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 2020 program year. Additional detail on GIQuIC’s QCDR measures available for public reporting follows on the subsequent pages.

The GIQuIC 2020 QCDR has been approved to support individual eligible clinician, group, and virtual group reporting to the Quality, Improvement Activities, and Promoting Interoperability performance categories.

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GIQIC22: Screening Colonoscopy Adenoma Detection Rate

**Description:** The percentage of patients aged 50 to 75 years with at least one conventional adenoma or colorectal cancer detected during screening colonoscopy.

**Denominator:** (Strata 1) Male patients aged 50 to 75 years undergoing a screening colonoscopy OR (Strata 2) Female patients aged 50 to 75 years undergoing a screening colonoscopy

**Denominator Exceptions:** (Strata 1) Documentation that neoplasm detected in a male patient is only diagnosed as traditional serrated adenoma, sessile serrated polyp, or sessile serrated adenoma OR (Strata 2) Documentation that neoplasm detected in a female patient is only diagnosed as traditional serrated adenoma, sessile serrated polyp, or sessile serrated adenoma

**Denominator Exclusions:** None

**Numerator:** (Strata 1) Number of male patients aged 50 to 75 years with at least one conventional adenoma or colorectal cancer detected during screening colonoscopy OR (Strata 2) Number of female patients aged 50 to 75 years with at least one conventional adenoma or colorectal cancer detected during screening colonoscopy

**Rationale and Supported Evidence:** The United States Preventive Services Task Force has recommended screening colonoscopy for adults, beginning at age 50 and continuing until age 75 (Grade A recommendation). Screening exams are those performed to detect lesions in the absence of signs, symptoms, or personal history of colon neoplasia. The adenoma detection rate is an independent predictor of risk of developing colorectal cancer between screening colonoscopies. However, studies have documented wide variation in adenoma detection rates, illustrating the need for measuring and monitoring this metric for endoscopists. The adenoma detection rate varies between genders, with a lower rate demonstrated in women. Multi-specialty and stakeholder guidelines support the importance of measuring the adenoma detection rate in the prevention of colorectal cancer. Guidelines and the supporting literature support performance targets for adenoma detection rate of 25% for a mixed gender population (20% in women and 30% in men).

**National Quality Strategy (NQS) domain:** Effective Clinical Care

**Measure type:** Outcome

**Meaningful Measure Area:** Preventative Care

If the measure is risk adjusted: No

**Number of performance rates required for measures:** 3

**High priority status:** Yes, Intermediate Outcome

**Traditional vs. inverse measure:** Traditional

**Proportional, continuous variable, outcome, and ratio measure indicator:** Proportional
**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**: None

**Denominator 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 Cancer¹* 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.

**National Quality Strategy (NQS) domain**: Communication and Care Coordination

**Measure type**: Process

**Meaningful Measure Area**: Appropriate use of Healthcare

**If the measure is risk adjusted**: No

**Number of performance rates required for measures**: 1

**High priority status**: Yes, Care Coordination

**Traditional vs. inverse measure**: Traditional

**Proportional, continuous variable, outcome, and ratio measure indicator**: Proportional

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**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**: None

**Denominator 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* 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.

**National Quality Strategy (NQS) domain**: Communication and Care Coordination

**Measure type**: Process

**Meaningful Measure Area**: Appropriate use of Healthcare

**If the measure is risk adjusted**: No

**Number of performance rates required for measures**: 1

**High priority status**: Yes, Care Coordination

**Traditional vs. inverse measure**: Traditional

**Proportional, continuous variable, outcome, and ratio measure indicator**: Proportional
GIQIC21: Appropriate follow-up interval of not less than 5 years for colonoscopies with findings of 1-2 tubular adenomas < 10 mm OR of 10 years for colonoscopies with only hyperplastic polyp findings in rectum or sigmoid

Description: Percentage of average-risk patients aged 50 years to 75 years receiving a screening colonoscopy with biopsy or polypectomy and pathology findings of 1 of 2 tubular adenomas < 10 mm with a recommended follow-up interval of not less than 5 years OR pathology findings of only hyperplastic polyp findings in rectum or sigmoid with a recommended follow-up interval of 10 years for repeat colonoscopy documented in their colonoscopy report.

