AMERICAN GASTROENTEROLOGICAL ASSOCIATION

COLORECTAL CANCER SCREENING AND SURVEILLANCE REGISTRY

IN COLLABORATION WITH CECITY

Non-PQRS Narrative Measure Specifications

Table of Contents

AGA DHRP CRC Measure #1: Colonoscopy Assessment (Procedure adequacy) - Assessment of Bowel Preparation 3

AGA DHRP CRC Measure #2: Colonoscopy Assessment (Cecum reached) – Cecal Intubation / Depth of Intubation........ 5

AGA DHRP CRC Measure #3: Hospital Visit Rate after Outpatient Colonoscopy........ 6

AGA DHRP CRC Measure #4: Performance of Upper Endoscopic Examination with Colonoscopy 7

AGA DHRP CRC Measure #5: Unnecessary Screening Colonoscopy in Older Adults 9

AGA DHRP CRC Measure #8: Colonoscopy Assessment (Procedure adequacy) - Assessment of Bowel Preparation

DESCRIPTION

The rate of procedures where examination is determined by the endoscopist as complete for patients aged 50-75. It takes into consideration whether or not the colon preparation was sufficient to allow exam of the entire colon, any anatomic factors that may minimize visualization of the colonic mucosa, and if any cancer of pre-cancerous areas were treated and/or identified for subsequent intervention.

NQS DOMAIN

Patient Safety

DENOMINATOR

Colonoscopy examinations performed on patients aged 50-75 for screening, surveillance and diagnostic purposes reported with CPT / HCPCS codes 45378, 45380, 45381, 45383, 45384, 45385, G0105, and G0121

Denominator Exclusions/Exceptions: CPT Modifiers 52, 53, 73, or 74.

NUMERATOR

Number of patients included in the denominator for whom bowel preparation adequacy for the right, transverse, and left colon is reported on the Boston Bowel Preparation Scale with a score of 2-3 in each segment or if a segment has been surgically removed.

RATIONALE

Poor bowel preparation is a major impediment to the effectiveness of colonoscopy because it affects the ability to detect polyps, can result in missed lesions, cancelled procedures, increased procedural time, and a potential increase in complication rates; ultimately influencing the timing of repeat examinations. Given the premalignant potential of advanced adenomas, suboptimal bowel preparation may cause an unacceptably high failure rate at identifying these important lesions, thereby compromising the effectiveness of the colonoscopy. Adenoma miss rates in the context of suboptimal bowel preparation are as high as 42%. AHRQ cost analysis suggests that inadequate bowel preparation could prolong the procedure time and increase the chance for an aborted examination and repeat colonoscopy earlier than suggested or required by current practice standards.

MEASURE TYPE

Process

MEASURE STEWARD

American Gastroenterology Association

AGA DHRP CRC Measure #2: Colonoscopy Assessment (Cecum reached) – Cecal Intubation / Depth of Intubation

DESCRIPTION

The rate of colonoscopy procedures in which the cecum or large bowel-small bowel anastomosis is reached in patients aged 50-75. (Note that the cecum should be entered in order to identify the appendiceal orifice and the area beyond the ileocecal valve. The cecum or large bowel-small bowel anastomosis is not visualizable from the right/ascending colon.)

NQS DOMAIN

Effective Clinical Care

DENOMINATOR

Colonoscopy examinations performed on patients aged 50-75 for screening, surveillance and diagnostic purposes under CPT/HCPCS codes 45378, 45380, 45381, 45383, 45384, 45385, G0105, and G0121.

Denominator Exclusions/Exceptions: CPT Modifiers 52, 53, 73, or 74.

NUMERATOR

Number of patients included in the denominator in which the physician has completed the colonoscopy and the cecum or large-bowel – small-bowel anastomosis has been reached.

RATIONALE

Studies have shown that physicians do not routinely document the depth of the insertion in the colonoscopy report. Quality evaluation of the colon consists of intubation of the entire colon, from the rectum to the cecum. Knowing the depth of insertion can inform physicians of whether a radiographic procedure, capsule examination or repeat colonoscopy is necessary if the procedure is incomplete.

MEASURE TYPE

Process

MEASURE STEWARD

American Gastroenterology Association

AGA DHRP CRC Measure #3: Hospital Visit Rate after Outpatient Colonoscopy

DESCRIPTION

Rate of all-cause, unplanned hospital visits within 7 days of an outpatient colonoscopy procedure for patients aged 50-75.

NQS DOMAIN

Patient Safety

DENOMINATOR

Colonoscopy examinations performed on patients aged 50-75 for screening, surveillance and diagnostic purposes at hospital outpatient facilities, ambulatory surgical centers (ASCs), or office settings under CPT/HCPCS codes 45378, 45380, 45381, 45383, 45384, 45385, G0105, and G0121.

NUMERATOR

The number of patients included in the denominator for which there is an all-cause, unplanned hospital visit within 7 days of an outpatient colonoscopy. A hospital visit is defined as an emergency department (ED) visit, observation stay, or unplanned inpatient admission.

