Following is an overview of the clinical quality measures in GIQuIC that can be reported to CMS for the Physician Quality Report System (PQRS) via GIQuIC’s status as a qualified clinical data registry (QCDR) for the 2015 program year. Additional detail for each measure follows on the subsequent pages.

Reporting via a QCDR for program year 2015, to avoid the negative 2% payment adjustment in calendar year 2017 a provider must successfully report at least 9 individual measures, of which at least 2 must be outcome measures, covering at least 3 National Quality Strategy (NQS) domains for 50% or more of the eligible provider’s applicable patients.

Note: Standard measures with a 0 percent performance rate will not count.

*indicates an inverse measure in which a lower performance rate (closer to zero versus 100) is better.

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GIQuality Improvement Consortium, Ltd. (GIQuIC)  
2015 QCDR Non-PQRS Measure Specifications

**GIQuIC Non-PQRS Measure 1: Adenoma detection rate**

**Measure Title:** Adenoma detection rate

**Description:** Percentage of patients age 50 and over undergoing screening colonoscopy with a finding of at least one adenomatous polyp

**Denominator:** Patients age 50 years or older undergoing a screening colonoscopy

**Denominator Exceptions/Exclusions:** N/A

**Numerator:** Number of patients age 50 years or older with at least one adenoma or other colorectal cancer precursor or colorectal cancer detected during screening colonoscopy

**Measure Type:** Outcome, standard measure  
**Measure Domain:** Effective Clinical Care

**Rationale and Supported Evidence:**

The adenoma detection rate is the best-established colorectal neoplasia-related quality indicator, and is defined as the proportion of patients undergoing colonoscopy in whom an adenoma or colorectal cancer is found.\(^1\) Studies show that high adenoma detection rates are associated with a significant reduction in colorectal cancer risk.\(^2\) Yet, virtually all studies on this subject have found marked variation in adenoma detection rates among physicians.\(^3,4,5,6\)

\(^1\) Church J. Adenoma detection rate and the quality of colonoscopy: the sword has two edges. Dis Colon Rectum 2008;51:520-3.


GIQuIC Non-PQRS Measure 2: Adequacy of bowel preparation

**Measure Title**: Adequacy of bowel preparation

**Description**: Percentage of colonoscopies with a bowel preparation documented as adequate or better

**Denominator**: All colonoscopies

**Denominator Exceptions/Exclusions**: N/A

**Numerator**: Number of patients for whom bowel preparation was assessed and documented as adequate

**Measure Type**: Process, standard measure  
**Measure Domain**: Effective Clinical Care

**Rationale and Supported Evidence**: 
Adenoma miss rates in the context of suboptimal bowel preparation are high; of all of the adenomas identified, 42% were discovered only during the repeat colonoscopy. The miss rate for advanced adenomas, although comparatively less, also remained high at 27%. This proportion remained similar after redefining an early repeat colonoscopy as occurring within 1 year of the index examination, suggesting a true miss rate rather than subsequent neoplasia. The miss rate was particularly high for those colonoscopies done with suboptimal bowel preparation in which any adenoma was found on the initial examination compared with none detected. Given the increased premalignant potential of advanced adenomas, suboptimal bowel preparation may cause an unacceptably high failure rate at identifying these important lesions, thereby compromising the effectiveness of the colonoscopy. While there is relative uniformity in surveillance intervals when bowel preparation is optimal, there is considerable variability when bowel preparation is suboptimal.7,8

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GIQuIC Non-PQRS Measure 3: Photodocumentation of the cecum (also known as cecal intubation rate) – All Colonoscopies

Measure Title: Photodocumentation of the cecum (also known as cecal intubation rate) – All Colonoscopies

Description: Percentage of colonoscopies into the cecum including photodocumentation of one or more of the cecal landmarks (ileocecal valve, appendiceal orifice, or terminal ileum)

Denominator: All (i.e., screening, surveillance, diagnostic/therapeutic) colonoscopies

