

IR

Interventional Radiology
Standardized Reporting
User Guide

Society of Interventional Radiology (SIR) and
SIR Foundation

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SIR VIRTEX REGISTRY

VIRTEX is the new IR data registry. With your participation, it will help drive quality patient care. The registry will extend beyond IR-patient engagement to standardize IR treatments and outcomes and advance evidence-based clinical practice guidelines. Contact information for signing up can be found [here](#).

STANDARDIZED REPORTING STRUCTURE AND NOMENCLATURE

The reports have been created in a modular format. Data elements are the words preceded by the colon character (e.g.: “Pre-procedure diagnosis:”). Data values are the options for the data element. Some information that is not critical for data collection has been placed in a free-text format (e.g.: narrative text).

UPDATES FOR VERSION 3.1

- Unique device identifiers for all implanted devices should be imported electronically, separated by a comma. If this is not possible at your institution, then the product and lot numbers can be entered instead in the UDI data field.
- Coded letters appear in the registry event data fields, such that information in these fields cannot be directly seen by patients.

THINGS YOU CAN DO

- Create different versions of templates as necessary (e.g.: *Lung* biopsy, *Liver* biopsy, and *Kidney* biopsy from a biopsy template).
- Modify procedure names, as necessary.
- Edit areas of narrative text.
- Set fields to default.
- Add or delete data values in picklists/dropdowns (but do not modify already present values using different names).
- Modify impressions or plans.
- Move the impression as needed based on hospital or practice requirements.
- Modify the language in the “Procedure Summary” section to optimize for local billers and coders.
- Modules:
 - Duplicate or delete modules.
 - Add or create modules. However, we recommend separate procedures performed in the same setting be reported separately.
 - Copy/paste data within modules (e.g., multiple vessel selections, angiography, biopsy sites, or multiple contrast types).
- Email the [SIR](#) for questions not answered by the User Guide.

THINGS YOU CANNOT DO

- Modify existing data values in picklists/dropdowns.
- Modify MIPS measures.
- Remove MIPS measures.
- Change the text prior to a colon (data element).
- Change or delete the information in the “Additional Details” module. This section includes The Joint Commission requirements and information that maps to the reports in the registry.
- Combine two procedure templates into a single report.
- Delete signer name.
- Delete or change the report name at the bottom of the report. This is critical for data extraction/submission to the registry.

FEEDBACK

- Please provide feedback regarding the standardized reports in the Standardized Reporting Subcommittee Community on [SIR Connect](#).

FREQUENTLY ASKED QUESTIONS

Do standardized reports take longer to fill out than free-handed reports?

Because the reports are templated, most users find them more efficient than free-handed reports once they are accustomed to them.

How do the reports help with coding and billing?

The reports were created with the help of experts in coding and billing. They are designed to contain the data elements and words to facilitate accurate coding.

How do the standardized reports help satisfy participation in the merit-based incentive payment system (MIPS)?

The reports contain the Interventional Radiology MIPS measures and therefore can help groups satisfy these requirements.

Can data such as radiation dose be imported electronically into the templates?

Institutions can set up data elements like unique device identifiers and radiation dose to be imported electronically automatically into the reports. This imported information may come from electronic medical records, inventory managers, and imaging equipment.

Can anyone use the standardized reports, including institutions outside of the United States?

The reports are available to use to anyone who is a member of the Society of Interventional Radiology.

If I use the templates, can I make changes to them?

Yes, these templates are meant to remain flexible for the user. Specific information on what should and should not be changed is included in the user guide.

If I do not see a report for a procedure I perform, can a new standardized report be created?

Definitely! The Standardized Reports Subcommittee currently meets on a bi-weekly basis. Reach out to us through [SIR Connect](#) or send an email to [SIR](#). We will work with you to modify an existing report or create a new one.

I do not want to keep filling in fields. Can I just default them?

Absolutely! Default as many fields as you like.

Do I have to use Nuance PowerScribe® in order to use the templates?

