2020 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 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.

Measure #	Title	Outcome/ High-Priority
GIQIC22	Screening Colonoscopy Adenoma Detection Rate	Outcome
QPP320	Appropriate follow-up interval for normal colonoscopy in average risk patients	High-Priority
QPP425	Photodocumentation of Cecal Intubation	N/A
QPP439	Age Appropriate Screening Colonoscopy	High-Priority
GIQIC15	Appropriate follow-up interval of 3 years recommended based on pathology findings from screening colonoscopy in average-risk patients	High-Priority
GIQIC17	Appropriate follow-up interval of 5 years for colonoscopies with findings of sessile serrated polyps < 10 mm without dysplasia	High-Priority
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	High-Priority
NHCR4	Repeat screening or surveillance colonoscopy recommended within one year due to inadequate/poor bowel preparation	High-Priority
GIQIC12	Appropriate indication for colonoscopy	High-Priority
GIQIC19	Appropriate indication for esophagogastroduodenoscopy (EGD)	High-Priority
GIQIC10	Appropriate management of anticoagulation in the peri-procedural period rate – EGD	High-Priority

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 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.

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

[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.

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* [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.

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 $\geqslant$ 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

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: 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

[2] ASGE Standards of Practice Committee, Early DS, Ben-Menachem T *et al.* Appropriate use of GI endoscopy. Gastrointest Endosc 2012;75:1127-31.
[3] 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.
[4] 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.
[5] de Bosset V, Froehlich F, Rey JP, et al. Do explicit appropriateness criteria enhance the diagnostic yield of colonoscopy? Endoscopy 2002;34:360-8.

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

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

[6] Ginzburg L, Greenwald D, Cohen J. Complications of endoscopy. Gastrointest Endosc Clin N Am 2007;17:405-32.
[7] Ben-Menachem T, Decker GA, Early DS, et al. Adverse events of upper GI endoscopy. Gastrointest Endosc 2012;76:707-18.
[8] Eisen GM, Baron TH, Dominitz JA, et al. Complications of upper GI endoscopy. Gastrointest Endosc 2002;55:784-93.