**Appropriate Follow-up Imaging for Incidental Abdominal Lesions** ***(CT, CTA, MRI and MRA of various body areas including the chest, abdomen and pelvis, spine)***	**Eligible Definition**: Patients 18 yrs. and older undergoing abdominal imaging studies w/ one or more of the following incidental abdominal lesions below: • Cystic kidney lesion (Renal) that is simple appearing (Bosniak I or II). • Adrenal lesion ≤ 1.0 cm • Adrenal lesion > 1.0 cm but < 4.0 cm classified as likely benign, or diagnostic benign by: - CT - Unenhanced CT/washout protocol - MRI w/ in-and opposed- phase sequences, or - Other equivalent institutional imaging protocols. **To Pass**: Document in Final Report that no follow-up imaging is recommended, OR Document medical reason(s) why follow-up imaging is indicated. CAUTION: PER CMS DECISION TO APPROVE QMM27, GROUPS/CLINICIANS THAT REPORT THIS MEASURE **CANNOT REPORT MEASURE QMM27**: APPROPRIATE CLASSIFICATION AND FOLLOW-UP IMAGING FOR INCIDENTAL PANCREATIC CYSTS.	**Include the following in the Final Report for MSN to identify eligible reports for this measure:** * Use the word "**Incidental**" when unexpected lesions are noted (helps coders identify eligible encounters). * For Adrenal Lesions: - Reference the specific **size of lesion** (e.g. < 0.5 cm). - If between 1-4 cm also document if lesion is classified as "**likely benign**" and the protocol followed to reach this conclusion. - Specifically state follow-up recommendations and clinical reasons supporting recommendation.** * For Renal Lesions: - Characterize the lesion. Any reference to "**simple appearing**" and/or Bosniak score of I or II is eligible for this measure. - Specifically state follow-up recommendations and clinical reasons supporting recommendation.** ** To meet the intent of the measure there should be no follow-up recommended OR if follow-up IS recommended you must state the clinical reason behind such recommendation to pass the measure. CAUTION: WHEN YOUR RECOMMENDATION IS "NO FOLLOW-UP IMAGING" YOU MUST SPECIFICALLY STATE THIS IN THE REPORT. YOU MAY NOT BE SILENT WHEN "NO FOLLOW-UP" IS YOUR RECOMMENDATION. **Example Documentation**: "There is an incidental note made of an adrenal lesion measuring 1 cm, recommend follow-up CT in 6 months due to {insert any clinical reason such as patient's history of cancer}." "Multiple simple cystic renal lesions classified as Bosniak I observed, no follow-up imaging recommended" "Noted a 3 cm adrenal lesion appearing likely benign on washout protocol CT, no follow-up imaging recommended"	
406 (HP)	**Appropriate Follow-up Imaging for Incidental Thyroid Nodules in Patients *(INVERSE)*** ***(CT, CTA, MRI and MRA of various body areas including the neck, chest)***	**Eligible Definition**: Patients 18 yrs. and older undergoing CT, CTA, MRI or MRA studies of the chest or neck w/ no known thyroid disease and w/ incidental thyroid nodule < 1.0 cm noted. **To Pass**: Document in Final Report that no follow-up imaging is recommended, OR Document medical reason(s) why follow-up imaging is indicated. *Note: CT and MRI of the sinus/orbit/face are also eligible for this measure if incidental thyroid nodules are noted in the report.*	**Include the following in the Final Report for MSN to identify eligible reports for this measure:** * Use the word "**Incidental**" when unexpected thyroid nodules are noted (helps coders identify eligible encounters). * Reference specific **size of thyroid nodule** (e.g. < 0.5cm). * Specifically state follow-up recommendations and clinical reasons supporting recommendation ** ** To meet the intent of the measure there should be no follow-up recommended OR if follow-up IS recommended you must state the clinical reason behind such recommendation to pass the measure. **Example Documentation:** "There is a benign appearing thyroid nodule measuring [less than 1.0 cm]. No follow up imaging required." "A 0.5 cm., incidental, thyroid nodule noted, recommend follow-up imaging in 6 months due to {insert clinical reason here}."	

MSN HEALTHCARE SOLUTIONS
2357 Warm Springs Rd 4th Floor
Columbus, GA 31904
800-889-8610
706-653-1230 (Fax)

