



New Hampshire Colonoscopy Registry

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Merit-based Incentive Payment system (MIPS) 2022 Qualified Clinical Data Registry (QCDR) Measure Specifications

Summary Listing of MIPS Quality Measures and QCDR measures supported by the NHCR

Measure #	Title	Description	Type / Priority
MIPS/ CQMS 185	Colonoscopy Interval for Patients with a History of Adenomatous Polyps	Percentage of patients aged 18 years and older receiving a surveillance colonoscopy, with a history of prior adenomatous polyp(s) in previous colonoscopy findings, which had an interval of 3 or more years since their last colonoscopy	Process / High Priority
MIPS/ CQMS 320	Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	Percentage of patients aged 50 to 75 years of age 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	Process / High Priority
MIPS/ CQMS 425	Photodocumentation of Cecal Intubation	The rate of screening and surveillance colonoscopies for which photodocumentation of at least two landmarks of cecal intubation is performed to establish a complete examination	Process
MIPS/ CQMS 439	Age Appropriate Screening Colonoscopy	The percentage of patients greater than 85 years of age who received a screening colonoscopy from January 1 to December 31	Efficiency / High Priority
NHCR4	Repeat screening/surveillance colonoscopy recommended within 1 yr due to inadequate / poor bowel preparation	Percentage of patients recommended for repeat screening or surveillance colonoscopy within one year or less due to inadequate/poor bowel preparation quality	Process / High Priority
GIQIC23	Appropriate follow-up interval based on pathology findings in screening colonoscopy	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	Process / High Priority
GIQIC24	Screening Colonoscopy Adenoma Detection Rate - Male	The percentage of male patients aged 50 to 75 years with at least one conventional adenoma or colorectal cancer detected during screening colonoscopy	Outcome / High Priority
GIQIC25	Screening Colonoscopy Adenoma Detection Rate – Female	The percentage of female patients aged 50 to 75 years with at least one conventional adenoma or colorectal cancer detected during screening colonoscopy	Outcome / High Priority

DETAILED DESCRIPTION OF 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

TYPE OF MEASURE / PRIORITY STATUS: Process / High Priority (Care Coordination)

CARE SETTING: Ambulatory Care: Clinician Office/Clinic, Ambulatory Care: Hospital, Ambulatory Surgical Center, Hospital, Hospital Inpatient, Hospital Outpatient, Outpatient Services

NQS DOMAIN: Communication and Care Coordination

NQF#: N/A

MEANINGFUL MEASURE AREA: Appropriate use of Health Care

MEANINGFUL MEASURE AREA RATIONALE: All patients for whom bowel preparation was assessed and documented as inadequate should receive a recommended follow up interval of one year or less to receive a complete screening or surveillance colonoscopy for colorectal cancer prevention. Colonoscopies with poor bowel preparation are considered incomplete due to inadequate mucosal visualization, and shorter follow-up intervals are recommended to ensure effective care.¹⁻⁵ National guidelines issued in 2012 by the US Multi Society Task Force on Colorectal Cancer recommend repeat colonoscopies within a year following most colonoscopies with poor bowel prep.⁶

DENOMINATOR: # of screening and surveillance colonoscopies with bowel preparation documented as inadequate/poor

DENOMINATOR EXCLUSIONS OR EXCEPTIONS: None

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

NUMERATOR EXCLUSIONS: None

INVERSE MEASURE: No

PROPORTIONAL MEASURE: Yes

CONTINUOUS VARIABLE MEASURE: No

RATIO MEASURE: No

OUTCOME MEASURE: No

RISK ADJUSTED: No

DATA SOURCE: NHCR Procedure form, (Q. 2 Indication for Procedure, Q. 4 Bowel preparation quality, Q. 9, Follow-up recommendation)

NUMBER OF PERFORMANCE RATES TO BE SUBMITTED: 1

SPECIALTY: Gastroenterology

CLINICAL RECOMMENDATION STATEMENT:

Evidence suggests that adherence to this guideline is surprisingly inconsistent, with intervals following poor bowel prep often highly variable.⁷⁻⁹

EVIDENCE OF A PERFORMANCE GAP AND CITATIONS: "If bowel cleansing is inadequate to identify polyps >5 mm in size, and the procedure is being performed for CRC 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." from Rex DK, Schoenfeld PS, Cohen J, Pike IM, et al. . Quality indicators for colonoscopy. *Gastrointest Endosc.* 2015;81(1):31-53. Epub 2014/12/07. doi: 10.1016/j.gie.2014.07.058. PubMed PMID: 25480100.

