

2018 QCDR Measures

Following is an overview of the clinical quality measures in GIQuIC that can be reported to CMS for the Quality performance category of the Merit-Based Incentive Payment System (MIPS) via the GIQuIC Qualified Clinical Data Registry (QCDR) for the 2018 program year. Additional detail on GIQuIC's QCDR measures available for public reporting follows on the subsequent pages.

The GIQuIC 2018 QCDR has been approved to support individual eligible clinician, group, and virtual group reporting to the Quality, Improvement Activities, and Advancing Care Information performance categories.

Measure #	Title	Outcome/ High-Priority
QPP343	Screening Colonoscopy Adenoma Detection Rate	Outcome
QPP425	Photodocumentation of Cecal Intubation	N/A
QPP320	Appropriate follow-up interval for normal colonoscopy in average risk patients	High-Priority
GIQIC15	Appropriate follow-up interval of 3 years recommended based on pathology findings from screening colonoscopy in average-risk patients	High-Priority
GIQIC20	Appropriate follow-up interval of 10 years for colonoscopies with only hyperplastic polyp findings	High-Priority
GIQIC17	Appropriate follow-up interval of 5 years for colonoscopies with findings of sessile serrated polyps < 10 mm without dysplasia	High-Priority
GIQIC18	Appropriate follow-up interval of not less than 5 years for colonoscopies with findings of 1-2 tubular adenomas < 10 mm	High-Priority
NHCR4	Repeat screening colonoscopy recommended within one year due to inadequate/poor bowel preparation	High-Priority
GIQIC12	Appropriate indication for colonoscopy	N/A
GIQIC19	Appropriate indication for esophagogastroduodenoscopy (EGD)	N/A
GIQIC10	Appropriate management of anticoagulation in the peri-procedural period rate – EGD	High-Priority

2018 QCDR Measures

GIQIC15: Appropriate follow-up interval of 3 years recommended based on pathology findings from screening colonoscopy in average-risk patients

Description: Percentage of average-risk patients aged 50 years and older receiving a screening colonoscopy with biopsy or polypectomy and pathology findings of 3-10 adenomas, Advanced Neoplasm (≥ 10 mm, high grade dysplasia, villous component), Sessile serrated polyp ≥ 10 mm OR sessile serrate polyp with dysplasia OR traditional serrated adenoma who had a recommended follow-up interval of 3 years for repeat colonoscopy

Denominator: All complete and adequately prepped screening colonoscopies of average-risk patients aged 50 years and older with biopsy or polypectomy and pathology findings of 3-10 adenomas, OR Advanced Neoplasm (≥ 10 mm, high grade dysplasia, villous component) OR Sessile serrated polyp ≥ 10 mm OR sessile serrated polyp with dysplasia OR traditional serrated adenoma

Denominator Exceptions/Exclusions: None

Numerator: Number of average-risk patients aged 50 years and older receiving a complete and adequately prepped screening colonoscopy with biopsy or polypectomy and pathology findings of 3-10 adenomas OR Advanced Neoplasm (≥ 10 mm, high grade dysplasia, villous component) OR Sessile serrated polyp ≥ 10 mm OR sessile serrated polyp with dysplasia OR traditional serrated adenoma who had a recommended follow-up interval of 3 years for repeat colonoscopy

Rationale and Supported Evidence:

The *Guidelines for Colonoscopy Surveillance After Screening and Polypectomy: Consensus Update by the US Multi-society Task Force on Colorectal Cancer*¹ presents recommendations for surveillance intervals in individuals with baseline average risk. Colonoscopies should follow recommended post-polypectomy surveillance intervals to be clinically effective and to minimize risk and further to be cost-effective. Average-risk patients aged 50 years and older receiving a screening colonoscopy with biopsy or polypectomy and pathology findings of 3-10 adenomas, advanced neoplasm (≥ 10 mm, high grade dysplasia, villous component), sessile serrated polyp ≥ 10 mm OR sessile serrate polyp with dysplasia or traditional serrated adenoma should receive a recommended follow-up interval of 3 years for repeat colonoscopy.

¹ Lieberman DA, Rex DK, Winawer SJ, et al. Guidelines for colonoscopy surveillance after screening and polypectomy: a consensus update by the US Multi-Society Task Force on Colorectal Cancer. *Gastroenterology* 2012;143:844-57.

2018 QCDR Measures

GIQIC20: Appropriate Follow-up Interval of 10 Years for Colonoscopies with only Hyperplastic Findings

Description: Percentage of average-risk patients aged 50 and older receiving a screening colonoscopy with biopsy or polypectomy and pathology findings of only hyperplastic polyp(s) with a recommended follow-up interval of 10 years for repeat colonoscopy documented in the colonoscopy report.