2025 MSN QCDR - Radiology Provider Documentation Guide

No changes / minor changes
Major / measure specification changes

Measure #	Measure Description Denominator Type	Measure Requirements Summary	Documentation Requirements	Significant Change Notes
~~413~~ (HP) (Outcome)	**Door to Puncture Time for Endovascular Stroke Treatment** ***(endo. stroke treatment)***	**Eligible Definition**: All patients, regardless of age, with cerebrovascular accident (CVA) (diagnosis of ischemic stroke) undergoing endovascular stroke treatment (excludes patients with secondary stroke within 5 days of the initial procedure) **To Pass**: Document a door to puncture time of 90 minutes or less.	**Patients excluded from this measure include:** * Patients transferred from one institution to another with a known diagnosis of CVA for endovascular stroke treatment, OR * Hospitalized patients with newly diagnosed CVA considered for endovascular stroke treatment. Be sure to document if one of these instances applies. **Example of Proper Documentation:** "Door to puncture time = 46 minutes" "Date/Time of Arrival: 18:09 ; Arterial Puncture: 19:05 ."	**Added Denominator Exclusion** for patients with secondary stroke within 5 days of the initial procedure
~~420~~ (HP) (Outcome)	**Varicose Vein Treatment with Saphenous Ablation: Outcome Survey** ***(Saphenous vein ablation)***	**Eligible Definition**: All patients treated for varicose veins (CEAP C2-S) who are treated with saphenous ablation (with or without adjunctive tributary treatment). **To Pass**: Report an improvement on a disease specific patient reported outcome survey instrument before vs. 3-6 months after treatment.	**Provider must document patient survey results pre procedure and 3-6 months post procedure in patient's medical record.** *** Note:** If patient was contacted to be surveyed at least twice 3-6 months after procedure, but no response was received, document the dates, and method in which patient was contacted and that no response was received. These instances will be considered Exceptions. **Outcome Survey Defined** – A normalized and validated outcome survey developed for the patient reported outcomes for saphenous vein ablation. The disease specific standardized outcome survey utilized must be documented in the medical record. Examples of outcome surveys include, but are not limited to: • Venous Insufficiency Epidemiological and Economic Study-Quality of Life (VEINES-QOL) • Chronic Venous Insufficiency Questionnaire (CIVIQ) • Aberdeen Varicose Veins Questionnaire (AVVQ) • Specific Quality of Life and Outcome Response - Venous (SQOR-V) • Varicose Veins Symptom Questionnaire (VVSymQ) • Venous Clinical Severity Score (VCSS) If claiming an Exception (moving to "E" in the Portal), be sure to have documentation in your records of the two (or more) failed attempts to reach the patient for follow-up survey results.	**Added New survey options**
421	**Appropriate Assessment of Retrievable Inferior Vena Cava (IVC) Filters for Removal** ***(IVC placement)***	**Eligible Definition**: All patients who have a retrievable IVC filter placed through Sept 30 with the intent for potential removal at time of placement. **To Pass**: Remove filter, assess patient for removal, OR contact patient twice within 3 months after placement.	**Document one of the following in the patient's record:** * Patient passed away within the 90 day post-op period, OR * Filter was a permanent filter, not a temporary one - this will make it clear to an auditor that the encounter is not eligible for this measure (as it only applies to temporary IVC Filters), OR * Patient had filter removed within the 90 day post-op period, OR * Patient was assessed for removal of temporary filter and include date of assessment and who performed, OR * Patient was contacted at least twice to schedule an assessment and they never responded. If you are sending reminder letters to patients, be sure to document when correspondence was sent. Maintain a copy of letters sent.	
465 (HP)	**Uterine Artery Embolization Technique: Documentation of Angiographic Endpoints and Interrogation of Ovarian Arteries** ***(IR)***	**Eligible Definition:** All final reports for female patients, regardless of age, undergoing uterine artery embolization for symptomatic leiomyomas and/or adenomyosis **To Pass:** Embolization endpoints are documented separately for each embolized vessel AND ovarian artery angiography or embolization performed in the presence of variant uterine artery anatomy. *Note: MSN has structured reports from Society of Interventional Radiology (SIR); copy of structured report is available upon request.*	**Provider must document embolization endpoints separately for each embolized vessel AND embolization strategies in the presence of unilateral or bilateral absent uterine arteries.** **Embolization Endpoints –** • Complete stasis (static contrast column for at least 5 heartbeats) • Near-stasis (not static, but contrast visible for at least 5 heartbeats) • Slowed flow (contrast visible for fewer than 5 heartbeats) • Normal velocity flow with pruning of distal vasculature • Other [specify] **Variant uterine artery anatomy – Treatment strategy:** • Not applicable – Normal uterine artery anatomy • Ovarian artery angiography • Ovarian artery embolization • Abdominal aortic angiography • No additional angiography or embolization performed (performance not met if there is presence of variant uterine artery anatomy)	

MSN HEALTHCARE SOLUTIONS
2357 Warm Springs Rd 4th Floor
Columbus, GA 31904
800-889-8610
706-653-1230 (Fax)

