

# OQR and ASC Reporting/Surveillance of Endoscopy Measures: Understanding the Guidelines



**Quality Improvement  
Organizations**

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CENTERS FOR MEDICARE & MEDICAID SERVICES

**Great Plains**



Quality Innovation Network

# Introductions

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# Learning Objectives

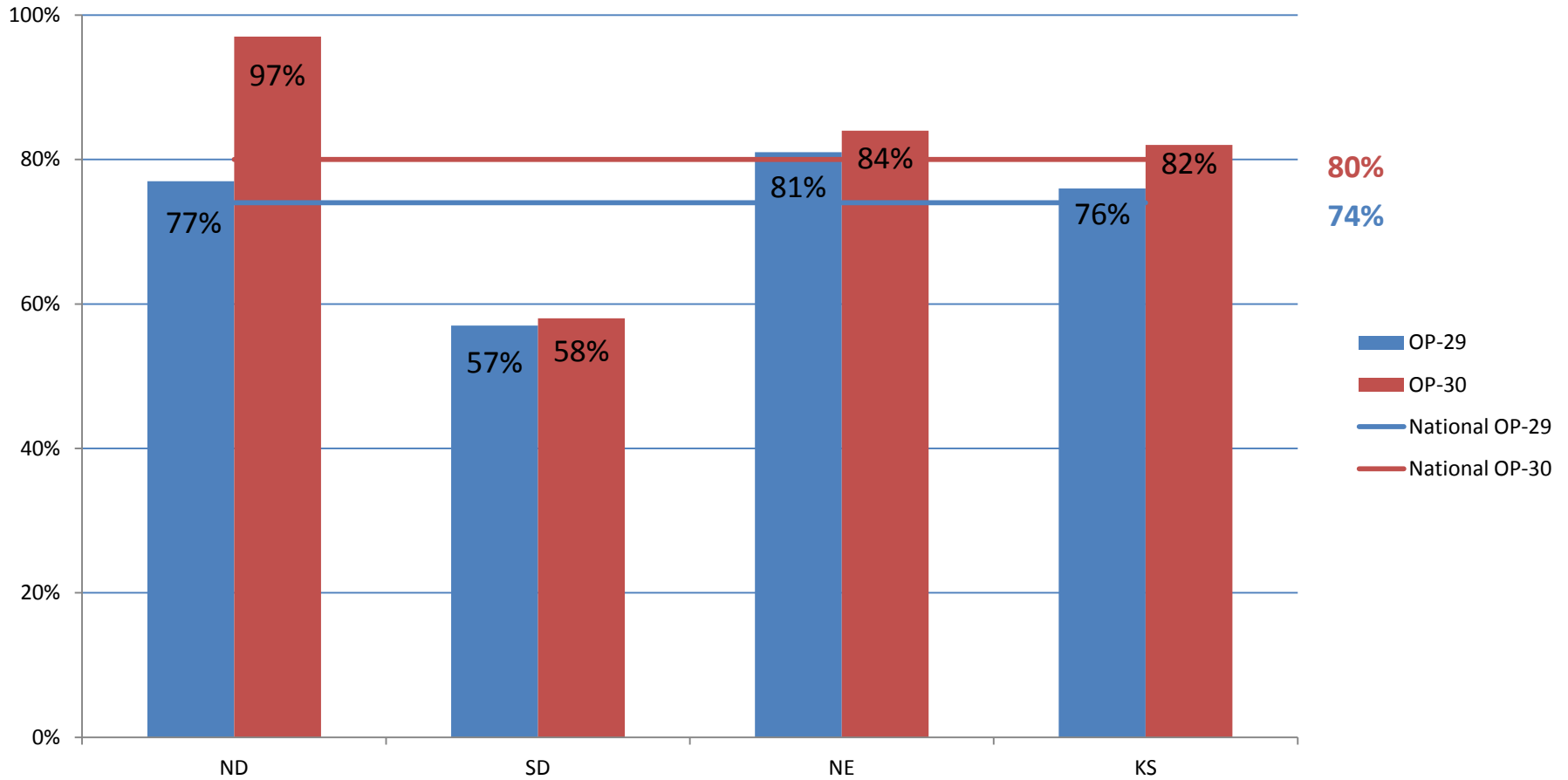
**Following this presentation, participants will be able to:**

- Discuss the role of quality colonoscopy in colon cancer prevention and adenomatous polyp detection
- Understand evidence-based quality indicators for screening colonoscopy
- Recognize and avoid overuse of screening and surveillance colonoscopy
- Identify responsibilities of endoscopy facilities and teams related to quality improvement in screening for colorectal cancer
- Understanding OP-29/ASC-9 and OP-30/ASC-10 measure specifications
- Report accurate and reliable endoscopy data to the CMS warehouse

