

## 2022 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 2022 program year. Additional detail on GIQuIC's QCDR measures available for public reporting follows on the subsequent pages.

The GIQuIC 2022 QCDR has been approved to support individual eligible clinician, group, and virtual group reporting to the Quality, Improvement Activities, and Promoting Interoperability performance categories.

<b>Measure #</b>	<b>Title</b>	<b>Outcome/ High-Priority</b>
GIQIC25	Screening Colonoscopy Adenoma Detection Rate - Female	Outcome
GIQIC24	Screening Colonoscopy Adenoma Detection Rate - Male	Outcome
GIQIC23	Appropriate follow-up interval based on pathology findings in screening colonoscopy	High-Priority
NHCR4	Repeat screening or surveillance colonoscopy recommended within one year due to inadequate/poor bowel preparation	High-Priority
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
GIQIC10	Appropriate management of anticoagulation in the peri-procedural period rate – EGD	High-Priority

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**GIQIC25: Screening Colonoscopy Adenoma Detection Rate - Female**

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

**Denominator:** Female patients aged 50 to 75 years undergoing a screening colonoscopy

**Denominator Exceptions:** 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:** 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:** 1

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

**Traditional vs. inverse measure:** Traditional

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

**Care Setting:** Outpatient Services

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**GIQIC24: Screening Colonoscopy Adenoma Detection Rate - Male**

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

**Denominator:** Male patients aged 50 to 75 years undergoing a screening colonoscopy

**Denominator Exceptions:** Documentation that neoplasm detected in a male patient is only diagnosed as traditional serrated adenoma, sessile serrated polyp, or sessile serrated adenoma

**Denominator Exclusions:** None

**Numerator:** Number of male 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:** 1

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

**Traditional vs. inverse measure:** Traditional

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

**Care Setting:** Outpatient Services

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**GIQIC23:** Appropriate follow-up interval based on pathology findings in screening colonoscopy

**Description:** Percentage of procedures among average-risk patients aged 50 to 75 years receiving a screening colonoscopy with biopsy or polypectomy and pathology findings who had a follow-up interval consistent with US Multi-Society Task Force (USMSTF) recommendations for repeat colonoscopy documented in their colonoscopy report.

**Denominator:** All complete and adequately prepped screening colonoscopies of average-risk patients aged 50 to 75 years with biopsy or polypectomy and pathology findings of

(Strata 1) only hyperplastic polyps

(Strata 2) findings of 1-2 tubular adenoma(s)

(Strata 3) findings of 3-4 tubular adenomas

(Strata 4) findings of 5-10 tubular adenomas

(Strata 5) Advanced Neoplasm ( $\geq$  10 mm, high grade dysplasia, villous component)

(Strata 6) Sessile serrated polyp  $\geq$  10 mm OR sessile serrated polyp with dysplasia OR traditional serrated adenoma

**Denominator Exceptions:**

(Strata 1) Patients aged 66 to 75 or polyps were removed via piecemeal

(Strata 2) Patients aged 66 to 75 or polyps were removed via piecemeal

(Strata 3) Patients aged 66 to 75 or polyps were removed via piecemeal

(Strata 4) Patients aged 66 to 75 or polyps were removed via piecemeal

(Strata 5) polyps were removed via piecemeal

(Strata 6) polyps were removed via piecemeal

**Denominator Exclusions:**

(Strata 1)  $\geq$  21 hyperplastic polyps or the number of polyps removed does not equal the number of polyps retrieved or Use of endoscopic mucosal resection

(Strata 2) The number of polyps removed does not equal the number of polyps retrieved or Use of endoscopic mucosal resection

(Strata 3) The number of polyps removed does not equal the number of polyps retrieved or Use of endoscopic mucosal resection

(Strata 4) The number of polyps removed does not equal the number of polyps retrieved or Use of endoscopic mucosal resection

(Strata 5) Colonoscopy with findings of > 10 adenomas or findings of adenocarcinoma or Use of endoscopic mucosal resection

(Strata 6) Colonoscopy with findings of > 10 adenomas or findings of adenocarcinoma or Use of endoscopic mucosal resection

**Numerator:** Number of complete and adequately prepped screening colonoscopies of average-risk patients aged 50 to 75 years

(Strata 1) with biopsy or polypectomy and pathology findings of only hyperplastic polyps for which a recommended follow-up interval of 10 years for repeat colonoscopy was given to the patient

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(Strata 2) with biopsy or polypectomy and pathology findings of 1-2 tubular adenoma(s) for which a recommended follow-up interval of not less than 7 years and not greater than 10 years was given to the patient

(Strata 3) with biopsy or polypectomy and pathology findings of 3-4 tubular adenomas for which a recommended follow-up interval of not less than 3 years and not greater than 5 years was given to the patient

(Strata 4) with biopsy or polypectomy and pathology findings of 5-10 tubular adenomas for which a recommended follow-up interval of 3 years was given to the patient

(Strata 5) with biopsy or polypectomy and pathology findings of Advanced Neoplasm ( $\geq 10$  mm, high grade dysplasia, villous component) for which a recommended follow-up interval of 3 years for repeat colonoscopy was given to the patient

(Strata 6) with biopsy or polypectomy and pathology findings of Sessile serrated polyp  $\geq 10$  mm OR sessile serrated polyp with dysplasia OR traditional serrated adenoma who had a recommended follow-up interval of 3 years for repeat colonoscopy was given to the patient

**Rationale and Supported Evidence:**

After high-quality screening colonoscopy, patients with polyps are risk-stratified based on the histology, number, location, and size of polyps detected. Studies support villous histology as a potential risk factor for advanced neoplasia and there is extended evidence to support high-grade dysplasia as a risk factor for metachronous advanced neoplasia and CRC; therefore, a shorter interval for follow-up colonoscopy is recommended for patients with these findings. Evidence to support best practices for surveillance colonoscopy has strengthened and has helped to support close follow-up for some groups, as well as less intense follow-up for others.

**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:** 7

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

**Traditional vs. inverse measure:** Traditional

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

**Care Setting:** Outpatient Services

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**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  $\leq 1$  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

**Care Setting:** Ambulatory Care: Hospital; Outpatient Services

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**2022 QCDR Measures**

**GIQuIC10:** 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, 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

**Care Setting:** Outpatient Services