2025 MSN QCDR - Radiology Provider Documentation Guide

No changes / minor changes
Major / measure specification changes

Measure #	Measure Description Denominator Type	Measure Requirements Summary	Documentation Requirements	Significant Change Notes
~~187~~ (HH)	**Screening for Social Drivers of Health** ***(Nuc Med and OP E&M Services)***	**Eligible Definition**: Patients 18 yrs. and older on the date of visit. **To Pass**: Document that patient has been screened for ALL the social risks listed below, on the date of admission: a. Food insecurity b. Housing instability c. Transportation needs d. Utility needs e. Interpersonal violence **Telehealth Note:** Telehealth Visits ARE INCLUDED in this measure (modifiers: GQ, GT, 95, POS 02).	**Document in the Final Report that patient was screened for food insecurity, housing instability, transportation needs, utility needs, interpersonal violence using a standardized health-related social needs (HRSN) screening tool, OR Document a patient reason for not screening (e.g., patient declined).** *** Note:** Patient must be screened for all five social risks to meet the measure. Measure is reported once per patient per reporting year, so such a screening only needs to be completed once per year, (even if you see the patient multiple times in the same year). **Example of Proper Documentation:** "PATIENT WAS SCREENED FOR THE FOLLOWING SOCIAL DRVERS OF HEALTH USING THE WELLRX QUESTIONNAIRE: FOOD INSECURITY, HOUSING INSTABILITY, TRANSPORTATION NEEDS, UTILITY NEEDS, AND INTERPERSONAL VIOLENCE." **Published Screening Tools:** AAFP Social Needs Screening Tool: https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/hops19-physician-form-sdoh.pdf PREPARE: https://prapare.org/wp-content/uploads/2021/10/PRAPARE-English.pdf PRAPARE (multi-language translated options): https://prapare.org/the-prapare-screening-tool/ WellRx Toolkit: https://www.jabfm.org/content/29/3/414 CMS's AHC HRSN: https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf Additional Published Screening Tools: https://sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison	
~~413~~	**Adult Immunization Status** ***(OP E&M Service)***	**Eligible Definition:** Patients 19 yrs. and older on the date of visit.* ** Eligibility Note: This measure is reported once per performance year.* **To Pass:** Document month/year that patient received each applicable vaccine: * Influenza vaccine (patients 19 yrs. and older) between 7/1/23 - 6/30/24 * Tetanus/diphtheria/pertussis (patients 19 yrs. and older) between 1/1/15 - 12/31/24 * Herpes Zoster (patients 50 yrs. and older) on or after patient's 50th birthday * Pneumococcal vaccine (patients 66 yrs. and older) on or after patient's 19th birthday **Telehealth Note:** Telehealth Visits ARE INCLUDED in this measure (modifiers: GQ, GT, 95, POS 02).	**Provider must document in the patient's medical record the date the patient received each applicable vaccine (applicability is based on patient's age), OR Document medical reason why patient did not receive vaccine.** This measure is calculated with 4 performance rates, one for each applicable vaccine* *** Note:** Submission of the 4 performance rates to CMS is required for this measure. A weighted average, which is the sum of the performance numerator values divided by the sum of performance denominator values, will be used for performance. **Examples of proper documentation:** "Flu vaccine administered December 2023, Tdap administered March 2016" (patient is 40) "Influenza vaccine received Feb 2024, Td received Dec 2021, Herpes Zoster recombinant vaccine received 2012, Pneumonia vaccine received Jan 2022" (patient is age 66) ****** "Flu vaccine not received due to allergy, Tdap received in 2019" (patient is 27) ****** **** Note:** If the month of administration is unknown, but it can be determined the vaccine was received within the timeframe defined in the measure specification, this will count as "Met".	**Updated Submission Criteria 4 Numerator Criteria:** Pneumococcal vaccine minimum age lowered to 19 years of age.
~~494~~ (Outcome) **NEW IN 2025**	**Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Clinician Level)**	**Eligible Definition:** Patients aged 18 years and older at the start of the measurement period that have an eligible CT scan with Dose and Image Quality Category performed during the measurement period. Electronic capture of CT/CTA radiation dose. **MSN does not code this measure. It is an eCQM measure.Electronic data files will need to be sent to MSN to track this measure in 2025.** **NOTE: This measure requires the use of additional software to access primary data elements stored within radiology electronic health records and translate them into data elements that can be ingested by this eCQM. There is no cost for the ALARA software.**	This measure provides a standardized method for monitoring the performance of diagnostic CT to discourage unnecessarily high radiation doses, a risk factor for cancer, while preserving image quality. It is expressed as a percentage of patients with CT exams that are out-of-range based on having either excessive radiation dose or inadequate image quality relative to evidence-based thresholds based on the clinical indication for the exam. Specific data elements must be captured and translated thru ALARA software. Measure resources: **ALARA Imaging, Inc. (measure steward)**: https://www.alaragateway.com/ **Measure speicifcations:** https://ecqi.healthit.gov/ecqm/ec/2025/cms1056v2?qt-tabs_measure=measure-information	**NEW in 2025**

MSN HEALTHCARE SOLUTIONS
2357 Warm Springs Rd 4th Floor
Columbus, GA 31904
800-889-8610
706-653-1230 (Fax)

