



Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to sub criterion 1b).

Brief Measure Information

NQF #: 0659

Corresponding Measures:

De.2. Measure Title: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use

Co.1.1. Measure Steward: American Gastroenterological Association

De.3. Brief Description of Measure: Percentage of patients aged 18 years 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

1b.1. Developer Rationale: Colorectal cancer is the 2nd leading cause of cancer death in the United States. Colonoscopy is the recommended method of surveillance after the removal of adenomatous polyps because it has been shown to significantly reduce subsequent colorectal cancer incidence. The time interval for the development of malignant changes in adenomatous polyps is estimated at 5 to 25 years. (ICSI, 2006) 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. (Lieberman et al, 2009)

S.4. Numerator Statement: Patients who had an interval of 3 or more years since their last colonoscopy

S.6. Denominator Statement: All patients aged 18 years and older receiving a surveillance colonoscopy, with a history of a prior adenomatous polyp(s) in previous colonoscopy findings

S.8. Denominator Exclusions: Documentation of medical reason(s) for an interval of less than 3 years since the last colonoscopy (eg, last colonoscopy incomplete, last colonoscopy had inadequate prep, piecemeal removal of adenomas, last colonoscopy found greater than 10 adenomas, or patient at high risk for colon cancer [Crohn's disease, ulcerative colitis, lower gastrointestinal bleeding, personal or family history of colon cancer])

Documentation of system reason(s) for an interval of less than 3 years since the last colonoscopy (eg, unable to locate previous colonoscopy report, previous colonoscopy report was incomplete)

De.1. Measure Type: Process

S.17. Data Source: Claims, Electronic Health Data, Electronic Health Records, Other, Registry Data

S.20. Level of Analysis: Clinician : Group/Practice, Clinician : Individual

IF Endorsement Maintenance – Original Endorsement Date: Jan 17, 2011 **Most Recent Endorsement Date:** Sep 27, 2013

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? N/A

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-

than-optimal performance. **Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.**

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

[NQF_-659_Evidence_Form_07_16_12_final-636426402238645942.docx](#)

1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?

Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

No

1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- Disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure (e.g., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.

Colorectal cancer is the 2nd leading cause of cancer death in the United States. Colonoscopy is the recommended method of surveillance after the removal of adenomatous polyps because it has been shown to significantly reduce subsequent colorectal cancer incidence. The time interval for the development of malignant changes in adenomatous polyps is estimated at 5 to 25 years. (ICSI, 2006) 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. (Lieberman et al, 2009)

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. *(This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.*

A recent pooled analysis of surveillance colonoscopy in 9167 patients from 8 studies confirmed the relative discrimination between high and low risk groups on the basis of patient features and endoscopic findings (Martinez, 2009). The index findings of advanced histology or greater size or number of polyps correlated with risk for subsequent advanced neoplasia. Hence, the timing of follow-up colonoscopy should be tailored to the number, size, and pathologic findings of the adenomatous polyps removed (Levin 2008).

In a large multi-state community-based study of colorectal cancer surveillance, one third of those with only 1-2 low risk adenomas were noted to undergo relatively premature repeat colonoscopy within 4 years (median 3.1 yrs), despite recommendations for repeat examination in 5 years, and more recently, 5 to 10 years (Schoen, 2010). Similarly, evidence from 4 surveys indicated that postpolypectomy surveillance colonoscopy in the United States is frequently performed at intervals that are shorter than those recommended in guidelines (Rex et al, 2006). Some endoscopists in these studies performed colonoscopy in patients with only small hyperplastic polyps or a single tubular adenoma at 1 year. These surveys underscore the importance of measuring intervals between examinations in continuous quality improvement programs.

In a 2006 study of 1282 colonoscopy reports, recommendations were consistent with current guidelines in only 36.7% of cases. (Krist et al, 2007).

This measure was used in the 2009-2012 CMS Physician Quality Reporting Initiative/System. There is a gap in care as shown by this data; 98.01% is the aggregate performance rate in the total patient population and 97.26% is the mean performance rate of TIN/NPI's.

10th percentile: 93.40%

25th percentile: 100.00%

50th percentile: 100.00%

75th percentile: 100.00%

90th percentile: 100.00%

Exception Rate: 13.50%

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

Institute for Clinical Systems Improvement (ICSI). Colorectal cancer screening. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2006 Jun. 50 p.