Denominator: All complete and adequately prepped screening colonoscopies of average-risk patients aged 50 and older receiving screening colonoscopy with pathology results of only hyperplastic polyp(s)

Denominator Exceptions: Patients aged 66 to 75

Numerator: Number of average-risk patients aged 50 to 75 years receiving a complete and adequately prepped screening colonoscopy with pathology results of only hyperplastic polyp(s) who had a recommended follow-up interval of 10 years for repeat colonoscopy documented in their colonoscopy report

Rationale and Supported Evidence:

The *Guidelines for Colonoscopy Surveillance After Screening and Polypectomy: Consensus Update by the US Multi-society Task Force on Colorectal Cancer*¹ presents recommendations for surveillance intervals in individuals with baseline average risk. Colonoscopies should follow recommended post-polypectomy surveillance intervals to be clinically effective and to minimize risk and further to be cost-effective. Average-risk patients aged 50 years and older receiving a screening colonoscopy with biopsy or polypectomy and pathology findings of distal small lesions (<10 mm) hyperplastic polyps should receive a recommended follow-up interval of 10 years for repeat colonoscopy.

2018 QCDR Measures

GIQIC17: Appropriate Follow-Up Interval of 5 Years for Colonoscopies with findings of Sessile Serrated Polyps < 10 mm without dysplasia

Description: Percentage of average-risk patients aged 50 years and older receiving a screening colonoscopy with biopsy or polypectomy and pathology findings of sessile serrated polyp(s) < 10 mm without dysplasia with a recommended follow-up interval of 5 years for repeat colonoscopy documented in their colonoscopy report.

Denominator: All complete and adequately prepped screening colonoscopies of average-risk patients aged 50 years and older with biopsy or polypectomy and pathology findings of sessile serrated polyp < 10 mm without dysplasia

Denominator Exceptions/Exclusions: None

Numerator: Number of average-risk patients aged 50 years and older receiving a complete and adequately prepped screening colonoscopy with biopsy or polypectomy and pathology findings of sessile serrated polyp < 10 mm without dysplasia who had a recommended follow-up interval of 5 years for repeat colonoscopy

Rationale and Supported Evidence:

The *Guidelines for Colonoscopy Surveillance After Screening and Polypectomy: Consensus Update by the US Multi-society Task Force on Colorectal Cancer*¹ presents recommendations for surveillance intervals in individuals with baseline average risk. Colonoscopies should follow recommended post-polypectomy surveillance intervals to be clinically effective and to minimize risk and further to be cost-effective. Average-risk patients aged 50 years and older receiving a screening colonoscopy with biopsy or polypectomy and pathology findings of sessile serrated polyp(s) < 10 mm with no dysplasia should receive a recommended follow-up interval of 5 years for repeat colonoscopy.

2018 QCDR Measures

GIQIC18: Appropriate Follow-Up Interval of Not Less than 5 Years for Colonoscopies with findings of 1-2 Tubular Adenomas < 10 mm

Description: Percentage of average-risk patients aged 50 years and older receiving a screening colonoscopy with biopsy or polypectomy and pathology finding of 1 or 2 tubular adenomas < 10 mm with a recommended follow-up interval of not less than 5 years for repeat colonoscopy documented in their colonoscopy report.

Denominator: All complete and adequately prepped screening colonoscopies of average-risk patients aged 50 years and older with biopsy or polypectomy and pathology findings of 1 or 2 tubular adenomas < 10 mm

Denominator Exceptions: Patients aged 66 to 75

Numerator: Number of average-risk patients aged 50 years and older receiving a complete and adequately prepped screening colonoscopy with biopsy or polypectomy and pathology findings of 1 or 2 tubular adenomas < 10 mm who had a recommended follow-up interval of ≥ 5 for repeat colonoscopy

Rationale and Supported Evidence:

The *Guidelines for Colonoscopy Surveillance After Screening and Polypectomy: Consensus Update by the US Multi-society Task Force on Colorectal Cancer*¹ presents recommendations for surveillance intervals in individuals with baseline average risk. Colonoscopies should follow recommended post-polypectomy surveillance intervals to be clinically effective and to minimize risk and further to be cost-effective. Average-risk patients aged 50 years and older receiving a screening colonoscopy with biopsy or polypectomy and pathology findings of 1-2 small (< 10 mm) tubular adenomas should receive a recommended follow-up interval of 5 to 10 years for repeat colonoscopy.