2025 MSN QCDR - Radiology Provider Documentation Guide

No changes / minor changes
Major / measure specification changes

Measure #	Measure Description Denominator Type	Measure Requirements Summary	Documentation Requirements	Significant Change Notes
ACRAD36 (HP)	**Incidental Coronary Artery Calcification Reported on Chest CT** ***(Non-contrast or w/wo Contrast CT of the Chest)***	**Eligible Definition**: Male patients 18-50 yrs. old and Female patients 18-65 yrs. old undergoing noncardiac chest CT exams, regardless of contrast usage (excludes patients who have received prior CABG or prior PCI w/ stent). **To Pass**: Document the presence or absence of coronary artery calcification, OR Document if not evaluable.	**Provider must document in the Final Report the presence or absence of coronary artery calcification.** If patient cannot be evaluated for presence of CAC, document such in report, stating reason why. **Examples of proper documentation:** "No coronary artery calcification noted" "Coronary Calcium Composite Agatston Score: 120." "Presence of coronary artery calcification cannot be determined due to <list reason(s)>" "Minimal calcification noted in the LAD"	
~~**ACRAD37**~~ (HP)	**Interpretation of CT Pulmonary Angiography (CTPA) for Pulmonary Embolism** ***(CTPA w/ finding of PE)***	**Eligible Definition**: Patients 18 yrs. and older undergoing CT pulmonary angiography (CTPA) with a finding of PE. **To Pass**: Specify the branching order level of the most proximal level of embolus (i.e., main, lobar, interlobar, segmental, subsegmental).	**Provider must document in the Final Report the branching order level of the most proximal level of embolus (i.e., main, lobar, interlobar, segmental, subsegmental) OR the numerical designation of the most proximal branch (i.e., first order branch, second order, third order, fourth order, etc.).** **Example of proper documentation:** "Main pulmonary artery normal in size. Study positive for segmental, subsegmental and to lesser degree lobar PE." "Central pulmonary emboli on the right in the first and second order branches."	
~~**ACRAD41**~~ (HP)	**Use of Quantitative Criteria for Oncologic FDG PET Imaging** ***(fluorodeoxyglucose (FDG)-PET)***	**Eligible Definition**: All patients, regardless of age, undergoing non-CNS oncologic FDG PET studies. **To Pass**: Document the four minimum key elements within the report (see detail to the right).	**Provider must document in the Final report ALL of the following key elements:** a. **Serum glucose** (eg, finger stick at time of injection) b. **Uptake time** (interval from injection to initiation of imaging) c. One **reference background standardized-uptake-value (SUV)** measurement (e.g., volumetric normal liver or mediastinal blood pool), along with description of the SUV measurement type (eg, SUVmax) and normalization method (eg, BMI) d. At least one **lesional SUV** measurement OR diagnosis of "no disease-specific abnormal uptake" **Examples of proper documentation:** "Serum glucose at time of study was measured at 135. The uptake time was an hour and twelve minutes; SUV_{BW} was 1.53. The SUV of the nodule in the right upper lobe is 4.0." "Serum glucose 90, uptake 90 minutes, SUV using BMI = 2.5, pleural lesion measuring 1.2 cm x 0.5 cm. SUV of 5.5." "Glucose = 120; imaging began 60 minutes after injection; SUVmax of the liver = 3.1; no disease-specific abnormal uptake."	
~~**Medtax55**~~	**Use of ASPECTS (Alberta Stroke Program Early CT Score) for Non-Contrast CT Head Performed for Suspected Acute Stroke** ***(Non-contrast Head CT)***	**Eligible Definition**: All patients, regardless of age, undergoing a Non-Contrast CT Head (NCCT) for suspected acute stroke (excludes patients with acute homorrhage). **To Pass**: Document ASPECTS value in the Final Report.	**Provider must document ASPECTS value in the Final Report.** Terminology in the report must include one or more of the following: * Alberta Stroke Protocol Early CT Score * ASPECTS * ASPECT Score **Examples of proper documentation:** "ASPECTS (Alberta Stroke Program Early CT Score) is 10" "ASPECT Score = no acute abnormalities noted"	
MSN13	**Screening Coronary Calcium Scoring for Cardiovascular Risk Assessment Including Coronary Artery Calcification Regional Distribution Scoring** ***(Calcium scoring)***	**Eligible Definition:** Patients, regardless of age, undergoing Coronary Calcium Scoring who have measurable coronary artery calcification (CAC) (CT for Calcium Scoring).* ** Eligibility Note: Encounters billed under a contract are NOT eligible for this measure (i.e., only encounters billed directly to insurance by your practice are eligible).* **To Pass**: Report regional CACS in the Left Main, LAD, LCx, RCA, and PDA in the Final Report along with total CACS score, **AND** reference whether the regional distribution/total CACS DOES or DOES NOT warrant further evaluation. **EXCLUSIONS: Exam performed for sole purpose of assessing aortic valve OR exam performed for surgical/pre-op clearance. MUST BE CLEARLY STATED.**	**Provider must document ALL of the following in the Final Report:** 1. Total CACS, AND 2. Regional CACS in ALL of the following regions: Left Main, LAD, LCx, RCA, and PDA, AND 3. Reference to whether the regional distribution/total CACS DOES or DOES NOT warrant further evaluation A report stating only TOTAL CACS or stating the CACS for only a few of the regions listed above, but not all, will fail this measure. *** Note:** Regional scores may not combine more than two regions. For instance, "Total CACS = 12. Left Main = 0, RCA&PDA = 2, PDA = 0, LAD = 0, LCx = 10" is considered acceptable. However, "Total CACS = 12. RCA = 0, PDA = 0, LAD & LCx & Left Main = 12" is NOT acceptable as the score combines > 2 regions. **Examples of proper documentation:** "CORONARY CALCIUM COMPOSITE AGATSTON SCORE: 374. Left Main: 121. LAD: 30. LCX: 21. RCA: 202. PDA: 0. SUBSTANTIAL L MAIN CALCIFICATION WARRANTS FURTHER EVALUATION." "CORONARY ARTERY SCORE, Left Main Artery (LMA) 0, Left Anterior Descending (LAD) 56, Left Circumflex (LCX) 10, Right Coronary (RCA) 16, Posterior Descending Artery (PDA) 0, TOTAL 82. Regional Distribution does not warrant additional evaluation."	**Minor change (exclusions):** Exam for sole purpose of assessing aortic valve OR performed for surgical/pre-op clearance

MSN HEALTHCARE SOLUTIONS
2357 Warm Springs Rd 4th Floor
Columbus, GA 31904
800-889-8610
706-653-1230 (Fax)