Denominator Exceptions/Exclusions: Patient has no cecum or hemicolecotomy

Numerator: Number of patients for whom photodocumentation of one or more cecal landmarks was recorded

Measure Type: Process, standard measure  Measure Domain: Effective Clinical Care

Rationale and Supported Evidence:

In the United States, colonoscopy is almost always undertaken with the intent to intubate the cecum. Cecal intubation is defined as passage of the colonoscope tip to a point proximal to the ileocecal valve, so that the entire cecal caput, including the medial wall of the cecum between the ileocecal valve and appendiceal orifice, is visible. The need for cecal intubation is based on the persistent finding that a substantial fraction of colorectal neoplasms are located in the proximal colon, including the cecum. Low cecal intubation rates have been associated with higher rates of interval proximal colon cancer.\(^9\) Effective colonoscopists should be able to intubate the cecum in ≥ 90% of all cases.\(^10\)

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**GIQuIC Non-PQRS Measure 4:** Photodocumentation of the cecum (also known as cecal intubation rate) – Screening Colonoscopies

**Measure Title:** Photodocumentation of the cecum (also known as cecal intubation rate) – Screening Colonoscopies

**Description:** Percentage of screening colonoscopies into the cecum including photodocumentation of one or more of the cecal landmarks (ileocecal valve, appendiceal orifice, or terminal ileum)

**Denominator:** All screening colonoscopies

**Denominator Exceptions/Exclusions:** Patient has no cecum or hemicolecotomy

**Numerator:** Number of patients for whom photodocumentation of one or more cecal landmarks was recorded

**Measure Type:** Process, standard measure

**Measure Domain:** Effective Clinical Care

**Rationale and Supported Evidence:**

A high-quality evaluation of the colon consists of examination of the entire colon – from the rectum to the cecum. This is especially important for colorectal cancer screening and surveillance colonoscopy examinations. A significant fraction of colonic neoplasms are located in the right colon,\(^{11}\) hence effective colonoscopists should be able to intubate the cecum in ≥ 95% of cases when the indication is screening in a healthy adult.\(^{12,13,14}\) Knowing the completeness of the examination can inform physicians whether an imaging procedure or repeat colonoscopy is necessary, and influences the timing of follow-up examination.

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GIQuIC Non-PQRS Measure 5: Incidence of perforation

**Measure Title:** Incidence of perforation

**Description:** Percentage of total patients experiencing a perforation during colonoscopy, recognized immediately (before the patient leaves the facility)

**Denominator:** All colonoscopies

**Denominator Exceptions/Exclusions:** N/A

**Numerator:** Number of patients experiencing a perforation during colonoscopy, recognized immediately (before the patient leaves the facility)

**Measure Type:** Outcome, inverse measure  
**Measure Domain:** Patient Safety

**Rationale and Supported Evidence:**

Perforation is generally considered the most serious adverse event presenting in the short-term during or after colonoscopy. About 5% of colonoscopic perforations are fatal.\(^\text{15,16,17}\) Published rates of colonoscopic perforation vary widely.\(^\text{10-12}\)


GIQuIC Non-PQRS Measure 6: Appropriate follow-up interval for normal colonoscopy in average risk patients

**Measure Title:** Appropriate follow-up interval for normal colonoscopy in average risk patients

**Description:** Percentage of average-risk patients aged 50 to 75 years receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report

**Denominator:** All average-risk patients aged 50 to 75 years receiving screening colonoscopy without biopsy or polypectomy

**Denominator Exceptions/Exclusions:** N/A

**Numerator:** Number of average-risk patients aged 50 to 75 years receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report

**Measure Type:** Process, standard measure  
**Measure Domain:** Communication and Care Coordination

**Rationale and Supported Evidence:**

In the average-risk population (persons age 50 years and older without other risk factors for colorectal cancer, or who have only one first degree relative with colorectal cancer and that cancer was diagnosed at age >60 years), colonoscopic screening is recommended in all past and current guidelines at 10-year intervals. Inappropriate interval recommendations can result in overuse of resources and can lead to significant patient harm. Performing colonoscopy too often not only increases patients' exposure to procedural harm, but also drains resources that could be more effectively used to adequately screen those in need.