Denominator: All complete and adequately prepped screening colonoscopies of average risk patients aged 50 years to 75 years with biopsy or polypectomy and pathology findings of: (Strata 1) 1 to 2 tubular adenomas < 10 mm OR (Strata 2) only hyperplastic polyp(s) in rectum or sigmoid

Denominator Exceptions: Patients aged 66 to 75

Denominator Exclusions: None

Numerator: Number of average-risk patients aged 50 years to 75 years receiving a complete and adequately prepped screening colonoscopy with biopsy or polypectomy and: (Strata 1) pathology findings of 1 to 2 tubular adenomas < 10 mm who had a recommended follow-up interval of \( \geq 5 \) years for repeat colonoscopy OR (Strata 2) pathology findings of only hyperplastic polyp(s) in rectum or sigmoid 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 1-2 small (< 10 mm) tubular adenomas should receive a recommended follow-up interval of 5 to 10 years for repeat colonoscopy. 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.

National Quality Strategy (NQS) domain: Efficiency and Cost Reduction
Measure type: Process
Meaningful Measure Area: Appropriate use of Healthcare
If the measure is risk adjusted: No
Number of performance rates required for measures: 3
High priority status: Yes, Appropriate Use
Traditional vs. inverse measure: Traditional
Proportional, continuous variable, outcome, and ratio measure indicator: Proportional
**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**: # of screening and surveillance colonoscopies with bowel preparation documented as inadequate/poor

**Denominator Exceptions**: None

**Denominator Exclusions**: None

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

**Rationale and Supported Evidence**: Colonoscopies with poor bowel preparation are considered incomplete due to inadequate mucosal visualization, and shorter follow-up intervals are recommended to ensure effective care.

**National Quality Strategy (NQS) domain**: Communication and Care Coordination

**Measure type**: Process

**Meaningful Measure Area**: Appropriate use of Healthcare

**If the measure is risk adjusted**: No

**Number of performance rates required for measures**: 1

**High priority status**: Yes, Care Coordination

**Traditional vs. inverse measure**: Traditional

**Proportional, continuous variable, outcome, and ratio measure indicator**: Proportional
**GIQuIC12: 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:** None

**Denominator 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.\(^2\) 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.\(^3, 4, 5\)

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

**National Quality Strategy (NQS) domain:** Effective Clinical Care

**Measure type:** Process

**Meaningful Measure Area:** Appropriate use of Healthcare

**If the measure is risk adjusted:** No

**Number of performance rates required for measures:** 1

**High priority status:** Yes, Appropriate Use

**Traditional vs. inverse measure:** Traditional

**Proportional, continuous variable, outcome, and ratio measure indicator:** Proportional

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GIQuIC19: 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

Denominator Exclusions: 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%.

National Quality Strategy (NQS) domain: Effective Clinical Care

Measure type: Process

Meaningful Measure Area: Appropriate use of Healthcare

If the measure is risk adjusted: No

Number of performance rates required for measures: 1

High priority status: Yes, Appropriate Use

Traditional vs. inverse measure: Traditional

Proportional, continuous variable, outcome, and ratio measure indicator: Proportional
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:** None

**Denominator 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,\(^6,7,8\) adherence to this quality measure is supported by GIQuIC for this population of patients.

**National Quality Strategy (NQS) domain:** Communication and Care Coordination

**Measure type:** Process

**Meaningful Measure Area:** Medication Management

**If the measure is risk adjusted:** No

**Number of performance rates required for measures:** 1

**High priority status:** Yes, Care Coordination

**Traditional vs. inverse measure:** Traditional

**Proportional, continuous variable, outcome, and ratio measure indicator:** Proportional

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