Last Updated 11/14/24

2025 MSN QCDR - Radiology Provider Documentation Guide

No changes / minor changes

Major / measure specification changes

Measure #	Measure Description Denominator Type	Measure Requirements Summary	Documentation Requirements	Significant Change Notes
MSN15 (HP)	**Use of Thyroid Imaging Reporting and Data System (TI-RADS) in Final Report to Stratify Thyroid Nodule Risk** ***(Thyroid US)***	**Eligible Definition**: Patients 19 yrs. and older undergoing **ultrasound of the neck** with findings of thyroid nodule(s). **To Pass**: Document TI-RADS score and provide follow-up recommendations based on appropriate scoring and treatment protocols per TI-RADS in Final Report. *Eligibility Note: soft tissue US of the neck are also eligible for this measure if thyorid nodules are noted in the report.*	**Provider must document in the Final Ultrasound Report use of TI-RADS, including score and recommendations.** *** Note Exceptions:** Patients with co-morbidities, with extremely shortened life span and/or patients with a history of thyroid cancer, and/or patients with multiple small nodules which do not meet assessment criteria for TI-RADS assignment, patient scheduled for FNA which was not performed, F/U nodule with TI-RADS score with no significant change noted are excluded from this measure; so if TI-RADS was not utilized, be sure to document these diagnosis in the Final Report so it will not harm your performance rate for this measure. **Helpful Resource on TI-RADs: https://www.acr.org/-/media/ACR/Files/RADS/TI-RADS/TI-RADS-Alternative-chart.pdf** **Examples of proper documentation:** "TI-RADS Score: TR 4 (4-6 points), Moderately suspicious. FNA if > 1.5 cm. Follow if > 1 cm. Reference: ACR Thyroid Imaging, Reporting and Data System (TI-RADS): White Paper of the ACR TI-RADS Committee. J AM Coll Radiol 2017;14:587-595. (additional recommendations based on American Thyroid Association 2015 guidelines.)" "Patient has a history of thyroid cancer" "Simple cyst noted, TI-RADS Score: TR 1, no further imaging necessary" "1.6 cm. thyroid nodule TI-RADS 4. Fine needle aspiration is recommended if not previously performed. If fine needle aspiration has been previously performed, recommend further follow up or repeat fine needle aspiration as clinically indicated."	**Minor change (Denominator Exception):** Patient scheduled for fine needle aspriation (FNA) which could not be performed OR Follow-up nodule with TI-RADS score and no significant change noted
~~QNM16~~ (HP)	**IVC Filter Management Confirmation** ***(X-ray, CT and CTA of the abdomen/pelvis)***	**Eligible Definition**: Patients, regardless of age, with an IVC filter visible on an XR, CT, and CTA of the abdomen and/or pelvis.* ** Eligibility Note: You must document the presence of an IVC filter each time you see one on an XR, CT or CTA to report this measure.* **To Pass:** Include a statement in the Impression of the Final Report reminding the ordering provider that the patient has an IVC filter and that all patients with IVC filters should have a management plan in place. *Note: This measure does not require you to verify if the patient has an active management care plan for their IVC filter, only to make the recommendation to the ordering provider.*	**For patients with an IVC filter visible:** * Document presence of an IVC filter, AND * Include a recommendation statement that reminds the ordering provider to ensure there is a management care plan in place for the patient's IVC and if one is not in place, to refer the patient to a relevant specialist on a nonemergent basis for evaluation and establishment of an IVC Filter management care plan*****, OR Document medical reason why recommendation statement was not provided (e.g. limited life expectancy)****** *** Note 1:** Both must be documented in the **IMPRESSION** of the Final Report. If NOT documented in the Impression, the encounter will fail this measure. *** Note 2:** For inpatients receiving multiple imaging studies during their inpatient stay, it is acceptable for the radiologist to document on each subsequent study a reference back to the initial study dated xx/xx/xxxx for the statement recommendation on IVC management. **** Note 3: Studies ordered for the purpose of monitoring an IVC will now be treated as an Exception** and will not impact your performance on this measure. **Examples of proper documentation:** "IVC filter present on image. It is recommended that all patients with IVC filters in place have an active management care plan to monitor their IVC filter. If a care plan is not in place, it is recommended this patient be referred to a vascular specialist for evaluation and establishment of an IVC filter management care plan." "Patient has IVC filter, as visible on image. It is recommended that ordering provider: 1) Assess if there is a management plan in place for the patient's IVC filter, and if such a plan does not exist, 2) Refer the patient to an interventional clinician on a nonemergent basis for evaluation and establishment of a management care plan to monitor their IVC Filter." "Patient has an IVC filter. Refer to initial CT report dated 2/3/2024 for IVC management recommendations."	**Minor change:** If there is no established management plan, refer the patient to a RELEVANT specialist

MSN HEALTHCARE SOLUTIONS
2357 Warm Springs Rd 4th Floor
Columbus, GA 31904
800-889-8610
706-653-1230 (Fax)