# Purpose

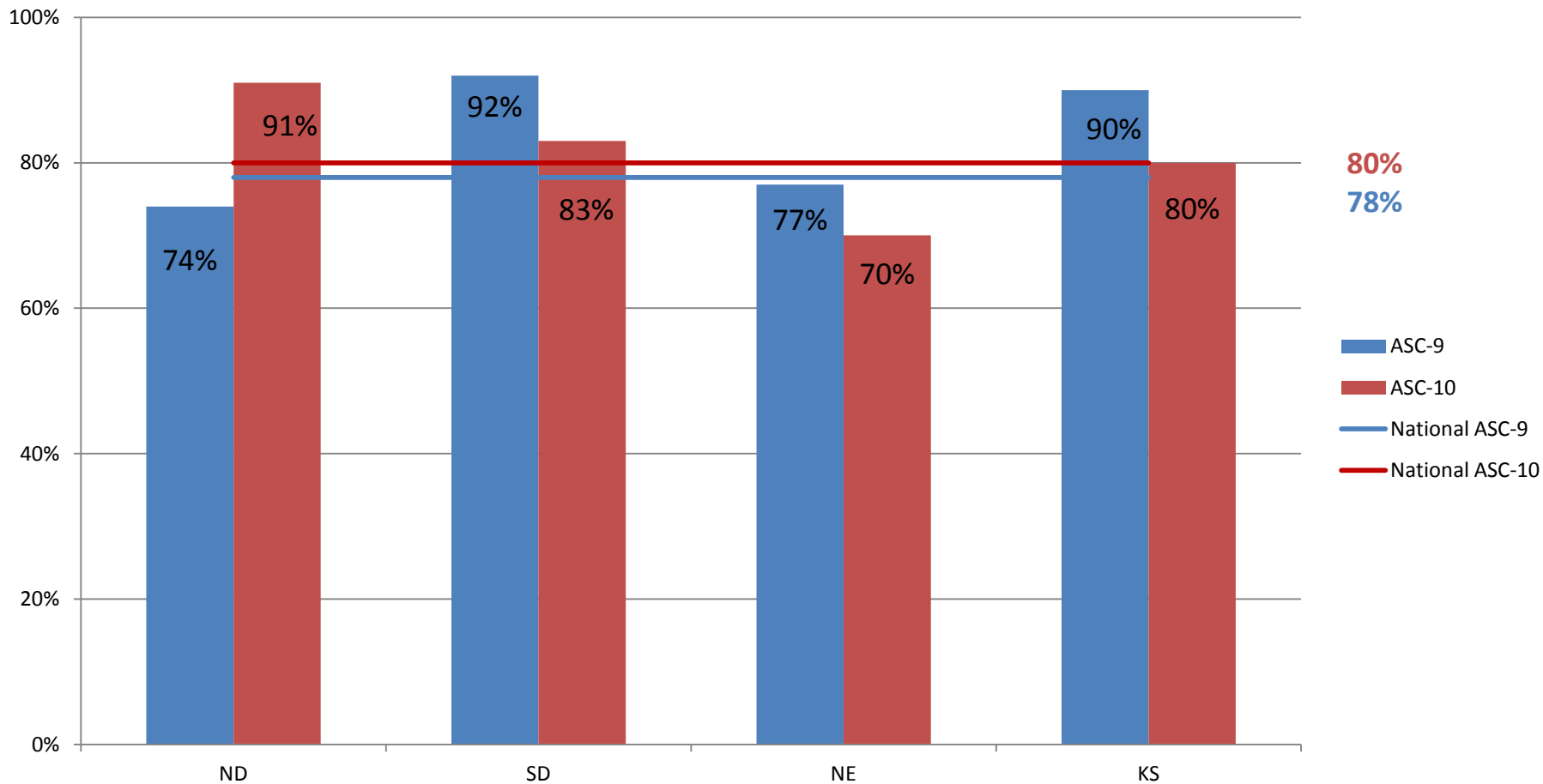
Endoscopy measures can be a challenge for hospitals and ambulatory surgery centers. Facility reported data suggests that locally, as well as nationally, there's significant room for performance improvement on OP-29/ASC-9 (*Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients*) and OP-30/ASC-10 (*Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use*).