2018 QCDR Measures

NHCR4: Repeat screening or surveillance colonoscopy recommended within one year due to inadequate/poor bowel preparation

Description: Percentage of patients recommended for repeat screening or surveillance colonoscopy within one year or less due to inadequate/poor bowel preparation quality

Denominator: Number of screening and surveillance colonoscopies with bowel preparation documented as inadequate/poor

Denominator Exceptions/Exclusions: None

Numerator: Number of screening and surveillance colonoscopies with bowel preparation documented as inadequate/poor and whose recommended follow-up was ≤ 1 year

Rationale and Supported Evidence:

If bowel cleansing is inadequate to identify polyps > 5 mm in size, and the procedure is being performed for colorectal cancer screening or colon polyp surveillance, then the procedure should be repeated in 1 year or less. Adequate preparation carries the implication that the recommended interval before the next colonoscopy will be consistent with guidelines.^{1,2}

² Rex, DK, et al. Quality indicators for colonoscopy. *Gastrointest Endosc* 2015;81:31-53 / DOI: <http://dx.doi.org/10.1016/j.gie.2014.07.058>.

2018 QCDR Measures**GIQIC12:** Appropriate indication for colonoscopy

Description: Percentage of colonoscopy procedures performed for an indication that is included in a published standard list of appropriate indications and the indication is documented

Denominator: All colonoscopies

Denominator Exceptions/Exclusions: None

Numerator: Number of colonoscopies performed for an indication that is included in a published standard list of appropriate indications

Rationale and Supporting Evidence:

In 2012, ASGE updated its indications for endoscopic procedures, Appropriate Use of Gastrointestinal Endoscopy.³ This list was determined by a review of published literature and expert consensus. Studies have shown that when colonoscopy is done for appropriate reasons, significantly more clinically relevant diagnoses are made.^{4, 5, 6}

Based on the evidence GIQuIC's supporting societies agree the performance target for an appropriate indication measure should be > 80%.

³ ASGE Standards of Practice Committee, Early DS, Ben-Menachem T *et al.* Appropriate use of GI endoscopy. *Gastrointest Endosc* 2012;75:1127-31.

⁴ Balaguer F, Llach J, Castells A, *et al.* The European panel on the appropriateness of gastrointestinal endoscopy guidelines colonoscopy in an open-access endoscopy unit: a prospective study. *Aliment Pharmacol Ther* 2005;21:609-13.

⁵ Vader JP, Pache I, Froehlich F, *et al.* Overuse and underuse of colonoscopy in a European primary care setting. *Gastrointest Endosc* 2000;52:593-99.

⁶ de Bosset V, Froehlich F, Rey JP, *et al.* Do explicit appropriateness criteria enhance the diagnostic yield of colonoscopy? *Endoscopy* 2002;34:360-8.

2018 QCDR Measures**GIQIC19: Appropriate Indication for Esophagogastroduodenoscopy (EGD)**

Description: Percentage of esophagogastroduodenoscopy (EGD) procedures performed for an indication that is included in a published standard list of appropriate indications and the indication is documented.

Denominator: All EGDs

Denominator Exceptions: None

Numerator: Number of EGDs performed for an indication that is included in a published standard list of appropriate indications.

Rationale and Supporting Evidence:

In 2012, ASGE updated its indications for endoscopic procedures, Appropriate Use of Gastrointestinal Endoscopy.³ This list was determined by a review of published literature and expert consensus. Studies have shown that when colonoscopy is done for appropriate reasons, significantly more clinically relevant diagnoses are made.^{4,5,6}

Based on the evidence GIQuIC's supporting societies agree the performance target for an appropriate indication measure should be > 80%.

2018 QCDR Measures

GIQIC10: Appropriate management of anticoagulation in the peri-procedural period rate – EGD

Description: Percentage of patients undergoing an EGD on an anti-platelet agent or an anticoagulant who leave the endoscopy unit with instructions for management of this medication

Denominator: All patients undergoing an EGD on an anti-platelet agent or an anticoagulant

Denominator Exceptions/Exclusions: None

Numerator: Number of patients on an anti-platelet agent or an anticoagulant who leave the endoscopy unit with instructions for management of this medication

Rationale and Supported Evidence:

Given bleeding is an adverse event associated with EGD,^{7,8,9} adherence to this quality measure is supported by GIQuIC for this population of patients.

⁷ Ginzburg L, Greenwald D, Cohen J. Complications of endoscopy. *Gastrointest Endosc Clin N Am* 2007;17:405-32.

⁸ Ben-Menachem T, Decker GA, Early DS, et al. Adverse events of upper GI endoscopy. *Gastrointest Endosc* 2012;76:707-18.

⁹ Eisen GM, Baron TH, Dominitz JA, et al. Complications of upper GI endoscopy. *Gastrointest Endosc* 2002;55:784-93.