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GIQuIC Non-PQRS Measure 8: Age appropriate screening colonoscopy

**Measure Title:** Age appropriate screening colonoscopy

**Description:** Percentage of patients age 85 years or older undergoing screening colonoscopy

**Denominator:** Patients age 50 years or older undergoing a screening colonoscopy

**Denominator Exceptions/Exclusions:** N/A

**Numerator:** Number of patients age 85 years or older undergoing a screening colonoscopy

**Measure Type:** Outcome, inverse measure

**Measure Domain:** Efficiency and Cost Reduction

**Rationale and Supported Evidence:**

The U.S. Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer in adults using fecal occult blood test, sigmoidoscopy, or colonoscopy, beginning at 50 years of age and continuing until 75 years of age. The risks and benefits of these screening methods vary. However, the USPSTF recommends against screening for colorectal cancer in adults older than 85 years as there is moderate certainty that the benefits of screening do not outweigh the harms.\(^{22}\)

\(^{22}\) [http://www.uspreventiveservicestaskforce.org/uspstf08/colocancer/colors.htm](http://www.uspreventiveservicestaskforce.org/uspstf08/colocancer/colors.htm)
GI QuIc Non-PQRS Measure 9: Documentation of history and physical rate - Colonoscopy

**Measure Title:** Documentation of history and physical rate - Colonoscopy  
**Description:** Percentage of colonoscopies with history and physical documented  
**Denominator:** All colonoscopies  
**Denominator Exceptions/Exclusions:** N/A  
**Numerator:** Number of patients for which history and physical are documented  
**Measure Type:** Process, standard measure  
**Measure Domain:** Effective Clinical Care  

**Rationale and Supported Evidence:**
When performing colonoscopy for colorectal cancer (CRC) screening, endoscopists should document if the patient previously had a colonoscopy, date of the last colonoscopy, and any histologic findings from polyps removed during that colonoscopy under “Indication” for procedure if that information is available. This documentation should demonstrate that colonoscopy for CRC screening or colon polyp surveillance is being performed at an appropriate interval. Evidence from surveys indicates that post-polypectomy surveillance colonoscopy in the United States is frequently performed at intervals that are shorter than those recommended in guidelines.  

GIQuIC’s supporting societies agree lack of documentation of history and physical should be considered essentially a "never event" and have recommended a performance target of > 98%. Data in the GIQuIC registry shows in 2012 not quite 90% of colonoscopies cases included in the registry had history and physical documented. That number improved to approximately 93% in 2013 and nearly 96% in 2014; however, improvement is still needed.

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GIQuIC Non-PQRS Measure 10: Appropriate management of anticoagulation in the peri-procedural period rate – EGD

**Measure Title:** 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:** N/A

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

**Measure Type:** Process, standard measure  
**Measure Domain:** Communication and Care Coordination

**Rationale and Supported Evidence:**

Given bleeding is an adverse event associated with EGD,\(^29\),\(^30\),\(^31\) adherence to this quality measure is supported by GIQuIC for this population of patients.

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GIQuIC Non-PQRS Measure 11: Helicobacter pylori (H. pylori) status rate

**Measure Title:** Helicobacter pylori (H. pylori) status rate

**Description:** Percentage of patients undergoing an EGD with a duodenal or gastric ulcer whose H. pylori status is unknown who have a plan documented for assessing H. pylori status

**Denominator:** All patients undergoing an EGD with a duodenal or gastric ulcer whose H. pylori status is unknown

**Denominator Exceptions/Exclusions:** N/A

**Numerator:** Number of patients undergoing an EGD with a duodenal or gastric ulcer whose H. pylori status is unknown and for whom a plan for assessing H. pylori status has been documented