Martinez ME, Baron JA, Lieberman DA, et al. A Pooled Analysis of Advanced Colorectal Neoplasia Diagnoses after Colonoscopic Polypectomy. Gastroenterology Vol 136, 2009.

Levin B, Lieberman DA, McFarland B et al. Screening and Surveillance for the Early Detection of Colorectal Cancer and Adenomatous Polyps, 2008: A Joint Guideline from the American Cancer Society, the US Multi-Society Task Force on Colorectal Cancer, and the American College of Radiology. CA Cancer J Clin Vol, No 58; 2008.

Schoen R, Pinsky PF, Weissfeld JL, et al. Utilization of Surveillance Colonoscopy in Community Practice. Gastroenterology Vol 138, 2010.

Rex DK. Overuse of postpolypectomy surveillance colonoscopy. - - Rev Gastroenterol Disord Vol 6, No 3; 2006.

Krist, AH, Jones, RM, Woolf, SH et al. Timing of Repeat Colonoscopy: Disparity Between Guidelines and Endoscopists' Recommendation. American Journal of Preventive Medicine. 2007.

Confidential CMS PQRI 2010 Performance Information by Measure. Jan 2010-Feb2011 TAP file.

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. (*This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.*) For measures that show high levels of performance, i.e., "topped out", disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

After a search of the medical literature, we are not aware of any publications/evidence outlining disparities in this area.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4

N/A

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area (check all the areas that apply):

Gastrointestinal (GI)

De.6. Non-Condition Specific(check all the areas that apply):

Primary Prevention, Safety : Overuse

De.7. Target Population Category (Check all the populations for which the measure is specified and tested if any):

Elderly

S.1. Measure-specific Web Page (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

www.gastro.org

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

[This is not an eMeasure](#) Attachment:

S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

[No data dictionary](#) Attachment:

S.2c. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

[No, this is not an instrument-based measure](#) Attachment:

S.2d. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

[Not an instrument-based measure](#)

S.3.1. For maintenance of endorsement: Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

[No](#)

S.3.2. For maintenance of endorsement, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

[Since the last endorsement date, there have been no changes to the measure.](#)

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome) DO NOT include the rationale for the measure.

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

[Patients who had an interval of 3 or more years since their last colonoscopy](#)

S.5. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

[Patients will be counted in the numerator if there is an interval of 3 or more years since their last colonoscopy.](#)

S.6. Denominator Statement *(Brief, narrative description of the target population being measured)*

All patients aged 18 years and older receiving a surveillance colonoscopy, with a history of a prior adenomatous polyp(s) in previous colonoscopy findings

S.7. Denominator Details *(All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)*

IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

The denominator of this measure includes patients at least 18 years of age receiving a surveillance colonoscopy during the measurement period with a history of a prior adenomatous polyp(s) in previous colonoscopy findings.

ICD-10-CM: Z86.010

AND

Patient encounter during the reporting period (CPT or HCPCS): 44388, 44389, 44392, 44394, 45378, 45380, 45381, 45384, 45385, G0105

WITHOUT

CPT Category I Modifiers: 52, 53, 73 or 74

S.8. Denominator Exclusions *(Brief narrative description of exclusions from the target population)*

Documentation of medical reason(s) for an interval of less than 3 years since the last colonoscopy (eg, last colonoscopy incomplete, last colonoscopy had inadequate prep, piecemeal removal of adenomas, last colonoscopy found greater than 10 adenomas, or patient at high risk for colon cancer [Crohn's disease, ulcerative colitis, lower gastrointestinal bleeding, personal or family history of colon cancer])

Documentation of system reason(s) for an interval of less than 3 years since the last colonoscopy (eg, unable to locate previous colonoscopy report, previous colonoscopy report was incomplete)

S.9. Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)*

Documentation of medical reason(s) for an interval of less than 3 years since the last colonoscopy (eg, last colonoscopy incomplete, last colonoscopy had inadequate prep, piecemeal removal of adenomas, last colonoscopy found greater than 10 adenomas, or patient at high risk for colon cancer [Crohn's disease, ulcerative colitis, lower gastrointestinal bleeding, personal or family history of colon cancer])

Documentation of system reason(s) for an interval of less than 3 years since the last colonoscopy (eg, unable to locate previous colonoscopy report, previous colonoscopy report was incomplete)

S.10. Stratification Information *(Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)*

We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language.