# Hospital OP-29 & OP-30 Performance GPQIN



Hospital Compare September 09, 2016 for discharges 04/01/2014 – 12/31/2014

# ASC-9 & ASC-10 Performance GPQIN



Hospital Compare September 9, 2016 for discharges 01/01/2014 – 12/31/2014

# OP-29/ASC-9

## Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval

### OP-29/ASC-9: Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval...

- **Description:** Percentage of patients aged 50 to 75 years 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
- **Denominator:** All patients aged 50 -75 years receiving screening colonoscopy without biopsy or polypectomy
- **Numerator:** Patients who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report

### OP-29/ASC-9 Denominator Exclusions

- Documentation of medical reason(s) for not recommending at least a 10-year follow-up interval
  - Above average risk
  - Inadequate prep
  - Medical reasons at the discretion of the physician

# Reasons for Not Meeting OP-29/ASC-9

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- Incomplete documentation
- No documentation of at least 10 years for repeat colonoscopy in the colonoscopy report
- Range of years given instead of 10 years or more for follow-up colonoscopy



# Frequently Asked Questions

## OP-29/ASC-9

- **Q:** When a patient comes in for a scheduled screening colonoscopy but has a biopsy performed, would this patient be included in the denominator for this measure?
- **A:** No. If the patient has a biopsy performed, they should not be included because the patient would be expected to have a follow-up colonoscopy prior to 10 years from the date of the exam.
- **Q:** Does the follow-up interval have to be documented in the colonoscopy report?
- **A:** Yes. The physician must document the recommended follow-up time (e.g., 10 years) after the exam is performed in the colonoscopy report.

# OP-30/ASC-10

## Endoscopy/Polyp Surveillance: ...Avoidance of Inappropriate Use

### OP-30/ASC-10: Endoscopy/Polyp Surveillance: ...Avoidance of Inappropriate Use

- **Description:** Percentage of patients aged 18 years and older receiving a surveillance colonoscopy, with a history of a prior colonic polyp(s) in previous colonoscopy findings, who had a follow-up interval of three or more years since their last colonoscopy
- **Denominator:** All patients aged 18 years and older receiving a surveillance colonoscopy, with a history of a prior colonic polyp(s) in previous colonoscopy findings
- **Numerator:** Patients who had an interval of three or more years since their last colonoscopy

### OP-30/ASC-10 Denominator Exclusions

- Documentation of medical reason(s) for an interval of less than three years since the last colonoscopy
- Documentation of a system reason(s) for an interval of less than three years since the last colonoscopy

# Reasons for Not Meeting OP-30/ASC-10

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- No documentation to substantiate it has been at least three years since the last colonoscopy
- No documentation of a medical reason for an interval of less than three years
- **System reason is used** without the proper documentation

# Frequently Asked Questions

## OP-30/ASC-10

**Q:** If there is documentation in the medical record of a medical reason (e.g., patients with high-risk for colon cancer, last colonoscopy incomplete, piecemeal removal of adenomas, inadequate prep, etc.) for an interval of fewer than three years since the last colonoscopy, would this patient be included in the denominator for this population?

**A:** No, this patient would be excluded from the population. Patients who have a documented system reason (e.g., unable to locate previous colonoscopy report) for performing the test in fewer than three years would also be excluded from the population.

**Q:** If there is a medical or system reason documented for performing the colonoscopy in less than three years, would this patient be included in the population?

**A:** No, as long as there is a medical or system reason documented in the current encounter's medical record for performing the colonoscopy in less than three years, this patient would not be included in the population.

**Q:** If the patient's past history of colonoscopy with colon polyps is documented in the patient's history and physical but not in the colonoscopy report, would this patient be included in the population?

**A:** Yes, documentation of the previous colonoscopy with polyps can be anywhere in the current encounter's medical record and can be documented by any healthcare professional.

**Q:** Does the information regarding the patient's history and date of last colonoscopy performed need to be documented by the physician in the current encounter record?

**A:** The reason for performing the colonoscopy and the date of the last colonoscopy performed need to be documented in the current encounter's medical record. This information can be documented by any healthcare professional and does not need to be documented by the physician.

# Regional Best Practices

- Involve physicians
- Utilize standardized templates
- EMR/Clinical documentation
- Pre-procedure patient interviews
- Annual review of specifications updates
- Sharing best practices and defining screening vs. surveillance
- Collaborative efforts/multi-disciplinary team approach
- Review criteria w/ nursing unit

# Barriers

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- Data collection burden
  - Complexities of EHR information retrieval
- Finding dedicated time
- Documentation inconsistencies
- Poor patient historians

# Contact Information

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