REFERENCES

1. Rex DK, Johnson DA, Anderson JC, et al. American College of Gastroenterology guidelines for colorectal cancer screening 2009 [corrected]. *Am J Gastroenterol* 2009;104:739-50.
2. Rex DK, Bond JH, Winawer S, et al. Quality in the technical performance of colonoscopy and the continuous quality improvement process for colonoscopy: recommendations of the U.S. Multi-Society Task Force on Colorectal Cancer. *Am J Gastroenterol* 2002;97:1296-308.
3. Bond JH. Should the quality of preparation impact postcolonoscopy follow-up recommendations? *Am J Gastroenterol* 2007;102:2686-7.
4. Levin TR. Dealing with uncertainty: surveillance colonoscopy after polypectomy. *Am J Gastroenterol* 2007;102:1745-7.

5. Rex DK, Bond JH, Feld AD. Medical-legal risks of incident cancers after clearing colonoscopy. *Am J Gastroenterol* 2001;96:952-7.
6. 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.
7. Ben-Horin S, Bar-Meir S, Avidan B. The impact of colon cleanliness assessment on endoscopists' recommendations for follow-up colonoscopy. *Am J Gastroenterol* 2007;102:2680-5.
8. Larsen M, Hills N, Terdiman J. The impact of the quality of colon preparation on follow-up colonoscopy recommendations. *Am J Gastroenterol* 2011;106:2058-62.
9. Menees SB, Elliott E, Govani S, et al. The impact of bowel cleansing on follow-up recommendations in average-risk patients with a normal colonoscopy. *Am J Gastroenterol* 2014;109:148-54.

GIOIC23: 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.

TYPE OF MEASURE / PRIORITY STATUS: Process / High Priority (Care Coordination)

CARE SETTING: Ambulatory Care: Clinician Office/Clinic, Ambulatory Surgical Center, Hospital Outpatient, Outpatient Services

NQS DOMAIN: Communication and Care Coordination

NQF#: N/A

MEANINGFUL MEASURE AREA: Appropriate use of Health Care

MEANINGFUL MEASURE AREA RATIONALE: Colonoscopies should follow recommended post-polypectomy surveillance intervals to be clinically effective and to minimize risk and further to be cost-effective.

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 (≥ 10 mm, high grade dysplasia, villous component)

(Strata 6) Sessile serrated polyp ≥ 10 mm OR sessile serrated polyp with dysplasia OR traditional serrated adenoma

DENOMINATOR EXCLUSIONS:

(Strata 1) ≥ 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

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

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

(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 (≥ 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 ≥ 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

NUMERATOR EXCLUSIONS: None

INVERSE MEASURE: No

PROPORTIONAL MEASURE: Yes

CONTINUOUS VARIABLE MEASURE: No

RATIO MEASURE: No

OUTCOME MEASURE: No

RISK ADJUSTED: No

DATA SOURCE: NHCR Data Collection Forms, Web-Based data collection, Paper Medical Record, EMR, Pathology reports, NHCR database

NUMBER OF PERFORMANCE RATES TO BE SUBMITTED: 7

DESCRIPTION OF PERFORMANCE RATES: This measure will be calculated with 7 performance rates:

Rate 1: Overall 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

Rate 2: Percentage of complete and adequately prepped screening colonoscopies of average-risk patients aged 50 to 75 years 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

Rate 3: Percentage of complete and adequately prepped screening colonoscopies of average-risk patients aged 50 to 75 years 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

Rate 4: Percentage of complete and adequately prepped screening colonoscopies of average-risk patients aged 50 to 75 years 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

Rate 5: Percentage of complete and adequately prepped screening colonoscopies of average-risk patients aged 50 to 75 years 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

Rate 6: Percentage of complete and adequately prepped screening colonoscopies of average-risk patients aged 50 to 75 years with biopsy or polypectomy and pathology findings of Advanced Neoplasm (≥ 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

Rate 7: Percentage of complete and adequately prepped screening colonoscopies of average-risk patients aged 50 to 75 years with biopsy or polypectomy and pathology findings of 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 consistent was given to the patient

SPECIALTY: Gastroenterology

CLINICAL RECOMMENDATION STATEMENT:

Average-risk patients aged 50 years and older receiving a screening colonoscopy with biopsy or polypectomy and pathology findings should have a recommended follow-up interval consistent with USMSTF recommendations for repeat colonoscopy.