S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

S.12. Type of score:

Rate/proportion

If other:

S.13. Interpretation of Score *(Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)*

Better quality = Higher score

S.14. Calculation Algorithm/Measure Logic *(Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)*

To calculate performance rates:

- 1) Find the patients who meet the initial patient population (ie, the general group of patients that a set of performance measures is designed to address).
- 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical.
- 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator
- 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator when exceptions have been specified [for this measure: medical reason(s) (eg, patients with high risk for colon cancer, last colonoscopy incomplete, last colonoscopy had inadequate prep, piecemeal removal of adenomas, or last colonoscopy found greater than 10 adenomas) or system reason(s) for an interval of less than 3 years since the last colonoscopy (eg, unable to locate previous colonoscopy report)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents performance not met.

S.15. Sampling *(If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)*

IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.

Not applicable. The measure does not require sampling or a survey.

S.16. Survey/Patient-reported data *(If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)*

Specify calculation of response rates to be reported with performance measure results.

N/A

S.17. Data Source *(Check ONLY the sources for which the measure is SPECIFIED AND TESTED).*

If other, please describe in S.18.

Claims, Electronic Health Data, Electronic Health Records, Other, Registry Data

S.18. Data Source or Collection Instrument *(Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)*

IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.

N/A

S.19. Data Source or Collection Instrument *(available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)*

NoAttachment

S.20. Level of Analysis *(Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)*

Clinician : Group/Practice, Clinician : Individual

S.21. Care Setting *(Check ONLY the settings for which the measure is SPECIFIED AND TESTED)*

Inpatient/Hospital, Outpatient Services

If other:

S.22. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

2. Validity – See attached Measure Testing Submission Form

[NQF_659_-_Testing_Attachment_FINAL-636426402239895942.doc](#)

2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

No

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

No

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1,2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

No - This measure is not risk-adjusted

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

[generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition](#)

If other:

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields) Update this field for **maintenance of endorsement**.

[ALL data elements are in defined fields in electronic health records \(EHRs\)](#)

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources. For **maintenance of endorsement, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).**

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Please also complete and attach the NQF Feasibility Score Card.

Attachment:

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Required for maintenance of endorsement. Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

IF instrument-based, consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

This measure was found to be reliable and feasible for implementation. Measure has been implemented by CMS since 2009 and is currently a high-priority measure in the Quality Payment Program (QPP)

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).

N/A

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Specific Plan for Use	Current Use (for current use provide URL)
	Public Reporting http://www.cms.gov/pqrs Payment Program QPP https://qpp.cms.gov/ Professional Certification or Recognition Program http://giquic.gi.org/

4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included
- Level of measurement and setting

Current Use 1

This measure is currently in use in CMS's Physician Quality Reporting System (PQRS) and has been since 2009.

Current Use 2

The GI Quality Improvement Consortium, Ltd. ("GIQuIC") is an educational and scientific 501(c)(3) organization established by gastroenterologists, physicians specializing in digestive disorders. GIQuIC is a joint initiative of the American College of Gastroenterology (ACG) and the American Society for Gastrointestinal Endoscopy (ASGE). GIQuIC is a procedure-focused benchmarking registry using established quality indicators. The geographic area is the entire United States. GIQuIC registry participants have contributed real-time procedure related data from over 100,000 colonoscopies, not claims data, and the growth rate for the registry has increased to almost 2,000 new cases per week in recent months, with an accompanying surge in the growth of the number of practices involved in this quality improvement effort. GIQuIC is a national registry that fosters the ability of endoscopists and endoscopy facilities to benchmark themselves, and provides impetus for quality improvement. Some 84 data fields for colonoscopy are collected and ten quality measures are benchmarked, including rate of cecal intubation, adenoma detection rate, prep assessment, and appropriate indications for procedure, among others. Currently, hundreds of physicians from endoscopy centers nationwide have registered to participate in this ground-breaking initiative.