2025 MSN QCDR - Radiology Provider Documentation Guide

No changes / minor changes

Major / measure specification changes

Measure #	Measure Description Denominator Type	Measure Requirements Summary	Documentation Requirements	Significant Change Notes
~~QMM17~~ (HP)	**Appropriate Follow-up Recommendations for Ovarian-Adnexal Lesions using the Ovarian-Adnexal Reporting and Data System (O-RADS)** ***(Non-OB transvaginal US)***	**Eligible Definition**: Female patients, regardless of age, undergoing NON-OB US examination of the pelvis performed transvaginal, with/without a transabdominal portion, that have a clinically relevant lesion (excludes nabothian or uterine cysts). **To Pass**: Document identification of clinically relevant lesion using appropriate O-RADS terminology, provide O-RADS score, AND provide subsequent recommendation of clinical management according to O-RADS criteria. *Eligibility Note: ONLY CPT 76830 NON OB TV US is eligible for this measure.*	**Provider must document the following in the Final Ultrasound Report when an ovarian/adnexal lesion is present:** * The clinical relevant lesion(s) using appropriate O-RADS terminology AND * A recommendation of clinical management according to O-RADS criteria. **Helpful Resource on O-RADs**: **https://www.acr.org/Clinical-Resources/Reporting-and-Data-Systems/O-Rads** * When referencing the O-RADS criteria, the radiologist must include **O-RADS score**, **appropriate lexicon descriptors**, and **appropriate premenopausal or postmenopausal management** for the patient. * If a patient's recommendation is "N/A" or "None" according to the O-RADS criteria, the radiologist should state "No imaging follow-up required" in the Final Report. * **Note Exception:** If there is a medical reason why O-RADs was not provided, document medical reason(s) for not documenting O-RADS score (such as, patients with a limited life expectancy, or if the cyst has ruptured). **Examples of proper documentation:** "Right ovarian simple-appearing cyst measuring 5.4 cm. O-RADS 2: Follow-up recommended in 8-12 weeks" (pre-menopausal patient) "Note a non-simple, unilocular ovarian cyst measuring 2.5 cm. in size with smooth inner margin = O-RAD 3. No follow-up necessary if patient is premenopausal. If patient is menopausal or postmenopausal, recommend a follow-up ultrasound in one year to monitor"	
QMM18 (HP)	**Use of Breast Cancer Risk Score on Mammography** ***(Screening mammography)***	**Eligible Definition**: All female patients, regardless of age, receiving a screening mammogram for malignant neoplasm of breast. **To Pass**: Document calculated cancer risk assessment number based on validated and published model AND appropriate recommendation(s) for supplemental screening based on patient's risk.	**Provider must document all of the following In the Final Mammography Report:** * Calculated risk assessment number based on one of the validated and published models ** AND * Appropriate recommendation(s) for supplemental screening based on the patient's estimated risk AND * Source of recommendation (Tyrer-Cuzick, Modified Gail, etc.). ** **Acceptable models include:** Tyrer-Cuzick (IBIS tool), Modified Gail, BRCAPRO, Breast Cancer Surveillance Consortium (BCSC), National Cancer Institute's Breast Cancer Risk Assessment Tool, Claus Model, or Myriad (myRisk Management Tool). * **Note Exception:** If there is a patient reason why a cancer risk score is not provided, document medical reason(s) for not providing (such as patient's limited-life expectancy, patient is outside the age parameters used by the validated/published breast cancer risk tool, etc.). **Please note your equipment's inability to calculate a cancer risk score is NOT a valid exception.** **Examples of proper documentation:** "Tyrer-Cuzick 10-year risk score of breast cancer is 3.4%, Lifetime risk is 10%. Recommend supplemental screening each year" "Breast cancer risk per Modified Gail is 17%. There are no consensus recommendations for additional screening in intermediate risk patients. (15-20% lifetime risk). Patients should use shared decision-making with their providers to decide on additional imaging such as screening breast ultrasound and MRI. These additional studies may not be covered by health insurance." "Patient's age exceeds the age parameters used by the Tyrer-Cuzick cancer risk assessment tool"	
~~QMM19~~	**DEXA/DXA and Fracture Risk Assessment for Patients with Osteopenia** ***(DXA studies)***	**Eligible Definition**: All patients, 40-90 yrs. old at the time of service, with diagnosis of osteopenia, receiving a DEXA scan. **To Pass**: Document the FRAX score in the physician's dictated Final Report **AND** a statement of whether patient meets criteria for pharmacologic treatment to prevent osteoporosis. *Note: This measure does not require you to recommend pharmacologic treatment, only to state whether the FRAX score falls within/outside of criteria for pharmacological treatment for prevention of osteoporosis per published guidelines.*	**Provider must document the patient's 10-year Fracture Risk (FRAX score) and provide insight as to whether the FRAX score falls into/outside of the range of when to consider pharmacologic intervention based on published guidelines in the physician's dictated Final Report.** ** ** **Note: FRAX score MUST be documented in the physician's dictated Final Report.** Including this value in the system-generated report only is not sufficient to meet the requirements of this measure. Also you must mention the published guidelines references for consideration of pharmacologic intervention for the prevention of osteoporosis. * **Note Exception:** If there is a patient reason why a FRAX score is not provided, document reason(s) for not providing (such as patient's refusal to cooperate, diagnosis of osteoporosis, bi-lateral hip replacements, etc.) AND include the FRAX risk tool used by your institution/equipment. **Examples of proper documentation:** "10-year Probability of Major Osteoporotic Fracture: 10.2%. 10-year Probability of Hip Fracture: 1.5%. Based on the FRAX score, the patient does not meet the criteria established by the Bone Health and Osteoporosis Foundation (or other cited source) for pharmacologic intervention, but pharmacological treatment may be considered." "10 year-Fracture Risk Score is 4.2%, which falls within the guidelines set by [cite source] when considering pharmacological treatment to prevent osteoporosis." "FRAX results demonstrate a 10 year probability of major osteoporotic fracture of 4.8%, and hip fracture of 0.6%. Patient's FRAX scores do not exceed the threshold stated in the pharmacological-treatment recommendations for prevention of osteoporosis per BHOF Guidelines."	**Minor change (Denominator Exception):** Added "diagnosis of osteoporosis"

MSN HEALTHCARE SOLUTIONS
2357 Warm Springs Rd 4th Floor
Columbus, GA 31904
800-889-8610
706-653-1230 (Fax)

