



**American College
of Radiology™**

**Meeting Minutes
Metrics Committee Meeting
QCDR Measure Revision Meeting
July 10, 2025**

Panel Attendees: Nadja Kadom, MD (chair); Kesav Raghavan, MD; Brianna Damadian, MD; Melissa Chen, MD; Melissa Davis, MD; Matthew Zygmunt, MD; John (Nicky) Grimes, MD

Staff Attendees: Judy Burleson, MHSA; Zach Smith, Brendon Alves

Meeting Purpose and Welcome

Today's meeting was convened for the Metrics Committee to consider modifications to ACRad 36 and 37, qualified clinical data registry (QCDRs) measures used in ACR's and other entities QCDRs. There is an urgency to revise these measures due to comments received by the Centers for Medicare and Medicaid Services in advance of the upcoming QCDR Self-nomination period (the time when organizations submit information on their measures for CMS approval of these unique specialty-focused measures for use in the MIPS Quality Performance category). CMS recently provided the ACR with comments indicating that these measures are topped out and may not be approved during the upcoming self-nomination period for MIPS participants as early as 2026. However, these measures are important as they augment the MIPS clinical quality measures (CQMs) available to radiologists (CQMs) by collecting additional meaningful data for demonstrating their performance quality.

Dr. Kadom, Committee chair, thanked participants for joining today's meeting. She also stated that the measures discussed today will address coronary artery calcification (CAC) and pulmonary embolism reporting. She invited Judy to kick off the conversation.

Measure Discussions

ACRad 36: Comprehensive Reporting of Coronary Artery Calcification (CAC) on Chest CT

Judy presented a spreadsheet documenting the current ACRad 36 measure specifications with the staff's proposed updates. The following describes the decisions made by the Committee for revising each section of the measure.

- *Denominator.* Meeting participants reviewing the spreadsheet information, noted that the draft proposed version aligned with the American Heart Association's guideline recommendation, indicating that patients aged 40 to 75 years maintain a higher

cardiovascular risk compared to younger patients. Although committee members recognized the low prevalence of calcification for patients under 40 years, they noted its significance to health outcomes when found in younger patients. As such, they agreed to broaden the age range of the denominator to 18 years and older so patients may modify their lifestyles to reduce the risks of heart disease and to identify younger patients with underlying heart conditions (e.g., familial hypercholesterolemia). Such modifications simplify the measure's criteria, avoid overly complex reporting requirements, and ensure feasibility across clinical settings, making the measure inclusive and patient centered.

- *Denominator Exceptions.* Issues associated with image quality and interpretation variability were considered. For instance, anatomical variability or patient positioning may affect calcification visibility, while technical influences like motion artifact impact radiologists' ability to assess calcification. Given the groups' concern, staff suggested two possible solutions: 1) create a specific denominator exception that would remove these exams from performance scoring or 2) develop a coding method to exclude these instances from measurement. Without coming to consensus on which solution to implement, ACR staff agreed to consider it further and request input from those on today's call by email.
- *Numerator.* Meeting attendees reviewed the staff's proposed new measure action to include a qualitative or quantitative assessment (Agatston) of severity for those exams indicating coronary artery calcification.
 - *Quantitative.* There were several problems discussed regarding the quantitative assessment severity rating, like difficulty calculating the Agatston score on non-gated studies, the burden for practices to adopt the Agatston technology, and questionable consistency of the severity determinations between contrast and non-contrast CT images. Others noted varying scanner technology, radiation exposure and imaging parameters, purposes for the exams, concluding that such challenges make the quantitative approach impractical.
 - *Qualitative.* Considering visual methods for illustrating CAC severity, the committee thought about using descriptive levels like mild, moderate, and severe and correlating these levels with the Agatston score ranges, where mild: 0 – 100, moderate: 100 – 400, and severe: greater than 400. However, they identified that challenges to correlate these visual descriptions with the Agatston score ranges would be unreliable due to the absence of standardized methods for distinguishing between mild/moderate/severe. Patients may also become anxious and confused by the information in the report when viewing the qualitative descriptions in correlation with Agatston score ranges.

Because of the identified challenges with the quantitative severity scoring in the radiology report, meeting participants agreed that the numerator should require a qualitative assessment (with sample language for which staff will include as a numerator note in the specifications) and the documentation of actionable recommendations, like patient consultation with primary care clinicians and/or completion of a comprehensive risk stratification analyses evaluating factors beyond calcification to determine patients' potential for cardiovascular disease.

ACRad 37: Interpretation of CT Pulmonary Angiography (CTPA) for Pulmonary Embolism (PE)

During the committee's review of this measure's proposed specification updates, they addressed the following.

- *Denominator.* Meeting participants agreed to retain the denominator used in the 2025 version of ACRad 37, stating "All final reports for patients aged 18 years or older undergoing CT pulmonary angiography (CTPA) with a finding of pulmonary embolism."
- *Numerator.* Agreeing to maintain existing documentation requirements associated with the original measure specifications regarding branching order when designating the most proximal clot location, the committee also decided to require right heart strain assessment in the measure numerator. Despite concerns with potential variability in its assessment, participants discussed that heart strain and right to left ventricle size comparison being a quick, meaningful indicator, that could prompt more urgent clinical interventions and provide more diagnostic information beyond standard PE reporting.

They also decided to augment the numerator with a second action requiring measure users to document the presence/absence of right heart strain (when assessable).

Next Steps

ACR staff shared that the meeting minutes and revisions discussed today will be included as track changes for review, as soon as possible. There will also be a comment period requesting feedback from QCDR users on the decided revisions, which will also ask about the measures' feasibility and face validity.

Action Items

1. Staff will draft the meeting summary.

2. Staff will revise the specifications reviewed today based on the meeting discussion.
3. Staff will support a comment period regarding the measures' proposed updates.

Adjourned.