The existing templates have been designed for PowerScribe®. We hope to have versions available for other vendors and Electronic Health Records in the future and are actively working with other vendors. If you are a reporting system or EHR/EMR interested in utilizing these templates, contact the [SIR](#) for further information.

STANDARDIZED REPORTING STRUCTURE AND NOMENCLATURE EXAMPLE REPORT

Key:
Data Element highlighted in turquoise = TJC (The Joint Commission) Requirement
 MIPS= Merit-based Incentive Payment System, part of the Quality Payment Program (QPP)

Executive Summary

PROCEDURE: Peripherally Inserted Central Catheter (PICC) placement

Procedural Personnel
 Attending physician(s): **Attending Name**
 Fellow physician(s): **Fellow**
 Resident physician(s): **Resident**
 Advanced practice provider(s): **APP**

Procedure Date (mm/dd/yyyy): **Report Create Date**

Pre-procedure diagnosis: **Diagnosis**
Post-procedure diagnosis: **Post Procedure**
Indication: **Indication:** Chemo/TPN/Administration of blood products/Administration of intravenous medications/Intravenous fluid administration/Repeated blood sampling/Other-
 Additional clinical history: **Additional history**

Complications: **No immediate complications.**

IMPRESSION:

Insertion of **Venous side:**right/left-sided PICC, with tip in the expected location of the **Catheter tip location:**subclavian vein/innominate vein/superior vena cava/**cavoatrial junction**/right atrium/inferior vena cava/common iliac vein/external iliac vein/other-.

Plan:

The catheter may be used immediately.

PROCEDURE SUMMARY: ← **PROCEDURE SUMMARY is meant for coders to know the reportable procedures performed**

- Venous access with ultrasound guidance
- PICC insertion with fluoroscopic guidance
- Additional procedure(s): **Additional procedures:**Diagnostic venography/Diagnostic venography and venoplasty/Other-/None

PROCEDURE DETAILS:

Pre-procedure
 Consent: Informed consent for the procedure including risks, benefits and alternatives was obtained and time out was performed prior to the procedure.
 Preparation (MIPS): The site **Prep:**was/was not prepared and draped using all elements of maximal sterile barrier technique including sterile gloyes, sterile gown, cap, mask, large sterile sheet, sterile ultrasound probe cover, hand hygiene and cutaneous antiseptis with 2% chlorhexidine.
 Medical reason for site preparation exception (MIPS): **Prep exception:**Not applicable/Chlorhexidine allergy/Emergency access/No medical reason/Other-

Allows for reporting of MIPS quality measures

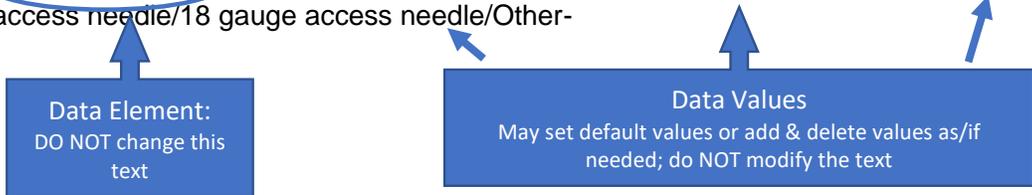
MODULE

Each **MODULE** may be copied/pasted or deleted as needed

Anesthesia/sedation

Level of anesthesia/sedation: **Anesthesia/sedation**:No sedation/Minimal sedation (anxiolysis)/**Moderate sedation (conscious sedation)**/Deep sedation/General anesthesia/Monitored anesthesia care/Other-
 Anesthesia/sedation administered by: **Anesthesia admin**:Anesthesiology/**Nurse or other independent trained observer**/Performing provider/Other-/Not applicable