2025 MSN QCDR - Radiology Provider Documentation Guide

No changes / minor changes

Major / measure specification changes

Measure #	Measure Description Denominator Type	Measure Requirements Summary	Documentation Requirements	Significant Change Notes
QMM23 (HP)	**Low Dose Cancer Screening Recommendation for CT of Chest with Diagnosis of Emphysema**	**Eligible Definition**: Emphysema patients 50-77 yrs. old at time of service undergoing CT/CTA of the chest (excludes patients with active diagnosis or history of lung cancer, OR Patients enrolled in a lung cancer screening program). **To Pass**: Document in the Final Report a recommendation to consider the patient for low dose CT (LDCT) lung cancer screening in the future **AND** mention that the presence of pulmonary emphysema on CT is an independent risk factor for lung cancer. *Note: This measure does not require you to recommend additional imaging, only to recommend the patient be evaluated/considered for entry into a low dose lung cancer screening program in the future (with the current chest CT serving as a baseline).*	**Final Report must include ALL the following:** 1. Diagnosis of emphysema, AND 2. Recommendation to evaluate patient for entry into low dose cancer screening protocol in the future, AND 3. Statement that the presence of pulmonary emphysema on CT is an independent risk factor for lung cancer *Note Exception: Documentation of clinical reason for not recommending patient be evaluated for LDLC screening (ex. finding of pulmonary nodule or lung mass; documentation that patient currently receives chest CT scans on a routine basis). **Examples of proper documentation:** "Emphysematic changes noted. Pulmonary emphysema is an independent risk factor for lung cancer. Recommend patient be evaluated for low dose cancer screening protocol." "Emphysema on CT is an independent risk factor for lung cancer. Low dose cancer screening should be considered in the future, if patient not already enrolled." "Patient currently receives routing chest CTs for (state reason). If patient no longer meets criteria for routine follow-up for recurrence of pre-existing cancer in the future, then patient should be considered for low dose CT lung cancer screening as emphysema on CT is an independent risk factor for lung cancer. However, routine lung cancer screening should not supersede pre-existing cancer surveillance." (patient with cancer other than lung cancer)	**Minor change (Denominator Exception):** Documented finding of lung mass or pulmonary nodule OR documentation that patient currently receives chest CT scans on a routine basis
QMM24 (HP)	**Acute Rib Fracture Numbering on ED Trauma Patients**	**Eligible Definition**: All patients, regardless of age, who undergo a CT/CTA of the chest in the Emergency Department, with acute rib fracture(s). **To Pass:** Document rib fracture numbering, laterality of rib fracture(s), AND the presence or absence of ribs fractured in two or more places.	**Provider must document ALL of the following in the Final Report:** 1. Rib fracture numbering, AND 2. Laterality of rib fracture(s), AND 3. Presence or absence of ribs fractured in two or more places (i.e., of those ribs fractured, identify ribs with multiple vs. single fractures). *** Note Exception:** Documentation of a patient reason why final report does not include all requirements listed above (e.g., patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status). **Examples of proper documentation:** "There is a nondisplaced fracture of the left 7th rib, anteriorly" (interpreted as a single fracture) "There are acute fractures of the left anterior and posterior 7th and 8th ribs" (interpreted as multiple fractures per rib) "There is acute fracture of the right 2nd through 5th ribs" (interpreted as single fractures per rib) "Acute displaced and overriding segmental fracture of the right anterior lateral fourth rib" (interpreted as multiple fractures per rib) "Comminuted fracture of the right 5th rib" (interpreted as multiple fractures per rib) "There are nondisplaced left rib fractures to the 4th through 8th ribs, anteriorly, with single fracture sites to each" (interpreted as single fractures per rib)	
QMM26 (HP)	**Screening Abdominal Aortic Aneurysm Reporting with Recommendations** ***(AAA screening US)***	**Eligible Definition:** Patients 50 yrs. and older undergoing a screening US for abdominal aortic aneurysm (AAA).* ** Eligibility Note: encounters billed under a contract are NOT eligible for this measure (i.e., only encounters billed directly to insurance by your practice are eligible).* **To Pass**: Document recommendation for follow-up of AAA (or recommendation of "no follow-up") according to recognized clinical guidelines **if positive for AAA** AND direct communication made to the ordering provider for **AAA ≥ 5.5 cm in size**, OR Document a clear statement that no future screenings are necessary/recommended **if negative for AAA**. *Note: Previously MSN16 with substantial changes made in 2024 (i.e., screening US that are negative for AAA are now included in the Eligible Definition).*	**For ALL Positive AAA findings**, provider must document appropriate follow-up recommendations (or recommendation of "no follow-up") in accordance with recognized clinical guidelines, such as "The Society for Vascular Surgery Practice guidelines on the care of patients with an abdominal aortic aneurysm", and cite the source of the guidelines in the Final Report. **IF the AAA finding ≥ 5.5 cm in size, direct communication of AAA findings and recommendation must also be made to the ordering provider and documented in the Final Report.** **For ALL Negative AAA screenings**, provider must document in the Final report a clear statement that no future screenings are necessary/recommended. **SVS guidelines on AAA can be found online: www.jvascsurg.org/article/S0741-5214(17)32369-8/fulltext** **Examples of proper documentation:** "AAA measuring 3.1 cm. noted....Recommend Ultrasound follow-up in 3 years per Society for Vascular Surgery guidelines on AAA." "AAA measuring 5.6 cm. noted...Recommend referral to a vascular surgeon per Society for Vascular Surgery. Finding and recommended referral communicated to the ordering provider on 1/23/25." "Negative for AAA...No future US AAA screenings are necessary/recommended."	

MSN HEALTHCARE SOLUTIONS
2357 Warm Springs Rd 4th Floor
Columbus, GA 31904
800-889-8610
706-653-1230 (Fax)

