NHCR
New Hampshire Colonoscopy Registry
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Merit-based Incentive Payment system (MIPS) Qualified Clinical Data Registry (QCDR)
2017 MIPS and non-MIPS Quality Measure Specifications

This document contains a listing of the clinical quality measures which the New Hampshire Colonoscopy Registry (NHCR), a CMS-Approved Qualified Clinical Data Registry (QCDR), can report to CMS for the Merit-based Incentive Payment system (MIPS) in 2017. For detailed specifications of the MIPS measures listed in the shaded portion of the table below, please email christina.m.robinson@dartmouth.edu. Detailed specifications of the non-MIPS measures can be found on pages 2-3 of this document.

Note: In order to participate in the MIPS program, **a provider must successfully report at least 6 quality measures**, including **at least one outcome or high priority measure**. In 2017, the NHCR is approved to submit 8 quality measures (6 MIPS and 2 non-MIPS) on behalf of participating providers.

Summary Listing of MIPS and non-MIPS measures supported by the NHCR

	Measure #	Measure Title	Measure Description	Measure Type / Priority
MIPS MEASURES	#100	Colorectal Cancer Resection Pathology reporting: pT Category and pN Category with histologic grade	% of colon and rectum cancer resection pathology reports that include the pT category (primary tumor), the pN category (regional lymph nodes) and the histologic grade	Process
	#185	Colonoscopy Interval for Patients with a History of Adenomatous Polyps - Avoidance of Inappropriate use	% of patients aged 18 yrs. and older receiving a surveillance colonoscopy, with a history of a prior adenomatous polyp(s) in previous colonoscopy findings, which had an interval of 3 or more years since their last colonoscopy	Process / High Priority
	#320	Appropriate Follow-up interval for normal colonoscopy in average risk patients	% of patients aged 50 yrs. and older 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 colonoscopy report	Process / High Priority
	#343	Screening Colonoscopy Adenoma Detection Rate	% of patients aged 50 yrs. or older with at least 1 adenoma or other colorectal cancer (CRC) precursor or CRC detected during screening colonoscopy	Outcome / High Priority
	#425	Photodocumentation of Cecal Intubation	% of screening and surveillance colonoscopies for which photo-documentation of landmarks of cecal intubation is performed	Process / Not High Priority
	#439	Age Appropriate Screening Colonoscopy	% of patients >85 years of age who received a screening colonoscopy in measurement year	Efficiency / High Priority
NON-MIPS MEASURES	NHCR4	Repeat screening or surveillance colonoscopy recommended within 1 year due to inadequate / poor bowel preparation	% of patients recommended for repeat colonoscopy due to inadequate bowel prep	Outcome
	NHCR5	Repeat colonoscopy recommended due to piecemeal resection	% of exams with polyps removed by piecemeal excision who are told to return in appropriate interval ≤1 year	Outcome

DETAILED SPECIFICATIONS OF NHCR NON-MIPS MEASURES

NHCR 4: Repeat screening or surveillance colonoscopy recommended within 1 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

NQS DOMAIN: Effective Clinical Care

TYPE OF MEASURE: Outcome

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

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

DENOMINATOR EXCLUSIONS: Colonoscopies with bowel preparation quality = excellent, good, or fair

DENOMINATOR EXCEPTIONS: None

RATIONALE AND REFERENCES: Since screening and surveillance colonoscopies with a poor bowel preparation are considered incomplete due to inadequate mucosal visualization, shorter intervals for follow-up have been recommended.[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] Limited evidence suggests that adherence to this guideline is surprisingly inconsistent, with intervals following poor bowel prep often highly variable. [7-9]

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

NHCR 5: Repeat colonoscopy recommended due to piecemeal resection

DESCRIPTION: Percentage of exams with polyps removed by piecemeal excision who are told to return in appropriate interval ≤1 year

NQS DOMAIN: Effective Clinical Care

TYPE OF MEASURE: Outcome

NUMERATOR: # of colonoscopies with polyps removed by piecemeal excision who are told to return for surveillance in ≤ 1 year

DENOMINATOR: all colonoscopies with piecemeal excision

DENOMINATOR EXCLUSIONS: Colonoscopies with no piecemeal resection

DENOMINATOR EXCEPTIONS: None.

RATIONALE AND REFERENCES: The USMSTF recommends consideration of a short interval for repeat colonoscopy (<1 year) if there is any question about the completeness of resection of large polyps removed using piecemeal resection.[6]

DATA SOURCE: NHCR Procedure form, (Q. 3 b treatment = Piecemeal excision , Q. 9 Follow-up recommendation)

References

1. Rex DK, Johnson DA, Anderson JC, Schoenfeld PS, Burke CA, Inadomi JM. American College of Gastroenterology guidelines for colorectal cancer screening 2009 [corrected]. The American journal of gastroenterology 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. The American journal of gastroenterology 2002;97:1296-308.
3. Bond JH. Should the quality of preparation impact postcolonoscopy follow-up recommendations? The American journal of gastroenterology 2007;102:2686-7.
4. Levin TR. Dealing with uncertainty: surveillance colonoscopy after polypectomy. The American journal of gastroenterology 2007;102:1745-7.
5. Rex DK, Bond JH, Feld AD. Medical-legal risks of incident cancers after clearing colonoscopy. The American journal of gastroenterology 2001;96:952-7.
6. Lieberman DA, Rex DK, Winawer SJ, Giardiello FM, Johnson DA, Levin TR. 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. The American journal of gastroenterology 2007;102:2680-5.
8. Larsen M, Hills N, Terdiman J. The impact of the quality of colon preparation on follow-up colonoscopy recommendations. The American journal of gastroenterology 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. The American journal of gastroenterology 2014;109:148-54.