EVIDENCE OF A PERFORMANCE GAP AND CITATIONS:

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.(1)

REFERENCES:

- (1) Recommendations for Follow-Up After Colonoscopy and Polypectomy: A Consensus Update by the US Multi-Society Task Force on Colorectal Cancer. Gupta, Samir et al. Gastroenterology, Volume 158, Issue 4, 1131 - 1153.e5

GIOIC24: 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.

TYPE OF MEASURE / PRIORITY STATUS: Outcome / High Priority

CARE SETTING: Ambulatory Care: Clinician Office/Clinic, Ambulatory Surgical Center, Hospital Outpatient, Outpatient Services

NQS DOMAIN: Effective Clinical Care

NQF#: N/A

MEANINGFUL MEASURE AREA: Preventative Care

MEANINGFUL MEASURE AREA RATIONALE: The removal of adenomatous polyps during a screening colonoscopy is associated with a lower risk of subsequent colorectal cancer incidence and mortality.

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

DENOMINATOR EXCLUSIONS: None

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

NUMERATOR: Number of male patients aged 50 to 75 years with at least one conventional adenoma or colorectal cancer detected during screening colonoscopy

NUMERATOR EXCLUSIONS: None

INVERSE MEASURE: No

PROPORTIONAL MEASURE: Yes

CONTINUOUS VARIABLE MEASURE: No

RATIO MEASURE: No

OUTCOME MEASURE: Yes

RISK ADJUSTED: No

DATA SOURCE: NHCR Data Collection Forms, Web-Based data collection, Paper Medical Record, EMR

NUMBER OF PERFORMANCE RATES TO BE SUBMITTED: 1

SPECIALTY: Gastroenterology

CLINICAL RECOMMENDATION STATEMENT:

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).

EVIDENCE OF A PERFORMANCE GAP AND CITATIONS:

The removal of adenomatous polyps during a screening colonoscopy is associated with a lower risk of subsequent colorectal cancer incidence and mortality. Higher adenoma detection rates (> 25% in a mixed gender population OR 20%

in women and 30% in men) are associated with significant protection against incident colorectal cancer in the five years following screening colonoscopy.

GIOIC25: 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.

TYPE OF MEASURE / PRIORITY STATUS: Outcome / High Priority

CARE SETTING: Ambulatory Care: Clinician Office/Clinic, Ambulatory Surgical Center, Hospital Outpatient, Outpatient Services

NQS DOMAIN: Effective Clinical Care

NQF#: N/A

MEANINGFUL MEASURE AREA: Preventative Care

MEANINGFUL MEASURE AREA RATIONALE: The removal of adenomatous polyps during a screening colonoscopy is associated with a lower risk of subsequent colorectal cancer incidence and mortality.

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

DENOMINATOR EXCLUSIONS: None

DENOMINATOR EXCEPTIONS: Documentation that neoplasm detected in a female patient is only diagnosed as traditional serrated adenoma, sessile serrated polyp, or sessile serrated adenoma

NUMERATOR: Number of female patients aged 50 to 75 years with at least one conventional adenoma or colorectal cancer detected during screening colonoscopy.

NUMERATOR EXCLUSIONS: None

INVERSE MEASURE: No

PROPORTIONAL MEASURE: Yes

CONTINUOUS VARIABLE MEASURE: No

RATIO MEASURE: No

OUTCOME MEASURE: Yes

RISK ADJUSTED: No

DATA SOURCE: NHCR Data Collection Forms, Web-Based data collection, Paper Medical Record, EMR

NUMBER OF PERFORMANCE RATES TO BE SUBMITTED: 1

SPECIALTY: Gastroenterology

CLINICAL RECOMMENDATION STATEMENT:

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).

EVIDENCE OF A PERFORMANCE GAP AND CITATIONS:

The removal of adenomatous polyps during a screening colonoscopy is associated with a lower risk of subsequent colorectal cancer incidence and mortality. Higher adenoma detection rates (> 25% in a mixed gender population OR 20% in women and 30% in men) are associated with significant protection against incident colorectal cancer in the five years following screening colonoscopy.