2025 MSN QCDR - Radiology Provider Documentation Guide

No changes / minor changes
Major / measure specification changes

Measure #	Measure Description Denominator Type	Measure Requirements Summary	Documentation Requirements	Significant Change Notes
QMM27 (HP)	**Appropriate Classification and Follow-up Imaging for Incidental Pancreatic Cysts** ***(CT, CTA, MRI and MRA of the abdomen/pelvis)***	**Eligible Definition:** Patients 18 yrs. and older undergoing CT, CTA, MRI or MRA studies of the abdomen or abdomen/pelvis w/ incidental pancreatic cyst noted. **To Pass**: Document in the Final Report the cyst classification AND follow-up imaging recommendation(s) in accordance with published guidelines AND source of recommendation(s) in the Final Report. CAUTION: PER CMS DECISION TO APPROVE QMM27, GROUPS/CLINICIANS THAT REPORT THIS MEASURE **CANNOT REPORT MEASURE 405**: APPROPRIATE FOLLOW-UP IMAGING FOR INCIDENTAL ABDOMINAL LESIONS.	**Include the following in the Final Report for MSN to identify eligible reports for this measure:** *Use the word **"incidental"** when an unexpected pancreatic cyst is present (helps coders identify eligible encounters). * State **specific follow-up recommendations**. If no follow-up is necessary based on referenced guidelines, it must be noted in the report. * Cite the source of the **Validated and Published Guidelines** you are basing your recommendation(s) on.** * **Validated and Published Guidelines** – All eligible exams must include documentation that at least one of the following validated and published guidelines for incidental pancreatic cystic lesions management was used: European based guidelines (European), American College of Gastroenterology (ACG), American Gastroenterological Association (AGA), International Association of Pancreatology (IAP), or American College of Radiology (ACR). **Examples of proper documentation:** "There is an incidental pancreatic cystic lesion in the tail of the pancreas measuring 1.5 cm in diameter...ACG guidelines recommend follow up of sub-cm BD-IPMNs every 2 yrs for 4 yrs; 1-2cm MRI every year for 3 yrs; 2-3cm MRI or EUS q 6-12 mths for 3 yrs; >3cm alternate MRI and EUS every year for 3 years." "Multiple pancreatic cysts with a 1.8 cm cyst in the head communicating with the main duct but no high risk features. Per ACR guidelines, follow-up contrast enhanced CT or MRI of the pancreas is recommended every 2 years for 10 years."	
~~QMM28~~	**Reporting Breast Arterial Calcification (BAC) on Screening Mammography**	**Eligible Definition:** All female patients 40 yrs. and older receiving a screening mammogram for malignant neoplasm of breast (excludes screening mammograms assigned a BIRADS 0: Incomplete). **To Pass**: Document the presence or absence of Breast Arterial Calcification (BAC)/vascular calcifications, AND if present, a statement of clinical relevance or recommendation for follow-up of BAC/vascular calcifications.	**Provider must document in the Final Report the presence or absence of Breast Arterial Calcification (BAC)/vascular calcifications. IF BAC/vascular calcifications are present, a statement of clinical relevance (such as "A strong association has been shown between BAC and cardiovascular disease (CVD) and/or coronary artery disease (CAD), independent of other known risk factors") OR recommendation for follow-up of BAC/vascular calcifications MUST also be included in the Final Report.** CAUTION: IF THERE IS NO EVIDENCE OF BAC, THIS MUST BE CLEARLY STATED IN THE FINAL REPORT TO PASS THIS MEASURE. *** Note Exception:** Documentation of medical reason(s) for not including a statement of clinical relevance or recommendation for follow-up of BAC/vascular calcification (such as, patient actively being treated for CVD/CAD). **Examples of proper documentation:** "Breast arterial calcifications are present. Particularly in patients aged 55 or younger, such calcifications may be a marker for cardiovascular disease. Consider further evaluation for cardiovascular disease risk assessment." "Moderate vascular calcifications noted bilaterally. Given patient age of 80 yrs, vascular calcifications are not highly concerning for CVD." "Extensive vascular calcifications are noted in both breasts. Patient already under active surveillence for known atherosclerotic disease." "Breast arterial calcifications = none"	
~~QMM21~~ NEW IN 2025	**Solid Organ Injury Grading on CT/CTA for Blunt Abdominal Trauma (BAT) Patients**	**Eligible Definition:** All female patients 18 yrs. and older receiving a computed tomography (CT) or computed tomography angiography (CTA) of the abdomen or abdomen/pelvis with acute blunt abdominal trauma (BAT) with solid organ injury of liver, spleen and/or kidney(s). **To Pass**: Document the solid organ grading of the injured liver, spleen, and/or kidney(s). Individual grade for each affected organ. Must include documentation of the validated/published BAT scoring system used.	**Provider must document BAT of the following in the Final Report:** 1. Grade for each affected organ (liver, spleen and/or kidney). AND 2. Validatd/published BAT scoring system used. *** Note Exception:** Documentation of a medical reason why final report does not include documentation of solid organ grading of the injured liver, spleen and/or kidney. **Examples of proper documentation:** "SPLEEN: Thin splenic subcapsular hematoma measuring 0.5cm. AAST SPLEEN INJURY GRADE: Grade 1 (Hematoma): Subcapsular hematoma, less than 10% surface area". "SPLEEN: Large splenic laceration extending from the hilum to the lateral aspect of the spleen and KIDNEYS: Occlusion of mid left renal artery; laceration of interpolar left kidney extending to renal hilum with active hemorrhage. AAST SPLEEN INJURY GRADE: Grade 5 (shattered spleen, or active bleeding beyond the spleen into the peritoneum); AAST KIDNEY INJURYGRADE: Grade 5 (shattered kidney or devascularized kidney)". "Kidneys/Ureters: A grade 2 laceration injury is seen involving the posterior medial aspect of the mid right kidney. Grade 2 (AAST classification of a smalll laceration less than 1 cm depth) injury of the right kidney".	**NEW in 2025**

MSN HEALTHCARE SOLUTIONS
2357 Warm Springs Rd 4th Floor
Columbus, GA 31904
800-889-8610
706-653-1230 (Fax)

Last Updated 11/14/24

2025 MSN QCDR - Radiology
Provider Documentation Guide

No changes / minor changes

Major / measure specification changes

Measure #	Measure Description Denominator Type	Measure Requirements Summary	Documentation Requirements	Significant Change Notes
QMM32 NEW IN 2025	**Intracerebral Hemorrhage (ICH) Scoring on Non-Contrast CT Head**	**Eligible Definition:** All patients 18 yrs. of age and older undergoing non-contrast CT (NCCT) Head with an initial diagnosis of intracerebral hemorrhage (ICH), also referred to as intra-axial or intraparenchymal hemorrhage (IPH), who have documentation of the location of ICH, ICH volume, and presence or absence of intraventricular hemorrhage (IVH) in the Final Report. **To Pass**: Document the location of ICH, ICH Volume (with unit of measurement) AND presence OR absence of intraventricular hemorrhage. **EXCLUDES**: Extra-axial hemorrhages (extradural, subdural, subarachnoid); traumatic brain injury, previously seen/diagnosed ICH; hemorrhages found ONLY in the ventricles.	**Provider must document ALL of the following in the Final Report:** 1. Location of Intracerebral Hemorrhage (ICH), AND 2. Volume of ICH (MUST report in mL, cc or cm^3) AND 3. Presence or absence of intraventricular hemorrhage (IVH) **NOTE:** The absence of IVH can be assumed if "no additional hemorrhages are identified" is documented in the final report. *** Note Exception:** Documentation of a patient reason why final report does not include ALL of the requirements listed above. **Examples of proper documentation:** "Acute right thalamocapsular hemorrhage, measuring approximately 12cc, with intraventricular extension into the lateral, third and fourth ventricles". "Intraparenchymal hemorrhage seen involving the right frontal and parietnal lobe. Intracranial Hemorrhage volume: 6.1cc. Intraventricular hemorrhage present? NO". "Extensive left frontoparietal hemorrhage, measuring 4.6 x 6.9 x 5.5 cm (correlating to a volume of 87mL). Extension into the bilateral lateral ventricles and thrid and fourth ventricles."	**NEW in 2025**

Coded ***Not Coded***