**Measure Type:** Process, standard measure  
**Measure Domain:** Communication and Care Coordination

**Rationale and Supported Evidence:**

H. pylori is a common cause of gastric and duodenal ulcer disease. Successful eradication of this organism results in dramatically reduced rates of ulcer recurrence.\(^{32}\) ASGE guidelines pertaining to the role of endoscopy for peptic ulcer disease recommends that all patients with gastric or duodenal ulcers should be assessed for this infection.\(^{33}\)

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GIQuIC Non-PQRS Measure 12: Appropriate indication for colonoscopy

**Measure Title:** 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:** N/A

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

**Measure Type:** Process, standard measure  
**Measure Domain:** Effective Clinical Care

**PQRS Status of Measure Concept:** N/A  
**NQF Endorsement Status:** N/A

**Rationale and Supporting Evidence:**

In 2012, ASGE updated its indications for endoscopic procedures, *Appropriate Use of Gastrointestinal Endoscopy.*\textsuperscript{34} 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.\textsuperscript{35, 36, 37}

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

\textsuperscript{34} ASGE Standards of Practice Committee, Early DS, Ben-Menachem T \textit{et al}. Appropriate use of GI endoscopy. Gastrointest Endosc 2012;75:1127-31.


**GIQuIC Non-PQRS Measure 14:** Repeat screening colonoscopy recommended within one year due to inadequate bowel preparation

**Measure Title:** Repeat screening colonoscopy recommended within one year due to inadequate bowel preparation  
**Description:** Percentage of patients with an inadequate bowel preparation who received a recommendation for a repeat screening colonoscopy of one year or less  
**Denominator:** Screening colonoscopies with an inadequate bowel preparation  
**Denominator Exceptions/Exclusions:** N/A  
**Numerator:** Number of patients for whom bowel preparation was assessed and documented as inadequate whose recommended follow up interval was one year or less  
**Measure Type:** Outcome, standard measure  
**Measure Domain:** Efficiency and Cost Reduction

**Rationale and Supported Evidence:**
The economic burden of repeating examinations because of inadequate bowel preparation is substantial. The Clinical Outcomes Research Initiative (CORI) on Colonoscopy Quality Indicators Study of 53 gastroenterology practice sites in 24 states looked at all patients undergoing colonoscopy (n=438,521); in this study, quality of bowel prep recorded was assessed. Findings indicated that 13.9% of reports did not have bowel prep quality reported and in 14 of 53 practices, over 20% did not have bowel prep quality.  
A study conducted in a public hospital and university hospital setting concluded that inadequate bowel preparation increased costs by 12% in the university hospital and 22% in the public hospital. The percentage of outpatient examinations with inadequate bowel preparation that require repeat colonoscopy in 1 year should not exceed 15%. All patients for whom bowel preparation was assessed and documented as inadequate should receive a recommended follow up interval of one year or less.

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**GIQuIC Non-PQRS Measure 15**: Appropriate follow-up interval of 3 years recommended based on pathology findings from screening colonoscopy in average-risk patients

**Measure Title**: 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 adequate screening colonoscopies of average-risk patients aged 50 years and older with biopsy or polypectomy and pathology finds of 3-10 adenomas, OR Advanced Neoplasm (≥ 10 mm, high grade dysplasia, villous component) OR Sessile serrated polyp ≥ 10 mm OR sessile serrate polyp with dysplasia OR traditional serrated adenoma

**Denominator Exceptions/Exclusions**: N/A

**Numerator**: Number of average-risk patients aged 50 years and older receiving a complete and adequate screening colonoscopy with biopsy or polypectomy and pathology finds of 3-10 adenomas OR Advanced Neoplasm (≥ 10 mm, high grade dysplasia, villous component) OR 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

**Measure Type**: Process, standard measure

**Measure Domain**: Communication and Care Coordination

**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 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.