RATIONALE

The planned admission algorithm is adapted from the Centers for Medicare & Medicaid Services (CMS) Planned Readmission Algorithm v2.1. The algorithm is a set of criteria for classifying admissions within 7 days of a colonoscopy procedure as planned or unplanned. CMS seeks to count only unplanned admissions in the measure outcome, because variation in planned admissions does not reflect quality differences.

MEASURE TYPE

Outcome

MEASURE STEWARD

American Gastroenterology Association

AGA DHRP CRC Measure #4: Performance of Upper Endoscopic Examination with Colonoscopy

DESCRIPTION

Patients may receive an esophagogastroduodenoscopy (EGD) in association of a colonoscopy for evaluation of occult gastrointestinal bleeding in an otherwise asymptomatic patient. There are clinically relevant reasons for performing both procedures within the same clinical encounter. This measure addresses whether or not and under what clinical circumstances patients aged 50-75 undergoing screening or diagnostic colonoscopy for evaluation of a positive stool or blood test receive an esophagogastroduodenoscopy (EGD) within the same clinical encounter.

NQS DOMAIN+

Efficiency and Cost Reduction

DENOMINATOR

Colonoscopy examinations performed (under CPT/HCPCS codes 45378, 45380, 45381, 45383, 45384, 45385, G0105, and G0121) for evaluation of occult gastrointestinal bleeding in otherwise asymptomatic patients aged 50-75 undergoing the colonoscopy for screening or diagnostic purposes where the colonoscopy is non-diagnostic and an EGD was recommended.

NUMERATOR

The number of patients included in the denominator in which an EGD was performed within the same clinical encounter as the colonoscopy.

RATIONALE

The primary indication for this measure is evaluation for occult gastrointestinal bleeding in otherwise asymptomatic patients undergoing colorectal cancer screening who are found to have a positive finding on stool FOBT, FIT, DNA, or blood septin-9 testing. If the diagnostic colonoscopy is non-diagnostic, it may be appropriate to perform the EGD for further evaluation. In that instance, colonoscopy performed within the same clinical encounter is actually the most cost-efficient option for the patient and the purchaser, as the multiple procedure payment rules impact the payment of

the second procedure if it is not performed within the same clinical encounter. Patients are also only administered one dose of anesthesia rather than two.

MEASURE TYPE

Process

MEASURE STEWARD

American Gastroenterology Association

AGA DHRP CRC Measure #5: Unnecessary Screening Colonoscopy in Older Adults

DESCRIPTION

The percentage of patients aged 85 years and older who received an unnecessary screening colonoscopy.

NQS DOMAIN

Efficiency and Cost Reduction

DENOMINATOR

Colonoscopy examinations performed on patients aged 85 and older for screening purposes only reported with CPT / HCPCS codes 45378, 45380, 45381, 45383, 45384, 45385, and G0121.

NUMERATOR

The number of patients included in the denominator who did not have a history of colorectal cancer or a valid medical reason for the colonoscopy, including: iron deficiency anemia, lower gastrointestinal bleeding, Crohn's Disease (i.e., regional enteritis), familial adenomatous polyposis, Lynch syndrome (i.e., hereditary non-polyposis colorectal cancer), inflammatory bowel disease, ulcerative colitis, abnormal findings of gastrointestinal tract, or changes in bowel habits.

RATIONALE

"Colorectal cancer is the third most common malignancy and the second leading cause of cancer-related deaths in the United States. The lifetime risk of being diagnosed with cancer in the colon or rectum is about 5 percent. The percentage of new cases is higher in people from 65–84 years of age; the median age of diagnosis is 69 (NCI, 2013). The overall incidence by age for both men and women are as follows:

- 4 percent between 35 and 44 years
- 13.8 percent between 45 and 54 years
- 20.8 percent between 55 and 64 years
- 24 percent between 65 and 74 years
- 24.1 percent between 75 and 84 years
- 12 percent in 85 years and older

The incidence and mortality rates for colorectal cancer are about 35 percent–40 percent higher in men than in women; however, both rates have decreased significantly since 1975 (ACS 2013). The incidence rate declined from 60 cases to 45 cases per 100,000 people, and the mortality rate declined from 28 deaths to 17 deaths per 100,000 people (NCI, 2013).

Declines in incidence and mortality are due, in part, to the routine performance of preventive screening: improved screening is responsible for half of the observed reduction in both rates, while the remaining half derives from changes in the population prevalence of contributing risk factors (NCI, 2013).

The charge for a colonoscopy can range from $1,000–$3,000; Medicare reimbursement covers 75 percent– 80 percent of charges. Based on the 2011 U.S. Census, there are currently 8.1 million individuals 85 and older in the U.S. Given this count, regular performance of colonoscopies among this population could result in significant health care spending (not including downstream costs due to subsequent clinical complications) (Goodwin, 2011). The population of individuals 85 years and older is projected to double by 2050; hence, the financial burden related to potentially inappropriate performance of colorectal cancer screening can be expected to increase (Goodwin, 2011)."

MEASURE TYPE

Process

MEASURE STEWARD

American Gastroenterology Association