<http://giquic.gi.org/>

Current Use 3

Multiple QCDRs including: Able Health; Academic Research for Clinical Outcomes (ARCO) in Collaboration with ReportingMD, Inc.; Citiustech, Inc.; Health-Advanta; Meditab Software, Inc.; New Hampshire Colonoscopy Registry; Searfoss Consulting Group; Sovereign QCDR Registry

4a1.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

Measure is currently reported in the Quality Payment Program and has been in use in PQRS since 2009. Measure has also been harmonized with the Ambulatory Surgical Center, ASC 10.

4a1.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

This measure is currently in use in CMS's Quality Payment Program (QPP) and has been in use in PQRS since 2009.

4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.

Measure has been implemented in the QPP as an individual measure for both claims and registry reporting, feedback is provided via CMS QRUR reports and quarterly feedback via QCDRs.

4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

Measure has been implemented in the QPP as an individual measure for both claims and registry reporting, feedback is provided via CMS QRUR reports and quarterly feedback via QCDRs.

4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

No feedback received

4a2.2.2. Summarize the feedback obtained from those being measured.

No feedback received from those being measured

4a2.2.3. Summarize the feedback obtained from other users

No feedback obtained from other users

4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

No feedback received

Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)

If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

Performance measurement serves as an important component in a quality improvement strategy but performance measurement alone will not achieve the desired goal of improving patient care. Measures can have their greatest effect when they are used judiciously and linked directly to operational steps that clinicians, patients, and health plans can apply in practice to improve care.

4b2. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

We are not aware of any unintended consequences related to this measurement.

4b2.2. Please explain any unexpected benefits from implementation of this measure.

We are not aware of any unexpected benefits from implementation of this measure.

5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

Yes

5.1a. List of related or competing measures (selected from NQF-endorsed measures)

0034 : Colorectal Cancer Screening (COL)

0392 : Colorectal Cancer Resection Pathology Reporting- pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade

0572 : Follow-up after initial diagnosis and treatment of colorectal cancer: colonoscopy

0658 : Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
 ACP-018-10 : Endoscopy/Polyp Surveillance: Comprehensive Colonoscopy Documentation

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

ASC 10: Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use - Telligen

ASC 9 - Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients

5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications harmonized to the extent possible?

No

5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.

The list of measures above, includes several different populations and capture different elements in the numerator. None of them are aiming to capture the same information as measure 0658. Measures 0572, ACP-018-10, and 0392 actually aim to capture specific elements within the colonoscopy report or pathology report (after colon/rectum resection). Measure 0034 has an entirely different patient population, as it captures patients ages 51-75 only. Measure 0658 focuses on a different patient population than measure 0659, as the patients in 0659 have had a history of a prior colonic polyp(s) in previous colonoscopy findings. The patient population in measure 0658 has a different follow up interval recommendation, according to evidence based guidelines.

5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

There are no competing measures.

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

Attachment Attachment: [NQF_GI_GUPProject_Stage2_Checklist_Memo_AMAPCPI_Answers-634935180482689492-636426402241145942.docx](#)

Contact Information

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Co.3 Measure Developer if different from Measure Steward: American Gastroenterological Association

Co.4 Point of Contact: David, Godzina, dgodzina@gastro.org, 301-272-1600-

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

PCPI measures are developed through cross-specialty, multi-disciplinary work groups. All medical specialties and other health care professional disciplines participating in patient care for the clinical condition or topic under study are invited to be equal contributors to the measure development process. In addition, the PCPI strives to include on its work groups individuals representing the perspectives of patients, consumers, private health plans, and employers. This broad-based approach to measure development ensures buy-in on the measures from all stakeholders and minimizes bias toward any individual specialty or stakeholder group. All work groups have at least two co-chairs who have relevant clinical and/or measure development expertise and who are responsible for ensuring that consensus is achieved and that all perspectives are voiced.

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Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2008

Ad.3 Month and Year of most recent revision: 08, 2008

Ad.4 What is your frequency for review/update of this measure? See Ad.9.

Ad.5 When is the next scheduled review/update for this measure? 08, 2013

Ad.6 Copyright statement: The Measures are not clinical guidelines, do not establish a standard of medical care, and have not been tested for all potential applications.

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Ad.7 Disclaimers: N/A

Ad.8 Additional Information/Comments: Coding/Specifications updates occur annually. The PCPI has a formal measurement review process that stipulates regular (usually on a three-year cycle, when feasible) review of the measures. The process can also be activated if there is a major change in scientific evidence, results from testing or other issues are noted that materially affect the integrity of the measure.