Local anesthesia was administered. The vessel was sonographically evaluated and determined to be **Access vein ultrasound findings**:patent/partially thrombosed/completely thrombosed/chronically narrowed or diminutive/chronically occluded/other-. Real time ultrasound was used to visualize needle entry into the vessel and a permanent image **access US image storage**:was stored/was not stored.
 Laterality: **Access Laterality**: Right/Left
 Vein accessed: **Vein accessed**:Brachial vein/Basilic vein/Cephalic vein/Antecubital vein/Common femoral vein/Femoral collateral vein/Popliteal vein/Hepatic vein/Other-
Access technique:**Access technique**:Micropuncture set with 21 gauge needle/19 gauge access needle/18 gauge access needle/Other-



MODULE

Venography

Indication for venography: **Indication for venography**:Diagnostic - no prior angiographic study/Diagnostic - change in patient condition/Diagnostic - inadequate visualization on prior/Diagnostic - clinical change during procedure/Non-diagnostic - roadmapping, guidance, or measurement/Other-
 Vein catheterized: **Catheter tip position for venography**
 Findings: **Venography findings**

MODULE

Catheter placement

The catheter was trimmed to appropriate length and placed into the vein under fluoroscopic guidance via a peel-away sheath. Catheter tip location was fluoroscopically verified and a permanent image was stored. A sterile dressing was applied.
 Catheter placed: **Manufacturer and device name**
 Lot number: **Catheter Lot Number**
 Catheter size (French): **Catheter size**:4/5
 Catheter intravascular length (cm): **Intravascular length**
 Lumens: **Lumens**:Single-lumen/Dual-lumen
 Power injectable: **Power injectable**:Yes/No
 Catheter tip: **Catheter tip location**:subclavian vein/innominate vein/superior vena cava/**cavoatrial junction**/right atrium/inferior vena cava/common iliac vein/external iliac vein/other-
 Catheter flush: **Catheter flush**:Heparin (100 units/mL)/Heparin (1000 units/mL)/Normal saline/Citrate/Other-
 Catheter securement technique: **Catheter securement**:Non-absorbable suture/**Stat-Lock**/None/Other-

MODULES

Contrast

Contrast agent: **Contrast agent:**Omnipaque 300/Omnipaque 350/Visipaque 320/Isovue 250/Isovue 300/Isovue 370/Ultravist 370/Other-/None
 Contrast volume (mL): **Contrast volume**

Radiation Dose

Fluoroscopy time (**Fluoro units:**minutes/seconds/mm:ss): **Fluoro time**
 Reference air kerma (**AK units:**Gy/mGy/Not provided by imaging equipment): **Air Kerma**
 Kerma area product (**KAP units:**uGy-cm2/mGy-cm2/cGy-cm2/Gy-cm2/uGy-m2/mGy-m2/cGy-m2/Gy-m2/Not provided by imaging equipment): **Kerma area product**

Additional Details

Additional description of procedure: **Additional description**
 Registry event: **Intraprocedure events:**None/Air embolism/Arrythmia/Bleeding/Contrast reaction/Device misplacement/Device malfunction/Device migration/Device fracture/Loss of access/Sedation requiring reversal/Vascular access site bleeding/Vessel perforation/**Cause of registry event:**Not device related/Device related without device failure/Device related with device failure/**Not applicable/Event treatment:**Endovascular/Surgical/Medical management/Transfusion/Observation/**Not applicable**
 Device used: **Registry event device manufacturer and device name**
 Equipment details: **Useful or additional equipment**
 Unique Device Identifiers: **Comma Separated UDI numbers for implants or devices used**
Specimens removed: **Specimens**
Estimated blood loss (mL): **Blood Loss:**Less than 10/11-50/51-100/101-200/201-500/501-1000/1001-2000/Greater than 2000
Standardized report: **SIR_PICC_v3.1**

 **DO NOT change or alter this module.** 

DO NOT change or alter this report title at the bottom of the report.
 **This is critical for data submission/extraction.** 

Attestation

Signer name: **Signer Name**

I attest that I **Presence:**was present for the entire procedure/was present for the key elements of the procedure and immediately available/supervised the procedure and was immediately available. I reviewed the stored images and agree with the report as written.

 **DO NOT delete signer name.** 

Attestation statement may be modified to meet specific procedure and/or institution needs and requirements.